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Determinants, self-management strategies and interventions for hope in people with mental disorders: Systematic search and narrative review

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ABSTRACT

Developing a recovery focus in mental health services is a policy goal internationally, and hope is a central component of recovery. Yet determinants of hope of people with mental disorders are not well known, nor are strategies and interventions that increase hope. This study aims to systematically summarise the available evidence to fill four relevant knowledge gaps: (1) hope scales used in psychiatric research, (2) determinants of hope, (2) hope-fostering self-management strategies, and (3) interventions to increase hope for people with mental disorders. We conducted a systematic literature search in April 2011 and a narrative synthesis of publications including qualitative and quantitative studies. Results for the first time provide a comprehensive overview of existing evidence and identify important scientific knowledge gaps: (1) Hope scales used do slightly vary in focus but are overall comparable. (2) Most published research used cross-sectional designs resulting in a high number of potential determinants of hope. No studies prospectively investigated the influence of these determinants. (3) Hope fostering self-management strategies of people with mental disorders were described in qualitative studies only with experimental studies completely missing. (4) While some recovery oriented interventions were shown to increase hope as a secondary outcome, there are no successful interventions specifically aimed at increasing hope. This review provides the basis for both practical and research recommendations: The five most promising candidate interventions to improve hope in people with mental disorders are (i) collaborative strategies for illness management, (ii) fostering relationships, (iii) peer support, (iv) helping clients to assume control and to formulate and pursue realistic goals, and (v) specific interventions to support multiple positive factors such as self-esteem, self-efficacy, spirituality and well-being. These may serve to directly improve care and to develop theory-based models and testable interventions to improve hope in mental health as well as in allied fields.

Background

Hope has been a relevant topic in mythology, philosophy and religion for centuries. However, it was only in the 1950s when Menninger (1959) identified it as integral to the profession of psychiatry, important for initiating therapeutic change, willingness to learn and personal well-being. Since then, a wealth of research has been conducted investigating hope in various medical fields and different settings (Castañeda, Carrion, Kline, & Martinez Tyson, 2010; Lalor, Begley, & Galavan, 2009; Rhodes, Bernays, & Terzic, 2009), but particularly in oncology and internal medicine (Olson, 2011; Rhodes et al., 2009). Recently, hope has also become a focus for mental health practice and research (Schrank, Stanghellini, & Slade, 2008). Hope is considered central to the concept of personal recovery from mental disorders, both as a trigger and as a maintaining factor, since it helps people to find the courage to start their recovery journey and the motivation to keep working on recovery despite potential obstacles (Bonney & Stickley, 2008). Hope is also essential for resilience (Ong, Edwards, & Bergeman, 2006), and consistently identified by both patients and therapists in various settings as a key factor in psychotherapy (Schrank et al., 2008).

Hope has been variously defined in the literature and different instruments have been proposed for its measurement. Also, hope may have different meanings in different cultures and among different population groups. However, with few exceptions cross-cultural research on hope is scarce (Eggerman & Panter-Brick,

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2010; Castaneda, 2010). A systematic literature review integrating all available definitions and measurement tools for hope has revealed a number of key components of the concept. These are summarized in a definition of hope as a primarily future orientated expectation (potentially informed by negative experiences such as mental disorder) of attaining personally valued goals which will give meaning, are subjectively considered possible and depend on personal activity or characteristics (*e.g.* resilience and courage) and/or external factors (*e.g.* resource availability) (Schrank et al., 2008). The new and evolving field of positive psychology may offer a framework within which to accommodate and unify the varying approaches to hope research. Despite ongoing debate about the exact remits and boundaries of positive psychology (Cowen & Kilmer, 2002), the essence of this 'movement' is clear, i.e. focussing on positive characteristics and strengths instead of exclusively amending deficiencies and treating symptoms (Csikszentmihalyi, 2009). It potentially provides an umbrella structure to accommodate and strengthen hitherto fragmented positively oriented research from areas such as humanistic psychology, prevention, resilience research, and social work (Becker & Marecek, 2008; Cowen & Kilmer, 2002).

As regards the measurement of hope, only a few of the available scales have been commonly used in quantitative research. These comprise multi-dimensional scales which include different subscales (*e.g.* spirituality) and Snyder's Hope Scale (1991) which takes a more narrow definition of hope as a mainly motivational concept of perceived goal orientation and goal striving (Schrank et al., 2008). One aim of the current study is to characterise the main scales used in empirical research, both as a resource for future hope research and in order to judge whether scales are sufficiently similar to allow meaningful comparison.

In contemporary mental health practice recovery orientation is evolving as the new service paradigm, for which hope is central (Slade & Hayward, 2007). This review applies systematic review techniques and a narrative synthesis approach in order to answer four questions in relation to people with mental disorders: (1) What are the main hope measures used in mental health research? (2) What predicts hope (*i.e.* determinants of hope)? (3) What can people do to increase their own hope (*i.e.* self-management of hope)? (4) What can mental health services do to enhance hope (*i.e.* interventions for hope)?

Methods

Data sources

We searched twelve bibliographic databases from inception (bracketed): AMED (1985); British Nursing Index (1985); EMBASE (1947); MEDLINE (1946); PsycINFO (1806); Social Science Policy (1890); CINAHL (1981); International Bibliography of Social Science (1951); British Humanities Index (1962); Sociological abstracts (1952); and Social Services abstracts (1979). The reference lists of all included studies, relevant reviews and opinion papers were hand searched for additional relevant papers. References of all included studies were entered in a Web of Science Cited Reference Search to identify all quoting articles. Four experts with a high research profile in the field were asked to identify research on determinants of hope.

Search strategy for electronic databases

All databases were searched in April 2011 using the following terms identified from the title, abstract, key words or medical subject headings: ('hope' OR 'hopeful$' OR 'hopeless$')' AND ('mental health' OR 'mental illness$' OR 'mental disorder' OR 'mental problem$' OR psychol$ OR psychiat$) AND ('instil$', OR 'maintain$', OR 'foster$', OR 'promot$', OR 'increas$' OR 'keep$' OR 'support' OR 'improv$' OR 'encourag$' OR 'lose' OR 'loss' OR 'diminish$' OR 'develop$' OR 'intervention$' OR 'practice' OR 'therap$' OR 'strateg$'). The search was adapted for the individual databases and interfaces as needed.

Eligibility criteria

We included articles published in peer-reviewed and non peer-reviewed journals available in full-text in English or German.

In terms of studies design we included intervention studies investigating hope as a primary or secondary outcome; repeated measures studies investigating predictors for hope; cross-sectional studies investigating the correlation of hope with other variables; and qualitative studies using established qualitative research methodology with at least three participants.

Qualitative studies were eligible when investigating determinants, self-management strategies or interventions for hope in the research question. Quantitative studies had to use a service user rated measurement tool for hope or with hope as a separately described and quantified sub-scale. Observational studies measuring change in hope over time without investigating potential determinants of change were excluded, as were programme descriptions without empirical data, dissertations, book chapters, conference presentations and other not publicly available sources.

As regards study participants we included studies on adults of working age with a past or present diagnosis of mental disorder, based on ICD or DSM (Andrews, Slade, & Peters, 1999), who use or have used mental health services. Data on users of forensic services were not included. Qualitative data from professional and informal carers were included if they dealt with potential determinants of hope in service users from others' perspective. Data on hope of providers or carers were excluded.

Data collection and analysis

All references were downloaded to Reference Manager (Miller, 1994), and duplicates were removed. The titles of all identified publications were read to identify those potentially eligible. From these, the abstracts were reviewed, and where they appeared to meet the inclusion criteria, the full publication was obtained and a decision made about inclusion. Articles for which no abstract was available and which could not be excluded by title were retrieved in full-text to establish their fit to the inclusion criteria.

The first 100 studies were independently rated for inclusion by two reviewers (BS, VB), achieving a concordance rate of 0.96. Disagreement was resolved by consensus. The remaining studies were appraised by one review author (BS or VB). Online Data Supplement 1 shows the excluded studies and reasons for exclusion. Online Data Supplement 2 lists the included articles indicating their research design, sample size, participants and hope measure used.

Data extraction and synthesis followed the Guidance on the Conduct of Narrative Synthesis in Systematic Reviews by Popay et al. (2006). This procedure allows for the synthesis of studies that include a wide range of research designs which are insufficiently similar to permit a specialist synthesis approach. Qualitative data were split according to their source (*i.e.* service users and non-service users) and inductively clustered into groups representing determinants, self-management strategies and interventions for hope. Where the original study distinguished between data obtained from users and staff it was adopted for our analysis. Where this was not possible we report the data as service user