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”IF ONLY I COULD”
~
“THERE IS ALWAYS A LOOPHOLE”

Hope and Hopelessness Experienced by

the Severely Depressive and Non-depressive Elderly

by

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"One cloud is enough to eclipse all the sun."
THOMAS FULLER.

To my father and Kallu

Virpi Pyykkö

"IF ONLY I COULD" ~ "THERE IS ALWAYS A LOOPHOLE"

Hope and hopelessness experienced by the severely depressive and non-depressive elderly

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ABSTRACT

The aim of this research was to structure a conceptual model of hope and hopelessness based on dictionary definitions, and to verify this model on the basis of the experiences of the severely depressive and non-depressive elderly. This research has produced a substantive theory of hope and hopelessness which is based on the experiences of the depressive and non-depressive elderly, and on the concept analysis of hope and hopelessness based on English dictionary definitions. The patients who participated in the research were 65 years old and older men and women (n=22) who had been admitted to a psychiatric hospital because of major depression, and another group: the non-depressive elderly (n=21), who were recruited from the pensioners' clubs. The data were collected in interviews using the Clinical Assessment Tool, developed by Farran, Salloway and Clark (1990) and Farran, Wilken and Popovich (1992), and it produced 553 pages of written text, which were analysed using the ATLAS/ti programme. ATLAS/ti is a tool for analysing qualitative data and is based on Grounded Theory. The medical and nursing records of the depressive elderly completed source triangulation. The concept analysis of hope and hopelessness was made on the basis of the definitions of English dictionaries (n=103), using semantic analysis and the ATLAS/ti programme.

The most important hope-promoting factors were human relations, health and managing in everyday living. Autonomy, self-determination and feeling of security were highly appreciated among the elderly. Hopelessness, on the other hand, was most often associated with the same factors: human relations, health and everyday living. Especially, losses of significant others were experienced as strongly hope-diminishing. Old age had brought freedom from duties concerning others, but now, when you finally had an opportunity to enjoy yourself, you could not accomplish anything; you were clasped in the arms of total inability, depression had come. The most obvious difference in the life course of the depressive and non-depressive elderly was the abundance of traumatic experiences in the childhood and youth of the depressive elderly. The continuous circulation of fearful thoughts was almost touchable, and suicidality was described in connection with these thoughts. You were afraid to be awake and also to go to sleep. Managing day by day was the goal.

The research produced the Basic Social Process (BSP) of hope: achieving - maintaining - losing, which expresses a continuous balancing between Being without and Being with. The importance of the object of hope was combined with the amount of hope and disappointment. The process of approaching defined the realisation of hope and the process of withdrawal that of losing. Joy and security versus grief and insecurity defined the Being with and Being without. Two core categories were found. The first one "If only I could" reflects lack of energy, lack of knowledge, lack of courage and lack of ability. The other one "There is always a loophole" reflects deliberate tracing of possibilities and the belief in finding solutions, and managing.

Keywords: Hope, hopelessness, depression, old person, Grounded Theory.

Virpi Pyykkö

”JOS VAIN PYSTYISIN” ~ ”AINA ON OLEMASSA TAKAPORTTI”

Toivo ja toivottomuus vakavasti depressiivisten ja ei-depressiivisten vanhusten kokemana

Hoitotieteen laitos, Turun yliopisto.
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TIIVISTELMÄ

Tämän tutkimuksen tavoitteena oli tuottaa käsitteelinen malli toivosta ja toivottomuudesta englanninkielisten sanakirjojen määrittelyihin perustuen ja varmistaa se vakavaa depressiota sairastavien ja ei-depressiivisten vanhusten toivon ja toivottomuuden kokemuksiin perustuen. Tutkimuksen tuloksena syntyi substantiivinen teoria toivosta ja toivottomuudesta, joka perustuu depressiivisten ja ei-depressiivisten vanhusten kokemuksiin ja englanninkielisten sanakirjojen pohjalta tehtyyn käsiteanalyysiin toivosta ja toivottomuudesta. Tutkimukseen osallistuneet potilaat olivat 65- ja yli 65-vuotiaita miehiä ja naisia (n=22), jotka olivat sairaalahoidossa vakavan masennuksen vuoksi. Toisen ryhmän muodostivat samanikäiset ei-depressiiviset vanhukset (n=21), jotka toimivat eläkeläisryhmissä. Tiedot koottiin haastattelemalla. Haastattelu perustui Clinical Assessment Tool - haastattelurunkoon, jonka ovat kehittäneet Farran, Salloway ja Clark (1990) ja Farran, Wilken ja Popovich (1992). Haastattelu tuotti 553 sivua tekstiä, joka analysoitiin käyttämällä ATLAS/ti- ohjelmistoa, joka on Grounded teoriaan perustuva kvalitatiivisen aineiston analyysiohjelma. Depressiivisten potilaiden sairauskertomuksia käytettiin täydentävänä lähteenä. Käsiteanalyysi toivosta ja toivottomuudesta perustui englanninkielisiin sanakirjoihin (n=103) ja ne analysoitiin ATLAS/ti-ohjelmalla.

Tärkeimmiksi toivoa edistäviksi tekijöiksi nousivat ihmissuhteet, terveys ja selviytyminen jokapäiväisessä elämässä. Vanhukset arvostivat autonomian, itsemääräämisoikeuden ja turvallisuudentunteen korkealle. Erityisesti läheisten menetys koettiin vahvasti toivoa vähentävänä tekijänä. Vanhuus merkitsi vapautta muihin liittyvistä velvollisuuksista, mutta nyt, kun vihdoinkin oli mahdollisuus nauttia, ei pystynytkään saamaan mitään aikaiseksi; täydellinen kyvyttömyys oli ottanut valtaansa, depressio oli alkanut. Selkein ero elämänkulun aikana tutkittavien ryhmien välillä oli depressiivisillä potilailla traumaattisten kokemusten runsaus lapsuudessa ja nuoruudessa. Jatkuva pelottavien ajatusten mielessä pyöriminen oli miltei käsin kosketeltavaa ja niihin liittyi myös itsemurhariski. Sekä valveillaolo että nukkumaanmeno pelottivat. Tavoitteena oli selviytyä päivä kerrallaan.

Tutkimus tuotti toivon perusprosessin (BSP - basic social process): saavuttaminen – ylläpitäminen – menettäminen, joka on jatkuvaa tasapainoilua osallisuuden ja osattomuuden välillä. Toivon kohteen tärkeys liittyi toivon ja pettymysten määrään. Prosesseina lähestyminen kuvaa toivon toteutumisen konkretisoitumista ja vetäytyminen toivon menettämistä. Ilo ja turvallisuus ja toisaalta suru ja turvattomuus kuvaavat osallisuuden ja osattomuuden kokemusta. Kaksi ydinkategoriaa muodostui: 1) ”Jos vain pystyisin” - kuvaa energian, tiedon, rohkeuden ja kyvyn puutetta ja 2) ”Aina on olemassa takaportti” - kuvaa mahdollisuuksien määrätietoista jäljittämistä, uskoa selviytymiseen ja siihen, että ratkaisu on löydettävissä.

Avainsanat: Toivo, toivottomuus, depressio, vanhus, Grounded teoria

CONTENTS

LIST OF FIGURES

LIST OF TABLES

APPENDICES

1 INTRODUCTION

Hope in everyday language is mostly connected with youth and future orientation. The same connection is to be seen also in hope research; mainly young and adult populations have been studied. This is evident also in nursing research concerning the elderly and hope. Moreover, there are very few studies about how older adults maintain hope in spite of multiple losses or changes (Herth & Cutcliffe 2002). The depressive elderly, as a patient group, is often, in public discussion, considered as an example of hopelessness. These patients are handed around health care organisations often without a proper intensity of handling the situation. Maybe, this is because the 'voice of depression' is so silent in the community. Also doctors, nurses and significant others, who are intensively involved in the lives of these elderly people, seem to be without sufficient means to handle the situation from different perspectives. (Virtanen et al. 1990; Virtanen 1991.)

However, the statistics show that especially this group of patients should be taken into serious consideration by the decision-makers, as users of health care services, and also because of the high risk of suicidality. The American Psychiatric Association reported in spring 2002, that care-resistant depressive patients are very expensive for the health care system, because they are heavy users of both psychiatric and somatic health care services. The care-resistant patients were divided into two groups: low-middle care resistance and high care resistance. The former group included those patients who had been treated with at least three different antidepressants, and the latter group included those patients who had been treated with at least two antidepressants and who had been in hospital treatment because of their depression. The average costs of care for the first group were, annually, 9191 USD, and for the latter group, with high resistance, 41 475 USD. The probability for need of hospital treatment is twice as high among the care-resistant group as among those of the control group and they had 15 % more visits to doctors. Patients who have care-resistant depression, use 2-3 times more other psychiatric medication, partly because these patients are often diagnosed as having anxiety disorders and alcohol and drug abuse problems. (http://www.apimall.com/masovkalpot.html). In a consensus statement conference on depression in Finland 1994, the total costs caused by depression were estimated as 5 billion FIM, corresponding to over 1 % of the GNP. One third of the costs were directly connected with treatment and care, and the rest were indirect, connected with the loss of productivity. (Lavikainen et al. 2000.)

Not only the economic factors, but also the human suffering involved in hopelessness and depression, should be taken into consideration. Especially, experience of meaninglessness and suffering, which are brought up in studies concerning depression and hopelessness, seem to bring up challenges for care (see Eriksson 1993; Eriksson & Barbosa da Silva 1991). The suffering concerns not only the depressive patient her/himself, but also the other people closely related to him/her (Virtanen 1991.) Our knowledge about the factors behind depression are still insufficient, but the consensus at the moment is that biological, psychological and social factors form the frame of reference, within which the background elements of severe depression are found. Severe depression is a threat to the self-determinance of human beings and it is associated with strong human suffering. This is also combined with the idea that the person has no hope for the future. (American Psychiatric Association 1993; Kuoppasalmi 1994).

The findings from hope research suggest that a sense of hopefulness can be nurtured even in very difficult circumstances (Herth & Cutcliffe 2002) and the nurses' role in helping to maintain hope is appreciated by the elderly. The Quality Recommendation for Mental Health Services of the Ministry of Social Affairs and Health in Finland includes the aspect of hope. It emphasises that in all mental health services, sustaining hope and trust in rehabilitation and getting through difficulties should be considered by professionals, and from the point of view of professional practices. (STM 2001.)

Hope research has been done in different areas of science. In nursing its meaning started to appear in the USA in the 1960's and since then the research on hope in nursing has spread to other countries. The research on hope in nursing has increased during the last few years also in Finland (Lindvall 1997; Juvakka 2000; Kylmä 2000). The dynamic nature of hope and hopelessness and their role in human life are inseparable. In depression, hopelessness is an important factor and included in the diagnostic criteria. The public health approach to mental health in Europe emphasises that mental health problems cause an increasing burden that contributes to high cost, long-term disability, increased mortality and enormous human suffering. Moreover, depression is becoming increasingly common. As an indivisible part of general health, mental health reflects, through its determinants, individual factors and experiences, social interaction, societal structures and resources, and cultural values. (Lavikainen et al. 2000.) The study of Arve et al. (1999) supports the findings of earlier studies suggesting that one should rely to a much greater extent on the subject's own views. Subjective health correlates fairly well with the results of clinical examinations.

This research is based on a concept analysis of hope and hopelessness defined in English dictionaries (n=103), and on the lived experiences of hope and hopelessness defined by the severely depressive (n=22) and non-depressive elderly (n=21). The need for this research has arisen from over twenty years' experience as a nurse and nursing supervisor in psychiatric care. The purpose of this research was to clarify the concept of hope and its relationship to hopelessness in the lives of the severely depressive and non-depressive elderly. The aim was to structure a conceptual model of hope and hopelessness based on dictionary definitions, and to verify this model on the basis of the experiences of the severely depressive and non-depressive elderly. One of the central aspects was to reveal the meaning of these concepts experienced by the elderly in question, and possibly to utilise these findings later in nursing practice. The research was mainly qualitative, but some quantitative methods were also used. In the care of the depressive elderly, the question: what forms the patients will to get well, is challenging. Is there some other explanation than medication? What is at the core of nursing interventions, and what indicates the change? These questions led the researcher to the concept of hope; hopelessness was obviously present.

2 REVIEW OF THE LITERATURE

2.1 THE GROUNDS OF HOPE AND HOPELESSNESS

The literature review is based on the central subjects concerning the research questions. Because hope and hopelessness are abstract concepts and their use varies, the definitions need more defining, although a lot of work in this sector has already been done. The most central earlier researches on hope and hopelessness have been presented in the series of six articles exploring the nature of hope (Herth & Cutcliffe 2002). Kylmä (2000) has also made a thorough analysis of the hope literature. The subjects examined in this literature review, are meaning and meaninglessness, emotions, time, will, desire, hope and hopelessness, despair and depression. Based on the former research on hope in nursing, philosophy, psychology and psychiatry, these subjects seem to arise, although mostly in different studies. Each of the subjects forms such an enormous area of research that they can only be briefly presented in this research.

According to Audi (1996) the oldest theories of *meaning* in modern philosophy are the seventeenth - to - nineteenth - century idea theory and the image theory of meaning, according to which the meaning of words in public language derives from the ideas or mental images that the words are used to express. As for what constitutes the representational properties of ideas, Descartes held it to be a basic property of the mind, inexplicable, while for Locke, it was a matter of resemblance (in some sense) between ideas and things. Contemporary analytic philosophy speaks more of propositional attitudes - thoughts, beliefs, intentions - than of ideas and images. In modern philosophy meaning is a core concept, which is used in different ways. Hetemäki (1999) points out that the concept may mean purely the meaning of linguistic expressions, or it may refer to the meaning of the whole existence. In this sense, it is emphasised that people do not only observe the world but also interpret it. Varto (1992) emphasises that meanings are always present when a human being is present. It is obvious that a linguistic meaning is only a special case of meaning and it takes for granted the existence of a wider meaning. The human world is the world of meanings. Through understanding we capture the meanings in our environment and observe our world by understanding these meanings. Also Hoffman (1993) brings up this aspect by saying that it should be noticed that whenever language is used, there is a speaker and his intent, and more often than not, the ultimate intent is hidden behind the literal meaning (i.e. 'between the lines') of what is said.

Meanings can be understood to be historical, bound in time and place, and also changing with time and place. They are also social and present in human interaction. Language is thus giving meaning to the world and making it meaningful. In theories of discourse, language is seen as a structure, which exists in a way before the human being, and in which human beings produce meanings, in which she/he can understand her/himself as a unique individual. (Lehtonen 1996.) Virtually all philosophers agree that propositional attitudes have some crucial connection with meaning. A fundamental element of a theory of meaning is where it locates the basis of meaning, in thought, in individual speech, or in social practices (Audi 1996). In recent philosophical writings, meaning can be used in two senses, the sense of an expression; its connotation being the reference of an expression and its denotation (Collins English dictionary 1994).

Yalom (1980) emphasises that living without meaning, goals, values or ideals seems to provoke considerable distress and, in a severe form, it may lead to the decision to end one's

life. Meaning and purpose have different connotations. Meaning refers to sense or coherence. It is a term for what is intended to be expressed by something. Purpose refers to intention, aim and function. It is connected to questions about its role or function: ”What does it do? To what end? In discussions of meaninglessness, there is a tendency for people to look for meaning from somewhere. Yalom (1980) brings up that the question is in conflict with the existential view of the human being as meaning-giving subject. There is no purpose ”out there” because each one of us constitutes our own ”out there”.

Combined with the care of the elderly this gives an interesting vision. During a long life span elderly people have been in many processes of creating meanings. Their generation in Finland has a special source of lived experiences, like experiences of the war time and life before and after it, which gives an extra richness to expressed meanings. This is also an interesting frame of reference in which to study hope and despair. Grayling (2001) points out that the Romans of classical antiquity valued old age, and honoured it with the principle of *seniores priores,* in which the respect due to experience gave it a front seat at the councils of state. And the Chinese took this to extreme; no one under seventy-five is regarded as yet fit for power - time induces perspective.

Yalom (1980) states that when one is unable to find a coherent pattern, one feels annoyed, dissatisfied, and also helpless. Frankl (2002) brings up the sense of entrapment which is also cited in connection with *meaninglessness.* The sense of mastery accompanies the belief that one has deciphered meaning (Frankl 2002). Antonovsky (1988) refres to meaningfulness as one component of the concept SOC: Sense-of-Coherence. The others are manageability and comprehensibility. He summarises SOC as a dispositional orientation. The fact of having grown up in a world of experiences shaped by the culture, social structure, and historical period in which one lives, as well as by the pattern of idiosyncratic events in one’s life, which push predominantly toward one or the other pole of consistency, load balance, and participation in socially valued decision making, determines one’s location on this dispositional orientation (Antonovsky 1988). As a summary of empirical research findings on meaning in life, Yalom (1980) states, on one hand, that a lack of sense of meaning in life is associated with the less the sense of meaning, the greater the severity of psychopathology. On the other hand, a positive sense of meaning in life is associated with deeply held religious beliefs, self-transcendent values, membership in groups, dedication to some cause, and adoption of clear life goals. According to Buchanan (1993) also the types of life meaning change over an individual’s life.

Emotion comes from Old English esmovoir to excite, from Latin emovere to disturb, from movere to move (Collins English Dictionary 1994). The etymology of emotion comes from the Latin *movere* meaning ‘to move’. To be emotional is to be literally moved, in a physical sense. The older expression for the term ‘psychological changes’ was ‘bodily motions’, which was later dropped from definitions, which centred on agitation in mind, feeling, excited mental state. Lyons (1980) defines four classical theories of emotions: 1) The Feeling Theory (see Descartes, Hume, James), 2) The Behaviourist Theory (see Watson, Skinner, Bard, Harlow & Stanger, Duffy), 3) The Psychoanalytic Theory (see Freud, Rapaport, Sartre) and 4) The Cognitive Theory (see Aristotle, Aquinas, Arnold, Spinoza, Shand, Shand-Dougall, Arnold, Wittgenstein, Kenny, Peters).

According to Oksenberg Rorty (1980), emotions do not form a natural class, but a heterogeneous group: various conditions and states have been included in the class for different reasons and on different grounds. They are also cross-culturally invariant, and variability has also been found even subculturally. MacLean (1980) presents six generally accepted types of behaviour that we identify with affective experience and emotional

expression: searching, aggressive, protective, dejected, gratulant and caressive and corresponding words of the associative affective states: desire, anger, fear, sorrow, joy, and affection. The affects differ, according to him, from other forms of psychological information by being either agreeable or disagreeable. There are no neutral affects, because, emotionally speaking, it is impossible to feel unemotionally.

The Cambridge Dictionary of Philosophy (1996) defines that emotion, as conceived by philosophers and psychologists, is any of several general types of mental states, which have been called "passions" by earlier philosophers, such as Descartes and Hume. Anger, fear and joy are examples of emotions. An emotion may also be a content-specific type. The various states typically classified as emotions are often linked together only by overlapping family resemblance rather than by a set of necessary and sufficient conditions. Thus, an adequate philosophical and psychological "theory of emotion" should probably be a family of theories. Even to label these states "emotions" wrongly suggests that they are all marked by emotion, in the older sense of mental agitation (a metaphorical extension of the original sense, agitated motion). A person who is, e.g. pleased or sad about something is not typically agitated. To speak of anger, fear, joy sadness etc., collectively as "the emotions" fosters the assumption that these are just qualitatively distinct feelings of mental agitation. This exaggerates the importance of agitation and neglects the characteristic differences, noted by Aristotle, Spinoza, and others, in types of situations that evoke the various emotions. One important feature of most emotions is captured by the old category of passions, in the sense of 'ways of being acted upon' like 'pleased, worried, upset'. Not only situations and facts, but also persons may "do" something to us, as in love and hate, while mere possibilities have effects on us, as in fear and hope. (Audi 1996.) Forward-looking and backward-looking emotions like fear and grief, as examples, have been distinguished in some writings, but according to today's opinions, these temporal characterisations are inaccurate and misleading. One may be fearful or hopeful that a certain event occurred in the past, in spite of the uncertainty about whether it occurred. And one may be embarrassed about what is going to occur, although one is certain that it will occur. (Lyons 1980; Audi 1996.) Aristotle (2000) believed that judgements or cognition were central to emotion. In general, a cognitive theory of emotions is one that makes some aspect of thought, usually a belief, central to the concept of emotions and, at least in some cognitive theories, essential to distinguishing the different emotions from each other. (Aristoteles 2000.)

Niiniluoto (2000) analysed the concept of *time* in the research forum of Finnish philosophers in 2000. The concept of time is found in all human languages: in ancient Greek, the words "khronos" (chronological, chronicle) and "hora", in Latin "tempus" (temporal), and in Germanic languages the ti-based words (English time, German zeit and Swedish tid). The Finnish term "aika" is supposed to have meant originally a year. The time concepts are essential elements in the philosophy of history, in which the nature of the temporal change has been under investigation: relations between past, present and future. The concept of possibility is needed in order to understand the ontological difference between past and future. (Niiniluoto 2000.) This is an interesting point concerning the concept of hope. Possibility is a central element in the future aspect of hope and, on the other hand, the future of the elderly is, as a time perspective, different than that of younger people because of the time left. According to Kamppinen (2000), the nature of the thing we expect is crucial to our feeling of time. This aspect also opens up interesting views in analysing the experienced hope and future elements of the elderly. Length is no more defined as length, but as a phenomenon depending on time. Jönsson (2001), who has studied the concept of time, divides it into two different types: personal, experiential time, and time which we follow by the clock, measurable time. In this research, the personal experiential time is important concerning the depressive elderly, for whom it is often hard to pass the days from morning

till evening. Also the lifetime, which is bound to measurable time, the amount of which is diminishing, raises perspectives which cannot go unnoticed. The future perspective and its connection with possibilities open up a vista, in which the lifetime is evaluated.

The concepts: *volition, desire, appetite and conatus,* which are widely studied by many philosophers, are important in understanding the "essence of hope". The terms expectation and desire have arisen in the analysis of dictionary definitions of hope. This led the researcher to further examine the concept of desire - what is the power or force that is activating people in the hoping process? Volition has been defined as a mental event involved in the initiation of action. 'To will' is in many contexts the corresponding verb form of 'volition'. The concept of volition is rooted in modern philosophy; it has been transformed by identifying volition with ordinary mental events, such as intentions, or beliefs and desires. Volition is often taken to be a complex mental event consisting of cognitive, affective, and conative elements, the latter being the impetus - the underlying motivation-for the action. (Audi 1996.)

Spinoza, who has been defined as a philosopher of joy by Pietarinen (1993), says (E3P9S) that in as far as conatus is related to the human mind alone, it is called 'will' (voluntas). In so far as it is related to the mind and body simultaneously, it is called 'appetite' (appetitus). According to Spinoza, appetite is the essence of man. Spinoza also takes account of the fact that human beings are sometimes unaware of their conatus, and to do so he makes use of the term 'desire' (cupiditas). Desire is the same as appetite, except that desire is ascribed to human beings in so far as they are conscious of their appetite. When Spinoza considers the conatus of human beings, 'desire' is the term that he uses most often. (see Pietarinen 1993; Parkinson 2000.) On the contrary, Marcel (1978), who has emphasised the spiritual aspects of hope, criticises the use of desire by saying that "most philosophers (mentioning Spinoza as an example) show a marked tendency to discredit Hope, reducing it to nothing more than what is called "wishful thinking", that is to say, a mode of thought essentially impure, because contaminated by desire". He adds, however, that "one could, of course, be tempted to remark that Spes signifies the act of hoping (espoir) rather than the virtue of Hope (Espérance)". Marcel brings up the relation to time, which shows the essential difference between desire and hope. Hope involves "waiting", which implies a confidence in the fact that a certain event will occur. By pointing out that desire seems to him to be essentially covetous (Marcel 1978), one feature of desire is described, but here seems to differences between Spinoza and Marcel. Pietarinen (1993) in his writings concerning Spinoza, points out that Spinoza uses conatus when he speaks of vitality of organims, which means a tendency to develop.

In depression, the lack of energy is often overwhelming and that is why, there is a need to examine more this aspect in nursing: how to support the underlying motivation for action; what arouses will and desire in spite of almost a total lack of energy. This is a great challenge for nursing personnel and more research is needed in this area.

2.2 PHILOSOPHICAL ASPECTS OF HOPE AND HOPELESSNESS

The philosophical basis of the concept of hope is built in this context on the writings of Niiniluoto and Räikkä (1997), Day (1969), Pietarinen (1993), Godfrey (1987), Oksenberg Rorty (1980) and Lyons (1980). According to Niiniluoto and Räikkä (1997), the traditional stoic model divides emotions into four main types: joy, grief, hope and fear. This was a quite commonly used typology in the early Middle Ages. Another classification is wider and it corresponds partly to the combination of theories of ancient philosophies defined by Thomas Aquinas, who tried to systematise psychophysiological emotions from the perspective of

natural philosophy so that in the attempts of a perceptive being there are three degrees of the attempts (appetitus sensitivus): a psychophysiological organism is moving towards the goal, is in the potential stage of movement, or has achieved the goal. The emotions are divided into two groups based on the cognitive evaluation, which precedes the change. A positive evaluation causes a potential goal-oriented movement in the mind. This can be called some kind of formation of directed energy. It is called affection (amor). Also a stronger effect might start, which appears as an actual action if nothing hinders it. This is called desire (desiderum). When the goal has been achieved, the affective state is joy. On the other hand, the affects connected with negative evaluation are dislike and aversion (odium, 'hate'), avoiding (fuga) and grief (tristia). (Niiniluoto & Räikkä 1997.)

Niiniluoto and Räikkä (1997) continue with the theory of Thomas Aquinas that the emotions of the passion soul (irascibilis) always presume the emotions of the desire soul (concupiscibilis). They are born from the evaluations concerning them. When a person notices that something is hindering the realisation of affection or desire, this may arouse evaluation and the affection connected with it, the content of which is that it is important and it will be realised sooner or later. This emotion is called hope (spes). But of the hindrances evaluated as being so great that realisation of the goal seems to be very uncertain, the emotion is despair instead of hope. Also when a person avoids something and it seems that the unwanted will come true, this might arouse courage (audacia) and may lead to resistance or, on the other hand, it may arouse a more powerful affect than the original avoiding: fear (timor). Anger (ira) is aggression, which is targeted at the cause of grief and suffering. Thomas Aquinas, like Aristotle, thought that emotions consist of a cognitive-evaluative side and an action paradigm which is typical of it, and that an actual emotion is turning a person's behaving in that direction. (Niiniluoto & Räikkä 1997.)

In his analysis of the classical theories of emotions (The feeling theory, The behaviourist theory, The psychoanalytic theory, The cognitive theory and The causal evaluative theory), Lyons (1980) speaks of the feeling theory of direct and indirect passions based on Hume's definitions. Direct passions; such as desire, aversion, grief, joy, hope, fear, despair and security result from the direct association of pleasure and pain, good or evil, with some aspect or quality of some object. For example, Joy is a direct impression of pleasure associated with something or other. Based on Hume's definitions of desire, aversion and will, Lyons states that if we realise that good and evil are, in other words, pain and pleasure and recall that the passions, both direct and indirect, are founded on pain and then passions, being sensations resulting from associating pain or pleasure with people, things or events, will naturally incline us to the sources of pleasure and to avoid the sources of pain. Lyons (1980) distinguishes three features of emotional reaction as such: the cognitive part (which will involve factual judgements which give rise to belief or knowledge), the evaluative part (which will involve objective evaluations or subjective appraisals), and the appetitive part (which will involve desires stemming from the cognitive and appetitive aspects). The emotions presuppose certain judgements, correct or incorrect, cursory or well-considered, irrational or rational, depending on what properties something possesses. (Lyons 1980.)

Day (1969) points out that according to Hume's doctrine, Hope and Fear are direct passions (i.e. direct emotions). The other direct passions are Desire and Aversion, Joy and Grief. Hume says that Hope and Fear are mixtures of Joy and Grief. When an event, E, is good and certain, a person, A, feels joy at the prospect of E. When, however, E, is bad and certain, A feels grief at the prospect of E. When E is good and probable, A hopes that E will occur. On the other hand, when E is bad and probable, A fears that E will occur. The predominance of Joy or Grief determines whether the Hope or Fear is present. According to Day (1969) virtually all philosophers (including Aristotle, Aquinas, and Descartes) share Hume's opinion

that Hope is emotion. Day disagrees with this opinion. His argumentation goes as follows: Hope involves (1) desiring and (2) estimating a probability. In other words "A hopes that P" is true if and only if "A wishes that P, and A thinks that P has some degree of probability, however small". Day argues that the estimation of probabilities is plainly not an emotion. He concludes: since a hope is identical with desire plus a probability estimate, and neither desires nor probability estimates are emotions, Hope is not an emotion either. He also concludes that the three chief tests of genuine emotion, viz., characteristic sensation, characteristic physical symptom, and characteristic behaviour pattern are satisfied in the case of Hope much less often than not and it therefore seems proper to withhold the name "emotion" from Hope (Day 1969).

According to Day (1969), hope has two important properties which genuine emotions also have: intentional object (A is afraid of X and angry with B, so he hopes for E) and motive for action (A Vs because A hopes that P). Day (1969) continues his argumentation as follows: hope includes Desire, and Desire is commonly, though mistakenly, thought to be an emotion. Even if Desire were an emotion, consideration would show at best that Hope involves emotion. The opposite of Hope is Fear. The opposite of any emotion is an emotion. Fear is an emotion, so Hope is an emotion. The argument is invalid according to Day, because the term "fear" has different meanings in the second and third premises. One must distinguish "A fears X" from "A fears that P". It is "A fears that P" which is contrary to "A hopes that P", but it is "A fears X" which ascribes an emotion to A. Day criticises the lack of this differentiation in Hume's work and adds that Hope has at least two important opposites, Fear and Despair. Day (1969) continues that according to Aristotle, the opposite of Fear the emotion is Confidence, or, in more modern terminology, the sense of security. It seems likely that Hume's thought that Hope is an emotion is based on his opinion that Hope is a mixture of Joy and Grief, so the argument goes: a mixture of contrary emotions is itself an emotion; Joy and Grief are contrary emotions; Hope is a mixture of Joy and Grief; therefore, Hope is an emotion. According to Day, Hume is right in pointing out that opposed emotions can mix, but he argues that mixed Joy and Grief are surely not Hope and Fear, as Hume alleges. From the linguistic standpoint, the degrees of Hope are expressed in two different ways. On the one hand, we say, "A has high hopes that P", or "A has only a faint hope that P" while on the other hand, we say "A hopes fervently that P" or "A hopes, but without much enthusiasm, that P". The "high-faint" scale relates to the estimative constituent of Hope, whereas the "fervent-tepid" scale relates to the desiderative constituent of Hope. There are degrees of both Probability and Desire. (Day 1969.)

Day (1969) continues pointing out that Aquinas defines Hope as one of the principal emotions like Fear, Joy and Grief. According to Aquinas, "hope is a movement of appetite aroused by the perception of what is agreeable, future, arduous, and possible of attainment." Hope involves both cognition and appetite, since A must perceive X before he can desire it. This sort of cognition is sometimes called "expectation", in the Latin sense of "watching out for". (see later analysis of dictionaries). There are two kinds of species of the possible, which is the object of Hope according to Aquinas: that which is done by Man and that which is done by God. The latter is connected with Hope as a Theological Virtue: Faith, Hope and Love. Aquinas defines two opposites to Hope: Fear and Despair. Fear and Hope are opposites because of their objects, which are, respectively, disagreeable and agreeable. Despair and Hope are opposites in the sense of approach and withdrawal. Despair is obvious in the situations when the object is desired but regarded as unattainable. Aquinas says that Hope is an aid to action, because the subject's awareness of the difficulty makes him concentrate his efforts on surmounting it, and because Hope causes Delight, which makes for more effective operation. (Day 1969.)

Day's argumentation (1969) is presented in the following because the structure he uses in his argumentation opens up the idea of the way the concepts and related concepts are formed and presented also in many dictionary definitions (hope as a noun, a verb, adverb etc.). Day (1969) refers to Aquinas that hope is not an emotion but a habit of the mind. According to Aquinas, Man has a higher and a lower appetite, the sensitive and the intellective. He names the intellective appetite the "Will" and this hope resides in the "Will". Day agrees that hoping necessarily involves wishing and willing; but it is not identical with it. Day emphasises that in making a philosophical analysis of "Hope", it is essential to realise that there are restrictions on the possible objects of hope. In the formula "A hopes that P", it is by no means the case that P can be substituted by any proposition whatever, although it is a common opinion that one can hope for anything. According to Day, one cannot, logically, want, and hope for, what one cannot have, and knows that one cannot have. The standard use of the word "hope" is the formula "A hopes that P", where A is the subject and some proposition P is an object of hope. However, there can be other constructions like "A hopes for E" (where E is an event-variable) and "A hopes to V (Where V is a deed variable). Hoping-to is a special case of hoping-for, since deeds are a species of events. There is another use of "hope" in which "hope" is followed by a "that" clause which must be distinguished from "A hopes that P", namely, "There is hope that P". Here there is not a subject of hope, and the word "hope" is a noun, not a verb. In this use, the main constituent of the meaning of "hope" is "probability". Possibly, the existence of this sense of "hope" explains the paradoxical-sounding locution "hoping against hope" (see later in dictionary definitions). To hope against hope is to hope against the odds or probabilities - which may be a reasonable thing to do. According to Day, there is an important difference between "A hopes that P" and "there is hope that P" in respect to objectivity. If A says "I have little hope that P", whereas B says "I have high hopes that P", they are not disagreeing with one another. But if A says, "there is little hope that P", and B says "there is high hope that P", they are disagreeing with one another. (Day 1969.)

According to Day (1969), hope has four important opposites: Fear, Resignation, Despair and Desperation. (1) "A hopes that P" means "A wishes that P and thinks that P is in some degree probable." (2) "A fears that P" means "A wishes that not-P but thinks that P is in some degree probable." (3) "A is resigned that P" means "A wishes that not-P but thinks that P is certain." Hence, Resignation is the upper limit of Fear. (4) "A despairs that P" means "A wishes that P but thinks that P is contracertain." (5) Likewise, "A is desperate concerning P" also means "A wishes that P but thinks that P is contracertain." Yet Desperation is not the same as Despair. The essential difference relates to action. If A, in a very tight corner, despairs of saving his life, he will do nothing to bring about his safety, but if he is desperate, he will do anything to bring about his safety. In the despairing man, the estimative element predominates over the desiderative element, whereas, in the desperate man, the predomination is vice versa. (Day 1969.)

Day (1969) presents that the standard formulas "A hopes that P" and "A believes that P" are alike. There are subjects and objects both in Hope and Belief. Beliefs and Hopes are both also dispositions; and there are degrees of belief, as well as of Hope. As there is both hoping-in and hoping-that, so there is also believing-that and believing-in (trust in). There are also more resemblance between Hope and Belief: Fear is contrary but not contradictory to Hope, so Disbelief is contrary but not contradictory to Belief. Also one species of hopes, the self-fulfilling ones, in which the object is an action of the subject, are such that the probability of the object tends to be increased by the very fact that the subject hopes for it. There is a resemblance with the "self-certifying" beliefs. Day criticises Hume's view that it is as false that Belief is a sensation as it is that Hope is an emotion. According to Day (1969) the chief genuine difference between Hope and Belief is: "A hopes that P" entails "A wishes that P," but "A believes that P" does not entail "A wishes that P". Consequently, there is no

desiderative test of Belief in the way that there is such a test of Hope. Since "A believes that P" does not entail "A wishes that P," it also does not entail "A is disposed to try to bring it about that P". But "A hopes to V" does entail this. So the action test for Hope does not apply to Belief. However, Belief is related to action even if it is not related to it in the way that Hope is. So one of the main differences is related to the desiderative element of Hope. Hope and Belief differ also in respect to their estimative tests, for one can say "A hopes that P although he thinks that P is improbable," but one cannot say "A believes that P although he thinks that P is improbable, but on the contrary, A thinks that P is more probable than not." In the relation between Hope and Belief, there is, according to Day (1969), an important aspect in that Belief forms part of the meaning of Hope. For a hope includes the probability-estimate and a probability-estimate is precisely a believed-probability. In other words, "A hopes that P" entails "A thinks (i.e. believes) that P has some degree of probability, however small." Thus, Day concludes: Hope can be defined in terms of the three concepts, Desire, Probability, and Belief. (Day 1969.)

Godfray (1987) defines a preliminary characterisation between ultimate hope and fundamental hope. Ultimate hope is one's highest and deepest hope. He states that we notice the comparative degree: some hopes are deeper, more heartfelt, more comprehensive and more important than others are, but the superlative degree is what is decisive for the core element. The language to describe ultimate hope is like: I hope for something with all my heart and more than anything else in the world. Ultimate hope has an aim, a target, and an objective. It is desire for or movement towards what is believed desirable and believed possible although difficult to obtain, but the difference from other hopes comes from its superordinative nature. An approach to superordination could be that hope is ultimate if its realisation is believed to fulfil all one's needs. The implications of ultimate hope are cognitional, conative, and affective, and they include beliefs, readiness or dispositions, and trust. (Godfray 1987.) Fundamental hope differs from ultimate hope in the sense that it is not aimed hope, with an objective or target. But it has an orientation, and this is towards the future. Fundamental hope is like an openness of spirit with respect to the future. Openness is not allied to denial of desires, but supports being in touch with them. It does not entail capitulation to desires, nor is its content to take will full of desire at the last and deepest impetus of the person. The implications of fundamental hope also have to do with trust. (Godfray 1987.)

As a summary of the thinking presented above, the following figure (Figure 1) was sketched as a mind map to clarify the different views presented above. The figure should be interpreted from left to right and also from bottom to top and vice versa because of the fluctuating nature of hope and hopelessness. The philosophical references emphasise (bring to a more concrete level) the need and motive for action by focusing on the will and desire which are impulses for action towards the goal which is considered worth striving for, and the achievement of which brings joy. This consideration needs cognitive judgement. Seeing possibilities helps in goal achievement and provides the energy needed to achieve the goal which is considered important. The nature of the goal might be abstract or concrete. The process is approaching one. On the other hand, when the realisation of the goal seems uncertain because of the obstacles, avoidance arises when the bad and the probable start to turn to the bad and the certain and this causes dislike, aversion and fear that the unwanted will come true. The process is withdrawal one, but might also turn to courage and resistance or anger and aggression towards the cause of grief and suffering. The process might vary from joy to grief and vice versa and should not be interpreted as a process of either approaching or withdrawal.

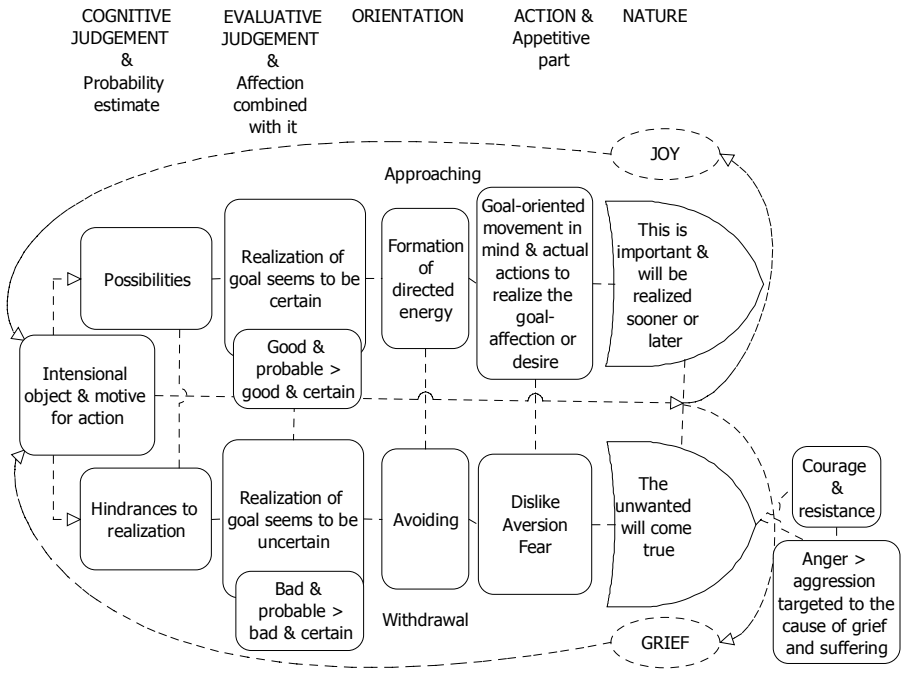

FIGURE 1. Philosophical aspects to hope and hopelessness

(see Day 1969; Lyons 1980; Oksenberg Rorty 1980; Godfrey 1987; Pietarinen 1993; Niiniluoto and Räikkä 1997)

It should be noticed that the figure above is simply a tool to promote thinking, it is not meant to be a developed model, because the researcher is well aware of her limitations in the philosophical field.

2.3 WELL-BEING AND ILL-BEING

Well-being and ill-being and, on the other hand, hope and hopelessness form a frame of reference within which the hope and hopelessness of the elderly has been studied in the following text. Without a wider understanding of the factors concerning the well-being and ill-being of the elderly, the care is insufficient. Public discussion often emphasises illnesses of the elderly, and the other aspects behind and around them are often left unnoticed. Anyway, there is an increasing tendency to widen the discussion and research within this area concerning the elderly. According to Marcel (1978), there can strictly speaking be no hope except when the temptation of despair exists. Hope is the act by which this temptation is actively or vigorously overcome. This is a usable starting point when well-being and *ill-being* are in question. *Well-being* is defined here as the condition of being contented, healthy, or successful (Collins English Dictionary, Third Edition 1994). The condition is seen as evolving from one moment to another. Ill-being is defined here according to The American Heritage® Dictionary of the English Language: Fourth Edition 2000: as lack of prosperity, happiness, or health, which also includes the possibility to develop into well-being. These definitions are used here without a deeper content analysis, which should be done for further use. The researcher wanted to bring up the concept of ill-being in this context as an opposite to the concept of well-being, because there is a lack of a suitable concept describing the wider sense of the opposite of well-being. Concerning the concept of hope, contentment and happiness offer a perspective, which is more suitable from the perspective of the elderly.

A commonly voiced desire in older persons is a comfortable and secure old age. There are certainly many differences in the perceptions of what constitutes comfortable and secure. Three important factors include adequate finances, positive health, and relationships (see ill-being as defined above) with family and friends. Also independence is a high priority of the elderly. Many are afraid of the long illness and dependence that precede the terminal event. (Hamilton 1990.) The quality of life of the elderly is greatly influenced by their previous life-style, culture, health care beliefs, education, family strengths, and integration into the community. A sense of well-being, a level of satisfaction with life, and a feeling of self-worth and self-esteem are related to the quality of life. A summary of several quality of life guidelines brings up the following factors which are important in experienced well-being: environment, activities, facility philosophy, privacy, choice and informed decision-making, interactions, personal/social/spiritual life, security, maintenance of the best possible physical condition with discomfort and pain minimised; movement of body; exercise; action; continued functioning at maximum potential, self-determination, personal control, involvement in group efforts and group decision-making, participation in civic affairs, kindness, cheerfulness, laughter from and with others, good listening, empathy, sympathy, and supportive, positive, constructive attitudes of individuals one lives with or who are always nearby, attractive, clean, comfortable surroundings, positive presentation of one's self in one's own life-style and positive relationship with staff, family and peers. (Harper 1990; see also Karen 1988; Holder & Frank 1988 and Wyckoff 1988.) Based on these results, well-being and ill-being are worth studying from different perspectives and among different cultures.

In a cross-cultural study of 252 elderly people from the USA, India and Congo, using a sentence-completing questionnaire on self-descriptions, the importance of health in old age emerged. For the American elderly, health was an important value; they expressed fears of becoming ill and dependent, hopes for maintenance of autonomy, health and cognitive functioning, and intentions to health behaviours. The Congolese elderly expressed fears of death, hopes for a good death, expectations of decline in mobility and strength, and of support from their children. The Indian elderly generally fell between the Congolese and American extremes, but culture-specific cognition about meditation and a peaceful death were also found. The results were examined in relation to chances in healthy ageing, specific illnesses, and medical systems, as well as care systems in each country. (Westerhof et al. 2001.)

Herth and Cutcliffe (2002) state that hope has been studied in several elderly populations, including as well as the grieving widow(er)s, the community-based elderly and the elderly living in long-term facilities, and also the elderly recruited from senior citizen centres. The results of the research concerning adults may be quite applicable concerning the elderly too, because many of the elderly have several severe diseases like cancer, for example, and the results may be useful when the scientific restrictions of generalizability of the results are taken into account. This means that the "general process" of hoping should be understood concerning the elderly in order to be able to compare the results and their applicability. Is the hope of the elderly then different to the hope of other age groups? This has not yet been discussed widely in nursing research. After a deep dive into nursing literature to find out the general features concerning hope, the results are multifarious: many age groups, many patient groups, many facilities, many diseases and different combinations of these. Also the results concerning the nature of hope are interesting. There are wider definitions and also lists of features, which are included in hope. The wider definitions are overlapping, depending on the frame of reference: 1) A multidimensional dynamic life force characterised by a confident yet uncertain expectation of achieving a future good which, to the hoping person, is realistically possible and personally significant (Dufault & Martocchio 1985) 2) A basic human response, which is at the core of every human life (Stotland 1969; Stephenson 1991)

3) A life-enhancing factor essential for the successful completion of life's tasks in the final stage of life (Westburg 2003) 4) A catalyst throughout the lifespan, which assists individuals to cope successfully with life's challenges and transitions in order to continue functioning during chronic illness and other significant losses (Farran et al. 1990; Hunt Raleigh 1992; Forbes 1999) 5) An essential experience of the human condition, which functions as a way of feeling, thinking, behaving, and relating to oneself and one's world. Hope has an ability to make its expectations fluid, and in the event that the desired object or outcome does not occur, hope can still be present. (Farran et al. 1995.) Farran (1990) has brought up the relevance of hope research for geriatric psychiatry. This was an interesting opening, which has produced some further research in this area (see Buchanan 1993.) The researcher did not find any nursing studies concerning hope and depression, in spite of the assistance of professional data miners. The hopelessness and depression combination seems to be usable to hint at different studies, maybe because of the diagnostic classifications, but hope and depression was an unknown combination in nursing research after the 1990s.

2.4 HOPE IN NURSING

Hope research in nursing has increased during recent decades from the end of the 1960s, especially during the 1980s and 1990s, and the interest seems to continue according to the publications around the 2000s. (see Wilman 1999; Begley & Blackwood 2000; Herth 2000; Juvakka 2000; Kylmä 2000; Cutcliffe & Grant 2001; Duggleby 2001; Touhy 2001; Herth & Cutcliffe 2002). Some studies examine central areas in hope research such as independence and locus of control (Wilken et al. 2002). Forbes (1999) has compared research methods in theory building of hope in older adults with chronic illness. Duggelby (2001) and Touhy (2001) have concentrated in hope and spirituality in late life. The trend that hope has been studied in elderly is increasing compared to former years. The former hope research from the 1980s and 1990s has been presented quite thoroughly in the research of Lindvall (1997), Juvakka (2000) and Kylmä (2000) in Finland, and by Farran et al. (1995) and Herth and Cutcliffe (2002), and so, these are not considered.

The interdisciplinary interest in hope and hopelessness has yielded an understanding about these constructs from three major perspectives, biological, theological/philosophical, and social-psychological, with contributions made by researchers in the disciplines of nursing, medicine, psychology, philosophy and the social-behavioural sciences (Farran et al.1995). In nursing, the majority of the hope research published in English has been made in the USA, but there are also published hope research in nursing like in Finland (Lindvall 1997; Juvakka 2000; Kylmä 2000) and Sweden (Jacobsson et al. 1993; Willman 1999).

Hope is a central phenomenon in nursing. From the point of view of the metaparadigm of nursing science - human being, environment, health and caring - hope can be seen connected to the whole thinking. These linkages have been confirmed in several nursing studies (see Dufault & Martocchio 1985; Nores 1992; Aavarainne et al. 1995; Lindvall 1997; Juvakka 2000; Kylmä 2000). In Finnish research, for example Lindvall (1997) and Iire (1999) have reported the central role of hope in health and recovery. Gerontologic nursing is one of the most challenging areas of nursing practice, in which hope cannot be underestimated (Farran et al. 1990; Farran et al. 1992). The need for continuing research in the area of hope in older adults with complex problems associated with ageing should be considered also in the development of hope scales. Longitudinal studies are needed to identify changes in functional status and hope in the elderly and also in people with long term illness in order to be able to determine the impact that these changes have on quality of life. (Iire 1999; Herth & Cutcliffe 2002.)

In Finland, hope of institutionalised elderly (Nores 1992) and of people with long term or severe illness (Lindvall 1997; Iire 1999; Kylmä 2000) has been studied and some common factors have been found in these studies. First, hope is combined with the experiences, which give the basic tone for human existence, like feelings of joy, happiness, calmness, peacefulness and longing (Nores 1992). Hope has also been defined as a basic resource, which implies recognising the constructive possibilities in one's life situation and believing in a life worth living at the present and in the future (Kylmä 2000). Juvakka (2000), who studied hope in the lives of adolescents, presented a sense of the possible, a will to live, the joy of living, future, continuity, integrity, and getting over difficulties. All these findings bring up the same elements which were defined in the philosophical analysis before (see figure 1). Nores (1992) points out that hope arouses wishes, dreams and positive expectations of the future including experiences of freedom and aesthetics. Also the meaning of human relations come up as an important factor in keeping up life worth living in these studies. Secondly, hope in care is combined with future prospects (Lindvall (1997), and hope is defined as a cornerstone in care (Iire 1999). In care, hope may mean a desire to continue the treatment, no pain, and a good or better feeling. Confidence in the treatment maintains hopeful feelings. (Lindvall 1997.) In the study of Iire (1999), knowledge and depression are emphasised to be the most important factors predicting the development and nature of uncertainty caused by illness. Also associations with fears were found in development and nature of uncertainty. These findings are in accordance concerning the nature of hope and hopelessness, especially the process of withdrawal (see figure 1).

2.5 HOPELESSNESS AND DESPAIR

Based on the NANDA (North American Nursing Diagnosis Association) definition, hopelessness is "a subjective state in which an individual sees limited or no alternatives or personal choices available and is unable to mobilise energy on own behalf" (Nanda 1994; Bartlett 1997). As specific nursing diagnoses, chronic low self-esteem, powerlessness, and hopelessness have been widely supported and linked with depressive illness in clinical practice and reflect Beck's cognitive theory of depression (1974), according to which depressive symptoms result from a negative view of self, world, and future. Despite the number of studies examining hopelessness as nursing diagnosis, the Clinical Diagnostic Validation model (CDV) has not been used earlier to validate this nursing diagnosis. CDV means the validation of the nursing diagnosis according to a procedure, presented by Fehring (1987), who has recommended the use of the CDV model when nursing diagnoses reflect affective or cognitive responses. Zausniewski made a study of a convenience sample of 63 acutely depressed adult inpatients using a modified CDV model to examine critical and supporting indicators for chronic low self-esteem, powerlessness and hopelessness. One item emerged as a critical indicator: current problems will always exist. Negative thoughts, feelings and expectations regarding the future met the criteria for supporting indicators for hopelessness. (Zauszniewski 1994). However, the results were limited by the deficits of the patient-focused clinical validation model and the lack of randomisation, as Zauszniewski points out. More investigation is needed to define the characteristics of hopelessness.

The sources of the literature review of hopelessness and despair have been used in several phases since the concept analysis started in 1995. The most used databases have been the PubMed, PsychLit and CINAHL databases, and the searches have been made on the basis of several search terms. In the end of 2002 the search in CINAHL was done with the terms: "(aged OR elder$ OR (old ADJ age).TI,DE. AND hope$.TI,DE AND (depression OR depressed OR despair).TI,DE (Info added since 1990, Results 28), of which 21 were relevant for this research.

Buchanan's study (1993) Meaning-in-life, depression and suicide in older adults: a comparative survey, consisted of 160 older adults, including equal numbers of men and women, who were depressed and not depressed. Data analysis included descriptive statistics, t-tests, correlation, analysis of variance, factor analysis, multiple regression and structural equation analysis. The findings supported the hypothesis (1) that higher levels of meaning in life (MIL) were associated with higher levels of spirituality, hope, health and social support, (2) the non-depressed sample had higher levels of MIL, spirituality, hope, health and social support, (3) there was an inverse relationship between MIL and depression and (4) higher levels of MIL and lower levels of depression predicted lower levels of suicidality. The findings did not support the hypothesis that females would have higher levels of MIL, spirituality, hope, health and social support than males. Structural equation analysis supported the hypothesis that spirituality, hope, health and social support moderate the relationship between MIL, depression and suicide behaviour.

In the study of Kylmä (2000) hopelessness was combined with helplessly giving up everything and living upon emptiness in the face of an assumed non-existent future, collapsing mentally and becoming paralysed without a reason to live. Juvakka (2000) defines hopelessness as a feeling of losing one's will to live, as well as losing one's chances. According to Kylmä (2000), despair means stopping and being stuck in one's situation, but there is glimmer of hope present, which means that the two are partly overlapping phenomena. There is a possibility to growth, but becoming locked up, having symptoms and committing suicide are other possibilities. The latter alternative is defined in dictionary definitions (see results), which bring up the difference between despair and hopelessness by pointing out that despair means a reckless readiness to take the first course that presents itself when every course seems hopeless. And desperation is energised despair, vigorous in action, reckless of consequences. (Fowler 1965.)

Hopelessness should not be considered a nursing diagnostic category label according to Bartlett (1997), who studied hopelessness and depression as to whether they are separate or connected phenomena (n=55, two groups: clients who were diagnosed with obstructive pulmonary disease (COPD) and clients with the primary diagnosis of depression) and found a positive correlation between hopelessness and depression (only 37 % of the time hopelessness and depression occur independently). When hopelessness is pathological and needs to be treated, it is a major symptom of depression.

Various cognitive methods can be used in the care of hopelessness. First, it is possible to convey to hopeless person that there are alternative interpretations of life and the future, which are less terrible than those brought up by the person himself. Secondly, the person has also other choices than the present behaviour, which leads to a dead end. The role of the person who is responsible for the care is to maintain and arouse hope, which may be done by building a bridge from one care meeting to another. Efforts should be made to bring up such positive proof concerning the patient's life, of which the patient is not aware himself. Also the qualifications of the negative proofs are worth thorough examination. Depressed and hopeless mood may make self-inspection difficult, while distortions in the thinking process belong to depression and hopelessness. (Toskala 1974; Achté 1993.) An important role of the thinking process aroused also in this research in the interviews of the depressive elderly.

2.6 DEPRESSION AS A DIAGNOSED DISEASE

According to Aalberg (1993), depression starts in the situation where a human being meets his/her own helplessness. The feeling of helplessness may be connected with many different situations like physical illness or symptoms, an imagined or real loss of an important object,

unbearable conditions or economic catastrophe, for example. Common to all these situations is that the individual loses his/her former feeling of well-being, which has meant security and continuity, and now there is helplessness, hopelessness and worthlessness instead. *The aetiology* of depression is multifactoral in nature and is still partly unknown, although it is one of the oldest known mental disorders. Depression causes immeasurable human suffering and emotional ill-being. According to estimates of the World Bank and WHO, depression is one of the leading causes of disability among the global burden of diseases, and its role will become even more important in the future. (Lavikainen et al. 2000.) *Epidemiological studies* have shown that depressions are the most common psychiatric disease in old age. In spite of its common nature, a significant part of depressions in old age remain latent, because they might be unnoticed. The symptoms are often mixed with somatic problems. (Pahkala 1994.) This is also a cultural aspect, because in many languages, especially Asian languages, there is no word for depression. In African and Asian countries people speak about different kind of somatic problems instead of depression. (Henriksson et al. 1994.) It has been shown in Finnish studies that 20 % of elderly men and 30 % of elderly women suffer from some kind of depression. The depression of the widowed is more common than that of others. Men who are treated in hospitals and other care facilities are more depressed than those living at home are. The prevalence of depression has connections with the status of health. (Sourander 1995.)

Approximately, 12-15 % of all people over 65 years suffers from depression. Depression is often an underdiagnosed and undermanaged illness in an elderly person. The incidence of severe depression declines with age, but the incidence of mild depression increases with age. The prevalence of severe depression is 2-3 % in men, and 3-5 % in women, over 64 years of age. The prevalence of mild depression is about 15-22 % in men, and 19-30 % in women, over 64 years of age. (Pitkälä 2000.) The estimations of the prevalence vary partly because of the difficulty in differentiating depression and grief, which is a normal process in losses which are quite common in the life of the elderly. Another reason for the variation is atypical symptoms. In many epidemiological studies, the prevalence of depression has decreased in the age group over 70 years compared to the group of middle-aged people. On the other hand, in Finnish studies, which have focused only on elderly people, the prevalence of depression has been exceptionally great. Pahkala et al. (1993) studied the prevalence of depression in the elderly (over 65 years) in the municipality of Ähtäri in Western Finland, and the results showed a prevalence of 14.4 % in men and 17.9 % in women. Also Stenbäck et al. (1979) found a depression prevalence of 24 % in the 1970's in the elderly (70 years old) living in the city of Helsinki. (Lehtinen & Kantola 2002). Of those who are treated in care facilities, the prevalence of depression is 30-40 %. The same percentage, 30-40 %, is associated with patients who have dementia. 40 % of stroke patients has depression and patients with Parkinson's disease have as high a prevalence of depression as $\leq$ 80 %. The symptoms of depression of old age can be divided into four groups: symptoms combined with emotions and will, cognitive symptoms, somatic symptoms and self-destructive behaviour. (Gottfries 1995.)

The *symptoms* in old age depression are diverse and partly overlapping with those of physical diseases: apathy, loneliness, fearfulness, dependence on other people, feeling of worthlessness, self-abuse, suicidal thoughts, difficulties in managing with daily activities, sadness especially in the mornings, depressive mood, lack of interest, irritability, weepiness, anxiety and pessimism. (Pitkälä 2000; Kivelä 2001.) Changes in appetite, losing and gaining weight and obscure pains are somatic symptoms, which should be evaluated in recognition of depression (Toivikko 2003). Concerning the psychological background, it has been found that many depressive elderly have traumatic experiences in childhood, adjustment problems, and depression also in adult life. If the self-esteem has diminished because of the traumatic

experiences and the possibilities of support from others have decreased, the readjustment to new situations fails and the alternative may be depression. (Kallioniemi 1993; Lavikainen et al. 2000; Kivelä 2001.) The depressive elderly often complain helplessness, fatigue, and the past life seems worthless, the present is dismal, and there is no hope of changes for the better in life. Wishes for death and suicidal thoughts may be emotional experiences, continuing on a daily basis. Neglecting nutrition and care may lead to collapse in physical health and a need for assistance and care. Lack of energy and motivation may lead to isolation. The symptoms are divided into four categories: emotional, somatic, cognitive and volitional. The integrated theory connected to the aetiology of depression consists of biological, psychological and social aspects. (Kivelä 2001.)

Major depressive disorder may begin at any age, although it usually begins in the mid- 20s and 30[s]. Symptoms usually develop over days to weeks. Some people have only a single episode, but more than 50 percent of those who initially suffer a single major depressive episode eventually develop another. (AHCPR guidelines for depression 1993.) Major depression is defined as a clinical syndrome that includes a persistent sad mood or loss of interest in activities that persists for at least 2 weeks in the absence of external precipitants. This should not be confused with a grief reaction (like the death of a loved one). Features may include change in eating habits, insomnia, early morning wakening, lack of interest, depressed mood, fatigue, and suicidal thoughts, feelings of worthlessness (guilt), impaired concentration, hopelessness regarding the future and recurrent thoughts of death or suicide and suicide attempts. (American Psychiatric Association 1987; Paykel & Priest 1992; Salokangas 1994; MEDhelp www 21.6.2001.) Core diagnostic criteria for major depressive disorder are: five or more of the following symptoms have been present during the same 2-week period, almost daily and represent a change from previous functioning. Either symptom 1 or 2 is present: 1) Depressed mood most of the day 2) Markedly diminished interest or loss of pleasure 3) Significant weight loss or increase (more than 5 %) or significant change in appetite 4) Insomnia or hypersomnia 5) Psychomotor agitation or retardation 6) Fatigue or loss of energy 7) Feelings of worthlessness or excessive guilt 8) Diminished ability to think or concentrate, or indecisiveness 9) Recurrent thoughts of death, recurrent suicidal ideation, suicidal plan or attempt. In addition to these criteria there are also excluding criteria concerning other diseases, medication and bereavement as an example.(Duodecim, EBM, 2002.)

Major depression is a common syndrome, the lifetime prevalence of which is about 15 % with the lifetime prevalence among women being as high as 25 % (YKT 01.09.1998). The point prevalence in severe depression is about 5 %. It is a little higher in women and lower in men. (Lehtonen 1994.) The recurrence of major depression is usual, and 10-20 % of the patients become long-term patients. Even 2/3 of the patients thinks about suicide, and 15 % commit suicide. The most important symptoms are depressed mood and loss of interest. Almost all the patients mention fatigue and lack of energy. About 80 % of the patients have problems with sleeping, and anxiety is present in 90 %. Even half of the patients usually deny the depressive mood or they do not look very depressive. (YKT 01.09.1998.)

Usually there is retardation of psychomotorics but on the other hand there might also be agitation. More than 50 % of the patients have cognitive impairment and difficulties with concentration and memory. Many depressive patients speak slowly and give delayed and short responses to questions. Patients may have perceptual and sometimes psychotic or catatonic symptoms. (Duodecim, EBM, 2002.) Central elements of the care of major depression depend on a co-operative effort by the patient and care personnel in helping the patient to clarify his or her life situation. It is important to support patients' self-esteem and help to change the distorted depressive thinking. If the patient has losses and is grieving,

she/he should be given help with the bereavement process, so that it does not become chronic. Providing information about depression and its treatment cannot be overestimated. Patients and their significant others need information about depression, recovery and risks of recurrence, treatment options, medication and other matters related to depression. Because of the cognitive level of many patients, this is a great challenge. (US Department of Health and Human Services, Public Health Service, Agency for Health Care Policy and Research 1993; Duodecim, EBM, 2002.)

In their study concerning the efficacy of psychosocial treatments in primary care, Brown and Schulberg (1995) point out that hospital care is considered an alternative in situations where the patient is unable to take care of her/himself, has lost the sense of reality or is self-destructive, or cannot co-operate. The generally used psychotherapeutic methods of care in depression are psychodynamic psychotherapy, cognitive psychotherapy, group therapy and family therapy. The results of the psychodynamic and cognitive short therapy in the care of depression have been found to be successful. (Brown & Schulberg 1995.)

2.7 SUICIDAL BEHAVIOUR

There is a paucity of research on the elderly concerning the presence of dissatisfaction with life or thoughts of death or suicide compared to other population. Elderly population reporting suicidal thoughts and feelings present markedly higher levels of physical and psychological suffering, characterised by manifestations such as hostility, anxiety, and depression. (Scocco et al. 2001). More than half of those who commit suicide have consulted their physician within the previous few months and at least 20% have been under psychiatric care during the preceding year. Because depression is often involved in suicide, the recognition and treatment of depression are the most important contributions a physician can make to suicide prevention. In persons threatening imminent suicide (e.g. a patient who calls and declares that he is going to take a lethal dose of a drug or a person who threatens to jump from a height), the desire to die is ambivalent and often transient. The physician or other person to whom the person appeals for help must support the desire to live. The person threatening suicide is in an immediate crisis, and he should be offered hope of its resolution. Emergency psychological aid includes establishing a relationship and open communication with the person; reminding him of his identity (i.e. using his name repeatedly); helping him sort out the problem that has caused the crisis; offering constructive help with the problem; encouraging him to take positive action; and reminding him that his family and friends care for him and want to help. (Duodecim, 2001.)

Depression is involved in over half of all attempted suicides. Depression may be precipitated by social factors, such as marital discord, broken and unhappy love affairs, disputes with parents (among the young), and recent bereavements (particularly among the elderly). Depression associated with a physical disorder may lead to a suicide attempt, but physical disability, particularly if chronic or painful, is more commonly associated with completed suicide. A physical disorder, especially if serious, chronic, and painful, plays an important role in about 20 % of suicides among the elderly. (Duodecim, 2001.) Askew Browning (1990) illustrates depression aptly as a challenge for nursing: " It is pervasive in nature and extinguishes the spark of life. It is often unrecognised in older adults and has the potential to destroy the quality of life and sometimes life itself. It eliminates joy, laughter, empathy, happiness, and love and finally it slams the gates to the outside world, leaving its victim alone and isolated." Certain nursing diagnoses have been associated with depression: anxiety, fear, dysfunctional grieving, ineffective individual coping, alteration in thought processes, high risk for violence, non-compliance, self-care deficit, sleep pattern disturbance, social isolation, impaired social interaction, and altered nutrition. (Zauszniewski, 1994.)

Suicidal behaviour includes suicide gestures, attempted suicide, and completed suicide. Statistics on suicidal behaviour are based mainly on death certificates and inquest reports, and they underestimate the true incidence. Even so, suicide is one of the top 10 causes of death among adults in urban communities. In Europe, the urban rate is higher than the rural; in the USA, they are about the same. In the USA, about 75 persons commit suicide every day. Suicide accounts for 10 % of deaths among those aged 25 to 34 years and for 30 % of deaths among university students. It is the second leading cause of death among adolescents. The steady rise in adolescent suicides during the last decade is due mainly to an increase in male suicides, which have more than doubled. More than 70 % of persons who complete suicide are > 40 years old, and the incidence rises sharply among those > 60 years old, particularly men. About 65 % of those who attempt suicide are < 40 years old. Of about 200 000 suicide attempts in the USA each year, 10 % are completed. Attempted suicides account for about 20 % of emergency medical admissions, and for 10 % of all medical admissions. Women attempt suicide 2 to 3 times more often than men, but men are generally more apt to die in their attempts. Several studies have found a higher incidence of suicide among family members of patients who have attempted suicide. Married persons of either sex, particularly in a secure relationship, have a significantly lower suicide rate than single persons. Attempted and completed suicide rates are higher among those who live alone because of separation, divorce, or spouse's death. The incidence of attempted suicide is disproportionately high among single adolescent girls, and is also high among single men in their 30s. (Duodecim 2001.)

Beck et al. (1985) emphasised that hopelessness has emerged as an important psychological construct for understanding suicide and hopelessness is a core characteristic of depression and serves as the link between depression and suicide. Bedrosian and Beck (1979) pointed out that it is important to enable a depressive patient to realise that there are other interpretations which are more bening than his/her current view of reality, that there still exist some compelling reasons to live and there are behavioral alternatives which he or she truly has not yet explored.

There are several studies in which the relationships between depression, hopelessness, parasuicides, suicidal ideation, and positive and negative future experiences have been examined. A central finding in most of the studies was that depression and parasuicides showed reduced anticipation of positive experiences, but no increased anticipation of negative experiences. However, MacLeod and Byrne (1996) found that mixed participants (anxious-depressed) showed both greater anticipation of negative experiences and reduced anticipation of positive experiences. Other results varied depending on the sample (depressed, mixed depression-anxiety, hospital patients, community-based sample) and tools used in the analysis. MacLeod et al. (1997) found out that lack of positive anticipation in the absence of increased negative anticipation is an independent feature of parasuicide, although lack of positive anticipation can occur in depression. The results of the study of MacLeod et al. (1998) confirmed that parasuicide patients exhibit a relative deficit in positive future thinking, and suggested that it could be remedied, at least partly, by a brief intervention. Byrne and MacLeod (1997) have suggested that future research should consider the relationships between measures and expectations of future positive and negative events.

In the study of Beck et al. (1993), the Beck Depression Inventory (BDI), the Hopelesness Scale (BHS), and the Scale for Suicide Ideation (SSI) were administered to 1306 (72.8 %) patients with at least one DSM-III-R mood disorder and 488 (27.3 %) patients without any mood disorders. A multiple regression analysis was conducted, and hopelessness was found to be 1.3 times more important than depression for explaining suicidal ideation. Mendonca and Holden (1996) found out in the study concerning 97 adults (51 men, 46 women) with

suicidal thoughts that the primary predictor of suicidal intent was the patient's cognitive distortion, not hopelessness. On the other hand, the concurrence of such unusual thinking with feelings of hopelessness rather than depression is also particularly strongly associated with preoccupation with the method of self-harm (Mendonca & Holden 1998).

A Finnish study on suicides, which was conducted 1987-1988, showed that of 1397 suicides, 211 (> 15 %) were committed by people over 65 years. The methods used by the elderly were more often violent compared to those used by others. About 70 % of them had been in contact with health care during the last month before death and about 50 % within the last week, but the risk of suicide had rarely been discussed. The elderly had received psychiatric care more seldom that the younger group, and only 8 % had received appropriate medication for their depression. The suicidal intentions and thoughts should be actively asked about because the elderly do not often bring up their thoughts and intentions in conversation. Especially the role of primary care is important in prevention. (Pitkälä et al. 1999.) The development of geropsychiatric care and medication for depression has changed the situation during the years since the study, but there is still a lot to do in the prevention of depression and suicides among the elderly.

Hintikka et al. (1998) studied patients with suicidal ideation (n=84) with a randomly selected group of nonsuicidal patients (n=166) in community-based psychiatric services. Their findings indicate that suicidal ideation is common among psychiatric patients, and it is associated with depression and hopelessness. However, it may also be associated with therapy dissatisfaction, which may also have effects on prevention of suicidality in psychiatric patients.

Psychological mechanisms leading to suicidal behaviour resemble those frequently implicated in other forms of self-destructive behaviour. Suicide is often the final act in a course of self-destructive behaviour. Traumatic childhood experiences, particularly the distresses of a broken home or parental deprivation, are significantly more common among persons with a tendency to self-destructive behaviour, perhaps because such persons are more likely to have difficulties establishing secure, meaningful relationships. Attempted suicide is more likely among battered wives and victims of child abuse, reflecting a cycle of deprivation and violence within the family. Suicidal acts usually result from multiple and complex motivations. The principal causative factors include mental disorders (primarily depression), social factors (disappointment and loss), personality abnormalities (impulsivity and aggression), and physical disorders. Often, one factor (commonly disruption of an important relationship) is the last straw. (Duodecim 2001.)

The latest studies concerning suicidality among *elderly population* examine mostly suicidal ideation, suicidal intent, parasuicidal behaviour, personality traits, hopelessness, and depression. The results indicate that a careful psychiatric assessment is necessary when suicidal thoughts are expressed by an elderly person (Forsell et. al 1997), that preventive or treatment measures initiated after the onset of the suicidal state may be insufficient, and that other preventive strategies ought to be considered (Duberstein et al. 1999). According to Duberstein et al. (2000), identification of risk factors for suicidal behaviour has become a major public priority because completed suicide may be preventable lethal complication of depressive disorders of older adults. Szanto et al. (1998) concluded that suicide attempts are associated with persistent, high levels of hopelessness following remission of depression in late-life patients. Their findings suggest that treatments designed specially to lower hopelessness (such as cognitive, behavioral or interpersonal therapy) may be effective in reducing suicide level.

Conaghan and Davidson (2002) examined whether older people who were depressed or had engaged in parasuicidal behaviour could be identified by a decrease in positive future-directed thinking, in the absence of any increase in negative future-directed thinking, in comparison with a community control group. A mixed design was used that compared three groups (community controls, depressed controls and parasuicidal participants) in terms of future-directed thinking (positive and negative), in relation to three future time periods (one week, one year and 5-10 years). Twenty-two participants over 65 years of age, who had been admitted to hospital following a non-fatal suicidal act, were compared with 22 older people being treated for depression, and 22 older community volunteers who were not experiencing any significant psychological symptoms. The main measure was an adaptation of the traditional verbal fluency paradigm (see Lezak 1976; MacLeod et al. 1993, 1997, 1998) and attempted to quantify future-directed thinking. Parasuicidal and depressed participants showed decreased positive future thinking, but no increase in negative future thinking, in comparison with the community control group. The results confirm that older parasuicidal and older depressed participants are characterised by a reduction in positive anticipation and depression rather than hopelessness may account that this for. (Conaghan & Davidson 2002.)

Howatt and Davidson (2002) examined interpersonal problem-solving performance in older adults with a recent episode (in the previous 14 days) of parasuicide (n=18), depressed patients (n=18) and community controls (n=22) using the Means End Problem-Solving (MEPS) procedure, which was modified for older adults. They found that parasuicide in older adults is related to a deficit in interpersonal problem-solving performance that cannot be completely explained in terms of depression. The cognitive element seems to emerge in findings that suggest that longstanding patterns of behaving, thinking, and feeling contribute to suicidal behaviour and thoughts in older adults, and highlight the need to consider personality traits in crafting and targeting preventive strategies (Duberstein et al. 2000). The specificity of negative thinking to depression, and the possibility of a vulnerable cognitive style, negative interpretations of unpleasant events and negative thinking related to the world was presented in the study of Blackburn et al. (1986). Negative depressive thinking reflects a change in schematic mental models through which the world is interpreted (Teasdale et al. 1998).

The association of suicidal thoughts with increased disability in daily living, institutionalisation, visual problems and the use of psychotropic drugs was found in the study of Forsell et al. (1997), the data of which were based on 969 elderly persons from a population-based study. In the same study, 13.3 % of the subjects had had suicidal thoughts during the last 2 weeks. Of those, who had fleeting suicidal thoughts, also 26.7 % had major depression, and 50 % of those who had frequent suicidal thoughts were depressed. Hill et al. (1988) examined the Hopelessness Scale (HS) and its relation to depression, changes in health, and anticipation of a limited future in a study of 120 elderly outpatients, who had applied for psychotherapy for depression, and revealed three distinct factors that were related to hope, feelings of giving up, and future planning: 1) items that were reflected in positive outcomes in the future, labelled hopefulness, 2) issues of control and feelings of giving up, labelled giving up and 3) future expectations because of the focus on the outcome of future events. They concluded that hopelessness, depression, and health perception were found to be inter-related, and all were predictive of suicidal ideation as measured by SADS.

The choice of methods is determined by cultural factors and availability and may reflect the seriousness of intent, since some (e.g. jumping from heights) make survival virtually impossible, whereas others (e.g. drug ingestion) make rescue possible. However, using a method that proves not to be fatal does not necessarily imply that the intent was less serious. A bizarre method suggests an underlying psychosis. Drug ingestion is the most

common method used in suicide attempts. Use of barbiturates has decreased (to < 5 % of cases), but use of other psychoactive drugs is increasing. Two or more methods or a combination of drugs is used in about 20 % of attempted suicides, increasing the risk of death, particularly when drugs with severe interactions are combined. Violent methods, such as shooting and hanging, are uncommon among attempted suicides. For completed suicides, firearms are the most common method used by men (74 %) and by women (31 %). Rates of suicide with firearms vary with the availability of guns and with handgun regulations. Any suicidal act has a marked emotional effect on all involved. The physician, family, and friends may feel guilt, shame, and remorse at not having prevented a completed suicide, as well as anger toward the deceased or others. However, they must realise that they are not omniscient or omnipotent and that the completed suicide was ultimately not preventable. The physician can provide valuable assistance to the deceased's family and friends in dealing with their feelings of guilt and sorrow. The effect of attempted suicide is similar. However, family members and friends have the opportunity to resolve their feelings by responding appropriately to the person's cry for help. (Duodecim 2001.) In her study of suicide notes by suicide victims, Ollikainen (1994) points out that, from the scientific and practical point of view, efforts are needed for a comprehensive discussion in multidisciplinary teams on suicide prevention and intervention.

Malone et al. (2000) stress that assessment of reasons for living should be included in the evaluation of suicidal patients. They emphasise that during a depressive episode, the subjective perception of stressful life events may be more germane to suicidal expression than the objective quantity of such events. A more optimistic perceptual set, despite equivalent objective severity of depression, may modify hopelessness and may protect against suicidal behaviour during periods of risk, such as major depression.

As a conclusion to the literature review, some aspects are highlighted. First, the linkages between hopelessness and depression have been indicated in several studies. Secondly, the role of the distorted thinking process has been associated with hopelessness and depression. Thirdly, suicidal thoughts and their associations with positive and negative thinking have also been confirmed in many studies. On one hand, hope and well-being and, on the other hand, hopelessness and ill-being have associations. However, more research is needed to combine the research of hope and hopelessness and well-being and ill-being, especially concerning the depressive elderly. Health care personnel should lay more emphasis on hope promotion and preventive actions before the distorted thinking process of the depressive patients turns to hopelessness and suicidality. As was pointed out in the introduction, the question is not only economic, but to a considerable extent, a question of personal suffering and its expansion to the lives of significant others.

3 PURPOSE OF THE STUDY AND THE RESEARCH QUESTIONS

The purpose of this research was to clarify the concept of hope and its relationship to hopelessness in the lives of the severely depressive and non-depressive elderly. The aim was to structure a conceptual model of hope and hopelessness based on dictionary definitions, and to verify this model on the basis of the experiences of the severely depressive and non-depressive elderly.

Research area 1:

The goal of this research area was to produce a conceptual model of hope and hopelessness, which were based on English dictionary definitions. The model was thought to be captured by using semantic analysis, which is a special method for structuring the meanings of concepts.

Semantic analysis of the concept of hope was structured from the following steps:

- Etymology of hope

- The contents and dimensions of the concept of hope and related concepts

- Discrimination analysis of the central elements of hope and synonyms of hope

- Theoretical definitions of the concept of hope.

The conceptual model of hope and hopelessness based on the English dictionaries is the final aim of research area 1.

The practical and contextual elements of semantic analysis were left out of this analysis (see Koort 1975), because they were supposed to arise from the empirical data and their analysis.

Research area 2:

The goal of research area 2 was to obtain descriptions of hope and hopelessness experienced by the depressive and non-depressive elderly. Answers were sought to the following questions:

- How do the depressive elderly define hope and hopelessness on the basis of their personal experiences?

- How do the non-depressive elderly define hope and hopelessness on the basis of their personal experiences?

- Are there differences between these two groups?

- Are there some special features in the hope and hopelessness of the elderly?

Research area 3:

The goal of this research area was to combine the results of research area 1 and research area 2, to examine the similarities and differences between the conceptual model of the English dictionary definitions and the empirical definitions, and to produce a combined definition, which also has practical and contextual elements of hope and hopelessness and which could be used in nursing practice.

- What is the meaning of hope and hopelessness in the lives of the severely depressive and non-depressive elderly?

- Are there some factors, which might be helpful in nursing practice in the care of the severely depressive elderly?

- Are there ways to support hope and prevent hopelessness?

4 METHODOLOGICAL APPROACH AND RESEARCH DESIGN

The methodological choices were based on the idea of how to grasp the central elements of hope and hopelessness based on both dictionary definitions and the lived experiences of the elderly. One criterion in choosing the methodological options was the fact that interviewing the severely depressive elderly was an extra challenge, because as informants they were not very 'productive', based on our former experiences in the care of the depressive elderly. Finding a tool, which could help in defining such a general concept as hope, was part of the methodological work.

One central question in building the methodological structure of the research was: What is the phenomenon under study. The Greek expression, from which the term 'phenomenon' is derived, comes from the verb, which signifies "to show itself". Thus, it means that which shows itself, the manifest [das, was sich zeigt, das Sichzeigende, das Offenbare]. The expression 'phenomenon' signifies that which shows itself in itself, the manifest. It is even possible for an entity to show itself as something, which in itself it is not. Showing itself in this way, it 'looks like something or other' ["sieht".."so aus wie.."]. This kind of showing-itself is what we call "seeming" [Scheinen] (Heidegger 1999, 51).

At first, the researcher found it quite natural to start with a phenomenological study in capturing the phenomenon of hope. Hermeneutics were also considered when the researcher was making the decisions concerning the interview material. How to capture the hidden meanings of those interviewed and could they be captured? Discourse analysis was also one possibility under examination concerning the analysis of the interview material. But, at the same time, the tools by which the phenomenon could be captured were under examination. It was obvious that the amount of data would be great, so computer programmes were thought to bring some help in the coding process and analysing phase. The next phase in decision-making was to find a programme with which both the dictionary definitions and the interview data could be analysed. As a result of these processes, the researcher ended up with Grounded Theory and the ATLAS/ti computer programme, which is based on Grounded Theory. The way to the solutions was laborious and produced an extra step to study the ATLAS/ti programme, but the same theoretical basis concerning the research method and the tool helped to organize the data in such format (structuring meanings from different data) that would make it possible to do the analysis without losing any essential elements and without harming the basic ideas of the study. Hermeneutics and semantics were used to capture external and internal meanings.

From the methodological point of view, the definition of the elderly, as it is understood in this research, was made. In this research, 'the elderly' was defined as a term which does not convey universally shared characteristics in the group that it refers to, but as a term which covers a range of different characteristics, lifestyles and health problems, none of which being found in all members of the group (Reed & Ground 1997, 142). It also covers individual life histories, which have become unique on the basis of lived experiences. Also the historical situatedness, which is an important element for this age group as a wartime generation, is an important factor in analysing the meanings of their experiences (Kögler 1999). As an exception to the definition: not universally shared characteristics mentioned above, the elderly are defined as 65 years old or older in this research.

4.1 SYMBOLIC INTERACTIONISM

Grounded Theory is based on the principles of pragmatism and symbolic interactionism and that is why these were studied to understand the premises of the method used to analyse the data (Cheniz & Swanson 1986). Mead's interactionist perspective included the essential defining of self through social roles, expectations, and perspectives cast on self by society and by those within society. In the 1960s, Herbert Blumer, a student of Mead, centralised within this theory the concept of self, constructed through social interaction (Blumer 1969; Annels 1996). In this research the emphasis is on symbolic interactionism and based mainly on Blumer's thoughts. According to Blumer (1969), symbolic interactionism rests on the following fundamental premises:

- Human beings act towards things on the basis of the meanings that the things have for them.

- The meaning of such things is derived from, or arises out of, the social interaction that one has with one's fellows.

- These meanings are handled in, and modified through, an interpretative process used by the person in dealing with the things he/she encounters.

The central concepts around which the theory of Symbolic Interactionism is organised are 1) *the self*, 2) *the world* and 3) *social action* (Meltzer et al. 1975, Stryker 1980, Bowers 1988). For the interactionist, *the self* is socially constructed. The Me is constructed through ongoing social interaction which begins at birth, in which the individual person receives and interprets social cues from the environment. The I is the active, interactive, dynamic, interpreting component of self. As the Me is the object of self-reflection, the I is the reflector. (Mead 1934; Bowers 1988.) *The world* refers to the social world as interpreted or experienced, rather than the physical world. This social world is called the "object world". (Meltzer et al. 1975, Bowers 1988.) For the symbolic interactionist, objects do not have inherent meaning, but the meaning is derived from how people act towards them. The meanings vary from one individual to another, from one context to another and over time. Individuals learn the meanings of objects by observing others and interpreting their actions. Our *actions* are built up during *social interaction*. The process of taking the role of the other is central. Individual action is always contextual and cannot be understood by extracting it from the social context. (Bowers 1988.)

Symbolic interactionism sees *meanings* as social products, as creations that are formed in and through the defining activities of people as they interact. The use of meanings occurs through a process of interpretation. A cardinal principle of symbolic interactionism is that the empirically oriented scheme of human society must respect the fact that human society consists of people engaging in action. Mead (1934) identifies two forms or levels of social interaction:"the conversation of gestures" and "the use of significant symbols", which Blumer names as "non-symbolic interaction" and "symbolic interaction". Non-symbolic interaction takes place when one responds directly to the action of another without interpreting that action; symbolic interaction involves interpretation of the action. The interactionist as researcher is concerned with discovering the realities of the subjects, the nature of the objects in their world, how they define and experience their world. (Bowers 1988.)

The methodological choices in this research rest very much on these premises. Because meanings are central in this research it must be noticed that they are social products and, through the interpretative process, also the researcher has her own role in creating the

meaning of hope in social interaction with those interviewed, as Blumer (1969, 11) defines it: "the meaning of objects for a person arises fundamentally out of the way they are defined to him/her by others with whom he interacts." This is also in congruence with the principles of Grounded Theory where the researcher is the instrument (see Bowers 1988, 54).

4.2 SEMANTICS - SEMANTIC ANALYSIS (RESEARCH AREA 1)

According to Gadamer (1977), both hermeneutics and semantics have as their starting point the linguistic form of expression in which our thought is formulated. Semanticm describes linguistic facts externally and makes it possible to develop classifications of types of behaviour with respect to these signs. On the contrary, hermeneutics focuses upon the internal side of the use of these signs, that is, the internal process of speaking. Both hermeneutics and semantics thematize the totality of our relationship to the world that finds its expression in language, and both do this by directing their investigations behind the plurality of natural languages.

In this research, the emphasis is on language organising our world in particular ways, which may or may not be appropriate ('depressive language') and behaviour, what people do/say as an expression of their former knowledge, feelings and experiences. The human organism-as-a-whole-in-an-environment-at-a-given-date is an interesting view applied in the sense of the life history of the elderly (see Nöth 1990; Pula 1996). As representatives of a war generation the experiences of the interviewed seemed to have very concrete dates, and memories were linked to emotionally important experiences (like biking 'alone' as a little girl with the army, which fled the enemy in the middle of bombing). Language and thought are indispensable to man's growing awareness of himself and his world. Sentience and thought are integral to the vital process itself. Man knowingly makes choices. Through awareness of himself and his environment, he is an active participant in his life and in reorganising the environment in accord with his desires. His choices are not necessarily wise ones. Some choices may even be detrimental to his well-being. Failure to make a choice is of itself a decision that is incorporated into the man-environment interaction process. (Fawcett 1984.)

Semantic analysis is not an analysis of the formulation of language or sentence, morphology or syntax, but an analysis of the meaning of symbols or lingual expression. Of course, there are words and terms to be analysed, but it is not a morpheme, which is the goal of the analysis, but the meaning of the terms representing the world. On the other hand, semantic analysis could be called the analysis of the meaning. The primary goal of semantic analysis is to find relations between similar concepts and, on the other hand, to find the discrepancies between concepts belonging to the same concept-family. (Koort 1975.) Shortly defined, the purpose of semantic analysis is to reveal the meanings of concepts. Etymological inspection studies the origin of the concept and its development. The concept under study is characterised by dictionary definitions. With dictionary definitions, it is possible to reveal a temporal dimension of the linguistic development of the concept. Part of the analysis is to define the nature of the concepts (pretheoretical, theoretical, and practical) and also the contextual elements of the concept.

According to Gadamer (1977) the great value of semantic analysis rests in no small part in the fact that it breaks through the appearance of self-sameness that an isolated word-sign has about it by making us aware of its synonyms and by demonstrating that an individual word-expression is in no way translatable into other terms or interchangeable with another expression. In semantic nihilism, which is perhaps the most radical response to the consequences of holism, there are views that, strictly speaking, there are no semantic properties: no mental states; words lack meanings. According to semantic nihilism, we must

abandon the notion that people are moral or rational agents and that they act out of their beliefs and desires. On the contrary, according to semantic holism, a metaphysical thesis about the nature of representation, the meaning of a symbol, is relative to the entire system of representations containing it. (Audi 1996.) In nursing, this perspective seems to be a more adequate starting point, because in nursing practice, more information is needed about patients' beliefs and desires in order to be able to help them properly. As Blumer (1969, 69) emphasises " Human beings are seen as living in a world of meaningful objects - not in an environment of stimuli or self-constituted entities. This world is socially produced in that the meanings are fabricated through the process of social interaction. Thus different groups come to develop different worlds and these worlds change as the objects that compose them change in meaning."

4.3 GROUNDED THEORY (RESEARCH AREAS 2 AND 3)

Grounded Theory derives its theoretical underpinnings from Pragmatism and Symbolic Interactionism, which provide the philosophical foundations for Grounded Theory (Mead 1934, Blumer 1969, Cheniz & Swanson 1986). The aim of Grounded Theory is to develop theory about social and psychological phenomena. Grounded Theory should explain as well as describe. It may also implicitly give some degree of predictability, but only with regard to specific conditions. Grounded theories are guided by the assumption that people do order and make sense of their environment, although their world may appear disordered to observers. People share common circumstances, experience-shared meanings and behaviours that constitute the substance of Grounded Theory (Hutchinson 1999). The term is used to designate theory and theory development which are grounded in empirical data and have their beginning in the empirical world. The role of the researcher, the research process, generating interview questions, early data analysis and memoing are crucial factors in analysing the final results of the research process. According to Bowers (1988), the relevance of Grounded Theory for nursing research should be evaluated on the basis of the theoretical foundation.

Each research method is linked to a perspective on a philosophy of science. Grounded Theory has its roots in social sciences, specifically, in the symbolic interaction tradition of social psychology and sociology (Glaser and Strauss 1967). The roots related to the ontology (what is the form and nature of reality and what can be known about reality) of the Grounded Theory method (GTM) can be found in the thinking of Mead and Blumer: a pragmatist view of what can be known and which can be evaluated as leaning toward critical evaluation. Critical realism is prominent in symbolic interactionist ontology in the acceptance that the social and natural worlds have different realities, but both forms of reality are probabilistically comprehensible, albeit imperfectly. (Annels 1996.)

The epistemological starting point (the nature of the relationship between the researcher and the interviewed and what can be known) is constrained by the reply to the ontological question, and the answer to the methodological question is always dependent on the answers to the preceding questions. The Grounded Theory method has traditionally been sited according to Annels (1996) in a postpositivist inquiry paradigm but is evolving and moving towards the constructivist inquiry paradigm. Philosophically, Grounded Theory is critical realist and modified objectivist in perspective, with a resultant slant towards theory generation that is postpositivist in inquiry paradigm. Annels continues that, however, when it is relativist, subjectivist, and dialectical, the Grounded Theory method has an evolving fit to the constructivist paradigm of inquiry and the next decade will show the relationship of the Grounded Theory method to post-modernism.

According to Audi (1996) ethical constructivism holds that there are moral facts and truths, but insists that these facts and truths are in some way constituted by or dependent on our moral beliefs, reactions, or attitudes. Audi continues that postmodern phoilosophy typically opposes foundationalism, essentialism, and realism. The term ´postmodern´ is less clear in philosophy, its application more uncertain and divided, than in some other fields. (Audi 1996.) However, the development of Grounded Theory is widely discussed among different sciences and the years to come will show the direction of the development.

One central focus of GTM is to answer the question: "What is going on in this area" by generating either a substantive or formal theory (Glaser & Strauss 1967). Basic Social Processes (BSP), which are central products of theory development, are conceptually developed to account for the organisation of social behaviour as it occurs over time. BSPs capture both micro- and macro- phenomena and are concerned with dynamics. The manner in which these processes exist in particular units may change over time, as conditions may change, but the fundamental core process and its essential properties will remain essentially intact. (Bigus et al. 1994.) Strauss (1987) has defined six essential characteristics for core variables as BSP: 1) it recurs frequently in the data 2) it links the various data together 3) because it is central, it explains much of the variation in the data 4) it has implications for a more general or formal theory 5) as it becomes more detailed, the theory moves forward and 6) it permits maximum variation in analysis. According to Hutchinson (1999) the formation of BSP requires simultaneous collecting, coding and analysing the data like discovering of sensitizing concepts, gaps in the knowledge and analysing masses of narrative data using constant comparative method. Coding proceeds from in vivo or substantive codes to categories and theoretical constructs via saturation of codes, categories and constructs and by secondary literature review towards a dense, parsimonius theory covering behavioral variation.

4.4 HERMENEUTICS (RESEARCH AREA 3)

Klemm (1983) proposes for the Greek word "hermeneia", from which hermeneutics comes, three directions of meaning: "to express/expression, to interpret/interpretation (in the sense of clarify by commentary), and to translate/translation. The more recent interest concerns understanding and interpretation as processes (epistemology) and modes of being (ontology). The focus has changed from literary texts to include also history, art, symbol and myth, and human action. (Bowers 1988.) Hermeneutics is defined as the art or theory of interpretation, as well as a type of philosophy that starts with questions of interpretation. In twentieth-century German philosophy, there are two competing positions in hermeneutics, with Dilthey representing the first one, seeing interpretation or 'Verstehen' as a method for historical and human science, and Heidegger representing the other one, seeing it as an 'ontological event', an interaction between interpreter and text that is part of the history of what is understood. Schleiermacher's analysis of understanding and expression related to texts and speech gives hermeneutics its modern sense as a scientific methodology. This approach culminates in Dilthey's attempt to ground the human sciences in a theory of interpretation, understood as the imaginative but publicly verifiable re-enactment of the subjective experiences of others. One result in the nineteenth century was "the hermeneutic circle" first developed by Schleiermacher. Shortly defined, the relation of parts to the whole is th basic idea of the hermeneutic circle: the interpretation of each part is dependent on the interpretation of the whole. Heidegger and Gadamer radicalised this circularity of interpretation in the twentieth century with the notion that the hermeneutic circle is a feature of all knowledge and activity. (Audi 1996.) Hermeneutic understanding constitutes the meaning of its objects principally through specific perspectives of significance. The meaning itself, which we are capable of comprehending, is shaped through the structure of historically situated preunderstanding. The historical course of meaningful events is important in the

sense that the text or action belongs to the historical unity that binds us to the other's meaning. That is why, focusing solely on the original semantic content is misguided. This comprehensive historical process, which mutually determines us as well as the other, is to be recognised as the actual source of hermeneutic meaning. (Kögler 1999, see also Gadamer 1977.)

Allen (1995) points out that nursing practice must be interpreted within its social political locations, and that we cannot treat as irrelevant the fact that nurses make a living from illness and suffering in an environment of economic advancement. We cannot speak of advocating for patients without simultaneously asking who will advocate for them against us. All forms and criteria for rationality, including health care decision making, involve social processes. Allen emphasises that hermeneutics is essential in both describing and explaining nursing practice in two senses (double hermeneutic necessity): 1) all hermeneutic activity is hermeneutic in that it is a socially structured, meaning-generating and perspective-dependent human pursuit, 2) how nurses, patients and other actors in the health care arena understand their own and each others' activities are necessary in describing and explaining clinical practice. Allen continues that this eliminates in no way the need for other methods such as epidemiological and clinical trial research. The emphasis on language, and particularly the insistence that individuals inherit and are constituted by their language, is a helpful corrective to the solipsistic and individualist models that continue to plague our theory and research on practice.

As a conclusion to the methodological choices of this research, the researcher has tried to reveal her thinking as follows: understanding language as a reflection of the human mind in which we process lived experiences. The lived experiences are captured by Grounded Theory and the external meanings (what is hope and hopelessness) are thought be caught by semantic analysis and, finally, internal processes through hermeneutic interpretations (the meanings of hope and hopelessness for the interviewed elderly). Experiences are understood as the totality of a person's characteristics, perceptions, feelings, memories and accumulated knowledge, which make up the particular quality of a person (see Collins 1994), although in the analysis of the data the experiences have been split into separated entities.

4.5 THE RESEARCH DESIGN

In the following figure, the design of the research is defined (Figure 2). The research areas are partly overlapping, but the structure defines the process on the theoretical level. The research areas 1 and 2 were conducted during the years 1997-2001 and the research area 3 during the years 2001-2003.

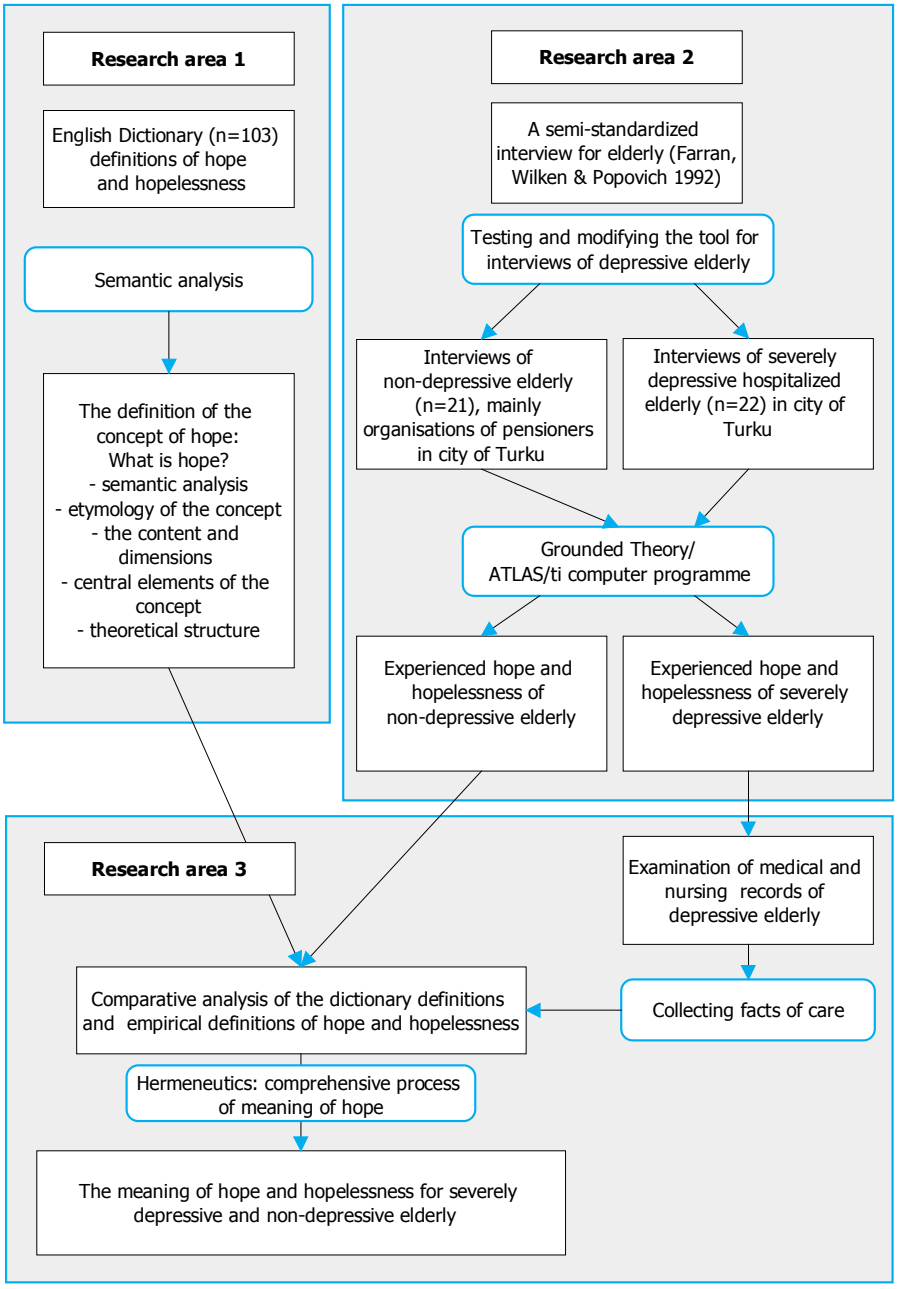

FIGURE 2. The research design 1995-2003

5 METHODS

5.1 DATA AND DATA COLLECTION

The data were collected and analysed as follows:

Definitions of hope and hopelessness in English dictionaries (n=103) (research area 1) - semantic analysis

Interviews of the severely depressive elderly (n=22) (research area 2) - Grounded Theory

Interviews of the non-depressive elderly (n=21) (research area 2) - Grounded Theory

The medical and nursing documents of the depressive elderly (n=22) (research area 2) - information gathering of facts like care periods, length of care, suicide attempts etc.

The meaning of hope and hopelessness in the lives of the depressive and non-depressive elderly (research area 3) - Grounded Theory and hermeneutics.

The sources were selected on the basis of the main interest of the research: what is the meaning of hope and hopelessness in the lives of the severely depressive and non-depressive elderly and how it can be structured conceptually. The data were gathered during the years 1995-2001.

5.1.1 ENGLISH DICTIONARIES

The starting point was to define the concepts of hope and hopelessness based on English dictionary definitions. *Firstly*, because the dictionary definitions reveal the use of everyday language and, on the other hand, the texts of the interviews are spoken language, the correspondence of the developing categories with the categories of the empirical data was supposed to be better. *Secondly*, the historical perspective of the concept development was made possible by examining the dictionaries from different centuries. *Thirdly*, the abundance of the definitions in English dictionaries was supposed to enrich the analysis. Also, the longer history of English language dictionaries was one criterion in the decision to choose particularly English dictionaries. *Fourthly*, The concepts of hope and hopelessness were so broad in scope that the concept analysis was necessary to reveal the different dimensions of the concepts.

The English dictionaries (n=114) were gathered during the years 1995-1996. The final number of dictionaries in the analysis was 103. The English dictionaries were from the 18th to the 20th century. The researcher was not sure in the beginning if the dictionaries should be only synonym dictionaries, or could others also be included. The more dictionaries were gone through the more convinced the researcher became of the richness of the analysis with a wider selection and from a longer time period of the published dictionaries. It was also a bothersome question - should there be only British English dictionaries or could also American English dictionaries be included, or should there even be other languages too, like Swedish, Finnish or German. After making some preliminary attempts to check different solutions, the researcher made a mini-analysis with 37 dictionaries and noticed that British English and American English dictionaries were complementary to each other when it was kept in mind

that the definitions were connected to a certain cultural background and should be interpreted on this basis. The dictionaries of the other languages mentioned above were used mainly as background material. Some dictionaries were left outside the analysis because of the antiquated language, which was too hard for the researcher to analyse because of the language. Another criterion for leaving some dictionaries outside the analysis was the sameness of different volumes: the definitions were identical. The target was to get as rich a selection of definitions as possible. The definitions of the dictionaries were written in textual format during 1997-1999. Then the texts were transferred to the ATLAS/ti programme in 2000-2001. The English dictionary definitions were analysed to get a more general idea of everyday definitions of the concept of hope. As a result of this part of the research, a semantic definition of the concept of hope based on English dictionaries was produced. The semantic analysis was made because of the broadness of the concept. At the same time hopelessness was also under study.

5.1.2 INTERVIEWS OF THE DEPRESSIVE AND NON-DEPRESSIVE ELDERLY

The interviews of the depressive elderly in hospital care were conducted from August 1997 to June 2001 (These included also 1-year follow-up interviews, the analysis of which was not included in this research). The data used in this research were collected in 1997-2000. There were times when the researcher was not contacted from the care units and usually the reason was that the doctors had changed and had not got the information about the research. This prolonged the interview process. The interviews were written verbatim at the same time and the last ones during summer 2001. The preliminary analysis was made at the same time as the writing episode.

The subjects for the interviews were selected on the basis of the following criteria: 65 years or older, diagnostic groups according to ICD 10 (year 1997) F32, F33, F34.1, F38, F39, F41.2, and F43.2. and, additionally MMSE (Mini Mental State) = 24 or > 24 and MÅDRS (The Montgomery-Åsberg Depression Rating Scale; 0-30) = 10 or > 10 (see section 5.1.2.1). The psychiatrists and nursing personnel of the psychiatric care units for the elderly were informed about the research, and the psychiatrists made the decisions about the patients who were offered the possibility to take part in the research. After this, the researcher met the patients and gave them information about the research (telling personally and giving material about the process, responsibilities, informed consent etc.) and gave them a few days to consider their participation. The interviews of the depressive patients were done during the stay in hospital (2 weeks from admission on average) and one year after the first interview, in order to get an idea of the process of hope and recovery.

The non-depressive elderly were selected for the interview on the following basis: 65 years or older and no psychiatric diagnosis based on their own information. The researcher made her own evaluation too (based on her over twenty years' experience in psychiatric nursing) and one of the volunteers was asked to contact the psychiatric care unit instead of taking part in the research because of her mental state and need to talk about her depression and anxiety with professionals. She was satisfied with the information she got from the researcher.

The non-depressive elderly were interviewed in order to avoid the bias of describing hope from the point of view of hopelessness alone. The idea was to reveal whether they had the same kind of life situations as the depressive ones and to raise the question - what is the meaning of hope in these life situations; how can some people manage without depression and what makes the others end up to depression?

The first interviews during the hospital care varied from 20 minutes to 2 hours and 15 minutes, the average length being 1 hour 25 minutes. Three interviews were conducted in two different meetings, because the patients were told that if they feel tired, the interview could be continued at another time. Altogether the first interviews lasted 30 hours 40 minutes. (The follow-up interviews varied from 30 minutes to 1 hour and 30 minutes. The three telephone interviews were shorter, from 2 to 10 minutes. The follow-up interviews lasted 17 hours altogether).

The material from the interviews was 553 pages (without the follow-up, which was not included in the final analysis) of written text (font size 11 and single-spaced) and the total time used in interviews was 72 hours and 10 minutes, plus the time for preparing and travelling. The researcher wrote all the text except for two interviews herself. The first idea was to have them all be written by someone else, but the researcher changed her mind. In spite of the heavy writing sessions, the process was worth it, because the thinking was enriched at the same time and the research proceeded during the writing process. In the table below (Table 1) is gathered the information on all the data of the interviews (708 pages, including the follow-up).

TABLE 1. Facts about the interviews

	Depressive patients/first interview n=22	Depressive patients/follow-up interview n=22 (not analysed in this research)	Interviews of non-depressive elderly n=21	Total n=65/total average/total variation
The length of all the interviews	30 hours 40 minutes	17 hours	24 hours 30 minutes	72 hours 10 minutes
The average length of one interview	1 hour 25 minutes	56 minutes	1 hour 10 minutes	1 hour 10 minutes
The variation in the length of the interviews	from 20 minutes to 2 hours and 15 minutes	From 30 minutes to 1 hour and 30 minutes (3 phone calls: 2-10 minutes)	From 30 minutes to 2 hours	From 20 minutes to 2 hours 15 minutes (3 phonecalls:2-10 minutes)
Written text in pages (single-spaced)	196 pages	155 pages	357 pages	708 pages
Written text/one interview on average	9 pages	7 pages	17 pages	11 pages (includes phone calls)
Variation in the length of texts	5-19 pages	1-18 pages	9-26 pages	1-26 pages

5.1.2.1 Tools of the analysis

All the interviews were based on the themes of *the clinical assessment tool* developed by Farran et al. 1990 and 1992. The decision to use a structured interview was made because of the broadness of the concept and, on the other hand, on the experiences in nursing the depressive elderly. Farran et al. had not used their clinical assessment tool in interviews of

depressive patients. This assessment tool was chosen on the basis of the conversation by E-mail with Farran in 1997, our former experiences in interviewing the depressive elderly in former clinical studies (Virtanen et al. 1990), and two test interviews. The aim was also to evaluate the suitability of the clinical assessment tool in interviewing the depressive elderly.

The themes of hope (Farran et al. 1990 & 1992) were structured on the basis of *the HOPE acronym* as follows:

H= health, **O**= others, **P**= purpose, **E**=engagement process and **G**= goal, **R**=resources, **A**=action, **C**=control, **T**= time,

The HOPE acronym has four central attributes: health, others, purpose and engagement processes. The attribute engagement processes were divided into five themes: goal, resources, action, control and time = acronym GACT. In this research, the acronyms were used as themes in interviews to grasp the central elements of hope, and the analysis was based on the data in texts. The themes were followed but in such a way that those interviewed were allowed to continue speaking in such areas of life which seemed to be interesting and, on the other hand, there were some topics that were not actually meaningful in the sense of the research but which helped to continue the interview.

The questions were based on these themes, questions concerning health were:

1. Do you have any problems with your health at the moment and

2. How does your status of health affect experiences of hope in your life?

The interview questions are presented in appendices 5a and 5b.

Both the dictionary definitions of hope and hopelessness and the interviews of the depressive and non-depressive elderly were written word for word and were analysed by *the ATLAS/ti computer programme*, which is based on the ideas of Grounded Theory. The analysis with the Atlas/ti programme was done in 2001-2003 concerning both the dictionary data and also the data on the interviews. The programme was chosen after several literature searches and questionings of the users of the programme. The final decision was made on the basis of the test coding of a couple of interviews. The researcher also followed the discussion group of the users worldwide for a year and a half to check the features of the programme and discussions concerning it. Also the web pages gave information about different areas of science where it is used (http://www.atlasti.de).

Atlas/ti is a workbench for the qualitative analysis of large bodies of textual, graphical and audio data. It offers tools (to manage, extract, compare, explore, and reassemble) for a systematic approach to "soft" data, e.g. material, which cannot be analysed by formal, statistical approaches in meaningful ways. It helps to uncover the complex phenomena hidden in the data in an exploratory way. The main principles of the ATLAS/ti "methodology" have been termed VISE: Visualisation, Integration, Serendipity (to find something without having searched for it) and Exploration. (Muhr 1997, p. 1-2.) In this research the version 4.1 for Windows NT was used. Miles and Huberman classify Atlas/ti as theory builders and conceptual network builders in their presentation of software comparison. This kind of software for qualitative data analysis offers a possibility to develop higher-order classifications and categories and to link the variables as nodes with other nodes by specified relationships (e.g., "belongs to", "leads to", "is kind of"). The relationships are "semantic

networks" that develop from data and concepts and the relationships between them (Miles & Huberman 1994). An example of the networks and relationships is presented in figure 9.

In construction of a theory the relations play an important role. In Atlas/ti they may be labelled: is-associated with, is-part-of, is-cause-of, contradicts, is-a, is-property-of etc. The concepts (codes) that are linked using relations represent aspects of the problem domain under investigation. The relations used to link these domain concepts are part of the methodology used to analyze the phenomena. As "epistemological primitives" they constitute the main questions that quide the development of a model, a theory. The semantic layout algorithm arranges the nodes into optimal positions using an invisible matrix of default positions and places the nodes with the highest connectivity into center positions. This feature helps in further thinking. Operands, also called argumets or descriptors, and operators (Boolean, semantic and proximity operators) are ingredients of queries with which the data is controllable. (see Muhr 1997.)

The data were arranged into three *Hermeneutic Units (HU):* 1) Dictionaries HU1, 2) Data of depressive elderly HU2 and 3) Data of non-depressive elderly HU3. A hermeneutic unit is an "idea container", which is meant to enclose the data, all codes, findings, memos, and structures (Muhr 1997, p.8). The programme offers the possibility to link the quotations and to check the lines in the text where you can find them, so it is easy to later analyse the context, which is important in the final analysis. The programme also offers possibilities to use Boolean and semantic operators, to build networks of different concepts, and to build concept families.

In the psychiatric care units for the depressive elderly in which the interviews were conducted, the *Montgomery-Åsberg Depression Rating Scale* (MÅDRS) was used to assess the severity of depression. The rating scale was built up according to the evaluation of the following symptoms: apparent sadness, reported sadness, inner tension, reduced sleep, reduced appetite, concentration difficulties, lassitude, inability to feel, pessimistic thoughts and suicidal thoughts. The ten ratings use 0-to-6 severity scales, with higher scores reflecting more severe symptoms. The limit of clinical depression is regarded as 20 points. The proposed cut-off point are 12 for mild depression, 24 for moderate depression and 35 for severe depression. The researcher filled up the rating scale in the beginning of the interviews of the depressive elderly.

The major goal in developing the MÅDRS was to provide an instrument which is sensitive to change and also practical to apply in a clinical setting. MÅDRS was developed largely in response to the criticism that methods like the Hamilton Rating Scale for Depression was insensitive to clinically important changes in level of depression. In McDowell and Newell (1996) has been presented the scale, its evaluations and reliability and validity aspects of the scale. In comparisons to other scales, most of which concern Hamilton Rating Scale for Depression, MÅDRS is stated to be easily administered and it provides the rater with clearer guidelines. The main contrast between the two scales is that MÅDRS does not include psychomotor symptoms and is valuable in assessing depression in physically ill people, but on the other hand, the Hamilton scale is assessed to be more suitable in cases where psychic, behavioural and somatic features of depression are assessed (see Achté & Tamminen 1993, 44-45; McDowell & Newell 1996, 276-281).

5.1.2.2 Participants

Altogether 25 depressive patients (19 women and 5 men) were asked to participate in the research. Three women refused. The reason for all refusals was tiredness; the patients said

that they were so depressed and so tired that they just wanted to be. Of all the 22 interviewed (see figure 3), 5 were men (2 married, 2 widowed and one divorced) and 17 were women (5 unmarried, 2 married, 2 divorced and 8 widowed). The age range was from 66 years to 86 years (mean 73.2 years). The basic education was primary school in 21 cases. One patient had secondary school education, and two patients also had vocational education.

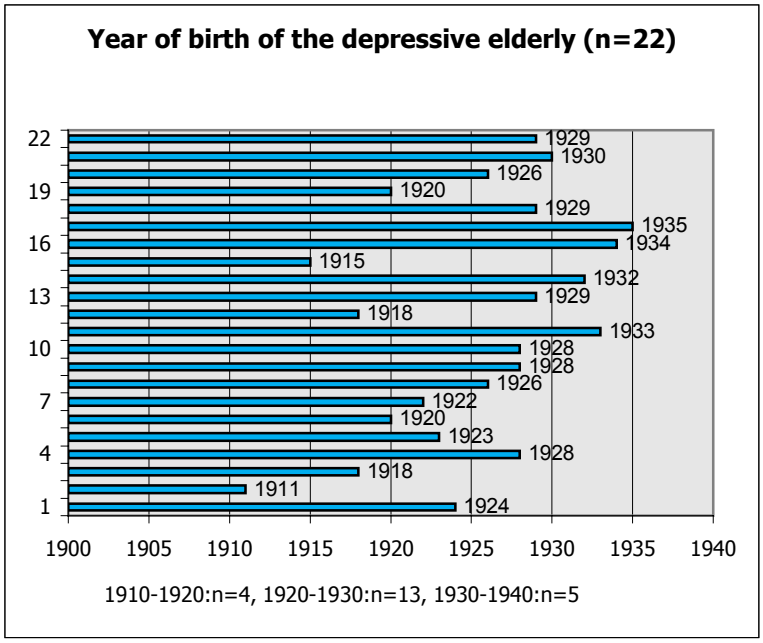

FIGURE 3. The year of birth of the depressive elderly

The interviews of the depressive patients were performed in the hospital in 19 cases. Two of the interviews took place in the office of the researcher in the hospital area and one at the home of the patient. In the history of the patients there were some former suicide attempts. The reason for the hospital treatment during that care period, which included the interviews, was in three cases attempted suicide (attempts of shooting and overdoses of medication). Suicidal thoughts (like plans for jumping into a river, or suffocating with a pillow) were more common.

Another group was formed of non-depressive elderly. Altogether 21 elderly people (see figure 4) from four pensioners' clubs were willing to participate in the research, but one refused later because of her busy timetable. One volunteer compensated this refusal. The clubs of the elderly were chosen because they are very popular among the elderly and it was supposed that through these clubs it was possible to reach the non-depressive elderly. Of the 21 interviewed 19 were women (2 unmarried, 6 married, 2 divorced and 9 widowed) and 2 were men (1 married and the other widowed). The age range was from 66 years to 82 years (mean 73.8 years). The basic education was primary school in 21 cases and two of those interviewed had vocational education. Some had had shorter courses like courses in gardening and trade.

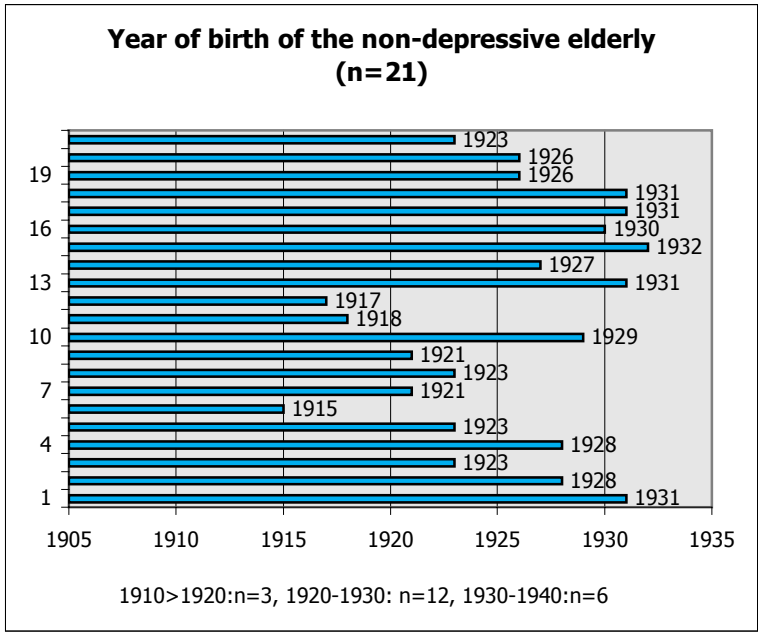

FIGURE 4. The year of birth of the non-depressive elderly

The group of the non-depressive elderly was very similar to that of the depressive elderly regarding age range, marital status and education, although this was not a deliberate selection criterion.

5.1.3 NURSING AND MEDICAL RECORDS OF THE DEPRESSIVE ELDERLY

Nursing and medical records of the psychiatric care history of the depressive patients were gathered during summer 2001 because the researcher was not willing to be influenced during the interview period by the previous written materials. The records were gathered from the archives of the care units, where the patients were treated. There was also information from other hospitals, like in cases of suicide attempts, and there were data from first aid units or somatic hospitals, information about surgeries or examinations. The medical and nursing records were from the years 1952-2001. In the oldest documents there were treatments which have not been used for years. The picture of the care history was sketched through the years.

Nursing and medical records of the depressive patients were examined to check the facts of care, such as care periods and length of care, suicide attempts etc. The idea was to get a picture of the care history and care proceedings of each patient. Permission to check the care documents was given by the Ministry of Social and Health affairs and the Ethical Committee of the City of Turku Health Care (see section 8.4 and appendices 1-4). A summary of the care from 1995-2001 is presented in table 4.

5.2 DATA ANALYSIS

Corbin and Strauss (1990) emphasise that the usual canons of "good science" should be retained, but they require redefinition in order to fit the realities of qualitative research and the complexities of social phenomena. These scientific canons include significance, theory-observation, comparability, generalizibility, consistency, reproducibility, precision, and

verification. Qualitative methods can be systematically evaluated only if their canons and procedures are made explicit.

In this research, the data analysis is explained in some detail because the methods used have partly been developed during the process (like the meaning units MU:s), and thus the consistency, reproducibility, precision and verification are easier to follow in the analysis phase. Also, the processual nature of writing the results means that part of the text included in this section has elements, which could be included in the section on results. Anyway, the solution is based on the readability of the results. One step to making the procedures explicit is to use the computer-assisted methods in coding and building up categories, linking memos and building up the theoretical structure. (Miles & Huberman 1994.)

In a computer-based analysis, the steps of data analysis are more visible and this helps the researcher and also others to follow the process (precision and reproducibility). To avoid the possibility that something essential concerning hope would be left out because of the structured interview, those interviewed were allowed a possibility to speak freely of other themes too. On the other hand, the researcher used a so-called spiral technique (by repeating the important words of the interviewed), which seemed to be helpful in discussing difficult themes like losses of significant others.

After the coding process the data analysis continued by checking the code families of the interviews and combining the names of the same families. There were some differences in the names of the families like in HU 2 there was a code family called problems concerning health; while in HU 3 it was named health, because the contents of the code families were not defined very exactly before all the coding was made. The names of the code families followed the themes of the interviews, but also others were formed during the coding process. The researcher knew beforehand, that this phase might result in definitions and some codes being moved into other code families, when the criteria and names of the families were defined more exactly. There were 14 code families, which were different in the two interview materials like self-destructiveness, which was not in the data of the non-depressive elderly. There were also two such code families included in the HU 2 to remind the researcher of the Montgomery-Åsberg scales to be mentioned in the final analysis. These were transformed to memos. The names of the code families and the number of codes in each family are presented in appendix 7.

The process of the data analysis concerning both the dictionary definitions and the interview data is presented below:

1. Code definitions from the raw data: dictionary definitions and interviews (Appendices 6 and 11 and figures 5 and 6) > arranging the raw data into codes and code families. Codes were defined as the smallest text units, which included some piece of knowledge (see Figure 7). Based on these knowledge contents the data was structured into the code families.

2. Arranging the codes into the meaning units (MU) (Figure 7 and Table 2) > preliminary ideas of the substance. A meaning unit (MU) was a cluster of codes, which together formed a meaning, which usually was a sentence or a whole 'idea' concerning some substantial area.

3. Building semantic networks and relationships of the codes (Figure 12) > connections between different concepts and meanings. These connections were based on the raw data (definitions in the dictionaries or expressions of the interviewed). Through semantic networks a more meaningful structure of semantically related concepts was built.

4. Rearranging the code families into the theoretical code families based on GT (Grounded Theory) (Figure 9 and Appendix 12, see also Appendices 9-10 and 15-22) > opening up the features and relationships of the theoretical structure and raising the abstraction level.

5. Reducing the theoretical code families into three theoretical categories (Figure 8 and appendices 12-14) > building up the theoretical structure > building up elements of the substantive theory.

6. Formation of the BSP (Basic Social Process) and the core categories (Appendices 23-28) based on the former analysis > continuous rereading and analysing the data from different perspectives and discrimination analysis: hope-promoting/hope-diminishing factors > revealing the most prominent features > finalising the basic theoretical structures > dynamic nature of the theory > testing the connections between concepts and dimensions > the generic nature of the theory.

5.2.1 DATA ANALYSIS OF THE DICTIONARIES

In the beginning of the analysis there were 114 dictionaries, of which 103 were chosen for the final analysis. Dictionaries, which were left outside the analysis, had expressions of the antiquated language and the researcher felt insecure about understanding them sufficiently. Some dictionaries were totally similar copies of former versions concerning hope definitions, so they were left out because they did not add anything new to the analysis. The dictionary analysis of the 103 English dictionaries was done using the ATLAS/ti programme and it produced in the first phase of primary coding 6780 codes, which were classified into 22 code families. The code families were:

1. Adjectives and adverbs/hope (n=682) **2.** Adjectives and adverbs/hopelessness (n=291) **3.** Hope and definitions (n=79) **4.** Hope-noun (n=482) **5.** Hope-verb (n=550) **6.** Lost hope (n=815) **7.** Hope and youth (n=93) **8.** Certain and uncertain hope (n= 160) **9.** Time (n=97) **10.** Synonyms of hope (n=193) **11.** Positive elements of hope (n=263) **12.** Religious and spiritual orientation (n=66) **13.** Hope associated with people (n=410) **14.** Hope associated with things and places (n=287) **15.** Expectation and desire (n=391) **16.** The amount of hope (n=246) **17.** Confidence, belief, assurance, trust and reliance (n=341) **18.** The development of hope - the process (n=661) **19.** The grounds and reason for hope (n=121) **20.** Hope and health (n=117) **21.** Hope and living (n=40) **22.** The object of hope (n=234).

In dictionaries, the nouns, verbs, adjectives and adverbs were usually defined according to these classifications so they were taken for granted as independent families. The role of these families was to deepen the definitions of other families, which were named more on the basis of content-factors. The family - Hope and definitions - was formed to find out how the definitions of hope situate hope in the hoping process as a whole. This family consisted of definitions like to hope in, to hope for, in the hopes of…-ing etc. Criteria for each content-based family were set as follows:

Religious and spiritual orientation: includes at least one of the following terms: God, Lord, heaven, Thou, eternal, Jesus, Christ or some other biblical/spiritual expression.

Lost hope: loss, depression, meaninglessness, nothing left, beyond all hope.

Hope associated with people: personal pronoun, name of a person, group of people, definition associated with person or people.

These classifications were the first attempt to try to capture the essential elements of hope. The number of codes in code families was a criterion for the following examination (see Koort 1975). The basic assumption was that if some term was presented in many dictionaries (often in 50 % or more), or was cited often in other dictionaries, the more probable is its importance. Of course, in the definition of the meaning it is important to see if some other terms seem to be central for other reasons too and the researcher made the choice also on other premises if necessary. The five families: nouns, verbs, adjectives and adverbs of hope and hopelessness and definitions of hope were left as defining factors in this phase. Adjectives of hopelessness were thought to define lost hope and adjectives of hope were thought to define positive hope. But this needed further examination. The names of the families were left quite flexible in this phase, because of the number of codes and the continuous need to reread the material.

The following figure presents the numbers of codes in the content-based code families and the average mean value (Figure 5).

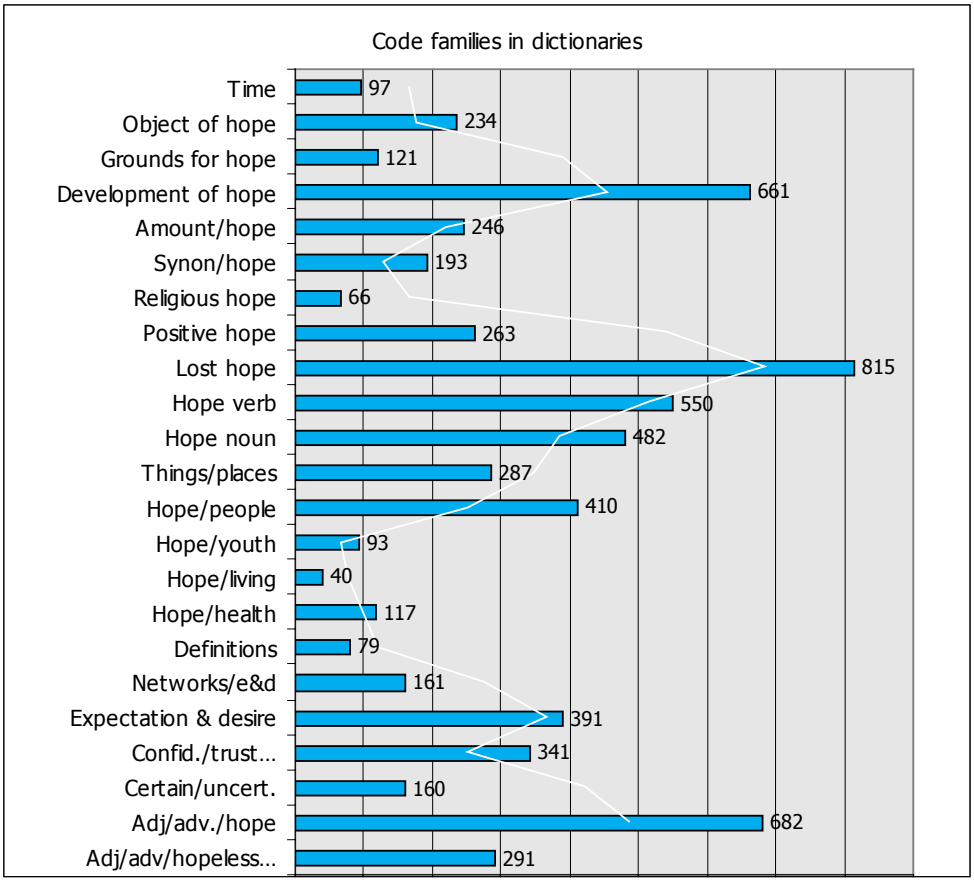

FIGURE 5. The number of codes in content-based code families based on dictionary definition

The number of codes in all dictionaries was 6780 and they were divided into different code families as described above. The number of codes in the family of lost hope gives some indication of its importance. The family positive hope consisted of 263 codes. On the other hand, the number of adjectives of hope (n=682) and hopelessness (n=291) were in the opposite direction. In this first phase, the idea of the developmental nature of hope was

rising. Also, the connection of hope with people was quite clear on the basis of the number of codes. The families: expectation and desire and confidence and trust also had many codes, and they were present in most of the dictionaries. For example, expectation and desire were cited in 66 dictionaries, and there were several examples in the same dictionaries. In the beginning, the researcher had the idea of using Koort's (1979) method in the analysis, but the number of codes and dictionaries changed the type of the analysis. Moreover, the expressions defining hope and hopelessness in English dictionaries were so multiform that the starting point should have been to choose synonym dictionaries to be able to proceed according to Koort's ideas of semantic analysis. For these reasons, the researcher continued to make the definitions based on the ideas of Grounded Theory, which was quite natural, because the analysis programme ATLAS/ti is also built on these theoretical premises and supported the basic thinking. The next phase was to classify the differences and similarities of the contents (discrimination analysis) and to produce new, more precise definitions.

For the next step, the material was organised on the basis of the contextual factors, which were faced with the research question: What is the meaning of hope and hopelessness in the lives of the depressive and non-depressive elderly? This raised the differences of hope and hopelessness and brought the development of hope into the central position. The researcher kept in mind the structure of Grounded Theory and evaluated the factors while structuring them in the context of conditions, strategies and consequences. This structuring of definitions is in appendix 11. The dictionary analysis proceeded so that all the 22 families presented in the table before were gone through as shown by the following example of lost hope. There were the same definitions in many dictionaries and the goal was to get all possible variations of the definitions concerning the family to obtain as rich definitions as possible.

Lost hope (n=815) describes being "out of hope, an absence of hope, without hope, no hope, empty hope". It also points at some limit which has been crossed "past, beyond all hope, no way out (68:338)" and passive abandonment of oneself (86:96). Some descriptions say it quite clearly "have shot one's last bolt" (88:374), "have no cards up one's sleeves" (88:375), "turn one's face to the wall" (88:384) "message of despair"(88:318), "sunk in despair" (88:350). Also tiredness and lack of resources belong to lost hope: "without resources", "unable to stand up for oneself" (91:153), "dead duck" (88:323). When a person has lost his hope, he is cheerless (38:34; 45:40), despairing (27:28; 38:26), depressed (46:80; 51:29) or cynical (46:74) and pessimistic (57:67). When a person has lost hope he gives up, abandons, has no expectation of good (57:75,76; 57:86; 64:70), he gives way to despair (68:296). The situation is ill omened (68:405), without comfort (68:398), past recall (68:420). These definitions are quite final from the point of view of care and raise the question, where is the limit, or is there one as long as a person is alive, where there is no point of return (see Ollikainen 1994)? Based on these definitions, the concepts of hope and hopelessness were defined. The next step was to define the synonyms of hope and hopelessness and, based on these definitions, produce the meaning of hope and hopelessness based on dictionary definitions. These definitions are presented in the section Results.

5.2.2 DATA ANALYSIS OF THE INTERVIEWS OF THE DEPRESSIVE AND NON-DEPRESSIVE ELDERLY

In the figure below (Figure 6), all possible code families (n=40) from the interviews of depressive patients (n=22), are presented. The analysis of the data of the non-depressive elderly was made similarly as presented here with the data of the depressive elderly, so the process is not repeated concerning them. These code families were structured on the basis of the themes of the interviews (see appendices 5a and 5b).

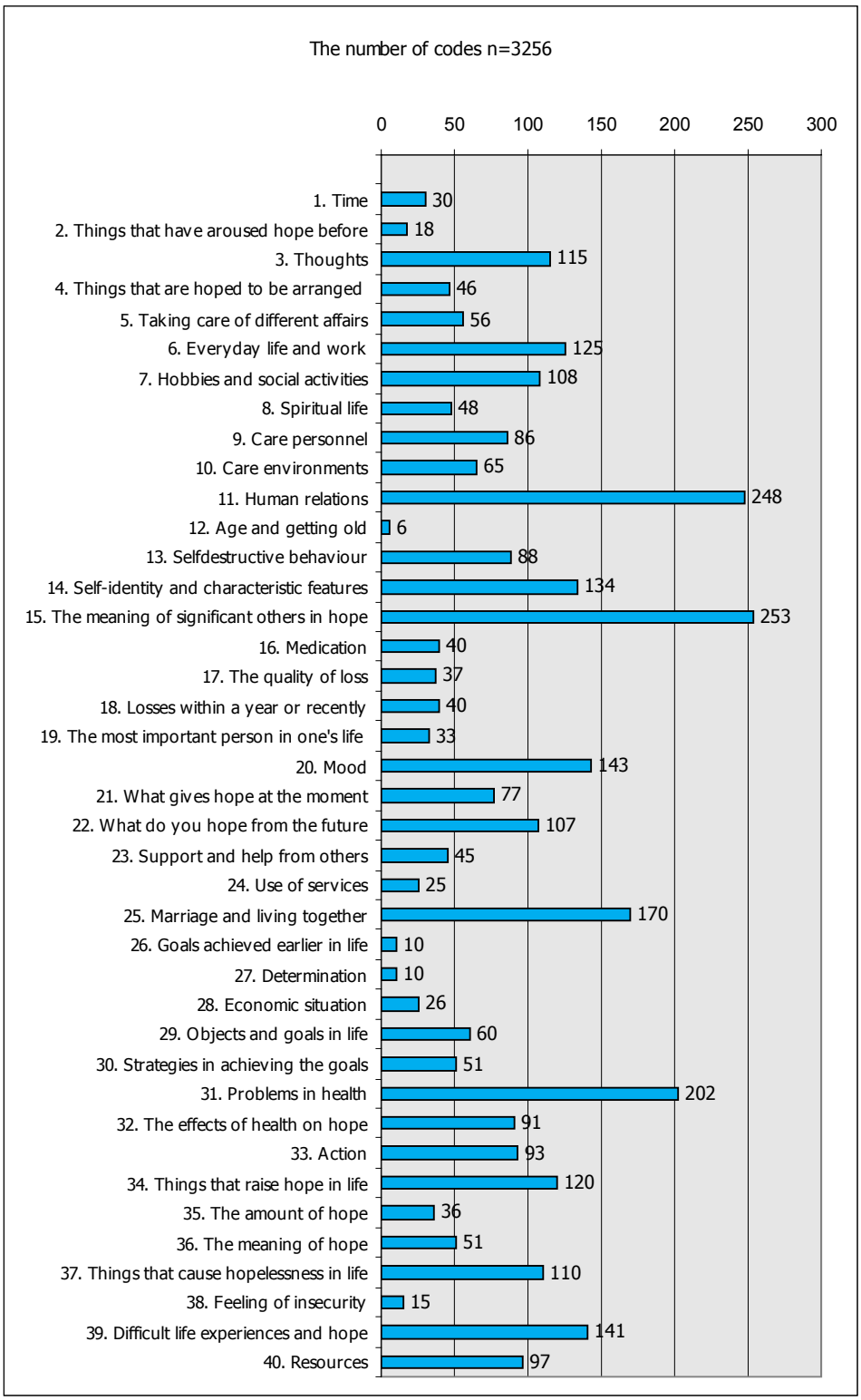

FIGURE 6. The number of code families in the interviews of the depressive elderly

At first, the researcher coded ten interviews (2439 codes) and the remaining twelve were coded after the first checking and structuring phase of the data. The next twelve interviews produced 817 new codes and the total number of the codes was 3256. New code-families were not produced after the 40 primary ones, which came up in the first ten interviews.

The next example describes the coding of the interview material: part of the code family of self-destructiveness (English/Finnish) in the HU 2 of depressive patients. There were altogether 88 single codes in the 22 Primary documents (part of which are presented below), which formed the family of self-destructiveness. As can be seen, there were all kinds of codes, describing reasons, experiences, feelings, goals etc. This sort of structuring in conceptual format was the next phase, which is described in the section Results. The following codes are derived from different interviews and describe the definitions after suicide attempts of some interviewed.

Examples of coding in code family 13: Self-destructive behaviour (English/Finnish):

HU 2: Self-destructiveness / Itsetuhoisuus / Codes in all [88]

[quite…quite a shock it was / aikalainen...aikalainen shokki se oli]

[to shoot right here / ampua tohon noin]

[I was going to jump into the river / jokkee mä aikoisin hypätä]

[I wasn't unconscious but / en ollu tajuttomana mutta]

[that I really..really got frightened / et mää oikeen ...oikeen pelästysi]

[that I would also get away / et määkin pääsisin poies]

[that the grief has done this to me / et se suru on tehnyt mulle tämmöstä]

[they would have then got rid of this kind of old one / he olis päässyt sit tämmösestä vanhasta]

[yes..an overdose / juu yliannoksen]

[I regret it very much / kadun hirveästi sitä]

[I tried twice / kaks kertaa yritin]

[anyway better for them all / kuitenkii heille kaikille parempi]

[when I took the sleeping pills / kun mää otin niitä unipillereitä]

[yes, I did consider it / kyl mää sitä harkitsin]

[because of the depression / masennuksen takia]

[I'm still a little sort of afraid of /mie vieläkin vähän niinku pelkään]

[I would have got rid of my suffering / mä olisin päässyt kärsimyksistäni]

[I had thought that they will find me / olin ajatellut et he löytää minut]

[in my opinion I had suffered enough / olin mielestäni tarpeeksi kärsinyt]

[it came little by little / se tuli pikkuhiljaa] …(continues).

Before the next phase in the data analysis the researcher checked the most prominent areas which seemed to arise from the data, in order to help focusing on the central elements. At the same time, those families which seemed to overlap were checked and the codes in vivo were reread continuously to get an idea of what the data were saying: how is the hope and hopelessness of these people expressed and what is the meaning of it to these people based on their experiences and life history? The researcher struggled between the richness of the data and the reduction of the phenomenon; how to express the results so that the reader could get an idea of the whole in a meaningful way? The solution was to combine some features of quantitative methods in the category-building phase (first decision made on the basis of structured themes and the number of codes, not a directly grounded approach, and after that diving back to the text itself). This helped to proceed with a large number of codes.

The next phase was to build up the meaning units from codes (Figure 7).

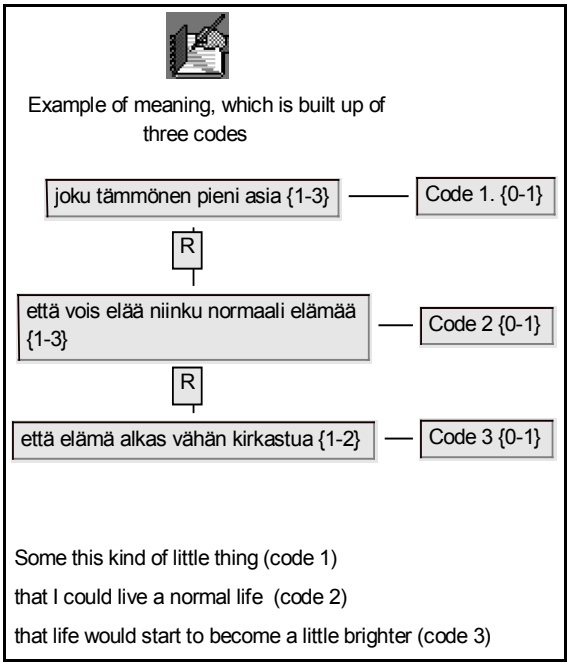

FIGURE 7. An example of code building and meaning

These meanings were not analysed further in the first phase of analysis because the number of codes and code families was great and the researcher did not want to make decisions too early. Later, these meaning units (later MU) were structured into code families so that one code family included all codes of all interview materials in one hermeneutic unit (HU), which was chosen for this family. This coding phase was very critical from the researcher's point of view for the results of the study, because an inappropriate choice would have spoilt a lot of the quality in the final analysis. The researcher could not find other studies, where the coding had been made on these premises in the nursing literature, but the more methodological literature was gone through, the more convenient the solution felt. Anyway, the basic idea was to get as good a picture as possible on the basis of the data on the meaning of hope and hopelessness, so the meaning unit felt appropriate, although building the linkages during the process of coding was very time-consuming.

The coding of this interview material was based on the meaning units (MU) as described above. The researcher coded the interview material in vivo and structured the codes into meaning units (MU) by combining one or a few codes into one meaning unit. The meaning of the code family was formed on the basis of the meaning units in it. Below (Table 2) is presented an example (of three interviews) of forming the meaning units (English/Finnish) under the family "Thoughts", and how the meaning unit of the whole family was formed.

TABLE 2. An example of codes and meaning units

Original codes (Finnish)	**Meaning units of the codes (MU)**
HU: M1, Global selection criteria:All,22 Primary Docs in query:124 quotation(s) found for Query (Infix-Notation):"Ajatukset" /Thoughts	
4:71 kyl se vaikuttaa kauheesti (107:107)	Thoughts have a great effect /Ajatuksilla on suuri vaikutus
4:72 sitä jotenkii ajattelee vaan (107:108) 4:73 kui sitä nyt et ei nuku (108:108) 4:74 ajatukset ovat niinku (108:108) 4:75 alkaa pyörimään vaa siin oman .. (108:109) 4:76 unettomuuden..hmm..ympäril. (109:109)	Thoughts are circulating round sleeplessness/ Ajatukset pyörivät unettomuuden ympärillä
4:168 ja kun yöl herää ja ajattelee.. (206:206)	In the night, when you wake up, you are thinking/Yöllä herätessä ajattelee
4:169 sitä mä teen tai sinne mä nyt meen .. (207:207) 4:172 ja sit syyttelee (208:208) 4:199 että sitä ajattelee (229:229)	Self-accusation of one's thoughts and unrealised plans/Itsesyytökset omista ajatuksista
4:200 äidin pitäis aina jaksaa kaik.. (230:230) 4:201 ei ainakaan niinku lasten silmis.. (231:231)	Mother ought to keep going, especially in front of her children/Äidin pitää jaksaa erityisesti lasten läsnäollessa
4:211 mää koko aika todistelin itteleni.. (241:242) 4:231 älä tommossii ajattele (248:248) 4:232 eikä se ol tullu toista kertaa.. (249:249) 4:235 ni ei ol kyl tullu (250:250)	Trying to prove to yourself that you are not thinking, keeps the thoughts away/ Itselle vakuuttelu pitää ajatukset poissa

4:237 et pelkäänk mää et tuleek niit.. (250:250) 4:239 sit sitä että jos se ajatus tulee.. (252:253) 4:240 eikä tiedä mitä (253:253) 4:241 sen kans tekee niin (253:253)	Being afraid of the coming thoughts and of not knowing how to cope with them/Pelkää ajatusten tuloa ja sitä, ettei tiedä miten niihin voi vaikuttaa
4:265 kyl mää olen tullu simmoseks (274:274) 4:266 et pienimmätkin asiat vähän (274:274) 4:267 niinku simmot huolestuttavat (274:274)	Starting to get worried about even the small matters/On alkanut huolestua pienimmistäkin asioista
4:269 ne huolet on aina semmost (275:275) 4:270 semmosia asioita kun sanotaan (276:276) 4:271 et ihminen kun kerää niitä huolia.. (276:276)	The worries are kind of accumulating/Huolilla on taipumusta kertyä
4:272 niist tulee äkkiä semmonen iso.. (276:276) 4:273 iso vyyhti sit (276:277) 4:274 ne alkaa niinku vallottaa sitä.. (277:277)	They get all tangled up and take over your mind/Niistä tulee pian iso vyyhti, joka valloittaa mielen
4:275 semmonen vähän tiedostamaton on.. (277:278)	Partly subconscious/Osittain tiedostamaton
4:276 et se sit varmaan tämmöt masentaakin.. (278:278)	That is what probably depresses/Se varmaan masentaakin
4:277 nykyisin määkin ajattelen (280:280) 4:282 ja murheet ol viel tänään tehtävis.. (281:282)	Nowadays you don't think today about the worries of tomorrow/Nykyisin ei ajattele tänään huomisen murheita
4:284 ja ihan ittelles saa kyl todisteltuu.. (282:282)	You can assure yourself/Itselle pystyy todistelemaan
4:294 ni ei se auta se ajatuskaa siin.. (285:286) 4:295 et ei saa niinku (286:286) 4:296 katkeemaan sitä (286:287)	You are not able to stop your thoughts by thinking, they come anyway/Ajattelemalla ei saa ajatuksia katkemaan, ne tulevat kuitenkin

4:297 niin se tulee vaan (286:286)	
4:298 se on niin kummallist (287:287)	It is so strange/Se on niin kummallista
4:323 sen takia se ehkä niinku pelottaakin.. (333:334) 4:324 sit kun tulee tällaisia ajatuksia.. (334:334)	That's why it's so frightening when you get thoughts like this/Siksi se on niin pelottavaa, kun tulee tällaisia ajatuksia
4:326 et jatkuuks se näin (334:335) 4:327 kyl sitä sit vähän niinku pelkää.. (335:335)	You are kind of afraid of will it continue like this/Sitä pelkää, että jatkuuko se näin
4:328 et niinku pelkää et (335:335) 4:353 voi se olla et se oli pahakii (354:354)	You are kind of afraid that it may be bad/Sitä pelkää, että se voi olla pahakin
5:6 mutta mä olen tätä asiaa ajatellu.. (29:30) 5:18 mä olen ajatellu sitä asiaa sit.. (34:35)	I have been thinking about it/Olen ajatellut sitä
5:24 No mä ihmettelen (47:47)	I am wondering / Minä ihmettelen
5:45 ja kaikki piti olla hyvin (55:55)	And everything was supposed to be all right/ Ja kaiken piti olla hyvin
5:270 Sitä pelätään (205:205) 5:271 se on aika vaikea asia (205:206) 5:276 ja niin poispäin ja sillä lailla.. (207:207)	It is scaring and quite a difficult matter and so on, like that/Se on pelottava ja vaikea asia
5:454 minua huolestuttaa se vähäsen (385:385)	I'm a little worried/Se huolestuttaa minua hieman
5:457 mää olen tämän asian näin ajatellu.. (388:388)	This is how I have thought about this matter/Olen ajatellut tämän asian näin
10:399 päivä kerrallaan (374:375) 10:400 et katotaan nyt ja (375:375) 10:404 että päivä kerrallaan. (377:378) 10:405 jos tuntuu vaikeelta (378:378)	Let's take it day by day, if it feels difficult/Katsotaan päivä kerrallaan, jos tuntuu vaikealta

Thoughts are connected with negative things/self-accusations/You don't succeed in stopping the thoughts from coming/You don't succeed in stopping thinking/Thoughts are accumulating and growing/Worrying accumulates and fear increases.

In Finnish: Ajatukset liittyvät negatiivisiin asioihin/Itsesyytoksiä/Ajatusten tulon torjuminen ei onnistu/Ajatusten katkaiseminen ei onnistu/Ajatukset kasaantuvat ja kasvavat/Huolestuminen kasaantuu ja pelko lisääntyy.

The meaning unit (MU) of the family "Thoughts": Self-accusation, fears and accumulation of worries caused by uncontrollable thoughts/In Finnish: Ajatusten hallitsemattomuuden aiheuttamat itsesyytökset, pelko ja huolten kasaantuminen

After the coding of the data into the 40 families, they were structured into 6 theoretical families, and then further into three theoretical categories as presented in the figure 8 (see more detailed in appendices 12-14).

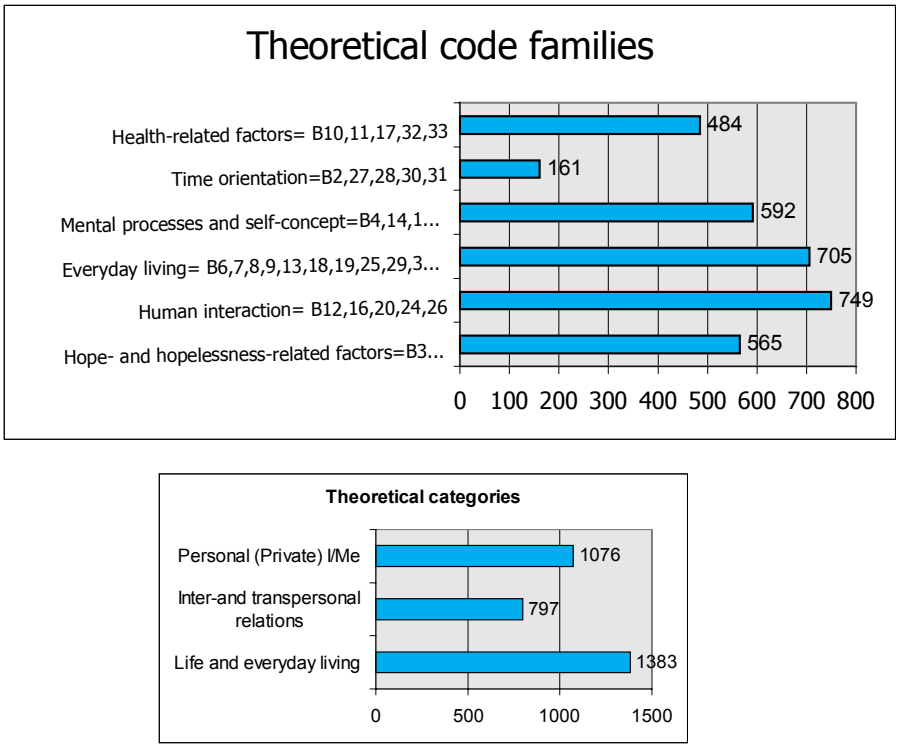

FIGURE 8. Structuring the data from the initial 40 code families into three categories

The final analysis was made on the personal, interactional and the experiential level of life and everyday living. This decision was reached through the synthesis of the concept families; returning back to the roots of symbolic interactionism. The dimensions, which arose in the synthetic writing of the meanings of the code families: experiential, interactional, mental, physical, emotional, spiritual, practical, recreational and aesthetic, were used in the analysis to check how hope and hopelessness were situated and combined in different dimensions of life as a whole from past to future, based on the descriptions of the elderly. The examination was done on the basis of the structure of Grounded Theory: conditions, strategies and consequences. The division into these areas was made by respecting the nature of the data expressed by the interviewed, and thus the conceptual strictness was given some liberties to show the phenomenon as it was brought up in the discussion. As an example, in the next figure (Figure 9), some strategies could be interpreted as belonging to consequences, but they were situated in the expressions as strategies, so they were also situated in strategies in the analysis.

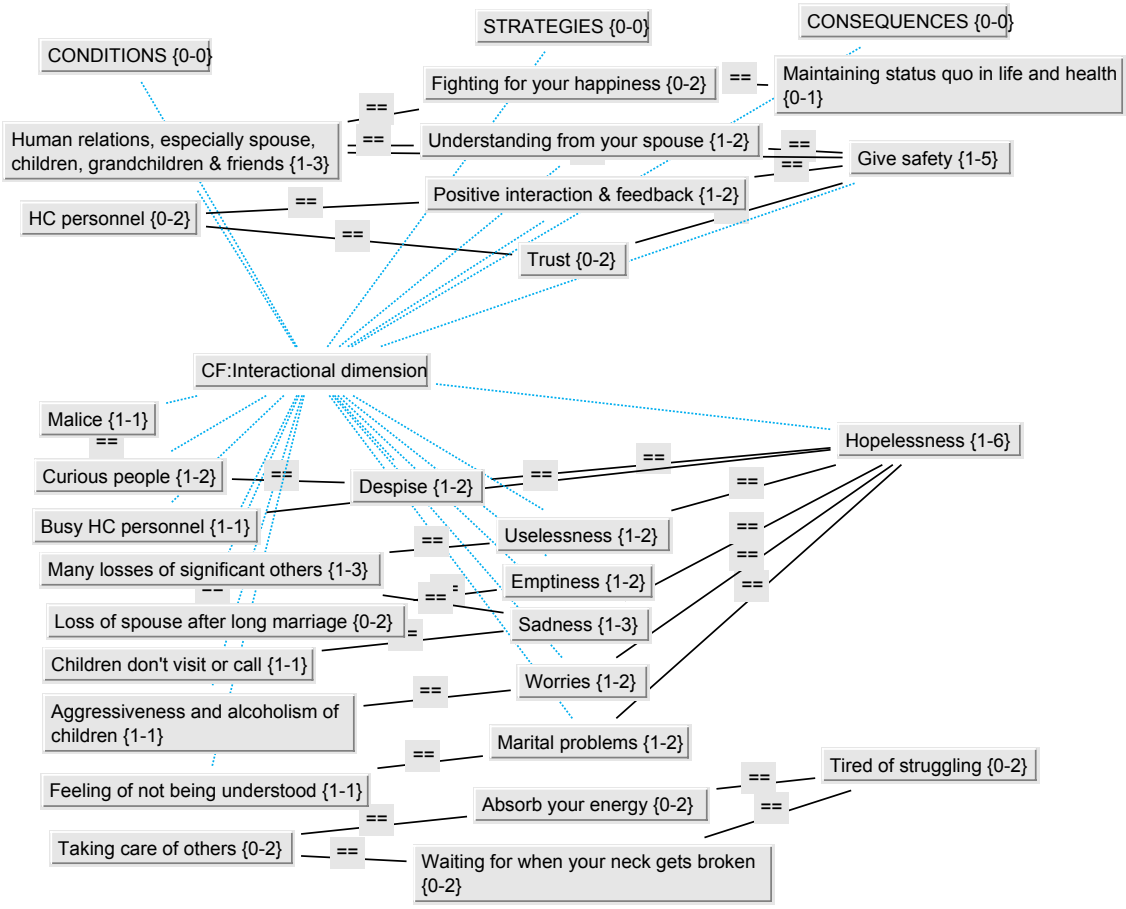

FIGURE 9. An example of the analysis made by the ATLAS/ti programme of the interactional dimension of the depressive elderly

The analysis proceeded by building networks of different dimensions concerning hope and hopelessness expressed by those interviewed as the example above shows, to find out the basic social process and the core category/-ies behind the linkages of the meanings. All the data on all the concept families of the depressive and non-depressive elderly were structured according to the previous example. These were the elements used in building up the relations and the final structure. In the following figure (Figure 10), the structure of the analysis process is defined and also the numbers of codes and code families, which were formed.

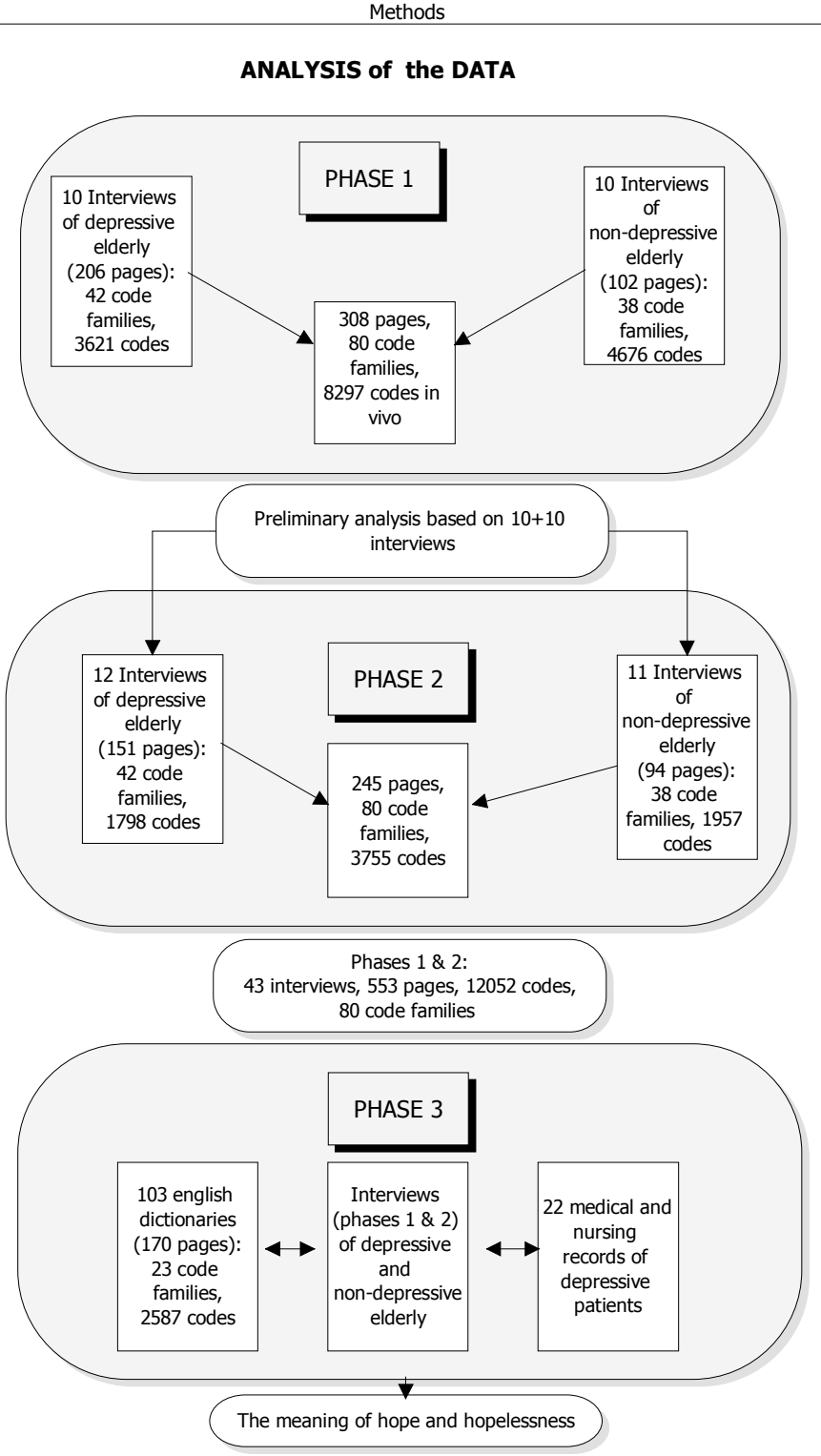

FIGURE 10. The process of the analysis

6 RESULTS

The results of this research were built up in the following phases (see figure 11), based on how the meaning of hope and hopelessness for the severely depressive elderly was defined. In interpreting these results it should be noticed that these results are based on a Finnish elderly population mainly from one city in Finland. The definitions of depression in Finland are based on ICD-10, according to which the criteria for the selection of depressive patients were set.

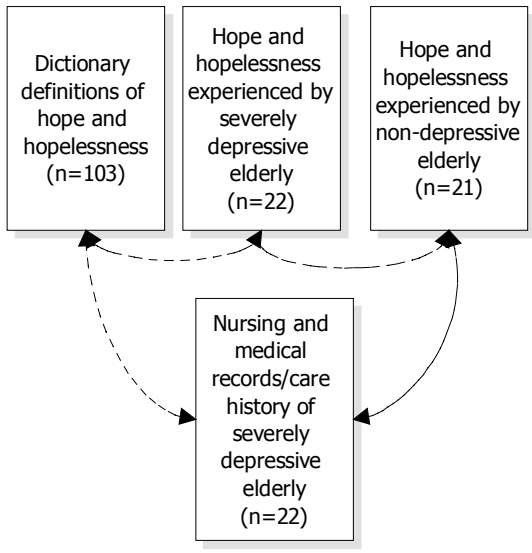

FIGURE 11. Elements of structuring the results of the study

6.1 THE CONCEPTS OF HOPE AND LOST HOPE

In this research the philosophical definitions (presented in the literature review and in the final synthesis) of hope emphasise its nature and definitions as a concept in a wider perspective, in living as a human being. The theoretical definitions (presented in the following results) concentrate on the concept of hope - what is hope, its synonyms and dimensions. The practical definitions deal with nurse's ability to help in maintaining hope in difficult personal situations. The empirical definitions of hope and hopelessness are based in this research on the experiences of hope and hopelessness of the elderly.

6.1.1 THE ETYMOLOGY OF HOPE

Anticipation of futurity is the common idea expressed by Hope, Expectation, Trust and Confidence. Hope is in Anglo-Saxon *hopa* (Crabb 1917). Hope as a noun is derived from *hop*, the ultimate origin of which is unknown. In the 15th century, hoppe, a. MDu. hoppe, DU.hop. (AS. hopa, hope: cf.SW.hopp; Dut. hoop; Ger. hoffen). Hop is a climbing plant whose seeds or flowers give bitterness to beer and ale (Stormonth 1918.) A climbing perennial plant (Humulus Lupulus, N.O. Urticacae, suborder Cannabinae), with rough lobed leaves like those

of the vine. Much cultivated for the green cones of the female plant (1538). To gather or pick hops (1717). To produce hops (1848) (Little et al. 1959.) Hop is also a short leap or spring on one leg; a light leap; hopping, imp. n. the act of advancing by short leaps. Hopscotch, a children's game, in which one hops about among a number of stones laid in regular form upon the ground, without touching any one of them. Scotch is a synonym of hop: to dance, jump, skip, leap, halt, move, play, spring (Stormonth 1918.) An informal dance 1731 (Little et al. 1959.) Hop-o'-my-thumb, a midget (Partridge 1958.) Hop; one stage of a long-distance flight in a flying machine (1909) (Little et al. 1959).

As a verb, hop means to hop, to frisk, to proceed by short leaps on one leg; to skip lightly; to walk lamely, to limp (Stormonth 1918.) Of animals; to move by leaps with both or all the feet at once (1440). Of a person: To leap on one foot, or move onwards by a succession of such leaps (1700). To limp (1700). To hop or jump on to or over (1900) (Little, Fowler & Coulson 1959.) The basic idea would be a leaping, or to leap, with expectation. Hop; to move by short, usually successive leaps, to dance, to tumble (Gr kubistan).(Partridge 1958.)

From the etymological perspective there seem to be at least three aspects which are quite often cited in dictionary definitions. Spring, leap and jump seem to refer to *action*, moving forward. Hop is usually connected with some sort of destination and expectation, but there are also a few hints at imperfection like limping or jumping on one leg. This might refer to *probability* elements of hope. In nursing, this is quite an applicable reference. Another reference hop-plant, which causes some kind of intoxication (Humulus Lupulus, Cannabinae) could be connected with synonyms of hope like, for example, castles in the air, utopianism, pipe dream and day dream, which all point at an aspect of hope which is more unrealistic. Cheerfulness and joy (hopscotch, dance) could classify the third perspective. In the dictionary definitions there are several synonyms which hint at this aspect of hope, like wishful thinking, rose-coloured spectacles, no cause of despair, airiness and optimism, for example.

6.1.2. SYNONYMS OF HOPE

The family synonyms of hope were defined to differentiate between the expressions of direct synonyms and other definitions in the family: hope as a noun. The synonyms of hope are described in the figure below, which defines the semantic field of the synonyms. There were synonyms in 59 dictionaries (57.3 %) out of all 103. The following figure (Figure 12) was formed from altogether 194 quotations.

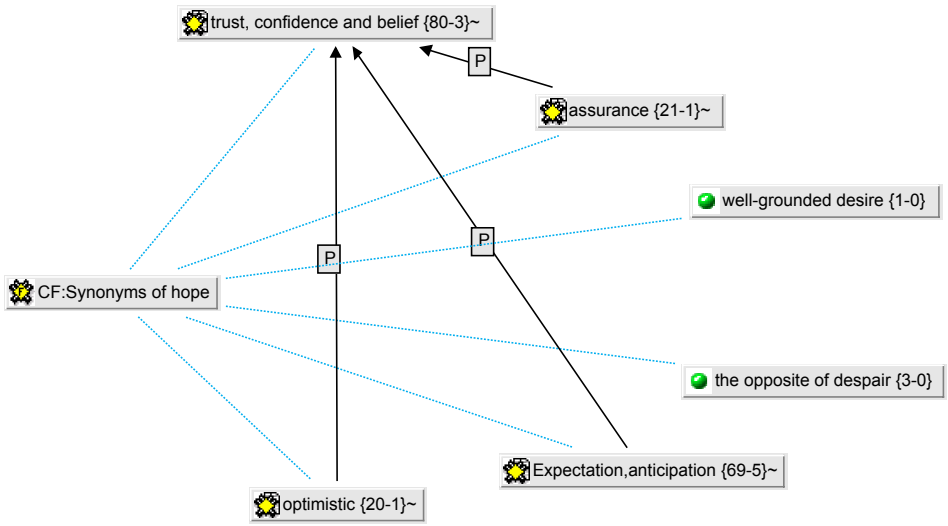

FIGURE 12. The semantic field of the synonyms of hope in English dictionaries (n=103)

Relations between the concepts were made by grouping the synonyms based on the etymology: assurance, assured and assuring formed one family, anticipation and expectation another, and the third one combined trust, confidence and belief in the same family. This is presented in the figure above, in which P-relationships mean - is part of - so that optimism, assurance and expectation and anticipation form part of the process of trust, confidence and belief.

Definitions of expectation often also included desire (expectation and desire were presented together in 66 dictionaries). In one dictionary, it was mentioned as a well-grounded desire. In this phase, the use of ATLAS/ti-programme was really useful, because there were a lot of linkages and relations, memos and quotations, which were of benefit in this phase.

6.1.3 RELATED CONCEPTS OF HOPE

The related concepts were examined on the basis of the following questions:

1. How are trust, confidence, belief, assurance and well-grounded desire related to each other?

2. What are the differences between expectation and anticipation?

3. How is optimism defined?

1) Confidence and assurance closely resemble each other; but *confidence* (confidentia, confidere, fides, faith) is properly used only in relation to *moral agents* and on the ground of probity of character. *Assurance* (fr. assurer, sur, securus, sure) is confidence in oneself, or such confidence as flows from *internal conviction* upon matters of fact. Assurance is passive; confidence is active. Confidence is such assurance as leads to a feeling of security or reliance. To *trust* is to rest upon another as able to bear what we impose; so we trust in what is solid or unsolid; men, who are trustworthy or otherwise, statements, which may be veracious or

not; strength or efforts, which may or may not be equal to the task. Trust in opinion is *belief*; in a religious opinion, *faith*; in pecuniary worth, stability, and integrity, credit; and in moral probity, combined with sufficiency or power, confidence. *Assurance* is based upon mental confidence on moral evidence in favour of the thing expected (7:15-27).

2) "In its general operation the indulgence of *hope* is mixed with certain portions of *doubt and solicitude*; but when doubt is removed, and the expectation becomes sanguine, hope rises into *joy*; and it has been known to produce transports and ecstasies equally with the full accomplishment of ardent *desires*."(Ibid). We hope for that which we much desire and somewhat expect. *Anticipate, await, dream, expect, forsee and wish* pertain to the attitude of looking forward to something that is to occur in the future. *Hope* suggests looking forward exclusively to some positive or favourable outcome; it may be well founded in probability or completely beyond the pale of the possible. *Wish* suggests something considerably less plausible or likely than hope. Where hope may be part of an ennobling or heroic attitude, wish gives off a flavour of idle childishness that is unwilling to take a realistic stand: wishing for the good things of life rather than working for them full of confidence and hope. If one *wishes* to do or have something, *one wants it without thinking whether it is possible*: I wish to go (=I want to go) The word is also used for *impossible desires*: I wish I were French./I wish you'd told me. But if one *hopes* to do or have something, *one wants it and believes that it is possible* to do or to get it: One cannot hope nor have hopes about impossible things. Compare: I have no wish to go (= I don't want to)/ I have no hope of going (=I want to but I know I won't). Wishful thinking is something, which you hope for or want to believe but which is very unlikely to happen or to come true. *Dream* suggests an even more tenuous basis for looking forward than wish, implying a complete, if momentary, retreat from reality. Unlike wish, dream can be used in a way that parallels the noble sense of hope: a person ceases to be human when he ceases to dream. Furthermore, both dream and wish are not necessarily restricted, as with hope, to future possibilities: wishing she had been born a princess; dreaming of a happier life on some other planet. *Expectation* comes from Latin expectare, e or ex, out, and spectare, to watch. Expectation suggests looking forward either *to a positive or to a negative outcome*, but the point is that it concerns itself with *supposed certainties*. *Anticipation* is closer to hope than dreaming or wishing because of its future orientation. But while the word is frequently connected to thoughts of a pleasant outcome, it can also be used for imagining an unpleasant outcome. Anticipate is commonly used like foretaste, of that which we expect with both confidence and pleasure. In this use it is a stronger word than hope, where often the wish is father to the thought. *Await* stresses a certain passiveness of attitude while watching for something imminent to occur, whether positive or negative, whether expected or not. *Foresee* introduces another aspect of looking forward to the future; it suggests an attempt to infer or guess what the future might be, rather than imagining an outcome either in accord with what is hoped or opposed to it; foreseeing by every sign. (7:1-35; 88:57; 51:15-17; 73:9-49; 83:42-48; 94:52-54.)

3) *Optimism* means being full of hope, expressing hope. Hopeful words stimulate optimism. Optimistic usually implies a temperamental confidence *that all will turn out for the best:* unlike hopeful, it often, but far from commonly, suggests a failure to consider things closely and realistically or, even, a willingness to be guided by illusions rather than by facts. Sometimes, however, the term carries a suggestion not of weakness but of a fundamental faith*. Roseate and rose-coloured*, in their figurative senses only, imply the optimism of an aboundingly cheerful temperament which enables such a one to see persons, events, situations, and the like, "through rose-coloured spectacles", that is, in their most attractive and alluring aspects. The terms definitely imply illusion or delusion and therefore connote the element of falsity, though not necessarily intentional falsity; a rose-coloured view of the world's future. (46:29-42; 86:63). The definition of optimism seems to have two-fold

elements: on one hand, the suggestion of a fundamental faith, and on the other hand, a failure to consider realistically.

6.1.4 LOST HOPE BASED ON DICTIONARY DEFINITIONS

Lost hope means an absence of hope, being without hope and empty hope, which point to the presence of hope as an opposite. Lost hope was used as a synonym to hopelessness in many dictionaries, but the nature of it seemed to be more ultimate, a situation without return. There is a limit, after the crossing of which, comes the point where one is beyond all hope and there is no way out. The person "has turned his face to the wall". The situation is ill omened, irreparable, dangerous and threatening, without comfort and past recall. It is useless and vain to try anything. The person gives up, abandons hope and has no expectation of good: he gives way to despair. He is incapable of solution, compliant, discouraged, inadequate, miserable, not able to learn or act, not competent, unqualified, completely lacking in ability. A person who has lost hope is tired and without resources. He is broken and worn out, faint and helpless. He is unable to stand up for himself, he is bootless. He is sad, downcast, cheerless, depressed, despairing, pessimistic and/or cynical. (See appendix 11.)

Hopeless, despairing, discouragement, despondent, desperate, all describe an absence of hope. *Hopeless* is used of a feeling of hopelessness and passive abandonment of oneself to fate. Hopelessness is negative, and may result from simple apathy; it implies loss of hope, often followed by discontinuance of effort; despondency and despair are more emphatic and decided. *Despairing* refers to the loss of hope in regard to a particular situation, whether important or trivial: it suggests an intellectual judgement concerning probabilities. Despair is the utter abandonment of hope. *Desperate* conveys a suggestion of recklessness resulting from loss of hope: as the time grew shorter, he became desperate. Desperate may apply either to feelings or to situations; the case seems hopeless but it is not yet desperate. Despairing and despondent may apply only to feelings. Despair may produce a stony calmness, or it may lead to desperation. Desperation is energised despair, vigorous in action, reckless of consequences. (see appendix 11.) In the dictionary from 1965 (Fowler), it was emphasised that desperation never now means, as formerly, mere despair or abandonment or loss of hope, but always the reckless readiness to take the first course that presents itself when every course seems hopeless. *Discouragement* is the result of so much repulse of failure as wears out courage. Too frequent and long continued discouragement might produce a settled hopelessness. *Despondent* always suggests melancholy and depression; it refers to an emotional state rather than to an intellectual judgement: despondent over ill health, she became more and more despondent and suspicious. Despondency is an incapacity for the present exercise of hope; it relaxes energy and effort and is always attended with sadness or distress. (51:33-39; 53:56-67.)

6.1.5 HOPE AND LOST HOPE BASED ON THE DICTIONARY DEFINITIONS

In the following figure (Figure 13) is presented the idea of hope and hopelessness based on the definitions of 103 English dictionaries. The figure does not give the whole picture of the process of hoping and its development, nor the diversity of life in interaction with others, but rather combines the central elements of the definitions.

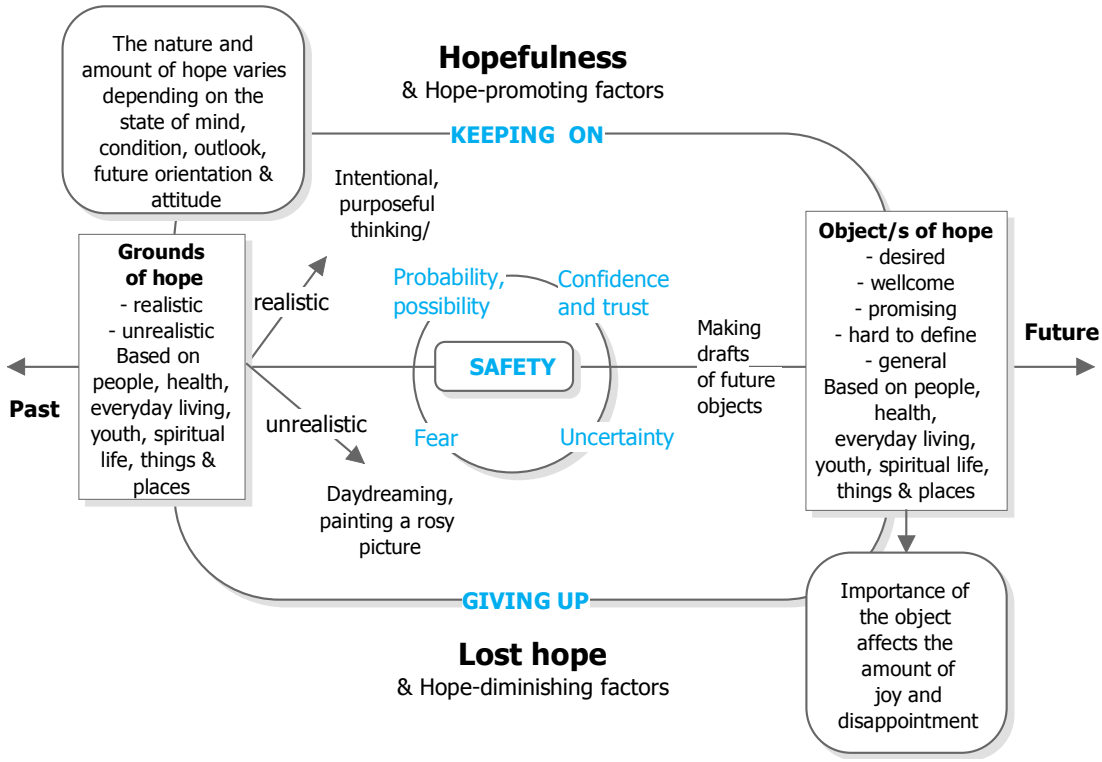

FIGURE 13. Hoping process based on English dictionary definitions (n=103)

On the basis of the dictionaries (n=103), hope can be defined as an orientation to the future with a certain amount of trust and confidence. The expectation includes possibility, which sets certain boundaries for security and belief. Hope is more often connected with the future and making drafts of the possible object belongs to it; but it may also be based on the past or present. Hope can be daily, temporary or continuous in nature. Sometimes the object might be hard to define or hope can be objectless or more general in nature. Different levels of hope can be defined: fundamental, interpersonal and personal levels of hope. The object of hope is something desired, favourable, welcome or promising, something which is positive in nature.

The nature and amount of hope might vary. Hope is defined as a state of mind, condition, outlook, future orientation and attitude. The hoping process can be intentional, purposeful thinking, imagining and dreaming, full of feelings combined with the object, the value of which is important concerning the amount of hope. Hope can be unrealistic and it may be supported and cherished in different ways. The experiences may vary between trust and distrust, faith and suspicion, fear and assurance. On one hand, uncertainty and threat and, on the other hand, confidence and possibilities may vary along time. Especially prolonged anticipation may crush and destroy hope; this is often combined with disappointment and a lost object.

A hoping person is calm and confident or fanatic and ready to take risks, daydreaming or intentional and joyful depending on how reality-based the hope is, and how important the object of hope is for the hoping person. Hope is often connected with youth and promising life situations. On the other hand, despair and hopelessness are always present because of

the uncertainty of the object. When the amount of hope diminishes to the extent that there is no more hope or hope is crushed - hope is lost - hope turns to despair, which is a joyless state in which there is no hope left.

The hoping process depends on the grounds of hope. If they are well defined and realistic, the process also is mainly deliberate and purposeful towards the desired object. If the grounds are unrealistic, also the process is often utopia-oriented, and feelings are guiding the process. In this case one could rather talk about wishing. The objects of hope seem to be the same as the grounds of hope based on these dictionary definitions. People, health, everyday living, youth, spiritual life and things and places are, at the same time, both grounds and objects of hope. For example, parents ground their hope in their son as heir of their fortune, and at the same, time their hope is centred in their son and his success in life is the object of their hope. The importance of the object is crucial concerning the amount of joy and disappointment. On the other hand, time plays a remarkable role in the hoping process, because lack of energy might be the result if the object is deferred and its attainment seems more impossible. There is a limit which is important in the sense that hoping might turn to losing hope, and the process may lead to total hopelessness, which is the situation where one has nothing to expect any more. Striving for safety is central in fighting against uncertainty and fear; this keeps the process moving in the direction of fulfilment. (This feature was explained more detailed in older dictionaries, which can partly be explained by wars, poorer health conditions and economic depressions). On the basis of these definitions, it is important to support and cherish the hoping in different ways. Making drafts of the future and imagining the desired object keep the hope alive. From the point of view of nursing, this provides many interesting challenges, which are brought up in the final discussion after all the results have been presented.

6.2 HOPE AND HOPELESSNESS EXPERIENCED BY THE SEVERELY DEPRESSIVE ELDERLY

Hope and hopelessness were studied by examining the care history and medical and nursing documents of the depressive elderly, the MÅDRS scale results and the interview data, which were gathered mainly within a two-week period after the hospital admission. One patient attended only the outpatient department and did not have hospital treatment.

6.2.1 THE PSYCHIATRIC CARE HISTORY OF THE INTERVIEWED DEPRESSIVE PATIENTS

The psychiatric care history was gathered to give a wider perspective of the development of depression and care. Some of the patients had also had some shorter care periods in the University Hospital or in private health care (not included in the table 3 below). The care periods of the interviewed patients were collected from the year 1995 until the end of June 2001 (when the last follow-up interviews were made). The one-year follow-up interview data are not included in this research). In the table below, the days of care are presented as follows: 1) hospital days (HD), 2) day-hospital or other kind of psychiatric care facilities and group treatment (DH/G), 3) Out-patient services, most often care in the psychiatric outpatient department for the elderly (OPS). In the first column P1/81/f stands for patient's number/age/gender.

TABLE 3. Psychiatric care periods of the depressive patients (n=22)

Patient/age/ gender	Hospital days (HD)	Day hospital and Groups (DH/G)	Out-Patient services (OPS)	All days of care	% of hospital days	% of all days of care
P1/81/f	47	1584	0	1631	2.0	5.8
P2/89/f	29	63	0	92	1.2	0.3
P3/75/f	208	262	1273	1743	8.8	6.2
P4/68/m	66	1274	266	1606	2.8	5.7
P5/71/m	45	352	0	397	1.9	1.4
P6/82/m	29	0	0	29	1.2	0.1
P7/69/f	79	2262	863	3204	3.3	11.4
P8/73/m	43	2800	0	2843	1.8	10.1
P9/72/f	207	5203	145	5555	8.7	19.8
P10/71/f	87	640	0	727	3.7	2.6
P11/66/f	285	110	92	487	12.0	1.7
P12/85/f	13	0	134	147	0.5	0.5
P13/72/f	184	438	1011	1633	7.8	5.8
P14:73/f	85	295	0	380	3.6	1.4
P15/77/m	0	573	0	573	0.0	2.0
P16/79/f	52	42	1498	1592	2.2	5.7
P17/77/f	302	225	655	1182	12.7	4.2
P18/67/f	174	848	16	1038	7.3	3.7
P19/82/f	265	144	124	533	11.2	1.9
P20/81/f	55	83	225	363	2.3	1.3
P21/72/f	59	624	722	1405	2.5	5.0
P22/71/m	60	817	0	877	2.5	3.1
Total	**2374**	**18639**	**7024**	**28037**	**100**	**100**
% of total	8,5	66,5	25			

Of all the hospital days the share of men was 10.2 % although their percentage of all those interviewed was 27 %. There were seven patients who had more that 100 hospital days within the five and a half years, and five of these seven patients had over 200 hospital days. Of these seven patients, four had had suicide attempts and the rest had had suicidal thoughts. All of them had several hospital treatments, and three had tens of years of care history. Three patients had very traumatic memories from childhood and the rest had loss of spouse, after which the self-destructive behaviour: alcoholism, overuse of medication and suicide attempts, had started. One patient had 100 prescriptions from fourteen different doctors at the same time, which shows the need to co-ordinate the care between different actors in health care. Two of these patients had hallucinations and fears, which led to suicide attempts. There were self-accusations and things, which worried continuously, problems with housing and coping with everyday living. Children made contact and took care of their parents, but in a few cases, there seemed to be tiredness with the situation and the continuous worrying, which came up in demands concerning hospital care. In table 4 is presented the care history of the depressive patients between 1.1.1995 and 30.6.2001. The last date was chosen on the basis of the last interviews in the 1-year follow-up (the results of which are not presented in this research as mentioned before).

TABLE 4. The care periods in mental hospital of the severely depressive 22 elderly patients 1995-2001

THE CARE OF THE SEVERELY DEPRESSIVE ELDERLY (N=22) IN MENTAL HOSPITAL IN THE TIME PERIOD: 1.1.1995-30.6.2001

The length of hospital care in days (columns)

Patient's number	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	All days/care period	% of all days	Average length/period
HC=hospital care																									
HC1	31	29	30	14	4	29	3	43	66	87	7	13	77	81	0	34	40	29	8	4	17	60	706	29,7	32,1
HC2	16		10	52	41		76		125		48		12	4		18	58	28	189	41	42		760	32,0	54,3
HC3			52						16		119		5				6	47	54	10			309	13,0	38,6
HC4			16								48		33				125	14	14				250	10,5	41,7
HC5			21								30		34				73	56					214	9,0	42,8
HC6			29								33		23										85	3,6	28,3
HC7			30																				30	1,3	30,0
HC8			20																				20	0,8	20,0
All days/patient	47	29	208	66	45	29	79	43	207	87	285	13	184	85	0	52	302	174	265	55	59	60	2374		
% of all the days	2	1	9	3	2	1	3	2	9	4	12	1	8	4	0	2	13	7	11	2	2	3		100,0	

Of all 22 patients, one patient managed without hospital treatment during the period 1.1.1995-30.6.2001.

Six patients had only one care period within the five and a half years.

One patient had eight care periods, and seven patients out of all 22 patients had more than three care periods.

The variation in the length of hospital care in days was from 0 to 302 days.

Death during follow-up time

First interview

First interview during outpatient care

The following figure 14 presents the hospital days of the depressive patients. The hospital periods were related to severe diseases (like operated cancer and fear of death), losses of spouse and overuse of medication, or alcohol overuse after the spouse's death. There were also losses of home after the spouse's death and cumulating things, which changed the life course. As one of the interviewees said " First was the hip operation which failed, and after that they started to give me medication for hypochondria, which muddled the rest of my life (P 13)." Those who had most hospital days, had in their medical documents the feeling of a lack of importance, which was often documented in connection with self-destructiveness or suicidal thoughts: "There is no-one to need me anymore (P 17)." In the medical records there were symptoms like: Lack of interest, inactivity, powerlessness, lack of appetite, sleeplessness, difficulties in concentration, tiredness, lack of energy, lack of will to do anything, fears, head does not feel normal, panic reactions, wish to die, self-destructiveness etc.

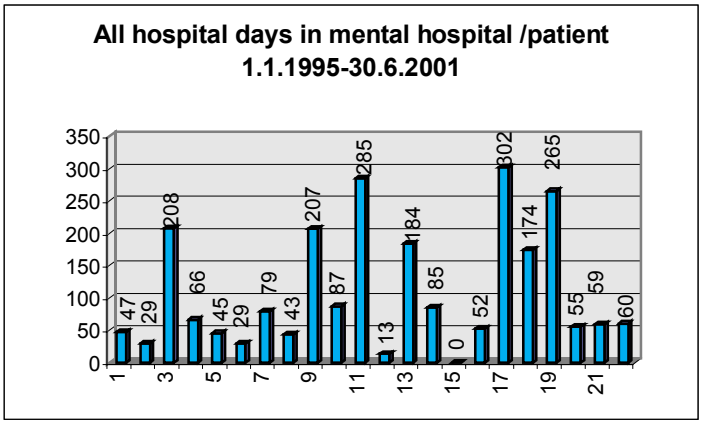

FIGURE 14. Hospital days in mental hospital of the depressive elderly (n=22)

When the researcher checked the interview memos concerning the seven patients who had had most hospital days, the notes told their own story: " A timid, silent wanderer through life, who has had hard experiences since childhood. Strict father, no joy from mother, husband has been several times in jail and son, whose wife died of cancer, is an alcoholic. The patient has self had cancer and now has a tumour in the stomach." Or another example:" The patient is living totally at the mercy of her feelings, stroke and cancer have left their marks. The fear is so real that you can almost touch it… the risk of suicide."

6.2.2 MONTGOMERY-ÅSBERG DEPRESSION RATING SCALE VALUES OF THE DEPRESSIVE PATIENTS

In the psychiatric care units for the depressive elderly in which the interviews were conducted, the Montgomery-Åsberg Depression Rating Scale (MÅDRS) was used to assess the severity of depression. These ratings, made by the personnel of the care units, were one of the criteria, on the basis of which the patients were selected for the research. The rating scale consists of the evaluation of the following symptoms: apparent sadness, reported sadness, inner tension, reduced sleep, reduced appetite, concentration difficulties, lassitude, inability to feel, pessimistic thoughts and suicidal thoughts. The ten ratings use 0-to-6 severity scales, with higher scores reflecting more severe symptoms. The limit of clinical depression is regarded as 20 points. The proposed cut-off point is 12 for mild depression, 24

for moderate depression and 35 for severe depression. Those included in this research were supposed to have 10 or higher scores in MÅDRS. The researcher filled in the scale with each patient in the beginning of the interviews even though they had been filled in before in the units. One reason for this was to get a concrete starting point for the interviews, because the researcher knew from previous experiences of interviews with the depressive elderly that it was easier to start the interview with a more concrete item. The researcher has been trained to use the scale when working as a nursing supervisor in those units. There were no remarkable differences compared to those filled in by others in the units. The following figure 15 presents the results of the rating scale values.

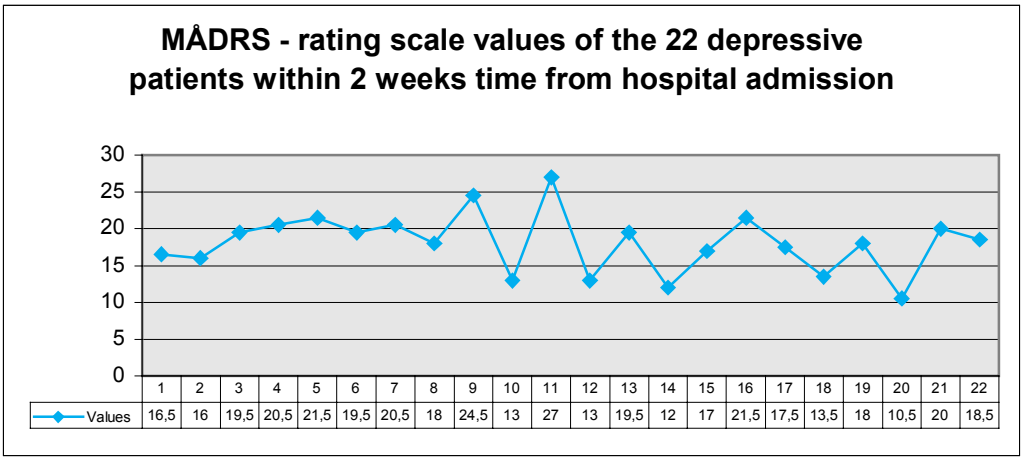

FIGURE 15. Montgomery-Åsberg Depression Rating Scale values of the 22 depressive elderly within two weeks from admission to psychiatric hospital

The values varied from 10.5 to 27. Sixteen patients expressed their suicidal thoughts and some of them told about the ways in which they had planned to commit suicide. Three of the patients reported having attempted suicide before hospital admission once or several times. When the results were compared with the hospital days of the patients, some similar trends could be seen, the higher the scores, the more hospital days, but this might also be just an interesting co-incidence, which needs further examination.

6.2.3 EXPERIENCES OF HOPE AND HOPELESSNESS IN SEVERE DEPRESSION

In the final analysis of the interview data of the depressive elderly, there were altogether 3256 codes in vivo, which were organised into 40 code families. The analysis was made in sequential phases as was described in figure 10. These code families were further grouped for the analysis (see figure 16):

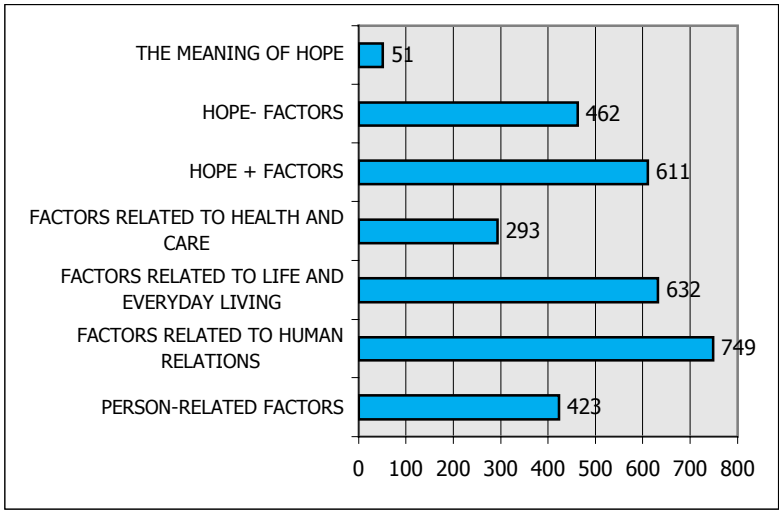

FIGURE 16. The number of codes in each factor in interviews of the depressive elderly

In the figure above the 40 families were grouped on the basis of their contents into: 1) person- related factors 2) factors related to human relations 3) factors related to life and everyday living 4) factors related to health and care and then A) hope + factor, which included the elements of hope-promoting factors and B) hope - factor, which were hope-diminishing factors and C) the meaning of hope, which was directly asked as such from the interviewed. There were some factors, which could have been organised in some other group too, but the final decision was made on the basis of the contents; how the content fitted into the group as a whole. The list of the factors is presented in the appendix 9.

The purpose of this structure was to make a difference between those questions which were asked directly as being connected with hope or hopelessness, and the other factors which were studied as "raw data" without direct hints at hope or hopelessness, except the factor: The effects of health on hope, which was grouped in the category, factors related to health and care, because of its contents. In the final analysis, the contents of the families were structured according to the Grounded Theory in conditions, strategies and consequences, and these were reported in three main areas: 1) Life and everyday living 2) Personal experiences and 3) Trans-and interpersonal relations. To find out the basic process and the core category, several groupings based on time span and relations between different codes and families were analysed (see appendices 13-17).

Life and everyday living

The participants of this research were born in the years 1911-1935, most of them between 1920 and 1930. This generation has an exceptional life history, because they have gone through two wars. Some of them were resettled around Finland. After the first war period (1939-1940) some went back to Eastern Finland, Karelia and built their houses again and they had to flee again, when another war period started (1941-1944). Some of the interviewed elderly were children and others were young during the wartime.

In the next descriptions the quotations from different interviews are collected and presented in parenthesis, but the sources (numbers of interviews and lines of documents) are not used in the text of results because the coding was made from all the interview data and it would

have made the text hard to read. Different quotations are separated from each other with comma within the parenthesis. Each quotation can be tracked by using the search operations of the used programme ATLAS/ti line by line. The results are written as follows: raw codes, meaning units, meanings of code families and synthesis based on these. Experiences are understood as the totality of a person's characteristics, perceptions, feelings, memories and accumulated knowledge, which make up the particular quality of a person (see Collins 1994, 546).

Childhood of the depressive elderly

The depressive elderly did not tell very much about their childhood at first. The descriptions were very short. Hard work and different kinds of fears were usual. As the interview proceeded, these themes started to rise spontaneously. Maybe it was a question of trust. Especially within one's own family, in the neighbourhood and among relatives, fears like assaults, different kinds of violence, drinking, attempts at sexual assault, saving parents from killing each other, severe diseases and other very difficult experiences were still, even after 40-60 years, emotionally very delicate subjects. The elderly were told that if it was difficult to speak about those memories, they had the choice to stop at any time. The amount of difficult experiences was unexceptional compared to the childhood of the non-depressive. Also an abundance of many emotionally hard experiences was common. The picture was one of gloom, and hopelessness was strongly present.

Youth of the depressive elderly

The youth of the depressive elderly followed the gloomy atmosphere from childhood. Earning one's bread with hard work since childhood came up in many interviews. There were several experiences of war babies, either their own or their sister's or girls' from the neighbourhood, and being despised by others. There were also effects on the later family life and fears in sexual life, which were rooted in those experiences. The guilt, which was associated with abandoning one's child, still followed them. Single parent life without social benefits was hard without the support of family and with the verdict of the society. There were also some brighter periods but, in general youth was cheerless, but one way or another it was gone through with persistence day by day.

Working-life of the depressive elderly

The work had been experienced mainly as hard because of the many work places during the same day (even three different jobs in one day). There were single parents who had to bring up their children without others' support and without social benefits. They had hoped not to become ill, because this was a real threat to well-being. There was no time to be anxious or worried because you had so much to do and, in the evening, you were so tired that you slept at once. Salaries were low, but the income was gathered from many sources. The basic process of everyday living was filled with earning one's living with hard work, and in some cases separated from the significant others or living in fear. Living day by day, working hard and without attempting anything special described most of the descriptions. Children and their success seemed to be desirable and that also gave pride to parents. The parents wanted to secure for their children such possibilities that were out of reach for themselves.

Satisfactory economic well-being was created by their own hands and with hard work. Continuous lack of money was a problem especially in situations, in which unexpected expenditures like long-term diseases occurred. It was hoped that the reallocation of social

benefits would be reconsidered in such cases. As one of the interviewees described her life in the words of a poet " Human life is mountains and valleys, lights and shadows."

Old age of the depressive elderly

Life had changed so that now it was time to concentrate to one's own life and the life of children. When life had sort of settled down, it was "like meaning of life had disappeared" like one of the interviewees told. Life was getting along day by day. Even the old age was burdened with the memories of former years "This is this earthly wanderings, human being adjusts to almost anything". After working hard all your life and after giving your children the possibilities of a better life and education than you had yourself, you find yourself unable to accomplish even the smallest activities of everyday living. The all-embracing lack of initiative and the feeling of guilt fill your days instead of satisfaction and joy, when looking back over your life as a whole. An example of a life-experience is defined in the following figure 17.

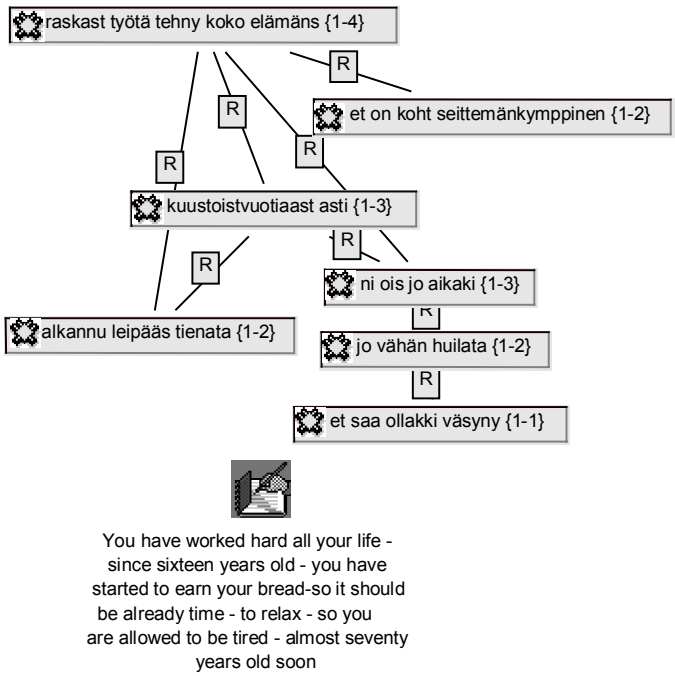

FIGURE 17. An experience of life of a depressive elderly

In depression, passing the time was a problem and time orientation was mainly in today or the past. The time concept was defined in connection with important people or events. Lack of initiative suffocated the plans to take care of different affairs, and this activated the circle of quilt (you should do this and that), which got worse and increased the lack of initiative and inability to get a grip on the fatigue, which was all embracing. You were sort of clasped in the arms of inability. Lack of energy and lack of will, fatigue and lack of initiative were repeated on and on. All efforts were felt to be compulsory, because of the lack of the necessary energy. The necessary efforts were in the mind all the time, but you could not even think about them.

If you happened to get something done, it gave you a very good feeling. Rest-try-rest, little by little, day by day - seemed to be the pattern to pass the time from morning till evening.

Religion was a source of comfort in difficult situations. However, many believed that no one except themselves could help them. They had been accustomed to trust themselves in difficult situations also earlier in life. In general, it was quite common that at this age you no longer set goals for the future, you have already achieved the things which were considered worth striving for or if you had not you have accepted the realities as such. Health, autonomy and general well-being were still considered very important goals in old age. The all-embracing lack of initiative was visible also in this sense - why plan strategies or set goals if you need all your energy to get out of bed. Also - at this age - was one expression, with which goal setting was questioned.

Hobbies were sources of joy, but many had given them up, especially social activities, because of physical and psychological restrictions. Hobbies were a source of enthusiasm, experiences, contacts, aesthetic pleasure, new skills and the possibility to be together with grandchildren through their hobbies. Without possibilities to attend social activities your days easily became boring.

Lack of knowledge concerning services and costs of services hindered their use. The possibility to make more decisions concerning the delivery of services was important from the point of view of the elderly. Help was needed mainly in shopping, cleaning and transportation. Children were asked to look for the information, because they were more used to it.

Hope was structured earlier in life on human relations, home, nature, work and getting over difficult phases in life. Interaction with others was an important factor. In old age, hope was based on the basic belief that managing step by step is possible. Assisted by others, it was easier, but you could also build your hope on your former experiences. Anyway, the plans mainly reached only as far as tomorrow. You did not dare think further. Hope could also be just waiting, waiting for tomorrow. Careful and slow progress defined the process of daily living:" ….then I lay down, then I warmed the meal, then I washed dishes, then I went to lie down, then I woke up, then I got up, then I drank tea, then I ate a little, then I watched TV, then it was evening and then I went to bed, so the days go on."

Hopes directed to the future meant maintaining the status quo or the status as it was before depression. The term future was described mostly as tomorrow. The worsening of the situation was a threat to both physical and mental well-being. Things that arouse hope were related to human relations and interaction with each other, mostly spouses, children and grandchildren. Hobbies that brought pleasure and activities at home were considered important hope-promoting factors. Health was mentioned as an important condition to be hopeful and also getting over difficult life situations like suicide attempts. There were also a few of those interviewed who could not see anything hopeful in their life: "There is nothing, just nothing…".

The amount of hope seemed to change already within a few weeks in the hospital and, on the other hand, over several years there were no big changes. The lack of hope was defined deliberately as total zero. The amount of hope was connected with the start of depression and, on the other hand, with the days without depression. Those interviewed seemed to be very well aware when they were hopeful and when not. The next two figures (figures 18 and 19) present the hope-diminishing and hope-promoting factors (from more detailed abstraction level/first figure, to more reduced level/second figure) in the lives of the depressive elderly based on the interview data.

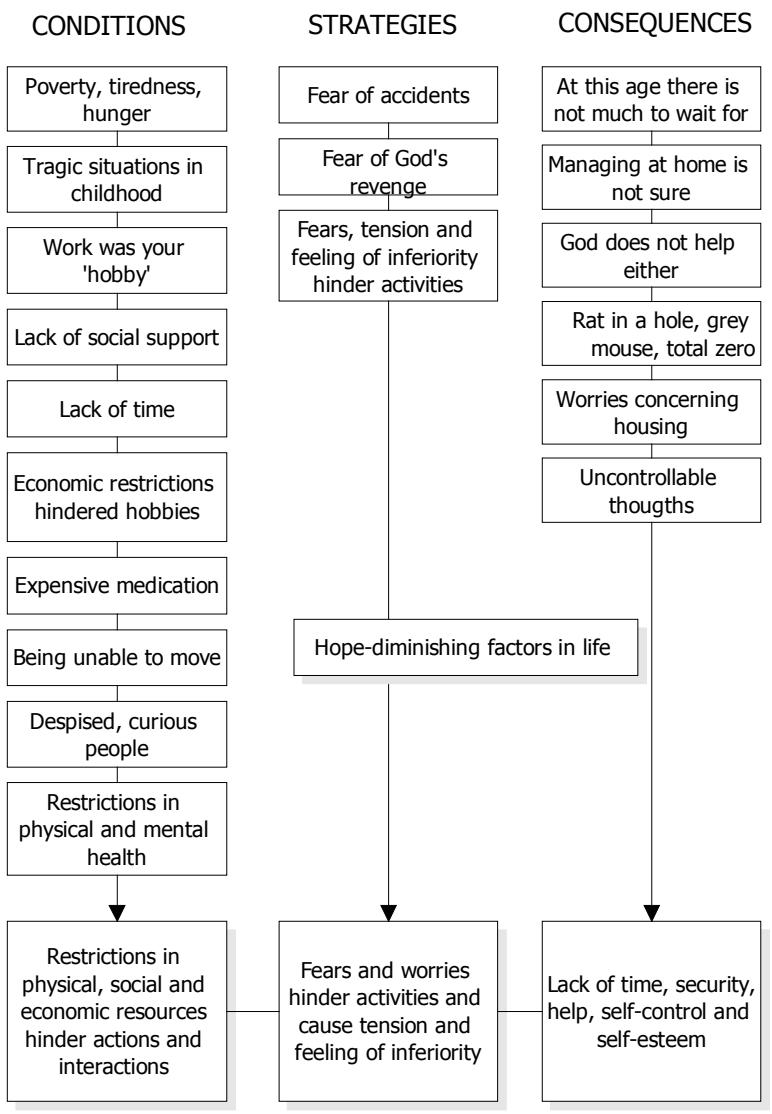

FIGURE 18. Hope-diminishing factors in the lives of the depressive elderly (n=22)

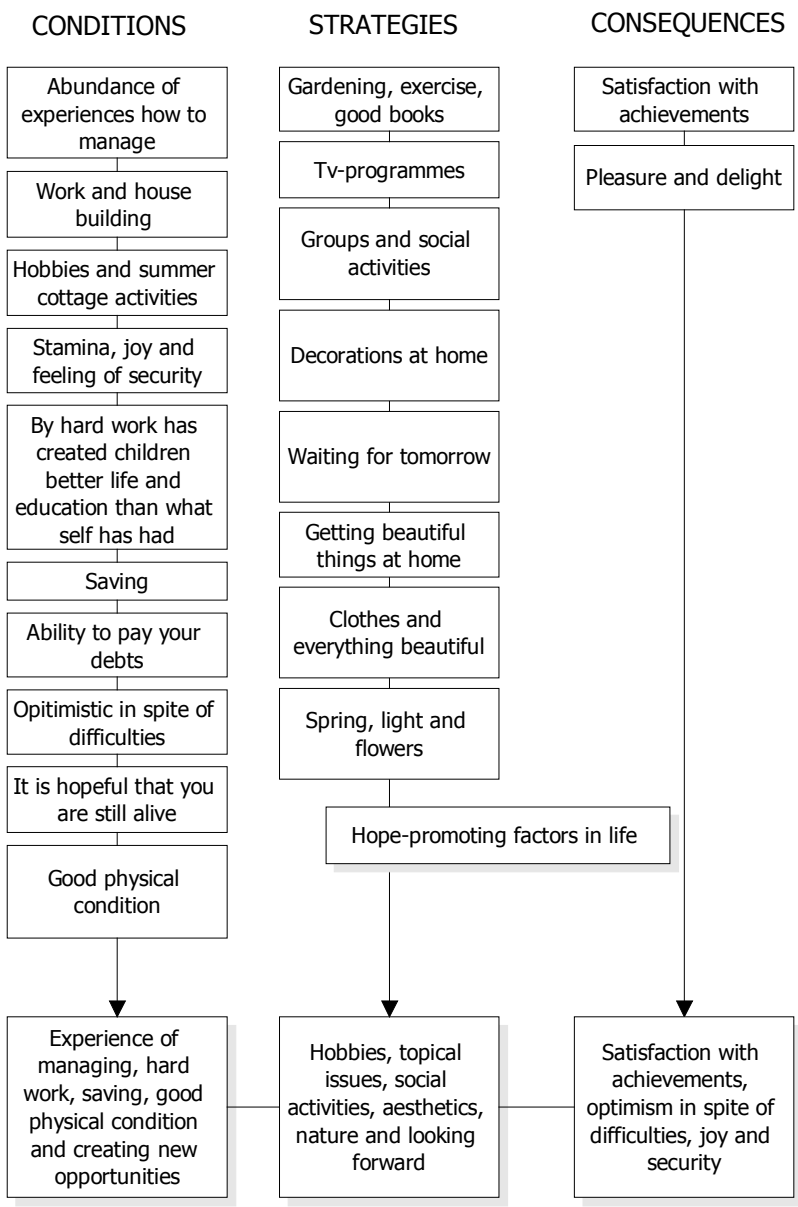

FIGURE 19. Hope-promoting factors in the lives of the depressive elderly (n=22)

Summary of the hope diminishing and hope-promoting factors in the lives of depressive elderly (see figures 20 and 21).

Hope-diminishing factors: Restrictions in physical and/or social and/or economic resources cause fears and/or worries, which hinder actions and/or interaction and cause tension and/or feeling of inferiority and promote insecurity, helplessness, lack of self-control and/or self-esteem and/or the feeling of the limitation of time.

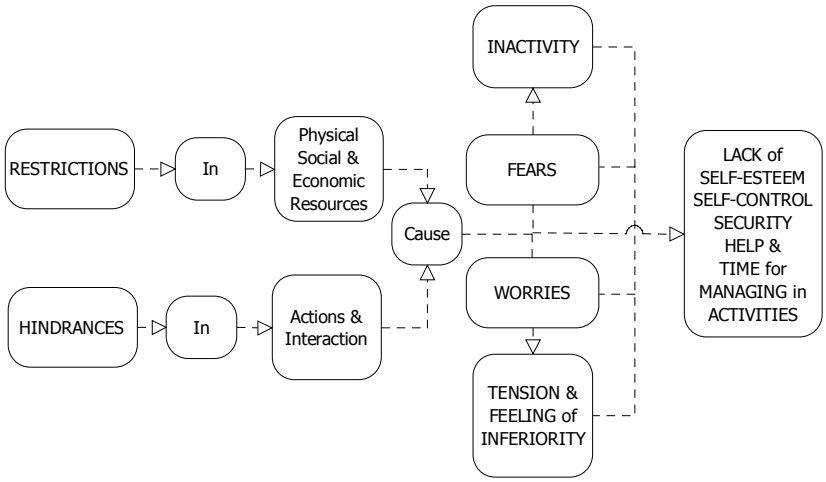

FIGURE 20. Summary of the hope-diminishing factors in the lives of the depressive elderly

Hope-promoting factors: Hard work, saving, good physical condition and/or experiences of managing and/or creating possibilities supported by hobbies, aesthetics, nature, social activities, and/or sharing experiences and/or looking forward promote satisfaction with achievements, optimism in spite of difficulties, security and joy.

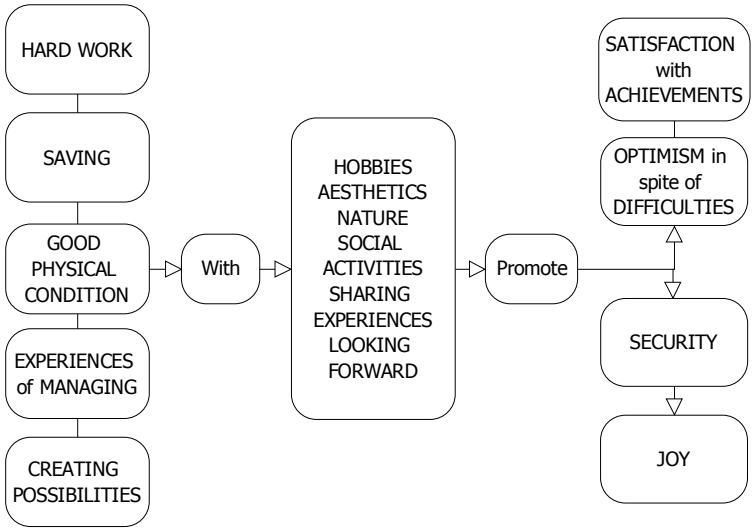

FIGURE 21. Summary of the hope-promoting factors in the lives of the depressive elderly

Personal experiences

Personal experiences were differentiated from life experiences on the basis of the ”inner world”, mental and cognitive processes, although the researcher wants to emphasise the interaction between inner and outer worlds. The differentiation was made only for analytical purposes. In some cases, the differentiation was difficult, but the decision was made on the basis of how the interviewees themselves put the things together in their lives. For example, the self-concept ”a rat in a hole”, is built on interaction with others, but the feeling of yourself is mainly on internal process.

In spite of the abundance of experiences of getting through difficult situations in life, there was an overwhelming inability to control gloomy thoughts, which caused continuous fear, helplessness, worries and blaming yourself. Insecurity and transferring decision making to others made the situation even worse. Managing from day to day in the utmost gloominess with occasional feelings and thoughts of pleasure, was the main trend in depression. The self-esteem was rather low, but experiences of getting through difficulties and achievements step by step had paved the way to a certain amount of satisfaction in life as a whole. Uncontrollable thoughts caused fears, accumulating worries and self-accusations at not being able to control your thoughts or life as a whole. This led to blaming you and the vicious circle continued. At this age, life had somehow settled down in everyday living, with the memories that still caused more or less anguish. At this age, it is as if the meaning of life had disappeared, when self-esteem was low and life was felt to be drifting without the sense of being able to control it. Hope-diminishing factors drained your energy and you could not enjoy anything when the situation developed as far as hopelessness. Being excluded from all possibilities described the situation as an experience. But when hope starts rising, the whole person feels well and starts to see new opportunities around him or her.

Health had a crucial meaning in the hope of elderly depressive people. Health was not defined as lack of diseases, but managing with diseases, because almost all of the interviewees had several long-term diseases, even severe ones. In spite of them, most of the time they felt themselves well and healthy, if the depression could be somehow managed. Health seemed to be a relatively changing concept based on the development of other aspects of life. Insecurity was connected with fears concerning the ability to move, to be safe at home, bad news concerning others, especially significant others, and lack of knowledge and inability to find the needed information. Health was mentioned as an important condition for being hopeful and also for getting over difficult life situations. In general, the elderly trusted the health care personnel and their ability to help. The age of the personnel played some role in the narratives in the sense that young doctors were not trusted as much as was the old and famous ones. The stories of good doctors were divided in the conversations of the elderly. Some of the elderly saw quite clearly their own role in recovery. The importance of understanding the developmental process of the health history, combined with important life situations, was brought up, as was the life of significant others in the planning of care. The lack of understanding seemed to increase the appeal to get help instead of quick medication and care: ”Because I know how busy they are, I don’t even start to tell them.” Those who had a good friend, often used them in this sense as a listener. The situation could be handled somehow, but in cases where there were no ‘compensating contacts’, the situation was often worse.

The difficulties in seeking professional help produced hopelessness. People who were looking for help and were not aware of the rules concerning the criteria for admissions to social or health care organisations became hopeless when trying to get help from the ‘wrong’ places from the point of view of professionals.

The elderly had a clear idea of changes in life, if only more resources available: the ability to accomplish different things and a general feeling of well-being. The lack of resources had elements of doubt: you did not really believe you could do anything, the threshold was too high. The energy needed to cross it did not seem to be found in yourself.

The positive effects of the *medication* for depression were the feeling of being able to get something done with medication, the weakening of the gloominess and the ability to sleep, although the thoughts were still circulating. The negative or worrying effects were, the fear that you will not get rid of the medication, or you have to take it for the rest of your life, or the unpleasant side-effects. Also the high price of medication, was a problem, especially when you had several medicines. Some reported that they did not take the medication in spite of doctor's orders because they could not afford them. Some showed their collections of medication, which they had got from doctors of the public and private sectors. If they did not get the medicines they wanted, they changed the doctor. Also herbs and other products of health food shops were used to supplement the 'collection'.

Determination was connected with decision making, self-respect and the situation in which it was needed. When you felt nervous in the presence of others, you preferred to let them decide and you followed others' decisions. Children were respected because of their ability to make decisions and because of their higher education but, on the other hand, there was also "wise listening" to preserve the relations with children and to avoid disagreements.

It cannot be overemphasised, on the basis of these descriptions, how important it is to understand the health history and the life situation of the elderly and their significant others to be able to offer adequate care. This takes time. Health policy and organisational decisions may support inadequate care in situations, in which 1) medicines are too expensive compared to the economic situation of the elderly 2) the priority settings are too complicated to be comprehended by the users of services 3) the resources are limited and 4) the personnel is so busy that the elderly see there is no point even starting to explain the problems. Not being able to do anything when faced with a situation promotes hopelessness. The following two figures define the hope-diminishing (figure 22) and hope-promoting factors (figure 23) in personal experiences. The terms negative and positive in the figures should not be taken literally, but they define the hope-promoting and hope-diminishing aspects of the personal experiences.

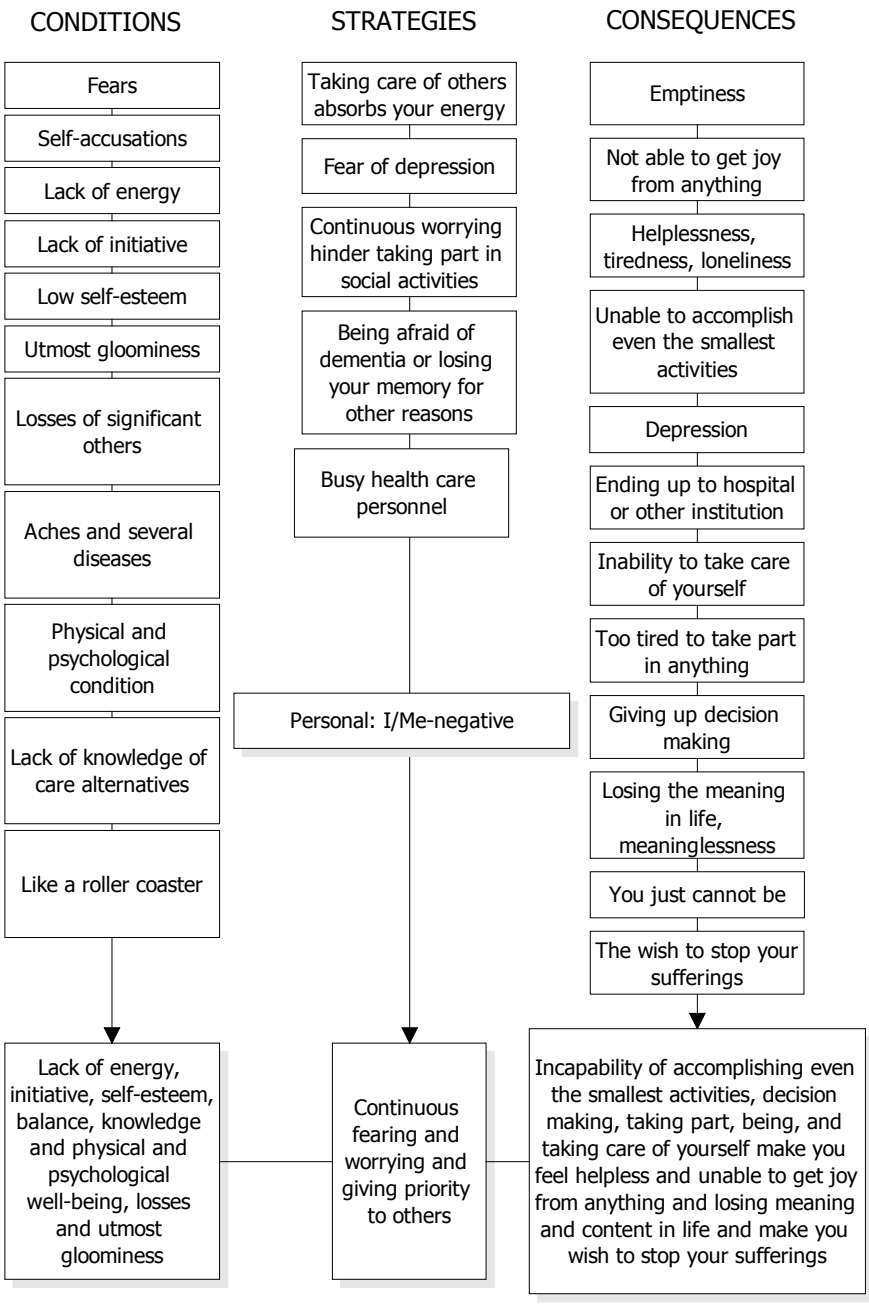

FIGURE 22. Hope-diminishing factors in personal experiences of the depressive elderly

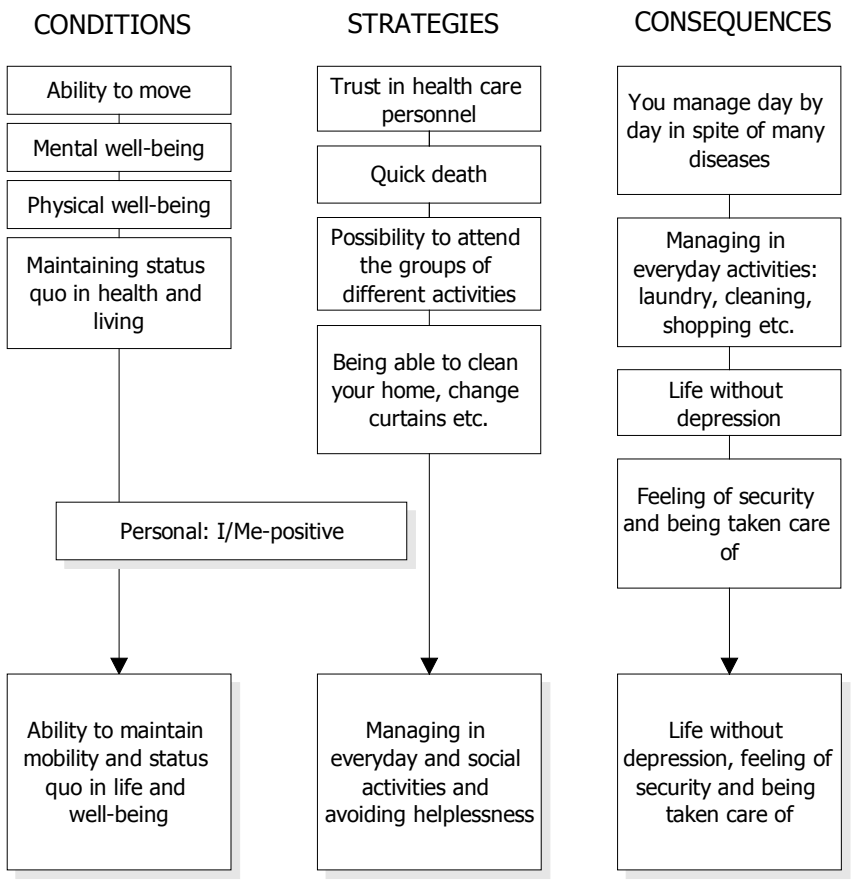

FIGURE 23. Hope-promoting factors in personal experiences of the depressive elderly

In depression, hope is based on the belief that managing step by step is possible. Assisted by others, it is easier, but you may also build your hope on your former experiences. Getting out of the hospital and coping with your physical and mental health, and being able to stay at home were the crucial matters. Aesthetic matters and the ability to get something done were important. Managing from morning till evening and a feeling of moving forward, although only step by step were hope-promoting. In spite of the quality of loss – a sudden or slower process - the experience of acute grief was strong. The acceptance varied depending on in what phase of the grieving process you were in. The loss of significant others, especially the loss of a spouse, was the most tragic experience, and the effects were also stronger. When you had forty or fifty years of marriage and a common life history, the feeling of emptiness was like a crater, on the edge of which you should plan a new start. On the other hand, when you have been standing several times on the edge of the craters you start to speak of them like different mountain tops, even with humour like: "When my first husband died, I was just relieved, because it was the only time I really knew where he was, when he was lying in the grave, but for my next husband I grieved a long time". The intensity of the relationship seemed to be related to the amount of grief in these descriptions. The losses were connected in speech with moments spent together, holidays, common activities and everything that was built together. Losses caused changes in practical matters like taking care of economic affairs, the household, and contacts with others. Hopelessness seemed to

be a cumulative pile, which led to giving up, when you had struggled as long as you could. Taking care of others and coping in their own life had absorbed their energy unnoticed and all of a sudden they found themselves in a hopeless situation. Generally the amount of difficult life experiences was great. Also the continuity of the situations, following one after another, was a feature that came up: when you had managed one hard experience, the second was waiting or happened at the same time, or when the situation of your child got better, that of your mother got worse. It was kind of waiting for when your neck will get broken. The strong will to keep on made the situations even worse and when you finally gave up, you were so broken that the situation was defined as hopeless. In a few cases, the depression had started without a known reason, all of a sudden, according to the descriptions of the interviewees, but when the situation was checked from the medical and nursing documents, it was found out that losses of friends, lack of appetite and sleeplessness were behind it, and these factors had been evaluated as causes of depression. Turning into oneself, and losing the joy and meaning in life, and losing the vision of the future describe the nature of personal experiences; a dwindling vista, narrowing scope and a shortening time-span.

Summary of the hope-promoting and hope-diminishing factors in the personal experiences of the depressive elderly (see figures 24 and 25).

Hope-diminishing factors: Lack of well-being means decrease of energy, joy, initiative, self-esteem, balance, knowledge and/or physical and/or psychological health and/or losses. Lack of well-being is fearing, worrying and/or giving priority to others, and promotes the inability to accomplish even the smallest activities, decision-making, participating, being, taking care of yourself, helplessness and/or inability to get joy from anything, which makes you lose content and/or meaning in life and/or makes you wish to stop your suffering.

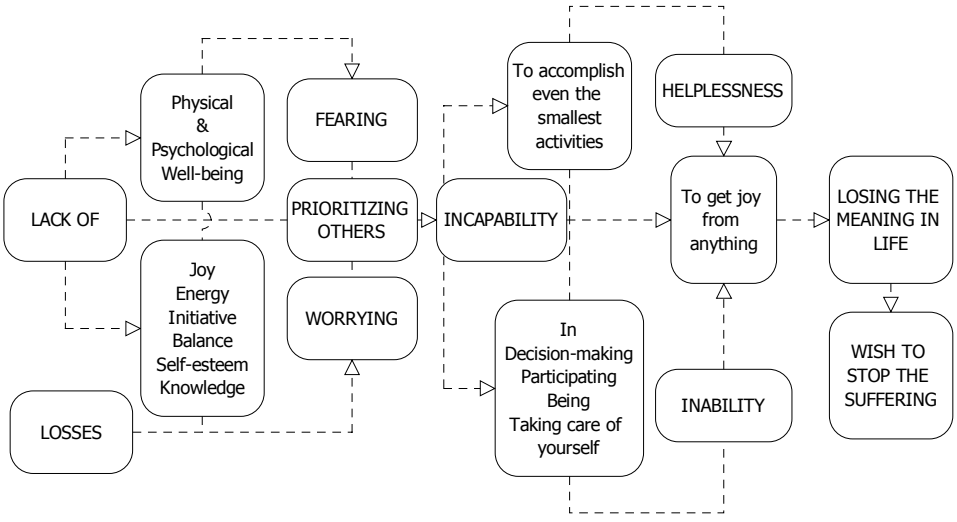

FIGURE 24. Summary of the hope-diminishing factors in the personal experiences of the depressive elderly

Hope-promoting factors: Ability to maintain mobility and/or present situation in life and well-being and/or managing in everyday living and social activities and/or avoiding helplessness

promotes life without depression and/or feeling of being taken care of and/or feeling of security.

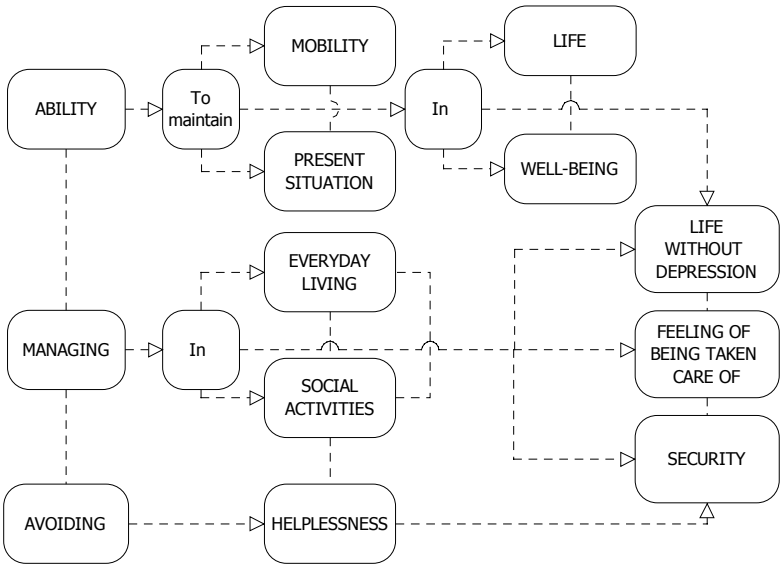

FIGURE 25. Summary of the hope-promoting factors in the personal experiences of the depressive elderly

Inter- and transpersonal relations

The term transpersonal relations means in this connection the relations, which have been made to the hereafter, like spouses' agreements to meet after death and also spiritual relations. The meaning of human relations was twofold: supporting psychological well-being and diminishing it. Supportive elements were based on managing in everyday living and experiences of positive interaction. The possibility to get help in everyday living and a feeling of being taken care of were important, and from these came the sense of security, which human relations brought. Mutual understanding, a feeling of togetherness and joy in human relations were supportive elements. The other dimension was a feeling of uselessness, sadness and continuous worrying, which had negative effects on psychological well-being. The elderly have a long life history and they wanted to have the autonomy of decision making to use or not to use the help available, whether official or unofficial. Respecting the autonomy of decision making of the elderly through positive interaction, by offering help and taking care of them when needed, and thus increasing the sense of security and well-being could support coping with depression.

Human relations were in general very important. On the one hand, they were supportive, and on the other hand, even traumatic, causing worries continuing through the whole life history. In difficult times, the tolerance in the society seemed to decrease. Being part of the war generation was mostly a unifying experience and time seemed to have softened even the difficult experiences in many cases. Significant others played an important role in the lives of the elderly by creating the meaning of life through a sense of security, joy, coping with everyday living, mutual understanding and a feeling of togetherness. Nevertheless, the significant others could also arouse feelings of uselessness, sadness and continuous worrying. The importance of a person was defined on the basis of the things, which were considered important in one's own life. The importance of a person was based on the feeling of security, the possibility to get help, emotional relationships and the feeling of being taken care of. In many interviews - the last years and days of my life - were the frame of reference within which these statements were made. Other people were considered as a source of security. Support and help from others was both unofficial (spouses, children, grandchildren, relatives and neighbours) and official (home help). The elderly tried to manage by themselves as long as possible, because asking for help was not usual for these elderly, who had got used to getting through difficult life situations by themselves. The elderly also had their own ways of doing things and their own timetable, changes in which were often experienced as disturbances. This is why some had given up the use of home help. They were also very considerate in asking help from significant others because these had their own obligations and were also busy.

Marriage and living together with the other formed the emotional basis for everyday living, which both supported and restricted the psychological well-being. Conflicts, restriction of other's rights, dishonesty, malice, threat and anger diminished well-being and, on the other hand love, same-mindedness, common decision-making, taking care of, and looking after each other, shared activities and raising children together were experiences, which increased the feeling of well-being. According to the experiences of the interviewees a good spouse was invaluable. Conflicts belong to marriage and living together, but it was emphasised that conflicts should be solved. Sometimes the children were used as judges, when the situation seemed difficult. Men mainly discussed problems with their sons and women with their daughters, if the children were asked to take part in the conflict-solving process. Some of the interviewees wanted, absolutely, that their children were kept outside their problems, although they could not find a way out themselves. Marital problems were of such a nature, that they were not shared even with friends very easily, because it was a sort of question of

honour; if you had chosen someone to live with, it was your own problem if you could not manage. The hope-promoting and hope-diminishing relations are presented in the following figures (figures 26 and 27):

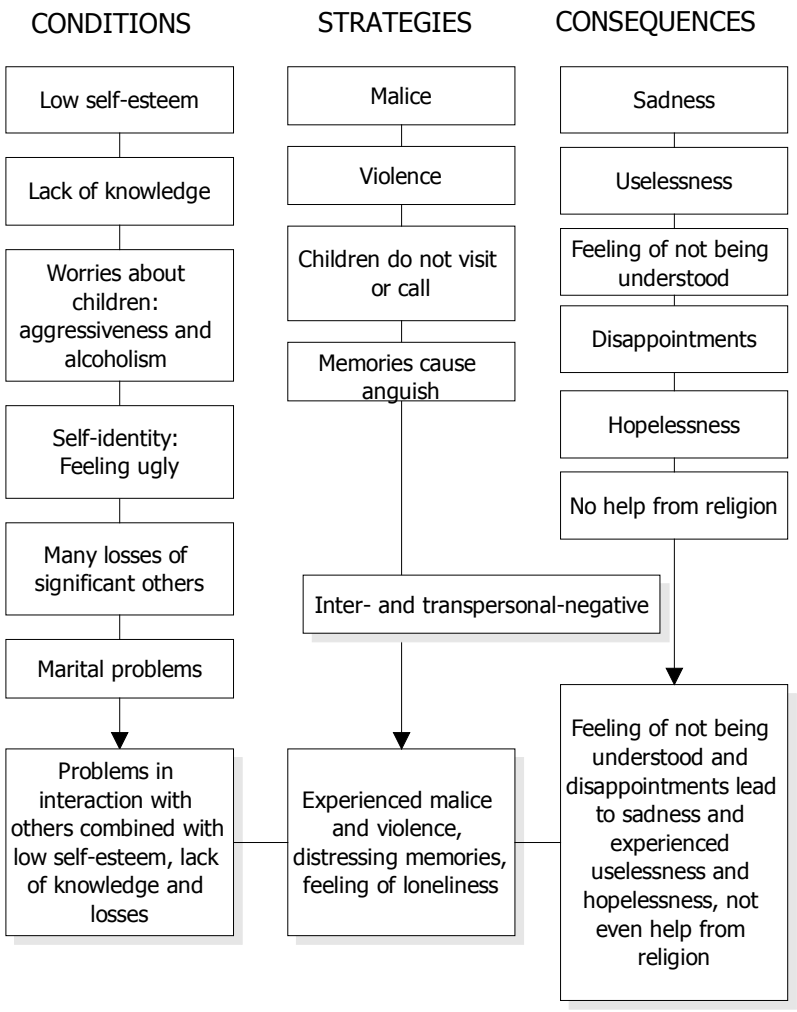

FIGURE 26. Hope-diminishing factors in the relations of the depressive elderly

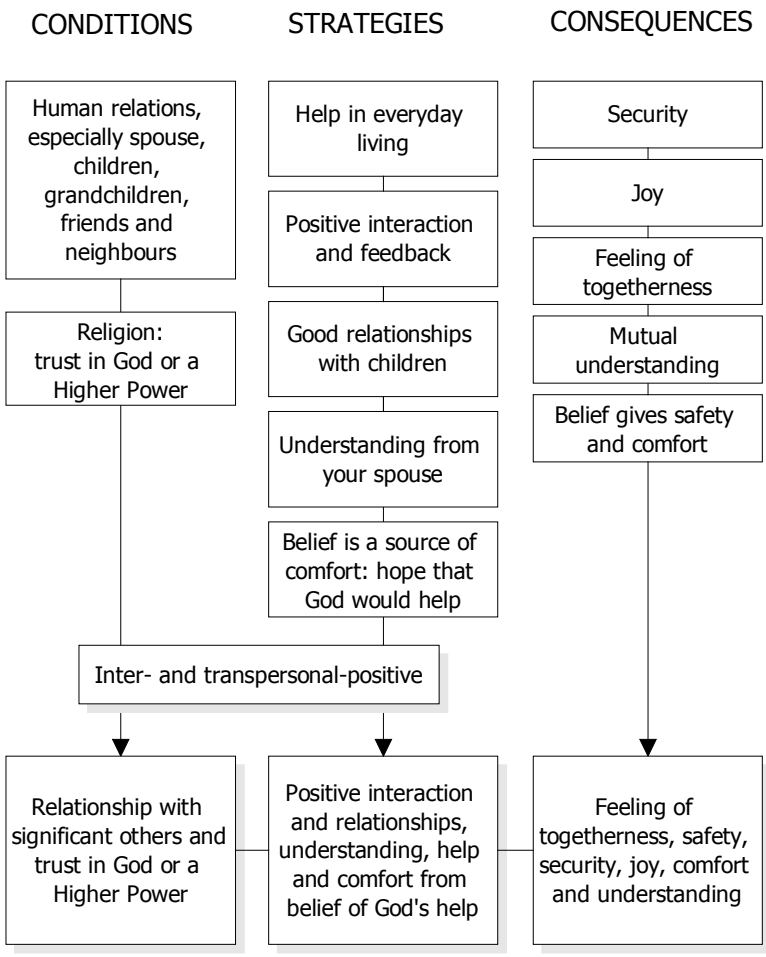

FIGURE 27. Hope-promoting factors in the relations of the depressive elderly

Summary of the hope-diminishing and hope-promoting factors in the relations of the depressive elderly (see figures 28 and 29).

Hope-diminishing factors: Problems in interaction with others and/or low self-esteem mean experiences of violence, malice and/or distressing memories. These and/or lack of knowledge and/or losses promote feeling of loneliness, disappointments and/or feeling of not being understood, sadness, uselessness and/or hopelessness.

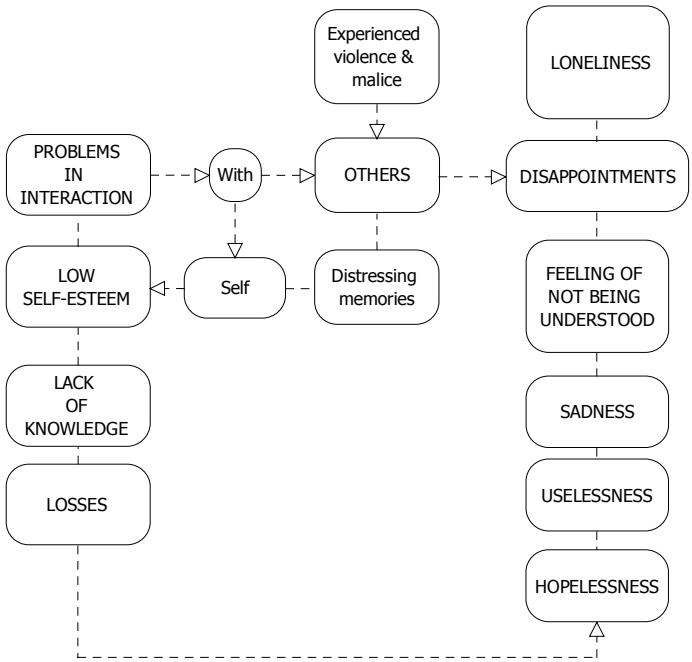

FIGURE 28. Summary of the hope-diminishing factors in the relations of the depressive elderly

Hope-promoting factors: Positive interaction in human relationships with significant others (spouse, children, grandchildren) and/or with neighbours and/or friends and/or trust, hope and/or belief in God's help or Higher Power bring the feeling of togetherness, safety, security, joy, understanding and/or comfort.

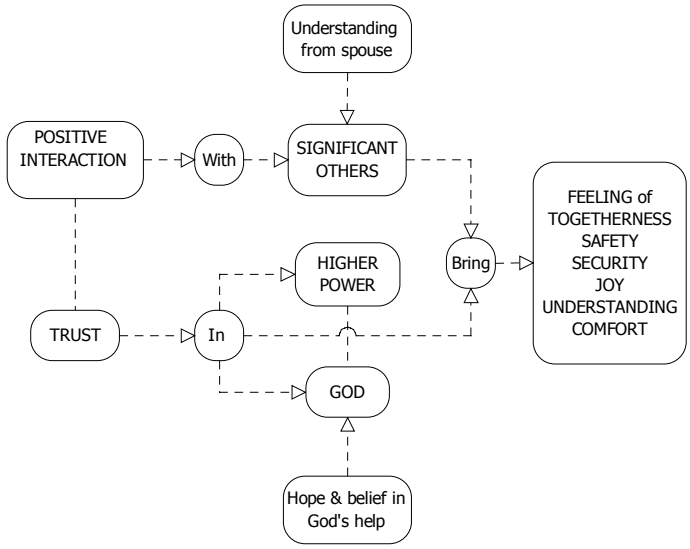

FIGURE 29. Summary of the hope-promoting factors in the relations of the depressive elderly

The core category defining the experience came up and it is described with the expression "If only I could", in short, **IF**, which includes: is not able to, doesn't dare, doesn't know and has

not enough strength. The reasons for these deficiencies and imperfections were multifarious and there were usually many factors affecting the situation at the same time. These are all very important care needs and give a picture of the direction in which the care of the severely depressive elderly should be co-ordinated, based on the experiences of these elderly people.

6.2.4 "WEAKENING PULSE OF LIFE" - THE PROCESS OF HOPING-LOSING HOPE

There were two types of processes, which could be defined based on the narratives of the depressive elderly:

1) The passive, apathetic waiting without strength and desire to do anything

This was described by passing the day from morning to evening till you get the sleeping pill and sleep comes, bringing relief. If there was hope it was mainly the feeling that one more day had been gone through in the long chain of boring days following one after another. The *sudden feelings of life* came from the successful little efforts in everyday living, anything that you managed to do. But also the worries came from things, which you could not do: unpaid bills, broken refrigerator etc. The day was full of little things, which you had to do: getting out of bed, putting your clothes on, getting the newspaper, if you were able to read or scan it, making tea or coffee, resting, making a sandwich and so on. Every step was an additional effort, which needed concentration: "I try little by little, I should get started, if only I could do something, I cannot get anything done. "

2) The fearful daily fighting with gloomy thoughts

In general, the interviewees spoke quite openly of their suicidal thoughts and attempts, and there were certain features which could be distinguished based on the process leading to suicidal actions: reasons, methods and consequences and evaluation afterwards. Part of the interviewees described the process as if it had happened outside them; you had no grip on the process yourself. Others described the process as a very deliberate process targeted to only one goal. In the first case, all the thoughts were sort of captured into this process only, and there did not seem to be anything else happening around you, neither did you think about the consequences at the moment. The second one, seemed to have features like: you were living and planning this "mission" at the same time, and waiting for the exact moment to carry out your plans. You had considered the effects on your significant others and found reasonable explanations for yourself, which would entitle you to act as you had planned. In the first type of suicidal behaviour, you usually regretted what you had done or planned and had feelings of guilt and some kind of puzzlement, how to explain your situation to others. In the other type, you were just disappointed not to have succeeded as you planned, and there was the risk of trying again and getting rid of this shame, although lack of feelings kind of described the emotional state at the moment shortly after the situation. The impression in both groups was the feeling of: *not to be needed any more, kind of emptiness and meaninglessness, and also the will to let others be rid of you, because you thought you were a burden to others.* You changed to being a benefactor instead of causing continuous trouble, although the means you used were rather unacceptable. Anyway, the result was thought to compensate for the questionable means.

Hopelessness was in many cases a *cumulative pile*, which led to *giving up,* when you had struggled as long as you could. Taking care of others and their managing in life had absorbed your energy unnoticed, and all of a sudden you found yourself in a hopeless situation.

Generally, the number of difficult life experiences was great. Also *the continuity of the situations following one after another:* when you had coped with one hard experience, the second was waiting or happened at the same time; when the situation of your child got better that of your mother got worse. It was a kind of *waiting until your neck gets broken*. The strong will not to give up kind of allowed the situations to get even worse and when you finally gave up, you were so broken that the situation was really hopeless.

A very *careful and slow progress* defines the process of hoping. The hopes mainly reach only till tomorrow, you dare not think further. Just waiting for tomorrow was hope-producing, if you had a vision of the next day. There were also those who could not see anything hopeful in their life, just nothing. Hopes were mostly maintaining the status quo or the status as it was before depression. The worsening of the situation was a threat concerning both physical and mental well-being.

The hoping process was strongly linked with the will to live as defined briefly in the next meaning unit in figure 30:

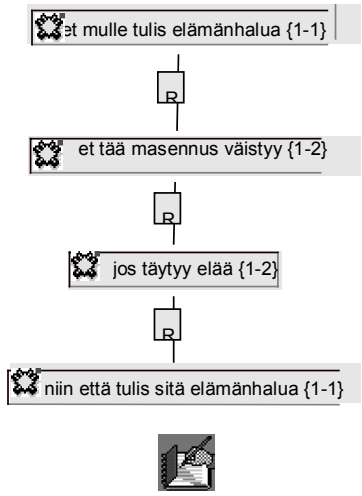

FIGURE 30. An example of a personal meaning of hope

Without the will to live the hope was hard to think about. This is in congruence with the definitions of hope: "It is life, there is hope as long as there is life."

6.2.5 THE MEANING OF HOPE AND HOPELESSNESS EXPRESSED IN THE INTERVIEWS

There was a separate question about the meaning of hope, which was presented in the interviews. It produced 51 codes, the contents of which produced mainly similar factors to

those definitions in other concept families. Based on the definitions, hope has a great meaning, which is built on the following definitions: "it is a brighter future, happiness, joyfulness, it is managing at home, it is something which is not yet fulfilled, it is being able to take care of different matters, it is health and well-being, getting out of hospital, better tomorrow, it is a precondition of life, longer life, enjoying life, being able to move, passing the day till evening when you get your sleeping pill, it is difficult because nothing interests you, it is a big question, it is the well-being of children and grandchildren, it is getting better, at the moment there is no hope."

Hope was defined on fundamental, interactional and personal levels. It was combined with life and its meaning, human relations, personal well-being and positive elements of life and everyday living. Managing in everyday living and maintaining health and well-being were important. In depression, hope was passing the day from morning till evening. It was either combined with thoughts of getting away, or its meaning had kind of disappeared.

6.3 HOPE AND HOPELESSNESS EXPERIENCED BY THE NON-DEPRESSIVE ELDERLY

The interviews of the non-depressive elderly produced altogether 5349 codes. Structuring of the codes into code families is presented in appendix 10.

Life and everyday living

The childhood of the non-depressive elderly had been modest and poor but mostly safe. The interviewed elderly had long stories of rich memories of joyful summers with lot of sisters and brothers and cousins (in many families 7-11 children in the same family). There were several families and generations in the same household, which meant an abundance of human relations. Children took part in working (farming, household) and many of them helped their parents taking care of sisters and brothers when parents were working. It was usual that in families with many children, there was no possibility for further education. Education was exceptional in those days outside urban areas. Experiences of wartime were part of their childhood. Bombing often interrupted playing and you had to flee to shelters. There was temporary accommodation of soldiers in many homes and war hospitals were near. Most of the interviewees who had fled from eastern parts of the country had sisters and brothers on the border.

Youth in general was described as a "wonderful time", full of expectations. Even wartime had left mainly positive memories. The period after the second flight from Karelia was more full of melancholy, because people had just built up a new life and they had to leave it again. Also mothers of war babies were despised in public and many women gave up their babies or moved away from their relatives and families to keep the secret. Dating and getting engaged were good memories. There were many possibilities on the labour market after the war when the country was under reconstruction. There was a lack of housing and family life was often started so that husbands went to look for accommodation and work and wives followed later. There were examples like "the kitchen was in one house and the other room in another one". After the war there was a lack of materials and goods. Women told how they went by bicycle even 50 kilometres to queue overnight for skirt materials, or how they got their first dancing shoes after the war. A new hopeful period was celebrated when the economic depression started to ease. Building their own houses and furnishing them was a very hopeful phase in the stories of both men and women. Life was started from almost nothing and little by little everyday life settled down. Especially, the difference between one's own home and the memories of many people living in the same room in childhood seemed to be very meaningful.

Working life was described as a good time after the war, because people were able to choose almost any work they wanted. Work was very important in building the life after the war. Industry, trade, hotels and restaurants offered a lot of work. The interviewees, who were mainly from working-class families, respected the unachievable education, which was only ”for the rich” and partly in the dreams of the interviewees ”if I had had the opportunity…when the teacher spoke with my parents”. Hierarchy was visible and offices were almost ”holy places”. Some of the interviewees told of their experiences, which were often connected with the permission to get sites and build houses. ”The neighbours asked how did you dare to go there”, when it was question of getting permissions for building sites. The courage was built on the experiences at the front. It was a relief to notice that even the ”generals, pilots and other heroes were just humans like us”. ”After these experiences there was no reason to be afraid of anything”. This came up in many interviews. Also the start of television broadcasting has been an important occurrence, which was described as ”when the television came, people stayed in their houses and did not visit each other like before”. The social interaction diminished. When people moved to towns from big families in the countryside, they felt as if they were coming to strange surroundings and strange work. Big factories were a totally new world: You were in ”strangers” work and ”you could not be yourself, it was best to be silent and just do your work”. The role of trade unions in the female-dominated industry came up in the idea that it was not ”allowed” to be too eager and hard working. This was an unfamiliar culture for people who were used to hard work since their childhood; it was like ”drifting apart from you” as one of the interviewees expressed the feeling.

Old age was described ”At this age”, which seemed to have a special value for the interviewees. People were prepared for the changes in their life; ”At this age you may die suddenly”. Getting old had happened almost unnoticed. From their life experiences they had gathered resources which equipped them for all events to come. ”At this age there is nothing impossible that could happen; you have seen everything”. In general, the interviewees had noticed that all activities seemed to take much more time than earlier. Good appetite was a problem, because now you had the time and possibility to enjoy good food and you were not allowed to because of weight problems and other health reasons: "But in spite of the doctor’s orders, we make good food anyway and enjoy it”. Resistance deteriorated, which was noticed, for example, as colds ”which I have never had before in my life”. Contacts with other people were ”the rays of light” and they were very important. In general, people told that ”at this age” they enjoy comfort and cosiness and like to be at home, which was their own territory, and the possibility to be just as you like. The importance of self-determination and autonomy were described again and again. A simple, peaceful, and steady life was the goal of many of the elderly.

There were some often cited conditions which defined *the ability to take care of different affairs*: death of the spouse, time before hospital care, hospital care of the spouse and time after hospital care, taking care of the spouse at home, physical disability, lack of knowledge, seeing no other possibility and the economic situation. ”I have nothing to worry about, you just cannot do anything except wait, you cannot cope with everything, you know nothing, I cannot move, I cannot arrange things, I’m too tired now, day by day, when you cannot walk, I kind of have to, I had to call there, you should go from one place to another, you have to take care of your pension, my bank account was empty, he is ready to help me, he gets these meal coupons, window cleaning, you have had to take care of things since you were a small child, we prepare our meals ourselves, everything is paid, I took care of everything when my husband was sick, all these technical matters, my husband used to take care of all these matters, when my husband got this terrible illness, when I have been forced to take care of the matters, when there are all kinds of messages, I wash the laundry myself, I used

to go shopping in town, I prepare the meals and do the shopping, we are always busy, we have such a good vacuum cleaner, my husband is not used to these things."

Different conditions led to varied solutions. You tried to get information by calling your acquaintances, officials, or children gave their helping hand. Sometimes, you just had to manage by yourself. There were a lot of different matters with which you had to cope: meals, shopping, cleaning, ironing, banking affairs, selling flats and houses, legal matters, inheritance, technical matters, different treatments and care, questions concerning social security etc. Men wondered, after the death of the spouse, how to iron and clean, and women sold houses and wondered about technical matters and banking affairs. "I don't know about the affairs at all, you have to do this and that, you kind of force yourself to take care of different affairs, then I call ..hello…what should I do now…, my children help me too, I even got quite a good price for it, although I knew nothing about selling houses, I can take care of everyday matters, if I need help I can find it, everything is handled by bank transfers, I have all the needed codes, I do all my housework, we manage, why should I wash these so often, they took away my driving license some time ago, he prepares the meals too, we just roll the carpets away, I just announced that our flat is for sale, then I called there, I have become lazy, I take care of everything, I said that I need a building site, places don't get so dirty nowadays, I find out, I had to learn to take care of everything, like banking affairs and so on, nowadays you get quite nice ready-cooked meals, taking care of things is kind of brain function at the same time - have you paid it or haven't you, I bring up different matters, the bank takes care of my bills, my husband comes home from hospital, little by little, it is enough for me, I have had enough of these cancer treatments, they have cleaners and they take care of their laundry, I should clean but I don't want to, legal assistance, we take turns in cooking and shopping, I have taken care of official matters." It was usually so that the matters in everyday living were divided between spouses and the other half, which you were not responsible for had not become familiar, so you had to learn them from the beginning. People who lived alone did not so often mention these worries, but these affairs were handled when the parents and sisters died.

Hobbies at home were watching television especially quiz shows, series and current affairs programmes, sewing, knitting, baking, reading, housekeeping, newspapers, gardening, summer cottage life and conversation groups in sheltered housing. There were different kinds of social activities: cancer association clubs, lung disease associations and associations for other diseases, Karelia clubs, veteran clubs, veteran's spouses clubs and other clubs based on wartime contacts, church clubs, grief clubs, men's clubs etc. Physical activities were quite popular: swimming, biking, walking, boxing and spectator sports. There were also all kinds of activities where you had the chance to meet others: porcelain painting, theatre, travelling, shopping, dining in restaurants, card games, discussions and exchanging opinions. The intensity of the activities was in some cases so great that it had already become a burden, but it was so hard to choose, because everything was so interesting. Physical restrictions sometimes made it impossible to take part, which in some cases, was a voluntary choice to stop going any more because you wanted to rest after an intensive club and travel period. Hobbies brought relaxation, pleasure and contacts with others. You could share your opinions and get help and valuable information about different matters. Also the need for medication was reported to have diminished when you had no time to follow your ails and worries. Hobbies supported the maintenance of a feeling of well-being and feeling of being important. Factors that diminished the possibilities to attend were: too much programme, long distances, one's own or spouse's physical restrictions, the curiosity of others and obligations to do one's duty in clubs, restricts personal freedom.

The *economic situation* was often tight: "It has been very tight with money, I know what is poverty, when you have a small income you also should have little expenses, my husband

built our house, I just have to manage, I know that others have quite a good situation, they have cars and beautiful houses, I don't know if the pension is enough, in the textile industry the salaries were so low, when both have been working the pensions are better, when we got married, he said that we have a common purse, if one needs money, so does the other one too, that you have the income every day, the economic situation is good, during the building phase it was quite tight, nowadays you don't spend so much money, we got the wood for the building from my parents, we have a house of our own." This generation has gone through economic depressions and also better times after the war. They have worked hard and the level of salaries in the jobs has not been very high because most of them did not have the education, which would have offered possibilities for better salaries. But these elderly people had developed the ability to save into 'almost an art', using their own hands in building and making clothes and fabrics. There had several jobs during the day, which gave the possibility to earn more. In some cases, it was like a competition, how to get money for the family and save it as effectively as possible.

There seemed to be two trends in *achieving goals* and objects in life: those who were waiting for something to come or happen "things change, you always hope" and those who made their goals come true themselves "I have made my goals with my own hands, I have never spared myself, that I would be able to take care of myself, that I could stay in the condition I am now, we have been such a couple that with hard saving and our own hands we have reached the goals." Usually the latter group also mostly mentioned having achieved their goals "first we had one room with cooking possibilities, then two rooms, then a house and debts and one year after my husband's death I paid the last investment of the debt." Maintaining health and autonomy was above all "health without question", but also the material goals like a flat or a house of one's own were very central factors "a flat, a better and bigger flat, this flat after the divorce was the last big goal." A few also mentioned the well-being of significant others. Hints about age came up: "what do you have to hope for at this age, you have already achieved what life has to offer, or concerning my age it is rather downhill now, 'now is the pond with frogs waiting'." Some hoped to be able to travel in spite of their age "if I could once more go to some warm place. "There was also disappointment concerning goals "I haven't got all I wanted in life, something is missing."

General conditions were mostly combined with housing and possibilities of social interaction. When you have lived dozens of years in some place, the changes are sometimes felt to be overwhelming, but in some case also a relief. The solutions to change apartment after the spouse's death or for other reasons were considered profoundly. Children often gave their helping hand, sometimes a little too eagerly from the elderly's point of view. Taking their time seemed to be important, because the solutions were considered as very final at this age. These decisions were connected with the economic situation. Securing the rest of your life was a bothering question, especially when you had lost the other who had given advice and support in big decisions of life: "I don't want to go there either, it is easy to leave from here, I think I'll manage, everything is secured, quite a good situation, it is annoying when others make so much noise in the corridor, this flat has such a good situation, maybe I have acted like a fool among others...but."

In spite of several things that gave hope in life, the process of life included many elements which in certain situations diminished hope and caused hopelessness depending on the whole life situation and the amount of matters affecting it at the same time. The next two figures (from more detailed abstraction level to more reduced level) present the elements which were defined as hope-diminishing (figure 31) and hope-promoting (figure 32) in the lives of the non-depressive elderly.

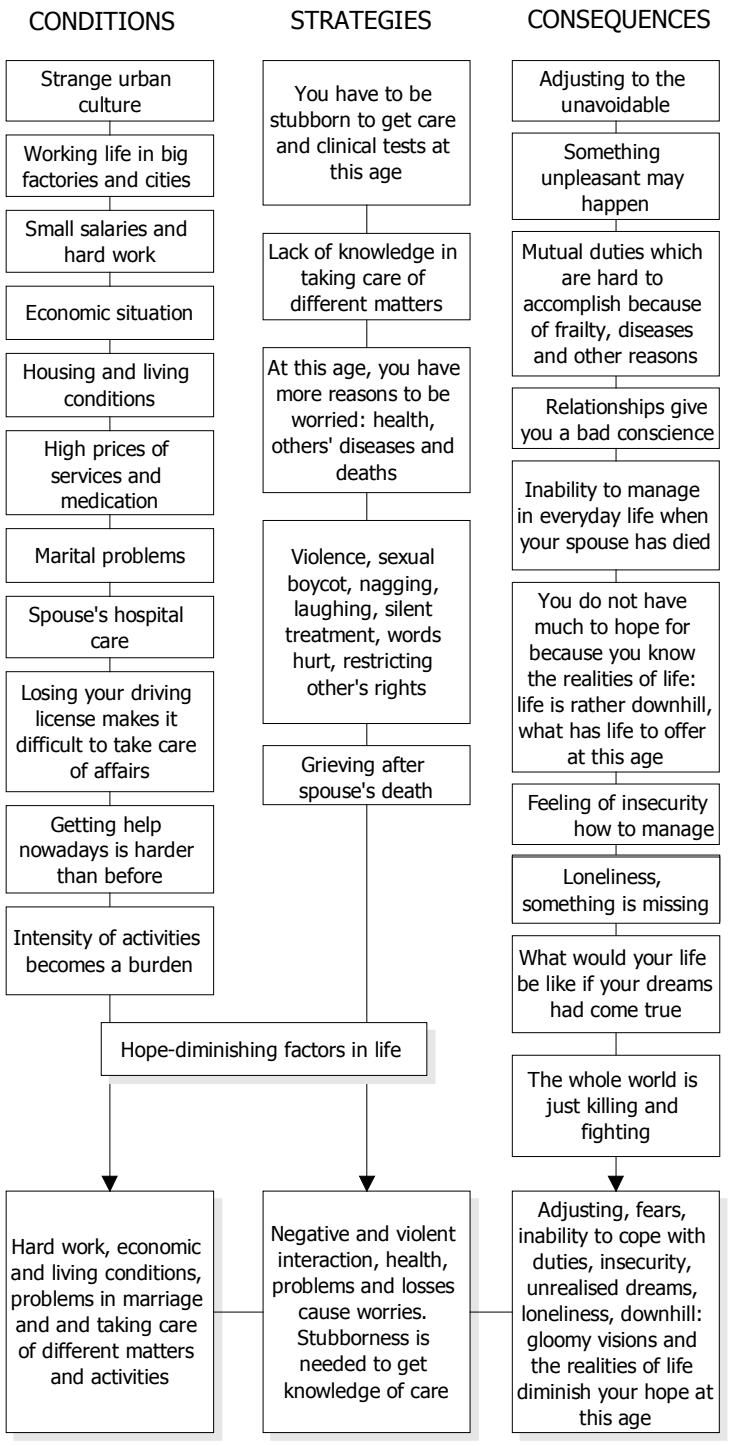

FIGURE 31. Hope-diminishing factors in the lives of the non-depressive elderly

Difficult life experiences were war, war babies, economic situation, illnesses and deaths of children, spouse, relatives and friends and own and children's divorces. There were also those who had not had such difficult situations. "The war of course, you wouldn't wish it on anyone, I have said that I don't take it so seriously but it has left scars anyway, it was a hard period when I gave birth to my war baby, it was that time, 1945, when everything like that was condemned, I don't remember any really difficult situations, not even in my marriage, also the economic situation has been satisfactory, even when I was widowed it did not hurt me so much that I would have needed the hangman's noose, if there is no hope, then there is no life either, it was hard for him and me too, he was left alone and it was hard for him when his wife left, I worried for him, my daughter's husband left and it is very hard for me too, because I liked him so much, I am not against this one either, but I got so accustomed to him." The elderly reported having experienced panic and shock reactions, sleeplessness, nightmares, worrying, humiliation and grief:" It was the greatest blow, I woke every morning at four o'clock for two years in a terrible shock, it was a nightmare, I drank several bottles of brandy." To get over the difficult situations one old person had developed strategies like the metaphor of a ball of yarn, where the strands of yarn were compared to experiences in life. Rewinding the yearn is analysing the experiences and reasons for the decisions made: "My life is like a ball of yarn, into which I wind these experiences, when these bitter twists of fate colour my ball, I rewind the ball to find out the reasons and then I wind it forward - you have to get up, life cannot end here, and then I found the moment when I understood that I'm able to get rid of it and I felt enormous relief when I had told about it, and after that life was bright again and hope appeared." There were also other methods, which were combined with determination:" But I had to go forward although my heart was bleeding, you have learnt to fight, so far I have got over all kinds of situations."

Things causing hopelessness were health problems of significant others, shortage of everything after the war, dark seasons, losses of significant others and regretting some earlier decisions in life: "When my son got a severe disease it was bitter, the autumn is depressing when everything is dark, when father died after the war, it was hopeless, I regret that I didn't make that decision then." Most of the interviewees described how it is not typical for them to be hopeless, in any case, you had to adjust: "It is not characteristic of me to be hopeless, not even in the war, it is a question of attitude and character too." There was a differentiation between hopeless thoughts and realising them: "Of course you may have such thoughts sometimes." The ways to get over the potential hopelessness were praying, adjusting and accepting:" I adjust, there have not been such bad situations that I haven't got through them when it is difficult, I ask help from up there, and I get hope from there, you just have to adjust to the situation at hand." In hopeless situations you ask 'the big questions' and think about the meaningfulness of life:" Sometimes you think: what is this life really." Anyway, you try to find an answer to the situation at hand: " Nothing is totally hopeless, there is always some chance."

Hope-promoting things in the lives of the non-depressive elderly are defined in the following figure 32:

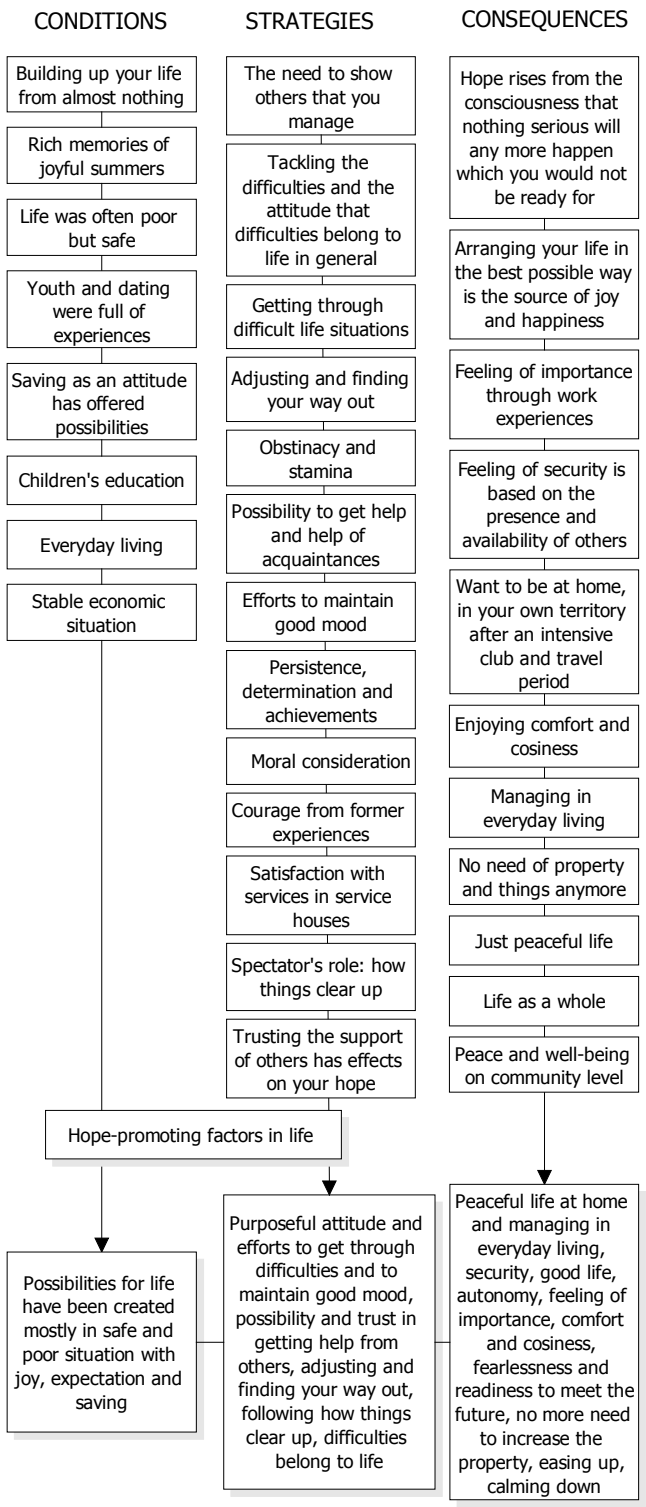

FIGURE 32. Hope-promoting factors in the lives of the non-depressive elderly

Things that have aroused hope in life are connected with youth and the excitement in dating and social life, the success of children and following their education and progress: ”I have two children and I’m proud of their success, I did not have the possibility to go to school in my youth, no more than elementary school, so it is quite a thing to take part in the life of your children and their success.” Other hope-promoting things were: health and lack of severe diseases, the ability to live peacefully and manage in your everyday living, possibility to rule your own life as you like, getting rid of former obligations, the fact that you are able to control your life and get through different phases in life: ”This time as a widow, I have now been retired for ten years and I have been twelve years a widow, this has been the best time in my life, I have been able to live as I like and I have not had to take others into consideration.” The possibilities to get help and new visions were appreciated as hope-promoting: ”I think it is important to be able to come to a place like this and find new acquaintances, when one door closes, many other doors open, I have been taught to live day by day but I cannot.” There were some elderly people who didn’t want to differentiate anything special, but they said that life as a whole was hope-promoting: ”Everything together, it is hard to analyse, life as a whole.” Persistence and positive attitude were hope-promoting: ”I have always succeeded in my attempts, I have always tried to get forward, when the sun is shining, I feel that the days are also brighter in my life. *There is always a loophole.”*

Hope at the moment rises from everyday living, little things: ”I have a beautiful home and possessions, they are important to me, as long as you have life, you have hope, that you could once more go out and enjoy biking, swimming travelling and nature.” Hope rises from the consciousness that nothing so serious will happen any more, which you would not be ready for. A feeling of security had developed through the experiences of getting through different situations in life. The possibility to live just for yourself is the best thing, after living for others all your life, it is really enjoyable to be able to be and do just as you like, although some people envy your situation: ”You can live for yourself...only for yourself, you may lie down this way or that way, it is something, some people seem to envy this, but let them, it is the best thing.” Health was considered a precondition for all other things, if you are healthy, you are also able to carry out other things in your life: ”First of all health, because if you are not healthy, you cannot enjoy other things either.” Human relationships: children, grandchildren and friends, were also named as bringing hope. Some of the elderly seemed to have the role of a spectator, they didn’t purposefully plan anything, life was just proceeding and you stated afterwards how the matters had cleared up: ”Things just go on, you should not take life so seriously, you just hope, you have gone through all difficulties, you don’t even think, life just goes on, it belongs to life, you just wonder, oh have a look, you seemed to get through it too, somehow you manage, everything has been cleared up.” Hope had arisen from achievements, which you found out about when you examined your life. Trust in yourself was in many cases the ground for hope: ”Nothing utopian, everything that is around you has been got by your own work, my life is so steady, there are no ups and downs, I cannot analyse it further, I try to manage on my own, I don’t lean on anyone, although things look bad, it will work out anyway, peaceful and harmonious future, there is no lack of anything, no sickness or burden of debts, and you don’t have to take care of anyone, everyone has their own lives.” Arranging your life in the best possible way was an important source of hope and happiness in general: ”Probably Heavenly Father has meant it so that he went there beforehand and I try to live as comfortably as possible or as well as possible, from this I get a lot of energy and happiness.”

There were *things which they hoped would be arranged* like questions concerning housing and changing living conditions: ”I have lived all my life in the same neighbourhood, my club members are there too, who could be then…like at the moment...you get help but…I would

not like to leave my home, I have to go to the nursing home for cancer patients, there is something in that house which is terrifying, I know one eighty-year-old woman who changed her flat at that age, I would like to have another flat." The feeling of insecurity was combined with the deterioration of health in general, cognitive functions and loneliness: "Getting rid of pain, this my cancer, you have to be so careful in everything, my knees have started to hurt, that my condition would be like this, that I could stay well, I don't have anyone, I suffer from dizziness, if I would be of sound mind, if I look for my toothbrush in the refrigerator, if something happens to me, that someone would take care of me then." Also incapability and lack of energy for certain actions caused worries: "It worries me that am I capable of doing anything else any more, I would be even more hopeful, if I could arrange things, that fate doesn't buffet me." Many of the interviewed said that at this age there was not much more to hope to be arranged, things had settled down and you did not expect anything special, just normal life: "there are no such things, there is no hurry, you cannot think of anything any more, at the moment there are no such things."

Hope concerning the future was associated with general well-being and peace on the community level: "why don't those who decide on military actions go to war themselves, why must innocent people suffer." It was also hoped that young people would find their place in society: "…that young people would get work so that they would not need to hang around the streets kicking people." The ability to live a steady and peaceful life with relatives and friends, a chance to follow grandchildren's growth and to follow the situation of their own children's life developing in a better direction and also avoiding greater upheavals, were central hopes on the personal level: "I like knitting, everyday life, I like visitors, a steady everyday life, I wish that everything would go as peacefully as now, and that there wouldn't be any greater upheavals in our life, not at least for the children, things are quite all right at the moment; that much we take care of each other, I would like to see my son's children grow up and go to school, that I would have a couple more years to see if my son would start to think seriously or will he." There were also a few hopes concerning the economic situation and travelling: "I must be satisfied with what I have at the moment, lottery prize, if I had more money, it would make me sick too, I would change all my furniture, my pension is so small, a couple of visits abroad, I'll go back to Karelia once more." Some of the elderly expressed their hopes through negative experiences: what they would not hope in the future such as "I won't take another husband in any case."

Conclusion on the hope-diminishing and hope-promoting factors in the lives of the non-depressive elderly (figures 33 and 34).

Hope-diminishing factors: Hard work, economic and living conditions and/or problems in marriage and/or taking care of different matters and activities promote health problems and/or negative and/or violent interaction. Health problems, losses and /or lack of knowledge cause worries and/or need of stubbornness. The realities of life in old age diminish hope and lead to adjusting, fears, insecurity, loneliness, inability to cope with responsibilities, non-realisation of dreams, downhill and/or gloomy visions.

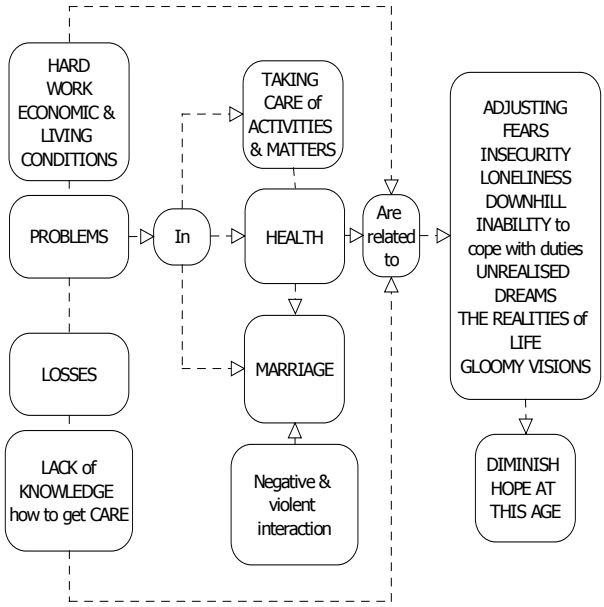

FIGURE 33. Conclusion on the hope-diminishing factors in the lives of the non-depressive elderly

Hope-promoting factors: Possibilities for life have been created in safe and often poor circumstances with expectation, joy and/or saving by a purposeful attitude, efforts to get through difficulties and/or to maintain good mood, possibility and/or trust in getting help from others, adjusting, finding your way out, following how things clear up and/or believing that difficulties belong to life. Hope promotion means managing in everyday living, security, fearlessness, autonomy, feeling of importance, comfort, cosiness, readiness to meet the future, easing up and/or calming down, no more need for more possessions and/or good and peaceful life at home.

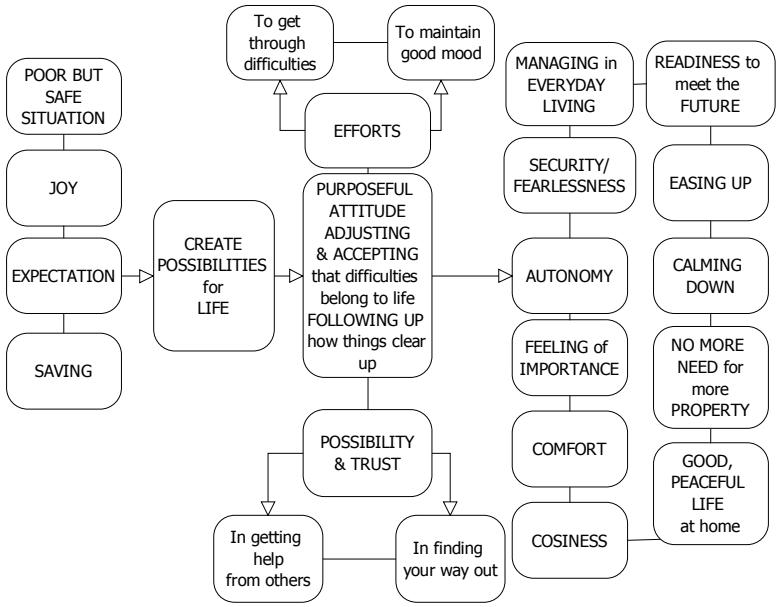

FIGURE 34. Conclusion of the hope-promoting factors in the lives of the non-depressive elderly

Personal experiences

The thoughts wandered from childhood to the future. Fears which they had had in childhood had disappeared with the war experiences, which gave courage. Some unrealised dreams, like education, made you think what life would have been like if the dreams had come true. The meaning of many things had changed, like marriage, which had become more liberal. They worried about the situation of the children, when they had many children and several marriages. The most worrying situation was the one that you or your spouse must go to hospital or other institution - which would be a hopeless situation. The more information you got, the more reasons you got to be worried, that's why only the necessary information was considered good for people. Rational thinking and analysing the reasons helped one to see one's own role in different situations. Worrying thoughts often came in the evening before falling asleep. Comparing your situation with that of others, whose situation was even worse, helped to see the realities. Strategies to manage were described as: "Everything takes time, thinking forward, it belongs to human life, I have decided not to complain, you just have to manage." Honesty, helpfulness and being easy to approach, were considered valuable virtues.

"At this age, when you have come to this age, when you are this old"; these expressions had certain contents, all of which had a common meaning: "you have seen almost everything, nothing surprises you anymore and nothing impossible can happen". There were also elements concerning health like tiredness, physical frailty, diseases and good appetite "although you should not eat so much". The end of life had come near, was brought up by preparedness to die suddenly and by comments on your friends' deaths or diseases. There was no longer the need for things and property like in youth. Shopping and attending activities had decreased. In many cases, it was possible to consider going into a service house when needed, if you didn't manage to stay at home. But "at this age" a stable, peaceful life at home was something hoped for.

Self-identity was divided into three groups: those who had strong self-identity, those with average self-identity, and those who felt that their self-identity was modest or low. Self-identity has changed during life and the direction of the change seemed to be mostly towards increasing self-identity. If you had been shy and timid in childhood, you had got courage from your experiences during the life, when you had noticed that even the most appreciated people were just human beings, especially in difficult situations like war. Also arranging different things with which you were not very familiar gave you faith in yourself that you will manage. One common example was coming from the safe surroundings of the countryside to big factories in the cities after the war, without the support of your significant others. This showed one dimension of definitions of self-identity: part of the self-identity was built on the significant others and their support like "I'm not alone here". Part of the self-identity was based on the working life. Also the historical situation gave some spice to these definitions. When you had been a servant in many families, you were educated to be a humble subject. This was also pointed out to you through many social symbols (salary, place to sleep, working time etc.). These experiences tended to extend to concern you as a whole person, not only the occupation and your role in it. This phenomenon could also be seen in the factories, where the supervisors made the women from the countryside know their place in the new environment. Men often fought for their positions on building sites and possibilities to do piecework or in the jobs in the public sector.

There were six different Finnish groups represented in the interviews, which gave an extra richness to the analysis. There were some features expressed in these interviews, which matched the stereotypes in Finnish colloquial language concerning the groups: Karelians are

lively, people from eastern areas want to be visible and they are boastful. People who live on western coast of Finland are determinate and stubborn. These group features and horoscopes were discussed as one entity, which defined your self-identity and character. These beliefs were deeply rooted in minds and they were supported by experiences of evacuee times, for example.

The definitions of *character* were made on the basis of how the elderly saw themselves compared to others and, on the other hand, how they thought others to evaluate of them: both internal and interpersonal evaluation. Some prominent features which seemed to come up in several interviews were certain kinds of activities and pride in achievements ”I’m persistent and proud, I’m energetic, I’ll manage”. Courage was also often mentioned ”You have to open your mouth if you want something”. Interactiveness was general, but there were also those who pondered the things themselves. ”I’m chatty and happy, there is no lack of stories but also: I cannot share my thoughts with anyone”. Some moral consideration was included in defining the characteristic features: ”I may say bad things, but I don’t apologise, I’m a little mean”. The meaning of groups came up also in these definitions: ”I’m Karelian and self-satisfied”. Experiences of being an evacuee were described: ”We were not even human beings in those days”. The experience of autonomy and the possibility to do what you want, was a remarkable feature. This came up in many connections, also on the contrary, when the elderly explained their working life and movement to cities, which as experiences have been connected with losing the freedom to be yourself, to be autonomous.

Mood was described often in similar terms as character. It was described on the basis of former experiences or on the situation at the moment. ”I’m a bright character, I have to manage by myself, I jump from the edge of a cloud, I try to stay in the middle, low-spirited and empty feeling, I don’t usually get depressed, I’m worth nothing, if there are cloudy days, after them there will be bright ones too. ”Mood was often described in words that pointed to development or process like ”I’m more easily furious nowadays, I get hurt more easily, sometimes I sink to the lowest level, first I become gloomy and cry, the anguish has disappeared, lift up your tail even with safety pin” (old saying). Health had effects to mood: ”these are the things which lower your mood”.

Determination was connected with stamina and obstinacy ” It is said that we Karelians have a damn bad stamina, it is as I decide, I don’t much compromise”. Although the decision making was not always easy, you kept on going afterwards ”I’m a lousy decision maker but I don’t give up”. It was a sort of question of honour, if you decided something you carried it out to the end.

Hope was certainly connected with *health* according to these evaluations. It depends on the person and attitude. Diseases were connected to hope in the sense that the more severe the disease the more it affected your hope, especially mental diseases and cancer, but if you still had the ability to act, it increased your hope, although it was supported with medication. Most hopeless was considered the situation where you are confined to bed without the possibility to move.

One problem in *getting help* was the fact that doctors changed and those who were responsible for the care were not available, also ”the louder the voice, the quicker the help” seemed to be the practice concerning the elderly. If you did not raise your voice, you had to wait. Lack of information came up, and also the fact that the personnel seemed to be without the necessary information for several reasons: the papers had disappeared, someone had forgotten to inform others, etc. ”I didn’t get the answer, they had somehow lost my papers”. There were a few examples of satisfaction concerning the determination of the care

personnel: ”luckily the nurse forced me to go and see a doctor”. Some of the elderly seemed to like the style that someone else made the decision on behalf of them. There were also some examples of the elderly being very hurt: ” When the doctor said, do you have to use the thermometer so often, I decided never to use it again and I haven’t.” Also the differences between young and older doctors and men and women came up, in the sense that older doctors and men were trusted more, although it was not said directly but rather in indicating to the care which was received: ”That young male doctor gave me only such capsules.”

You had to be quite determined to get examinations and care and sometimes you had to fight for it: ”I have quarrelled and fought for my care.” It was an important fact that the care was offered when needed, especially when you were tired yourself: ”They called me from that hospital and I was as happy as can be when they said that help is coming.” There were also some misunderstandings, which led to incorrect care: ”I said that I don’t think I am a hypochondriac, my neck is so stiff that I cannot move my head, he asked why I was sent there, I said that I wonder the same thing, then he took up the phone and said that he had been sent a stiff-necked patient who is in need of massage, not a psychiatrist”. In some cases, the elderly had got used to the rules of the health care system and knew how to get through in spite of the control: ”they asked who is your doctor, but I knew that there is always a doctor in charge here and I got the appointment within two hours.” Patient information had shortcomings, which had effects especially on worries and feelings of insecurity, but also on interpersonal relationships: ”it takes almost three weeks to hear the results, I was planning to go to my daughter’s family to celebrate Easter, but I didn’t want to spoil their celebration and, however, everything appeared to be all right, they had just forgotten to tell me.” There were several elderly people who had first got treatment in the public sector and after that had changed to the private sector, and in some cases the rehabilitation was again gone through in the public sector. ”My leg has been in plaster three times, it failed, how come you have such a luck, it hurt for such a so long time, then I went to the private hospital and it was operated, it was expensive, you get treatment if you can afford it, I said that I cannot come again because I don’t even get as big a pension as the price of the operation, I had to stay in a queue even there. I called there because of my hand and I got in, it became quite good, but still my other fingers, except the little finger, go numb, I rub them and keep them in cold and warm water in turn.” The examinations and tests were described in detail, and the results and experiences were compared to those of others: ”Almost every time the blood tests have been taken, they have been normal, but when that result, which is important for cancer patients, is high, I have to go for new tests.” In some cases, care had become an important matter in everyday living. It sort of scheduled the day and week, especially when it was a question of a long-time disease. You could not avoid the feeling that now and then it was meaningful to have all those treatments, examinations and contacts with health care personnel. It served also as a topic with friends. Comparing experiences in health matters was experienced as important.

Medication varied from good Finnish food and red wine to big doses of cortisone and cytotoxines: ”I don’t use any medication, my medication is normal Finnish food, red wine is good medication, my doctor from the rehabilitation unit recommended it.” It was hard to understand why the doctors did not want to renew sleeping pills: ”One tablet for night, but they are not willing to renew it, I said that we only leave once from here anyway, if it is so dangerous and fatal, is it wise to produce such medicine at all, you like to sleep anyway.” Also the side effects of some medications were known. ”I haven’t used any tranquillisers, you become dependent if you use them.” It was a common problem that medicines were very expensive, but you could not do without them either.

There were *several diseases* and all kinds of aches and pains which were connected with ageing or former accidents: ”My feet are worn out, my blood pressure is high, they have examined my feet and they hurt during the night, my throat is always sore, I have always pushed my health problems aside, my friend said once that we shall see what disease you will get because you have had so many difficult life situations, sometimes I’m afraid of those people who talk to themselves in the buses, my feet don’t function any more, they are so degenerated, if I lose my eyesight, how can I read after that, I have had colds and this osteoporosis, diabetes, poor bones, I fell down and broke my left arm. ”Joints had been operated on even several times and problems with eyesight, sleeping, walking, digestion and constipation were quite common. There were a few who had had good health all their life and still had: ”I take everything day by day, everything is in order, I have good health. ”The fears concerning health were connected with mental problems, inability to move and brain functions like losing memory or intelligence and, via these, dignity: ”My health is like that of General Ehnrooth’s: your head is clear but your feet don’t follow, I have always hoped to retain my ability to use my brain.” There were all kinds of diseases, even severe ones, but they were thought to be part of old age and belonging to it: ”Something wrong with my heart, coronary heart disease, cancer, I had cancer, two years went well, then there was a metastasis in my upper stomach, I hope it has not become bad yet.” The health problems cause worries to spouses: ”My husband was worried, when he found me lying on the floor while I was cooking porridge.” In general the elderly had got used to the diseases, but they were mentioned as causing insecurity, and also loneliness was mentioned as a health problem. In old age getting help was harder when you couldn’t move easily.

Economic attitude and stinginess were common in these interviews, most of which stemmed from wartime experiences and the fact that this generation really knows the meaning of shortage. Especially after the war there was a shortage of food, materials, housing possibilities, etc. One feature, which popped up in many connections, was the need to show others that the situation was better than it really was ”I show the world that everything is fine”. The need to succeed was strong.

The feeling of *security/insecurity* was connected with the presence of others or the possibility to reach other people: ”I feel safe when my daughters are near”. The possibility that something might happen to you and you have no one to help was connected with the feeling of insecurity: ”Anything may happen to me, I felt insecure about how to manage”.

The following two figures (35 and 36) present the hope-diminishing and hope-promoting factors in the personal experiences. The terms negative and positive in the figures should not be taken literally, but they define the hope-promoting and hope-diminishing items in the personal experiences.

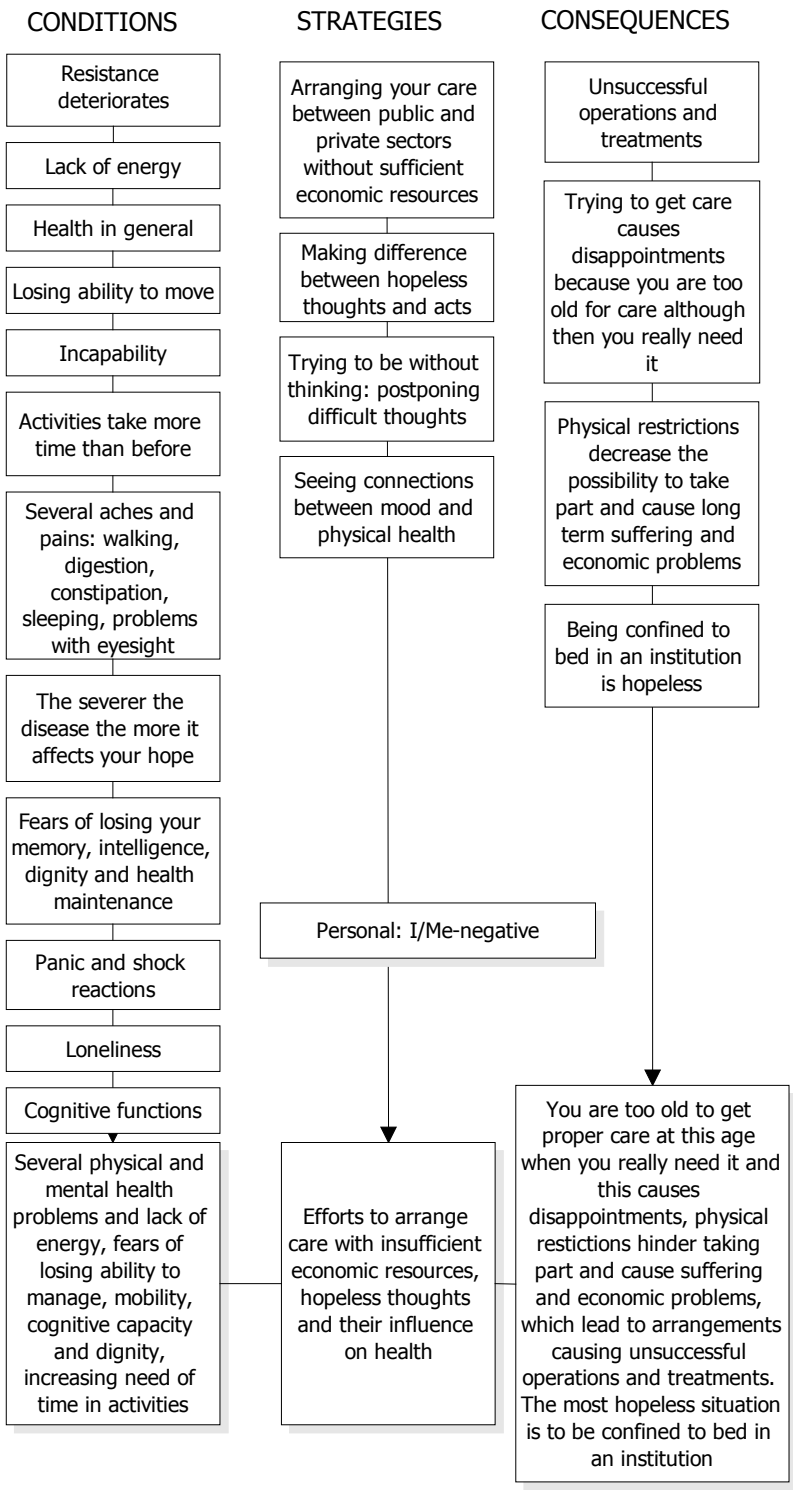

FIGURE 35. Hope-diminishing factors in the personal experiences of the non-depressive elderly

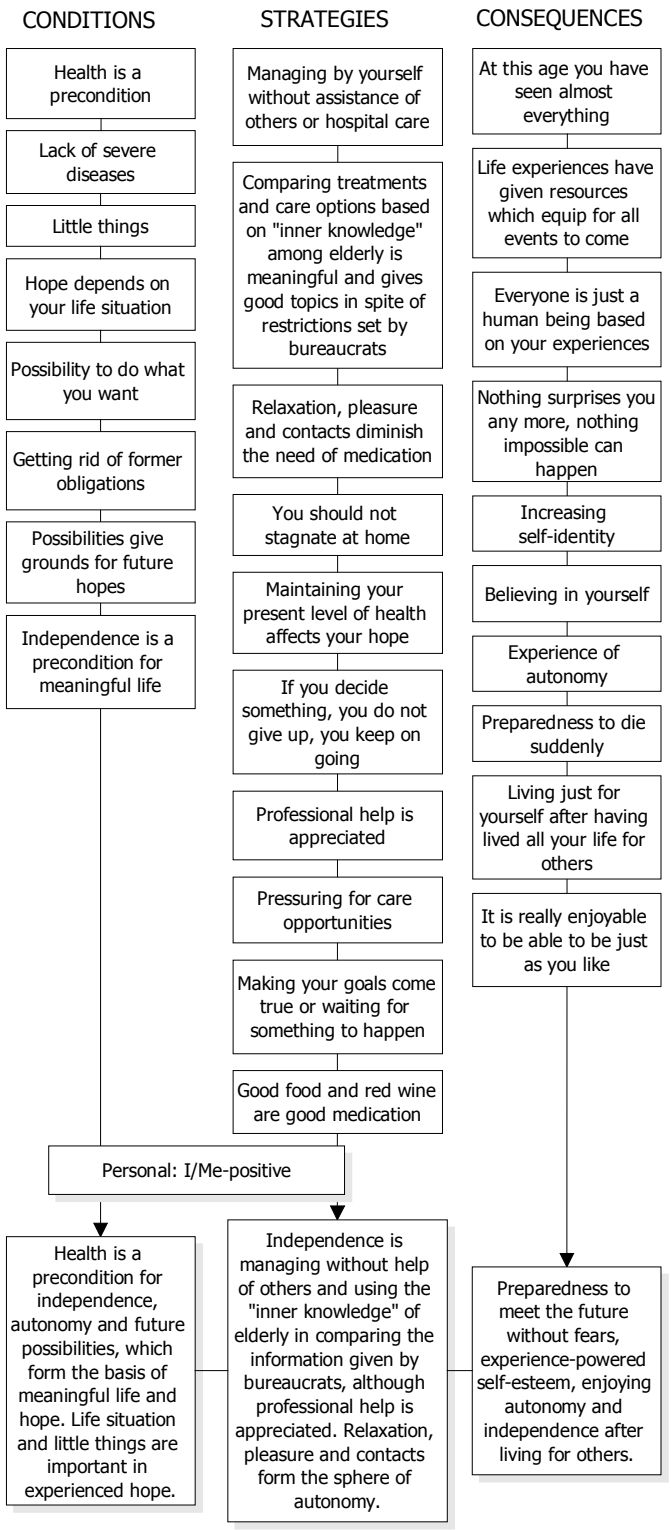

FIGURE 36. Hope-promoting factors in the personal experiences of the non-depressive elderly

Possibility to control life and to save *independence and autonomy* in human relations, economy, decision-making and well-being were experienced as important hope-promoting factors. When these factors are examined in the context of the life history of this generation (wars and evacuee periods) the meaning of these factors is given extra emphasis: freedom to have mastery over your life.

But before all came *health*, which was seen as a precondition for fulfilling other hopes. Also the health of significant others came up as an important hope concerning the future: ”Health above all, when you have health life is all right, if I had to stay alone, I would not manage, that my husband would stay healthy, that he could continue doing his job in spite of his disease, health of children, it would be terrible if you had to use others’ services and you were not able to manage yourself, it is health, absolutely, it is the first condition, that I would never have to go into a home for the elderly, that I would stay in this condition.” Retaining cognitive functions was hoped for in order to be able to manage by yourself, without the assistance of others and hospital care: ”that you would have such a cognitive function that you could manage, that you could just be and nothing terrible would happen, when you think about those people in hospitals who have no other choice than to lie in bed on drips and have pain and who can do nothing for themselves; it doesn’t feel meaningful.”

The evaluations of *the amount of hope* at the time of the interview, on the scale from 1 to 10, were on average nine, most were between seven and ten. One person evaluated her hope as five because of her life situation at that time. The question was considered a bit strange, because these elderly people had not been so accustomed to evaluate themselves, which came up in many connections. It was general that “the others should evaluate me not me myself”. In general, the amount of hope was connected with the life situation and when there were no bigger problems, life was evaluated as good and this also meant higher hope scores.

Maintaining the same kind of life and health condition as at the moment, managing by yourself as long as possible, and trusting the support of others, were possibilities which gave ground for future hopes. This was aptly described by one of the interviewees: ”when you know that there are no possibilities any more, then your dreams will run out.”

Summary of the hope-diminishing and hope-promoting factors in the personal experiences of the non-depressive elderly are presented in the following figures (37 and 38):

Hope-diminishing factors: Several physical and mental health problems and restrictions and/or lack of energy cause suffering. Fears of losing mobility, ability to manage, cognitive capacity and/or dignity and/or increasing need of time to manage in activities lead to efforts to arrange care, unsufficient economic resources, unsuccessful operations and treatmentsa. Hopeless thoughts have Influence on health. These bring disappointments and/or experience that you are too old to get care at this age when you really need it. The most hopeless situation is to be confined to bed in an institution.

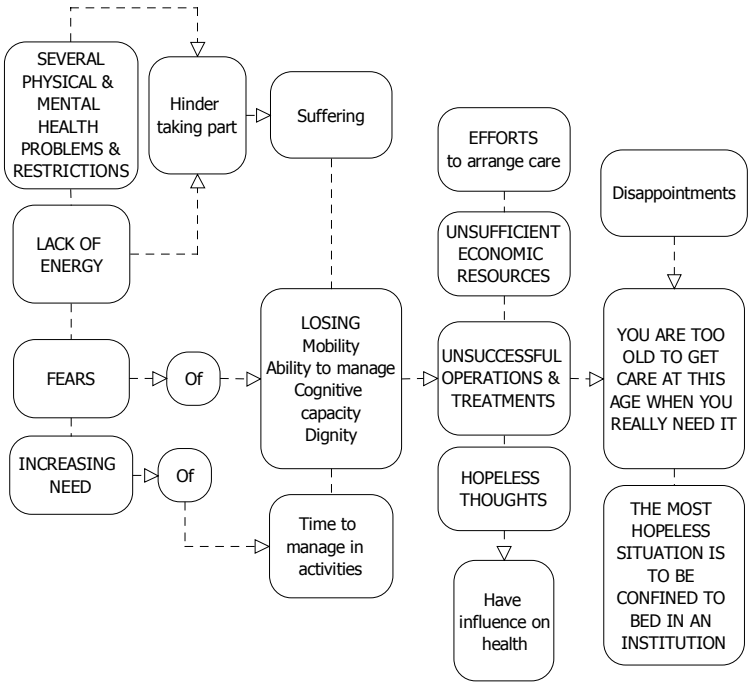

FIGURE 37. Summary of the hope-diminishing factors in the personal experiences of the non-depressive elderly

Hope-promoting factors: Health is a precondition for autonomy, independence and/or future possibilities, which form the basis for meaningful life and hope. Independence means managing without help of others and/or using the elderly's own knowledge base and informants. Autonomy is related to relaxation, pleasure and human relations. Strategies used in hope promotion are driving and/or promoting things and/or making goals come true, keeping on and avoiding giving up and/or stagnating, maintaining well-being and pressuring for care opportunities. Hope promotion leads to preparedness to meet the future without fears, experience-powered self-esteem and/or possibility to enjoy autonomy and/or independence after living for others.

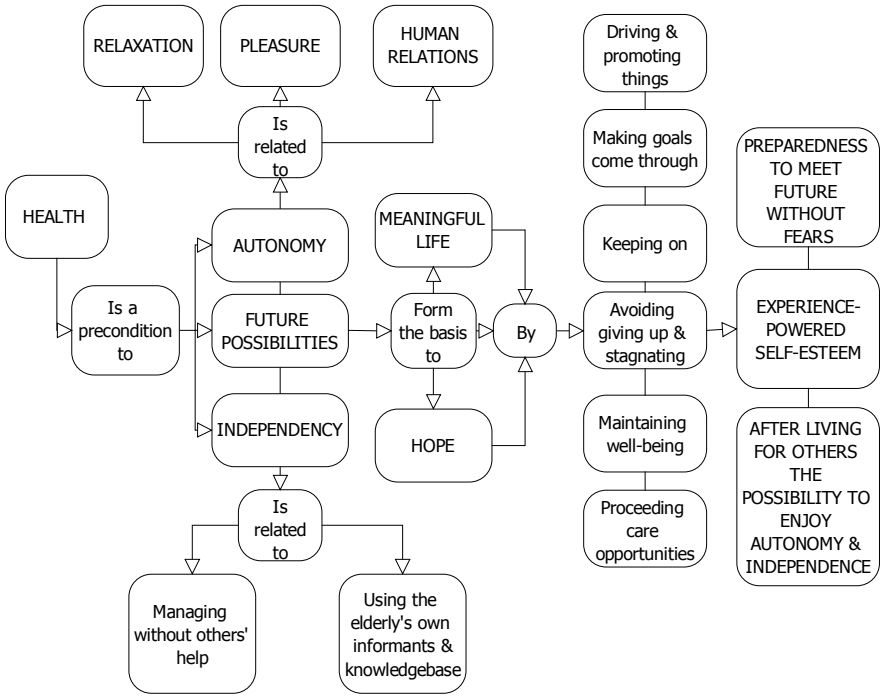

FIGURE 38. Summary of the hope-promoting factors in the personal experiences of the non-depressive elderly

Inter-and transpersonal relations: Human relations were experienced as very important but there were also expressions which described the annoying nature of too 'eager' neighbours who only meant well but you yourself were not willing to have such a close relationship or contacts so often. On the other hand, you did not want to hurt others and so you were caught in relationships, which were not only positive in nature. Also the 'coffee culture' nurtured by women, formed a kind of baking competition - who offered the best baking - which was described as "I am a very good baker and I used to bake something very good, but now she has diabetes and I have to try to find something which is not sweet to offer her next time. She asked us to coffee and now we should ask her, although I don't want to." Sometimes it was also a question of the ability to move and to get the supplies from the shop, which caused extra worries. The interviewees had quite a lot of relationships and some wanted to reduce them, partly because of getting frail and because of diseases, but also because the contacts produced more annoyance than joy. But there were also those who "almost felt sick" if they did not see anyone to talk to.

There was a clear difference in the attitudes towards the excursions arranged for the retired. Some enjoyed them very much and found new contacts, which gave joy and a feeling of importance, while others had more moral attitudes, wondering how the elderly could act like young people and dance and have fun together; "at this age your life should already have become even". The discussion groups in pensioners' clubs, downstairs in sheltered housing or in other regular places seemed to form *social forums*, where you acted as a listener, commenting seldom, or as an active participator. The common topics were children, grandchildren, daily news and especially catastrophes and politics. Some groups were so cliquish that you didn't dare join at all. Somehow, there was a kind of power culture to be seen also in these relationships. Especially the group leaders seemed to have power and they were usually very active in nature, sometimes so active that there was criticism that "This

should be a group for the elderly but there is only dancing". However, the human relations were also a source of security. Calling every day to each other secured your personal feeling of safety. These phone calls were very common and they were often timed in the evening to make sure that this day had gone well - a kind of *security network.*

Significant others were defined by the interviewees as spouses, children, grandchildren, relatives, friends and neighbours. To parents, the worries of children and their well-being were important. Usually the worries were connected with children's diseases, divorces, use of alcohol and drugs, and the fate of grandchildren in divorces. "My son got divorced, he is a jolly fellow, he was a wonderful child, unemployment and drugs have caused his problems, I scold him when he comes home, but he says to me that I should let them live their own life and concentrate on mine." Women spoke still of "girlfriends", although their age was mostly between 70 and 80 years. They formed groups but the men in these interviews were mainly alone or had a few friends whom they met. Most of the contacts were with children and grandchildren. The importance of the children was repeated again and again. Also sisters seemed to have become more important in old age although many had already lost most of their sisters and brothers. "I have taken care of the children of my sisters and brothers when the children were little and I have become attached to them, when you meet a friend and you notice that he cares, you become happy, it is important that you feel welcome when you visit your relatives, I took care of my mother till her death." The meanings of significant others were connected with managing in daily living, a feeling of safety, happy moments together, but also worries and the wish to help others, and through that, the meaning of being important. *The most important person* was most often a family member or close relative. In some cases, also a friend was mentioned. Spouse, children and grandchildren, sisters and brothers and their children formed the network of most important persons. The explanations were connected to feelings of security and common experiences.

Some of the interviewees said that it was rather hard to get used to sitting down and just watching when others were cleaning your home, because you had always done all the housework yourself, "but you seem to get used to anything". Many said that they still took care of everything themselves in spite of their decline in performance "I have managed so far, I don't need any special help, everything is all right at least so far." Those who were in sheltered housing were quite satisfied with the arrangements "You get food and medication here, you don't have to go anywhere to buy them with these feet." However, the prices of the service houses were considered to be too high. Some had used professional help like health care professionals in difficult life situations and also legal advice in divorce or in property inventory matters.

There was *criticism of the services* "When you really need help, you are too old to get it. I told them that I have never before in my life used your help and now when I'm old and really need it, you say that I'm too old to get it. You usually need help in the final part of your life, when you wish that your life would be a little easier, you don't have to extend the life, just a little help to manage. This is humiliating, this decreases human dignity." *Stamina,* which has come up in many contexts, was visible also here "I have never asked for help from anybody, I have been so proud and stubborn. I also hope that I won't have to ask for help any more." The effects of *help* were described as "The help really consoled me." Others' help came mainly from spouse, children, friends and neighbours. The friends and neighbours were often also themselves old and asking for help was difficult, but the elderly had developed quite good two-way solutions: one did the shopping, because she had 'good legs' and the other took the carpets out because she was not able to walk far but had no heart disease and could beat the carpets. There were also situations when you wished to get help but didn't dare ask for it: "When you have always served others, you cannot ask for help, even when a

man offers me my coat, I feel annoyed, because I'm the one who should serve others, or I couldn't ask her because her hands were shaking as much as mine." When you had diseases, which hindered you from taking part in certain activities, your spouse often took responsibility for them, like cleaning, cooking and shopping. If you lived alone, you had arrangements as described above or you used the official home help. But the price was often considered too high, so other solutions were appreciated more. "I bought the window cleaning service because I got it at a discount." *Saving* was a kind of 'virtue' which was cherished whenever possible and buying services was something which was hard to accept because principally you should manage one way or another as in life in general.

Taking care of children in some cases caused worries, which were not always solved with mutual understanding " it was a hard experience for me when our child became severely ill and my husband just said that I was fussing too much. Then we got a divorce and it was terrible, I blamed myself." *Marriages* and other relationships had continued mostly for a very long time, 40 or 50 years were not a rarity in these data. There were very rich descriptions of how the living together was cherished and maintained. There were certain tactics, which were developed with time. When there were disagreements men often let the things be and just listened or laughed behind the newspaper, they were planning to move away or there could also be violence, and there were a few cases where there was a threat of totally losing control and a danger of taking the other's life. The latter ones were connected with the use of alcohol or cerebral haemorrhage. Women used nagging, accusing or silent treatment as their methods. Sometimes they even wondered themselves how their husbands could stand them, " …but I cannot stop nagging when I have started and I cannot apologize afterwards. Unfortunately I got such a husband, my husband battered me, it has not happened suddenly, it has developed over a long time, he took away my knitting and turned off the TV and said that you don't watch my TV, he tried to kill me with a knife in the middle of the night, I don't understand where I got the strength to get away because at first I thought that now I'll die. I said that you cannot have both, alcohol and me, you have to choose and he chose alcohol, he is a drunk. Now he lives in the old people's home and I don't let him come back, although he regrets everything now, my husband lives his own life and I live mine, for at least five years I have felt very lonely, especially in the evenings, haven't I deserved anything better, I have tried to leave him dozens of times, nowadays it is easier to leave, but you couldn't in those days when you had children and everything, I have always been such a 'feminist' that if the life is like hell, it is best to get out of such a situation." Some descriptions were really painful and some of the interviewees asked for them not to be described in the results, a wish, which has been respected.

There were some very warm descriptions of how the spouse was good and the relationship was very valuable: "He was too good for me, always so kind and helpful in every way, he was so wonderful when one of his hands was paralysed, he even peeled the potatoes and made the soup for me with one hand, he suffered so much because he couldn't express himself although he tried hard, he was too good for my character, we cannot quarrel if I don't really provoke, he is so good-natured, we have grown together." The strategies used to get things done, were developed by some women as "Many matters have been started by me, first I give a short introduction…what do you think if we…and when the time comes closer we might discuss the matter a little and when it is so near that it must be decided, I bring it up again and usually he says yes, but he has to get used to the idea in peace." Some of the elderly had avoided marriage purposefully " I didn't get married because I was not sure if the decision was good or bad, I wanted to be free from the worries of marriage, you have to think rationally about this kind of decision." Sexuality was not so much brought up. The emphasis was on closeness and helping each other in everyday living. A few spoke more about their sexual life and its problems: "I had such a trauma, which has troubled me, and

I'm kind of dumb in these things but he understood me well." Some mentioned jealousy, which often came up when the spouse was drinking alcohol. In general, the negative sides of marriage were abundant, based on the preconceived opinion of the researcher. But perhaps this kind of interview is an exceptional situation for talking about matters which cannot be brought up in conversation with family and friends so easily, because "you want to give a better picture of your situation than it really is" as one of the interviewees said. After the *death of the spouse* the longing came up: " We were married 53 years and now he is gone, now he is away." Arranging different matters after the other's death had been often discussed before: "I have told him to keep the apartment undivided as long as he lives." There were people who were religious and spoke about the importance of *spiritual life* and also those who didn't believe that there was any 'higher power' but believed only in themselves. There was also a group which could be situated 'in the middle' who attended services now and then or who were interested in the history of the Bible or who had childhood memories of the faith of their parents or grandparents. "Heavenly Father helps me, He has always helped me, I like to pray, I listen to the service on the radio, but they are sometimes so poor and short that they end like the flight of a hen, I hate pretending, the whole world is just killing and fighting, I have a basic faith still left, faith is the anchor." In some cases, faith was a daily matter like "the last thing in the evening is to pray", while some connected it with annual celebrations. Some mentioned it with hope in that they could not imagine life without faith, which brings a brighter future or had saved their life. Faith was 'transferred' to children too by teaching them about the spiritual life. *Hope and joy* were considered to belong together. Lack of resources was almost a certainty, but you had managed to accept it and readjusted to the fact that the situation was not as before:" It is not the same, of course, as at the age of fifty, when you have now got twenty years more." But there were some elderly people who did not even mention that the situation was somehow worse. *Importance of mobility* had, however, been noticed: you should not stay in bed or stay at home, but go out and take care of things:" If I stay at home, then I'll really stagnate, I don't have strength any more, I don't have any greater difficulties, when you are able to do a little something and go out, then you'll manage well, you cannot stay in bed."

The following figure (figure 39) presents the hope diminishing factors in the inter- and transpersonal relations of the non-depressive elderly. There seemed to be a difference in the way the relations were experienced, in the sense that the depressive elderly often found the reason for problems in themselves, whereas the non-depressive emphasised more the general circumstances and other reasons.

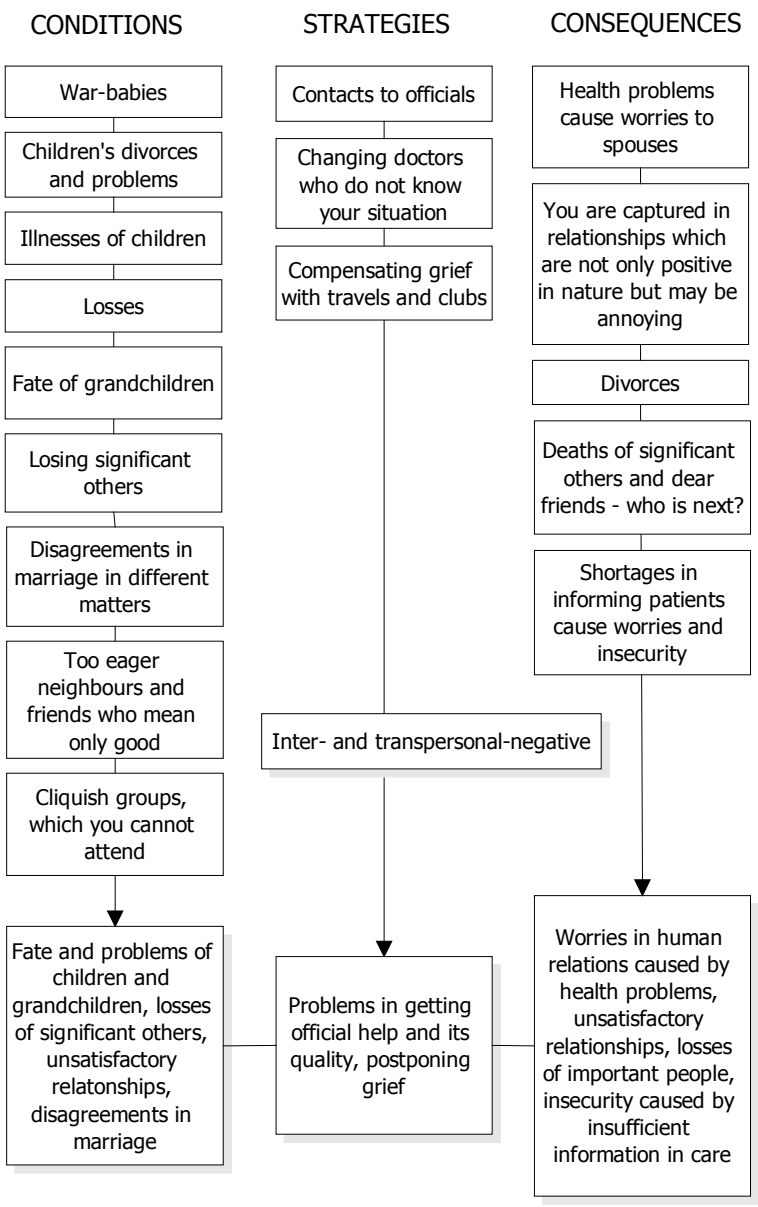

FIGURE 39. Hope-diminishing factors in the relations of the non-depressive elderly

The following figure (figure 40) defines the hope-promoting factors in the relations of the non-depressive elderly. There is a clear difference between the experienced dependence and independence between these two groups. The non-depressive emphasised again and again independence and autonomy, while the depressive ones seemed to rely on others and built their hope much more on them.

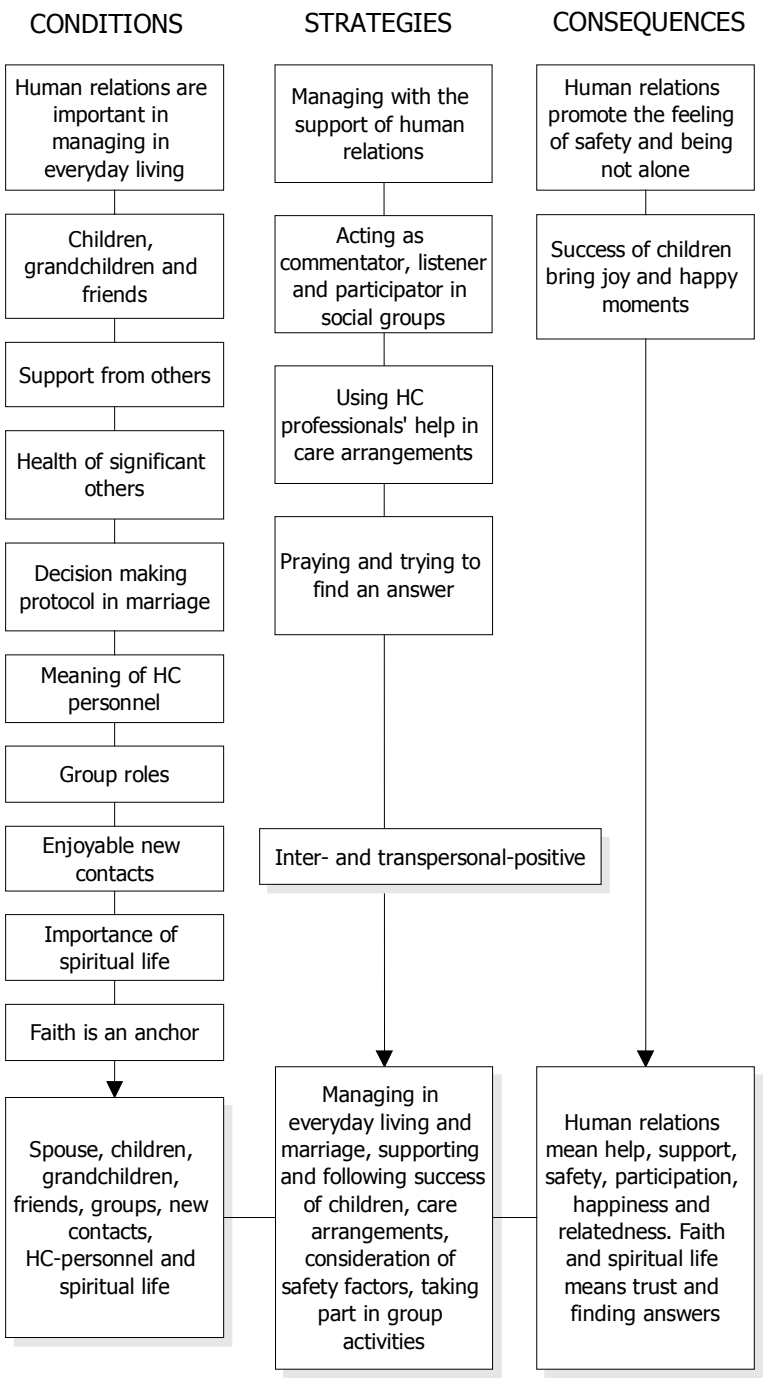

FIGURE 40. Hope-promoting factors in the relations of the non-depressive elderly

Security achieved through the presence of others was an important factor: ”That I could keep these friends and relatives, that I could die before them, that the death would be quick when it comes, like I laughed when I was young that I took a much younger husband so that he’ll

take care of me, but nowadays men die so much younger than women that it fits quite well at the same time." Although the elderly also used humour in their descriptions, there was a real underlying worry about, how to manage without others' help and support.

Losses were such an important factor in these interviews that they are defined in more detail in this connection. In general, the losses were connected mostly with deaths, but some mentioned also divorces and loss of health or ability to move. "Then came the divorce and self-accusations; what is the matter with me, and my mother died two years ago, a couple of years ago I lost my friend, a workmate of mine, it affected me too, because I don't have many friends. "Economic losses as such were not described in this connection. Some of the interviewees described how they hadn't had any losses: "I haven't had any losses because I don't even have a husband." The number of losses and funerals were counted and some of the elderly listed the deaths of acquaintances like 'shopping lists', which sounded a little strange, but after several interviews it came up that the experiences were so common that the attitude towards them had changed: "You just think whose turn is next, in our group the leader said that they have had widows who have come next time with a new friend and the third time he has died too." This does not mean that the losses of significant others or important friends would have been somehow easier, but the amount of experiences had increased. The terms in which the losses were described were: "He died, he passed away, she is gone, she slept away, I lost him, it was a shock, it was really hard, you cannot have a greater loss." Although only the losses within the last year or in the recent past were asked about, there were descriptions of losses since childhood when sisters and brothers had died, because the mortality of children in those days was higher than nowadays. Also the wartime was a period of losses, many of the interviewees had lost their sisters, brothers and relatives in the war: "My brother died in the war, he asked for my bicycle to be able to flee the Russians and he never came back."

The most difficult losses were those of a spouse or a child or a very dear friend. The death of one's own parents was rather a normal process, which was accepted as an inevitable fact. Deaths of sisters were in some cases hard experiences, but in some cases not so difficult:" My brother died two years ago during the medical examination, it was shocking because it happened so suddenly, he was ten years younger than me." If you had not had a very close relationship with your sisters while they were alive, also their death was not so hard and vice versa. Children's spouses formed a group, which came up through the worry about, how the child manages after the loss; the loss was a strong shared experience. One's own relatives and the relatives of the spouse formed a group in the funerals of which the experiences of the whole family were shared. Because the families were often large, also the funerals were many. "The mother of my male friend passed away, she was very close to me, it affected me, it left a vacuum, it was hard, it was the first and the worst, I cry when I feel like it, his son had cancer, the worst kind of cancer, we took care of him, he would have liked to live, it was a hard time, he said that he'll leave us now."

The death of a spouse or a dear friend was in most cases the greatest loss one can imagine: "My husband died last year, he died within seven months after having heard that he had cancer, seven months later he was not alive any more, it came so *suddenly*, he was in good condition till the two last weeks, then we saw that nothing helps any more, I think that one cannot have a greater loss than that, I don't know if I can live alone, I have this longing, he is waiting there behind the border of death and I'll go there...that is the deal we made, if he has to go first, then he'll wait for me, you have to start thinking like this: which one goes first, he has a very beautiful grave, the name up there and the flowers, I went there three times a week, but when it started to ease off, then I noticed that I'm really alone now, but then I went running back to the churchyard, you sometimes think that although you know

that there is nothing, you have to go, but it is changing little by little, I was crying there and running and crying and I thought: am I a fool, just crying and running and crying, but the others did the same, the grief is so personal that in the end the other people kind of vanish from sight."

But there were some examples of other types of grieving: "My husband died but I have to deal with it, he was seven days in the hospital, so I had time to adjust, my sister died a year ago but we were not so close, then I have lost my two brothers in war and one of my brothers died recently, I have also lost my sisters when they were little, here in this nursing home it is usual that someone dies almost every day."

On the basis of these interviews, the grieving process was a very personal experience. There seemed to be at least two trends which came up 1) *The time to adjust* to the loss varied individually, irrespective of the time, which had passed since the death. As in the examples above: one thought that seven months is not enough while another spoke of seven days. The interviewees had attended various kinds of groups and seemed to be aware of the length of the 'normal grieving process': "They said that it takes two years to get over the grief, I have tried to be sensible." The number of experienced losses seemed to affect the time needed to adjust in these interviews, in the sense that the more losses the shorter time: "You have to get adjusted and accept it." 2) *The intensity of the reaction* depended on the importance of the person who had died, and also the quality of the relationship:" I lost one of my cousins, cancer is terrible, she also died suddenly, sixty years old, the cancer should be overcome. "

Losses were described as leaving a vacuum, which people tried to fill with activities of everyday living: travel, clubs, etc. Also children seemed to be active in this 'filling process': "I travelled with another widow, who was also widowed a short time ago, because our children forced us to go, there we were two widows in a strange country." There were different kinds of attempts to avoid thinking, and also to postpone the thoughts that had to be handled afterwards. Summer cottages seemed to be difficult places to visit after the spouse's death because memories hurt. Children often helped by arranging visits with grandchildren to help over the emotionally hardest period. The methods in grieving changed: some went to the 'grieving' groups and wanted to handle the grief thoroughly "to be able to live fully again", as they expressed it. Others postponed the process because it was too hard to handle at once. Some had strong support from children and relatives and managed day by day. Some reported relief after a long time of worrying and grieving during the last phases of the severe disease of the deceased. There were also those for whom the supportive elements were their own experiences of getting through difficult life periods, with death representing one of them, which should be handled rationally, when it comes your way.

One phenomenon, which came up, was the elderly's own position in the life span, and understanding the limitations of the remaining time: "who is next." Through every death that you follow closely, you kind of prepare for your own death. In the clubs for the elderly, in the nursing homes, and in old people's homes, death is a common topic and you follow, on a daily or weekly basis, the others who are widowed.

Summary of the hope-diminishing and hope-promoting factors in the relations of the non-depressive elderly (figures 41 and 42).

Hope-diminishing factors: Illnesses, divorces, problems and/or fate of children and/or grandchildren, losses of significant others, unsatisfactory relationships and/or disagreements in marriage, and/or insufficient information about care promote worries, insecurity and/or problems in getting the correct official help.

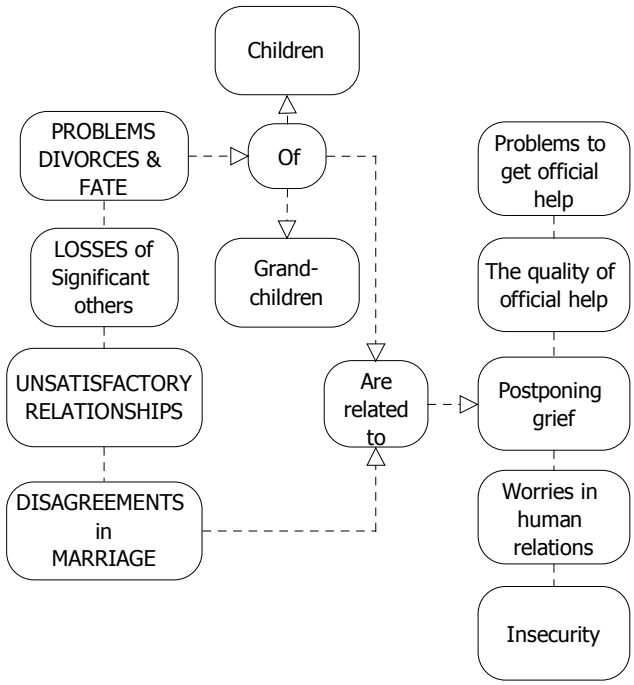

FIGURE 41. Summary of the hope-diminishing factors in the relations of the non-depressive elderly

Hope-promoting factors: Human relations (family, relatives, friends, acquaintances, official contacts) and spiritual life mean managing in everyday living and/or marriage, supporting and following the success of children and grandchildren, care arrangements, considering safety matters, and/or taking part in group activities. These are related to help, support, safety, participation, happiness, relatedness and/or spiritual life, which means trust and finding answers.

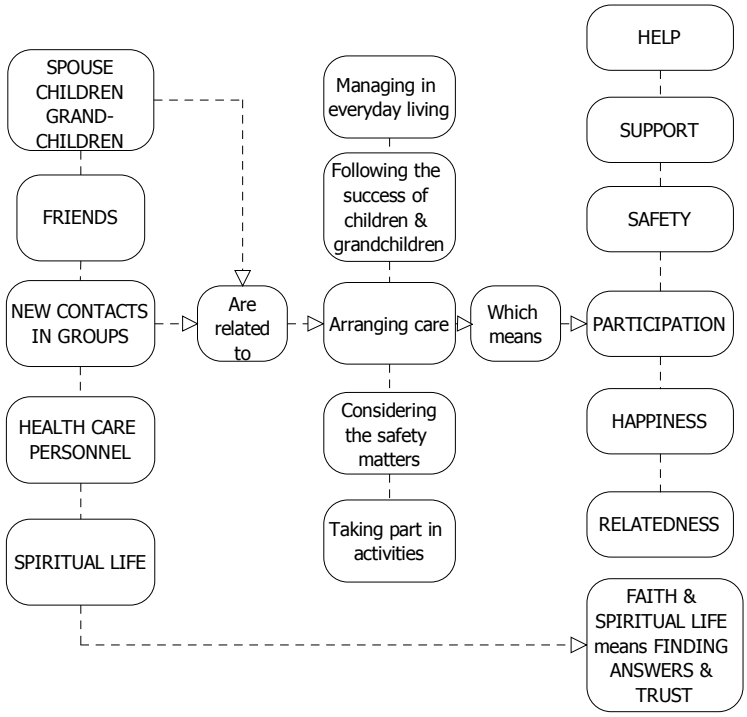

FIGURE 42. Summary of the hope-promoting factors in the relations of the non-depressive elderly

6.3.1 THE MEANING OF HOPE AND HOPELESSNESS IN THE INTERVIEWS

The meaning of hope was asked about as a separate question and it gave results rather similar to those for the meaning built up from other research questions. The meaning of hope was defined as: ”Well-balanced life, you wish everything good for the younger generations, everyone always has hope, hope for a better life, my life is all right, it means a lot to people, if you have no hope, then you would not have life either, it means life, you don’t have life anymore if you don’t have hope, hope is combined with people’s lives.” The meaning of hope was combined with life as a whole. Although cancer was generally considered quite a desperate situation, there was hope based on own and near relatives’ experiences: ”Whatever life is like, when you think of cancer patients for example, they have also hope, I know this after following my brother’s life with cancer, human life is built on hope.” The only situation, in which the presence of hope was doubted, was to be a patient in a long-term ward: ”You should never lose your hope totally, unless you are on the ward of chronic invalids.” Work was an important source of hope: ”It was the time when I got work, it was like stepping on a tree stump, it means life.” A steady and peaceful life forms the basis for hope. It was hoped that younger generations would have a good life and, on the other hand, it was stated that at least at this age one should have hope. One should never lose hope.” Comparisons were made concerning own family and others:” I’m happy to come from a family whose members have all died quickly, anyway I wish that I could die in my bed, not like my uncle who died at the bus stop.” There had been many hopes during life, which had not been fulfilled, but with the ’right attitude’ you have managed to make your life meaningful: ”Some people always complain of something: they are not feeling well and the elderly are treated badly and all sorts of whining, it is quite needless, if you adopt the attitude of oh, oh, but if you think that this is not so serious, I’ll manage quite well, then it is

much easier, if you take it like a burden: oh, this is serious, you just have to accept it, you have to face the situation at hand."

Human relations were a source used to build a meaningful life: "It is good to live in hope, when you go and serve others, you get the meaning through it, grandchildren are everything, that you know that they need me there, and others find it so important, for me it is natural, like the others said that it was so hard when I took care of my husband when he was ill, but I didn't think about it that way." Also the skills in social interaction were considered to be important in the analysis of the meaning of hope: "That you would manage better in the social interaction, that you could avoid quarrels and such, that you would get along better with others." Especially at this age, you seem to wish that things would become better or at least to be settled in your life: "You wish for a better life, at least health.. what else..seriousness, at least you don't wish for worse things, at this age you should already have a little hope there will be no more greater shocks, just a peaceful and steady life."

As a conclusion, hope was experienced as closely connected to 1) life and living. Usually it was a question of a well-balanced, good or steady and peaceful life - something without disturbances or shocks. But there were also experiences, which pointed out, that whatever life is like, there is hope as long as you live. Hope was also connected with 2) age. At least two meanings were attached to it. Hope was linked to younger generations and their life in the sense that it was hoped good and without misfortunes. On the other hand, hope was connected to "this age", which meant that at least at this age you should have a right to have some hope after all difficulties before in life. Hope was also linked to 3) work, which was very important for this generation. The meaning of work came through the possibilities, which it promoted. It was seen as a precondition for a good life. 4) The "right" attitude was emphasised in the sense that accepting facts, facing the situation and avoiding complaining helped to build up a meaningful life. 5) Human relations were an essential element of hope to construct a meaningful life. Skills in social interaction were highly appreciated, because they gave tools to avoid quarrels and discomfort in interaction. Appreciation from others was hope-promoting, as was the feeling of being needed, which was achieved by serving others. Human relations create security, and joy, and help you to cope.

6.4 DIFFERENCES BETWEEN HOPE AND HOPELESSNESS DEFINED BY THE TWO GROUPS

To find out the *differences* between the two groups examined, all the factors were regrouped on the basis of time: past, present and future. The following two tables (tables 5 and 6) present the groupings.

TABLE 5. Hope-promoting and hope-diminishing factors in past, present and future in the lives of the depressive elderly

HOPE-PROMOTING FACTORS	**HOPE-DIMINISHING FACTORS**
PAST: Getting over difficult periods in life, stamina, joy and feeling of security, good physical condition, optimistic in spite of difficulties, religion gives comfort, work and building a home, saving, human relations, especially spouse, children, friends and neighbours, hobbies and summer cottage activities, gardening, nature, decorating the home, clothes and everything beautiful	**PAST:** Tragic situations in childhood, fears, tension, feeling of inferiority: rat in a hole, grey mouse, total zero, violence, tiredness, hunger, low self-esteem, uncontrollable thoughts, memories cause anguish, fears of God's revenge, lack of social support, poverty, lack of knowledge, humiliation, inquisitive people, malice, disappointments, marital problems, lack of time and economic restrictions hindered hobbies, work was your

PRESENT: Abundance of experiences of how to manage, it is hopeful that you are still alive, waiting for tomorrow, feeling of togetherness, mutual understanding, joy, security, in spite of many diseases you manage day by day, satisfaction of achievements, trust in God or in Higher Power, belief is source of comfort, by hard work, has created for children a better life and education than one has had oneself, good medication, help in everyday living, positive interaction and feedback, feeling of security, trust in health care (HC) personnel, gardening, exercise, good books and TV programmes, groups and social activities, spring, light, flowers, beautiful things at home. **FUTURE:** Maintaining the status quo in health and living, feeling of security and being taken care of, physical well-being, ability to move, quick death, mental well-being and life without depression, hope that God would help, managing in everyday activities: laundry, cleaning, shopping, ability to pay your debts, understanding from your spouse, good relationships with children and grandchildren provide security, possibility to attend groups of different activities, being able to clean your home, change curtains etc.	'hobby', self-identity: feeling ugly **PRESENT:** Continuous worrying, unable to accomplish even the smallest activities, lack of initiative, losing the meaning of life, "you just cannot be", low self-esteem, meaninglessness, emptiness, helplessness, loneliness, like a roller coaster, lack of energy, tiredness, aches and several diseases, uncontrollable thoughts, fears, self-accusations, wish to put an end to your sufferings, not able to get joy from anything, depression, utmost gloominess, no help from religion, giving up decision making, lack of knowledge of care alternatives, expensive medication, worries concerning housing, many losses of significant others, uselessness, sadness, hopelessness, feeling of not being understood, children don't visit or call, aggressiveness and alcoholism of children, busy HC personnel, too tired to take part in anything, physical and psychological condition hinder taking part in social activities, nothing gives you pleasure. **FUTURE:** Ending up in hospital or other care institution, insecurity, loneliness, fear of depression, inability to take care of yourself, being unable to move, being afraid of dementia or losing your memory for other reasons, God does not help either, managing at home is not certain, fear of accidents, severe diseases or losses of significant others, taking care of others absorbs your energy, restrictions in physical and mental health may hinder your activities, at this age there is not much to look forward to.

TABLE 6. Hope-promoting and hope-diminishing factors in past, present and future in the lives of the non-depressive elderly

HOPE-PROMOTING FACTORS	**HOPE-DIMINISHING FACTORS**
PAST: Rich memories of joyful summers in childhood, it was often poor but secure, youth and dating full of expectations, building up your life from almost nothing, achievements, tackling the difficulties, getting through difficult life situations, the attitude that difficulties belong to life in general, adjusting and finding your way out, courage from former experiences, feeling of importance through work experiences, lack of severe diseases, brandy brought relief, noticing based on experiences that all people are just human beings. **PRESENT:**	**PAST:** Losses, war babies, economic situation, "what would your life be like, if your dreams had come true-something is missing", strange urban culture and working life in big factories and cities, small salaries and hard work, regretting some former decisions, divorces, illnesses of children. **PRESENT:** Deaths of significant others, at this age you have more reasons to be worried: health, others' diseases and deaths, you don't have that much hope any more because you know the realities of life, something unpleasant may happen at this age, which has

Success of children, living just for yourself after having lived all your life for others, hope depends on your life situation, at this age you have seen almost everything, nothing surprises you any more, nothing impossible can happen, if you decide something, you don't give up, you keep on going, believing in yourself, peaceful life, feeling of security is based on the presence and availability of others, relying on the support of others has effects on your hope, life as a whole, it is really enjoyable to be able to be just as you like, independence is a precondition for meaningful life, growing self-identity, experience of autonomy, possibility to do what you want, moral consideration, obstinacy and stamina, health is a precondition for other things, health of significant others, managing by yourself without assistance of others or hospital care, maintaining your present level of health affects your hope, professional help is appreciated, relaxation, pleasure and contacts diminish the need of medication, meaning of HC personnel in arranging care, taking advantage of care opportunities based on "inner knowledge" among the elderly in spite of restrictions set by "bureaucrats", good food and red wine are good medications, you should not stagnate at home, comparing treatments and care options is meaningful and gives good topics for conversation, hope rises from the realisation that nothing serious will any more happen which you would not be ready for, persistence, determination, efforts to maintain good mood, praying, trying to find an answer, importance of spiritual life, faith is an anchor, getting rid of former obligations, children's education, managing in everyday living, possibility to get help, everyday life, stable economic situation, help of acquaintances, no need of possessions and things any more, just peaceful life, satisfaction with services in sheltered housing, saving as an attitude has offered possibilities, on community level peace and well-being, children, grandchildren and friends, spectator's role in following how things clear up, avoiding another marriage, the need to show others that you manage, human relations bring joy and happy moments and are important in managing in everyday living and promoting the feeling of security, decision-making 'protocol' in marriage, enjoyable new contacts through social activities, group roles: commentator, listener, participator, arranging your life in the best possible way is source of hope and happiness, travelling, enjoying comfort and cosiness, want to be at home in your own territory after an intensive travel and club period, little things. **FUTURE:** Possibilities give grounds for future hopes,	connections with insecurity - how to manage, you have to be stubborn to get care and examination at this age, words hurt, feeling of insecurity, loneliness, grieving, at this age, intensity of activities becomes a burden, health problems cause worries to spouses, loneliness as a health problem, cognitive functions and health in general, incapability, lack of energy, losing ability to move, connections between mood and health, trying to get care causes disappointments because you are too old for care although then you really need it, arranging your care between public and private sectors without sufficient economic resources, activities take much more time than before, resistance deteriorates and physical restrictions decrease the possibility to take part, changing doctors, who don't know your situation, lack of in informing the patient causes worries and insecurity, unsuccessful operations and treatments cause long-term suffering and economic problems, several aches and pains: problems with eyesight, sleeping, walking, digestion, constipation and fears of health maintenance were general, the severer the disease the more it affects your hope, being confined to bed in an institution is hopeless, panic and shock reactions, postponing difficult thoughts, trying to be without thinking, difference between hopeless thoughts and hopeless acts, fears of losing your memory, intelligence and dignity, housing and living conditions, adjusting to the unavoidable, contacts with officials in different matters, high prices of services and medication, economic situation, arrangements in situations when your spouse has died or is in hospital or coming home from there, lack of knowledge in taking care of different things, "life is rather downhill - what has life to offer at this age", losing your driving licence makes it difficult to take care of affairs, inability to manage in everyday life after the spouse's death, getting help nowadays is harder than before, losing significant others and dear friends "who is next", you are trapped in relationships, which are not only positive in nature, but may be annoying: too eager neighbours and friends, who mean only good, mutual duties, which are hard to accomplish because of frailty, diseases and other reasons, these relationships give you a bad conscience, cliquish groups, which you cannot join, children's divorces and problems, fate of grandchildren, disagreements in marriage: restricting, violence, nagging, sexual boycott, silent treatment etc., compensating for grief with travels and clubs **FUTURE:** The whole world is just killing and fighting.

preparedness to die suddenly, life experiences have given you resources, which equip you to all events to come, making your goals come true or waiting for something to happen, you are not alone: support from others.	

There were some *similarities* in the life experiences of the both groups: war time and evacuee periods (good but also racist experiences), hard work since childhood and youth and lack of possibilities for education. Time after the war meant for many of the interviewees moving to cities and working in factories and services. This was a cultural change, which was described with a feeling of alienation in the sense: "in working for others you couldn't be yourself". The social activities and contacts with others were experienced as very important but also annoying, when you became older and did not have so much energy to take part. At this age, there were plenty of losses and severe diseases of friends and significant others. This generation had an exceptional feeling of togetherness, based on their war experiences. "Our country" was valuable in many senses. This could be seen, for example, in the amount of clubs you belonged to, which were established during the war and were still very active. Another example was the meaning of building sites, when you started to build your own house on the land, which "had taken sisters, brothers and parents" of many of the interviewees or their acquaintances.

The most prominent *differences* were: The *depressive patients* had many traumatic experiences (violence, assaults, alcoholism etc.) in childhood, which had affects throughout the whole life, although there were many positive experiences too. Experiences of shame because of war babies, were hard because of the consequences: separation from the community and significant others and humiliation. Life as a whole was experienced as hard and cheerless, but you had to manage, and you did, day by day. Lack of self-esteem was common and the forms of it were quite absolute: "total zero, rat in the hole". Worrying continues through life till old age. The energy had been used up in helping others and trying to manage by you. It was hard to realise that, although you had worked hard and raised your children and lived so long, now you cannot perform even the smallest activities. The future perspective was painted with dark colours and fears, the realisation of which was seen as quite probable. Many had already tried to solve the burden by self-destructive thoughts and acts. The reasons for negative matters were often connected to you yourself, not sought from other sources, and this had also turned the focus inside out in examining life as a whole.

In the lives of the *non-depressive elderly*, the happy memories have won in spite of difficulties. Although the work was hard, the meaning of it has been very important. Dating, romances and building up homes were mentioned as especially hopeful periods. Also the time when children were small was full of interaction with others. But there were also a lot of marital problems, which were not shown to others, this was 'a question of honour'. Also the descriptions of how to manage in marriage were abundant. Divorce was not a common solution in those days; it was considered a failure. There were also war babies in this group, but the experiences were mostly contrary, you had even managed that and got courage from others despising you. Trust in own self was strong. The difficulties were overcome with stamina and the idea that they belong to life and you have to manage. In old age the most enjoyable feeling was the possibility to have independence and to get rid of all the obligations of one's former life. Also the autonomy, the feeling that you can be just as you like, was greatly appreciated. You could just follow the life of others and act as a mediator based on your life experiences. This was also seen as an important role concerning children and

grandchildren; you wanted to leave memories, which would stay alive after the end of your own life. The future perspective was not very bright concerning the development of living in the world in general "the whole world is just killing and fighting", but your own life experiences and living together with your significant others have equipped you with trust, that nothing surprises you any more and you'll handle the situations to come (see appendix 8).

In answer to the research question: Are there some *special features* in the hope and hopelessness of the elderly, some features were found. *First*, the shortness of the rest of the life gives hope and hopelessness another kind of perspective than earlier in life. This can be noticed in planning and setting goals. Most of the interviewees said that they had already achieved what life has to offer, and had no special hopes for the future concerning their own life. Hope was mostly connected with the lives of their children and grandchildren. If some objects of hope were mentioned, they were often connected to everyday living, and the time perspective was shorter than earlier in life. Hope is here today in the whole of living, so is hopelessness. The visions of a better future were hard to see in depression; living day by day was the strategy.

Secondly, the perspective often involved looking back in time: memories and unrealised dreams were examined as hopes. They sort of gave a new content for living: painting rosy pictures and imagining gave pleasure almost like real experiences. Some of the elderly spent quite a lot of time, according to their own descriptions, living in memories, which gave the same kind of pleasure as hope. Sometimes, this imaginative processing also led to activities like contacting with friends from one's youth and activating old romances, or moving back to where you had lived in your youth, or travelling to districts full of memories. Painful memories were, on the contrary, put aside or activities and social interaction consciously postponed them. Here, there seemed to be a difference between the depressive and non-depressive in the sense that the depressive ones did not have the energy to take part in the activities, and the hopeless thoughts and memories ruled the thinking process more actively and, in many cases, stifled other thoughts almost completely. Hopelessness in old age was reflected in former life and unrealised hopes and dreams: "Didn't I deserve anything better?" Feelings of bitterness emerged in many cases. There was also the worry that now you no longer have time to start to build up your life again, there is no use trying anything. Also physical restrictions, aches and pains, made it impossible to realise some hopes.

Thirdly, the objects of hope had changed from what they had been earlier in life. Nowadays, you just hope for a steady and peaceful life, not for such powerful experiences as earlier in life, although you give them a chance too. There were a few mentions of "once more in my life" dreams. The rhythm of life had settled down. Also the hopes concerning material goods have diminished, because you no longer need possessions and things as you did before; your living conditions and home are 'ready' compared to the phase when you were building and furnishing your home. Cosiness, freedom, aesthetics and enjoying former achievements were hope-bringing factors in everyday living.

Fourthly, health was a precondition for other well-being, and its meaning was more important the older you became, because it gave you the possibility to achieve other important things like the possibility to move and meet others. These were important elements in a meaningful life. Because other activities had diminished, the meaning of health had increased compared to the former phases in life.

Fifthly, a prominent feature was the interactive nature of hope. This generation seemed to have lived all their lives for others, and hope was also based on these relationships, as was

hopelessness. That is why the freedom from obligations and responsibilities concerning others, was an exceptional source of joy and happiness, which was hard to admit. The possibility to be, as you like at home, in your own territory, was invaluable. Some of these elderly people felt guilty expressing their enjoyment of something that is just for them: comfort and cosiness. Hope had sort of turned inside out in a positive way; interacting with you was a new liberating experience and perspective of hope.

6.5 THE BSP - BASIC SOCIAL PROCESS, ACHIEVING - MAINTAINING - LOSING

The Basic Social Process (BSP) came up as defined before during the analysis when the feature of -lack of- was found. It guided the examination to the structure, lack of /full of, being full of and being without. By examining the descriptions of the depressive and the non-depressive elderly and the numerous networks based on the meaning units, the dynamics were captured as defined in the following figure. Achieving-maintaining-losing was examined on the personal and interactional level, and also in life and everyday living.

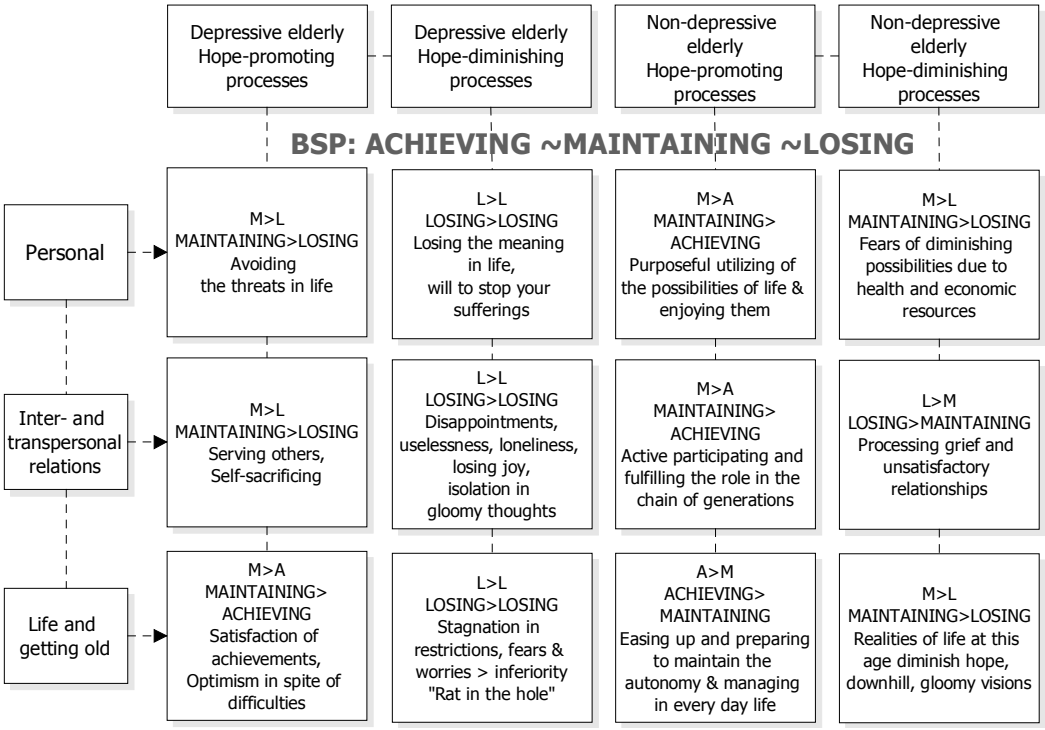

FIGURE 43. The Basic Social Process (BSP): Achieving - Maintaining - Losing

The hope-promoting processes on the personal level of the depressive elderly meant avoiding threats in life and gaining positive experiences of managing in difficult situations. In inter- and transpersonal relations, the main trend was living for others. It seemed to be important to be accepted by others. Pleasing others beat the personal needs, which meant self-sacrificing. But when the life was examined as a whole, satisfaction with achievements and optimism in spite of difficulties were the most often expressed experiences. Although life had been hard and you had not been able to fulfil your dreams, you were anyway satisfied, because you understood that in these circumstances, life had gone quite well all in all. This was experienced as hope-promoting.

The hope-promoting processes on the personal level of the non-depressive elderly were more purposeful, driving and forcing things forward. The possibilities were utilised carefully and the achievements were enjoyed. Inter- and transpersonal processes were active participating, joining others and taking on new responsibilities in the chain of generations. It was a privilege to leave something that remains after your death like skills for grandchildren with which they can remember grandmother or -father afterwards. When life was examined as a whole, easing up and calming down had started, but the purposefulness continued in maintaining autonomy and managing in everyday living. As values, these were so important that efforts were made to maintain health, which was a precondition for autonomy and managing in life in general.

The hope-diminishing processes in the lives of the depressive elderly brought up the gloomier colours. On a personal level, life had lost its meaning and you wanted to stop the suffering. Many had also thought about it intensively, and some had even tried once or several times. Tiredness from fighting with yourself had taken all your energy and death was a hoped-for relief. In inter- and transpersonal relations, isolation in gloomy thoughts was the result of continuous disappointments, feelings of uselessness and loneliness, and that there was no joy in life anymore. When life was examined as a whole, it had stagnated in restrictions, fears and worries, which continued from morning till evening, and you just followed your inner world and felt inferior, with no will to be in connection with others: just like ”a rat in a hole”.

The hope-diminishing processes in the lives of the non-depressive elderly, on the personal level, were fears of losing financial resources and through them your autonomy and the possibility to control your life. The loss of control of health and economic resources, due to illnesses and other factors that were hard to foresee, was feared. Decisions made in interpersonal relations were regretted and losses and grief were strongly experienced as hope-diminishing. Losses and their meaning were combined with the importance of the person in the experiences. Loss of a spouse, child or a very dear friend brought up the strongest feelings of being left alone and losing hope in life, especially when the experience was in the recent past. When life was examined as a whole, the realities of ”at this age” were examined and found to be hope-diminishing. Life was downhill from now on and mainly gloomy visions lay ahead.

It was a remarkable finding that because the situation of the depressive elderly was already full of experiences of losing, losing your mental health, human relations and joy, the total analysis of life was seen as more positive, you still had something to achieve: your health, if the treatment helps. You had a lot to hope for because health was highly appreciated. But the non-depressive elderly were preparing themselves to avoid the threats of life, which might appear in old age: you did not have so much to gain any more. On the other hand, the hope-diminishing processes were much more severe, even life threatening, in the lives of the depressive elderly.

6.6 THE MEANING OF HOPE AND HOPELESSNESS BASED ON THE DICTIONARY - AND EMPIRICAL DATA

As presented before, meanings can be understood to be historical, bound to time and place, and also changing with time and place. They are also social and present in human interaction (Lehtonen 1996, 32-33). Yalom emphasised that there is no purpose ”out there” because each one of us constitutes *our own ”out there”.* (Yalom 1980, 461-462.) These aspects are also supported in these definitions. The meanings are defined in connection with the contextual aspects through the personal life history.

6.6.1 CONCLUSION ON DICTIONARY DEFINITIONS

According to the dictionaries, hope was defined as an orientation to the future with a certain amount of trust and confidence. The expectation includes a possibility, which sets certain boundaries for security and belief. Hope is more often connected with the future, and making drafts of the possible object belongs to it, but it may also be based on the past or present. Hope can be daily, temporary or continuous in nature. Sometimes the object might be hard to define or hope can be objectless or more general in nature. Different levels of hope can be defined: fundamental, interpersonal and personal levels of hope. The object of hope is something desired, favourable, welcome or promising, something which is positive in nature. The nature and amount of hope might vary. Hope is defined as a state of mind, condition, outlook, future orientation and attitude. The hoping process can be intentional, purposeful thinking, imagining and dreaming, full of feelings connected with the object, the value of which is important in terms of the amount of hope. Hope can be unrealistic and it may be supported and cherished in different ways. The experiences may vary between trust and mistrust, confidence and insecurity may vary with time. Especially prolonged anticipation may crush and destroy hope; this is often combined with disappointment and a lost object.

A hoping person is calm and confident or fanatic and ready to take risks, daydreaming or intentional and joyful, depending on how reality-based the hope is and how important the object of hope is for the hoping person. Hope is often connected with youth and promising life situations. On the other hand, despair and hopelessness are always present because of the uncertainty of the object. When the amount of hope diminishes to the extent that there is no more hope or hope is crushed - hope is lost- hope turns to despair, which is a joyless state in which there is no hope left.

The hoping process depends on the grounds of hope. If they are well defined and realistic, the process also is mainly intentional and purposeful towards the desired object. If the grounds are unrealistic, also the process is often utopia-oriented and feelings guide the process. In this case one could rather talk about wishing. The objects of hope seem to be the same as the grounds of hope based on these dictionary definitions. People, health, everyday living, youth, spiritual life and things and places are, at the same time, both grounds and objects of hope. The importance of the object is crucial concerning the amount of joy and disappointment. On the other hand, time plays a remarkable role in the hoping process, because lack of energy might be the result if achieving the object is deferred and its attainment seems more impossible. There is a limit which is important in the sense that hoping might turn to losing hope, thus the process may lead to total hopelessness, which is the situation where one has nothing to look forward to any more.

Striving for security is central in fighting against uncertainty and fear; this keeps the process going in the direction of fulfilment. Based on these definitions, it is important to support and cherish the hoping in different ways. Making drafts for the future and imagining the desired object keeps the hope alive.

6.6.2 CONCLUSION ON THE EMPIRICAL DEFINITIONS

Hope was defined on a fundamental, interactional and personal level. On the *fundamental* level, it was connected with life and its meaning: ”Human life is built on hope, hope has a great meaning, life as a whole, it is a precondition of life or a better life, a steady and peaceful life forms the basis for hope, it is a big question.” On the *interactional* level, it was connected with human relations. Connections to younger generations came through children and grandchildren. Work was an important source of hope for this generation. Happiness, joy

and a brighter future were connected with hope and often with human interaction. Also, skills in social interaction were considered to be important in the analysis of the meaning of hope. *Personal* well-being and positive elements of life were often connected with everyday living. The ability to manage in everyday living and maintaining health and well-being were important preconditions for other hope promotion like possibilities of human interaction, ability to manage and taking care of different affairs, and a well-balanced life: "It is managing at home, getting out of hospital, being able to move, passing the day till evening when you get your sleeping pill". In depression, hope was passing the day from morning till evening. It was either connected with thoughts of getting away or its meaning had sort of disappeared: "It is difficult because nothing interests you, at the moment there is no hope". The *future orientation* came through younger generations and ideas of fulfilment: "It is something which is not yet fulfilled, a better tomorrow, a longer life. There had been many hopes during the lifetime, which had not been *fulfilled,* but with the 'right attitude' you have managed to make your life meaningful.

Whatever life was like, hope was seen to be present, except during the gloomiest phase of depression and in the situation, where you would be a patient in a long-term ward. *"This age"* seemed to be a determinant for certain hopes like a good death and a peaceful life.

In conclusion, hope was experienced as being closely connected to 1) life and living. Usually it was a question of a well-balanced, good or steady and peaceful life - something without disturbances or shocks. But there were also experiences, which pointed out that whatever life is like, there is hope as long as you live. Hope was also connected to 2) age. At least two meanings were attached to it. Hope was linked to younger generations and their life in the sense that it was hoped it would be good and without misfortunes. On the other hand, hope was connected to "this age", which meant that, at least at this age, you should have a right to have some hope after all the earlier difficulties in life. Hope was also linked to 3) work, which was very important for this generation. The meaning of work came through the possibilities, which it promoted. It was seen as a precondition for a good life. 4) The "right attitude" was emphasised in the sense that accepting facts, facing the situation and avoiding complaining helped to build up a meaningful life. 5) Human relations were an essential element of hope in building up a meaningful life. Skills in social interaction were highly appreciated, because they gave tools with which to avoid quarrels and discomfort in interaction. Appreciation from others was hope-promoting, as was the feeling of being needed, which was achieved by serving others. Human relations create security and joy, and help you to cope.

Hopelessness was defined on the *personal level* as being connected with restrictions in physical, social and economic resources, which caused fears and worries, and hindered actions and interaction. They resulted in tension, feeling of inferiority, insecurity, helplessness, and lack of self-control, self-esteem and the experienced feelings of the limitation of time in getting things done. Lack of well-being meant decrease of energy, joy, initiative, self-esteem, balance, knowledge and physical and psychological health, and losses. The results were fearing, worrying and giving priority to others, which promoted the incapability to accomplish even the smallest activities, inability in decision-making, participating, being, taking care of you, helplessness, and the inability to derive pleasure from anything. This made you lose content and meaning in life and made you wish to put an end to your suffering.

Problems in *interaction* with others and low self-esteem meant experiences of violence, malice and distressing memories. These, along with lack of knowledge and losses, promoted feelings of loneliness, disappointments and feeling of not being understood, sadness,

uselessness and hopelessness. Hard work, economic and living conditions, and problems in marriage and taking care of different matters and activities, promoted health problems and negative and violent interaction. Health problems, losses and lack of knowledge caused worries and required stubbornness. The realities of life in *old age* diminished hope and led to adjusting, fears, insecurity, loneliness, inability to cope with duties, unrealised dreams, going downhill. Several physical and mental health problems and restrictions, lack of energy, fears of losing mobility, ability to manage, cognitive capacity and dignity, and increasing need to use more time for managing activities, diminished hope and led to efforts to arrange care with insufficient economic resources, unsuccessful operations and treatment and thus promoted hopeless thoughts and had influences on health by the realisation that you were too old to get care at the age, when you really need it. This was disappointing. Physical restrictions hindered taking part and caused economic problems and suffering. The most hopeless situation was to be confined to bed in a long-term institution. Illnesses, divorces, problems and fate of children and grandchildren, losses of significant others, unsatisfactory relationships and disagreements in marriage, and insufficient information about care, promoted worries, insecurity and problems in getting the correct official help.

7 SUMMARY OF THE RESEARCH FINDINGS

7.1 THE CORE CATEGORIES, BSP, AND THE DIMENSIONS OF HOPE AND HOPELESSNESS

The following figure (Figure 44) describes the final results of the empirical part of the research in the lives of the depressive and non-depressive elderly by defining the elements of the basic social process (BSP): maintaining - achieving - losing, and the core categories: "If only I could" and the other, "There is always a loophole", which means that even in difficult situations you will find means to move forward.

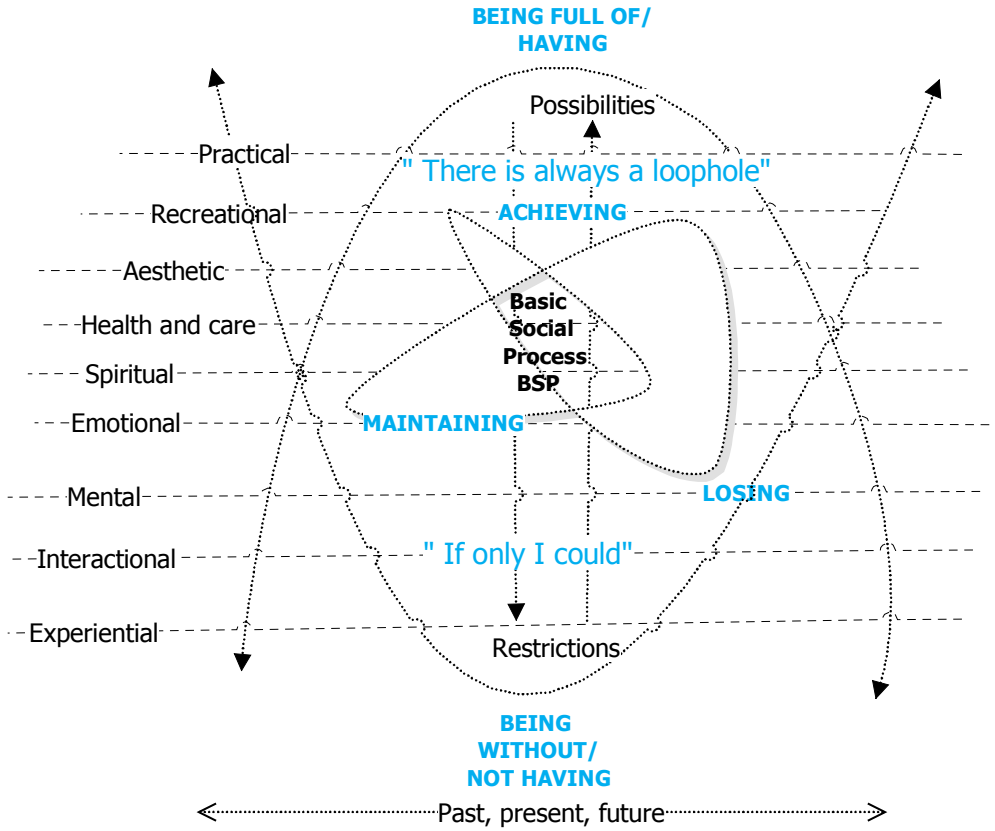

FIGURE 44. The basic social process (BSP) and the core categories of the meaning of hope and hopelessness in the lives of the depressive and non-depressive elderly

The basic social process (BSP) was defined on the basis of the data produced by the severely depressive elderly. The process was compared with the data of the non-depressive elderly, and the results are the combined meaning of both groups. The core category "If only I could" defines the general experience of the depressive elderly, which covered the field of different dimensions. The other, "There is always a loophole", defines the experience of the non-depressive elderly. This was a basic feature in facing the experiences of life. Both of the

groups were balancing in maintaining - achieving - losing, the Basic Social Process (BSP). The structure: being without/not having - being full of/having came from the data, in which the continuity of lack of something came up again and again. This lack brought up the structure: being without/not having, through which the rest of the structure began to be built up. The suitability of the structure was tested by checking the different factors in the dimensions and after that the relevance was found (see appendices 24-26).

7.1.1 THE CORE CATEGORY "IF ONLY I COULD"

The core category - "If only I could" - emerged in the data of the depressive elderly. It described the basic features, which were present in the expressions of the elderly. Everyday living and all activities were felt to be impossible, because of the lack of energy, lack of will and lack of reason to do anything. Just waiting that the situation would change somehow. Lack of energy, lack of courage, lack of knowledge and lack of ability was repeated again and again. It was hard to see any meaning in life, because all the activities were impossible to carry out, even getting out of bed needed an extra attempt. The solution to the situation was expected from outside, that someone would come and help, because you yourself did not seem to have any solution to the situation at hand. Unsatisfactory human relations and problems in health and well-being were central reasons, which promoted the IF-attitude. Emotion-driven could be an appropriate expression in these cases; rational decision-making was kind of put behind, you just spent the days according to different fears, tension, disappointments, and without being able to control your thoughts.

7.1.2 THE CORE CATEGORY "THERE IS ALWAYS A LOOPHOLE"

This core category emerged in the data of the non-depressive elderly, but was also present in the descriptions of the depressive elderly, when they described the time without depression. A central element was not to give up. You found the solutions one way or another, there was no other possibility. Life had to go on. This attitude included the idea that there was no one else who could solve your problems; you simply had to manage by yourself. This did not mean that you did not use the help of other people, but you were the 'conductor' of the process. At the same time, you purposefully traced the possibilities which life had to offer and made your goals come true. You were ready to fight for your happiness, if needed. One central element was the belief that things will clear up, as has happened before, you just had to find the solution: there is always a loophole.

7.2 SUMMARY OF ALL THE DATA

This section presents a synthesis of the dictionary definitions, the empirical results, and the philosophical aspects presented in the review of literature. Hope is an orientation to the future with a certain amount of trust and confidence. The expectation includes the possibility, which sets certain boundaries for security and belief. If the evaluative judgement produces the result that realisation of the goal seems to be certain, the process is approaching in nature, but if the realisation of the goal seems uncertain, the process is withdrawing in nature. Hope is more often connected with the future and making drafts of the possible object belongs to it, but it may also be based on the past or present. Hope can be daily, temporary or continuous in nature. Sometimes the object might be hard to define or hope can be objectless, or more general in nature. According to Aristotle and Aquinas, emotions include a cognitive-evaluative side and an action paradigm (Niiniluoto & Räikkä 1997). According to Farran et al. (1992) when patients hope they are engaging in a process that involves setting goals, taking action, assuming some control, and placing the process within

some time frame. Hope generally involves the process of setting goals or hoping to do something. By combining the philosophical aspects, dictionary definitions, and empirical findings of hope and hopelessness, the following structure (Figure 45) has been defined:

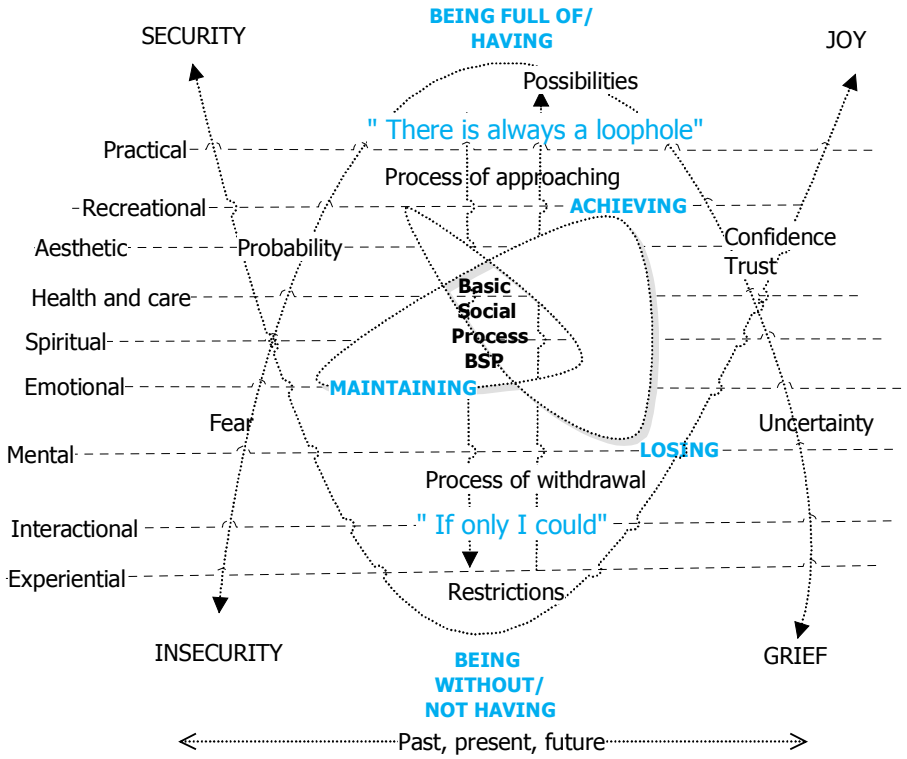

FIGURE 45. The process of hope and hopelessness based on philosophical definitions, dictionary definitions (n=103), and experiences of the depressive (n=22) and non-depressive (n=21) elderly

The ability to maintain probability, trust and confidence, and avoiding fear and uncertainty, support the approaching process towards security and joy, which come from achievement of the meaningful object in which the hope is centred.

The inability to avoid uncertainty and fear support the withdrawal process towards insecurity and grief, which come from losing the meaningful object in which the hope is centred.

The process of hoping is a continuous balancing between the ability and inability in maintaining, losing and achieving the meaningful object.

7.2.1 INABILITY AND ABILITY

The concepts of inability and ability emerged in the final combination of different data. The structure: problems, restrictions, hindrances and lacks made up the stages of the process of

losing. Losses were further defined as lack of human relations, hindrances were defined as lack of abilities, and restrictions as lack of resources, based on the definitions. Lack of resources (physical, social and psychological, especially self-esteem), lack of knowledge and important person had effects on ability/inability in actions and interaction.

According to Collins English Dictionary (1994), ability is possession of the qualities required to do something, the necessary skill, competence, or power: the ability to cope with a problem. Able means 1) having the necessary power, skill, time, resources, opportunity etc. to do something 2) capable, talented, competent. The etymological roots come via Old French from Latin- habilis – easy to hold, manageable, apt, from habére, to have hold. En or –em prefix forming verbs 1) from nouns a) put in or on b) go on or into c) surround or cover d) furnish with: empower, 2) from adjectives and nouns: cause to be in a certain condition: enable, encourage. Enable 1) to provide (someone) with adequate power, means, opportunities or authority (to do something) 2) to make possible 3) to put into an operative condition by supplying a suitable input pulse (a digital electronic circuit element), enablement, enabler.

The particular object of an emotion is always some particular item - such as a thing, a person or animal, an event, or the content of one's own beliefs or imaginings. There also seem to be people who are afraid or depressed, but also unable to pick out anything, real or illusory, as the particular object of their fear or depression. That is, there are cases of emotional states that appear to have no focus or target of any sort and so certainly nothing which could be called a particular object. These might be vague, inexpressible, or imponderable and the content of a false belief. For example, objectless fear or depression might be focussed on something like one's consciously or subconsciously realised ignorance or inability to cope with the situation; that is, the object is complex and difficult to describe: perhaps one's inability to cope with life itself. (Lyons 1980.)

According to the previous definitions, the role of ability/inability, action and cognitive processes arose from the data on the personal level. The critical points seem to be the moments when trust and confidence turn to uncertainty, and probabilities turn to fear. These are important aspects in care, because the personnel are in a central position to promote trust in managing, and on the other hand, to diminish fear and offer knowledge to be able to evaluate probabilities. According to Aristotle and Aquinas, emotions include the cognitive-evaluative side and the action paradigm (see Niiniluoto & Räikkä 1997). The goals might change and the time perspective might shorten on a daily level, but this means that, although the situation looks bad, "there is always a loophole", which should be examined together with the elderly.

8 ETHICAL ASPECTS OF THE STUDY

Examining meanings, which are built on the basis of experiences in interaction with others, there are certain ethical aspects to be considered. In old age, memories bring an extra nuance to these meanings because time has effects on the intensity of the feelings, which are combined with the memories. From the point of view of science, it must be remembered that memories are subjective and, in that sense, unreliable sources of knowledge about the past, but its role both in intelligence and self-identity is unquestionable. Aeschylus called memory 'the mother of the Muses', according it thereby the role of the foundation of all the arts. The Greeks sometimes called the Muses 'Mneiai', which means 'the Remembrances'. In this sense, memory is not individual recollection but collective tradition. (Grayling 2001.) In this research, the combined meanings are a tool to handle the collective tradition, but the researcher is well aware of the risk in interpreting these traditions. Thus, one of the non-depressive elderly has acted, as an informant with whom the researcher has gone through these meanings and historical aspects to avoid interpretations which would be 'out of the question'. Also some historical facts were checked first from the documents and after that from the informant. An example was the society's attitude towards the mothers of war babies.

8.1 THE ELDERLY AS PARTICIPANTS

Using elderly people as participants in this research led to some matters having to be considered. At least, the following facts should be considered carefully according to these interviews: historical time-span and changes in beliefs and customs, different surroundings, environment, cultural matters, social situation, time concept, speech, old age, diseases and restrictions, arrangements of the interview situation and informing the elderly of the research and its meaning, and the rights of the elderly concerning the research. The time when an elderly person can participate in the interview should be considered with care, because various pains and ailments can make it difficult to sit for a long time, or there might be other matters which lead to the need of breaks now and then. These must be discussed before starting. It is often wise to divide the interview into two sessions, if it seems to continue a long time. Also the place for interviews must be considered with care, because it might have affects even on the results in the sense that when the elderly feel secure and cosy, the environment might even promote the discussion. Creating a trusting and respectful atmosphere cannot be overemphasised, because sharing experiences is a delicate situation.

It is important to be aware of the differences between generations in the ways of talking about different matters. As an example, the elderly of today are the generation, which has seen the start of television broadcasting in their youth but are not very accustomed to the use of the Internet, which is a new way to contact their children and grandchildren. They have experienced wars, which are only seen on television by the younger generations. The community despised mothers of war babies in wartime, but nowadays single mothers form one group in the society, and the general attitude has changed. Lack of social benefits created a totally different situation in which to raise children during the war and after it. Also the cultural differences between different groups need understanding to draw the correct conclusions. There were subjects, which required discretion from the interviewer like marital issues, which were more "taboo" for the generation interviewed than for the generation the interviewer herself represented. In interviews of the elderly, it is very important to speak clearly and loud enough to be heard and understood. The use of some concepts was noticed to be "timebound" in a certain sense: goals and resources needed to be clarified several

times in these interviews, because many of the people expressed having lived on a daily basis without any special focus on goal-setting, and long-term planning was not so familiar as today, when the books and programmes are full of goal-setting. Resources were often understood as physical strength, so mental or economic resources had to be asked about separately. Nowadays, the busy rhythm of life has also been transmitted to speech, which might cause an additional need to concentrate in hearing and understanding. There should be enough time for the elderly to think the answers in order to be able to reach the meaning. The elderly seem to be used to the fact that in health care nowadays "it is no use to start telling, because they don't have time". This needs special attention not to lose important information for care planning. A peaceful and quiet environment and total concentration on the whole life situation of the elderly is important on the basis of the experiences in this research.

8.2 DEPRESSIVE PATIENTS AS PARTICIPANTS

Depressive patients (diagnosed with major depression) as participants in interviews were a challenge for the interviewer for at least four reasons. Firstly, because the interviews were conducted shortly after the hospital admission (mainly within two weeks) and the patients were really lacking any interest of the world around them. Secondly, the mood was so low that it was hard to see any sense in participating in 'some research'. Thirdly, this generation had memories of times, when mental disorders were a real shame in society. And fourthly, the questions of trust and security of the information were delicate matters. One major challenge came up in the coding phase, when the muddled thinking process emerged in a concrete way, and it was hard to find out, where the idea started and how they were formed, when the meanings in the speech were examined.

On the other hand, the patients found it very important to be able to participate "if it could help others, who are in the same situation". Self-evaluation combined with low self-esteem "I don't know if I am good enough to take part", was often mentioned. The patients had two to three days time to consider their participation after personal and written information and, finally, three patients refused because of their tiredness. It was important to emphasise that the interview was not a therapeutic session, but a study, in order to direct the discussion towards the goals concerning the purpose of the research.

8.3 THE ROLE OF THE RESEARCHER

The researcher has been working for over twenty years in psychiatric nursing and, at the time of the interviews, as a nursing supervisor in the units where the depressive patients were. This gave an understanding of the nature of the work and the meaning of the surroundings. On the other hand, there was a risk that the patients would be careful in their comments concerning the care, because it could be interpreted as criticism. But because the focus of the research was not care, this did not cause additional challenges from the ethical perspective. The researcher's conception is that it was an advantage that the researcher was able to understand ageing based on her working experience, although now and then you had to remind yourself, that you represented the same age group as the children of the interviewees. As an ethical starting point, the researcher respected the autonomy of the elderly by informing them properly about their rights concerning the research, giving them documents concerning the research, and informing them that their decision to take part in the research would have no effects on their care. The researcher called the nurses of the care units to confirm the decisions made, so that it was easier for the elderly to say no if they wanted, because the researcher knew that it is easy to say yes, especially if you are in a psychiatric ward and someone asks you personally to take part. This generation had experiences of the development of psychiatric care, which was earlier experienced as

restrictive in many ways. That is why this aspect was considered a very important one in terms of the patients' rights.

The role of the researcher in this kind of research is very delicate in the sense that as for as meanings are concerned the researcher also has a role in the twofold process in creating meanings. By bringing new visions like delineating aspects of hope into interview questions, also the persons interviewed might gain new ways of thinking, and this also emerged in these interviews in the beginning, when the first question was: "What is the meaning of hope in your life", which was often answered that it was such a difficult question, that it cannot be answered, but later, at the end of the research, the answers were easier to describe.

8.4 PERMISSION AND CONSENT

Permission for the research was applied for from the ethical committee of the health care organisation (16.4.1997 § 7). The research was also presented and decisions were made in 1997 in the Board of the mental health organisation (13.5.1997 § 5), in which the interviews of the depressive elderly were conducted. Permission to use the nursing and medical documents was granted by the Ministry of Social Affairs and Health (11.7.1997, Dnro 76/08/97). Also permission to use the Clinical Assessment Tool developed by Farran et al. (1990, 1992) was granted in 1997 (e-mail: C. Farran 20.5.1997). The participants gave their signed informed consent after a few days of consideration, and after getting the verbal and written information on the research. This was considered a very important matter in the research concerning psychiatric patients; to make sure that the patients really understood in what kind of research they would be taking part. Also the privacy of the information was emphasised by pointing out that the results will be reported in a way through which the individuals cannot be traced. The co-operation with doctors and nurses was prepared in meetings, in which the researcher explained the research. Written material concerning the including/excluding criteria and research proceedings and contents were delivered in the units where the research took place.

9 DISCUSSION

The purpose of this research was to clarify the concept of hope and its relationship to hopelessness in the lives of the depressive and non-depressive elderly. The aim was to construct a conceptual model of hope and hopelessness based on dictionary definitions, and to verify this model based on the experiences of the depressive and non-depressive elderly. One of the central aspects was to reveal the meaning of these concepts as experienced by the elderly in question, and possibly to utilise these findings later in nursing practice. The research was mainly qualitative, but some quantitative methods were used on some occasions (like code numbers focusing on the central areas of interest in the first phase of the analysis).

The methods used were semantic analysis (in the concept analysis of dictionary definitions), Grounded Theory (in the analysis of the interview data) and hermeneutics (in interpretations of the meaningful contents and meanings). As a result, a substantive theory of hope and hopelessness in the lives of the depressive and non-depressive elderly was developed. The BSP: maintaining - achieving - losing was found and two core categories: "If only I could" and "There is always a loophole". In the final phase, the concepts of activity and inactivity arose, but they need further definition in the future.

It must be pointed out that the concept development and the definitions of the dimensions of the theory need further testing. It is a fact that theories are human constructions, no matter how rigorously they are built, and in the hands of other researchers, the results might look different, based on the worldview, experience and other things. But, at the same time, this is the richness of the qualitative approach: the same data may bring new aspects again and again. However, the theory, in order to be of good quality, should be developed in a way that it stands certain changes in time and life. As Hutchinson (1999) points out, social life is not static, and a quality theory must be able to capture its constantly fluctuating nature. A theory must be modifiable. A quality theory must explain the major behavioural and interactional variations of the substantive area and it must possess relevance related to the core variable and its ability to explain the ongoing social processes in the action scene.

9.1 THE PREMISES

A paradigm may be viewed as a set of basic beliefs (or metaphysics) that deal with ultimate or first principles. It represents a worldview that defines, for its holder, the nature of the "world", the individual's place in it, and the possible relationships to that world and its parts (Lincoln & Guba 1994). The ontology and epistemology in this research follow the thinking of Lincoln and Guba, who have presented a blending of an essentially interpretivist philosophy with an outside warrant for social action, into what they call a constructionist framework for evaluation. "The term constructivism denotes an alternative paradigm whose breakaway assumption is to move from ontological realism to ontological relativism" (Lincoln & Guba 1994, p.109). Based on these ontological premises, realities are apprehensible in the form of multiple, intangible, mental constructions, socially and experientially based, local and specific in nature, and dependent for their form and content on the individual persons or groups holding the constructions, which are alterable as are their associated "realities". (Lincoln & Guba 1994, p.110-111.) The terms defining the epistemology are transactional and subjectivist. When the researcher and the subject of the research are interactively linked, the findings are literally created as the research proceeds and the conventional distinction between ontology and epistemology disappears. Methods are hermeneutic and dialectical.

The variable and personal nature of social constructions led to interpreting them using hermeneutic techniques, and they are compared and contrasted through a dialectical interchange. Finally, a consensus construction is built, which is more informed and sophisticated than former constructions. The aim of constructivism is understanding and reconstruction. (Lincoln & Guba 1994, p.111.) According to Denzin and Lincoln (1994), a good constructionist interpretation (text) is based on purposive (theoretical) sampling, a Grounded Theory, inductive data analysis, and idiographic (contextual) interpretations. The foundation for the interpretation rests on triangulated empirical materials that are reliable.

As mentioned above in the chapter concerning research methods, this research is built on the basic ideas of symbolic interactionism. This means that the concept – self - is examined through the perspective of an old person with a long life history. In this structural context the world is seen as a social world as interpreted and experienced, rather than a physical world. However, the world in this research is defined as an environment, in which the life of an old person takes place: home, neighbourhood, family, groups and the wider society, in which the health care institutions play an important role in the present lives of the elderly. Social interaction is examined through the relationships in the world. Actions are built up through social interaction in the world. The meanings created are social products, which are creations of interaction with others. The three basic premises are briefly defined below.

The first premise: "Human beings act towards things on the basis of the meanings that the things have for them" (Blumer 1969). In this research, the meanings of hope and hopelessness were revealed through the structure of hope-promoting and hope-diminishing factors, which were organised on three levels: personal, inter- and transpersonal, and life and everyday living. Through this structure, and with assistance of the Atlas/ti -programme for qualitative analysis, the abundant written text could be build in such a format, that the relations between different levels could be analysed.

The second premise: "The meaning of such things is derived from, or arises out of, the social interaction that one has with one's fellows" (Blumer 1969). The tool, which was used in the interviews, defined by Farran et al. (1990; 1992), seemed to work in differentiation of the context in a way that it was possible to focus on those aspects, which were central in defining the meanings. In this process, the decision to make a quantitative selection based on the number of codes in different code families was necessary to be able to proceed within some time limit. But because of the curiosity of the researcher, a synthesis of all the meanings of the code families was written (not presented as such in this research) to be able to highlight the overall life process.

The third premise: "The meanings are handled in, and modified through, an interpretative process used by the person in dealing with the things he encounters" (Blumer 1969). This interpretative process has two steps: 1) the actor points out to himself the things that have meaning, 2) communicating with himself, interpretation becomes a matter of handling meanings. The actor selects, suspends, regroups, and transforms the meanings in the light of the situation in which he is placed and the direction of his action.

This was a very delicate premise in the sense that the researcher tried to be open to the hints which the interviewed gave of the direction to proceed, because the tool (Farran et al. 1990; 1992) was not designed for the use of the depressive elderly and had not been modified for this purpose. This is why the interviews now and then handled subjects, which were not asked directly. In spite of the decision to focus on the subjects, which brought up most of the codes and meanings, also those areas, which were not at first brought up, were checked. One such area was the marital problems. It was almost a 'cultural practice' for this

generation to handle these matters "inside the four walls" as it was defined. However, some of the interviewees noticed that 'once in their life' they have someone to listen to them, and started to produce material, which the researcher had to remind being such things, which would be useful to handle with health care professionals afterwards.

The Grounded Theory method aims at the development of either substantive or formal theory. It is based on symbolic interactionism, the basic assumption or "root images" of which have been guiding the structure of this research, and the results should be evaluated on the basis of these premises. According to Blumer (1969), the empirical social world is the world of everyday experience. The life of human society consists of the action and experience of people as they meet the situations that arise in their respective worlds. "Reality" for empirical science exists only in the empirical world and can be verified only there. The root images refer to the following matters: human groups or societies, social interaction, objects, the human being as an actor, human action, and the interconnection of the lines of action.

As a summary of the evaluation of these premises, the applicability of the results must be verified in the empirical world, as Blumer (1969) has emphasised. In evaluation of the results, it should be considered whether the results help the experts of the substantive area to see the social processes, phenomena and relationships of the meanings in a way which is helpful in practice to also see other circumstances and relationships which have not been found before (Janhonen & Latvala 2001).

9.2 ASSESSING QUALITATIVE RESEARCH

In nursing research, the methodological discussion has stressed the intentionality of human action, which is closely associated with the consciousness presented by Husserl. Also Wittgenstein's and later many social scientists' views of connecting human research with language, culture and history have been presented in nursing research. (Glaser & Strauss 1967.) Without social connections, the research may be wasted or the interpretations start to live their own life as Glaser and Strauss have pointed out. In nursing research in the 1990's, the emphasis has been on stressing that different methodologies produce different and complementary results in terms of quality. (Janhonen & Nikkonen 2001.)

Triangulation is a combination of different perceptions to increase the trustworthiness of the results. Generally, triangulation has been considered the process of using multiple perceptions to clarify meaning and verifying the repeatability of an observation or interpretation, and also to clarify meaning by identifying the different ways in which the phenomenon is being seen (Stake 1994; Flick 1998). Triangulation seems to have its origin in the metaphor of radio broadcasting by using directional antennas set up at the two ends of a known baseline and by measuring the angle at which each of the antennas receives the most powerful signal, and so the triangle can be erected and solved (Lincoln & Guba 1985). On the other hand, Lincoln and Guba (1985) have pointed out that the use of multiple theories as a triangulation technique seems to be both epistemologically unsound and empirically empty by pointing out that facts do not have an existence independent of the theory within whose framework they achieve coherence. However, this discussion continues, emphasising both views, rigorous theory-related concepts versus the quality of results, which might be different by combining different theoretical structures. In this research, the triangulation of different sources and methods has been used. The sources (dictionaries, medical and nursing documents and the interviews of two groups: the depressive and non-depressive elderly) were selected on the basis, which was evaluated beforehand to cover the phenomena under research sufficiently for the purposes of the research. Leino-Kilpi (1998) emphasises that nursing research is targeted to a complicated relationship between human being and health,

which often arises the need to use different methods in research, both qualitative and quantitative.

Goodness or quality criteria of constructivism are combined with *trustworthiness* criteria of credibility (paralleling internal validity), transferability (paralleling external validity), dependability (paralleling reliability), and confirmability (paralleling objectivity) and authenticity. (Lincoln & Guba 1985; Denzin & Lincoln 1994) Trustworthiness is considered as the main one (Flick 1998). The basic issue is persuading others and oneself too that the findings are worth paying attention to, which means according to Lincoln and Guba "Truth value", "Applicability", "Consistency" and "Neutrality". Within the conventional paradigm, the criteria are known as "Internal validity", "External validity", "Reliability" and "Objectivity". Trustworthiness points to the "truth" and how the trustworthiness has been created between the researcher and the subjects of the research. Trustworthiness consists of four components: credibility, transferability, dependability, and confirmability, which are the constructionist equivalents of internal and external validity, reliability, and objectivity (Lincoln & Guba 1985, p.300). Trustworthiness may be strengthened by repeated contacts, and by using different methods to collect the data (Nikkonen, Janhunen & Juntunen 2001). Trustworthiness is combined with the connection between the produced theory and the relations between the data and the analysis. Thus, the researcher is able to prove that the theory is true and works in practice. (Lincoln & Guba 1985.) Trustworthy materials are subjected to constant comparative methods of analysis that Grounded Theory deploys. This means comparing incidents applicable to categories, integrating categories and their properties, delimiting and writing the theory. (Lincoln & Guba 1985, Denzin & Lincoln 1994.)

Credibility (paralleling internal validity), means convincing others that the theory is grounded in the data under research. To be able to show this, the researcher has a duty to show the theoretical claims, on the basis of which the theoretical frame of reference is structured. Another criterion for credibility is reporting the results based on the data gathered from the field of research by describing the frame of reference in a way that the reader almost hears and feels what is going on in the field of the research. Usually this means that enough data are presented to validate the results. (Glaser & Strauss 1967; Janhonen & Nikkonen 2001.) Activities increasing the credibility are prolonged engagement, persistent observation and triangulation. Sufficient time is needed to learn the "culture", test the misinformation (distortions, self, interviewed) and to build up trust (Lincoln & Guba 1985).

The criterion concerning the applicability of the findings in qualitative research is *transferability* (paralleling external validity) (Lincoln & Guba 1985). Evaluation of the possibility to carry out same kind of research process in other similar surroundings is a question of transferability. This is combined with the definitions of the research process, how well it is defined and is it possible to repeat the same procedures.

Dependability (paralleling reliability) is connected with the possibility to strengthen the results with other research. One central criterion is the auditability of the results, which means that another researcher is able to repeat the research by following the same procedures. Because personal experiences are unique, the differences between experiences and unique situations in qualitative research are not repeatable in that sense, but it is central that the research process and solutions are made clear enough, to be followed. Method triangulation confirms that the interpretations of the researcher are based on the data. (Janhonen & Latvala 2001.) Procedural dependability is combined with the raw data, data collection and recording, data reduction and results of synthesis and summarising, theoretical notes and memos, concept and category development and their linkages, findings and reports, and integration of concepts and links to the existing literature, process notes, decisions concerning the

trustworthiness and credibility of the findings, personal notes of the expectations of the participants, and development of instruments (Lincoln & Guba 1985, Flick 1998).

Confirmability (paralleling objectivity), according to Denzin and Lincoln (1994), is related to the fact that text is valid if it is sufficiently grounded, triangulated, based on naturalistic indicators, carefully fitted to a theory (and its concepts), comprehensive in scope, credible in terms of member checks, logical, and truthful in terms of its reflection of the phenomenon in question. In this research, one informant was used to verify certain aspects (such as cultural beliefs and use of some concepts), that needed more examination.

Authenticity has been structured in the way in which the results have been presented. It was a conscious choice to use quite a lot of references from many interviews to confirm the building of the more abstract structures of the theory. This perhaps made the results harder to read, but the choice was made to confirm the authenticity of the data. Although the numbers of the quotations were not used, they can be checked line by line using the search operators of the analysing programme ATLAS/ti used for the coding and building of the structures and semantic networks.

9.3 EVALUATION OF THE METHODS

Denzin and Lincoln (1994, p.3) stated that "Qualitative research, as a set of interpretative practices, privileges no single methodology over any other. Nor does qualitative research have a distinct set of methods that are entirely its own." The methods used in this research were carefully considered beforehand. The researcher was aware of the risks in using different methods in the same research. However, the structure of the research: concept-analysis, empirical research and the interpretative process in revealing the meanings, were as such, independent parts, which were combined after the analysis phase as a combined conceptual structure. In general, qualitative research is interested in language, finding the regularities, understanding the text or action, and reflection. When the language is studied as communication, its contents are usually studied through content analysis, and when the process is under examination, it is studied through discourse analysis. On the other hand, language can be studied as culture emphasising the cognitive aspects, and then the method used is ethnography. When the culture of the language is under examination and the interest is in interaction (like in this research), then one of the premises is symbolic interactionism. Looking for regularities comes via finding models and conceptualising (Grounded Theory). In finding the meaning in texts, interpretation is needed, and hermeneutics is the method chosen for this purpose in this research. (Hirsjärvi et al. 1998.)

The cultural elements of the language gave the deep historical perspective in this research and also the muddled thinking process of the depressive elderly was visible in the language in the sense that it was hard to find out where the thought started and where it ended, because of the lack of sentences as such. The meaning of these cognitive processes only emerged once the twelfth interview had been analysed and the saturation of this phenomenon started to open up. Based on the experiences of this research, the discussion of the saturation of the data might also be combined with the tools of analysis. Building up several semantic networks was one tool to open up features, which the researcher could not have found out by manual methods. This afterwards aroused the idea that it would be interesting to use ethnography as a method in the research of the cognitive processes in depression and suicidal thoughts. This could be an idea for further research; to study cognitive processes combined with the hope and hopelessness of depressive patients using ethnography as a method.

The premises for the selection of the methods needed consideration because the choice of the phenomenological method seemed so obvious in analysing meanings. However, the aim of building up a conceptual structure, which could be usable in nursing practice, steered the process in another direction, to choose Grounded Theory. Grounded Theory is a general methodology for developing theory that is grounded in data systematically gathered and analysed. Interpretation must include the perspectives and voices of the people who are studied. The major difference between this methodology and other approaches to qualitative research is its emphasis on theory development. Most Grounded Theory studies have developed a substantive theory. Strauss and Corbin (1997) emphasise that the theory evolves during the actual research, and it does this during continuous interplay between analysis and data collection. The verification is done throughout the research process, rather than assuming that verification is possible only through follow-up quantitative research. Conceptual density refers, according to Strauss and Corbin (1997), to the richness of concept development and relationships which rest on great familiarity with associated data, and are checked out systematically with these data. (Strauss & Corbin 1997.) Grounded Theory, whether substantive or formal, requires at least four highly interrelated properties. First, the theory must closely fit the substantive area, in which it will be used. Secondly, it must be understandable by laymen concerned with this area. Thirdly, in must be general enough to be applicable to different daily situations within the substantive area. And it should allow partial control in changing situations. (Glaser & Strauss 1967). Constant comparisons, systematic asking of generative and concept-related questions, theoretical sampling, systematic coding procedures, suggested guidelines for attaining conceptual (not merely descriptive) density, variation and conceptual integration, are such procedures which have made this methodology effective and influential (Strauss & Corbin 1997).

9.4 EVALUATION OF THE FINDINGS

In evaluation of the research findings, it must be noticed that the evaluation criteria are not the same in different qualitative approaches, which is insufficiently emphasised in the literature of this area. However, different approaches emphasise the importance of presenting a rich, contextual understanding of the subject matter. (Cohen & Knafl 1999.)

The results of this research are based on the English dictionaries and experiences of hope and hopelessness of elderly Finnish people with a certain background, and the medical and nursing records of the depressive patients. Although there were two groups of the elderly, who had quite similar background variables, in spite of depression, and triangulation of sources of data was used, the results need to be interpreted with care concerning others. Substantive theories arise from a certain substantive area and should be evaluated on the basis of these premises. In qualitative research, the generalising of the findings comes through the usability of the results in practice.

Dictionary definitions versus the empirical findings were evaluated concerning the final results: what new features of hope and hopelessness did the empirical findings bring up, which were additional compared to the dictionary definitions. Also the philosophical analysis of the concept was evaluated in this context.

1. Grounds and objects of hope and hopelessness

The empirical findings confirmed the dictionary definitions of grounds and objects of hope and hopelessness. The same grounds and objects were found in the empirical data: people, health, everyday living, youth, spiritual life and things and places. The contents of these were centred round human relations, health and managing in everyday living, which seemed to be

the most important areas in the lives of the elderly. The meaning of youth came up through the life of children and especially grandchildren at the moment. Expecting to see certain phases (starting school, marriages, and occupation) in the lives of the grandchildren was hopeful, and in some cases even saved the elderly from carrying out the suicidal acts. Spiritual life was a ground/object of hope in cases in which the spiritual life had played some role also earlier. Things and places seemed to be highlighted in losses of significant others. Things and places, which meant common memories, were important sources of hope, which were cherished.

2. The nature and amount of hope and hopelessness

Based on the dictionary definitions, the nature and amount of hope and hopelessness varied, depending on the state of mind, condition, outlook, future orientation and attitude. The empirical findings showed that the state of mind was defined as "total zero" in the severe phase of depression, and another definition that emerged in several cases was the "roller-coaster" effect, which the interviewees thought, depended on medication. Within the same day, the mood could change from utmost gloominess to quite a good feeling. The state of mind and the thinking process and fears were associated with each other. The conditions were combined with living conditions, health, and the state of human relationships, which were the most significant factors concerning the state of mind. Outlook in empirical findings was associated with gloomy visions and "this age", which meant that the perspective was different than earlier in life. There seemed to be differences between the groups of the depressive and non-depressive elderly in outlook, when the whole life was in focus. The depressive elderly had a more positive outlook, because the starting point for making comparisons was gloomier and the outlook was seen as more positive, if health could be achieved, and the care would help. On the contrary, the non-depressive elderly had the outlook of diminishing opportunities in the future. Future orientation was defined through the shortness of the time span and age. The future was often planned day by day. Attitude came up in many contexts in the empirical definitions. In a deeper sense, the core categories define the differences in the two groups: "If only I could" and "There is always a loophole", both include elements of attitude, although in the essential meaning they have a deeper experiential meaning.

3. Intentional, purposeful thinking/unrealistic, daydreaming and painting rosy pictures

On the basis of the dictionary definitions, these elements of the hoping process seemed to be somehow opposites, but the empirical definitions placed these as partly overlapping elements. Although you might act purposefully and your decision-making is intentional, there might be factors, which drive the process in a more unrealistic direction, and occasionally hinder your activities almost totally. These intervening factors were often changes in human relations, health or everyday living. Worries and fears seemed to have effects on the intentional efforts based on these definitions by diminishing the energy needed to accomplish activities.

4. Importance of the object

The object might be clear or hard to define, which was confirmed also in the empirical findings. The factor of human relations and health were also in this sense central. Fear of loss or losses of significant others were defined as the most traumatic experience. Losing an important person or health was central in hope and hopelessness. How to manage afterwards, was in association with the core categories: "If only I could" and "There is always

a loophole". On the basis of these findings, it seems that the association between the grief process and the elements of the core categories are worth further research.

5. Processes of approaching and withdrawal

The philosophical analysis confirmed the processual structures of hoping and focused the empirical structure to being with and being without. In dictionary definitions, the processual elements were defined as keeping on and giving up. These had a more fluctuating nature in the final analysis, when the processes of approaching and withdrawal were defined.

6. Security and joy/insecurity and grief

The philosophical analysis based on the used references of the concepts of fear, joy, grief, insecurity and their associations to hope and hopelessness, was confirmed by the empirical findings concerning the meaning of hope and hopelessness. Especially the concept of fear in depression emerged strongly in the thinking process and suicidal thoughts. Total lack of hope and lack of joy in these situations was defined by the interviewees. In the situations in which hope started to rise, the joy came up little by little. The association between security and joy, and on the other hand, insecurity and grief had connections with life and everyday living, human relations and health. Through this analysis, the concept of activity and inactivity came up through hindrances and restrictions and, on the other hand, possibilities. Joy was also combined with the aesthetic dimension, all little things, hobbies, and activities in everyday living, and achievements in life. Also the comfort and cosiness of home were important. Home was a forum of security and threats concerning home were experienced as increasing insecurity, which emerged in situations like after the spouse's death, moving to some other place. Concepts of autonomy and self-determination played an important role in life in old age - "at this age". Although you had served others all your life, "at this age" you had earned a certain amount of autonomy and self-determination, and the threats concerning these were to be avoided as long as possible. Health was defined as a precondition that gave possibilities to maintain and achieve other goals and hindered the process turning to losing. Balancing between maintaining – achieving – losing formed the Basic Social process (BSP) in the process of hoping and losing hope.

In conclusion, without the empirical part, the definitions of dictionaries would not have given the perspective of hope in old age. This was a result that confirmed the importance of the substantive theories. The contents of the definitions brought "the flesh around the bones"; what the phenomenon under research looks like. In building up the hoping process, the philosophical analysis was needed; it brought "the blood" to the theory, the linkages without which the relations would have been left loose. The core categories gave the touch of "survival"- even in difficult life situations. They brought the circulation and the dynamism to the theory by showing the direction in which to arrange the concepts arising from the data, and through this, revealed the Basic Social Process: maintaining-losing achieving, the meaning of being with and being without, the linkages to joy and security, and, on the other hand to grief and insecurity.

9.5 COMPARISON OF THE RESEARCH FINDINGS WITH EARLIER RESULTS

First, this research has given some conceptual tools to understand hope and hopelessness as concepts based on dictionary definitions. Secondly, the substantive theory produced offers a conceptual framework within which to analyse the reality of the depressive elderly based on their own descriptions of the factors influencing hope and hopelessness. Thirdly, the data achieved through the interviews was abundant and offers possibilities for further research

concerning the concept definitions, and for defining the dimensions more thoroughly than was possible in this research. Fourthly, some recommendations are presented for the nursing practice to support hope in the care of depressive patients. And finally, hope belongs to life as long as life goes on; the elderly are no exception in this sense. On the other hand, their experiences should be made use of because of their long life history and abundant examples of managing in life. At its best, old age can be a rich, joyful period. The smoothening of edges comes via experiences; "wise listening" and offering one's own experience to support others are important elements in family and social life. But also the gloominess in the face of fears and worries and fighting in continuous insecurity may be paralysing not only for the elderly themselves, but also for the significant others and health care personnel.

In Finnish nursing research, there are studies, which have linkages to hope. Arve (1999) reports statistically highly significant differences between the depressed and non-depressed elderly in the sense that the depressed elderly were not satisfied with their life, and they did not feel needed, nor did they have any plans for the future. Negative attitudes to life also seemed to increase with age. Having no plans for the future, and the experience of being needed, came up also in the findings of this research. On the other hand, the concept - future - needs more research because the life of the depressive elderly seemed to be actualised on a daily basis, and also in depression the plans were made from morning till evening according to the findings of this research. The experience of being needed seems to have associations with being a burden to others in the sense that the experiences seem to intertwine through helping others and being helped by others in these interviews. These are understandable through the concepts of autonomy and self-determination, which were highly appreciated in the lives of the elderly in this research.

Välimäki (1998) has studied self-determination in psychiatric patients (aged 16-64 years) and found that sense of control and knowledge showed a statistically significant association with the support received by patients. This finding is in line with the findings in this research: lack of knowledge was an important factor in the process of losing and being without, by having associations with incapability, and through that, losing the meaning in life. According to Välimäki, self-determination is manifested and perceivable to outsiders through actions. This is also a very interesting finding compared to activity and inactivity, which came up in the final analysis of this research. The basic elements of self-determination, defined by Välimäki, were obtaining information, refusal, consent, expressing opinions, decision-making, and making choices. Giving up the decision-making to others was in this research a factor, which seemed to have associations with inability and helplessness and, via these, the inability to get joy from anything. The findings of Välimäki showed that patients who are most sensitive and vulnerable to violations of self-determination are those who have the most pessimistic views about their opportunities to exercise their self-determination.

Iire (1999) has studied experiences of uncertainty caused by illness from the patient's point of view (a total of 304 patients with different diseases). The findings showed that knowledge and depression were the most important factors predicting the development and nature of the uncertainty caused by illness. The central role of knowledge is important, especially concerning the depressive elderly because, as was also brought up in this research, the elderly do not make reguest when they see how busy the personnel are and thus experience incapability. On the other hand, when every action needs an extra attempt, you prefer to give up. Other factors which were associated with uncertainty in Iire's study were age, gender, matriculation examination, vocational training, retirement, disease, duration of illness, number of hospital admissions, emotional support received from nursing staff, and fears. In the semantic analysis made by Iire, she differentiated positive and negative experience of uncertainty. Positive uncertainty gives hope and negative uncertainty takes hope away, is

depressing and a threat for the future. The fears, which came through the depressive thinking process in this research, seemed to be in a central position also in defining uncertainty, and linkages to hope were found. An interesting aspect was the finding of Mishel (1990), which Iire (1999) raises in her research, that security is not always a hoped for situation, but a 'comfortable uncertainty' could also be a possibility. It is an interesting challenge for nursing whether uncertainty is a voluntary choice or an answer to inability to control the fear, and which should be taken seriously. In the light of the findings of this research, in which worries and fears seemed to be sucking dry the energy, which was already very low, its positive elements were not visible. Iire emphasises that realistic hope maintenance is a cornerstone in patient care.

Ollikainen (1994) in her research has analysed suicide notes (n=389) left by suicide victims. In her analysis concerning the subjective state of mind of the actor, she has uncovered the following subcategories: 1) unhealthy, or a state of helplessness, 2) good-for-nothing, or worthlessness, 3) cannot manage, or despair, 4) no resources, or powerlessness and 5) nothing to expect, or hopelessness. The contents of these subcategories were all present in the data concerning the depressive elderly in this research, although the structuring was different. Some kind of inactivity in physical, mental and social fields covers these experiences, when ability is defined as: having necessary power, skill, time, resources, opportunity etc. to do something, or capable, talented, competent, as presented before. The structure of - being without - also seems to come up in the findings of Ollikainen; lack of health, worth, managing, resources and future expectations, which are parallel to the findings in this research.

Nores (1992) has developed a substantive theory concerning the experience of existence of female patients. A subcategory of hope was developed, and it was associated with experiences, which give the basic tone to existence. They may be combined with joy, happiness, rest, peace and longing. Hope produces wishes, dreams, and positive future expectations. Experiences of aesthetics and freedom were connected with hope. Also being able to be yourself and being accepted as oneself were associated with hope. According to Nores (1992), hope includes philosophical, ethical and creative aspects, as well as a view of life. Hope connected with everyday living may come up in humour. These findings are in accordance with the findings in this research. Quite a lot of emphasis was put on everyday living, and aesthetic aspects in managing in everyday living in this research. Maybe they played some role in structuring the meaning in life, when the wider perspectives had vanished. Living in dreams and wishes was a form of internal experience of hope among the elderly in this research, which was supported in situations in which the possibilities of the surroundings were limited, like in marital conflicts.

Rissanen (1999) has studied the ability of elderly people (n=157) to cope at home. According to her findings, the average self-evaluated physical and psychological health of people over 65 who participated in the study was good. Men evaluated their health as slightly poorer than women did, and they were also more depressive. For both men and women, well-being was manifested as a rich diversity of everyday life, such as activity and social relations. For women, life had been full of challenges despite hardships. Men tended to reminisce about the hardness of life, and many still had bitter and unpleasant memories of the wartime. The major resources of women were family, religion and positive outlook, whereas men derived strength from their responsibilities, expectations of a better future and religion. The self-evaluated health and well-being was better than the objective factors would show also in this research. In spite of several long-term diseases, aches and pains and medicines, health was evaluated to be good. The lack of abilities was evaluated in connection with "this age", which had a special meaning. In this research it was not possible to make comparisons between

men and women, because of the number of the interviewees, but the general life course had similar contents: challenges and hardships, responsibilities and expectations, and everyday living was an important factor in evaluating health and well-being.

Fagerström (1999) studied the patients' caring needs, which appeared on three levels of interpretation, as problems, needs and desires, where man's desire for love, life and meaning was seen as primary. According to Fagerström, patients' caring needs can be regarded as a message of their suffering and can contain a possibility of individual growth and development. As an important result she found that the view of information should be changed. Factual information is not always enough, but deep uneasiness and insecurity, rooted in the patient's desires, can be found in the background. The associations between the experiences of depressive patients and suffering comes in this research through the experience of having no joy, meaninglessness and the wish to stop the suffering, the deepest meaning of suffering. (See Eriksson 1994.) Also lack of time was clearly pointed out in patients' stories as in this research.

Halldórsdóttir (1996) has shown, in her research, that uncaring involves perceived incompetence and indifference, creating distrust, disconnection and the 'wall' of negative or no communication. On the other hand, a 'bridge' is developed through mutual trust and the development of a connection between the professional and the recipient, which is a combination of professional intimacy and professional distance. Halldórsdóttir emphasises that caring influences the recipient very positively and empowerment is a perceived consequence, including increased well-being and health. On the other hand, a decreased sense of well-being and health, summarised as discouragement, is the result of uncaring. These are parallel to the findings of this research concerning the factors in relations of depressive patients, in which feelings of togetherness, safety, security, joy, understanding and comfort were defined as hope-promoting factors.

9.6 PRACTICAL IMPLICATIONS OF THE RESEARCH

These research findings brought up certain aspects that are important from the point of view of hope maintenance and hope promotion. When nursing interventions are planned, the hope supportive elements should be examined carefully to find methods for nursing interventions. As Hill et al. (1988) have stated: "Beyond knowing that an older depressed person has suicidal ideation, an awareness of interacting factors, namely, hopelessness and health perceptions, may suggest distinctive avenues for intervention." Based on the findings of this research, at least the following steps can be recommended in hope promotion:

Checking the crucial features in getting near the critical line of abandonment and giving up

This can be compared to maintaining vital functions in first aid units. When the critical line has been passed, all efforts are needed to bring the situation back to the former level. When the elderly have slipped into the withdrawal process, which is aiming at insecurity and grief through uncertainty and fear, hope promotion is more difficult than in maintaining the approaching process, aiming at joy and security by maintaining trust and confidence, and evaluating the probabilities of achieving the meaningful goal, which in the lives of the depressive elderly was defined as: "life without depression" or "managing day by day", depending on the situation.

Mapping hope producing things (everyday living, people, health etc.) in the patient's life

If there are no recognisable things at the moment, then it is useful to map the things, which have brought joy and aroused hope previously in life. Bringing up memories is often energising, when the focus is kept on hope-producing factors. They are often considered as such a normal thing in life that you have not come to think about them, and it brings you joy, when you notice that there are actually many things which have brought hope and joy in your life. This can be the start, from which the mapping can proceed.

Drafting possibilities (and dreams) in one's life and making drafts for the future

In depression, the vision has often vanished, and this phase should be carried out in very small steps -day by day- as the depressive patients themselves live. Hurry does not help here, although the grip should be determinate in building the path together with the patient, so that the patient feels that he is not "drifting in the gloominess". The importance of the necessary knowledge cannot be overemphasised because the patient does not often dare to ask or asking is just too much trouble at the moment.

Checking the resources of the patient and need for support

There is often an almost total lack of energy and all initiatives need a lot of effort. If the patient does not seem to have energy even in the smallest efforts, the supportive network should be planned and activated. Let the patient be a 'spectator' for some time and gradually arouse his/her will.

Making deliberate plans in keeping hope alive

Severe depression is an emergency situation and it should be treated like a first aid case. The situation in hopelessness is "deadly, fatal and grave". When a person is hopeless, "he sees no way out, he has shot his last bolt, he is unable to stand up for himself ". In these situations, the leadership must be taken by the professionals with determination and, at the same time, respecting the patient's own rhythm.

Increasing safety and diminishing uncertainty and fear

Fear of one's own thoughts and the situation to which they might lead, is very real and it takes all your energy. It "is in you" all the time. You are afraid to go to sleep and also to be awake with these thoughts. Concentrating on controlling your thinking process means neglecting other areas of life, and you turn into your inner world, which does not offer you many positive inputs. This forms a circle that captures you in an environment of fear and uncertainty. It is very important to affect this circle. Medication is one way to have effects on this process. Cognitive therapy and group therapy should be considered more profoundly in the care of the elderly, and more research is needed in this area. Nurses have a vital role in offering a safe relationship to discuss these feelings, and also in assuring that the situation can be overcome. People of this generation have a lot of very hard experiences in their former life to go through. They have also developed all kinds of strategies to manage. These should be utilised more actively in care. Unfortunately, these experiences have not been used much as a resource in care.

Waking up desire

Expectation and desire are related to something welcome. Without mapping the hope-producing things and without sketching the possibilities, desire is hard to wake up. Lack of initiative and lack of energy should be compensated with an energising network. The network can be another patient who has gone through the same process or a grief group, if the depression has started from the death of a spouse. Support from children or a neighbour or friend to talk to, anything that is suitable concerning the situation of the patient and his life at the moment. People are often very cautious when it is a question of depression and thus the patients feel even more lonely and deserted in their situation of uncontrollable fear. But of course the situation should be handled with utmost consideration so that it is not felt to be embarrassing for the elderly.

9.7 SUGGESTIONS FOR FURTHER RESEARCH

There are several areas, which need further research, which emerged during the research process. *First*, the conceptual field in psychiatric nursing needs much further basic research. During this research process, such concepts as powerlessness, dispiritedness, fatigue, helplessness, inactivity, inability, incapability, self-esteem, loneliness, security, safety and suffering seemed to have some kind of association with hopelessness. How these concepts are associated with each other, are they overlapping and how many of them have been defined so that they are usable in nursing practice, are questions, which need further research. *Secondly*, the utilisation of the voice and experience of the elderly should be emphasised also in research much more strongly than they have been so far. An interesting subject for further examination is courage and stubbornness, which this generation has, and it's meaning in getting through difficult life situations. *Thirdly*, hope, hopelessness and depression seems to be such a challenging area of research that different areas of science should combine their resources into a multiscientific research programmes to clarify the linkages between cognitive, emotional, behavioural, physical, social etc. areas. It seems to be so, as mentioned in many earlier studies, that the methods used to answer the health problems, are too separated to offer proper help. When this is combined with lack of time in health care practice, it is not a 'miracle' that the costs are rising. Different sciences each cover such a narrow area of human life that the problems and challenges, which are so multifaceted, especially concerning the elderly who have a long 'memory history', should be tackled with a similar severity as heart diseases and cancer. It is a question of life and death and long-term suffering for those living with the depressive elderly. *Fourthly*, the questions of will, desire, inner power and conatus have been examined in philosophy, psychology and psychiatry from different perspectives. It seems to be a central phenomenon in different areas of life. Especially its meaning in caring cannot be underestimated. This is an area where more nursing research would be usable, because nurses work with this topic daily; how to motivate the patients to start again after the "bad news" or after losing the will to live. *Fifthly*, The concepts activity and inactivity and their linkages with hope and hopelessness are worth further research. Also the use of action theory might be interesting in the study of depressive patients. This research produced also dimensions, which need further definitions and more thorough examinations concerning their overlapping nature. It was not possible to widen the research in this sense, but the contents are abundant for further examinations.

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I want to give special thanks to my closest colleagues during this process. I will remember discussions with Seija Arve during your own research process concerning the depressive

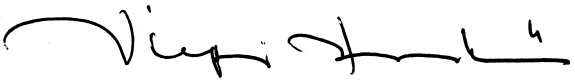
elderly. I also want to thank Ulla-Maija Haukka; I don't forget our train journeys and the joy, which you brought in the midst of my methodological disbelief. I also want to thank my colleagues from earlier years, nursing supervisors Airi Nikkilä, Ritva Soljala and Veli-Matti Vaahtovuo, who encouraged me during my studies in many ways, thank you. I also thank my friend and colleague Eija Luoto for interesting discussions and support during the whole process, thank you very much.

I owe thanks to Mika, Sari, Arma, Pirkko and Irina for your help, co-operation and inspiring atmosphere. There are so many of you, who deserve special thanks, that is why I want to express my warm gratitude to all of you together.

I owe my warmest thanks to my father Ville. You were the one who taught us girls to understand the meaning of studying by your almost immortal words: "Girls, do not trust just men, they come and go, but knowledge is lasting. Study as long as you can." And we have tried. Anyway, the men have stayed too. Kallu, thank you for your patience and support through all these years, I do not find words to express it. I also want to thank my sister Mirja, who finalized her dissertation before me, in spite of her later start. You know, as a little sister, I just had to give way to you, and I did it with pleasure. It is nice to follow in the paths of such a sister.

This research process has been an interesting journey through the history of Finland from the beginning of independence with the guidance of the elderly, who have shared their experiences with me, thank you very much all of you. I hope to be able to convey the message you wanted to send to the other elderly: depression can be overcome, finally, there is always a loophole.

Turussa
Marraskuussa 2003



Virpi Pyykkö

TERVEYDENHUOLLON EETTINEN TOIMIKUNTA

(Käsitelty 16.4.1997 § 7)

TUTKIMUSLUPA-ANOMUS

Yleistä tutkimushankkeesta:

Toimin Turun terveydenhuollossa ylihoitajana geropsykiatrian vastuualueella. Opiskelen Turun yliopiston lääketieteellisessä tiedekunnassa hoitotieteen laitoksella. Teen väitöskirjatutkimustani aiheesta: Toivon merkitys iäkkäiden ihmisten selviytymisessä depressiosta.Tutkimus on mukana itsenäisenä hankkeena STAKESin johtamassa valtakunnallisessa Mieli-Maasta-projektissa. Tutkimuksen ohjaajina toimivat tutkimusprofessori Ville Lehtinen Stakesista ja professori Sirkka Lauri Turun yliopiston lääketieteellisestä tiedekunnasta hoitotieteen laitokselta.

Tutkimuksen ensimmäinen vaihe koostuu semanttisesta analyysista, jonka lopputuloksena syntyy toivo-käsitteen teoreettinen määrittely. Analyysi perustuu englanninkielisten sanakirjojen (n~100) käsitemäärittelyihin. Analyysi valmistuu kevään ja kesän 1997 aikana. Toivon filosofiset lähtökohdat sekä semanttinen analyysi muodostavat teoreettista perustaa haastattelututkimukselle. Tutkimusmenetelmänä empiirisessä vaiheessa on strukturoitu haastattelu, joka perustuu Farranin, Sallowayn ja Clarkin tutkimukseen: "Measurement of Hope in a Community-Based Older Population" sekä tämän pohjalta Farranin, Wilkenin ja Popovichin kehittämään instrumenttiin: "Clinical Assessment of Hope". Haastattelun lisäksi käytetään sairauskertomusanalyysia. Sairauskertomusmerkintöjen käyttöön anotaan erillinen lupa sosiaali- ja terveysministeriöstä.

Geropsykiatrian yksiköissä on hoidettavana masennusta sairastavia yli 65-vuotiaita henkilöitä. Haastateltavien valintakriteereistä on neuvoteltu vastuuylilääkärin (LKT Hilkka Virtanen) kanssa. Tutkimukseen valittavat diagnoosiryhmittymät ICD 10:n mukaan ovat: F32, F33, F34.1, F38, F39, F41.2 ja F 43.2., lisäksi edellytetään, että MMSE=24 tai > 24 ja MÅRDS (The Montgomery-Åsberg Depression Rating Scale ; 0-30) = 10 tai > 10. Se, missä vaiheessa hoitoa haastattelu on mahdollista toteuttaa, ratkaistaan jokaisen potilaan kohdalla yksilöllisesti vastuulääkärin ja hoitavan työryhmän kanssa neuvotellen.

Haastattelu on kaksivaiheinen. Ensimmäinen haastattelu tapahtuu hoidon aikana tarvittavin lisätarkennuksin (uusintahaastattelu epäselvien kohtien tarkistamiseksi tai mikäli potilas haluaa vielä täydentää jälkikäteen omaa osuuttaan) ja toinen haastattelu toteutetaan vuoden sisällä hoidon alkamisesta. Tavoitteena on koota potilaan itsensä ilmaisemat kokemukset masennuksestaan ja siitä selviytymisestä sekä yleisemmin toivon ja epätoivon dialektiikasta. Toiseksi tutkittavaksi ryhmäksi on suunniteltu psyykkisesti terveitä vanhuksia ja heidän kuvaustaan toivosta. Tämä osuus toteutetaan myöhemmässä vaiheessa, eikä kuulu tämän tutkimuslupa-anomuksen piiriin.

Tausta-aineistona laajemman kokonaiskuvan saamiseksi käytetään geropsykiatrisessa tutkimuksessa (I-osa 1988 ja II-osa 1992) koottuja tietoja masennuspotilaiden selviytymisestä ja heidän hoitohistoriastaan, joka on ollut myös eräänä lähtökohtana tälle tutkimushankkeelle. Geropsykiatriseen tutkimukseen on lupa olemassa eettiseltä toimikunnalta ja olen tutkimuksen toinen vastuuhenkilö LKT Hilkka Virtasen ohella. Tutkimuksen II-aineiston 5-vuotisseurannat toteutetaan kevään 1997-aikana, johon ko. tutkimusprosessi päättyy.

Tutkimuksen kohderyhmä ja kesto

Tutkimuksen kohderyhmän muodostavat depression vuoksi Turun terveydenhuollon psykiatriseen erikoissairaanhoitoon lähetetyt/hoitoonotetut yli 65-vuotiaat henkilöt (ks. tarkemmin liitteenä oleva tutkimussuunnitelma) aikaisemmin mainittujen kriteerien

perusteella. Haastattelut toteutetaan vuosien 1997 ja 1998 aikana hoidossa olevista ja seurantahaastattelut vastaavasti vuosien 1998 ja 1999 aikana.

Tutkittavan asema ja oikeudet

Jokaisen mahdollisen tutkimukseen osallistujan kanssa käydään kahden-keskinen keskustelu, jossa selvitetään tutkimuksen tarkoitus ja menetelmät sekä kerrotaan mahdollisuudesta kieltäytyä tutkimukseen osallistumisesta tai keskeyttää tutkimus haluttaessa ja haastateltavilta pyydetään kirjallinen suostumus tutkimukseen osallistumisesta (ns. informed concent). Mahdollinen tutkimukseen osallistuja saa myös lyhyen kirjallisen selvityksen tutkimuksesta sekä omista oikeuksistaan siihen liittyen (ks. liite 2). Mahdollisille tutkittaville varataan myös harkinta-aikaa tiedon saannin ja päätöksenteon välillä, jotta osallistumista voi rauhassa harkita. Henkilöille, joille tarjotaan mahdollisuutta osallistua tutkimukseen, selvitetään, että kieltäytyminen ei vaikuta heidän hoitonsa sisältöön, vaan haastattelu on erillinen tutkimushanke, jonka tuloksia pyritään käyttämään hyväksi hoidon kehittämisessä jatkossa.

Pyydän kohteliaimmin, että Turun terveydenhuollon eettinen toimikunta antaisi tutkimushankkeestani lausuntonsa, joka tulee liitteeksi STM:ltä anottavaan lupahakemukseen sairauskertomusmerkintöjen käyttämisestä tutkimuksessa. Lisäksi pyydän, että Turun terveydenhuollon eettinen toimikunta myöntäisi luvan tutkimuksen suorittamiseksi.

Virpi Pyykkö

Ylihoitaja

Liitteet:

1. Tutkimussuunnitelma

2. Selvitys haastattelututkimuksesta

3. Suostumus osallistumisesta tutkimukseen

MIELENTERVEYSKESKUKSEN JOHTORYHMÄ

(Käsitelty 13.5.1997 § 5)

TUTKIMUSLUPA-ANOMUS

Yleistä tutkimushankkeesta:

Opiskelen Turun yliopiston lääketieteellisessä tiedekunnassa hoitotieteen laitoksella. Teen väitöskirjatutkimustani aiheesta: Toivon merkitys iäkkäiden ihmisten selviytymisessä depressiosta.Tutkimus on mukana itsenäisenä hankkeena STAKESin johtamassa valtakunnallisessa Mieli-Maasta-projektissa. Tutkimuksen ohjaajina toimivat tutkimusprofessori Ville Lehtinen Stakesista ja professori Sirkka Lauri Turun yliopiston lääketieteellisestä tiedekunnasta hoitotieteen laitokselta. Tutkimuksesta vastaavana lääkärinä toimii apulaisylilääkäri Hilkka Virtanen.

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Turussa 22.4.1997

Virpi Pyykkö

Ylihoitaja

Liitteet:

1. Selvitys haastattelututkimuksesta

2. Suostumus osallistumisesta tutkimukseen

SELVITYS HAASTATTELUTUTKIMUKSESTA 1997 - 1999

Tutkimuksen aihe on: **Toivon merkitys iäkkäiden ihmisten selviytymisessä masennuksesta.** Tutkimuksen ohjaajina toimivat tutkimusprofessori Ville Lehtinen Sosiaali-ja terveysalan kehittämiskeskuksesta ja professori Sirkka Lauri Turun yliopiston lääketieteellisestä tiedekunnasta hoitotieteen laitokselta. Tutkimus kuuluu osana valtakunnalliseen Mieli Maasta -hankkeeseen, jonka tarkoituksena on kehittää masennuksen hoitoa ja varhaista toteamista. Tämä osatutkimus toteutetaan vuosien 1997 - 1999 aikana. Tutkimuksen tarkoituksena on saada uutta tietoa siitä, miten iäkäs ihminen itse kokee elämässään toivon ja masennuksen vaihtelun. Tutkimuksen vastuulääkärinä toimii apulaisylilääkäri Hilkka Virtanen.

Koska Teillä on omakohtaista kokemusta masennuksesta, on Teidän osallistumisenne meille ensiarvoisen tärkeää juuri oman kokemuksenne vuoksi.

Toimin ylihoitajana Turun mielenterveyskeskuksessa ja vastaan hoitotyön toteutuksesta vanhusten psykiatrisissa hoitoyksiköissä. Jotta pystymme kehittämään hoitoa parhaaseen mahdolliseen suuntaan, tarvitsemme lisää tietoa tältä alueelta ja Te voitte omalta osaltanne olla mukana tässä tutkimuksessa tuomalla oman kokemuksenne yhteiseksi hyödyksi osallistumalla haastatteluun.

Tarkoituksenani on haastatella Teitä 1 - 2 kertaa hoidon aikana ja kerran vielä vuoden sisällä hoitoon tulostanne. Jokaisen tutkimukseen osallistujan kanssa käyn vielä kahdenkeskisen keskustelun, jossa selvitän yksityiskohtaisemmin tutkimuksen tarkoituksen ja menetelmät sekä kerron mahdollisuudestanne kieltäytyä tutkimukseen osallistumisesta tai keskeyttää tutkimus niin halutessanne sekä siitä, että tutkimukseen osallistuminen on vapaaehtoista. Haastattelut nauhoitetaan, jotta sisältö saadaan mahdollisimman oikein tutkimuksellisista syistä, mutta Teidän henkilöllisyytenne ei paljastu missään vaiheessa, vaan tulokset julkaistaan yleisellä tasolla. Teillä on mahdollisuus kuunnella kanssani nauha vielä jälkikäteen ja keskustella siitä mikäli niin haluatte. Tutkimuksen jälkeen nauhat hävitetään ja vain kirjallinen materiaali jää tutkimuskäyttöön. Haastattelun lisäksi tutkimuksessa käytetään sairauskertomusmateriaalia.

Teillä on mahdollisuus harkita osallistumistanne muutaman päivän ajan, jotta voitte rauhassa tehdä päätöksenne. Mikäli vastaatte myönteisesti, pyydän teiltä allekirjoituksen suostumuksestanne tutkimukseen osallistumiseksi. Se ei kuitenkaan tarkoita sitä, että ette voisi keskeyttää tutkimusta halutessanne. Tutkimuksen keskeyttäminen ei vaikuta hoitoonne. Iäkkäiden henkilöiden omista kokemuksista on vähän tutkittua tietoa tältä alueelta ja siksi tutkimus on tärkeä osa hoidon kehittämistä.

Virpi Pyykkö

Ylihoitaja

SUOSTUMUS OSALLISTUMISESTA TUTKIMUKSEEN:

Toivon merkitys iäkkäiden ihmisten selviytymisessä masennuksesta

Minulle on tehty selväksi tutkimuksen tarkoitus ja käytettävät tukimusmenetelmät: haastattelu ja sairauskertomustietojen käyttö tutkimuksessa. Minulle on myös selvitetty omat oikeuteni tutkimukseen osallistujana ja se, että tutkimukseen osallistuminen on vapaaehtoista ja halutessani voin myös keskeyttää tutkimuksen. Olen tietoinen, että tutkimus kuuluu osana valtakunnalliseen Mieli-Maasta tutkimushankkeeseen ja liittyy hoidon kehittämiseen. Tutkimuksessa käytettävästä haastattelujen nauhoituksesta on sovittu kanssani ja myös siitä, että nauhat hävitetään, kun niiden sisältö on kirjoitettu ylös.

Tietoisena edellä mainituista seikoista annan suostumukseni osallistumisestani tutkimukseen.

Turussa ..päivänä .....kuuta 199..

Tutkimukseen osallistuvan allekirjoitus:

Tutkijan allekirjoitus:

Guidelines for the Clinical Assessment of Hope

H= Health', O= Others, P= Purpose, E= Engagement Process,

G= Goals, A= Action, C=Control, T= Time

Patient Interview questions

1. What type of illness/health concern are you experiencing?

HEALTH:

NA= Nursing Assessment: Determine whether the patient's health concern is acute, chronic, or terminal; and how severely his or her hope is being tested.

2. How hopeful would you say you are?

NA: Gain a general understanding of the patient's feelings of hopefulness.

3. How has your health affected your sense of hope?

NA: Try to understand the relationship between the patient's current health and sense of hope.

OTHERS:

1. Do you have family and/or friends who are supportive of you?

NA: Determine whether the patient is in contact with family members or a larger community.

2. Are there particular people in whom you confide?

NA: Examine whether the person has a basic trust in others

3. What types of difficult experiences have you and your family dealt with in the past ? How did you manage those experiences?

NA: Gain an understanding of the ability of the patient and family to deal with difficult experiences. Help the patient and the family to see that what they have learned in the past may help them deal with their current health concern.

4. What things do others do that make you feel more hopeful (or more hopeless)?

NA: Determine whether these relationships are supportive or antagonistic: and whether they foster a reality-based hope.

PURPOSE:

1. What gives you hope or keeps you going?

NA: Determine the patient's source of hope (Higher Being, relationships with family and friends, self, or some combination of these)

2. What helps you make sense out of what is happening in your life right now?

NA: Examine whether the person's source of hope helps him or her make sense out of or rise above the current situation.

3. Would you say that you are a religious/spiritual person?

NA: Determine what role religion plays in the patient's life (a help or hindrance)

Do your religious beliefs help you understand what is happening to you in your current illness?

Do you find yourself questioning your basic spiritual beliefs?

NA: Determine whether religion is an integrating force or whether religious beliefs are being tested and negatively experienced.

4. Are you currently involved in a church/parish/synagogue?

NA: Determine the role that formal religious structures serve in the patient's life.

How supportive are others from your church/parish/synagogue?

NA: Understand whether others support or contradict the patient's belief system.

5. Are there rituals or practices that are helpful to you (meditation, prayer, others)?

Are there things I can do to help you maintain these rituals and/or practices?

NA: Understand the meaning that the patient's personal practices and rituals have and facilitate their continued practice.

GOALS:

1. What do you hope will happen in the present and in the future?

NA: Examine whether the patient's goals are general or specific. If specific, determine if the patient expects only a positive outcome, or if there is some flexibility concerning outcome. Observe whether the patient's goals are congruent with thoughts, emotions, and behaviour, and whether they are congruent with goals of the family and health professionals.

2. What are the chances that these things will happen in the present or the future?

NA: Explore whether the goals are reality-based and attainable given the patient's current abilities, past accomplishments, and future capabilities and support. Examine whether unattainable goals are causing discouragement or hopelessness.

ACTION:

1. What do you feel you can do to meet these goals?

NA: Examine specific behaviours in which the patient is involved to meet goals. Determine whether the goals need to be modified so the patient can be more actively involved in the hoping process. Examine whether there are any conditions or situations that influence the patient's ability to actively engage in the hoping process.

CONTROL:

1. How much control do you feel you have over your current situation?

NA: Determine whether the patient needs to have a sense of "I am in control" or is content to have a sense that "Things are under control."

TIME:

1. What kinds of things have made you hopeful in the past?

NA: Determine whether the patient's hope is based in the past, present or future.

2. What gives you hope at the moment?

NA: Determine what the patient has learned from past experiences and how helpful this information is at the present time and potentially for the future.

3. What do you hope for in the future?

HAASTATTELUKYSYMYKSET:

(mukaeltu Farran et al. 1990 ja 1992)

YLEISTÄ

Mitä toivo teille merkitsee?

Jos arvioitte tämänhetkistä toivoanne asteikolla 1-10 (jossa 10 edustaa korkeinta/suurinta mahdollista toivon tunnetta), mihin numeroon päädytte tällä hetkellä elämässänne?

KOETTU TERVEYDENTILA

Onko teillä joitakin terveydentilaan liittyviä ongelmia tällä hetkellä?

Miten terveydentila yleensä vaikuttaa toivon tunteeseenne?

(määrittele onko haastateltavan terveyteen liittyvät ongelmat akuutteja/kroonisia ja miten ne vaikuttavat hänen toivon tunteeseensa)

Onko teillä viimeiksi kuluneen vuoden sisällä ollut merkittäviä menetyksiä elämässänne?

(viestittääkö haastateltava olemus tai kuvaus tilanteestaan kokemuksesta, josta ei ole ulospääsyä)

Mitkä asiat elämässänne herättävät toivoa tai toisaalta synnyttävät toivottomuuden tunnetta?

(a: mikäli haastateltava ilmaisee toivottomuutta – onko se ”oikeassa suhteessa” tilanteeseen vai liittyykö se kliiniseen depressioon tai itsemurha-ajatuksiin, b:yleinen käsitys haastateltavan toiveikkuuden tunteista ja haastateltavan nykyisen terveydentilan ja toivon välisestä suhteesta)

SUHTEET LÄHEISIIN JA MUIHIN IHMISIIN JA YHTEISÖIHIN

Kerrotteko ihmissuhteistanne, millaisia ne ovat.

Onko teillä harrastuksia tai muuta toimintaa, jossa olette tekemisissä toisten kanssa?

(uskonnolliset yhteisöt, luonto, lemmikkieläimet)

Kuka on teille merkittävin ihminen?

Millaista apua te odotatte muilta ja miten uskotte itse voivanne auttaa itseänne?

Miten läheiset ihmiset vaikuttavat toivon tunteeseenne?

Miten te ja läheisenne olette selvinneet aikaisemmin vaikeista elämäntilanteista ja löytäneet uutta toivoa?

Miten arvioisitte omaa merkitystänne ihmisenä/omanarvontunnettanne suhteessa itseenne ja läheisiinne?

ELÄMÄN TARKOITUKSELLISUUS

Mitkä asiat synnyttävät teissä toivoa - mistä ammennatte toivoa elämässänne?

(perhe, ystävät, usko omaan kykyyn selviytyä, uskontoon liittyvät tekijät, aikaansaannokset elämässä, yhdistelmä em:sta)

Mikä merkitys näillä asioilla on teille tällä hetkellä ja aikaisemmin elämässänne?

(a: tuen saatavuus, rituaalien tuoma turvallisuus, positiiviset/negatiiviset vaikutukset, b: mistä tekijöistä haastateltavan elämän tarkoituksellisuus rakentuu)

TAVOITTEET JA PÄÄMÄÄRÄT

Onko teillä jotain tiettyjä tavoitteita/päämääriä elämässänne?

(ovatko haastateltavan päämäärät yleisiä, spesifejä vai sekä että/mikäli ne ovat spesifejä, määrittele odottaako haastateltava vain positiivisia asioita vai onko päämäärien suhteen myös joustomahdollisuuksia/ovatko haastateltavan päämäärät yhdensuuntaisia ajatusten, tunteiden ja käyttäytymisen kanssa ja toisaalta perheen ja terveydenhuoltohenkilöstön kanssa)

Miten uskotte pystyvänne saavuttamaan nämä päämäärät?

(ovatko tavoitteet todellisuuspohjaisia ja saavutettavissa suhteessa haastateltavan nykyisiin kykyihin, aikaisempiin saavutuksiin, tuleviin mahdollisuuksiin ja saatavissa olevaan tukeen suhteutettuina)

VOIMAVARAT

Pidättekö itseänne päättäväisenä, optimistisena tai rohkeana henkilönä?

Miten arvioitte fyysisiä ja psyykkisiä voimavarojanne?

Mitkä asiat vaikuttavat vähentävästi fyysiseen ja psyykkiseen tilaanne?

(arvioi haastateltavan kognitiivista suoriutumiskykyä/arvioi ulkoisia resursseja: inhimillisiä ja materiaalisia - saatavuus, vahvuudet ja heikkoudet)

Saatteko/käytättekö joitakin yhteiskunnan tarjoamia palveluja?

TOIMINTA

Miten olette aikaisemmin menetelleet saavuttaaksenne asettamanne tavoitteet/päämäärät?

(arvioi onko haastateltavan toiminta tavoitteiden saavuttamiseksi ja toivon ylläpitämiseksi realistista ja tavoitteiden suuntaista/toimivatko toiset henkilöt haastateltavan puolesta joko positiivisesti tai haitallisesti)

HALLINTA

Onko jotain sellaisia asioita, joita te toivoisitte saavanne järjestykseen, jotta voisitte sanoa olevanne toiveikas tilanteen suhteen?

(arvioi missä määrin haastateltava pystyy hallitsemaan tilannettaan/onko haastateltavassa merkkejä opitusta avuttomuudesta tai toivottomuudesta)

Pystyttekö/jaksatteko tarvittaessa selvittää asioita, joihin tarvitsette ratkaisua/apua?

(avuntarpeen arviointi hankalampien asioiden suhteen, jotta haastateltava voi löytää ratkaisuja niihin ongelmiin, joita hän pystyy ratkaisemaan)

AIKA

Onko teillä sellaisia kokemuksia aikaisemmista elämänvaiheistanne, joista uskotte olevan apua nyt ja tulevaisuudessa?

(arvioi perustuuko haastateltavan toivo menneisyyteen, nykyhetkeen vai tulevaisuuteen/pystyykö haastateltava käyttämään näitä kokemuksia hyväksi/miten haastateltava kuvailee ajankulkua aikamäärein/kalenterin perusteella ja/tai tapahtumien ja luonnon vaihteluitten kautta)

Millaiset asiat ovat tehneet teidät aikaisemmin toiveikkaaksi?

(määrittele perustuuko haastateltavan toivo menneisyyteen, nykyisyyteen vai tulevaisuuteen)

Mikä antaa teille toivoa tällä hetkellä?

(määrittele mitä haastateltava on oppinut aikaisemmista kokemuksista ja miten hyödyllistä tämä tieto on nykyisin ja mahdollisesti tulevaisuudessa)

Mitä toivotte tulevaisuudelta?

AN EXAMPLE OF CODING

HU: M1

File: [C:\Ohjelmatiedostot\Scientific Software\ATLASti\TEXTBANK\M1]

Edited by: Super

Date/Time: 07.04.03 16:21:22

Code Family: Ihmissuhteet

Created: 05.11.01 08:19:12 (Super)

Comment:

Codes (70)

[ei ol lapsia] [elossa oli kaks] [et kyl mää aina sieltä aina tulen sit] [H on siel jossain] [hyvin seurallinen] [hän käy katsomassa usein ja soitellaan] [hän oli sairaanhoitaja kans] [hän oli semmonen kauhian vitsikäs] [hän oli semmonen vanha...vanha kiva] [hän oli sentään semmonen kauhian mukava] [hän oli sydäninfarktin takia sairaalassa] [hänel monta lasta] [ja hän on ollut kauhian tyytyväinen] [ja kasvatti hyvin] [joka kuoli pari vuotta sitten] [jollain taval semmonen hyvä suhde] [jos en minä ymmärrä niit poikia] [juu meil oli sellast hauskaa aina] [juur samas portaas päivää sanotaan] [kaks kertaa viikossa tavattiin kyllä] [kaks tyttöö ja kaks poikaa] [kun saa yhdessä syödä niin] [kun siel pitäis olla korttisakki] [kyl mää heihin nyt luotan täysin] [kävinkin veljeä katsomassa] [lapset] [meil oli hyvin onnellinen avioliitto] [meit on kolme siskosta] [melkein pari kertaa kuukaudessa] [miesystävä] [muitakin sukulaisia on] [mul on kaks tytärtä] [mul on viel vuokralainen] [mut ne on kaikki pois] [mut se on kans heil kans oma elämä] [mutta kun hän tuli niin mää laitoin…] [mutta siin se sit onkin] [mä kiinnyn lapseen hirveästi] [mää lähetän sul lentosuukon] [ne oli kaikki ihania ihmisiä] [neiti P on pois] [niin ei ne mihinkään häviä] [niinku mää nyt oon nähnyt siskon elämän] [niinku ne on tännekin nyt soittanut] [niit on useampia.] [No omat tyttäret on] [nuori opiskelija-pariskunta] [on ainakin semmoset suhteet] [onnellisessa avioliitossa] [paras kaveri] [partiopoikalippukuntaa] [puhelinkeskustelus aika usein] [R nyt vähän useemmin käy] [Ruissalon kylpyläkavereita] [samanhenkistä seuraa] [siellä sit sais simmost sopivaa seuraa] [sieltä on vielä muutamia jälellä] [silloin vaimo vielä eli] [sit haudas oli kolme jo] [sitte niin aina soiteltiin] [toivon ainakin] [tulevat tällä viikolla tänne kattomaan] [Tämä R rouva on ihan mun kotinaapuri] [usein hän kävi tämän sulhaspojan] [vaimo oli aika jär..järkyttyyt tietysti] [vanhempi tytär ja hänen miehens] [yhteenkasvattu toinen toisiimme] [yhtenäänkin aika usein] [Yhteyksiä veljiin on] [yksi serkku täällä]

Quotation(s): 107

Code families and the number of codes in each family in the preliminary phase of analysis.

The names of code families and the number of codes in the code families in the dictionaries: HU 1	The names of code families and the number of codes in the code families in the interviews of depressive patients: HU 2	The names of code families and the number of codes in the code families in the interviews of non-depressive subjects: HU 3
1. Adjectives and adverbs/hope (n=682)	1. Time (n=30)	1. **Not in these interviews**
2. Adjectives and adverbs/hopelessness (n=291)	2. Things that have aroused hope before (n=18)	2. Things that have aroused hope before (n=122)
3. Hope and definitions (n=79)	3. Thoughts (n=115)	3. Thoughts and fears (n=193)
4. Hope-noun (n=482)	4. Things that are hoped to be arranged better (n=46)	4. Things that are hoped to be arranged better (n=81)
5. Hope-verb (n=550)	5. Taking care of different affairs (n=56)	5. Taking care of different affairs (n=155)
6. Lost hope (n=815)	6. Everyday life and work (n=125)	6. Everyday life and work (n=399)
7. Hope and youth (n=93)	7. Hobbies and social activities (n= 108)	7. Hobbies and social activities (n= 177)
8. Certain and uncertain hope (n= 160)	8. Spiritual life (n=48)	8. Spiritual life (n=84)
9. Time (n=97)	9. Care personnel (n=86)	9. Care personnel (n=77)
10. Synonyms of hope (n=193)	10. Care environments (n=65)	10. **Care** (n=310)
11. Positive elements of hope (n=263)	11. Human relations (n=248)	11. Human relations (n=164)
12. Religious and spiritual orientation (n=66)	12. Age and getting old (n=6)	12. Age and getting old (n=58)
13. Hope associated with people (n=410)	13. Self-destructive behaviour (n=88)	13. **Not in these interviews**
14. Hope associated with things and places (n=287)	14. Self-identity and characteristic features (n=134)	14. **Characteristic features** (n=246)
15. Expectation and desire (n=391)	15. The meaning of significant others in hope (n=253)	15. The meaning of significant others in hope (n=425)
16. The amount of hope (n=246)	16. Medication (n=40)	16. Medication (n=79)
17. Confidence, belief, assurance, trust and reliance (n=341)	17. The quality of loss (n=37)	17. **Not in these interviews**
18. The development of hope - the process (n=661)	18. Losses within a year or recently (n=40)	18. Losses within a year or recently (n=234)
19. The grounds and reasons for hope (n=121)	19. The most important person in one's life (n=33)	19. The most important person in one's life (n=41)
	20. Mood (n=143)	20. Mood (n=154)

20. Hope and health (n=117) 21. Hope and living (n=40) 22. The object of hope (n=234).	21. What gives hope at the moment (n=77) 22. What do you hope from the future (n= 107) 23. Support and help from others (n=45) 24. & 25. Scales, which were referred to memos (included Montgomery Åsberg depression rating scales for further analysis) 26. Use of services (n=25) 27. Marriage and living together (n=170) 28. Goals achieved earlier in life (n=10) 29. Determination (n=10) 30. Economic situation (n=26) 31. Objects and goals in life (n=60) 32. Strategies in achieving the goals (n=51) 33. Problems in health (n=202) 34. The effects of health on hope (n=91) 35. Action (n=93) 36. Things that raise hope in life (n=120) 37. The amount of hope (n=36) 38. The meaning of hope (n=51) 39. Things that cause hopelessness in life (n=110) 40. Feeling of insecurity (n=15) 41. Difficult life experiences and hope (n=141) 42. Resources (n=97)	21. What gives hope at the moment (n=156) 22. What do you hope from the future (n= 142) 23. Support and help from others (n=105) Were combined from two code families 26 & 29 with the same name 24. & 25. **Not in these interviews** 26. **Not in these interviews** 27. Marriage and living together (n=323) 28. **Not in these interviews** 29. Determination (n=60) 30. Economic situation (n=72) 31. Objects and goals in life (n=167) 32. **Not in these interviews** 33. Health (n=338) 34. Hope and health (n=82) 35. **Not in these interviews** 36. Things that raise hope in life (n=122) 37. The amount of hope (n=54) 38. The meaning of hope (n=132) 39. Hopelessness and regret (n=77) 40. Feeling of insecurity (n=28) 41. Difficult life experiences and hope (n=140) 42. Resources (n=86)

		43. **Childhood (n=58)** 44. **Youth (n= 136)** 45**. Advice for depression (n=8)** 46. **Self-identity and self-esteem (n= 178)**

The differences in the code families are marked in the table above with bold text. The interviews of the depressive elderly were conducted before those of the non-depressive and some changes were made for practical reasons to make the interviews more fluent. There were also some extra code families in the HU 3 (non-depressive), because those interviewed produced a lot of material concerning their life and, thus, the researcher had to split one code family into parts (childhood and youth). Also the families, self-identity and self-esteem, were added for the same reason. The changes were taken into account in the analysis of the HU:s.

LIFE SITUATIONS

Non-depressive	Depressive
CHILDHOOD: Modest and poor but safe childhood, rich memories, joyful summers with lot of sisters, brothers and cousins, several families in the same household and many generations, hard work as a child, no possibility for further education, war time and evacuee experiences.	CHILDHOOD: A few comments on childhood, which mainly were connected with hard work as a child and fears within own family (assaults, violence, drinking), sexual assault attempts and other difficult experiences .
YOUTH: Wonderful time, full of expectations, even wartime has left mainly positive memories, a lot of possibilities on labour markets after war, lack of housing and materials and goods, joy and hope after the war when the economic depression was over, will to build up own household, another evacuee period, dating and engagement, war babies and the shame, which was the "spirit" of that time	YOUTH: Earning one's bread since childhood with hard labour, long distances to school and work, war babies; leaving one's family and relatives and abandoning one's children, single parent life: providing for children without social welfare, cheerless phases but adjusting in the realities.
WORKING LIFE: A lot of work and easy to get after the war. Work was very important in building the circumstances within the framework of the rebuilding of the whole country. Great respect of education (which was possible only for rich families' children), great office hierarchy, building own houses, when television came-human interaction diminished, strange work in strange towns: mutual distrust in female-dominated industry-trade union's go-slow orders for hard workers, no knowledge of languages, hotels, restaurants, industry and shops provided a lot of employment.	WORKING LIFE: Hard work and hard life: several different workplaces within the same day,there was no time to be anxious, salaries were low, but everything turned out right; children have got education and it gives grounds for pride. "Human life is mountains and valleys, lights and shadows."
OLD AGE: At this age, you may die suddenly, getting old has happened unnoticed, at this age there is nothing impossible that could happen, you have seen everything, activities take more time, you have good appetite, but are not allowed to eat, resistance deteriorates, contacts are rays of light, you look for comfort and cosiness, not to old people's home; rather sheltered housing, expensive rents, own territory and self-determination are important, simple, peaceful and steady life.	OLD AGE: It is like the meaning of life had disappeared, concentrating on one's own life and at the same time worries of children's life. Getting along day by day.

CATEGORIES BASED ON THE CODE FAMILIES IN THE INTERVIEWS OF THE DEPRESSIVE ELDERLY (first analysis n= number of codes in 10 interviews, second analysis number of codes in 22 interviews)

CATEGORIES: Depressive elderly	**n=10**	**n=22**
1. Thoughts	93	115
2. Age and getting old	5	6
3. Self-identity and characteristic features	75	134
4. Mood	71	143
5. Determination	9	10
6. Feeling of insecurity	12	15
PERSON RELATED FACTORS	**265**	**423**
1. Human relations	212	248
2. The meaning of significant others in hope	204	253
3. The most important person in one's life	20	33
4. Support and help from others	28	45
5. Marriage and living together	136	170
FACTORS RELATED TO HUMAN RELATIONS	**600**	**749**
1. Time	30	30
2. Taking care of different affairs	36	56
3. Everyday life and work	106	125
4. Hobbies and social activities	89	108
5. Spiritual life	38	48
6. Use of services	25	25
7. Achieving goals earlier in life	9	10
8. Economic situation	22	26
9. Objects and goals in life	40	60
10. Strategies in achieving the goals	42	51
11. Action	89	93

FACTORS RELATED TO LIFE AND EVERYDAY LIVING	**526**	**632**
1. Care personnel	48	86
2. Care environments	53	65
3. Medication	16	40
4. Problems in health	170	202
5. The effects of health on hope	65	91
6. Resources	78	97
FACTORS RELATED TO HEALTH AND CARE	**430**	**581**
1. Things that have aroused hope before	16	18
2. What gives hope at the moment	28	77
3. What do you hope for from the future	73	107
4. Things that raise hope in life	88	120
5. The amount of hope	17	36
HOPE + FACTORS	**222**	**358**
1. Things that you hope you can arrange	34	46
2. Self-destructive behaviour	80	88
3. The quality of loss	20	37
4. Losses within a year or the recent past	33	40
5. Things that cause hopelessness in life	77	110
6. Difficult life experiences and hope	123	141
HOPE - FACTORS	**367**	**462**
1. The meaning of hope	29	51
THE MEANING OF HOPE	**29**	**51**
Total	**2439**	**3256**
Difference (n=22-n=10)		**817**

CATEGORIES BASED ON THE CODE FAMILIES IN THE INTERVIEWS OF THE NON-DEPRESSIVE ELDERLY (n=21)

CATEGORIES: Non -depressive elderly	**n=21**
1. Thoughts	193
2. Age and getting old	58
3. Characteristic features	246
4. Self-identity and self-respect	178
5. Mood	154
6. Determination	60
7. Feeling of security	28
PERSON RELATED FACTORS	**917**
1. Human relations	164
2. The meaning of significant others in hope	425
3. The most important person in one's life	41
4. Support and help from others	105
5. Marriage and living together	323
FACTORS RELATED TO HUMAN RELATIONS	**1058**
1. Taking care of different affairs	155
2. Everyday life and work	399
3. Hobbies and social activities	177
4. Spiritual life	84
5. Economic situation	72
6. Objects and goals in life	167
FACTORS RELATED TO LIFE AND EVERYDAY LIVING	**1054**
1. Care personnel	77
2. Care	310
3. Medication	79
4. Problems in health	338

5. The effects of health on hope	82
6. Resources	86
FACTORS RELATED TO HEALTH AND CARE	**972**
1. Things that have aroused hope before	122
2. What gives hope at the moment	156
3. What do you hope for from the future	142
4. The amount of hope	54
HOPE + FACTORS	**474**
1. Things that you hope you can arrange	81
2. Losses within a year or the recent past	234
3. Things that cause hopelessness in life	77
4. Difficult life experiences and hope	140
HOPE - FACTORS	**532**
1. The meaning of hope	132
THE MEANING OF HOPE	**132**
1. Advice in depression	8
2. General conditions	8
3. Childhood	58
4. Youth	136
OTHERS	**210**
TOTAL	**5349**

CODE-DEFINITIONS IN DICTIONARIES

The references after the quotations are examples from the dictionaries in which they were presented, but all the references were not marked because of the large amount of them, which would have made the text hard to read and fragmented. In the beginning of the definitions there is (n=), which defines the number of codes in each family.

Grounds and objects of hope (n=121) seemed to be based on the same elements. Persons things or circumstances may be the grounds of hope but also the object of hope. Generally the ground of hope is defined as "that which gives hope". In some dictionaries they have been mentioned together: "ground or object of hope" (24:3). Ground, reason, source, basis and cause have been used to describe the grounds of hope. The object of hope is defined also with "that which gives hope" but also "what is hoped for" (16:8; 21:8), which better describes the difference between the grounds and objects. The object has more positive attributes like: "good prospect, success of an affair, more reward, better things from the future, winning, benefits, progress, reconciliation, certain things to occur, well earned rest, what you want to happen, that which is longed for, favourable result (2:21,22; 40:44; 40:57), but also to avoid something or to remain unnoticed, some help, peace (95:18; 98:7)". Object is the target of an action: you want to get, to achieve, to happen, to be true, progress, to do something or to avoid something. Ground is more stable: source and basis.

Expectation and desire (n=391) have been defined as expectation of something pleasurable, future good, desired success, but bad as well. It is also connected with obtaining or fulfilment of something. In connection with hopelessness, it is defined: hopeless means having no expectation (62:48). In Crabb's synonym dictionary from 1917, hope is that which is **welcome**; expectation is either welcome or unwelcome: we hope only for that which is good; we expect the bad as well as the good. Maybe this is why the dictionary definitions often combine **expectation and desire**, because desire is connected with something which is welcome. Hope is a presentiment; it may vary in degree, more according to the temper of the mind than the nature of the circumstances; some hope where there is no ground for hope, while others despair where they might hope. Expectation is a conviction that excludes doubt; we expect in proportion, as that conviction is positive: we hope that which **may be or can possibly be**; we expect that which must be or which ought to be. Expectation includes a probability (73:39), a possibility to attain or obtain the object (44:68). Hope and expectation consist in **looking for some good** (4:1), something desired (24:4), which could be fulfilled (64:51).

Confidence, belief, assurance, trust and reliance (n=341) lie in the dependence on a **person or thing** to bring about the good. We may, therefore, have either hope or expectation grounded on trust or confidence, or we may have them where there is no room for either trust or confidence; a person may hope that something good may turn up because the future is uncertain. Trust and confidence denote the same sentiment, but trust is applied to objects generally, confidence to particular objects; we may trust partially, but we confide entirely; we may trust strangers, we confide in friends or those we are partial to. Trust and confidence may both be applied to man's self, or that which belongs to him, with a similar distinction (Crabb, G.1917). Confidence is active and often connected with expectation and future event (7:18; 20:5). Assurance on the other hand is passive in nature like rest assured (7:17; 88:181). Belief is combined with possibility and (56:48) something obtainable (6:2; 20:13; 29:13) and fulfilment (76:5), that something desired will happen (97:5). Trust includes the thought that things will go well (81:37). Reliance and also security were mentioned in a few dictionaries in this sense (22:5; 56:9; 88:26).

Lost hope (n=815) describes being "out of hopes, an absence of hope, without hope, no hope, empty hope". It also points at some limit which has been crossed "past, beyond all hope, no way out (68:338)", and passive abandonment of oneself (86:96). Some descriptions say it quite clearly "have shot one's last bolt" (88:374) , "have no cards up one's sleeves" (88:375), "turn one's face to the wall" (88:384) "message of despair"(88:318), "sunk in despair" (88:350). Also tiredness and lack of resources belong to lost hope: "without resources", "unable to stand up for oneself" (91:153), dead duck (88:323). When a person has lost his hope, he is cheerless (38:34; 45:40), despairing (27:28; 38:26), depressed (46:80;51:29) or cynical (46:74) and pessimistic (57:67). When a person has lost hope he gives up, abandons, has no expectation of good (57:75,76; 57:86; 64:70), he gives way to despair (68:296). The situation is ill-omened (68:405), without comfort (68:398), past recall (68:420). These definitions are quite final from the point of view of care and raise the question of, where is the limit, or is there one as long as a person is alive, where there is no point of return (see Ollikainen 1994).

Uncertainty, probability, likelihood, possibility (n=160) refer to "not amounting to certainty" (6:6). They have elements of wishing, fearing, doubting, guessing, imagining and supposing. "There is a chance that it will..." (87:60). Descriptions like "keep one's fingers crossed" (88:211), "if things go well" (93:71) "it is likely to happen" (94:132) point to the possibility that if the circumstances are favourable the object of hope might be realised.

Hope as a noun (n=482) refers to "state, feeling, action and quality of mind" (29:17). It is the "opposite of despair" (50:9). Terms like "prospect, anticipation, presentiment and promise" (6:9; 56:12) situate hope in accordance with the future. Imagining the realisation of hope is described in terms of "foretaste, foreknow, foresight, forecast, forethought" (46:21; 51:23). Hope has elements of "gambling, courage, intention, ambition and want" (68:72; 82:5) and a certain kind of purposefulness (46:111). On the other hand, there are also elements of "dependence and discouragement" (22:6; 51:32). Joy, which is connected with hope in etymology, is described in terms of "optimism, cheerfulness, buoyancy, airiness, breeziness, enthusiasm" (46:106; 88:54). The unrealistic elements are connected with "utopia and dreams" like "rose-coloured spectacles, self deception, pipe-dream, fool's paradise" (57:40; 88:73). "Light at the end of the tunnel, a glimmer of hope, clouds with silver lining, omen, glimmer and ray" (68:73; 88:50; 94:255) refer to the situation anteceding the realisation of hope, which is often uncertain and involves doubting.

Hope as a verb (n=550) points to 1) imagining the future - dream, imagine, foresee, foreknow (46:20; 68:270) 2) purposeful thinking/action -think, count, aim, intend - leap, stand firm (40:40; 68:231) 3) supporting the hoping process - cherish, feed, mainstay, inspire, comfort (57:17; 68:66) 4) feelings combined with the importance of the object - have one's heart set on, yearn, long, hunger, pine, thirst, hope against hope (46:8; 85:58) 5) uncertainty - doubt, fear, distrust, suspect, remember, recollect, recall, keep one's fingers crossed (51:12; 88:211) 6) dependence - lean on, count on, bank on (46:16; 68:216) 7) unrealistic aspects - paint a rosy picture, delude oneself (68:264; 68:290) 8) confidence and security - doubt not, have faith, rest assured, secure (57:30; 82:35) 9) expecting - anticipate, look forward to, expect, await, to see land ahead, to catch a straw (22:12; 46:3) 10) Crushing hope - wring one's hands, crush, destroy, dash, give way to despair and hopelessness (57:82; 88:372).

Positive elements of hope (n=263) **-** a concept family was formed to make the difference between elements of hope and hopelessness/despair during the analysis. This concept family included **firstly** the same kinds of elements like hope as a noun: 1) state of mind (44:90) 2) condition (54:22) 3) outlook (62:35); 73:46) 4) future orientation (73:37) 5) feeling (62:35) and 6) attitude (46:106). **Secondly**, it also consisted of adjectives defining elements like - cheerful, welcome, promising, favourable (12:26; 22:13). **Thirdly**, there were elements of strategy - how to support and maintain hope - "hope against hope, that it may be avoided, expressing hopes, feeling and showing hope, the recognition of better things, there is always a chance, smiling face but lingering feet, to look on the bright side" (50:31; 94:80). **Fourthly**, the concept family included terms which defined the consequences which follow the positive elements of hope - "success, good prospect, something welcome, good days and long life, recovery, happy outcome, favourable auspices" (2:21; 24:103) .

Hope associated with people (n=410) is defined as personified: "one on whom hopes are centred" and "one who hopes"- "you are my only/last hope, who seems likely to succeed, who gives good promise - prisoner of hope, hoper, candidate" (29:7; 40:3). It also refers to many people or groups of people like - "troop of soldiers, hope of the Allies, the team's only hope for victory, hope is a lover's staff, hope is the poor man's bread" (17:2; 43:40). The contexts were most often war, politics, economy and education.

Hope associated with things and places (n=287) brings interesting elements to the examination of hope. The places often refer to security and safety: "a haven, a small bay, a blind valley, anchor, Cape of Good Hope, Hope Diamond, ElDorado, Hope of Israel, promised land, a very safe harbour for the ship, a hollow among the hills" (12:2; 24:67; 54:11; 66:35; 80:7). When you reach a safe place from a storm or enemies, you have hope. This is near the category of hope and living: "while there is life there is hope"(43:29).

Adjectives and adverbs of hope (n= 682) can be divided into seven main types: 1) fanatic and risky hope 2) steady and anticipative hope 3) basic, fundamental hope 4) daydreaming, imaginative hope 5) intentional hope 6) joyful hope 7) probability elements of hope. 1) "Fervent, uncritical, self-deluding, bullish, rash, incautious, foolhardy, impetuous, reckless, risky, hazardous, frenzied, frenetic, wild, violent, passionate, incautious and imprudent" are examples of adjectives which describe this kind of hope (82:145; 85:133). 2) Steady and anticipative hope was described by adjectives like: " expectant, hopeful, like a foretaste, favourable, probable, promising, optimistic, sanguine expectation, good hopes, unfearing" (66:95; 68:133). 3) Basic, fundamental hope was connected with elements of trust and confidence like:" assuring, confident, implies some ground of hope, sure, be reassured, safe hope, final hope" (22:14; 46:95; 88:25) 4)

Daydreaming, imaginative hope often had unrealistic features. The adjectives referring to imagination and daydreaming were like:" starry-eyed, dreaming, euphoric, illusory, imaginary, uncritical, rosy picture, rose-coloured view of the world" (46:28; 68:138), but there were also elements which referred to the possible situation which could be the object of hope like "foretaste, glimmer at the bottom, silver lining" (83:25; 88:50). 5) Intentional, realistic hope also included elements of courage and boldness:" their brave hope, intending, encouraging, fortifying, vivifying, realistic, reasonable, ambitious, go-getting (51:44; 88:115). 6) Joyful hope was expressed as :" exciting, sanguine, cheer, elated, jubilant, buoyant, happy in the hope, fond hope, airy hope, bright, fair, golden, inspiring, gaily, gladdening" ((68:325; 82;107). 7) Probability elements of hope were most often described with term like: "plausible, probable, likely, optimistic about, encouraging, promising, auspicious" (66:100; 88:167).

Adjectives and adverbs of hopelessness (n=291) could be divided into five groups: 1) something which cannot be restored to its former condition: "irremediable, irrecoverable, irreparable" (22:20-22; 68:425) 2) "futile, fruitless, vain, useless" (22:27; 82:197) 3) "sad, gloom, grave, downcast" (46:82; 82:125) 4) "dangerous, threatening" (41:41; 66:401) 5) "incapable of solution, compliant, discouraged, inadequate, miserable, not able to learn or act, unable to do it well, not competent, unqualified, completely lacking in ability" (46:88; 86:81; 93:98; 97:120). The general feeling was some kind of ultimate nature of the definitions. 1) Adjectives like: "irretrievable, irremediable, irreversible, irrecoverable, lost, gone, dejected, absence, last hope, comfortless, irreparable, beyond repair, unmanageable, unteachable, breakneck, last throw"(68:425; 85:129) and 2) "futile, fruitless, empty, completely lacking in ability, incapable of solution, vain, idle, poor, bad, cynical, unavailing, unfit, bootless, unskilful, wretched, pessimistic" (22:27; 82:201) described the situation where it is not much use to try anything. 3) Sad and gloom and other adjectives like :"discouraged, funereal, downcast, woeful, woebegone, lugubrious, miserable, doleful, disheartened" (82:89; 93:115) point to the mental state in a hopeless situation. 4) Dangerous elements in hopelessness were like:" serious, dangerous, deadly, fatal, grave, last hope, lost (82:127; 85:120). The hopeless situation referred to the end of something, most often to the end of life (68:70). 5) Broken and worn out pointed to the lack of energy and not feeling well:" heartbroken, grief-stricken, plaintive, dolorous, ineffective, faint, slender, daunted, helpless" (82:174; 84:14).

Youth (n=93) and hope are linked together with the idea of youth as a promising time of life, continuity of life, and youth representing the hope of parents or school: "a promising youth" (2:20), "a young gentleman of great hopes" (12:20), "a son and heir" (65:13). Hope and youth have often also ironic or sarcastic connections: "young hopeful's debts" (40:60), "the air of youth" (56:80).

Hope and Living (n=40) was described as "live in hope(s) of better times" (78:19), "while there is life there is hope"(43:29), "hope of long life" (58:26), "he feeds upon hope"(2:18), "to live in expectation of something" (102:10). There are also hints of hopelessness: "no hope of his life"(1:9) and "his life was a hopeless mess" (97:116) and "things seem bad but we live in hope" (81:15).

Hope and health (n=117) was most often described by the contrast, such as "past cure, beyond recovery, no hope of improvement" (2:11; 85:114). The general tendency was to cross some boundaries where there were no solutions/very few solutions available: " past/beyond recovery, incurable, irremediable, inoperable, terminal, lethal, suicidal, a hopeless case/illness" (43:102; 68:414). A few more promising expressions were included: "If he should mend as I hope, the doctor had some encouraging news, there is now a hope of improvement, good hopes of recovery" (43:28; 95:7). The family could also have been divided also into two different families, hopelessness and health and hope and health, but they were classified in this phase in the same family, because there were under 10 codes hinting at positive elements of health in connection with hope, which were easy to analyse separately.

Time (97) associated with hope was connected with "future but also with no reference to future" (7:5; 68:267; 94:257). It can be connected also to "past or present" (97.78). The hints at future were most often connected with "better situation or pleasure in the future" (87:55). Time was also divided into different units like: daily, temporary and continuous: "hope is a good breakfast but a bad supper, today was a disaster, but tomorrow…" (58:16). Anticipation was connected with time (16:6; 82:41).

Spiritual and religious orientation (n=66) was described on a general level and on a personal level. The definitions on the general level were connected with Christian virtues of three heavenly graces, divine promises and other such expressions which referred to religion or spiritual elements of life in general like "hope springs eternal in the human breast" (40:13; 63:14). The personal level expressions were: " God is my only hope, I hope in Thy word, Job's comforter" (1:1; 2:1; 68:361). Hopes were centred in "Thou, God, Heaven, Ihesu Christe" (28:2; 63:19) and the strategies were "to pray and to trust" (94:58; 103:37). Some hints of

hopelessness were also mentioned like "beyond any hope of salvation or in hopeless conflict with religion" (87:47).

The amount of hope (n=246) was formed because there were variations in the descriptions of hope. The differences were on the scale - "no hope at all" - to "full of hope" (12:52; 92:17). The definitions were associated with the definitions of hopelessness such as "not a hope means hopelessness, which was almost despairing" (39:3) . "Not much hope" described "the lower part of hope" as well as "no reasonable grounds of hope or not much chance that" (78:3; 94:352). "A little hope and some hope" were examples of some amount, and the terms "carried a suggestion" (79:44; 92:17; 46:47). "Great hope" was defined as the next on the way to "full of hope or in all hopefulness, full of qualities which produce hope", which were associated with "to want very much" (68:318; 101:10). There were also examples of some kind of suitable amount of hope like: "don't raise his hopes too much, too much to hope for and to build up your hopes too much…" (78:22; 87:28). Also hints at "the only hope" were expressed as: "you are my only hope, God is my only hope" (94:15; 97:25).

The development of hope (n=661) described the hoping process; what was happening along the way as the hope arises until the realisation or unrealisation of hope. There were four trends which could be distinguished on the basis of these dictionary definitions: 1) Recognition of possible hope producing things in the future and a combined rational thinking process 2) Continuous hoping in spite of realities, also illogical hoping 3) Pushing forward with will and purposefulness 4) Building up hope step by step on former experiences. Examples of the alternatives were like: 1) "The recognition of better things, affording promise of good, promising advantage or success, in such a manner as to raise hope" (16:3; 27:20) 2) "There is always a chance, gambling, inadequate for the purpose, not able to learn, you haven't got a hope in hell, you want it to be true, even when it is very unlikely" (68:72; 86:80) 3)"but we keep hoping, keeping hope alive, something that we hope will happen, fix (centre) one's hope, hope against hope, foster hope, pin your hopes on, continue to hope for something, to entertain expectation (84:7, 94:37) 4) "Fighting that a bad situation will improve, cling to a mere possibility, she never completely gave up, hope deferred maketh the heart sick, prolonged disappointment destroys hope". (41:17; 43:20; 50:51; 92:15). The direction could be both hope-producing and diminishing, the latter of which was often a consequence of some kind of disappointment, or realising the impossibility of achieving the goals (43:37; 57:83).

CODE FAMILIES, THEORETICAL CODE FAMILIES AND THEORETICAL CATEGORIES

Code families	Codes	**Theoretical code families**	Codes	**Theoretical categories**	**Codes**
(A1: not used in coding)					
A2: Time	30				
A3: Things which have earlier created hope	18	B1: Hope and hopelessness related factors=A3,5,22,23,35, 36,37,38	565	Time orientation= B5	161
A4: Thoughts	115	B2: Human interaction= A12,16,20,24,26	749	Hope and hopelessness= B1	565
A5: Things which are hoped to be in order	46	B3: Everyday living= A6,7,8,9,13,18,19,25,29,34 ,40	705	Everyday living= B3(-A9)	657
A6: Taking care of things	56	B4: Mental processes and self-cocept=A4,14,15,21,39,41	592	**C1: Life and everyday living**	**1383**
A7: Life, everyday living and work	125	B5: Time orientation=A2,27,28,30,31	161		
A8: Hobbies	108	B6: Health related factors= A10,11,17,32,33	484	Human interactions= B2	749
A9: Religious and spiritual life	48		3256	Religious and spiritual life= A9	48
A10: Care personnel	86			**C2: Inter-and transpersonal relations**	**797**
A11: Care facilities	65				
A12: Human relations	248			Health-related factors=B6	484
A13: Getting old	6			Mental processes and self-concept=B4	592
A14: Self-destructiveness	88			**C3: Personal (Private) I/Me**	**1076**
A15: Character and self-esteem	134				
A16: The meaning of others in hope	253			**Total**	**3256**
A17: Medication	40				
A18: Quality of losses	37				
A19: Losses in recent past	40				
A20: The most important person	33				

A21: Mood	143
A22: What gives you hope at the moment	77
A23: What do you hope from the future	107
A24: Support and help from others	45
A25: Use of services	25
A26: Marriage and living together as couple	170
A27: Achieving goals earlier in life	10
A28: Determination	10
A29: Economic situation	26
A30: Goals and targets in life	60
A31: Achieving goals and targets in general	51
A32: Health problems	202
A33: Effects of health on hope	91
A34: Action	93
A35: Things creating hope in life	120
A36: The amount of hope	36
A37: The meaning of hope	51
A38: Hopelessness	110
A39: Feeling of insecurity	15
A40: Difficult life experiences	141
A41: Resources	97
	3256

CATEGORIES OF THE DATA OF THE DEPRESSIVE PATIENTS BASED ON CONDITIONS, STRATEGIES AND CONSEQUENCES

Conditions: Why/When they occur Depr-Hope+/ Depr Hope -	**Strategies:** How the action in the situation takes place	**Consequences:** Results of the action
LIFE AND EVERYDAY LIVING **"At this age"** Hope-promoting factors		
- Difficult periods in life - Work and building house - Saving - Ability to pay your debts - Hobbies and summer cottage activities, gardening, nature - Decorations at home, clothes and everything beautiful	- Optimistic in spite of difficulties - Good physical condition - By hard work has created a better life and education for children than one had oneself - Gardening, exercise, good books and TV-programmes, groups and social activities, spring, light, flowers - Getting beautiful things at home	- Stamina, joy and feeling of security - Abundance of experiences of how to manage - It is hopeful that you are still alive, waiting for tomorrow - Satisfaction of achievements - Pleasure and delight
INTER- AND TRANSPERSONAL RELATIONS Hope-promoting factors		
- Human relations, especially spouse, children, friends and neighbours - Religion and Trust in God or in Higher Power	- Help in everyday living - Positive interaction and feedback - Good relationships with children and grandchildren - Understanding from your spouse - Hope that God would help	- Feeling of togetherness, mutual understanding, joy, security - Give safety - Gives comfort; belief is source of comfort
PERSONAL (Private) I/ME Hope-promoting factors		
- In spite of many diseases - Maintaining status quo in health and living - Physical well-being - Mental well-being	- Feeling of security and being taken care of	- You manage day by day - Trust in HC personnel - Ability to move - Quick death - Managing in everyday activities: laundry, cleaning, shopping - Possibility to attend different activity groups - Being able to clean your home, change curtains etc. - Life without depression

LIFE AND EVERYDAY LIVING **"At this age"** **Hope-diminishing factors**		
- Tragic situations in childhood - Poverty - Expensive medication - Worries concerning housing - At this age there is not much to look forward to - Managing at home is not certain	- Uncontrollable thoughts - Lack of social support - Fears of God's revenge - Lack of time and economic restrictions hindered your hobbies - God does not help either - Fear of accidents	- Fears, tension, feeling of inferiority: rat in a hole, grey mouse, total zero - Humiliation, curious people - Tiredness, hunger - Work was your 'hobby' - Being unable to move - Restrictions in physical and mental health may hinder your activities
INTER- AND TRANSPERSONAL RELATIONS Hope-diminishing factors		
- Violence - Marital problems - Many losses of significant others - Aggressiveness and alcoholism of children worries - Children don't visit or call	- Memories cause anguish - Lack of knowledge/information - No help from religion - Feeling of not being understood	- Low self-esteem - Self-identity: feeling ugly - Malice, disappointments - Uselessness, sadness, hopelessness
PERSONAL (Private) I/ME Hope-diminishing factors		
- Lack of initiative - Lack of energy - Aches and several diseases - Lack of knowledge and information about care alternatives - Physical and psychological condition - Inability to take care of yourself - Severe diseases or losses of significant others	- Continuous worrying - Unable to accomplish even the smallest activities - Uncontrollable thoughts, fears, self-accusations, wish to put an end to your sufferings, not able to get joy from anything - Giving up decision making - Too tired to take part in anything, - Hinders taking part in social activities - Taking care of others absorbs your energy	- Losing the meaning in life - "You just cannot be", -Low self-esteem, meaninglessness, emptiness, helplessness, loneliness, like a roller coaster, - Tiredness, - Depression, utmost gloominess, - You cannot get joy from anything, busy HC personnel, - Ending up in hospital or other care institution - Insecurity, loneliness, fear of depression, - Being afraid of dementia or losing your memory for other reasons

CATEGORIES OF THE DATA OF THE NON-DEPRESSIVE ELDERLY BASED ON CONDITIONS, STRATEGIES AND CONSEQUENCES

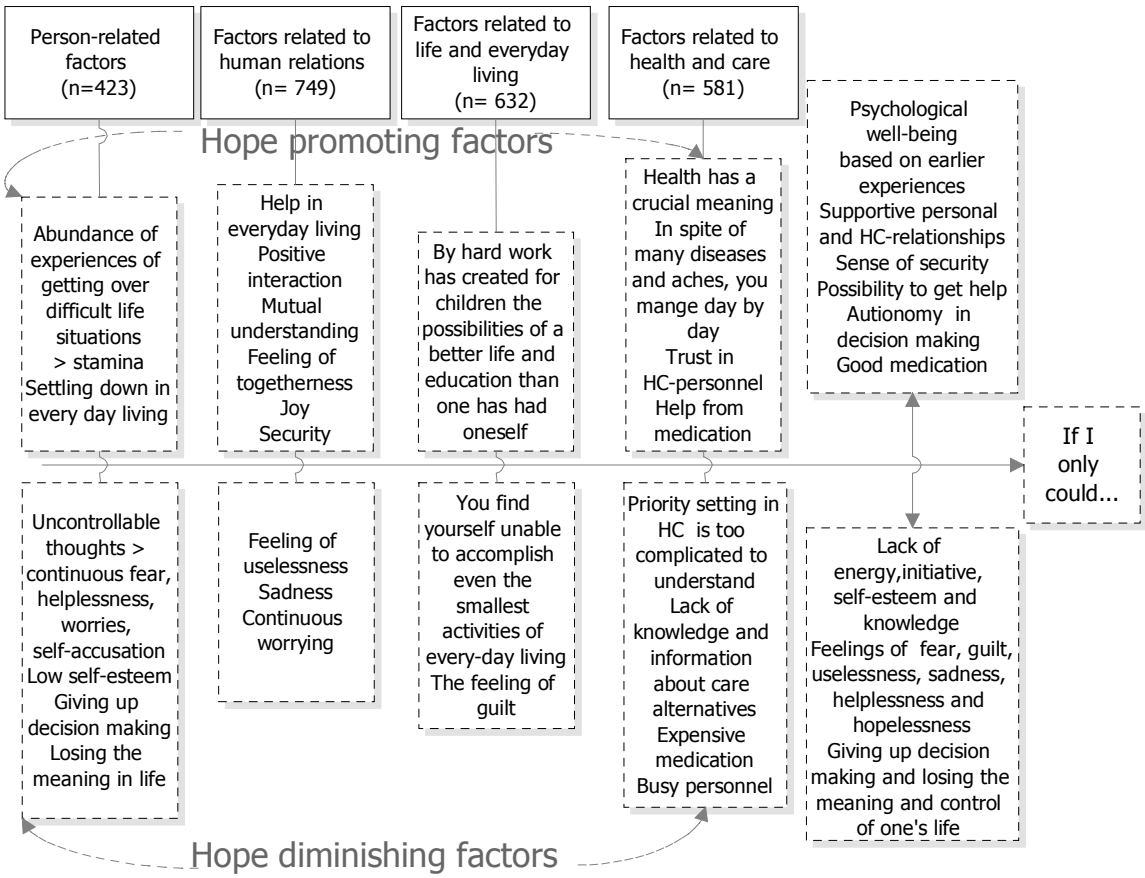
Conditions/- Why/When they occur	**Strategies/**How the action in the situation takes place	**Consequences/**Results of the action
LIFE AND EVERYDAY LIVING/"At this age"/Hope- promoting factors		
- Rich memories of joyful summers in childhood, although it was often poor but safe - Youth and dating full of expectations - Building up your life from almost nothing - Achievements - Getting through difficult life situations - Peaceful life - Life as a whole - Managing in everyday living - Everyday life - Stable economic situation - Satisfaction with services in sheltered housing - Travelling, enjoying comfort and cosiness	- Tackling the difficulties - The attitude that difficulties belong to life in general - Adjusting and finding your way out - Moral consideration - Obstinacy and stamina - Brandy brought relief - On community level peace and well-being - Feeling of security is based on the presence and availability of others - Trusting the support of others has effects on your hope - Spectator's role in following how things clear up - Persistence, determination, efforts to maintain good mood, - Children's education - Possibility to get help - Help of acquaintances - No need of possessions any more - Saving as an attitude has offered possibilities - Arranging your life in the best possible way is source of hope and happiness	- Feeling of importance through work experiences - Courage from former experiences - Hope arises from the realisation that no longer will anything serious happen that you would not be ready for - The need to show others that you manage - Want to be at home in your own territory after an intensive travel and club period - Just a peaceful life
INTER- AND TRANSPERSONAL RELATIONS/Hope-promoting factors		

- Success of children - Health of significant others, - Importance of spiritual life - Children, grandchildren and friends - Avoiding other marriage - Enjoyable new contacts through social activities - You are not alone	- Meaning of HC personnel in arranging care - Praying, trying to find an answer - Faith is an anchor - Decision making 'protocol' in marriage - Group roles: commentator, listener, participator - Support from others	- Human relations bring joy and happy moments and are important in managing in everyday living and promoting the feeling of security
PERSONAL (Private) I/ME/Hope-promoting factors		
- Lack of severe diseases - Noticing based on experiences that everyone is just a human being - Living just for yourself after having lived all your life for others - Getting rid of former obligations - At this age you have seen almost everything - If you decide something, you will do it - Managing by yourself without assistance of others or hospital care - Little things - Possibilities give grounds for future hopes - Preparedness to die suddenly - Life experiences have given resources, which equip you for all events to come	- Hope depends on your life situation - You don't give up, - You keep on going - Health is a precondition for other things - Maintaining your present level of health affects your hope - Professional help is appreciated - Promoting care opportunities based on "inner knowledge" among the elderly in spite of restrictions set by "bureaucrats" - Comparing treatments and care options is meaningful and gives good topics for conversations - Good food and red wine are good medications - You should not stagnate at home - Making your goals come true or waiting for something to happen	- It is really enjoyable to be able to be just as you like - Independence is a precondition for a meaningful life - Experience of autonomy - Possibility to do what you want - Nothing surprises you any more - Nothing impossible can happen, - Believing in yourself - Growing self-identity - Relaxation, pleasure and contacts diminish the need of medication
LIFE AND EVERYDAY LIVING **"At this age"/Hope-diminishing factors**		
- Economic situation	- Regretting some former decisions	- You don't have that much hope any more because you know the realities

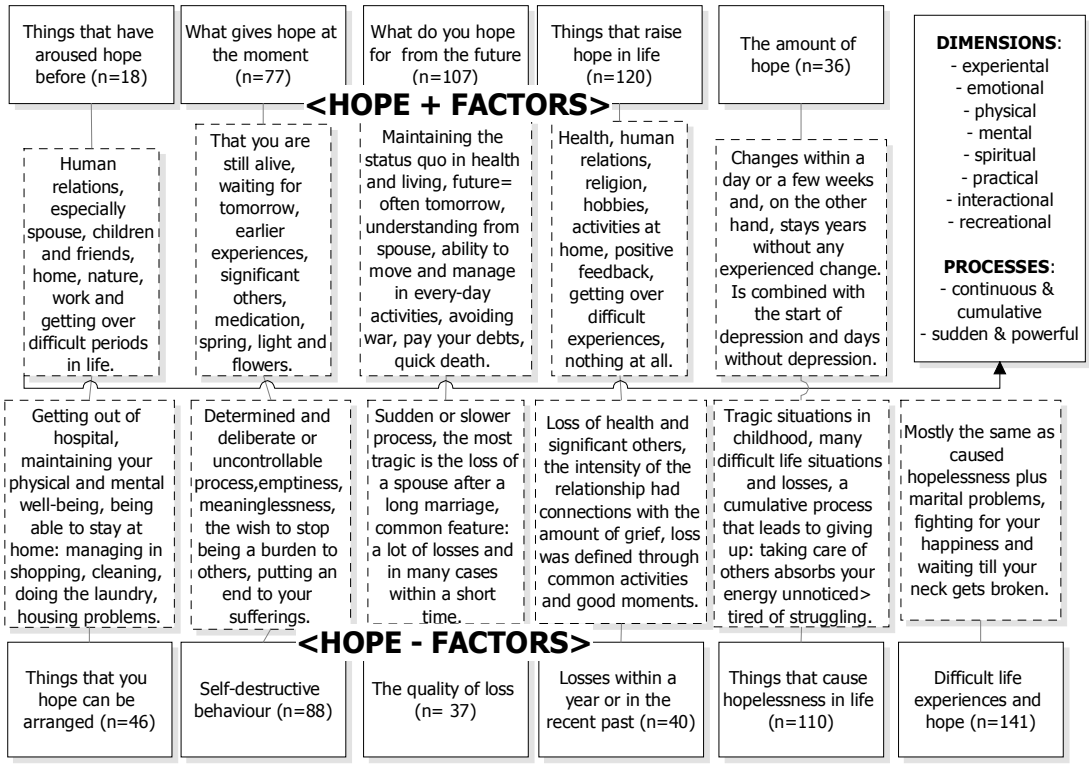
- "What would your life be like, if your dreams had come true-something is missing", - Strange urban culture and working life in big factories and cities - Small salaries and hard work - At this age you have more reasons to be worried: health, others' diseases and deaths - At this age intensity of activities becomes a burden - Housing and living conditions - High prices of services and medication - Arrangements in situations when your spouse has died or is in hospital or coming home from there - "Life is rather downhill-what has life to offer at this age" - The whole world is just killing and fighting.	- Something unpleasant may happen at this age, which has connections with insecurity - how to manage - You have to be stubborn to get care and examination at this age - Adjusting the unavoidable - Economic situation - Lack of knowledge and information about taking care of different things - Mutual duties, which are hard to accomplish because of frailty, diseases and other reasons - Laughing, restricting others rights, violence, nagging, sexual boycott, silent treatment etc.	of life - Words hurt - Feeling of insecurity, loneliness, grieving - Losing your driving licence makes it difficult to take care of affairs - Inability to manage in everyday life after the spouse's death - Getting help nowadays is harder than before - These relationships give you a bad conscience
INTER- AND TRANSPERSONAL RELATIONS/Hope-diminishing factors		
- Losses - War babies - Divorces - Illnesses of children - Deaths of significant others - Losing significant others and dear friends "who is next" - You are caught in relationships, which are not only positive in nature, but may be annoying: too eager neighbours and friends, who mean only good - Cliquish groups, which you cannot join		- Shortcomings in informing the patient cause worries and insecurity

- Children's divorces and problems, fate of grandchildren - Disagreements in marriage - Compensating for grief with travels and clubs - Health problems cause worries to spouses - Changing doctors, who don't know your situation - Contacts with officials in different matters		
PERSONAL (Private) I/ME/Hope-diminishing factors		
- Loneliness as a health problem - Cognitive functions and health in general - Activities take much more time than before - Resistance deteriorates - Unsuccessful operations and treatments - Several aches and pains: problems with eyesight, sleeping, walking, digestion, constipation and fears of health maintenance - Fears of losing your memory, intelligence and dignity - Difference between hopeless thoughts and hopeless acts	- Connections between mood and health - Arranging your care between public and private sectors without sufficient economic resources - Panic and shock reactions - Postponing difficult thoughts - Trying to be without thinking	- Incapability - Lack of energy - Losing ability to move - Trying to get care causes disappointments, because you are too old for care, although then you really need it - Physical restrictions decrease the possibility to take part - Cause long term suffering and economic problems - The severer the disease the more it affects your hope - Being confined to bed in an institution is hopeless

EXPERIENCED HOPE-PROMOTING AND HOPE-DIMINISHING FACTORS IN THE LIVES OF THE DEPRESSIVE ELDERLY



FACTORS RELATED TO HOPE AND HOPELESSNESS BASED ON THE DEFINITIONS OF THE DEPRESSIVE ELDERLY - Questions including the concepts of hope and hopelessness: Hope-promoting factors (Hope +, n=358) and hope-diminishing factors (Hope -, n= 462)



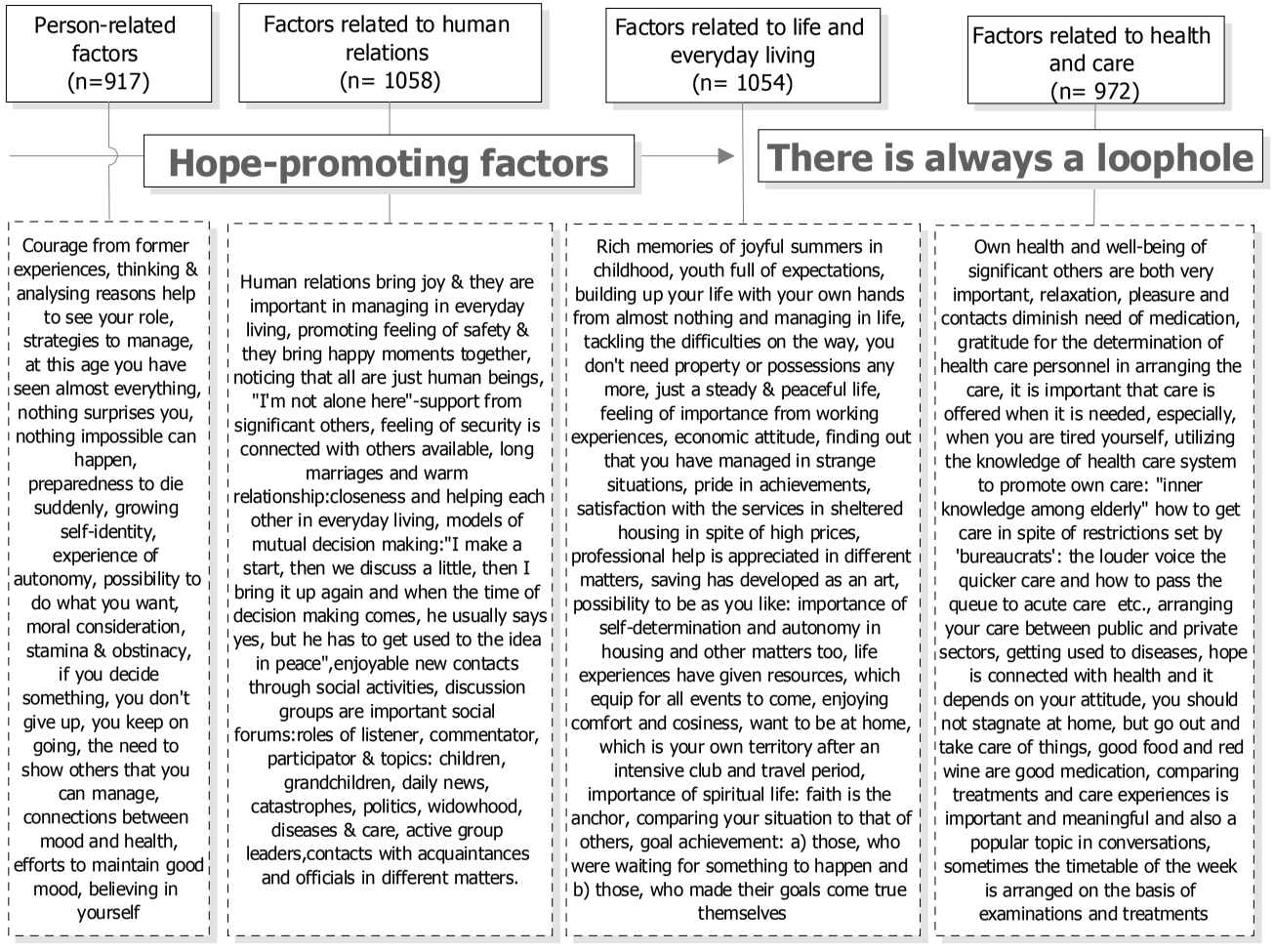
Hope+ and Hope - factors divided into the span of past, present and future on the basis of dimensions of hope and hopelessness in the lives of the depressive elderly

Dimensions	**PAST**		**PRESENT**		**FUTURE**	
	Hope +	Hope-	Hope+	Hope-	Hope+	Hope-
Experiential	Getting over difficult periods in life	Tragic situations in childhood	Abundance of experiences of how to manage, it is hopeful that you are still alive, waiting for tomorrow	Continuous worrying, unable to accomplish even the smallest activities, lack of initiative, losing the meaning in life, "you cannot just be"	Maintaining status quo in health and living	Ending up in hospital or other care institution
Emotional	Stamina, joy and feeling of security	Fears, tension, feeling of inferiority: rat in a hole, grey mouse, total zero	Feeling of togetherness, mutual understanding, joy, security	Low self-esteem, meaninglessness, emptiness, helplessness, loneliness, like a roller coaster	Feeling of security and being taken care of	Insecurity, loneliness, fear of depression
Physical	Good physical condition	Violence, tiredness, hunger	In spite of many diseases you manage day by day	Lack of energy, tiredness, aches and several diseases	Physical wellbeing, ability to move, quick death	Inability to take care of yourself, being unable to move
Mental	Optimistic in spite of difficulties	Low self-esteem, uncontrollable thoughts, memories cause anguish	Satisfaction with achievements	Uncontrollable thoughts, fears, self-accusations, wish to put an end to your sufferings, not able to get joy from anything, depression, utmost gloominess	Mental wellbeing, life without depression	Being afraid of dementia or losing your memory for other reasons
Spiritual	Religion gives comfort	Fears of revenge	Trust in God or in Higher Power, belief is source of comfort	No help from religion	Hope that God would help	God does not help either
Practical	Work and building house, saving	Lack of social support, poverty, lack of	By hard work has created for children a better life and education than	Giving up decision making, lack of knowledge and information	Managing in everyday activities: laundry,	Managing at home is not certain

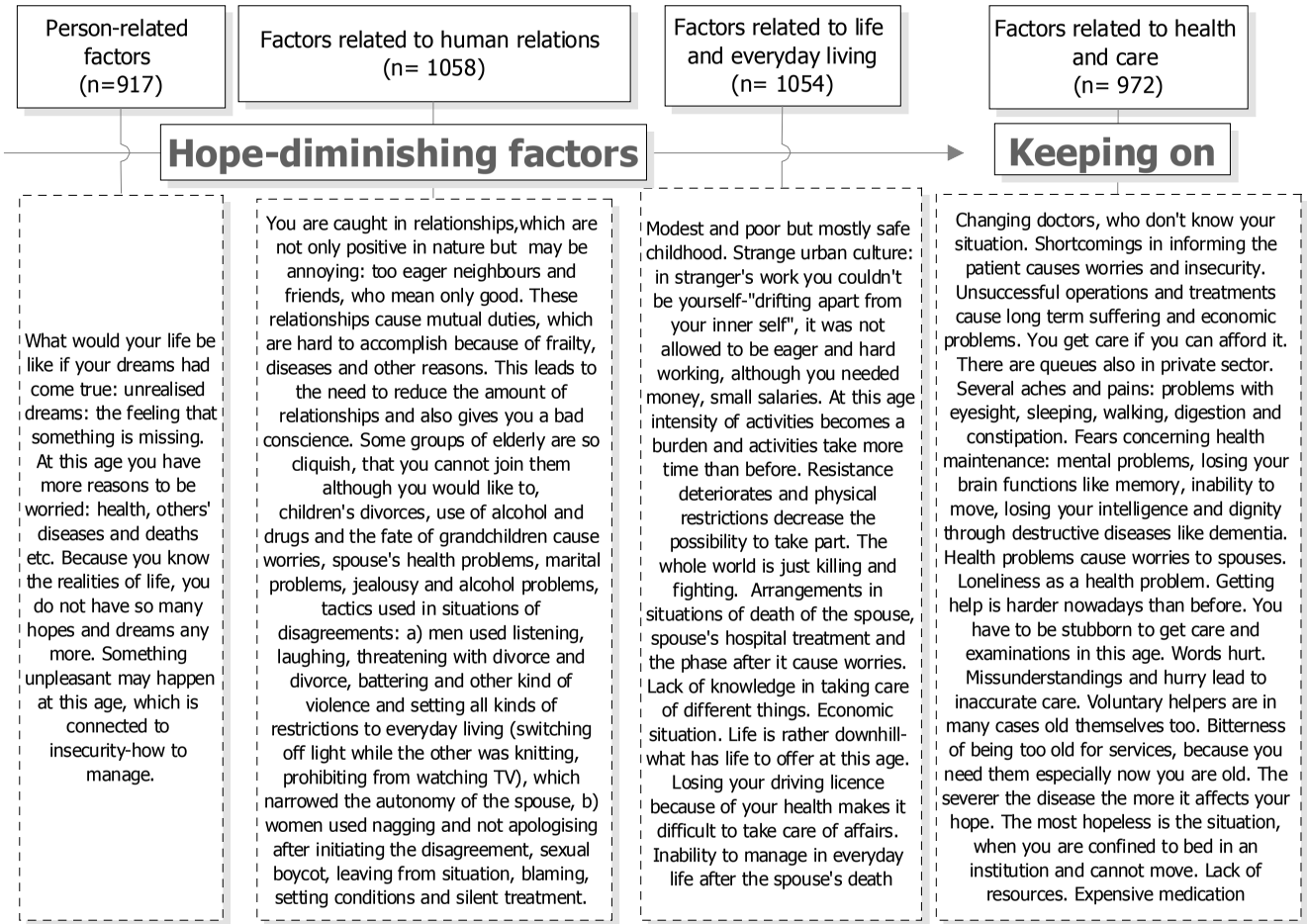
		knowledge	one had oneself, good medication	about care alternatives, expensive medication, worries concerning housing	cleaning, shopping, ability to pay your debts.	
Interactional	Human relations, especially spouse, children, friends and neighbour contacts	Humiliation > curious people, malice, disappoint ments, marital problems	Help in everyday living, positive interaction and feedback, feeling of security, trust in HC personnel	Many losses of significant others, uselessness, sadness, hopelessness, feeling of not being understood, children don't visit or call, aggressiveness and alcoholism of children worries, busy HC personnel	Understan ding from your spouse, good relationshi ps with children and grandchild ren give security	Fear of accidents, severe diseases or losses of significant others, taking care of others absorbs your energy.
Recreational	Hobbies and summer cottage activities, gardening and nature	Lack of time and economic restrictions hindered your hobbies, work was your 'hobby'	Gardening, exercise, good books and TV-programmmes, groups and social activities	Too tired to take part in anything, physical and psychological condition hinder taking part in social activities	Possibility to attend different activity groups	Restrictions in physical and mental health may hinder your activities
Aesthetic	Nature, decoratio ns at home, clothes and everythin g beautiful	Self-identity: feeling ugly	Spring, light, flowers, beautiful things at home	Nothing gives you pleasure	Being able to clean your home, change curtains etc.	At this age there is not much to look forward to.

The division into different dimensions was made on the basis of the expressions of the interviewees as a final criterion. The differences between emotional, experiential and mental dimensions were to some extent overlapping. The criteria were set so that the experiential dimension included happenings, memories and experiences during the lifetime, the mental dimension included thinking and intellectual processes like evaluation, and the emotional dimension included emotions like fear, sorrow, joy and feelings connected with emotions. As an example, the feeling of security was included in the interactional dimension because the interviewees connected the feeling of security strongly with other people, although it should have been included in the emotional dimension based on the criteria.

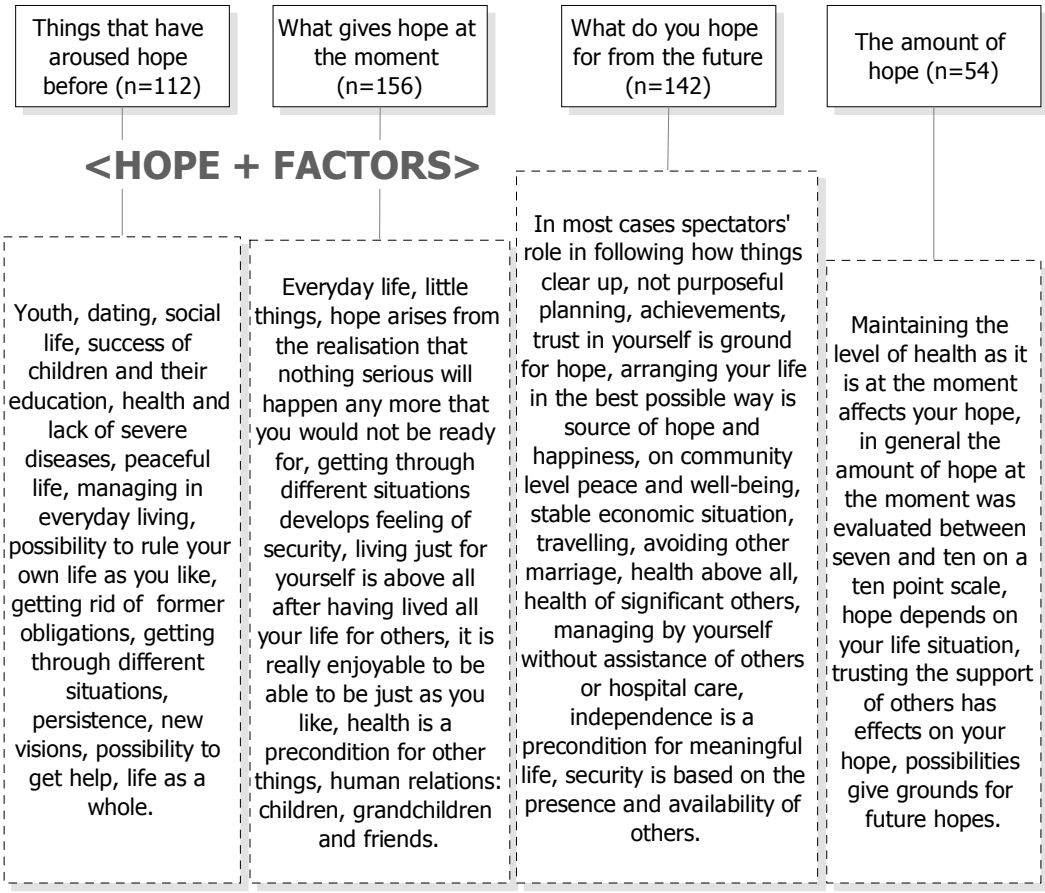
EXPERIENCED HOPE-PROMOTING FACTORS IN THE LIVES OF THE NON-DEPRESSIVE ELDERLY



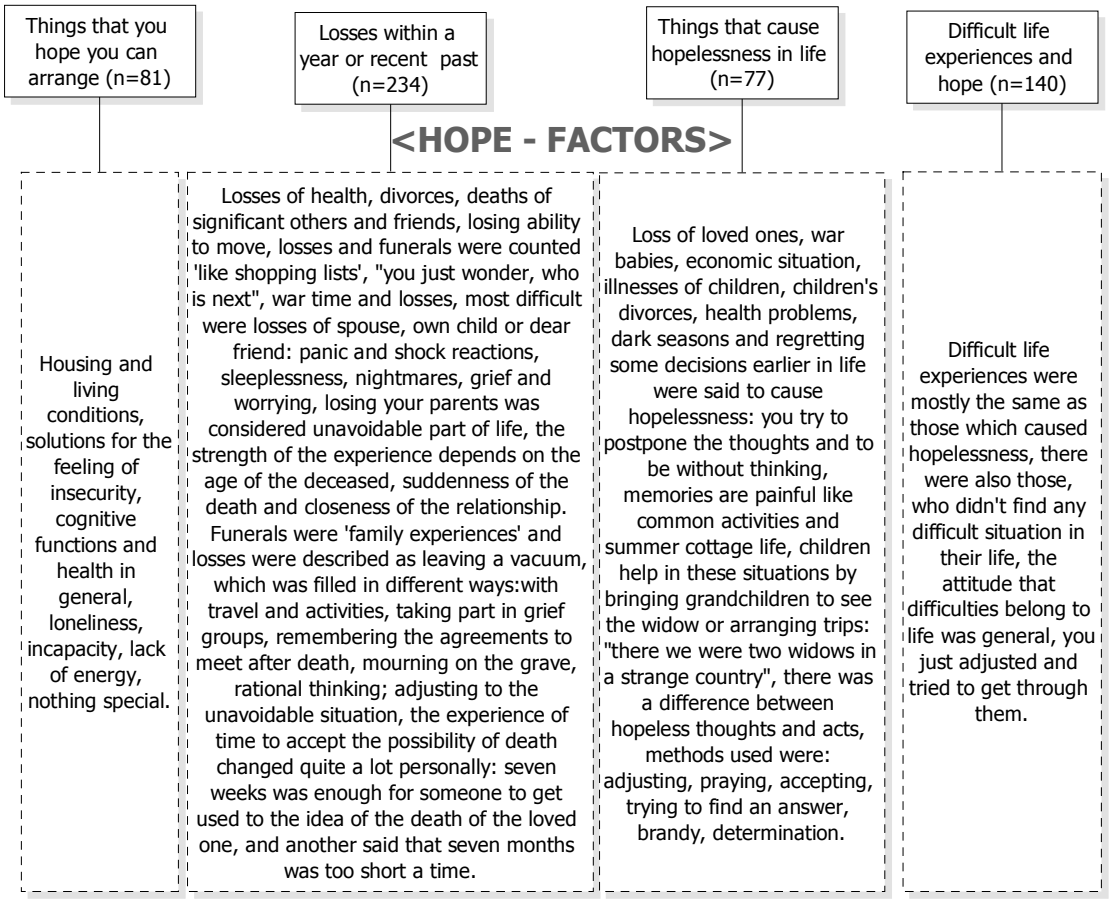
EXPERIENCED HOPE-DIMINISHING FACTORS IN THE LIVES OF THE NON-DEPRESSIVE ELDERLY



FACTORS RELATED TO HOPE BASED ON THE DEFINITIONS OF THE NON-DEPRESSIVE ELDERLY - Questions including the concept of hope: Hope-promoting factors (Hope + n=464)



FACTORS RELATED TO HOPELESSNESS BASED ON THE DEFINITIONS OF THE NON-DEPRESSIVE ELDERLY - Questions including the concept hopelessness: Hope-diminishing factors (Hope - n=532)



Hope+ and Hope - factors divided according to the span of past, present and future on the basis of dimensions of hope and hopelessness in the lives of the non-depressive elderly

Dimensions	**PAST**		**PRESENT**		**FUTURE**	
	Hope +	Hope-	Hope+	Hope-	Hope+	Hope-
Experiential	Rich memories of joyful summers in childhood, although it was often poor but safe, youth and dating full of expectations, building up your life from almost nothing, achievements, tackling the difficulties	Losses, war-babies, economic situation, "what would your life be like, if your dreams had come true- something is missing", strange urban culture and working life in big factories and cities, small salaries and hard work	Success of children, living just for yourself after having lived all your life for others, hope depends on your life situation, at this age you have seen almost everything, nothing surprises you any more, nothing impossible can happen, if you decide something, you don't give up, you keep on going, believing in yourself	Deaths of significant others, at this age you have more reasons to be worried: health, others' diseases and deaths, you don't have that much hope any more because you know the realities of life, something unpleasant may happen at this age, which has connections with insecurity - how to manage, you have to be stubborn to get care and examination at this age, words hurt	Possibilities give grounds for future hopes, preparedness to die suddenly, life experiences have given resources, which equip for all events to come, making your goals come true or waiting for something to happen	The whole world is just killing and fighting
Emotional	Getting through difficult life situations, the attitude that difficulties belong to life in general, adjusting and finding your way out, courage from former experiences, feeling of importance through work experiences	Regretting some former decisions	Peaceful life, feeling of security is based on the presence and availability of others, trusting the support of others has effects on your hope, life as a whole, it is really enjoyable to be able to be just as you like, independence is a precondition for meaningful life, growing self-identity, experience of autonomy,	Feeling of insecurity, loneliness, grieving, at this age intensity of activities becomes a burden, health problems cause worries to spouses, loneliness as a health problem		

			possibility to do what you want, moral consideration, obstinacy and stamina			
Physical	Lack of severe diseases		Health is a precondition for other things, health of significant others, managing by yourself without assistance of others or hospital care, maintaining your present level of health affects your hope, professional help is appreciated, relaxation, pleasure and contacts diminish the need of medication, meaning of HC personnel in arranging care, promoting care opportunities based on "inner knowledge" among the elderly in spite of restrictions set by "bureaucrats", good food and red wine are good medications, you should not stagnate at home, comparing treatments and care options is meaningful and gives good topics for conversations	Cognitive functions and health in general, incapability, lack of energy, losing ability to move, connections between mood and health, trying to get care causes disappointments , because you are too old for care, although then you really need it, arranging your care between public and private sectors without sufficient economic resources, activities take much more time than before, resistance deteriorates and physical restrictions decrease the possibility to take part, changing doctors, who don't know your situation, shortcomings in informing the patient causes worries and insecurity, unsuccessful operations and treatments cause long term suffering and economic problems, several aches and pains: problems with		

				eyesight, sleeping, walking, digestion, constipation and fears of health maintenance were general, the severer the disease the more it affects your hope, being confined to bed in an institution is hopeless		
Mental			Hope arises from realisation that no longer will anything serious happen that you would not be ready for, persistence, determination, efforts to maintain good mood	Panic and shock reactions , postponing difficult thoughts, trying to be without thinking, difference between hopeless thoughts and hopeless acts. fears of losing your memory, intelligence and dignity		
Spiritual			Praying, trying to find an answer, importance of spiritual life, faith is an anchor			
Practical	Brandy brought relief		Getting rid of former obligations, children's education, managing in everyday living, possibility to get help, everyday life, stable economic situation, help of acquaintances, no need for property and possessions	Housing and living conditions, adjusting to the unavoidable, contacts with officials in different matters, high prices of services and medication, economic situation, arrangements in situations when your spouse has died or is in hospital or coming home		

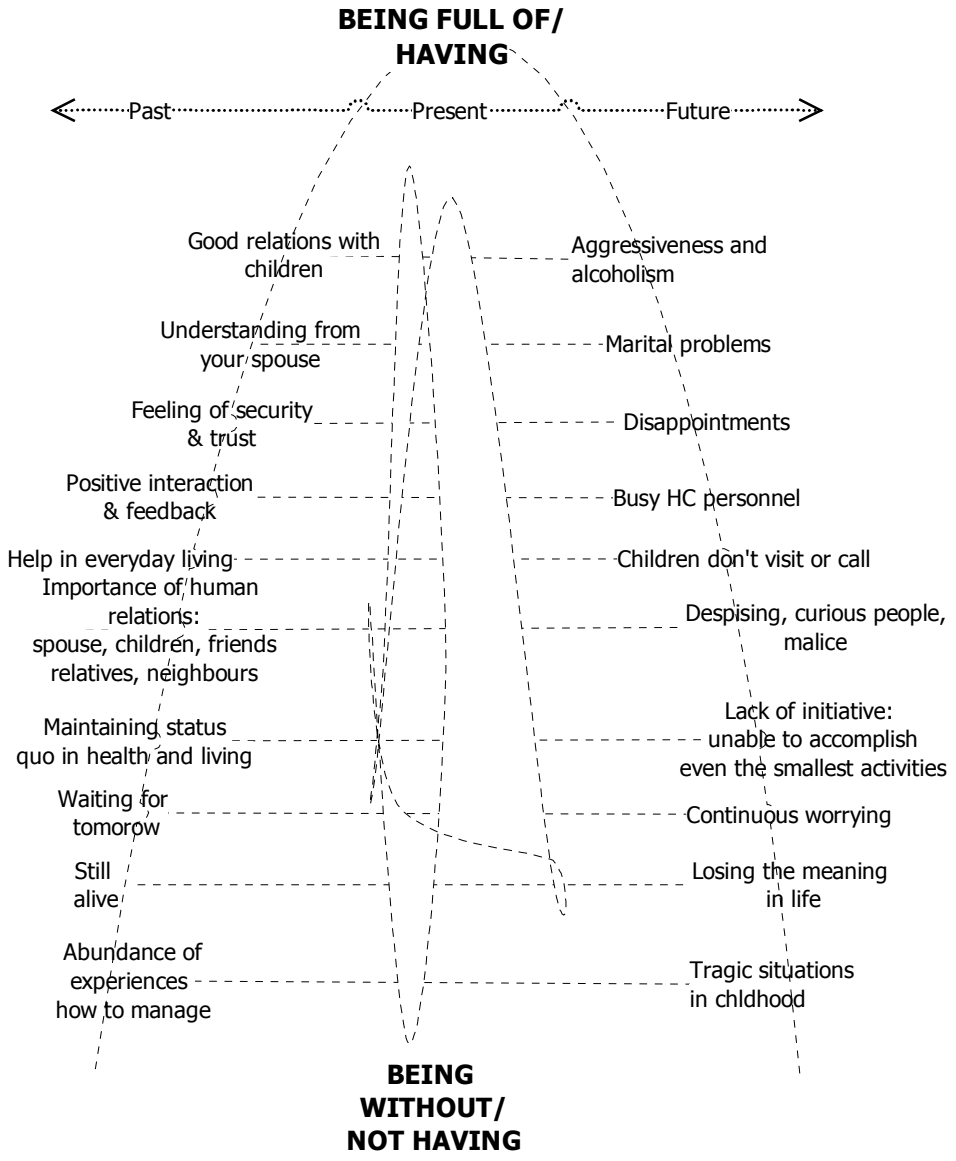
			any more, just peaceful life, satisfaction with services in sheltered housing, saving as an attitude has offered possibilities	from there, lack of knowledge and information about taking care of different things, "life is rather downhill-what has life to offer at this age", losing your driving licence makes it difficult to take care of affairs, inability to manage in everyday life after the spouse's death, getting help nowadays is harder than before		
Interactional	Noticing, based on experiences that all people are just human beings	Divorces, illnesses of children	On community level peace and well-being, children, grandchildren and friends, spectator's role in following how things clear up, avoiding other marriage, the need to show others that you can manage, human relations bring joy and happy moments and are important in managing in everyday living and promoting the feeling of safety, decision making 'protocol' in marriage, enjoyable new contacts through social activities, group roles: commentator, listener, participator	Losing significant others and dear friends "who is next", you are caught in relationships, which are not only positive in nature, but may be annoying: too eager neighbours and friends, who mean only good, mutual duties, which are hard to accomplish because of frailty, diseases and other reasons, these relationships give you a bad conscience, cliquish groups, which you cannot join, children's divorces and problems, fate of grandchildren, disagreements in marriage: restricting, violence,	You are not alone-support from others	

				nagging, sexual boycott, silent treatment etc.		
Recreational and aesthetic			Arranging your life in the best possible way is source of hope and happiness, Travelling, enjoying comfort and cosiness, want to be at home in your own territory after an intensive travel and club period Little things	Compensating for grief with travel and clubs		

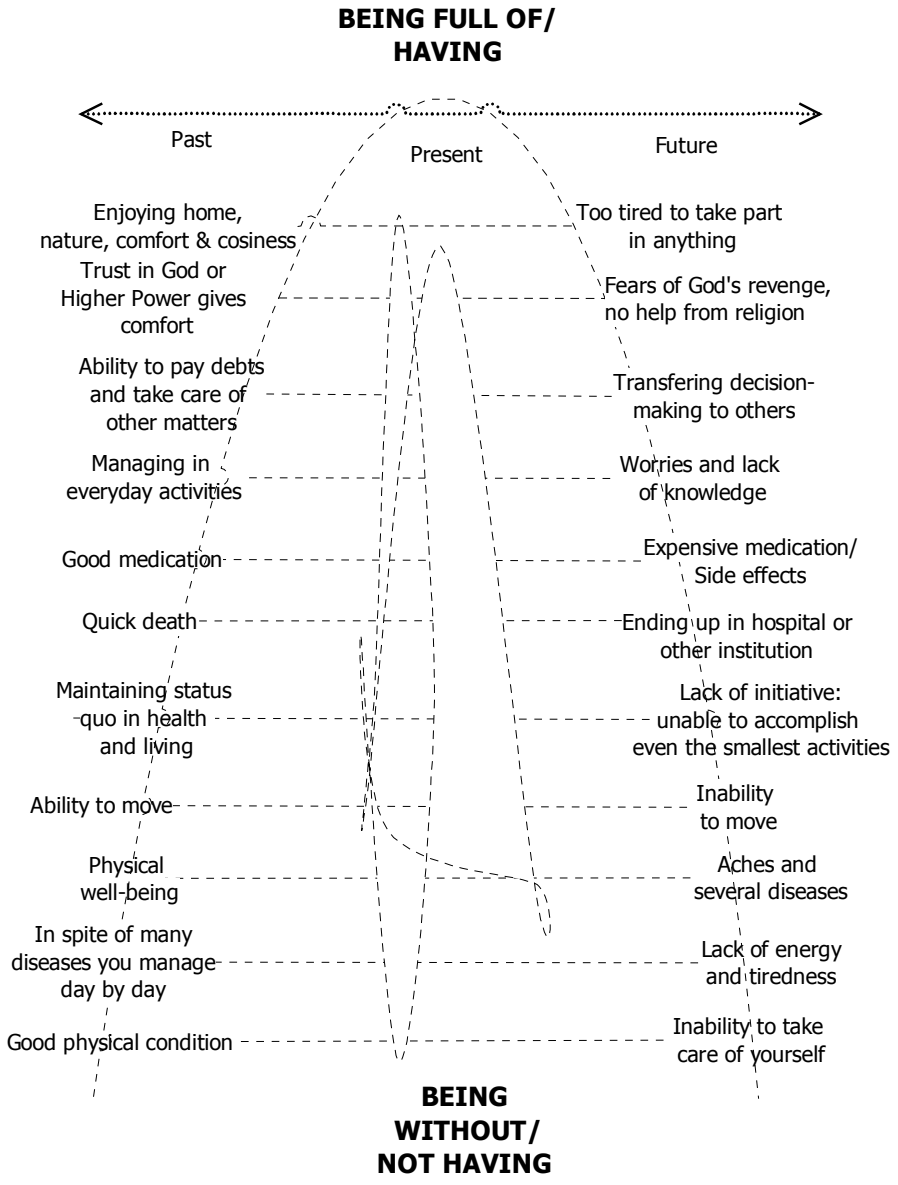
THE PROCESS OF BUILDING UP THE CORE CATEGORIES AND BSP (Basic Social Process)

The whole data produced eight dimensions: experiential, mental, interactional, emotional, practical, spiritual, recreational and aesthetic. These dimensions were built quite loosely in terms of the borders between different dimensions. The final decision, into which dimension some statement was placed, was based on the expressions of the elderly. In the lives of the depressive elderly the importance of the dimensions varied according to which phase of depression was undergone. The aesthetic dimension, which is not very much presented in nursing literature concerning depressive patients, was important in the starting phase of recovery. The hope was found in ”little things”. Human relations and health were very important dimensions in all phases, except in the most gloomy phase, when nothing seemed to have meaning according to the definitions, not even significant others, because the whole life felt ”meaningless”. Experiential, mental and emotional dimensions were central in both losing and achieving hope. The feelings, cognitive assessments and former experiences formed the frame of reference within which different aspects of life were evaluated. Especially, the thinking process and uncontrollable thoughts seemed to be very important in the self-destructive behaviour in these data. The spiritual dimension was important for those, who had faith and religious thinking. For them it was very important, ”an anchor”. This was also emphasised in cases in which the losses were in near past. Faith brought comfort. This came up in describing the transpersonal relations after the spouse’s death; common agreements to meet in the hereafter. The recreational element was often combined with human relations and especially in the phase of recovery based on former experiences of depression. The practical dimension was present all the time, because of its nature in everyday living. You had to buy food and you had to pay bills, although they were real efforts, and were also left undone in some cases, but the consciousness that they should be done, was real. In the lives of the non-depressive elderly, human relations were abundant and important, but also the feelings of autonomy and independence were strongly present. Comfort and cosiness were appreciated. The meaning of health in hope was central in both groups.

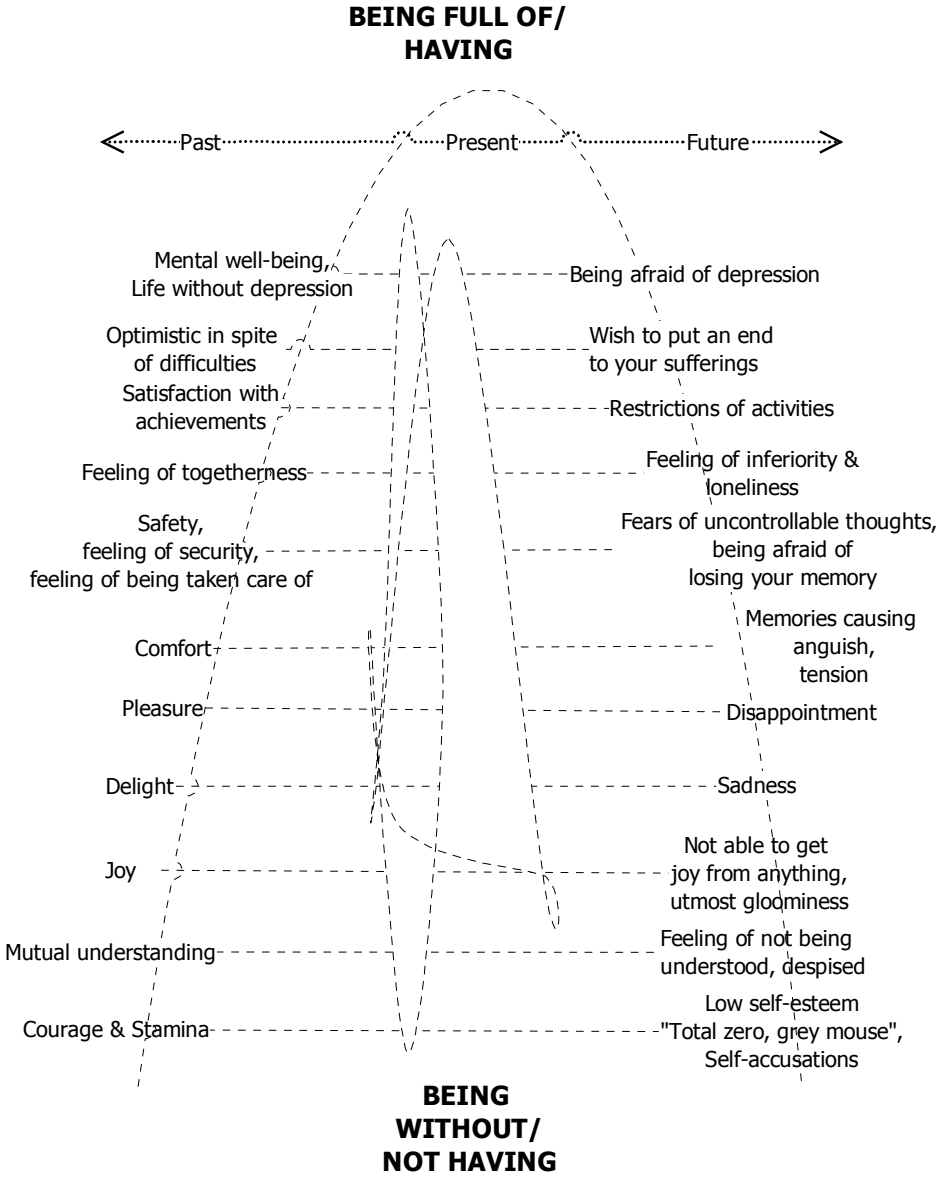
The dimensions of hope and hopelessness are defined in the following three figures as follows: 1) the BSP in experiential and interactional dimensions 2) the BSP in health and care, aesthetics, spiritual, practical and recreational dimensions 3) the BSP in mental and emotional dimensions. Although the lines in the figures show the dimensions like a dichotomy, the figure in the middle defines the nature of the hoping process as continuously evolving. First, it should be noticed that the figures should not be interpreted so that the hope-diminishing factors are all present in the lives of the depressive elderly and the hope-promoting factors in the lives of the non-depressive elderly. The factors vary depending on the life situations and the factors also affect each other on the personal level. Some factors may be present and some not in the lives of the elderly like trust in God or medication. Secondly, it should also be noticed that the ´pairs´ at the ends of the horizontal lines are not complete opposites, but are based on the data expressed in the interviews as opposite experiences (hope-promoting and hope-diminishing) and they are present in this sense in the span of experiences. Thirdly, being full of is not only a positive and being without not only a negative alternative, but they may also have an opposite sense depending on the contents of the experiences. Having many tragic situations in childhood may be a really depressing factor, and on the contrary, being without continuous worrying may be a very hopeful situation.



A combination of the experiential and interactional dimensions of hope and hopelessness in the lives of the depressive and non-depressive elderly



A combination of health and care, spiritual, aesthetic, practical and recreational dimensions of hope and hopelessness in the lives of the depressive and non-depressive elderly



A combination of mental and emotional dimensions of hope and hopelessness in the lives of the depressive and non-depressive elderly

HOPE-PROMOTING FACTORS IN THE LIVES, RELATIONS AND PERSONAL EXPERIENCES OF THE DEPRESSIVE AND NON-DEPRESSIVE ELDERLY

PRECONDITIONS

HOPE-PROMOTING:
Life:
- Poor but safe situation
- Hard work
- Saving
- Good physical condition
- Experiences of managing
- Joy
- Expectation
- Creating possibilities

Relations:
- Interaction with spouse, children, grandchildren and friends
- New contacts in groups
- Trust
- Health Care (HC) personnel
- Spiritual life

Personal experiences:
- Health
- Mobility
- Managing in EDL
- Ability to maintain present situation
- Avoiding helplessness

CONDITIONS and PROCESSES

HOPE-PROMOTING:

Life:
- Efforts to get through difficulties
- Efforts to maintain good mood
- Purposeful attitude
- Adjusting
- Accepting that difficulties belong to life
- Possibility and trust in getting help from others
- Trust in finding your way out
- Following how things clear up
- Hobbies
- Aesthetics
- Nature
- Social activities
- Sharing experiences
- Looking forward

Relations:
- Understanding from your spouse
- Significant others
- Hope and belief in God's help and Higher Power
- Managing in EDL
- Following the success of children and grandchildren
- Arranging care
- Considering the safety matters
- Taking part in activities

Personal experiences:

CONDITIONS & PROCESSES
- Autonomy
- Independence: managing without help of others, using the elderly's own informants and knowledge base
- Pleasure
- Driving and promoting things
- Making goals come true
- Keeping on
- Avoiding giving up and stagnating
- Maintaining well-being
- Promoting care opportunities

OUTCOMES
Personal experiences:
- Life without depression
- Feeling of being taken care of
- Security in life and well-being
- Relaxation
- Human relations
- Meaningul life
- Preparedness to meet future without fears
- Experience-powered self-esteem
- After living for others the possibility to enjoy autonomy and independence

OUTCOMES

HOPE-PROMOTING:
Life:
- Managing in EDL (everyday living)
- Security
- Fearlessness
- Autonomy
- Feeling of importance
- Comfort
- Cosiness
- Joy
- Readiness to meet the future
- Easing up
- Calming down
- No longer need for more property
- Good, peaceful life at home
- Satisfaction with achievements
- Optimism in spite of difficulties

Relations:
- Feeling of togetherness and mutual understanding
- Relatedness
- Participation
- Safety
- Security
- Joy
- Comfort
- Help
- Support
- Happiness
- Faith and spiritual life
- Finding answers
- Trust

HOPE-DIMINISHING FACTORS IN THE LIVES, RELATIONS AND PERSONAL EXPERIENCES OF THE DEPRESSIVE AND NON-DEPRESSIVE ELDERLY

PRECONDITIONS

HOPE-DIMINISHING:
Life:
- Restrictions in physical, social and economic resources
- Problems in health and marriage
- Hindrances in actions and interactions
- Problems in taking care of activities and matters
- Lack of knowledge of how to get care

Relations:
- Problems in interaction with others
- Losses of significant others
- Illnesses
- Lack of knowledge
- Lack of self-esteem

Personal experiences:
- Lack of physical and psychological well-being
- Mental problems and restrictions
- Lack of joy, energy, initiative, balance in life, self-esteem and knowledge
- Losses
- Fears
- Increasing time needed to manage in activities

CONDITIONS and PROCESSES

HOPE-DIMINISHING:
Life:
- Inactivity
- Fears
- Worries
- Tension
- Feeling of inferiority
- Need of stubborness
- Negative and violent interaction

Relations:
- Distressing memories
- Experienced violence and malice
- Problems, divorces and fate of children and grandchildren
- Unsatisfactory relationships
- Disagreements in marriage
- Insufficient information about care
- Losses

Personal experiences:
- Fearing
- Prioritizing others
- Worrying
- Incapability in decision-making, participating, being, taking care of even the smallest activities
- Suffering
- Losing mobility, ability to manage, cognitive capacity and dignity
- Hindrances in participation

OUTCOMES

HOPE-DIMINISHING:
Life:
- Insecurity
- Helplessness
- Lack of self-esteem and self-control
- Increasing amount of time needed in managing activities
- Adjusting
- Fears
- Loneliness
- Downhill
- Inability to cope with duties
- Unrealised dreams
- Gloomy visions caused by the realities of life
- 'This age'

Relations:
- Feeling of not being understood
- Loneliness
- Disappointments
- Sadness
- Uselessness
- Not even comfort from religion
- Problems in getting official care
- Problems in the quality of care
- Postponing grief
- Worries in HR (human relations)
- Insecurity

Personal experiences:
- Helplessness
- Inability to get joy from anything
- Insufficient economic resources
- Unsuccessful operations and treatments
- Hopeless thoughts
- Disappointments
- You are too old to get care at 'this age' when you really need it
- The most hopeless situation/vision is to be confined to bed in an institution
- Losing the meaning in life
- Wish to put an end to your suffering