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REFLECTION

The multidimensional model of hope as a recovery-focused practice in mental health nursing

O modelo multidimensional de esperança como uma prática focada no recovery em enfermagem de saúde mental

El modelo multidimensional de la esperanza mientras práctica dirigida por el recovery en enfermería de salud mental

Carlos António Laranjeira[I,II]
ORCID: 0000-0003-1080-9535

Ana Isabel Fernandes Querido[I,II]
ORCID: 0000-0002-5021-773X

[I] *School of Health Sciences, Polytechnic of Leiria. Leiria, Portugal.*
[II] *Center for Innovative Care and Health Technology (ciTechcare), Polytechnic of Leiria. Leiria, Portugal.*

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Corresponding author:
Carlos António Laranjeira
E-mail: carlos.laranjeira@ipleiria.pt

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ABSTRACT

Objective: To analyze the theoretical dimensions of hope as a recovery-oriented practice in mental health nursing. **Method:** This is a reflective and discursive study based on theoretical and experiential aspects of hope in the recovery process of people facing mental health disorders. **Results:** Maintaining hope in adverse situations, especially while facing mental suffering, requires skills to manage the factors that promote and inhibit hope. This balance can be tricky to reach without the presence of high-skilled professionals. The study presents the concept of hope-inspiring competence and its main dimensions. The nurse's hope-inspiring competence is recognized as a crucial advanced practice that optimizes mental health by providing motivational resources. **Final Considerations:** Hope-inspiring competence should be a core principle for recovery-oriented mental health professionals. Despite this recognition, the promotion of hope in mental health nursing specialized practice lacks evidence and visibility.

Descriptors: Hope; Mental Health Recovery; Psychiatric Nursing; Patient-Centered Care; Clinical Competency.

RESUMO

Objetivo: Analisar as dimensões teóricas da esperança enquanto prática orientada pelo *recovery* em enfermagem de saúde mental. **Métodos:** Estudo reflexivo e discursivo baseado nos aspectos teóricos e vivenciais da esperança no processo de *recovery* de pessoas que enfrentam transtornos mentais. **Resultados:** Manter a esperança em situações adversas, principalmente no sofrimento mental, requer habilidades para gerenciar os fatores que a promovem e a inibem. Esse equilíbrio pode ser difícil de alcançar sem a presença de profissionais qualificados. Apresentamos o conceito de competência inspiradora de esperança e suas principais dimensões. A competência do enfermeiro inspirador de esperança é uma prática avançada crucial que otimiza a saúde mental ao fornecer recursos motivacionais. **Considerações finais:** A competência inspiradora de esperança deve ser um princípio fundamental para profissionais de saúde mental orientados para o *recovery*. Apesar desse reconhecimento, a promoção da esperança na prática especializada de enfermagem em saúde mental carece de evidências e visibilidade.

Descritores: Esperança; Recuperação da Saúde Mental; Enfermagem Psiquiátrica; Assistência Centrada no Paciente; Competência Clínica.

RESUMEN

Objetivo: Analizar dimensiones teóricas de esperanza mientras práctica dirigida por *recovery* en enfermería de salud mental. **Métodos:** Estudio reflexivo y discursivo basándose en aspectos teóricos y experiencias de la esperanza en el proceso de *recovery* de personas que enfrentan trastornos mentales. **Resultados:** Mantener la esperanza en situaciones adversas, principalmente en el enfrentamiento del sufrimiento mental, requerir habilidades para administrar factores que proveen e inhiben. Ese equilibrio puede ser difícil de alcanzar sin la presencia de profesionales altamente cualificados. Presentamos concepto de competencia inspiradora de esperanza y sus principales dimensiones. Competencia del enfermero inspirador de esperanza es reconocida como una práctica avanzada crucial que optimiza la salud mental al fornecer recursos motivacionales. **Consideraciones finales:** Competencia inspiradora de esperanza debe ser un principio fundamental para profesionales de salud mental dirigidos por *recovery*. Aunque ese reconocimiento, la promoción de esperanza en práctica especializada de enfermería en salud mental carece de evidencias y visibilidad.

Descriptores: Esperanza; Recuperación de la Salud Mental; Enfermería Psiquiátrica; Atención Dirigida al Paciente; Competencia Clínica.

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INTRODUCTION

Mental health issues are a prominent feature of international health agendas, but the challenges presented by people with mental disorders are complex, and there are no easy solutions. Several ongoing changes, namely in the field of nursing, given the need for continuous care for the mentally ill in the community and shared responsibility in the management of therapeutic interventions, is promoting several changes. Advanced nursing practice in Psychiatric-Mental Health (PMH) involves those areas in which nurses assume greater responsibility in clinical practice and provide quality, patient-centeredness care. The Advanced Practice Psychiatric Nurse (PMH-APRN) is a registered nurse with specialized clinical knowledge and skills, capable of making decisions and acting according to their context and country. The complexity of their functions is a solution to the increased health needs of populations and the very restricted healthcare budgets. A highly qualified, dedicated, and motivated workforce is one of the main pillars of high-quality healthcare. Particularly, the advanced functions that nurses promote attest to the increased quality/safety of patient care and the cost-effectiveness of health care. One function that has gained prominence is the prescription and promotion of hope in people with mental illness, using decision support tools, information on current best practices, and peer support[1].

Hope is an integral part of the human experience and has particular relevance to mental health. Therefore, preserving hope in adverse situations, especially when facing mental suffering, requires skills to manage the factors that promote and inhibit hope. This balance can be hard to accomplish without the presence of highly qualified healthcare professionals. The professional practice of PMH-APRNs should focus on promoting and maintaining hope, which helps patients cope with suffering and is considered a powerful healing mechanism. Despite the recognition of their role in building capacity for hope, how to develop this specialized practice lacks evidence and visibility[1]. Therefore, we attempt to sketch a holistic picture of how hopefulness enhances positive psychosocial outcomes and reduces psychopathology in adults with mental health disorders.

OBJECTIVE

To analyze the theoretical dimensions of hope as a recovery-oriented practice in mental health nursing.

THE HOPE IN MENTAL HEALTH RECOVERY

In the mental health literature, working on hope means focusing on the users' possibilities, looking beyond the present and preparing the future, reinforcing effective coping strategies, and allowing them to sustain physical and mental well-being. Based on theoretical and experiential aspects of hope in mental health recovery, this reflective and discursive study was organized in four domains: (1) the recovery paradigm; (2) the multidimensionality of hope; (3) challenges [How to identify hope/hopelessness? How to diagnose? How to intervene?]; and (4) hope-inspiring competence.

The recovery paradigm

The growth and increasing prominence of recovery in health institutions reflect innovations developed in the last two decades, including several approaches aimed at individualized treatment, which promote the autonomy and subjectivity of individuals with poor mental health. Recovery is a complete and adequate model to respond to the needs of people with mental health disorders, allowing them to transcend and grow beyond the impacts of their dysfunction as it focuses on the management of problems related to mental health and emphasizes self-efficacy and so-called natural needs and desires, such as employment, leisure activities and independent living in the community[2].

The diversity of perspectives and the complexity of the recovery phenomenon have been a challenge concerning its understanding and evaluation. Although the recovery process differs from person to person, it is possible to identify natural dimensions of recovery, namely: a) hope for the future and personal determination towards the recovery process; b) adopt healthy lifestyles and learn to manage symptoms and difficulties; c) overcoming stigma and establishing and diversifying social connections and relationships; d) set personal goals and have the support of others who believe in them and don't give up on them; e) regaining valued social roles and exercising citizenship; and f) empowerment, in which internal strengthening and taking control of one's own life are combined with mutual help activities, advocacy, and community participation[2-3].

Therefore, recovery is a complex and dynamic process that involves individual components influenced by the characteristics and opportunities of the contexts and by the quality of relationships and interactions between individuals and the surrounding contexts. Given that recovery is a person-centered process, professionals must be able to use the person as a reference for action.

Understanding how people continue hopeful in the face of difficult circumstances and how PMH-APRN can instill and maintain hope in mental health service users is essential towards improving nursing practice[4]. From this perspective, nurses play a pivotal role in building or sustaining hope in their patient interactions[4]. Hope is defined in the International Classification for Nursing Practice as "the feeling of having possibilities, trust in others and in the future, zest for life, expression of reasons and will to live, inner peace, optimism, associated with setting goals and mobilization of energy[5]". Hence, hope is an idiosyncratic process in which individuals, based on past experiences, live the present, projecting themselves towards the future, implying the establishment and achievement of goals that, for the person, are significant[5]. Helping individuals and their families find meaning in suffering and maintain a sense of hope is a common aspect of nursing care. As therapeutic agents, all nurses should be concerned with promoting satisfactory hope, regardless of their specialty. However, as important determinants of mental illness, hope and hopelessness assume particular importance for mental health nurses[2]. While hopelessness is a nursing diagnosis and a key symptom of depression and suicidal behaviors, most people can recover from mental health disorders through specific nursing interventions promoting hope.

Hope has a positive influence on people's mental health, on increasing comfort, subjective well-being, and satisfaction with life,

and reducing negative emotions, the predisposition to addiction and suicide, and preventing family exhaustion[1,4]. The promotion of realistic hope and the definition of goals are recommended as a principle of good clinical practice in approaching people with mental disorders and considered an efficient intervention within the scope of psychosocial support in situations of psychotic disorders[5]. Hope is considered the central tenet in an ongoing personal recovery process since it is the catalyst for change and suggests how people with severe mental health disorders can perceive and work towards a better future[2]. Their "hope scores are lower than those reported by community groups, and a negative association was found between psychiatric symptoms and levels of hope[6]".

Studies have found hope to be the most potent predictor of recovery and crucial to the process of making meaning out of negative experiences[3]. Counseling on hope is a specific nursing intervention that involves regaining strength, health, and the normal condition or way of life of people with mental health disorders, especially in situations of threat and uncertainty, when personal resources are exhausted[5]. Positive effects on the hope of people with schizophrenia, depression, and suicidal behavior are also known. Although studies have found that homelessness limits recovery, having a realistic sense of hope can improve the client's motivation to participate in the recovery process[6]. "Recovery experiences are inherently personal," and the recovery of people experiencing mental suffering "can be complex and non-linear[7]". Nevertheless, the most recent recovery-oriented models stress "the person's changing recovery needs, focusing on underlying processes and the service frameworks to support and reinforce hope as a primary catalyst for symptomatic and functional recovery[7]". There seems to be a consensus that PMH-APRNs have a fundamental role in people's resilience, reinforcing the use of strategies to foster their hope and enabling them to face complex mental health challenges[6].

Multidimensionality of hope

Hope is a multifaceted, multidimensional, and transversal phenomenon, with multiple meanings and studies across several disciplines, including Philosophy, Psychology, Medicine, and Advanced Clinical Practice in Psychiatric-Mental Health Nursing. References to hope in this specific scope date back to Vaillot in the early 1970s, defending the promotion of hope as particular nursing practice. Based on previous work by Dufault and Martocchio in the late 1980s, this was later supported by the multidimensional model of Farran et al.[8] and the Hope Process Framework, which became a significant theoretical basis for nursing hope-inspiring interventions to improve quality of life throughout life[4]. This framework characterizes hope in four core attributes that support the ontological assumptions that it is possible to promote hope within the context of chronic illness[4,8]:

> 1) Experiential process – Hope is dialectically related to hopelessness. It is grounded in some trial or suffering at physical, psychological, social, and spiritual levels experienced while living with a severe mental health disorder. Experiences from the past provide the foundation for hope. Hope as an experiential process encompasses a series of emotions and feelings such as confidence, excitement, sense of well-being, but also includes uncertainty manifested by anxiety, doubt, vulnerability, anger, suffering, and sometimes despair;
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> 2) Spiritual or transcendence process – involves a connectedness with something greater: for some, a belief in a higher being or force, for others finding the meaning and purpose of life. Hope is one of the basic spiritual needs associated with gratitude, forgiveness, and compassion. The inner personal relationship with the sacred and the transcendent facilitates the finding not only of meaning for life but also the well-being and happiness of oneself and others, in addition to the ability to deal with stressful situations and overcome with success the difficulties.
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> 3) Rational thought process – refers to the cognitive dimension and encompasses the intellectual processes through which a person identifies their goals (desired objective or intended result). The acronym GRACT identifies the components of hope: G=Goals that motivate persons (goal definition should constitute a realistic process, combining what is desired with what is objectively possible); R=Resources (physical, emotional, or social) that allow people to use imagination and experience to foster hope and attain energy to achieve the objectives; A=Active process where people take small sequential steps towards attaining their goals or dealing with a particular situation; C=Control over one's destiny (the sense of losing control leads to feelings of powerlessness and hopelessness); T=Time, encompassing the sense of past, present, and future;
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> 4) Relational process – reinforces that hope occurs within a relationship between persons. This attribute includes components of social interaction, reciprocity and interdependence, bonding, and intimacy. The authors[4,8] emphasize the power that people must influence hope, and this can be enhanced by others through presence, communication of positive expectations, and showing confidence in the person's abilities.

In this context, hope is a delicate balance between the experience of pain (suffering from symptoms, stigma, and other trauma situations related to anomalous life experiences[3]), feeling connected to oneself and others (including the spiritual realm), and, ultimately, keeping a rational approach to life events[8].

The application of this model in advanced clinical practice in psychiatric-mental health nursing must include, as a guiding principle, the relationship of help established with the client, considering the intentionality necessary for the therapeutic encounter and the set of specific conditions for therapeutic intervention through interpersonal relationship as a response to situations of suffering, indecision, or emotional burden, with the mutual growth of the nurse and the client. Koehn and Cutcliffe[1] reaffirmed that inspiring hope happens in the context of the interpersonal relationships established between the nurse and the client, which is congruent and harmonious with the approach of PMH-APRNs based on the psychodynamic theory of Hildegard Peplau. Advising hope is knowing yourself as a person and a professional, in person-centered interventions, with a non-judgmental posture, being present, listening, and maintaining a positive attitude. Illustrating this perspective, research with nurses working in a recovery setting and patients with mental health disorders identified interpersonal relationships as the core

issue in engendering hope[2,4]. Nurses referred to interpersonal engagement as necessary to their work with patients. Accordingly, patients identified the most meaningful aspects of care to be feeling validated, cared for, respected, and listened to by nurses[2,4].

Challenges [How to identify hope/hopelessness? How to diagnose? How to intervene?]

Hope is an essential constituent of the recovery model[9]. The "need for a holistic plan, which supports hope through a range of strategies that build confidence and competencies and address vulnerabilities," underscores the importance of the early involvement of PMH-APRNs. Hope is crucial for individuals who have exhausted their personal resources or are in a threatening situation. Most research evidence on the experience of hope has been conducted with cancer patients, while hope is also very helpful in the recovery process from severe mental health disorders[7]. To that end, this represents a challenge for the health services because it involves a deep conviction that recovery is possible, even with more vulnerable people, and implies a rebalancing of power between clients and professionals. Thus, the "recovery-oriented services moved away from the traditional approach of 'treating' mental health 'symptoms' and are guided instead by principles including promoting wellness, strength and health, hope and personal agency, and social inclusion[9]." Similarly, for Frost et al.[7] this integrated recovery model includes "clinical rehabilitation practices, processes, and partnerships that facilitate access to psychosocial evidence-based interventions to promote hope, recovery, self-agency, and social inclusion[7]." The evidence points to a positive relationship between hope and the determinants of positive mental health, with an emphasis on individual factors and personal attributes of hope, the quality of relationships, spirituality, and well-being[3].

The identification of hope is the first challenge for nurses, for which it is essential to know the models and theories that define hope in psychiatric-mental health nursing. Several definitions and conceptualizations highlight the cognitive or affective aspects of hope. Other authors, like Farran et al.[8], state that the individual's action is decisive to achieve goals, choosing activities with potential and capacity to attain results (e.g., "I can, and I will do this"), with an emphasis on creating alternative paths and specific strategies to achieve certain goals. With this knowledge, nurses must listen and identify outbreaks of hopelessness/hope. Examples of verbal expressions deeply marked by hope and that express the need for hope include: "it's no longer worth it," "everything is lost," "I am nothing anymore," "we live one day at a time," "this goes on, I just don't know how" or "hope is the last to die." In the same sense, non-verbal expressions such as sighs, sadness, passivity in the provision of care are indicators of the same need[5].

The second challenge faced by nurses is how to diagnose hope, which as an emotional, subjective, and highly individualized feeling, must be assessed using specific instruments. One way to evaluate hope is through semi-structured clinical interviews, using open questions to characterize hope, identify goals or hope objects, identify resources, threats, and actions.

Examples of narratives to evaluate hope recognized in the literature include questions such as "When you hear the word 'hope,' what image or idea occurs to you?," "How do you describe hope in your life?," "How does the disease you are experiencing at the moment affect your hope?," "Could you identify a source of hope for yourself?", "What helps you to keep hope, or what makes you feel desperate?" and "What do you expect in the future[5]?"

Some of the most widely used measures of hope are: Herth Hope Index, Snyder Hope Scale, State Hope Scale, and Miller Hope Scale. Professionals can also use the "Thermometer of hope," which measures hope on a numerical scale of 0-10, like a numerical scale of pain[5]. Lastly, the genogram and the ecomap of hope are also essential tools for assessing and understanding the bonds of hope and patterns of family interaction[10].

The third challenge for PMH-APRNs is promoting hope. Maintaining hope in situations of adversity and mental suffering requires a balance that can be very tricky to achieve without the presence of competent professionals. Nurses inspire and promote hope "by taking care of the person in a holistic way, taking into account their well-being, in a context of a therapeutic partnership" that recognizes the person being cared for and affirms their value[10]. Thus, PMH-APRNs can play a pivotal role in promoting hope among their clients in the context of the therapeutic relationship that is intended to encourage hope[9].

According to the Rogerian humanistic approach, a helping relationship requires acceptance, empathy, and congruence in communication[1,5]. A therapeutic relationship that promotes hope presupposes that nurses use themselves as a therapeutic intervention tool to unveil and encourage others' hope. In this sense, self-analysis fosters a nurse's self-awareness of their values, feelings, and perceptions of hope so they do not interfere in the relationship.

Therefore, the promotion of hope occurs within the scope of the relationship in the different stages of the relationship defined by Peplau[5]. During the orientation stage, when nurse and client are strangers, hope must be used implicitly, although intentionally, and the professional must prioritize the identification of hope in the client's narrative. The identification and exploitation stages of the relationship are conducive to attributes of hope identification and realistic goals as part of negotiation regarding the therapeutic plan. Hope, as a resilience factor, can be explored by the nurse using therapeutic communication techniques centered on the hope narrative, with verbal expressions that stimulate the client's potential, in the role of counselor and resource person. Hope is promoted through interventions to identify and support potential and strengths, teaching cognitive reframing strategies, reinforcing the client's self-efficacy and abilities. Therapeutic activities that promote hope may include identifying symbols of hope, preparing hope diaries and sets, and planning goals and ways to achieve them. In the resolution phase, the promotion of hope involves the use of therapeutic discharge forms[1,5].

Finally, PMH-APRNs have identified challenges experienced by clients, including "the unpredictability and severity of mental health or emotional difficulties and cognitive impairment, particularly those related to a background of trauma or abuse. The study also considered these factors as negatively impacting a client's ability to develop a therapeutic relationship[9]." In addition, maintaining hope and progressing in recovery was seen as challenging when severe mental symptoms remain[6-7]. "Clients in an inpatient

or secure mental health services are more likely to experience complex or multiple mental health difficulties, have a history of trauma and abuse, and experience higher social exclusion levels. These factors may negatively impact nurses' perceptions of their ability to inspire hope in service users within such settings[9]."

Hope-inspiring competence

The concept of hope-inspiring competence is introduced to denote a relatively high level of the PMH-APRNs ability to instill and maintain hope in people with mental health disorders in recovery[2]. Hope can be a powerful therapeutic agent in times of uncertainty for people or groups facing a mental health crisis. Niebieszczanski[9] posit that hope could be "fostered by providing information to service users, helping them to understand psychological difficulties and encourage an active role in their self-care. Other means of facilitating hope included cognitive strategies, e.g., by helping clients to develop different perspectives of themselves and their futures, uncovering values, and setting goals." The same author also points that nurses are catalysts and facilitators of hope "by helping service users develop or maintain personal relationships, develop links to the local community and meet with other people who had been through similar experiences[9]". Patient feedback can help nurses recognize strategies to enhance hope-focused practices, including active patient involvement in their care, a safe caring environment, a patient-oriented relationship, and the provision of comfort[5]. Working on hope in mental health means focusing on clients' possibilities, working the present and preparing the future, based on trust and the ability to believe in change, reinforcing effective coping strategies, allowing them to sustain physical and mental health.

Acting as models, nurses might instill hope for clients' mental health recovery. As the PMH-APRN provides "a secure base and has genuine aspirations for their client, it is not surprising that the therapist's level of hope has a significant influence on therapy outcomes, over and above that of the client's hope. These practices reflect the principles of the recovery model by developing individual agency, promoting social inclusion, and developing a meaningful personal identity[9] ".

FINAL CONSIDERATIONS

The recognition of the key role of hope in promoting the recovery process in mental health presents new demands regarding the professional competence of PMH-APRNs working with this population. The evidence seems to point to the importance of incorporating hope in collaborative strategies to promote mental health and manage mental health disorders. The study recommends some interventions to promote hope: focus on the quality of the relationship between health professionals and the people targeted and caution; facilitate social relations and strengthening support networks; help increases personal attributes such as self-esteem and self-efficacy through empowerment; help people take control and establish and formulate realistic goals; design specific interventions of hope, incorporating spirituality and well-being.

The promotion of hope as a focus of nursing is imperative in the practice of PMH-APRNs to assist and support clients to use hope strategies in training to manage the complexity of mental suffering. Despite recognizing the key role of the mental health nurse in training for hope, the way it develops in the context of specialized practice lacks evidence and visibility. Adequate training and the development of skills that promote hope can enhance the transfer of knowledge to the contexts of nurse intervention and contribute to the optimization of people's mental health. These, in addition to interpersonal communication skills, may increase nurses' competencies to meet users' needs for recovery-focused care.

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