Effectiveness of Snyder's Hope Theory as a Nursing Motivational Model on Self-Compassion, Depression and Quality of Life among Women with Ovarian Cancer

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ABSTRACT

Background: Women's quality of life might be negatively impacted by the complicated treatment process and severe depression that can accompany an ovarian cancer diagnosis. Planning to increase these women's hope in light of Snyder's hope theory thus appears to be essential. **Aim:** To evaluate the effectiveness of Snyder's hope theory as a nursing motivational model on self-compassion, depression and quality of life among women with ovarian cancer. **Design:** a quasi-experimental research design with two groups ("control/ study"). **Settings:** Clinical oncology,obstetrics and gynecology departments and outpatient clinics at Benha University hospitals in the Qaliobya governorate, Egypt. **Study Sample*:***A Purposive sample of 42 women diagnosed with ovarian cancer meeting inclusion/exclusion criteria. **Tools:** A structured interviewing questionnaire, Herth hope index, self-compassion scale, Beck's depression inventory, quality of life Instrument-ovarian cancer patient version. **Results**: After the application of nursing motivational model based on Snyder's hope theory was used, there were highly statistically significant differences between the study and control groups in terms of women's knowledge, Herth hope index, self-compassion, depression, and quality of life. **Conclusion:** The Snyder's hope theory-based nursing motivational model significantly improves the knowledge, self-compassion, and quality of life of women with ovarian cancer. Furthermore, it guided the woman actively confront the problems, lower level of depression, and enhancing hope for life. **Recommendations:** Women with ovarian cancer should be educated and managed using the Snyder's Hope Theory as an effective motivational paradigm

Keywords:Depression, Nursing Motivational Model, Ovarian Cancer, Quality of Life, Self-Compassion, Snyder's Hope Theory

INTRODUCTION

One of the most fatal gynecological cancers is ovarian cancer (OC), which has the second-highest incidence rate among malignant tumors and the highest death rate. 70% of women with OC are diagnosed in advanced stages (III or IV) since OC is difficult to detect in its early stages due to its sneaky beginning. Although it makes up just about 23% of all gynecological cancer diagnoses, OC is the cause of 47% of all gynecological cancer fatalities ***(Fan et al., 2024: Benna-Doyle et al., 2024).*** High levels of aggression, severe morbidity and mortality, and the absence of obvious symptoms are some of its defining characteristics, which collectively pose significant challenges for early detection ***(Fu et al., 2024).***

The risk of developing OC rises, as woman age. Ovarian cancer typically appears after menopause. Additionally, it is more prevalent among women who have had more ovulations during their lives. Those who have never had children, those who started ovulation earlier in life, and those who enter menopause later in life are all included in this. Hormone replacement therapy, genetics, family history, fertility drugs, nulliparity, and obesity are additional risk factors. Pregnancy, breastfeeding, and hormonal birth control are risk-reducing factors ***(Smith et al., 2024).***

Facing a life-threatening disease as OC can be an incredibly challenging and distressing experience. One internal defense mechanism that can be used when dealing with emotional, bodily, or mental suffering is self-compassion. Research from women with illnesses (such OC) shows that having a high level of self-compassion is linked to better QOL and less psychological and disease-specific discomfort ***(Sullivan-Myers et al., 2023).*** Women who practice self-compassion can develop a sympathetic and understanding relationship with themselves, which helps to lessen the detrimental effects of fertility-related depression ***(Sahraian et al., 2024).*** Psychological resilience can be enhanced by self-compassion, which enables women to manage stress, maintain a positive outlook, and adopt adaptive behaviors ***(Ahmad and Khanum, 2024).***

Women with ovarian cancer experience both physical symptoms as well as a myriad of psychosocial concerns. Because it is associated with mortality, it produces a great deal of anxiety, sadness, and uncertainty ***(Miller et al., 2024).*** Depression and other mental health issues impact the quality of life for women with OC and exacerbate the disease's symptoms. Two of the most common reasons of depression may be the loss of reproductive function and the inability to afford costly medical care. Given the importance of women as the backbone of the family and the need to attend to both their physical and mental health, it is imperative to assess their physical and mental health at the time of OC ***(Ghamari et al., 2023)***.

Quality of life (QOL) is a significant consequence for women with OC. The role of QOL is paramount in evaluating the nursing outcomes of cancer women ***(Xiong et al., 2024).*** Most women with OC start treatment with some QOL dysfunction, probably due to the severity of their symptoms at presentation, because most of them appear in advanced stages. QOL can be tracked to record these women's needs and shortcomings ***(Dana et al., 2023).*** QOL is a crucial area of care for women with OC since it has been linked to an improved prognosis. Finding modifiable elements that could affect QOL in women with ovarian cancer could assist guide treatment and enhance results ***(Ross et al., 2020).*** Nonetheless, the illness and its therapies have a profound influence on women, resulting in bodily alterations and psychological repercussions, such as psychosocial and psychosexual effects, that lower their QOL ***(Gil-Ibanez et al., 2023).***

A cancer diagnosis can negatively affect a woman's ability to do a variety of tasks, such as psychological adaptability and hope for the future ***(Sharifpour et al., 2024).*** Snyder's hope theory states that hope is a combination of three interconnected elements—goals, pathways, and agency—that make up goal-oriented thinking. This "hope therapy," which has become widely employed in the medical field, is mainly intended to assist women in alleviating negative emotions, improving their capacity for self-control, and encouraging rehabilitation. For women with malignant tumors, Snyder's hope hypothesis in nursing has been demonstrated to help women sense hope and lessen stigma ***(Du et al., 2024).*** Because hope activates peripheral circuits that release endorphins, it can have a good impact on the regulation of pain and physical

weakness, lowering pain and enhancing daily living abilities ***(Hedayatian and Ebrahimi, 2024).***

A holistic approach to cancer care should incorporate nursing interventions to help women who are burdened by unmet needs ***(DiSipio et al., 2024)***. Women with OC receive specialized, easily accessible, and knowledgeable care from the specialist nurse. In order to enable women to live well and attain the greatest possible health in the future, oncology nurses are essential in the assessment, education, symptom management, and supportive care of women. Giving advice and assistance on leading a healthy lifestyle, preventing and controlling disease, and aiming for a long lifespan and high QOL ***(Miller et al., 2024).*** Furthermore, in order to provide effective preventive and therapeutic interventions, it is necessary to thoroughly evaluate the potentially traumatic load of OC and its correlation with depressive symptoms for their effects on women's global functioning ***(Carmassi et al., 2024).*** Furthermore, for both women and caregivers, holding onto hope is a key tenet across the cancer care spectrum ***(Lutgendorf et al., 2024).***

Significance of the research

Ovarian cancer is the fifth most prevalent cause of cancer-related mortality in women worldwide and is regarded as the deadliest gynecologic cancer. The absence of reliable screening methods and distinguishing symptoms often result in delayed diagnosis, typically at an advanced stage, leading to a 5-year survival rate of 29% and a high recurrence rate, currently at 75% ***(Chen and Liu, 2024).*** OC is predicted to rank as the second most deadly gynecologic disease in 2024 ***(Gitto et al., 2024).*** An estimated 207,000 women worldwide lose their lives to OC each year, and by 2040, that number is expected to rise by 50%. The high death rate is caused by the absence of disease symptoms, which prevents early detection and results in minimal progress in therapy ***(Yeoh et al., 2024).***

Ovarian cancer is the second most common malignancy in females in Egypt. Primary malignant ovarian tumors account for 42.76% of all ovarian lesions, 32.58% of

female genital tract malignancies, and 1.82% of all primary malignant neoplasms, according to the most recent Egyptian National Cancer Institute (NCI) cancer registry. Of all ovarian malignancies, serous carcinoma makes up 46.38%, whereas malignant ovarian surface epithelial tumors make up 49.16% ***(Amin et al., 2023).***

Women who have OC are more likely to experience mental health issues, depression, and distress. With a high chance of recurrence and the need for numerous treatment lines, diagnosis is frequently postponed. These women's biology and QOL outcomes may be impacted by their mental health and social support. It has been demonstrated that social support is linked to improved psychosocial functioning as well as decreased levels of general distress and depression ***(Telles et al., 2024).*** Furthermore, a number of female reproductive problems have been linked to depression. According to estimates, about 27% of women with OC have it ***(Ling et al., 2024).*** It is essential to comprehend how self-compassion, anxiety, and depression interact in order to protect cancer women's psychological wellbeing ***(Unal and Ordu, 2023).***

AIM OF THE RESEARCH:

The study was aimed to evaluate the effectiveness of Snyder's hope theory as a nursing motivational model on self-compassion, depression and quality of life among women with ovarian cancer. This aim achieved through the following objectives:

1. Assessment of women's knowledge, self-compassion, depression and quality of life regarding ovarian cancer.
2. Designing nursing motivational model based on Snyder's hope theory.
3. Implementing nursing motivational model based on Snyder's hope theory.
4. Evaluating women's knowledge, self-compassion, depression and quality of life regarding ovarian cancer.

Research hypotheses

H1: Women who will receive nursing motivational model based on Snyder's hope theory will have a higher level of knowledge, self-compassion and quality of life than those who will not receive it.

H2: Women who will receive nursing motivational model based on Snyder's hope theory will have less level of depression than those who will not receive it.

H3: Women who will receive nursing motivational model based on Snyder's hope theory will have better hope for life than those who will not receive it.

Operational definition:

Snyder's Hope Theory: according to a motivational nursing model, hope is a result of three main factors—goals, pathways, and agency—that work together to either increase or decrease hope. According to Snyder, goals are the objects of one's aspirational planning, pathways are the accessible means to reach a specific objective, and agency is the drive to pursue goals despite barriers related to OC ***(Feldman and Corn, 2023).***

Conceptual definitions:

Self-compassion: is a strategy for controlling emotions that consists of three interconnected elements: self-kindness (as opposed to self-criticism), attentive awareness, and a sense of shared humanity (as opposed to self-isolation) ***(Sullivan-Myers et al., 2023).***

Quality of Life: the way women view their role in life in relation to their objectives, standards, expectations, and worries, as well as the culture and value systems in which they live ***(Gil-Ibanez et al., 2023).***

Depression: a mental illness that leads women with OC to experience ongoing emotions of melancholy, despondency, disinterest, and low energy ***(Shapiro et al., 2024).***

SUBJECTS AND METHOD

Research Design:

To accomplish the aim of this research, a quasi-experimental research design with two groups ("control/study") was used.

Research Settings:

The study was carried out in the clinical oncology and obstetrics and gynecology departments of Benha University hospitals in the Qaliobya governorate, Egypt, as well as its outpatient clinics of both departments.

Sampling:

Type, size, criteria, and methodology of the sample: From the aforementioned research settings, 42 women with a medical diagnosis of OC were chosen as a purposive sample. At the end of 2023, there were 420 women with an OC diagnosis, according to the Benha University Hospitals statistical center, 2023. Forty-two women, or 10% of the flow rate, were chosen

The sample was split into two groups at random: 21 women in the study group received routine hospital care together with the nursing motivational model application based on Snyder's hope theory, and 21 women in the control group received simply routine hospital care. The women were randomly assigned to the study group in the first month and control group in the second month in order to prevent bias in the data gathering process. The following inclusion and exclusion criteria were used in the selection of the examined sample:

Inclusion criteria were:

- Women who were diagnosed with OC based on histopathology.
- Women under 65 years of age or of comparable age.
- Married women.
- No history of serious psychiatric disorders, such as depression, schizophrenia, or other mood or psychotic diseases

Exclusion criteria were:

- Women who suffer from any other chronic medical illnesses.
- Existence of malignant tumors or cancer metastases in other bodily parts.
- Recent use of antidepressants and anxiety medications.
- Cognitive impairment prevents the ability to complete questionnaires.

Tools of data collection:

Five tools were used for data collection:

Tool I: A structured Interviewing questionnaire: After examining relevant literature, the researchers created it and translated it into Arabic. It included two parts:

Part (1): **Personal characteristics of studied women:** It included six items: age, residence, level of education, occupation, year since diagnosis of ovarian cancer and history of existing ovarian cancer among the relatives.

Part (2): **Women's knowledge questionnaire:** Researchers created it after reading pertinent literatures ***(Ali and Jasim, 2022; Mosconi et al., 2022 and Awwad et al., 2021)*** to evaluate women's knowledge about ovarian cancer. There were eleven questions regarding meaning of cervical cancer, types, risk factors, causes, physical symptoms, psychological symptoms, diagnosis, complications, screening methods, prevention and treatment.

Scoring System:

The correct answer was scored as "1" and the incorrect "0". The sum of the scores for each question was used to get the overall knowledge score. Higher scores indicated a greater understanding of OC. ***The total knowledge score was classified as the following:***

- Inadequate knowledge: < 60% = 0-6 score
- Adequate knowledge: 60% to 100% = 7-11 score

Tool II: Herth hope index (HHI): Women's hope levels were assessed both before and after the intervention. It was adopted from ***(Herth, 1992)*** It comprised three dimensions with twelve items split up as follows: items 1, 2, 6, and 11 that represented positive attitudes toward reality and the future; items 4, 7, 10, and 12 that represented positive actions; and items 3, 5, 8, and 9 that represented sustaining strong relationships with others.

Scoring system:

On a 4-point Likert scale, each single-item score varied from 1 to 4 as follows: 1 (strongly disagree), 2 (disagree), 3 (agree) to 4 (strongly agree) with reverse items (3 and 6). The scale's overall score falls between 12 and 48. The more optimistic a patient is, the higher their score. ***The total scoring was categorized as following:***

- Low hope level = 12–23 score.
- Medium hope level = 24–35 score.
- High hope level = 36–48 score.

Tool III: Self-Compassion Scale (SCS): It was used to assess women's self-compassion before and after intervention. It was adopted from ***(Neff, 2003)*** and translated by ***(Mantzios et al., 2015)*** to the Greek version. It is a 26-item Self-Compassion Scale that divided into 7 subscales as following:

- ***5 items*** Self-Kindness subscale: ***5, 12, 19, 23, 26*** (*e.g., "I try to be understanding and patient toward aspects of my personality I don't like"*)
- ***5-items*** Self-Judgment subscale (reverse scored): ***1, 8, 11, 16, 21*** (*e.g., "I'm disapproving and judgmental about my own flaws and inadequacies"*)
- ***4-items*** Common Humanity subscale: ***3, 7, 10, 15*** (*e.g., "I try to see my failings as part of the human condition"*)
- ***4-items*** Isolation subscale: ***4, 13, 18, 25*** (*e.g., "When I think about my inadequacies it tends to make me feel more separate and cut off from the rest of the world"*)
- ***4-items*** Mindfulness subscale: ***9, 14, 17, 22*** (*e.g., "When something painful happens I try to take a balanced view of the situation"*)
- ***4-items*** Over-identification subscale (reverse scored): ***2, 6, 20, 24*** (*e.g., "When I'm feeling down I tend to obsess and fixate on everything that's wrong."*).

Scoring System:

A 5-point rating system, with 1 denoting "Almost Never" and 5 denoting "Almost Always," was used to collect responses. Following the reverse-coding of negative items, the mean scores on the six subscales were summed to produce an overall self-compassion score that ranged from 26 to 130. Higher self-compassion scores are correlated with higher scores.

Tool IV: Beck's Depression Inventory (BDI-II): It was adopted from ***(Whisman, 2000)***. It was designed to assess the degree of depression in women and comprises of 21 sets of statements the woman was told to carefully read each set of statements in order to determine which statement best reflected her feelings throughout the previous two weeks, including today. Circle the set's greatest number if many statements appear to apply equally well.

Scoring System:

The depression score may be computed by summing the scores for each of the twenty-one statements. The scale ranged from 0 (best feeling) to 3 (worst feeling). Zero

and sixty-three would be the lowest and highest possible scores for the entire test, as the lowest and highest possible scores for each statement are 0 and 3. The worst feeling was indicated by a higher score. ***The total depression score could be classified according to the following:***

- 1-10: These are normal ups and downs
- 11-16: Mild mood disturbance
- 17-20: Borderline clinical depression
- 21-30: Moderate depression
- 31-40: Severe depression
- Over 40: Extreme depression

Tool V: Quality of Life Instrument--Ovarian Cancer Patient Version: It was adapted from ***(Ersek et al., 1996)*** and revised by ***(Ferrell et al., 2002).*** This 45-item tool was used to look at four aspects of ovarian cancer women's QOL, including:

- Physical wellbeing (9 items) (e.g. fatigue, appetite changes, general aches or pain, sleep changes, constipation …etc).
- Psychological wellbeing (18 items) (e.g. difficulty to cope today as a result of disease and treatment, feeling of happiness, control of things in the life…etc).
- Social wellbeing (10 items) (e.g. distressing of illness on family, amount of support received from others to meet your needs, personal relationships…etc).
- Spiritual wellbeing (8 items) (e.g. participation in religious activities such as praying, spiritual activities such as meditation, changing in spiritual life as a result of cancer diagnosis…etc).

Scoring System:

A scale from 0 (worst outcome) to 10 (highest outcome) was used for scoring. The best QOL was indicated with a higher score. The researchers had to reverse the ratings of a number of items since their anchors were inverted. Items 1–8, 10, 17–28, 30-37, 41, and 45 need to be inverted. The total QOL score was between 0 and 450.

Better QOL was indicated by a higher score. ***The total scoring was categorized as following:***

- Low QOL if total score < 50% = 0–224 score.
- Moderate QOL if total score 50% - < 75% = 225–337 score.
- High QOL if total score ≥ 75% = 338–450 score.

Administrative approval:

In order to obtain consent for the study, the dean of the faculty of nursing provided formal written approval, which was subsequently submitted to the director of Benha University Hospitals after the research's purpose was clarified.

Tools validity:

Three jury experts from Benha University's obstetrics and gynecological nursing program assessed the validity of the questionnaires to make sure they were clear, pertinent, thorough, and applicable. There was nothing to change. The instruments were regarded as legitimate by the experts.

Tools reliability:

The Cronbach's Alpha coefficient test was used to assess the tools' reliability, and the results showed that the research tools' internal consistency was as follows:

Tool	Cronbach's alpha value
Tool I: Women's knowledge questionnaire.	Internal consistency (α =0. 79) .
Tool II: Herth hope index (HHI).	Internal consistency (α =0. 85) .
Tool III: Self-Compassion Scale (SCS).	Internal consistency (α =0. 91) .
Tool IV: Beck's Depression Inventory (BDI-II).	Internal consistency (α =0. 89) .

Tool V: Quality of Life Instrument-Ovarian Cancer Patient Version.	Internal consistency (Overall α =0.93) (Spiritual α =0.71) (Physical α =0.77) (Social α =0.81) (Psychological α =0.89).

Ethical consideration:

Before the study begins, the following ethical considerations were made: The scientific research ethics committee (REC-OBSN-P61) of Benha University's nursing faculty granted research approval for the study's completion. The chosen study settings formally granted permission for the study to be conducted. Prior to using the instruments, the researchers gained the trust of the women by outlining the purpose and significance of the study. Women gave the researchers their formal agreement to take part in the study, and confidentiality was guaranteed. There were no dangers to the women's physical, social, or mental health during the study. After statistical analysis, all data gathering instruments were burnt to protect the privacy of the women who took part. The study's instruments made sure that it respected human rights and contained no unethical remarks. The women could leave the research at any moment.

Pilot study:

Ten percent of the sample size, or four women, participated in the pilot study to test the tools' objectivity, clarity, feasibility, and applicability. It also aimed to identify any obstacles that might arise for the researchers and impede data collection, as well as any issues that might be specific to the statements, such as the order of the questions or their clarity. Estimating the time required for data gathering was also beneficial. Based on the pilot results, no changes were made. Because of the comparatively limited number of cases, the pilot sample was included in the research.

Field work:

The research was conducted over nine months, starting in early January 2024 and completed at the end of September 2024. The researchers went to the aforementioned settings three times a week (on Saturdays, Mondays, and Wednesdays) from 9:00 a.m. to 1:00 p.m. till the predefined size was completed. Before or after gynecological and oncological consultation, the researchers conducted individual or small-group interviews with the women; on average, 1-2 women were questioned per week. In order to spread the advantage, the handout (booklet) from this research was placed in research settings and given to all women who had OC.

The following five phases were used to carry out the current research: preparatory phase, interviewing and assessment phase, planning phase, implementation phase, evaluation phase and break phase.

Preparatory phase:

The first stage of the research process is called the preparatory phase, during which the researchers examined relevant local and international literature regarding the research problem. This aided the researchers in understanding the scope and gravity of the problem and directed them in preparing the necessary instruments for gathering data. Three obstetrics and gynecological nursing experts from Benha University's faculty were given the instruments, and the jury outcomes were completed.

Interviewing and assessment phase:

To find women who met the inclusion requirements, the researchers visited the designated settings and reviewed clinical records. Early in the interview the researchers greeted the women, outlined themselves, explained the goal of the research, informed the women in the study group of the number and frequency of educational sessions based on Snyder's hope theory to ensure their adherence to interventions, and obtained their signed consent to participate in the research. Interviews with the women in the study and control groups were conducted first to gauge their personal characteristics

and then to gauge their knowledge regarding OC ***(Tool: I)***. The researchers next used ***(Tool: II)*** to gauge the women's level of hope, ***(Tool: III)*** to gauge self-compassion of the women, and ***(Tool: IV)*** to gauge their degree of depression and characterize their feelings during the previous two weeks. Lastly, the QOL of women with OC was investigated using ***(Tool: V).*** The average time to complete each tool was between 10 and 20 minutes.

Planning phase:

Based on the findings from the assessment phase, the researchers created educational sessions using a nursing motivational model based on Snyder's hope theory for OC. These sessions were presented as a printed booklet with colored illustrations. The booklet was created especially in simple Arabic to meet the study women's knowledge gaps and to fit their comprehension level. The number of sessions, their topics, and the various teaching modalities and educational materials are decided. Objectives were designed to be achieved once the intervention was over. The overall Objective of the educational sessions was for each woman to get basic understanding about OC, improve her QOL and self-compassion, and experience less depression.

Implementation phase:

For control group

Without any additional intervention from the researchers, the control group's women got standard hospital care from the responsible health personnel. The women of control group were followed and evaluated as the same in the study group.

For study group

On the basis of routine care, the study group's women participants were given a nursing motivational model based on Snyder's hope theory. Following the conclusion of the assessment phase, the model was applied throughout the course of four planned sessions spread over four weeks in a row (session each week), each lasting 40 to 60

minutes based on their performance and feedback. To provide greater anonymity, each woman attended all four sessions in a private, prepared room in the previously described settings. Interviews were conducted one-on-one or in groups, depending on the woman's preference (three to five women can attend each session).

Couples were given an overview of the first session's contents at the start. The next session began with a review of the previous one and the objectives of the new one. To accommodate women's comprehension levels, basic Arabic was employed. A few minutes were set out at the conclusion of each session to allow women to ask questions in order to clear up any confusion and clarify the session's contents. Every woman was notified of the next session's time.

- ***A. 1st session* (*knowledge regarding ovarian cancer).*** Improving information of ovarian cancer, including its definition, types, risk factors, causes, physical and psychological symptoms, diagnosis, complications, screening methods, prevention, and treatment, was the first stage of this model.
- **B. *2nd session (Correct the women's wrong perception).*** The second phase of this approach focused on changing the inaccurate impression of ovarian cancer, as some of these women had lost hope on life. To address this, the researchers educated women about the disease, offered them treatment options and communicated to them in an empathetic way. Additionally, in order to give women health education and inspire them to face reality, researchers not only use multimedia, lectures and instructional booklets, but they also highlight successful recovery stories to give women hope for the future. This helps women accurately assess their condition, improves their poor cognitive function, boosts their self-esteem and increases treatment compliance.
- ***C. 3rd session (Clear life goals).*** In this phase, the researchers assisted women in creating attainable life objectives. For example, they gave women instructions on how to listen to music or perform their favorite exercise to reduce anxiety and depression. The researchers support women and completing daily goals, as well as providing encouragement and positive

reinforcement when the goals have been achieved. After examining the reasons behind the failure, the researchers urged the women who had not reached their goals to try again and to keep up their commitment to their life objectives. Women's emotional and physical fitness were modified when the researchers assisted them in performing certain everyday tasks; this lessened the impact of unpleasant emotions, decreased their level of exhaustion and increased their self-compassion and optimism about survival.

D. ***4th session (Establish a good family social support system).*** In this step, the researchers educate the families of the women about the health benefits of companionship and urge them to support their loved ones by being there for them during the treatment process. This helps to meet the psychological needs of the women and boosts the confidence of the women in their ability to overcome ovarian cancer. In addition, the researchers advised the women to establish social connections with their friends, solicit their moral support, and extend an invitation to their friends to take part in the therapy. Following hospital discharge, nurses made an effort to stay in touch with women via phone calls, video chats, visits and other means to boost their confidence in going back to their social lives and, as a result, increase treatment compliance.

Lectures, group discussions, downloaded videos, critical thinking, problem solving, and brainstorming were among the several teaching techniques that were employed. In order to accomplish its objectives, the booklet was given to all recruited women from the first session, along with useful resources like laptop and PowerPoint presentations. Additionally, stickers and flyers that highlight the ideas and the impact of the nursing motivational model based on Snyder's hope theory are examples of supportive tools that the researchers employed as stimulus control to encourage desired changes.

The break phase:

In order to ensure that the women followed the instructions, the researchers followed up with them via phone calls or social media, such as WhatsApp messages, during the time between the application and evaluation phases. They also conducted educational sessions to address the women's questions and improve application.

After the women were released from the hospital, the researchers made an effort to stay in touch with them by video or any other easily available means in order to give them the confidence they needed to resume their social lives. In order to prevent research bias, the women in the control group were also monitored by telephone to prevent them from discontinuing the research, but they were not given any extra care during a break.

Evaluation phase:

Using the same pretest approach, the effect of the motivational nursing model based on Snyder's hope theory application was evaluated. A post-test was first administered to the control group and subsequently to the study group. This was done twice, one month and three months following the last educational session. Additionally, in accordance with research ethical guidelines, the control group's women received the booklet that the researchers had created once the research was finished.

Statistical analysis:

Data were checked before being entered into the computer. Using the proper statistical techniques and tests, the gathered data will be arranged, coded, computerized and analyzed. Version 25.0 of the Statistical Package for Social Sciences (SPSS) was employed. Means, standard deviations, and frequencies and percentages were examples of descriptive statistics. The research hypotheses were tested using inferential statistics such as the independent t-test and the Chi-square test. The relationship between the study variables' total scores was examined using the correlation coefficient. P-value > 0.05 denoted no statistically significant difference, p-value <0.05 denoted a statistically

significant difference, and p-value $P \leq 0.001$ denoted a highly statistically significant difference for all statistical tests performed.

RESULTS

Table (1): clarifies that the control and study groups (57.1% and 66.7%, respectively) had mean ages of 48.57±11.99 and 50.71±8.06 years old respectively, falling into the same age range (40–60 years). In terms of residence, the control group resided in a rural region, while the study group did the same (71.4% & 61.9%) respectively. In terms of level of education, it was shown that 52.4% and 57.1% of the control and study groups, respectively, had completed secondary education. Housewives made comprised 81.0% and 85.7% of the control and study groups, respectively. Additionally, 57.1% and 52.4% of the control and study groups, respectively, stated that they were diagnosed one year ago, and every member of both groups stated that there was no history of existing ovarian cancer among the relatives. Consequently, no statistically significant difference in personal characteristics reflecting group homogeneity was found between the control and study groups ($p > 0.05$).

Table (2): demonstrates that, with regard to all items of knowledge concerning OC prior to intervention, there was no statistically significant difference between the study and control groups ($P > 0.05$). Following the intervention, there was a statistically significant difference between the study and control groups ($P < 0.001$).

Figure (1): shows that before intervention, 38.1% and 42.9% of the study and control groups respectively, had adequate knowledge about OC. Following the intervention, however, 85.7% and 47.6% of the study and control groups, respectively, had adequate knowledge about OC.

Table (3):

demonstrates that the total mean score of all Herth Hope Index items before to intervention did not differ statistically significantly between the study and control

groups (P>0.05). Nonetheless, the study group's overall mean score across all Herth Hope Index items was considerably higher than the control group's scores at one and three months following the intervention (P≤0.001).

Figure (2): shows that, before to intervention, 0.0% and 9.5% of the study and control groups, respectively, showed high levels of hope regarding OC. At one month and three months following the intervention, the study and control groups, respectively, reported a high level of hope regarding OC (38.1% and 14.3%) compared to 42.9% and 14.3%.

Table (4): elaborates that the two groups' pre-intervention mean scores on the self-compassion scale and its subscales did not differ statistically significantly (p > 0.05). The study group's overall mean score on all self-compassion subscales was considerably higher than the control group's at one and three months following the intervention (P≤0.001).

Figure (3): shows that the study and control groups' respective total mean scores for self-compassion were 90.57 and 91.23 prior to the intervention. However, the study group's overall mean self-compassion scores increased significantly compared to the control group one and three months after the intervention (94.28 and 96.95 versus 114.38 and 119.85, respectively).

Table (5): explains that the two groups' pre-intervention total mean depression scores did not differ statistically significantly (p > 0.05). In the meantime, the study group's overall mean depression score was considerably lower than the control group's at one- and three-months following intervention (P≤0.001).

Figure (4): demonstrates that prior to intervention, the study and control groups' respective total mean depression levels were 33.76 and 34.38. However, one and three months after the intervention, the study group's overall mean depression scores fell sharply from 32.95 and 32.10 to 21.05 and 19.24 in the control group.

Table (6): shows that the two groups' preintervention mean scores for the QOL and its subscales for OC patients did not differ statistically significantly ($p > 0.05$). In the meantime, the study group's overall mean score across all OC patient QOL subscales was considerably higher than the control group's scores at one- and three-months following intervention ($P \leq 0.001$).

Figure (5): illustrates that the study and control groups had high levels of OC patient QOL before to intervention (4.8% and 14.3%, respectively). In the meantime, the study and control groups showed high levels of OC patient QOL one month and three months after intervention (47.6% and 19.0%, respectively) compared to 57.1% and 19.1%, respectively.

Table (7): explains that, before to, one and three months following the intervention, there was a highly significant statistical positive association between the total hope score and the total scores of self-compassion, depression, and QOL in both groups ($P \leq 0.001$).

Table (1) Distribution of the studied women in both groups (control and study) according to their personal characteristics (n=42).

Personal characteristics	Control group n=21		Study group n=21		FET/X^2	P value
	No	%	No	%		
Age (years):						
<40	4	19.0	1	4.8		
40 – 60	12	57.1	14	66.7	**2.04**	**0.360**
>60	5	23.8	6	28.6		
Mean ± SD =	48.57±11.99		50.71±8.06		**Independent t= 0.679**	**0.501**
Residence:						
Rural	15	71.4	13	61.9	**0.429**	**0.513**
Urban	6	28.6	8	38.1		
Level of education:						
Basic education	3	14.3	5	23.8		
Secondary education	11	52.4	12	57.1	**1.36**	**0.506**
University education	7	33.3	4	19.0		
Occupation:						
Housewife	17	81.0	18	85.7	**0.171**	**0.679**
Working	4	19.0	3	14.3		
Year since diagnosis of ovarian cancer:						
1 year	12	57.1	11	52.4		
2 years	9	42.9	8	38.1	**2.10**	**0.350**
3 or more years	0	0.0	2	9.5		
History of existing ovarian cancer among the relatives:						
Yes	0	0.0	0	0.0	-	-
No	21	100.0	21	100.0		

Table (2): Distribution of the studied sample in both groups according to their knowledge regarding ovarian cancer before and after the intervention (n=44).

Knowledge Items	Before intervention				X^2	P value	After intervention				X^2	P value
	Control group n=21		Study group n=21				Control group n=21		Study group n=21			
	Correct answer		Correct answer				Correct answer		Correct answer			
	No.	%	No.	%			No.	%	No.	%		
Meaning of ovarian cancer	12	57.1	10	47.6	**0.382**	**0.537**	13	61.9	21	100.0	**9.88**	**0.002***
Types of ovarian cancer	9	42.9	8	38.1	**0.099**	**0.753**	10	47.6	20	95.2	**11.66**	**0.001****
Risk factors of ovarian cancer	7	33.3	10	47.6	**0.889**	**0.346**	10	47.6	21	100.0	**14.90**	**0.000****
Causes of ovarian cancer	7	33.3	9	42.9	**0.404**	**0.525**	9	42.9	19	90.5	**10.71**	**0.001****
Physical symptoms of ovarian cancer	13	61.9	12	57.1	**0.099**	**0.753**	13	61.9	21	100.0	**9.88**	**0.002***
Psychological symptoms of ovarian cancer	13	61.9	15	71.4	**0.429**	**0.513**	14	66.7	21	100.0	**8.40**	**0.004***
Diagnosis of ovarian cancer	14	66.7	13	61.9	**0.104**	**0.747**	14	66.7	20	95.2	**5.55**	**0.018***
Complications of ovarian cancer	14	66.7	15	71.4	**0.111**	**0.739**	15	71.4	21	100.0	**7.00**	**0.008***
Screening methods of ovarian cancer	8	38.1	9	42.9	**0.099**	**0.753**	10	47.6	19	90.5	**9.02**	**0.003***
Prevention of ovarian cancer	6	28.6	9	42.9	**0.933**	**0.334**	8	38.1	17	81.0	**8.00**	**0.005***
Treatment of ovarian cancer	14	66.7	13	61.9	**0.104**	**0.747**	16	76.2	21	100.0	**5.67**	**0.017***

No statistical significant p > 0.05 ****A highly statistically significant difference (P ≤ 0.001)**

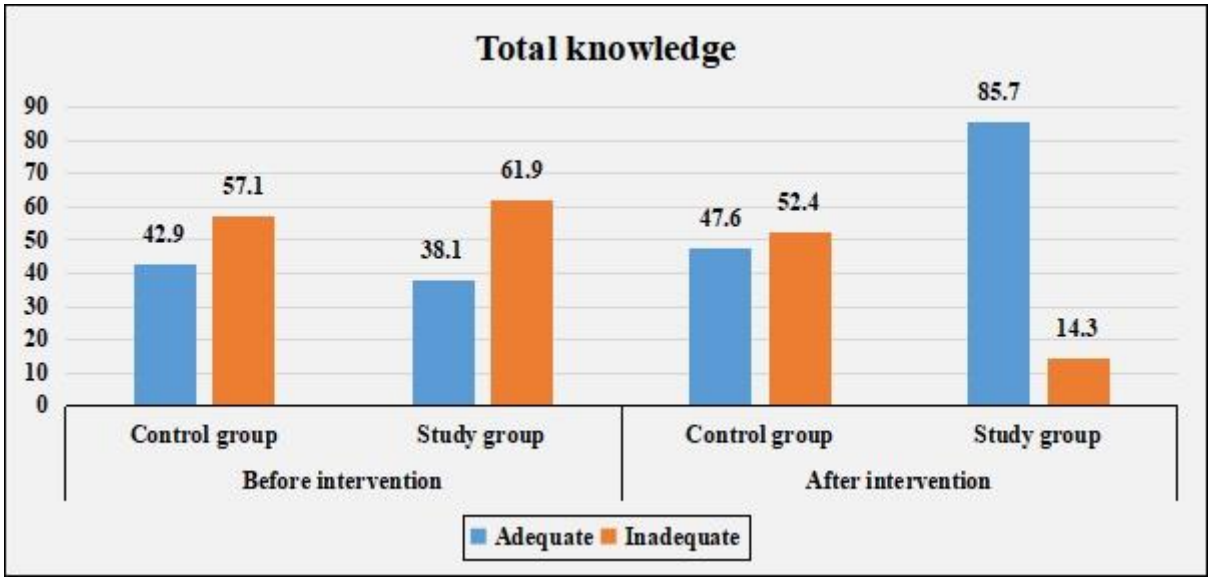

Figure (1): Distribution of studied women according to their total knowledge score regarding ovarian cancer in both groups before and after intervention (n=42).

Table (3): Mean scores of Herth hope index regarding ovarian cancer in both groups before intervention, one and three months after intervention (n=42).

Herth hope index domains and its items	Possible score	Control group n=21 Mean ± SD	Study group n=21 Mean ± SD	Independent t-test	P value
Dimension 1: Positive attitudes towards reality and the future					
Positive outlook toward life					
Before intervention	**1-4**	1.95±1.07	1.86±1.01	2.96	0.769
One month after the intervention		1.95±1.02	3.05±0.80	3.85	0.000**
Three months after the intervention		1.71±0.90	3.38±0.59	7.08	0.000**
Short and/or long-range goals					
Before intervention	**1-4**	2.29±1.05	2.00±0.89	0.946	0.410
One month after the intervention		2.43±1.02	3.43±0.67	3.72	0.001**
Three months after the intervention		2.71±1.00	3.62±0.49	3.69	0.001**
Feeling alone					
Before intervention	**1-4**	2.43±1.02	2.19±1.07	0.372	0.357
One month after the intervention		2.71±1.00	3.62±0.66	0.342	0.001**
Three months after the intervention		2.86±1.01	3.71±0.46	0.352	0.001**
Seeing possibilities in the midst of difficulties					
Before intervention	**1-4**	1.76±0.76	2.05±0.80	1.17	0.246
One month after the intervention		2.05±0.66	3.05±0.66	4.84	0.000**
Three months after the intervention		2.33±0.79	3.43±0.81	4.41	0.000**
Dimension 2: Taking positive actions					
Faith that gives me comfort					
Before intervention	**1-4**	2.62±0.66	2.81±0.75	0.869	0.390
One month after the intervention		2.81±0.60	3.52±0.68	3.60	0.001**
Three months after the intervention		2.95±0.66	3.81±0.40	5.03	0.000**
Feeling scared about my future					
Before intervention	**1-4**	1.86±0.72	1.57±0.67	1.31	0.195
One month after the intervention		2.05±0.74	3.48±0.60	6.86	0.000**
Three months after the intervention		2.29±0.95	3.76±0.53	6.16	0.000**
Recalling happy/joyful times					
Before intervention	**1-4**	2.90±0.70	2.67±0.73	1.07	0.287
One month after the intervention		3.00±0.77	3.76±0.62	3.50	0.001**
Three months after the intervention		3.14±0.72	3.90±0.30	4.43	0.000**
Deep inner strength					
Before intervention	**1-4**	1.90±0.88	1.71±0.71	0.764	0.449
One month after the intervention		2.10±0.99	3.14±0.79	3.77	0.000**
Three months after the intervention		2.33±1.15	3.52±0.81	3.86	0.000**
Dimension 3: Maintaining close relationships with others					
Ability to give and receive caring/love					
Before intervention	**1-4**	1.95±0.49	2.19±0.68	1.29	0.203
One month after the intervention		2.14±0.79	3.19±0.87	4.07	0.000**
Three months after the intervention		2.38±0.74	3.43±0.92	4.05	0.000**
Sense of direction					
Before intervention	**1-4**	2.29±1.05	2.00±0.89	0.946	0.410

One month after the intervention		2.71±1.00	3.62±0.66	0.342	0.001**
Three months after the intervention		2.95±0.66	3.81±0.40	5.03	0.000**
Each day has potential					
Before intervention	**1-4**	1.86±0.72	1.57±0.67	1.31	0.195
One month after the intervention		1.95±1.02	3.05±0.80	3.85	0.000**
Three months after the intervention		2.43±1.02	3.43±0.67	3.72	0.001**
My life has value and worth					
Before intervention	**1-4**	2.76±0.70	2.62±0.74	0.643	0.524
One month after the intervention		2.95±0.80	3.71±0.56	0.356	0.001**
Three months after the intervention		3.14±0.72	3.95±0.21	4.88	0.000**
Total score					
Before intervention	**12-48**	**26.57±4.03**	**25.23±3.22**	**1.18**	**0.244**
One month after the intervention		**28.85±4.06**	**40.61±2.61**	**11.14**	**0.000****
Three months after the intervention		**31.23±5.05**	**43.76±1.51**	**10.86**	**0.000****

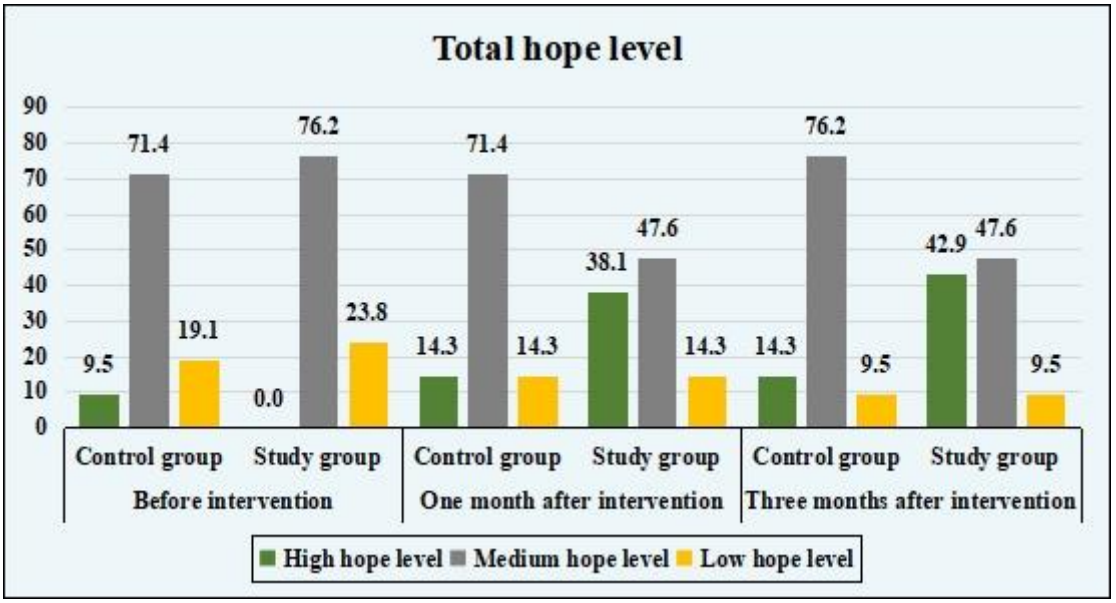

Figure (2): Distribution of studied women in both groups according to their total hope-level score regarding ovarian cancer before intervention, one and three months after intervention (n=42).

Table (4): Mean scores of self-compassion among ovarian cancer women in both groups before intervention, one and three months after intervention (n=42).

Self-compassion subscales	Possible score	Control group n=21 Mean ± SD	Study group n=21 Mean ± SD	Independent t-test	P value
Self-Kindness					
Before intervention	**5-25**	14.48±3.29	14.95±3.15	4.78	0.635
One month after the intervention		15.24±3.46	20.62±2.29	5.93	0.000**
Three months after the intervention		15.62±3.93	21.05±2.22	5.50	0.000**
Self-Judgment					
Before intervention	**5-25**	16.00±3.98	16.43±3.78	3.57	0.723
One month after the intervention		16.43±3.98	20.24±2.04	3.89	0.000**
Three months after the intervention		16.90±3.94	21.52±2.44	4.55	0.000**
Common Humanity					
Before intervention	**4-20**	14.10±2.42	13.62±2.20	0.666	0.509
One month after the intervention		14.52±2.35	17.62±1.62	4.95	0.000**
Three months after the intervention		14.90±2.38	18.67±1.49	6.12	0.000**
Isolation					
Before intervention	**4-20**	16.05±1.74	15.52±1.86	0.941	0.352
One month after the intervention		16.43±1.77	18.86±1.38	4.93	0.000**
Three months after the intervention		16.76±1.75	19.71±0.78	7.02	0.000**
Mindfulness					
Before intervention	**4-20**	15.10±2.82	14.29±2.93	0.910	0.368
One month after the intervention		15.62±2.50	18.57±1.32	4.78	0.000**
Three months after the intervention		16.33±2.70	19.43±0.92	4.95	0.000**
Over-identified					
Before intervention	**4-20**	15.52±2.65	15.76±2.73	0.286	0.776
One month after the intervention		16.05±2.72	18.48±1.43	3.60	0.001**
Three months after the intervention		16.43±2.69	19.48±1.07	4.81	0.000**
Total score					
Before intervention	**26-130**	**91.23±7.50**	**90.57±7.36**	**0.290**	**0.773**
One month after the intervention		**94.28±7.50**	**114.38±4.28**	**10.65**	**0.000****
Three months after the		**96.95±7.76**	**119.85±3.10**	**12.54**	**0.000****

intervention					

Figure (3): Total mean score of self-compassion of study and control groups before intervention, one and three months after the intervention (n=42).

Table (5): Mean scores of depression among ovarian cancer women in both groups before the intervention, one and three months after the intervention (n=42).

Depression	**Possible score**	**Control group n=21**	**Study group n=21**	**Independent t-test**	**P value**
		Mean ± SD	**Mean ± SD**		
Before intervention	**0-63**	33.76±11.64	34.38±11.73	**1.72**	**0.865**
One month after the intervention		32.95±11.09	21.05±8.00	**3.98**	**0.000****
Three months after the intervention		32.10±10.81	19.24±7.44	**4.48**	**0.000****

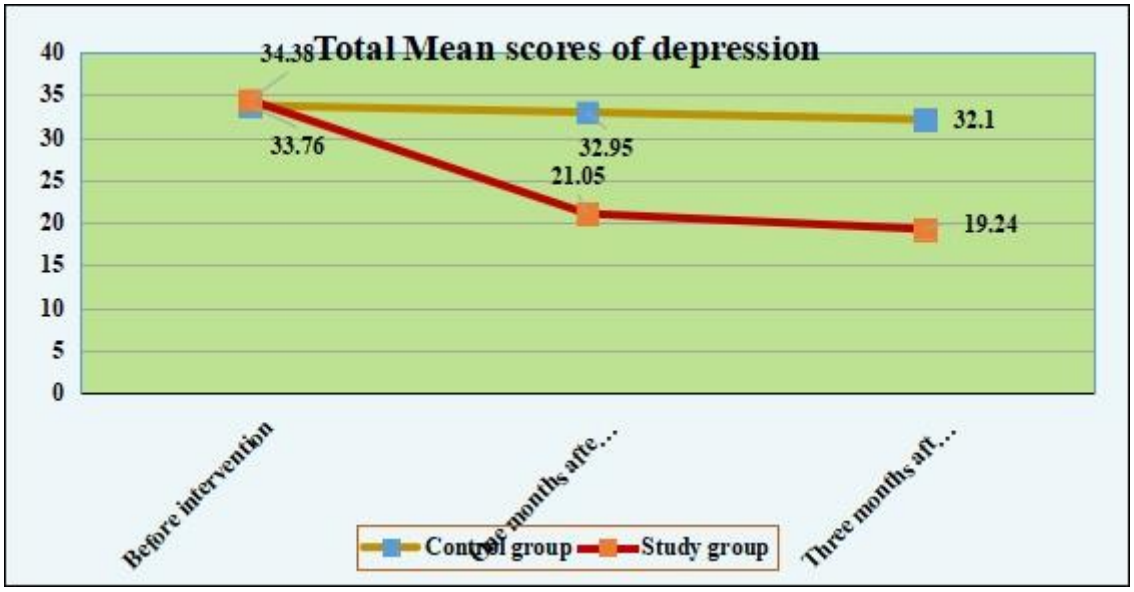

Figure (4): Total mean score of depression of study and control groups before intervention, one and three months after the intervention (n=42).

Table (6): Mean scores of ovarian cancer patient quality of life in both groups before the intervention, one and three months after the intervention (n=42).

Quality of life subscales	Possible score	Control group n=21	Study group n=21	Independent t-test	P value
		Mean ± SD	Mean ± SD		
Physical wellbeing (9 items)					
Before intervention	**0-90**	46.57±14.16	45.86±13.60	0.167	0.868
One month after the intervention		49.10±13.33	64.00±8.57	4.30	0.000**
Three months after the intervention		48.67±13.73	65.24±8.56	4.69	0.000**
Psychological wellbeing (18 items)					
Before intervention	**0-180**	37.52±8.26	36.57±8.48	3.68	7.14
One month after the intervention		38.67±7.76	70.52±9.85	11.64	0.000**
Three months after the intervention		40.00±7.22	76.24±12.19	11.71	0.000**
Social wellbeing (10 items)					
Before intervention	**0-100**	67.62±8.20	66.57±8.83	0.398	0.697
One month after the intervention		69.76±10.47	89.81±5.24	7.84	0.000**
Three months after the intervention		71.05±10.08	92.19±5.91	8.29	0.000**
Spiritual wellbeing (8 items)					
Before intervention	**0-80**	56.05±9.52	57.29±8.68	0.440	0.662
One month after the intervention		57.33±8.42	74.57±5.11	8.01	0.000**
Three months after the intervention		58.62±8.58	76.10±5.26	7.95	0.000**
Total score					
Before intervention	**0-450**	**207.76±21.29**	**206.28±20.37**	**0.230**	**0.820**
One month after the intervention		**214.85±20.66**	**298.90±16.21**	**14.66**	**0.000****
Three months after the intervention		**218.33±21.15**	**309.76±20.08**	**14.36**	**0.000****

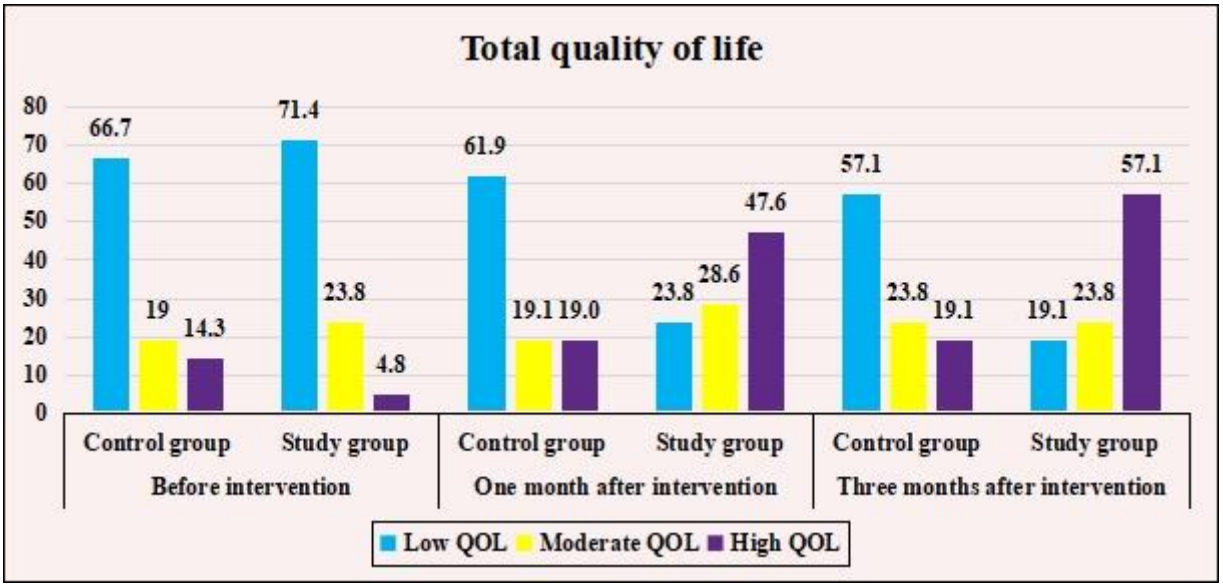

Figure (5): Distribution of studied women in both groups according to their total ovarian cancer patient quality of life score before intervention, one and three months after intervention (n=42).

Table (7): Correlation between total hope score and total scores of (self-compassion, depression and quality of life) before the intervention, one and three months after the intervention (n=42).

Variables	Total hope score											
	Control group (n=21)						Study group (n=21)					
	Before intervention		One month after the intervention		Three months after the intervention		Before intervention		One month after the intervention		Three months after the intervention	
	R	P-value	r	P-value	r	P-value	r	P-value	r	P-value	r	P-value
Total self-compassion score	0.560	0.000**	0.414	0.000**	0.564	0.000**	0.489	0.000**	0.641	0.000**	0.694	0.000**
Total depression score	0.418	0.000**	0.487	0.000**	0.539	0.000**	0.521	0.000**	0.408	0.000**	0.562	0.000**
Total quality of life score	0.539	0.000**	0.643	0.000**	0.544	0.000**	0.467	0.000**	0.647	0.000**	0.637	0.000**

**A Highly Statistically significant $p \leq 0.001$

DISCUSSION

The health of women around the world is seriously threatened by ovarian cancer, a common gynecological cancer. With a mortality rate that ranges from 41% to 87% and is expected to rise, OC is referred to as a "silent killer ***(Nogueira-Rodrigues et al., 2024).*** A key component in improving cancer patients' QOL, self-compassion has been found to have a favorable impact on psychological well-being and is linked to higher levels of happiness, positive affect, and life satisfaction ***(Ahmad and Khanum, 2024).*** For cancer patients to manage their conditions, hope is essential, according to Snyder. It has a positive correlation with reduced depression and improved health outcomes, everyday functioning, and QOL optimization ***(Sabri et al., 2024).*** Thus, the current study aimed to evaluate the effectiveness of Snyder's hope theory as a nursing motivational model on self-compassion, depression and quality of life among women with ovarian cancer.

Based on the personal characteristics of the studied women, the current study's findings made it clear that over half and almost two-thirds of the control and study groups, respectively, were in the 40–60 age range, with mean ages of 48.57±11.99 and 50.71±8.06 years old. Less than three-quarters of the control group and less than two-thirds of the study group, resided in rural areas. In terms of level of education, it was shown that over half of the study and control groups, respectively, had completed secondary education. The majority of the study and control groups were housewives, based on occupation. Furthermore, over half of the control and study groups, respectively, stated that they were diagnosed one year ago and all of the participants in both groups stated that there was no history of existing OC among the relatives. Consequently, no statistically significant difference in personal characteristics reflecting group homogeneity was found between the control and study groups ($p > 0.05$).

These findings were consistent with study by ***Güler and Mete (2023),*** which discovered that the mean age of the women with OC was 54.75±13.76 years and that there was no statistically significant difference in descriptive characteristics between the experimental and control groups (P >.05). Additionally, these findings aligned with those of ***Elmashad et al. (2021),*** who noted that the females' mean age was

45.827 ± 6.715 years, with a range of 35 to 50 years. Moreover, the median age of women with OC was 58 years old, according to the study conducted in New York by ***Frey et al. (2020),*** which also supported similar findings. Furthermore, these findings supported the study by ***El-Sabagh and Shaban (2018),*** which demonstrated that 64.0% of women lived in rural regions, 76.0% were housewives.

It has been demonstrated that women's awareness of OC and its symptoms can significantly slow the disease's progression and reduce the financial strain of treatment on the healthcare system. This knowledge may also motivate women to modify their lifestyle and reduce their exposure to risk factors ***(Bohsas et al., 2023).*** **Regarding knowledge of the studied women about OC,** the current study's findings demonstrated that, with regard to all knowledge items about OC prior to intervention, there was no statistically significant difference between the study and control groups (P> 0.05). Following the intervention, there was a statistically significant difference between the study and control groups (P < 0.001). This suggested that women's knowledge was positively impacted by the nursing motivational model, which was founded on Snyder's hope theory. To improve survival rates and obtain an earlier diagnosis, women who are well-informed about the signs of OC are better able to have enlightening conversations about the illness with their healthcare provider. Thus, it is critical to address the illness at an early stage before it progresses to a point where there is no realistic chance of hope. These findings were almost identical to study conducted in the Netherlands by ***Frijstein et al., (2023),*** which found that while there were no appreciable differences in the intervention group's pre-intervention knowledge compared to the control group, the mean level of knowledge about OC increased following the intervention. Furthermore, these findings supported the study conducted in Turkey by ***Güler and Mete (2023),*** which demonstrated that the experimental group's mean scores in the knowledge level significantly increased following the implementation of a relaxation-focused nursing program for women with OC.

According to our research, women with OC experience anxiety and depression as a result of their ignorance regarding the symptoms, side effects, and treatment ***(Güler and Mete, 2023).*** **Regarding total knowledge score**, the current study's findings made it clear that, prior to intervention, over one-third and over two-fifths of

the study and control groups, respectively, had adequate knowledge about OC. Following the intervention, less than half of the control group and the majority of the study group, respectively, had adequate knowledge about OC. The use of photos, PowerPoint slideshows, online and offline videos, and an illustrated booklet with colored pictures to raise awareness for educating women during the intervention may be the cause of this, as well as the fact that all of the women are interested in learning more about OC. Additionally, excellent communication and direct engagement with the women made it possible to get clarification on any ambiguities and learn crucial information. "Women who will receive nursing motivational model based on Snyder's hope theory will have a higher level of knowledge than those who will not receive it" according to the research hypothesis, was validated by this finding.

These findings concurred with those of ***Ali and Jasim (2022),*** who demonstrated that the program had an impact on the study sample's knowledge of OC over the course of two test periods. The study sample's pretest knowledge was low, and the posttest showed an increase to a high level of knowledge. These findings also supported those of ***Puckett et al. (2018),*** who showed that following instructional sessions, all participants' knowledge of OC significantly increased. Furthermore, our findings aligned with those of ***Mohamed and Abd Elkader (2016),*** who demonstrated that the OC health education session had a noteworthy impact by significantly raising the participants' level of illness knowledge.

Hope is a fundamental coping mechanism for women living with ovarian cancer. It promotes patients' adaptability to their illness ***(Lutgendorf et al., 2024)***. **According to Herth hope index regarding ovarian cancer**, the current study's results clarified that there is no statistically significant difference between the study and control groups in terms of the overall mean score of all Herth hope index items prior to intervention ($P > 0.05$). However, the study group's overall mean score across all Herth Hope Index items was considerably higher than the control group's scores one and three months following the intervention ($P \leq 0.001$). This could be linked to with the fact that women who felt more hopeful were more upbeat about the state of affairs and more inclined to use positive thinking to inspire themselves to reach their objectives. Furthermore, nursing interventions grounded on hope may determine the capacity to manage the disease in a meaningful manner, meet the requirements of

cancer patients, and assist women in finding meaning and purpose in the face of a life-threatening illness.

The aforementioned results were very identical to study conducted in Iran by ***Sharifpour et al., (2024),*** which found that both cognitive-behavioral therapy and compassion-based therapy were beneficial for cancer patients' hope for life (P<0.001). Furthermore, these results went in the same line with ***Hedayatian and Ebrahimi (2024),*** who showed that group treatment based on acceptance and commitment greatly increased cancer women's hope (P = 0.001) and happiness (P = 0.001). Additionally, the current study's findings were consistent with research by ***Faghihi and Dahmardeh (2024)*** that showed a substantial increase in the intervention group's mean total score of hope three months after the educational intervention ended (P=0.001).

Pertaining to total hope-level score regarding OC, according to the study's findings, no woman and only a small percentage of women in the study and control groups, respectively, had high hopes for OC before to intervention. Meanwhile, more than one-third and almost one-seventh of the study and control groups, respectively, showed high levels of hope regarding OC one month and three months after intervention, compared to more than two-fifths and nearly one-seventh of both groups. This may be because Snyder's hope theory-based nursing interventions can enhance treatment confidence and management skills by utilizing dynamic thinking, goal-setting, and path strategy planning to maintain a positive psychological state and optimize a speedy recovery. "Women who will receive nursing motivational model based on Snyder's hope theory will have better hope for life than those who will not receive it", according to the research hypothesis, was validated by this finding".

These findings concurred with those of ***Du et al. (2024),*** who explained that the application of nursing intervention based on Snyder's hope theory can raise hope levels and lower depression levels. Furthermore, these findings were almost identical to study conducted by ***Zhang et al. (2024),*** which noted that health education grounded in the theory of protective motivation successfully raises cancer patients' hope levels. Additionally, our findings aligned with ***Teskereci et al. (2022),*** who demonstrated that a nursing care program grounded in the theory of human caring

may help women with gynecologic cancer feel more hopeful and purposeful in their lives.

The feeling of self-compassion, which stands for the warmth and acceptance of one's good elements of life and oneself, is a significant contributor to cancer patients' increased hope. It is adaptive way of self-communication when one is conscious of shortcomings and dealing with challenging circumstances ***(Faghihi and Dahmardeh, 2024).*** **Concerning self-compassion among OC women,** the current study's findings showed that, prior to intervention, there was no statistically significant difference between the two groups' mean scores on the self-compassion scale and its subscales ($P > 0.05$). At one and three months following the intervention, the study group's overall mean score on all self-compassion subscales was considerably greater than the control group's ($P \leq 0.001$). The researchers think that by using Snyder's theory of hope to improve self-compassion, the woman will be more motivated to receive treatment and there will be a lower chance of undesirable outcomes like resistance to therapy and noncompliance. These findings were consistent with the Taiwanese study by ***Fan et al. (2023)*** and showed that self-compassion was rising ($P < 0.001$), suggesting that compassion-based interventions could be a useful tactic for enhancing self-compassion in cancer patients. Furthermore, these findings were almost identical to study conducted by ***Faghani et al., (2022),*** which found that group supportive psychotherapy significantly increased cancer patients' self-compassion in the experimental group during the post-test phase ($P < 0.05$).

A significant technique for reducing suffering that cancer patients can readily access at any time is self-compassion ***(Grégoire et al., 2024).*** **According to total mean score of self-compassion,** according to the current study's findings, the study and control groups' respective pre-intervention mean scores for self-compassion were 90.57 and 91.23. However, the study group's overall mean self-compassion scores increased significantly compared to the control group one and three months after the intervention (94.28 and 96.95 versus 114.38 and 119.85, respectively). From the researchers' opinion, women who are more self-compassionate and accepting of their challenges are able to engage with others more deeply in spite of challenges, cope with issues more effectively, and try harder to keep their psychological equilibrium.

Because they are more optimistic, women with high levels of self-compassion are better able to manage their negative emotions and have more psychological flexibility. The research hypothesis, according to which "Women who will receive nursing motivational model based on Snyder's hope theory will have a higher self-compassion than those who will not receive it", was validated by this finding.

These findings were in accordance with study conducted in London, UK, by ***Hoffman and Baker, (2023)***, which discovered statistically significant increases in self-compassion between the baseline and post-intervention of a mindful self-compassion program (P <.001). Additionally, these findings were almost identical to study conducted in Germany by ***Dreisoerner et al., (2023),*** which noted that the intervention enhanced overall self-compassion as demonstrated by a significant interaction between time and treatment (P =.005), with notable distinctions between the intervention and the control group at the 1-week follow-up.

It is well recognized that depression makes life more difficult for cancer patients than for the general public and is linked to making the results of cancer therapy more difficult ***(Geremew et al., 2024).*** **Regarding depression among OC women,** the current study's findings showed that, prior to intervention, there was no statistically significant difference between the two groups' total mean scores of depression (P > 0.05). At one and three months following the intervention, the study group's overall mean depression score was considerably lower than the control group's (P ≤0.001). This may be explained by the significant impact of nursing interventions grounded in Snyder's hope theory, which raises hope among OC patients, ultimately resulting in less depressive symptoms and an improved QOL.

These findings were corroborated by ***Du et al. (2024),*** who demonstrated that, following nursing intervention based on Snyder's hope theory, the observation group's depression levels were lower than the controls' (P<0.05) post-nursing scores. Furthermore, these findings were consistent with ***Wang et al. (2022),*** who explained that the post-intervention score was lower than the pre-intervention score, the reduction was more significant in the observation group (P < 0.05), and there was no difference in depression scores (P > 0.05) between the control and observation groups. These findings also supported those of ***Liu et al., (2021)*** who displayed that the study

group with OC experienced a more substantial ($P < 0.05$) decrease in their Self-Rating Depression Scale (SDS) score following the nursing intervention.

Concerning total mean score of depression, according to the current study's findings, the study and control groups' respective total mean depression scores prior to intervention were 33.76 and 34.38. However, the study group's overall mean depression scores dropped dramatically from 32.95 and 32.10 to 21.05 and 19.24, respectively, one and three months following the intervention compared to the control group. The research hypothesis, according to which "Women who will receive nursing motivational model based on Snyder's hope theory will have less level of depression than those who will not receive it", was supported by this finding.

These findings went in the same line with a study conducted in Tehran by ***Bayan et al. (2024),*** which found that hope treatment can dramatically improve happiness and QOL while also reducing depression. These findings also aligned with those of ***Kahlil et al. (2024),*** who found that implementing educational guidelines for coping strategies had a positive impact on lowering depression among women more so than before. Additionally, our findings supported those of ***Ellawindi et al. (2021)*** and demonstrated that a psychosocially supportive health care model reduced depression in cancer patients.

The medical, psychological, and social issues that women with OC face have a detrimental impact on their QOL ***(Stragapede et al., 2023)***. **In relation to mean scores of OC patient QOL,** the current study's findings showed that, prior to intervention, there was no statistically significant difference between the two groups' mean scores on the QOL subscales and overall score for OC patients ($P > 0.05$). At one and three months following the intervention, the study group's overall mean score across all OC patient QOL subscales was considerably greater than the control group's ($P \leq 0.001$). The application of Snyder's hope theory-inspired nursing strategy, which emphasizes health promotion, gives women medical information about managing OC, and raises their knowledge of the condition, was credited by the researchers with this outcome. In addition, it highlights the woman's objectives and encourages her to carry out everyday activities, which lowers the likelihood of problems, improves her prognosis, and raises her QOL.

These findings were almost identical to study conducted by ***Sun et al., (2024)*** which clarified that meaning therapy improves cancer patients' QOL (P = 0.006). Furthermore, ***Li and Zhang (2022)*** in China corroborated these findings, showing that the mean QOL score was 51.73 ± 13.91 prior to the intervention and 60.46 ± 13.80 following it (P <0.001). These findings also supported the findings of ***Liu et al. (2021),*** who noted that there was no statistically significant difference in the two groups' quality-of-life assessments prior to nursing (P > 0.05). Following nursing intervention, the study group of patients with advanced OC showed improvements in their emotional, physical, physiological, and social/family status levels (P < 0.05).

Regarding total OC patient QOL score, the minority and approximately one-seventh of the study and control groups, respectively, showed high levels of OC patient QOL prior to intervention, according to the current study's findings. Less than half and less than one-fifth of the study and control groups, respectively, reported high levels of OC patient QOL one month and three months after intervention, compared to more than half and less than one-fifth of both groups. "Women who will receive nursing motivational model based on Snyder's hope theory will have a higher level of quality of life than those who will not receive it", according to the research hypothesis, was validated by this finding

These findings supported the Polish study by ***Baczewska et al. (2024)*** and demonstrated how hope can enhance the QOL and offer emotional support to cancer patients in the terminal stage of their disease. Furthermore, our findings supported those of ***Paşalak et al. (2024)*** in Turkey and showed that, at times two and three, the QOL of cancer patients in the intervention group was noticeably better than that of the control group. Additionally, these findings were in line with ***Gao et al. (2021)*** and showed that the study group with OC had a considerably higher QOL at three months of follow-up than the control group.

Concerning correlation between research variables, the present study's findings demonstrated a statistically significant positive correlation between the total hope score and the total scores of self-compassion, depression, and QOL in both groups prior to, during, and three months following the intervention (P≤ 0.001). These findings concurred with study conducted in Uruguay by ***Camejo et al. (2024),*** which

found that hope and QOL were positively correlated in patients with advanced cancer. ***Ahmad and Khanum (2024)*** further corroborated these findings by showing a strong favorable correlation (P<.01) between cancer patients' QOL and self-compassion. Additionally, the findings aligned with ***Feldman and Corn's (2023)*** study, which showed that hope is linked to a number of psychological factors in cancer patients, such as depression, coping, and posttraumatic growth. Moreover, the findings supported those of ***Kitashita and Suzuki (2023),*** who found a correlation between cancer patients' hope and their QOL and depression.

Conclusion

The current research's findings demonstrate that the Snyder's hope theory-based nursing motivational model significantly improves the knowledge, self-compassion, and quality of life of women with ovarian cancer. Furthermore, it guided the woman actively confront the problems, lower level of depression, and enhancing hope for life. Additionally, there was a statistically significant positive association between the total hope score and the total scores of depression, self-compassion, and QOL in both groups before to, one, and three months following the intervention (P≤ 0.001). Consequently, the research hypotheses were supported and the research aim was achieved.

Recommendations:

Based on the research findings it was recommended that:

- Women with ovarian cancer should be educated and managed using the Snyder's Hope Theory as an effective motivational paradigm
- Organize periodically training programs and scaling up health education for enhancing hope, self-compassion and reduce of depression level among women with ovarian cancer.
- An urgent need to increase awareness and enlightenment on ovarian cancer is highly recommended for improving quality of life to reduce the associated mortality and morbidity.
- Distribution of the colorful booklets and brochures regarding ovarian cancer for women who attending to obstetrics and gynecological units and

outpatient clinics to improve women's hope, self-compassion as well as promote quality of life.

Further research:

- Provide maternity nurses with a straightforward, understandable training program based on Snyder's hope theory to help them collaborate to develop a care plan for women with OC.
- To replicate the research on a larger representative probability sample in other circumstances and allow the findings to be more broadly applied, more research is essential.

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فعالية نظرية الأمل لسنايدر كنموذج تحفيزي تمريضي في تعزيز التعاطف الذاتي، الاكتئاب، وجودة الحياة لدى النساء المصابات بسرطان المبيض

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أستاذ مساعد تمريض النساء والتوليد، كلية التمريض، جامعة بنها، مصر [1] , مدرس تمريض النساء والتوليد، كلية التمريض، جامعة بنها، مصر [2] ,مدرس تمريض صحة الأسرة والمجتمع، كلية التمريض، جامعة قناة السويس، مصر [3] , مدرس تمريض النساء والتوليد، كلية التمريض، جامعة قناة السويس، مصر [4]

الخلاصة

الخلفية : تعد جودة الحياة لدى النساء المصابات بسرطان المبيض عرضة للتدهور نتيجة تعقيدات العلاج والاكتئاب المصاحب للتشخيص. ويُعتبر تعزيز الأمل وفقًا لنظرية سنايدر من الأساليب الفعالة في دعم الصحة النفسية وتحسين التكيف مع المرض.**الهدف :**تقييم فعالية نظرية الأمل لسنايدر كنموذج تحفيزي تمريضي في تحسين التعاطف الذاتي، تقليل الاكتئاب، وتعزيز جودة الحياة لدى النساء المصابات بسرطان المبيض .**التصميم والمنهجية** :تم استخدام تصميم شبه تجريبي شمل مجموعتين (ضابطة وتجريبية). أُجريت الدراسة في أقسام الأورام السريرية والنساء والتوليد والعيادات الخارجية التابعة لها بمستشفيات جامعة بنها بمحافظة القليوبية، مصر. تكونت العينة من 42 امرأة تم اختيارهن بطريقة قصدية، ممن تم تشخيصهن بسرطان المبيض واستوفين معايير الاشتمال والاستبعاد.**أدوات جمع البيانات:** شملت أدوات الدراسة استبيان مقابلة منظم، مقياس هيرث للأمل، مقياس التعاطف الذاتي، مقياس بيك للاكتئاب، وأداة جودة الحياة الخاصة بمريضات سرطان المبيض.**النتائج:**أظهرت النتائج فروقًا ذات دلالة إحصائية عالية بين المجموعتين بعد تطبيق النموذج التحفيزي التمريضي المبني على نظرية الأمل، حيث تحسنت مستويات المعرفة، الأمل، التعاطف الذاتي، جودة الحياة، وانخفضت معدلات الاكتئاب لدى المجموعة التجريبية مقارنة بالمجموعة الضابطة.**الاستنتاج :**يُعد النموذج التحفيزي التمريضي المبني على نظرية الأمل لسنايدر فعالًا في تحسين الجوانب النفسية والمعرفية لدى النساء المصابات بسرطان المبيض، كما يعزز قدرتهن على مواجهة التحديات ويقلل من حدة الاكتئاب.**التوصيات:**ينبغي دمج نظرية الأمل لسنايدر في البرامج التثقيفية والرعاية التمريضية المقدمة للنساء المصابات بسرطان المبيض، باعتبارها نموذجًا تحفيزيًا فعالًا يعزز الصحة النفسية وجودة الحياة.

الكلمات المرشدة **:**الاكتئاب، النموذج التحفيزي التمريضي، سرطان المبيض، جودة الحياة، التعاطف الذاتي، نظرية الأمل لسنايدر