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Hope in psychiatry

ARTICLE

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SUMMARY

Hope has long been considered a relevant variable in medical disciplines, but little attention has been paid to the concept, and its clinical and research implications, in psychiatry. This article illuminates the topic of hope from four different perspectives relevant to psychiatric research and practice. The four authors discuss hope from the viewpoint of their specific area of expertise, providing an overview of philosophical, conceptual, research and recovery-related reflections concerning hope in psychiatry.

DECLARATION OF INTEREST

None.

Hope has been of interest across centuries and cultures, gaining particular relevance at times of crisis and the desire to change. Various controversial connotations have been attributed to hope: in Greek mythology it is one of the evils in Pandora's box, whereas in the Judaeo-Christian tradition it is a virtue and a spiritual gift from God.

Karl Menninger identified hope as integral to the profession of psychiatry, important for initiating therapeutic change, willingness to learn and personal well-being (Menninger 1959). The psychiatric literature today offers at least three reasons why hope is an important variable in mental health practice and research. First, hope is central to the concept of recovery from mental disorders, considered to be both a trigger of the recovery process and a maintaining factor (e.g. Bonney 2008). Second, it is central to the concept of resilience (e.g. Ong 2006). Third, it is central to human adaptation and psychotherapeutic change (e.g. Magaletta 1999; Hayes 2007), consistently identified by both patients and therapists as a key factor in psychotherapy (Schrank 2008). Nevertheless, the concept itself, as well as its clinical and research implications, have received little attention in psychiatry, a field in which the presence or absence of hope may have especially profound consequences.

Hence, we offer here some reflections on hope from the perspectives of our specific areas of expertise. Each of us has written a section individually, before working together on the conclusions. Providing these different perspectives on hope is intended to stimulate discussion and research on this topic in mental health.

Philosophical considerations of hope in mental illness

By Giovanni Stanghellini

To understand the phenomenon of hope in psychopathology, the connection between meaning and temporality is of specific interest. Hope, as a future-oriented attitude, restores the unification between past, present and future that can be lost during illness and it therefore constitutes a prerequisite for attributing new meanings to one's past and overcoming associated difficulties.

Time and illness

Severe mental illnesses can be interpreted as disorders of lived time, and more exactly as the crystallisation of the time flux, the uncoupling of past, present and future (Minkowski 1933; Kimura 1992). Lived time in psychotic existence is suspended between hopelessness and despair and a fanatical and groundless type of trust – the expectation of a new significance.

People with a diagnosis of schizophrenia, especially during the early phase of their illness, are fixed in the anticipation of something (*ante festum*) whose meaning will change their life, be it the revelation of a new identity, or a profound insight into the innermost secrets of the universe. People diagnosed with borderline personality disorder are trapped in an eternal present (*intra festum*), a traumatic kind of existence that eludes the elaboration of any personal meaning, in which they can neither learn from past experiences nor effectively project their future. They contribute to the continual re-creation of the same kind of distressing experience.

Perhaps the best example of the connection between disorders of lived time, abnormal meaningfulness and mental illness is that offered by individuals with major depression. What is affected in major depression is the norm of time – i.e. becoming. We live and experience in a state of becoming. The norm of time, our *modus vivendi*, is the 'imperfect' since we turn to new problems before the old ones have found a 'perfect' solution. Major depression is a pathology of becoming (Straus 1947): in depressive psychoses, discordance between past, present and future reaches a maximum. With a standstill of becoming, the past is but an archive of unsuccessful actions and the future is rendered

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inaccessible. Also, discordance between personal and objective (interpersonal) time is experienced as vanishing of time (existence does not grow in the stream of objective time) and unreality (since the feeling of reality is coexistence of the world and oneself). Typical depressive delusions are the mode in which individuals with depression are forced to read their history. Typically, in their delusions of guilt, depressed people are overwhelmed by the impact of the past. History is experienced in its absolute irrevocability, the past as an unpardonable guilt, the future as inevitable catastrophe and the present as irreparable ruin. People affected by major depression live a *post-festum* kind of existence in which all that is important already happened in the past: the meaning of what happens in the present and future is entirely contained and conditioned by the past, and the past is but the time at which one committed an irredeemable transgression. The meaning of what takes place now and what will happen in the future is but the consequence of one's past culpability.

Time and consciousness

As we have seen from the examples taken from mental illness, there is a strong connection between meaning (and the disorders of meaning-bestowing) and lived time. In everyday life, consciousness is characterised by horizontal intentionality: the intentional unification of experience/consciousness over time (Husserl 1966). First and foremost, we do not experience past, present and future (what Husserl calls *retentio*, *praesentatio* and *protentio*) as disjointed, but as a flux. Past is the retention of what has already happened, and future is the protention to what is going to happen. Retention is the way the present phase (or *praesentatio*) 'intends' the past phase and keeps it in view. Retention means that the past is only intentionally contained in the present (the past, literally speaking, does not exist). Self-consciousness is the unification of *retentio–protentio–praesentatio*. The very essence of the phenomenon of hope is that it restores this unification between past, present and future that is lost within illness. It restores the flux of lived time and of becoming.

In human existence, the meaning of an experience is set within a temporal dynamic that is highly non-linear. Not only do past experiences (retentional meanings) influence the future (protentional ones), but also what is expected affects the meaning of past experiences. Hope, as a future-oriented attitude, is integral to protention and, as such, a prerequisite for attributing new meanings to one's past and overcoming it. Hope is a primarily future-oriented expectation of attaining personally valued goals that will give or restore meaning to one's experiences. The orientation towards the future bestows new meaning(s) on the past. As the process of recovery in mental health is often based on restoring meaningfulness or attributing new meanings to one's past experiences, hope can be seen as a prerequisite for recovery.

Philosophical considerations on the nature of hope and its relevance to illness and therapy in mental health provide an important basis for understanding the phenomenon itself, for its classification and operationalisation. In contrast to philosophical reflections on hope, which in Western cultural tradition can be dated back at least to Greek mythology, the process of making the concept accessible to research has begun only in recent decades. These empirical conceptualisations, developed since the 1970s, are described in the following section.

Concepts of hope in health research

By Beate Schrank

Since its introduction into the field of academic research in the 1960s, hope has been conceptualised in numerous ways and against various theoretical backgrounds.

Emotion-based definitions

Some early concepts of hope may be described as being based primarily on emotion. Lynch (1965), for example, defines hope as a 'fundamental knowledge and feeling that there is a way out of difficulty, that there are solutions, and that as humans we can somehow manage our internal and external reality'. Similarly, Lazarus (1999) describes hope as 'believ[ing] that something positive, which does not presently apply to one's life, could still materialise'. In these concepts, current unsatisfactory life circumstances are a fundamental condition of hope, with hope for the better developing in deprived, damaging or threatening situations. Lazarus provides two reasons to regard hope as an emotion. First, hope arises partly from a strong desire to be in a different situation; second, it develops from the impression that this is possible, be it through one's own efforts or external forces. One major critique of the above and similar theories is that they preclude hopefulness about improving an already satisfactory situation (Snyder 2002). Further definitions of hope are 'the extent to which an individual anticipates a personal future' (Hinds 1984), or 'a feeling of possibility, an internal disposition and a resource for coping' (Rustoen 1995). Such emotion-based concepts have been criticised as being unclear and thus difficult to measure (Hammelstein 2002).

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Cognition-based definitions

Other concepts of hope may be regarded as primarily based on cognition. Stotland's (1969) hope theory, for example, equates hope with the expectation of goal attainment. According to this concept, the level of subjectively perceived probability of goal attainment equals the extent of hope. Here hope refers only to goals that can be achieved through an individual's own abilities; hence, it is restricted to internally controllable events (Hammelstein 2002). Breznitz (1986) also describes hope as a cognitive state, distinguishing the opposites of helplessness and hope, in that hope comes after there has been a feeling of helplessness. According to this concept, specific information (e.g. the prospect of cure) is central to the development of hope-related cognitions and, as with the emotional concepts of Lynch and Lazarus, an undesirable baseline situation is a necessary condition.

Emotion- and cognition-based definitions

Several authors have suggested concepts of hope in which both emotion and cognition are essential components. Staats (1987), for example, defines the cognitive component of hope as 'the expectation of a future event that has some probability of occurring' and the affective component as 'the things that are hoped for are pleasant events or good outcomes'. Here, hope refers to future referenced events that are wished for, are associated with positive affect and have some cognitively perceived probability of occurrence. For Ulrich (1984), in hope feelings of power, courage and confidence are accompanied by the motivation of 'wanting to assert oneself' together with a cognitive relation to the future or to positive goals. Someone who hopes heartily wishes for something, is unsure of its attainment and is not only or not at all in control of bringing it about. Ulrich postulates that in hope the wish outweighs the certainty, whereas in expectation it is the other way around. Other writers have criticised this concept of hope as being only a specific category of expectation, i.e. expectation with an uncertain goal (Hammelstein 2002).

The most prominent example of a concept of hope combining cognition and emotion is that developed by Snyder and colleagues since the 1980s. It comprises the two interrelated elements of 'agency', defined as 'goal-directed determination', and 'pathways', defined as 'planning to meet goals'. Agency and pathways are conceptualised as reciprocal, additive and positively related, but not synonymous. Later, 'goals' were included as a third component, defined as the cognitive component anchoring hope and providing the target of mental action (Snyder 2002). According to this theory, hope is primarily a way of thinking, with feelings playing an important, albeit contributory, role: an individual's perception of potential success in achieving a personal goal influences subsequent emotions.

Several measurement scales have been developed on the basis of Snyder's hope theory. They have attracted a wealth of conceptual criticism, including the claim that they measure not hope but simply generalised self-efficacy and outcome expectation (Schwarzer 1994). Since the achievement of the hoped-for goal depends on personal action, Snyder's concept excludes goals that are mainly dependent on external factors as well as the simultaneous occurrence of helplessness and hope.

Multidimensional definitions

A further important view on hope in medical practice emerged from the nursing sciences, where there is broad agreement on nurses' responsibility to understand, maintain and foster hope in clinical practice. Given this crucial role of hope within the nursing profession, a wealth of research has been conducted involving patients with severe and terminal physical illnesses or with mental health problems. This has resulted in a number of multi-dimensional concepts of hope that also include components such as personal characteristics of the hoping person and a varying number of hope-hindering and hope-supporting factors (e.g. Miller[a] 1988; Herth 1991).

A consensus definition

One essential prerequisite for the use of the concept of hope within mental health practice and research is a comprehensive and precise definition of hope. We have generated such a definition on the basis of a systematic literature review (Schrank 2008). Incorporating all hope concepts previously published in the health literature, a number of key dimensions can be identified as integral to the concept (Table 1). These include (i) time, both past experience as well as the important future reference of hope; (ii) broad and specific goals; (iii) control, which may be internal (personal activity) and/or external (environmental and contextual factors); (iv) relations, such as partnerships and spirituality or a sense of purpose in life; and (v) personal characteristics such as inner strength, motivation and energy to pursue one's goals. The concept includes a (vi) reality reference, in that the desired outcomes or goals are subjectively perceived as being possible, and (vii) it allows for hope to arise both from a negative as well as

a. The Miller Hope Scale is freely available from Judith Miller, Sinclair School of Nursing, University of Missouri, Columbia, MO 65211, USA. Email: millerjud@missouri.edu

TABLE 1 **Key dimensions of the concept of hope**

Dimension	Explanation
Time	
Past experience	Such as the belief that past experiences have prepared one for the future
Future reference	Looking forward to a positive future, planning and working towards a goal
Goals	
Broad	Rather vague goals
Specific	Well-defined goals
Control	
Internal	Personal activity towards goal attainment
External	Environmental and contextual factors influencing goal attainment
Relations	Such as partnerships, the relational aspect of medical care, spirituality, meaning and purpose in life, basic trust in a world that makes sense
Personal characteristics	Determining, for example, inner strength, motivation, energy to pursue one's goals
Reality reference	Desired outcomes are subjectively perceived as being possible
Starting point	
Positive	Hope may arise from both a positive and a negative starting point
Negative	

a positive starting point, i.e. as a desire for the improvement of an undesirable or an already satisfactory situation.

Hitherto published research on hope in mental health used varying concepts and measurement tools (Schrank 2008). Although such diversity in measurement may limit the comparability of quantitative research results, a number of relevant findings have still been generated on the value of hope in mental health. The following section will discuss some relevant questions pertaining to the state of contemporary research on hope in this field.

Hope in psychiatric research

By Mark Hayward

Holloway (2008: p. 245) positions hope as pivotal to recovery by stating that:

> 'the four elements of the recovery concept identified by Resnick (2004) [life satisfaction; hope and optimism; empowerment; information] are by no means universally agreed as uniquely significant in the burgeoning recovery movement, although the centrality of hope is undoubtedly a common theme.'

Yet what is the evidence to support a pivotal role for hope? Can this universality be justified? If so, is hope the same for everybody? What about experiences where a shared sense of temporality may not be the case?

Quantitative evidence of hope

Reflection on these questions prompted consideration of what was meant by evidence. My research training insists that persuasive evidence is primarily quantitative in nature and is generalisable, that is we are talking about the same phenomena. In their review of the quantitative literature on hope in psychiatry (Schrank 2008), Beate Schrank, Giovanni Stanghellini and another colleague searched with the terms 'hope and outcome'. They found seven studies in peer-reviewed journals relevant to people with mental health problems, spanning a range of diagnoses and measuring hope in differing ways (see Table 2 for details of all the studies identified in that search). Three of the studies used Snyder's hope theory, described above, whereby hope exerts an influence through three distinct elements. Irving and colleagues (1997, 2004) suggest that treatment should reflect the patient's specific hope-related needs, for example if the individual is low in agency thinking, the focus should be on motivational interventions. They further suggest that psychotherapeutic interventions should be oriented towards the active element of hope at different stages of therapy, for example agency should be focused on during the early stages of therapy and pathways considered during the middle and late stages.

Snyder's hope theory has also been used to guide an intervention aimed at enhancing hope. Cheavens and colleagues (2006) offered eight sessions of hope therapy to increase hopeful thinking and enhance goal-pursuit activity, using a strengths-based approach to teach skills in setting goals, developing multiple pathways, identifying sources of motivation and monitoring progress. Thirty-two participants (18 with an Axis I diagnosis; 14 with no diagnosis) completed the therapy and reported an increased sense of agency, but no difference in relation to pathways. This finding was attributed to the shortness of therapy and interpreted as further evidence of the influence of distinct elements of hope theory at different stages of therapy.

Snyder's hope theory is a highly linear understanding of the therapeutic benefits of hope, with clearly defined stages, pathways and goals. The resulting intervention is, in principle, applicable to everyone and, perhaps more important, measurable. Yet, my clinical experience suggests another story, that engaging qualitatively with patients' narratives enables us to respect the differences between people's definitions of hope, their respective emphasis on process and goal, and their temporal and cultural orientation to these. Is it really the case that hope is specific to a shared linear time consciousness and absent in disordered temporalisations? What about those unnameable sparks of hope that, like feelings of love, are impossible to capture in words? Further, while shared temporalisations are necessary to shared realities, how is it possible to consider communication with people whose temporalities

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TABLE 2 **Studies investigating the relationship between hope and outcome in mental health patients**

Study	Patient group and diagnoses	Participants, *n*	Design	Intervention	Hope measure used	Results
Cheavens *et al* (2006)	Out-patients with depressive and anxiety disorders	32	RCT	Hope-based group therapy (eight weekly 2 h sessions) *v.* waiting-list control	State Hope Scale	Pre-treatment hope scores and hope change from pre- to post-treatment were predictors of post-treatment depressive and anxiety symptoms
Kraatz (2004)	Psychotherapy clients with depression and distress	Not stated	Uncontrolled psychotherapy outcome study	Six counselling sessions	State Hope Scale	Clients' level of hope before treatment predicted reduction in psychological distress, but not reduction in depression
Irving *et al* (2004)	Psychotherapy clients with various diagnoses (mainly depression)	98	RCT	Group motivational orientation followed by 12 weeks of individual therapy *v.* individual therapy alone	State Hope Scale and Dispositional Hope Scale	Baseline hope predicted subjective well-being and symptom reduction but not functioning or emotional regulation after 11 therapy sessions Specific baseline hope subscores were associated with positive changes in clinical variables in early and later therapy sessions
Hart *et al* (2001)	Young adults with remitted major depression	65	18-month follow-up	None	Dispositional Hope Scale	Cognitive and interpersonal variables (including hope, dysfunctional attitudes and personal problems) did not predict recurrence of depression
Udelman & Udelman (1985)	Out-patients with dysthymic disorder	20	Controlled clinical trial	3 months' maprotiline *v.* no medication (both groups got psychotherapy)	Gottschalk Hope Scale	Pre-drug hope scores correlated positively with improved post-drug immune response
Irving *et al* (1997)	Vietnam combat veterans with PTSD	72	Uncontrolled therapy outcome study	6–22 weeks of in-patient PTSD treatment	Dispositional Hope Scale	Baseline hope scores did not differ between those who completed therapy and those who dropped out Hope scores were positively related to a higher number of coping measures at discharge than at admission The authors conclude that hope confers a beneficial effect once veterans undergo treatment for combat-related PTSD
Johnson (2001)	Combat veterans with PTSD	Not stated	Uncontrolled therapy outcome study	In-patient PTSD treatment	Dispositional Hope Scale	Hope was not found to have an effect on the level of improvement in PTSD or quality of life
Farley & Zimet (1987)	Moderately to severely disturbed children, some with organic impairment	62	Uncontrolled therapy outcome study	Standard psychiatric day treatment for an average of 2 years (follow-up for 18 months after treatment termination)	Gottschalk Hope Scale	Hope scores were a modest predictor of improvement both during psychiatric day treatment and 1–1.5 years after treatment ended Children with high hope scale scores at entry to day treatment had greater change scores in Rare Deviance at treatment termination The organically impaired group's hope scores were positively correlated with change in Neuroticism scores from treatment entry to termination
Byrne *et al* (1999)	People in supported community group homes with chronic mental health conditions	214	RCT	Weekly health education *v.* empowerment education groups for 1 year (follow-up at 18 months)	Cantril Self-Anchoring Ladder	Individuals in the health education group who at baseline rated low hope for the future had both higher per person annual expenditure for health services at 18 months, and a 13% (i.e. far higher than average) increase in their Global Life Satisfaction score by 18 months
Talmadge (2003)	Psychotherapy clients	Not stated	Uncontrolled psychotherapy study	Five psychotherapy sessions	Dispositional Hope Scale	No relation was found between hope at pre-treatment and premature drop-out from treatment or readiness for change
Magyar-Moe (2004)	Counselling clients	124	Uncontrolled psychotherapy study	Three counselling sessions	Not stated	Hope at therapy intake was the best predictor when outcome was measured in terms of symptom distress, whereas score on the Personal Growth Initiative at intake best predicted outcome in terms of well-being

PTSD, post-traumatic stress disorder; RCT, randomised controlled trial.

Source: Schrank *et al* (2008), with permission of Wiley-Blackwell.

(and therefore realities) are out of synch with the majority, for example patients who are experiencing psychosis?

Qualitative evidence of hope

Qualitatively, the existence of hope within accounts of recovery from severe mental illness has been rigorously explored by Andresen *et al* (2003), who found hope referred to in approximately 80% of the narratives, articles and studies they reviewed. Their analysis and interpretation of this evidence suggested that hope is one of four components of 'psychological recovery' (in addition to self-identity, meaning in life and responsibility), spanning five temporal stages (moratorium, awareness, preparation, rebuilding and growth). They considered hope to be capable of stimulating and maintaining recovery and to emanate from both within the person and from others.

A less interpreted form of qualitative evidence is offered by Chandler & Hayward (2009), who report nine unedited narratives of recovery from psychotic experience. Hope was mentioned on 56 occasions within these narratives and reflected hope for the self and others (Box 1). Consistent with the components of hope theory, these narratives offer a sense of hope as something that is oriented towards both process (pathways) and outcome (goals). What is novel here is the emphasis on the role of others: how hope can become a relational construct that can be held for, demonstrated and received from others in a dynamic and synchronic fashion.

Combining the evidence?

What can be learnt about the influence of hope across these differing forms of evidence and about the relationship between them? Quantitative explorations of hope remain indispensable to its conceptualisation and measurement, and to the assessment of interventions to facilitate the influence of hope. Arguably, qualitative evidence is the form of evidence to which the patient is most closely aligned, and in it hope may seem raw, idiosyncratic, uncertain, pre-goal and ungraspable. Yet, this space of uncertainty may be one where the practitioner spends little time, and where a shared language between patient and practitioner has yet to develop. Disconnection from hope as it is idiosyncratically expressed may leave both parties feeling hopeless. The dual drivers of hope understood from both quantitative and qualitative perspectives are necessary for travel. However, the emphasis has been historically weighted on methods that proceed by eliminating differences that matter for patients, which results in a structural imbalance between general and situated truths about hope. Research seeking to understand the role of hope in recovery needs to correct this imbalance by making room for linear and non-linear expressions.

Both the first-person accounts of people in recovery and qualitative research suggest that hope plays a crucial, and early, role in promoting recovery. The next section reviews the various mechanisms by which hope exerts this beneficial effect, and some of the implications that can be derived from this knowledge to improve the care of people with serious mental illness.

BOX 1 Expressions of hope in recovery narratives (Chandler 2009)

Hope to…	(manage, get…, continue…)
Hope for…	(help, stability, the future, things to be different…)
Loss of hope…	(personally and by other people in distress…)
Hope of others	('who stuck by me')
Hope for others	(the reader, practitioner, services…)
Modelling hope	(for others in distress)

Hope and recovery

By Larry Davidson

How hope promotes recovery

After witnessing significant improvements in the mental status, and life, of a young man with schizophrenia, I had the opportunity to ask him what he had found to be the most helpful aspect of the therapeutic work we had done together over several years. His response was: 'You believed in me, even when I didn't believe in myself.' In one form or another, I have now heard this response from many people who describe it as one of the cornerstones of their recovery. Patricia Deegan, a leader of the mental health consumer/survivor movement, also highlighted the importance of this experience in her life, labelling the phenomenon 'surrogate hope' (Deegan 1994). This is the first of many ways in which hope may be crucial in providing a starting point for recovery, in this case being held by someone else when a person feels they may have lost all hope in and for themselves.

A second experience of hope that plays an early, and often crucial, role in promoting recovery has emerged with peer support services. These are provided by people in either volunteer or paid

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positions, both inside and outside of mental health settings. People struggling with mental illnesses have described the surprise, power and inspiration they have derived from meeting someone else who has been in the same life circumstances, in the same shoes, and who has lived not only to tell the tale, but also to become a positive role model. They explain that, prior to meeting this person, they did not know that recovery was even a remote possibility. They did not know that someone who had the same illness, who had been as disabled as they were, could succeed in regaining a meaningful and gratifying life. The instillation of hope that results from such experiences is often the first step on the path to recovery.

For other people, who have been beaten down by the disorder, their repeated experiences of failure, disappointment, rejection, loss and discrimination, hope may come through different means. One of these sources of hope is found in what are often unexpected experiences of pleasure – unexpected as these individuals have become resigned to no longer experiencing any sense of pleasure. Because of poverty, they no longer have the resources to participate in many of the activities from which they previously derived pleasure. Because of rejection and isolation, they may no longer have people in their lives with whom they can experience pleasure. And because of their demoralisation and loss of hope, they may no longer believe that they are capable or worthy of experiencing pleasure. For these individuals, hope can be reawakened through the smallest and most unexpected of pleasures, from sipping a 'bottomless' glass of iced tea by the ocean to being able to afford to give birthday cards and Christmas presents to loved ones (Davidson 2001a).

For one middle-aged man, who had been offered a few extra dollars a week and had been instructed to spend these dollars on himself, on 'having fun', pleasure was derived from being able to buy French fries and coffee and to enjoy them with his acquaintances from Alcoholics Anonymous meetings. As he explained, being able to go out with them to a diner after meetings – because he could now buy his own food – transformed what had been acquaintances into friends. For him, the seemingly simple act of sharing fries and coffee with friends 'jump started' his recovery, as it offered him a glimpse into a world of opportunities that he thought had long been closed off to him. As he said (quoted in Davidson 2001b):

> 'Initially it started out as having the ability to do it because of a couple of extra bucks every month. But that's what I kind of needed to get my engines started and it got to the point where, then, it wasn't necessarily the money, it was just the desire to get out of the house and do something […] it's almost like opening up a little hole in a piece of paper that you kind of poke and it gets bigger and bigger […] To me, the project gave me that opening. Maybe I made it a little bit bigger, but I think without the project, it would have been tough for me to find another way to […] see something other than that 'I can't' mode.'

It is on the basis of such experiences of glimpsing what life still has to offer them, of seeing that there is more to life than the 'I can't' mode, that people are encouraged – and feel that it will be worthwhile – to take the risks required by recovery. Taking the steps involved in pursuing recovery requires having faith in oneself that these efforts will eventually pay off. Without a sense of hopefulness that good things will come, whether derived from myself or from others, I have no reason to take any actions on my own behalf.

Implications for practice

To promote a sense of hopefulness, and to help a person with a mental illness to experience pleasure, practitioners need to shift from a deficit and problem focus to a strength and solution focus (Fig. 1). This shift is made all the more necessary by the history of pessimism towards outcomes, which dates back to the earliest days of psychopathology. To combat

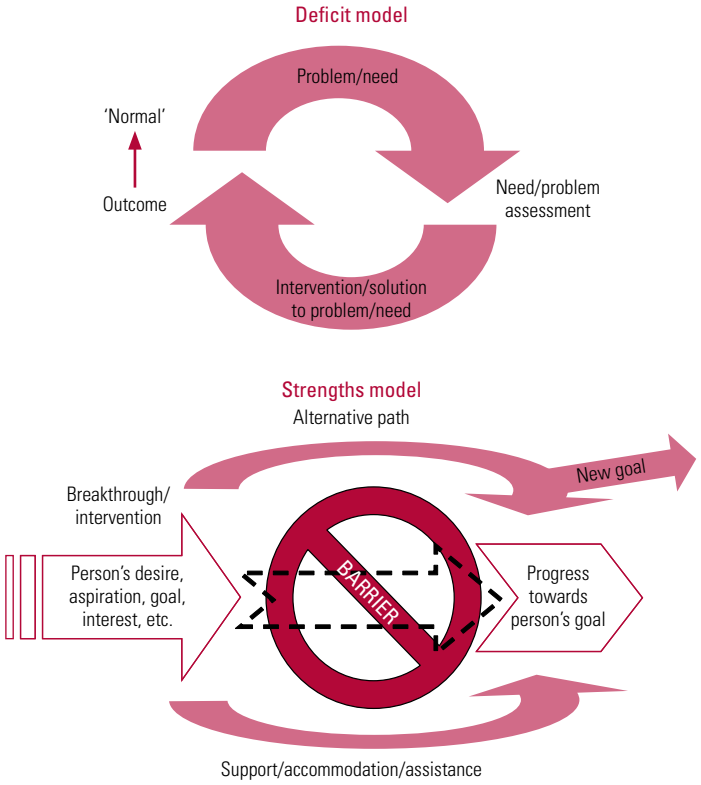

FIG 1 Moving from a deficit and problem focus to a strengths and solution focus (after Davidson *et al* (2006) with permission of Wiley-Blackwell).

MCQ answers
1 d 2 d 3 c 4 e 5 c

this legacy, and the associated stigma, practitioners have to be proactive in conveying an explicitly hopeful message to their patients, emphasising that recovery is not only possible, but also quite common. In addition to eliciting and building on each person's interests and strengths, recovery-oriented practice requires practitioners to expand their customary view of their role as clinicians who fix people, to incorporate the additional tasks of enhancing access to opportunities for success and pleasure and providing the community supports that may be required to help the person to be able to take advantage of these opportunities.

Conclusions

Numerous definitions of hope have been proposed, based on both philosophical roots and psychological concepts. This reflects the importance of hope in various health fields as well as the complexity of the concept and the potential constraints of imposing a measurement framework on such an intricate notion. However, to allow for comparable research to be carried out, a consensus definition of hope most comprehensively spanning the concept's components is required.

Initial prospective research has established a number of benefits of hope and evaluated therapeutic interventions supporting hope. However, some idiosyncratic connotations of the concept may never be captured in a definition or questionnaire designed to fit all. This reflects the manifold conceptualisations of hope and underlines the continuing importance of qualitative research.

Qualitative evidence gained from patient accounts also suggests ways of instilling hope outside of structured hope-supporting interventions. These may be simple or small things such as the psychiatrist's continued confidence in a person's recovery, an unexpected experience of pleasure or a single social intervention, or they may be more service-based experiences such as peer support.

An overarching implication for practitioners concerns their personal sense of hopefulness, and the extent to which it can enable a process of understanding and encourage the hope of the patients they serve. In terms of research, further prospective observational and intervention studies are needed to establish an increased understanding of why, and how, hope is central to mental health recovery.

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MCQs

Select the single best option for each question stem

1 The components of Snyder's hope theory are:

a agency and goals
b pathways and goals
c hope and goals
d agency, pathways and goals
e agency, hope and goals.

2 The percentage of narratives, articles and studies reviewed by Adreson (2003) that referred to hope is:

a 20%
b 40%
c 60%
d 80%
e 100%.

3 Recovery-oriented practice focuses on:

a elimination of symptoms
b reduction of symptoms
c patient's strengths and interests
d adherence to medication
e developing insight.

4 A consensus definition of hope (Schrank 2008) incorporates:

a control
b a negative or positive starting point
c personal characteristics such as inner strength
d broad or specific goals
e all of the above.

5 Hope restores the unification of:

a past and present
b present and future
c past, present and future
d past and future
e none of the above.