Should be cited as: Psychiatr. Pol. 2013; 47(5): 933–943
ISSN 0033-2674
www.psychiatriapolska.pl

The importance of hope in coping with schizophrenia

Małgorzata Libman-Sokołowska, Tadeusz Nasierowski

Department and Clinic of Psychiatry, Medical University of Warsaw
Head of the Department: Prof. dr hab. Med. M. Wojnar

Summary

Hope is an important dimension of psychological functioning, the source of strength in existential challenges both in health and illness. It is already known that hope is connected with the subjective well-being in people suffering from schizophrenia. Therefore, increasing hope is a promising goal of therapeutic interventions. On the other hand, multiple definitions of hope and methodological differences in the approach to the subject do not lead to determining therapeutic indications, useful in clinical practice. Most scientific projects about hope in people with schizophrenia concentrate on description of mechanisms influencing the patients welfare or determining the relationships between hope intensification and other factors. The paper reviews the concepts of hope and related psychometric techniques and presents the results of research on hope in people with schizophrenia. The presented studies are focused mainly on relationships between hope and psychopathology, the recovery and well-being of the patients. Continuing the research in this topic and analysis of current data may contribute to beneficial changes in the treatment of schizophrenia

Keywords: schizophrenia, hope

Hope is one of the dimensions of psychological functioning, thus an element integrating human psychical life, a source of strength in existential challenges both in health and illness.

Psychological factors supporting sickening and recovery, predictors of the illness progress and therapeutic cooperation, as well as events accompanying recovery are distinguished when describing psychical disorders. However, hope is not always considered an important element of the psychical state, influencing the effects of therapeutic activities of the medical staff. The most recent scientific literature on hope in patients with schizophrenia suggests that this aspect of patients functioning is beyond the interest of most psychiatrists [1]. This approach is quite strange, because the influence of hope on the condition of a chronic patient and their mutual relationship are commonly recognized. Moreover, these relations are a promising goal of therapeutic interventions, also in patients with schizophrenia.

Till quite recently, hope was also neglected by psychologists. It became present in scientific literature thanks to positive psychology. This current of modern psychology arose in 1998 when Martin Seligman addressed the members of the American Psycho-

logical Association to focus psychology on human strength and not on weakness [2]. Positive psychology was created as an opposition to the perception of human beings through psychopathological description. It focuses on those elements of psychical accoutrements that help to increase the quality of life. Undoubtedly, hope is one of such accoutrements. Nurses and psychoeducators have a significant contribution in the development of knowledge on the role of hope in treatment of schizophrenia. Their commitment in scientific research on this topic is a natural consequence of their significant contribution in healthcare.

Defining hope for the survey

According to the "New Dictionary of the Polish Language" [3], hope refers to "expectation of accomplishing something desirable, trust that it will be fulfilled, become real". This definition refers to the common understanding of this term. According to authors of scientific publications, hope is a trait, state or psychical mechanism. Analysis of the studies about hope in patients with schizophrenia requires answering the following questions: what was measured, what instruments were used in the survey and what theory was the instrument based on. As a consequence, analysis and comparison of the results will help to avoid mistakes resulting from a false assumption that all scientific studies about hope refer to the same phenomenon.

Most scientific projects about hope in people with schizophrenia concentrate on two basic issues: 1) description of mechanisms influencing the patients welfare, and 2) determining the relationships between hope intensification and other factors. Accomplishing the first objective requires an exploration survey, in which description of hope experienced by patients may be one of the results. Aiming at the second target is linked with matching an instrument to measure hope by the scientist and thus accepting a specific definition of hope used in the creation of the instrument.

Concepts of hope and techniques of its measurement

Beate Schrank, Victoria Bird, Abraham Rudnick and Mike Slade, the authors of a review paper published in 2012 on hope in people with mental illnesses, have determined that scientists working on this subject commonly apply one of the three instruments used for assessing hope: the *Snyder Hope Scale* (SHS), the *Herth Hope Index/Scale* (HHI/HHS) and the *Miller Hope Scale* (MHS) [4]. Each of them is a "paper-pencil" questionnaire, requiring self-reflection in the patient and then marking the answer that best describes his experience.

According to the author of the *Snyder Hope Scale*, hope is a positive motivation state, based on mutually connected convictions on: successful actions ("agency") and methods of accomplishing the goal ("pathways") [5]. According to the concept, hope is based on cognitive processes and the positive mental state is secondary. Moreover, hope as such is a relatively permanent predisposition, shown in various situations [6, 7]. People with high hope are convinced to be able to accomplish a taken plan, because they are determined, steadfast and capable of considering several solutions – they are elastic in their aspirations. This characteristics is reflected in three significant areas: 1)

hope favours the construction of a positive self and concentration on success, 2) hope increases the adaptation possibilities in difficult life situations, and 3) hope allows to set ambitious goals and their achievement in all important domains of life [8]. In turn, belief in favourable external conditions or in finding a solution from a difficult situation are not expressions of hope as defined by Charles Snyder. Hope does not require belief but conviction on self-competence and activity in setting a course to ones actions.

The Snyder Scale was adopted in Poland as the Questionnaire on Hope of Success (KNS – Kwestionariusz Nadziei na Sukces). At present it comprises 12 statements which are assessed by the patients on a 4-point or 8-point (in the Polish version) scale. It allows the measurement of two components of hope: assumption of a strong will and assumption of the ability to find solutions [7].

The first version of the *Herth Hope Scale* was created based on the transactional theory of stress by Richard Lazarus and Susan Folkman and the theory of hope by Ezra Stotland [9, 10]. In this case hope is defined as a state of mind agitation linked with a positive expectation, focused on action, that goals or needs of the self or the future are capable of accomplishing, and the present state or situation are temporary. The following version of the questionnaire was constructed based on the theory by Karin Dufault and Benita Martocchio. They described hope as process, not a trait or state. They distinguished 2 spheres of hope and 6 dimensions common for both zones. The external sphere is generalized hope, which protects from breakdown in difficult situations and allows to retain or recover the sense of life. The internal sphere is particularized hope, which concentrates on a particular object and motivates to overcome obstacles in achieving the goal [12]. The following dimensions of hope were distinguished in the two spheres:

- affective, comprising emotions and experiences sensed during feeling hope, such as uncertainty of the result or its significance;
- cognitive, encompassing exploratory processes, such as e.g. thinking, learning, imagining or expressing an opinion referring to hope;
- behavioural, composed of actions undertaken with hope, directly focused on achieving or approaching the goal, e.g. participation in religious practices;
- affiliative, which is the sense of link between the person feeling hope and other people or God, reflected also by the readiness to accept help;
- temporal, referring to the perception of time by the person feeling hope; hope is generally directed on future goodness, but is also connected with former or contemporary events that influence the process of hope in a given person;
- contextual, composed of life situations and circumstances that accompany hope, induce it or are its part [11, 12, 13].

In the HHS scale, the six dimensions have been joined in pairs and reduced to three. Thus, the following dimensions were created: cognitive-temporal, affective-behavioral and affiliative-contextual; ten questionnaire positions have been assigned to each of them, which are assessed in a 4-point scale. The reduced version of the Kaye Herth instrument (HHI) comprises 12 positions. It was created for scientific studies and clinical applications in a group of adults with changes in the health conditions.

The author of the *Miller Hope Scale* defined hope as a state, in which welfare sustainment, situation improvement and deliverance from constraints are anticipated. She distinguished three levels of hope. The first, referring to low-significance wishes, whose non-fulfillment does not lead to despair, is characterized by shallow optimism, easy to sustain. The second level pertaining to crucial aspects of life, such as hope for a close relationship or self-realization, engaging much more psychical energy than the first level. Non-fulfillment at this level causes anxiety. The third level is related to release from suffering, from a trap, passage through a difficult life experience, requiring engagement of all reserves of energy. If the solution seems unrealistic, the person falls into deep despair and abandons further efforts [12]. Beside three hope levels, J. Fiztgerald Miller also distinguished its eleven components: 1) mutual relations with other people, 2) sense of possible, 3) avoidance of absolutizing, 4) anticipation, 5) goal establishing and achieving, 6) psychologic well-being and coping, 7) purpose and meaning in life, 8) freedom, 9) reality surveillance, 10) optimism and 11) mental and physical activation.

The MHS comprises 40 statements whose aptness is assessed in a 5-point scale. The factor analysis indicated that the questionnaire content refers not to eleven but to three categories, including: 1) Satisfaction with Self, Others and Life, 2) Avoidance of Hope Threats, and 3) Anticipation of a Future[14].

Worth noting is a new instrument for measuring hope, the *Integrative Hope Scale* published in 2011. The instrument was formed by the combination of the three questionnaires mentioned above – SHS, HHI and MHS – and after analysis of a representative group of Austrians, the number of its positions was reduced by factor analysis. As a result, four regions of hope were distinguished: 1) trust and confidence, 2) lack of perspectives, 3) positive future orientation, and 4) social relations and personal value [15].

An interesting concept of hope is the basic hope concept, which so far has not been applied in studies about schizophrenia, despite the fact that it seems to be useful in them. The basic hope concept is derived from the concept of the life cycle by Erik Erikson. In Poland the concept was developed by Jerzy Trzebiński and Mariusz Zięba [16, 2]. It is defined as the assumption of an individual that the world is ordered and sensible and generally favourable to people. It is thus an important element of the vision of the world and at the same time represents a rather durable structure of personality. According to the Polish authors, "the adaptive role of basic hope is particularly significant in cases of irreversible loss forcing the individual to choose new alternatives of life". The stigmatizing diagnosis of schizophrenia and the possible consequences of the illness, as e.g. loss of relations with intimates, are often interpreted by the patients as such losses. Therefore it can be assumed that in their case the level of basic hope influences coping with the consequences of the psychosis. Interestingly, the level of hope according to Erikson is positively correlated with the level of hope of success (according to Snyder), although it is an assumption about the external world and does not refer to the competence of the individual. Moreover, the positive relation of both types of hope with the level of emotional intelligence has also been determined [17].

The instrument for measuring basic hope is the *Basic Hope Inventory-12* (BHI-12) questionnaire. It comprises 12 statements, evaluated in a 5-point scale [16].

Hope as the lack of hopelessness

Some authors of papers on the functioning of people with schizophrenia have assumed that the high level of hope corresponds to the low level of hopelessness. They often did not express this opinion directly. However, this conclusion is justified by the fact that they used *The Hopelessness Scale* (BHS) by Aaron Beck in the assessment of the level of hope [18, 19, 20]. At the same time, there is no agreement on the issue whether hope and hopelessness are on the same continuum, or they represent relatively independent psychical constructs in one person [12].

Contrary to the questionnaires described above, BHS is an empirically constructed instrument. It comprises items from the test of attitudes to the future by Richard Heimberg as well as pessimistic statements expressed by the patients, who according to clinicists have lost hope [21]. The analysis has shown that the instrument has a tri-variate structure, according to which hopelessness comprises: feelings on the future, loss of motivation and expectations referring to the future. If lack of hopelessness is assumed to be identical with hope, then hope is thus composed of: feelings and expectations with regard to the future and motivation to undertake efforts to change one's life.

According to the team of Holger Hoffmann, Beck's proposal does not use up the hopelessness issue [22]. For example it omits significant psychical properties that are closely related to hopelessness in a cognitive-affective sense, which are useful in the study of people with schizophrenia. According to Hoffmann and his team, hopelessness includes: locus of control, self concepts, expectations with regard to the rehabilitation results and strategies of overcoming stress. Based on empirical data they created an interesting model of relationships between these variables, illness symptoms and results of vocational rehabilitation.

Hope in patients with schizophrenia. Results of explorative studies

A study was conducted in South Korea on the exhaustive description of hope from the perspective of patients with schizophrenia [23]. During ambulatory treatment, twenty five patients with retained ability of abstract-thinking ability were asked to respond to three questions: "what does hope mean to you?", "what do you hope for?" and " what are your sources of hope?". The patients described hope as: sense of life, happiness, prediction of a better future, energy needed for living. Their hope was focused on: an untroubled life (as normal members of the society), restoration of family relationships, close inter-personal relationships, health, being free (from the trap of present life), owning possessions, and spiritual fulfilment. They gained hope from internal sources: self-confidence and youthfulness as well as external sources: love, inter-personal relationships, relations with God, beauty of nature and learning of people facing greater difficulties. These results indicate that the way of feeling hope by people with schizophrenia does not differ significantly from the feeling of hope by

other people, whereas the goals indicated by the patients are connected to their illness. It can be assumed that the most severe consequences of schizophrenia can be found in inter-personal relationships – with the closest persons and in social structures. What is important is that the authors have pointed out the positive influence of hope on the subjective feeling of health improvement. This observation is concordant with the conclusions of Sylvie Noiseux and Nicole Ricard [24], who have applied the grounded theory method in their studies. This approach requires formulating opinions based on regularities recognized in the study material collected regardless the earlier assumptions and models. The authors state that one of the significant elements of recovery (subjective approach) is "striking a sparkle of hope". The sparkle appears when the person, whose life is dominated by the appalling symptoms of the illness, starts to feel what the authors have called after the patients the instinct for survival. Moreover, analysis of data from an extensive questionnaire carried out on a large group of patients has also confirmed that hope and optimism belong to one of the elements of subjective recovery, beside satisfaction from various spheres of life and feeling of agency in the recovery process, i.e. feeling the capacity to influence its course [25].

Associations of hope with other variables in people with schizophrenia

A significant issue for the clinicists is the association of hope with the intensification of schizophrenia symptoms. The most recent results confirm this relationship to a certain degree, moreover, they indicate that full recovery may only partly be predicted based on the intensification of psychopathological symptoms. Hope should be considered. This refers both to the objective (result of vocational rehabilitation), as well as subjective expressions of recovery (perception of the quality of one's life) [19, 22, 26]. Results of the Beck's Hopelessness Scale do not correlate with the negative and positive symptoms of schizophrenia, assessed by the PANSS scale. Only the emotional discomfort factor distinguished in PANSS was associated with increased hopelessness [18]. Referring to hopelessness as a complex cognitive-affective phenomenon has allowed to describe numerous correlations between its elements as well as between them and groups of psychopathological symptoms. After eliminating the influence of other variables in the statistical analysis, external locus of control (one of the elements of hopelessness) had the most negative effect on the vocational achievement of patients among all studied cognitive factors – to the same degree as psychopathological negative symptoms [22].

Paul Lysaker and his cooperatives have studied the association of the personal narratives of people with schizophrenia with recovery and hope level. According to them, the change of the way of self-experience, renewed identification of oneself as a person taking part in life in a significant way is an important element of the recovery process, whereas personal narratives indicate the way to give sense to one's life [19]. Schizophrenia reduces narratives much more than depression [27]. In people with schizophrenia, rich narratives are positively correlated with the quality of life and negatively – with the hopelessness level measured in the BHS scale [19, 20]. Apparently, this regularity is explained that for full self-experience, the key factors are social contact

and hope. Other studies have shown the positive influence of hope measured with the SHS scale on the quality of life in people with acute mental illnesses [26].

In schizophrenia, the percentage of suicides is 8–15% according to different data, whereas the risk of suicide increases with each attempt [28, 29]. According to Beck, suicide is the effect of considering one's fate as hopeless. Suicidal attempts are promoted by negative predictions of the future and lack of apparent solutions of problems in a hardly bearable situation. Many authors point out the influence of depression on suicidal attempts, however the studies undertaken by Beck and his cooperates have indicated that in this case hopelessness is an important predictor [30]. In an over 300-group of the survey participants, patients with diagnosed schizophrenia summed up to c. 25%.

The role of hope as a factor protecting against a suicidal attempt has been indicated in studies of the influence of religiousness on suicidal behaviour of psychotic patients [31]. Religion can be both a protective factor (for 1/4 patients) and a conductive factor (for 1/10 patients) to undertake the attempt. Psychotic patients without suicidal behaviour in their illness history have assumed that religiousness prevents suicidal attempts e.g. by building hope. In this context has to be discussed the association of religiousness and spirituality with hope in people with schizophrenia. Authors of one paper have assumed that the positive relation with one's religiousness/spirituality influences the reduction of psychopathological symptoms. This effect was attributed e.g. to the increase of hope in religious patients [32]. Another report shows the influence of spirituality on the quality of life in patients with residual schizophrenia. One of the aspects of spirituality in the questionnaire was the domain 'hope and optimism'. However, there was no association with the quality of life or increase of symptoms. The quality of life, but not the symptoms, were influenced by spirituality aspects from the domains 'spirituality' and 'inner peace' [33].

Part of the studies show that high hope may be linked with unfavourable phenomena in the illness, and low hope – with positive phenomena. Lysaker and cooperatives have observed, thus confirming earlier studies, that better cognitive functioning reflected in the results of neuropsychological tests favours pessimism in people with schizophrenia [18]. Thus an important question arises: is action aimed at improving the cognitive functions unfavourable for the patients, decreasing their hope level?

Therapeutic interventions are often focused on increasing insight in people with psychotic symptoms. In turn, insight may worsen the quality of life because, as shown by the studies of Ilanit Hasson-Ohayon and cooperatives, it is negatively correlated with hope for success. However, if the patient can separate the illness from the self-image, then hope allows to use insight as an instrument for overcoming restrictions resulting from schizophrenia [34]. This was pointed out by authors of a review paper on suicidal behaviour in people with schizoaffective disorders [28]. They observed that people, who socially functioned well before they became ill, may feel a larger loss and experience stronger hopelessness linked with schizophrenia that people that did not function well. On the other hand, social abilities are resources that favour the improvement of life quality and most probably allow better managing with the illness.

Conclusions

The current state of knowledge on hope in people with schizophrenia is sufficient to assume that hope is a very important aspect of psychical life, playing a crucial role in activities aiming at increasing the functioning of the patients. Relationships between hope and other variables are very complicated and building coherent knowledge is additionally hindered by lack of a uniform definition of hope. Although the need to increase hope in the patients is commonly noted, there are very few scientific reports on the undertaken therapeutic interventions. Thus, it is important to continue studies on the topic, in the first place to systematize the data collected so far. This may result in changes in clinical practice that will be profitable for the patients.

Роль надежы в преодолении шизофрении

Содержание

Надежда составляет существенный фактор психического функционирования человека, источником силы в экзистенциональной борьбе здоровых и больных людей. У пациентов, больных шизофренией надежда связана с субъективным чувством выздоровления, поэтому ее утверждение является обещающим фактором в терапевтических занятиях. С другой стороны, разнородные дефиниции надежды и методологические различия между, посвященными ей немногочисленными исследованиями, затрудняют сделать выводы. Они бы позволили на формирование конкретных терапевтических показаний, пригодных для использования их в практике клиницистов. Большинство исследовательсиких проектов, посвященных надежде у больных шизофренией, концентрируется на описании механизмов, влияющих на чувство доброго состояния здоровья больного или же на определении зависимости между верой в надежду и иными изменчивыми. В настоящей работе представлены концепции надежды вместе с отвечающими им психометрическими пособиями, а кроме того – результаты исследований, относящихся к понятию надежды у больных шизофренией. К таким относятся вопросы о связях надежды с утяжелением психопатологических симптомов, процессов выздоравливания и хорошим общим самочувствием. Продолжение исследований над этой проблемой, а прежде всего систематика до сего времени собранных данных могут причиниться положительными, для пациентов изменениями в процессе лечения.
Ключевые слова: шизофрения, надежда

Rolle der Hoffnung in Coping mit Schizophrenie

Zusammenfassung

Die Hoffnung bildet ein signifikantes Ausmaß der psychischen Funktionsweise des Menschen, eine Quelle in Coping – Strategien der gesunden und kranken Personen. Bei den Patienten mit der Diagnose Schizophrenie ist die Hoffnung mit dem subjektiven Gefühl der Heilung eng verbunden, deshalb ist ihre Verstärkung ein vielversprechendes Ziel der therapeutischen Interventionen. Andererseits erschweren die Unterschiedlichkeit der Definitionen und methodologische Unterschiede zwischen ihr gewidmeten wenigen wissenschaftlichen Studien, Schlussfolgerungen zu ziehen, die erlauben, eindeutig konkrete therapeutische Anweisungen zu formulieren, die man in der klinischen Praxis anwenden kann. Die meisten Forschungsprojekte, die der Hoffnung bei Kranken an Schizophrenie gewidmet wurden, fokkusieren auf die Beschreibung der Mechanismen, die das Wohlgefühl bei den Kranken beeinflussen oder die die Abhängigkeiten zwischen der Intensität der Hoffnung und anderen Variablen bestimmen. In der vorliegenden Arbeit wurden die Konzepte der Hoffnung mit den ihr entsprechenden psychometrischen Instrumenten beschrieben. Hier wurden auch die Ergebnisse der Studien an der Hoffnung bei den Personen mit der diagnostizierten Schizophrenie besprochen, u.a. die

sich auf die Zusammenhänge der Hoffnung mit der Intensität der psychopathologischen Symptome, Heilung und Wohlgefühl der Patienten beziehen. Die Fortsetzung der Studie zu diesem Thema, vor allem das Systematisieren der bisher erworbenen Angaben, kann mit der für den Patienten günstigen Veränderungen verbunden sein.

Schlüsselwörter: Schizophrenie, Hoffnung

L'importance de l'espoir dans la lutte contre la schizophrénie

Résumé

L'espoir constitue une dimension importante du fonctionnement psychique de l'homme, elle est une source de force dans les luttes existentielles des personnes saines et malades. Chez les patients souffrant de la schizophrénie l'espoir se lie fortement avec leur subjectif sentiment de guérir donc le renforcement de l'espoir est objectif de plusieurs interventions thérapeutiques. D'autre part la multitude de définitions de l'espoir et les différences méthodologiques des recherches peu nombreuses en question rendent plus difficile les conclusions pratiques pour les thérapies. La plupart de recherches s'occupant de l'espoir chez les schizophrènes se concentrent aux descriptions des mécanismes influant sur le bien-être des malades ou bien aux présentations des relations de l'espoir et d'autres facteurs. Ce travail donne une revue des conceptions de l'espoir et des techniques psychométriques respectives ainsi que les résultats des recherches en question, touchant par ex. les corrélations de l'espoir et de l'intensité des symptômes psychopathologiques, du processus de quérir et du bien-être des patients. La continuation des recherches en question, l'analyse systémique des données actuelles peuvent contribuer aux changements favorables pour les thérapies de schizophrénie.

Mots clés : schizophrénie, espoir

References

1. Lieberman JA, Stroup TS, Perkins DO. *Schizofrenia*. Washington/London: The American Psychiatric Publishing; 2006.
2. Trzebińska E. *Psychologia pozytywna*. Warszawa: Wydawnictwa Akademickie i Profesjonalne; 2008.
3. Sobol E. (red.). *Nowy słownik języka polskiego*. Warszawa: Wydawnictwo Naukowe PWN; 2002.
4. Schrank B, Bird V, Rudnick A, Slade M. *Determinants, self-management strategies and interventions for hope in people with mental disorders: Systematic search and narrative review*. Soc. Sci. Med. 2012; 74: 554–564.
5. Snyder CR, Irving L, Anderson JR. *Hope and Health: Measuring the will and the ways. W: Snyder CR, Forsyth DR (red.) Handbook of social and clinical psychology: The health perspective*. Elmsford, New York: Pergamon Press; 1991. s. 285–305.
6. Snyder CR, Rand KL, Sigmond DR. *Hope Theory*. W: Snyder CR. *Handbook of Positive Psychology*. Oxford University Press; 2002. s. 257–276.
7. Łaguna M, Trzebiński J., Zięba M. *Kwestionariusz Nadziei na Sukces*. Podręcznik. Pracownia Testów Psychologicznych Polskiego Towarzystwa Psychologicznego 2005, Warszawa
8. Kwiatek P. *Znaczenie i rozwój psychologii nadziei w ujęciu Charlesa Richarda Snydera*. Seminare 2012; 31: 157–170.
9. Herth K. *Development and refinement of an instrument to measure hope*. Sch. Inq. Nurs. Pract. 1991; 5: 39–51.
10. Stoner MH. Measuring Hope. W: Frank-Stromborg M, Olsen SJ. *Instruments for Clinical Health-Care Research*. Jones and Bartlett Publishers; 2004. s. 215–228.

11. Dufault K, Martocchio BC. *Hope: Its spheres and dimensions*. Nurs. Clin. North Am. 1985; 20 (2): 379–391.
12. Hunt Raleigh ED. *Hope and Hopelessness*. W: Rice VH (red.). *Handbook of Stress, Coping, and Health: Implications for Nursing Research, Theory, and Practice*. SAGE; 2000.
13. Sułek K, Piusińska-Macoch RA. *Struktura i budowanie nadziei*. Acta Haematol. Pol. 2010; 41: 209–217.
14. Miller JF, Powers MJ. *Development of an instrument to measure hope*. Nurs. Res. 1988; 37: 6–10.
15. Schrank B, Woppmann A, Sibitz I, Lauber C. *Development and validation of an integrative scale to assess hope*. Health Expect. 2011; 14: 417–428.
16. Trzebiński J, Zięba M. *Kwestionariusz Nadziei Podstawowej BHI-12*. Podręcznik. Warszawa: Pracownia Testów Psychologicznych Polskiego Towarzystwa Psychologicznego; 2003.
17. Matczak A, Salata E. *Inteligencja emocjonalna a nadzieja*. Fides Et Ratio. Kwartalnik naukowy 2010; 2: 19–24.
18. Lysaker PH, Davis LW, Hunter NL. *Neurocognitive, social and clinical correlates of two domains of hopelessness in schizophrenia*. Schizophr. Res. 2004; 70: 277–285.
19. Lysaker PH, Buck KD, Hammoud K, Taylor AC, Roe D. *Associations of symptoms, psychosocial functioning and hope with qualities of self-experience in schizophrenia: Comparisons of objective and subjective indicators of health*. Schizophr. Res. 2006; 82: 241–249.
20. Lysaker PH, Ringer J, Maxwell C, McGuire A, Lecomte T. *Personal narratives and recovery from schizophrenia*. Schizophr. Res. 2010; 121: 271–276.
21. Beck AT, Weissman A, Lester D, Trexler L. *The Measurement of Pessimism. The Hopelessness Scal*e. J. Consul. Clin. Psych. 1974; 1974: 861–865.
22. Hoffman H, Kupper Z, Kunz B. *Hopelessness and its impact on rehabilitation outcome in schizophrenia – an exploratory study*. Schizophr. Res. 2000; 43: 147–158.
23. Noh C, Choe K, Yang B. *Hope From the Perspective of People with Schizophrenia (Korea)*. Arch. Psychiat. Nurs. 2008; 22: 69–77.
24. Noiseux S, Ricard N. *Recovery as perceived by people with schizophrenia, family members and health professionals: a grounded theory*. Int. J. Nurs. Stud. 2008; 45: 1148–1162.
25. Resnick SG, Fontana A, Lehman AF, Rosenheck RA. *An empirical conceptualization of the recovery orientation*. Schizophr. Res. 2005; 75: 119–128.
26. Werner S. *Subjective well-being, hope, and needs of individuals with serious mental illness*. Psychiatry Res. 2012; 196: 214–219.
27. Lysaker PH, Wickett AM, Davis LW. *Narrative qualities in schizophrenia: associations with impairments in neurocognition and negative symptoms*. J. Nerv. Ment. Dis. 2005; 193: 244–249.
28. Harkavy-Friedman JM, Nelson EA, Venarde DF. *Suicidal behavior in schizophrenia and schizoaffective disorder*. Clin. Neurosci. Res. 2001; 1: 345-350.
29. Caldwell CB, Gottesman II. *Schizophrenics kill themselves too: a review of risk factors for suicide*. Schizophr. Bull. 1990; 16: 571–589.
30. Beck AT, Kovacs M, Weissman A. *Hopelessness and Suicidal Behavior*. An Overview. J. Am. Med. Assoc. 1975; 234: 1146–1149.
31. Huguelet P, Mohr S, Jung V, Gillieron C, Brandt P-Y, Borras L. *Effect of religion on suicide attempts in outpatients with schizophrenia or schizo-affective disorders compared with inpatients with non-psychotic disorders*. Eur. Psychiatry 2007; 22: 188–194.

32. Mohr S, Perroud N, Gillieron C, Brandt P-Y, Rieben I, Borras L, Huguelet P. *Spirituality and religiousness as predictive factors of outcome in schizophrenia and schizo-affective disorders*. Psychiatry Res. 2011; 186: 177–182.
33. Shah R, Kulhara P, Grover S, Kumar S, Malhotra R, Tyagi S. *Contribution of spirituality to quality of life in patients with residual schizophrenia*. Psychiatry Res. 2011; 190: 200–205.
34. Hasson-Ohayon I, Kravetz S, Meir T, Rozencwaig S. *Insight into severe mental illness, hope, and quality of life of persons with schizophrenia and schizoaffective disorders*. Psychiatry Res. 2009; 167: 231–238.Iquodion inatume nderturbit; hocatilium sedo, tabus hae te patem, videm imis. Fulicae, C. Sen videm, sentife nteret vo, convolint.