Schizophrenia is a major mental illness that affects 2 to 3 million people in the United States and has a personal, family, social, and economic cost unmatched by any other single illness (Keith, Schulz, & Shore, 1989). Long-term follow-up studies are challenging the traditional view that schizophrenia has a chronic deteriorating course. Harding, Zubin, and Strauss (1987) reviewed five long-term follow-up studies (with 22 to 37 years follow-up). They reported that over time, one-half to two-thirds of over 1,300 subjects recovered or showed significant recovery. They concluded that "the possible causes of chronicity may be viewed as having less to do with any inherent natural outcome of the disorder and more to do with a myriad of environmental and other psychosocial factors interacting with the person and the illness."

Harding (Garwood Jones Lecture, Hamilton, Ontario, October, 1987) conveyed the message sent to clinicians by consumers with schizophrenia in a 32-year follow-up study: "Don’t lose hope."

Nurses have many opportunities to assist individuals with schizophrenia because of the frequency and nature of their contacts. These contacts may occur during inpatient crisis periods or during more long-term relationships with the nurse functioning as a community-based therapist. How can nurses effect hope in working with their clients? Starck (1993) admonishes health professionals to "determine their proper role in affirming hope because they are in a position to either enhance or diminish it."

This paper reports on a qualitative study in which clinicians identified hope-instilling strategies for their clients with schizophrenia. Although the clinicians were from several disciplines, all of the strategies identified were relevant to, and within the practice of nursing.

BACKGROUND

Judith Miller, a nurse-researcher in the area of hope, characterizes hope as an:

...anticipation of a continued good state, an improved state, or a release from a perceived entrapment. The anticipation may or may not be founded on concrete, real world evidence. Hope is an anticipation of a future which is good and is based upon mutuality (relationships with others); a sense of personal compe-

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**Hope and Schizophrenia: Clinicians Identify Hope-Instilling Strategies**

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tence; coping ability; psychological well-being; purpose; and meaning in life, as well as a sense of "the possible" (1992, p. 414). Given this definition of hope, it is important to note that schizophrenia itself may create unique challenges that affect a person's capacity to hope. Symptoms of schizophrenia can, and often do, include difficulties in interpersonal relationships and disturbances in volition and the individual's sense of self (American Psychiatric Association [APA], 1994). The early age of onset, usually in the late teens to early adulthood, leaves many developmental stages incomplete.

According to the widely accepted vulnerability model, schizophrenia is characterized by the presence of vulnerability, not the presence of continuous illness (symptoms). Without social support, stress, which leads to a breakdown of coping ability, causes this vulnerability to evolve into a disorder (Wasylenki, 1992).

Schizophrenia includes both positive and negative symptoms. "The positive symptoms appear to reflect an excess or distortion of normal functions, whereas the negative symptoms appear to reflect a diminution or loss of normal functions." (APA, 1994). Psychotropic medications traditionally have targeted the positive psychotic symptoms, such as delusions and hallucinations. The negative symptoms include "restricted and blunted affective arousal and responsiveness, narrowing of ideation and curiosity, paucity in content of speech, diminution in social drive, apathy or inertia, and abulia" (Carpenter, Heinrichs, & Alphs, 1985). Carpenter and colleagues proposed that at least some negative symptoms may be secondary to factors separate from the illness, such as an understimulating environment, or as a consequence of the positive symptoms associated with schizophrenia. Such secondary negative symptoms are considered treatable, with treatment aimed at the underlying factor.

There is increasing awareness that schizophrenia is a complex disorder with a complex course. The individual with the illness plays an important role in the course and outcome of the illness. Individuals may play a critical role in symptom control, in choosing and regulating the kind of help they receive, in choosing whether to collaborate with treatment, and in deciding whether to risk new situations (Strauss, 1986).

Many first-person accounts suggest that consumers can feel robbed of hope because of the way they are treated by the health care system, service providers, friends, and family (Deegan, 1992; Houghton, 1982; Leete, 1988; Lovejoy, 1984). Experiences, such as living in large institutions or going for help in emergency departments, take away, or do not allow, the growth of hope. Deegan describes a "cycle of disempowerment and despair" that leads to symptoms of learned helplessness, including apathy, resignation, anger, submissionism, depression, anxiety, withdrawal, and compliance. Deegan notes that the symptoms of learned helplessness often are mistaken for the "so-called negative symptoms of psychotic disorders."

There is an overlap between negative symptoms and those of learned helplessness. Whatever the source, these symptoms may interfere with the person's ability to function successfully. How to help the person move forward, despite these symptoms, is the challenge for all health care professionals.

**Hope**

Consumer input and knowledge of psychosocial factors and schizophrenia point to the importance of looking beyond the "symptoms" of schizophrenia and exploring ways in which realistic hope can enhance the rehabilitation process. There is recognition that psychosocial rehabilitation, the widely accepted approach for assisting individuals severely disabled by mental illness, assists with recovery (Anthony, 1991; Deegan, 1988; Strauss, 1986). Hope has been termed both an essential ingredient (Anthony, Cohen, & Farkas, 1990) and a distinguishing feature of psychosocial rehabilitation (Bachrach, 1992).

Dr. Patricia Deegan (1988), a clinical psychologist, characterized the onset of her schizophrenia as a catastrophic shattering of her world, hopes, and dreams, and the "birth of hope" as a stage in her recovery. Consumers have written that setting and achieving goals and having positive role models were key to inspiring their hope and eventual recovery (Deegan, 1988; Houghton, 1982; Leete, 1988; Lovejoy, 1982). In the psychosocial rehabilitation literature, there is increased interest in the therapist-client relationship. The nature and strength of the therapist-client relationship has been deemed "one of the most potent therapeutic ingredients of effective rehabilitative interventions" (Goering & Stylianos, 1988). Mosher and Buri (1992) suggest that when a rehabilitation failure occurs, attention may need to be directed to the practitioner-client relationship. It remains a challenge for nurses to facilitate hope in their clients given the complex nature of schizophrenia and the important role hope plays in its recovery.
Method
A research study was undertaken to understand staff’s perspective on the relationship of hope and schizophrenia better. Future research will explore this relationship from the perspective of individuals with schizophrenia. The study’s quantitative component explored whether staff working with individuals with schizophrenia differed in the degree of hopelessness they experience and, if so, what factors affect their levels of hopefulness. A survey was conducted of 121 staff members of hospital and community-based programs in Hamilton, Ontario who work with clients with schizophrenia. Results of the quantitative component have been reported elsewhere (Woodside, Landeen, Kirkpatrick, Byrne, Bernardo, & Pawlick, 1994).

Because there has been limited research on the relationship of hope and schizophrenia, a qualitative component of this study was designed to elicit staff’s understanding of the concept of hope and what influences that hope. Survey respondents were asked to volunteer to participate in individual indepth interviews, and 15 staff members were selected from a cross-section of settings, disciplines, and years of experience in working with individuals with schizophrenia. Clinicians interviewed were from psychiatry, vocational counseling, social work, psychology, chaplaincy, nursing, and occupational therapy. Each interview lasted approximately 45 minutes and was audi-taped. Transcripts from the audiotapes were read by all of the researchers, coded as to content, and then analyzed by content themes.

As part of the qualitative interviews, the 15 participants were asked if they thought they could affect the level of hopefulness in a client with schizophrenia and, if so, in what way. It was clear that all staff interviewed felt they could affect their clients’ level of hopefulness positively. They described both hope-instilling strategies and obstacles to hopefulness for their clients.

Results
Hope-instilling strategies
Clinicians identified several areas in enhancing hope for clients: building relationships, facilitating success, connecting to successful role models, managing the illness, and educating clients and the community. The most frequently mentioned strategies concerned the client/clinician relationship.

Building relationships. Most participants explicitly mentioned the importance of the relationship, rapport, communication, and/or trust between the health professional and client in instilling hope. The majority portrayed what might be called being present—listening to the client and valuing the person. Several described the importance of understanding the client’s perspective and accepting the person as who she is. As one said, “Understanding is the intervention.” For another, it was conveying the feeling of acceptance as a worthwhile person that engenders hope. This accepting perspective was summed up by one participant who noted that “you can find meaning and hope in life, no matter which rules you bring to it.” Acceptance was geared to the client’s perspective even when it was not what the clinician might wish. One participant described valuing the client’s experience, even if it is of hopelessness, “But I think part of instilling hope is allowing them to feel the hopelessness. So, I guess, it’s that, allowing them experience whatever they’re having in a safe kind of way.”

Several staff members described the interaction between the staff and client in terms of a journey by the client with the staff member as facilitator. Staff stories were rich in imagery. One suggested the person may need to go through “another channel.” Several said the hope had to be present in the patient, but the staff member could be a catalyst to assist or nurture it. “Hope in many ways comes from within themselves, but in other ways we seed it”; “If there’s a spark, hopefully, I can light a fire.”

Similarly, several respondents referred to a “contagion” effect wherein the staff’s hopefulness could positively influence the client. As one staff member described, “When she had that spark of, I don’t know, trust I guess, that she perceived from the people around her, that the team really thought she could do it, she just went with it.”

A common theme expressed was the issue of time, that is, working with the individual over time. Several hospital-based participants particularly discussed the difficulty of initiating a working relationship with someone who was ill, and felt that considerable perseverance was required.

Facilitating success. Almost half the participants identified assisting the person to have a successful experience as a hope-instilling strategy. Setting and reaching goals were important components of the strategy. Experiences described took place both in and out of hospital. Participants also depicted the assisting role of staff who helped clients to move forward both in exceptional situations and in their daily lives. When success occurred, it allowed clients to have increased control in their own lives and resulted in increased self-esteem. One staff member who helped a client assertively confront a negative interpersonal relationship in his board-
ing home, said now he knows, "I can do it. If I can do it with this person, I can do it with someone else." Staff reported supporting clients even when this was risky. A nurse described the anxiety she felt when supporting her client to pursue her goals. "That was scary, but she wanted it so much."

One nurse described negotiating and renegotiating a plan with a suicidal client to remain in hospital, where the client could have both professional support and control. "It was a pivotal time when he could have totally fallen into despair and killed himself and it swung into hope."

A vocational counselor described working with a client who had experienced many vocational and educational failures. Working together they were able to obtain a job delivering papers. A job coach helped the client learn the route piece-by-piece over time. At the time of the interview, the client was completing three-quarters of the route and felt proud of his achievement and the fact that he was working and being paid by the newspaper, not a workshop.

Connecting to successful role models. This strategy involved assisting clients by providing them access to another individual with schizophrenia, who had succeeded in some aspect of his or her life. In some situations, the staff member recounted a previous experience with a different client who had faced a similar situation. One staff member began a group so that individuals with schizophrenia could share their common experiences. In all the stories, the strategy was to increase the connectedness the person had with others in a similar situation and, thereby, decrease the feeling of aloneness.

Managing the illness. Several participants described the importance of good medication management and symptom control. Symptom control, particularly of the acute positive symptoms, often was considered a precondition to implementing other interventions. Often, as clients obtained some symptom relief, they could address areas of their lives in which the illness had interfered.

Not surprisingly, illness-management was an important area for the two psychiatrists who were interviewed. One emphasized his role in assessment, differentiating the person who might feel hopeless or depressed from the illness-related factors, such as the effects of the illness, the effects of the medication, or response to the illness. The second psychiatrist focused on his role of managing medication as hope-instilling, a role that he noted his clients expect of him. This psychiatrist described a process of reviewing past documentation to learn what might provide symptom relief for a client. "Occasionally, one discerns a pattern or something that wasn't tried and so I go at it methodically, maybe try a certain drug and occasionally it works and works miraculously . . . I'm just trying something that wasn't tried before."

Educating clients and the community. Education was considered important both for clients regarding their illness, and for community members, including other professionals. The importance of education for the client about the illness was not limited to symptoms and symptom-control. Rather, the schizophrenia was put in a framework for recovery, that is, letting people know that in spite of what is a fairly disabling mental illness, many people do go on to have fulfilling lives. Others talked about putting the illness in a context, either through its connection with others who also have schizophrenia or with other chronic illnesses, such as diabetes or multiple sclerosis. This again worked to decrease the sense of isolation for the client.

Obstacles to hope

While respondents discussed strategies that enhance hope, many also commented on external and internal obstacles to hope for their clients. The primary external obstacle identified was stigma, from both society and professionals. Some participants indicated that their clients had been "ghettoized," and that the real world often was not kind to them. A small number of respondents cautioned about the negative impact staff could have if they had a negative attitude or if their professional roles got in the way. A few cautioned that staff hopefulness might have a negative impact if it led to an inability to be present with, and really listen to, the client.

Internal obstacles for clients included illness-related factors, such as the effects of symptoms and difficulty in forming relationships. In addition, participants noted that some people may simply have a less hopeful attitude, separate and apart from the schizophrenia.

Conclusion

This qualitative study was conducted with 15 volunteer staff who may be more hopeful than other staff working with similar clients. However, it is staff who feel they can make a difference and can identify hope-instilling strategies from their practice who have much to teach us.

The importance of this study for nurses lies in its identification of, and nature of, the client-clinician relationship as central in instilling hope. Participants reinforced the view that the relationship between the person, the illness,
and hope is a complex one. While relationships were seen as central in instilling hope, the difficulty in establishing that relationship was viewed as hope-inhibiting. This paradox—that one of the strategies can be one of the obstacles—highlights the struggle for many clinicians. Recognizing that the establishment of the relationship is central in assisting the development of client hope, and (hopefully) eventual recovery, may assist nurses in persevering with what may be a challenging and lengthy process.

All of the strategies mentioned by respondents are consistent with psychosocial rehabilitation principles, literature written by consumers, and Miller’s definition of hope. The strategies include assisting persons with schizophrenia to set goals, seeing them as people, and joining with them on their journey of recovery. By recognizing the importance of these strategies, nurses can use them in many situations, whether in inpatients settings, medication clinics, or in more long-term community services.

Stigma from professionals and community members often was mentioned as an obstacle to hope for people with schizophrenia. Nurses must focus their educational and lobbying efforts on reducing stigma both in the public and the health care community, as well as examining their own practice. Focusing on the areas identified in this study is likely to have an impact on the level of hope in many individuals who have schizophrenia.

References