THE LIVED EXPERIENCES OF HOPE AMONG PEOPLE RECOVERING FROM SCHIZOPHRENIA IN HONG KONG

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CERTIFICATE OF ORIGINALITY

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Abstract

The notion of recovery has been introduced to the mental health field for over 25 years. Under the new definition of recovery, people with mental illness are believed to be able and capable of a better future. In recovery literature, a lot of inspiring stories have been published about people who experience recovery from their schizophrenia. From these stories, some important components of recovery have been pointed out, with ‘hope’ being the most mentioned.

By employing an inductive thematic analysis approach, this study explores the lived experience of hope amongst people recovering from schizophrenia in Hong Kong. Overall, eight participants, comprising three females and five males who were diagnosed with schizophrenia, are interviewed. Their lived experience of hope and recovery is written down for analysis and interpretation. Drawing from the data collected in the study, six overarching themes and seventeen related sub-themes have been identified. Their first-person experiences reveal that their experience of hope, firstly, intertwine with their ups and downs of illness in their recovery process, and, secondly, interact with other contributing factors. All main themes and sub-themes are interrelated. A description and discussion of the results are supported by rich first-person narration. Implications for clinical practice and future research are proposed.

Keywords: Hope, Recovery, Schizophrenia, Hong Kong, Lived experience

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CHAPTER 1: INTRODUCTION

Background

This thesis is all about the experience of hope and schizophrenia in Hong Kong. Specifically, the concept of hope is the key topic for in-depth understanding. Let me explain the reasons and the logic behind this.

Recovery is now the leading concept in the field of mental health all around the world. It was first derived by Patricia Deegan (1988), who is a scholar with first-person experience in schizophrenia. According to Deegan, recovery was defined as the making of new meaning in one's life beyond the distress brought by the mental illness. The development of such personal meaning in recovery is indeed personal and unique. Over the years, the concept of recovery has been changing and is enriched by different research and studies, with the most important being first-hand narration from people with mental disability. Nowadays, psychiatric recovery is mainly defined as a non-linear personal and psychological recovery process in which the individual in question is responsible for his own recovery and not led or forced by others.

Hope has been identified as one of the important factors in mental health recovery by different sources, including personal narration (Deegan, 1988; Lovejoy, 1984), signed congress charter (SAMHSA, 2004) and academic papers (e.g. Onken *et al.,* 2007). Nowadays, hope has even become the big slogan in representing recovery from mental illness. However, ironically speaking, very limited efforts have been spent in expanding our knowledge of the relationship between hope and recovery. It is one of my reasons in selecting this research topic.

On the other hand, in the fields of philosophy, psychology and nursing, the concept of hope has been discussed widely for many years ago. In the field of nursing, the experience of hope is one of the key concepts in working with various life-threatening or terminal illnesses, such as cancers. In the field of psychology, the rise of positive psychology in the 1970s elicited a shift of research focus from psychopathology to human strengths, and hope as a human virtue has been put into the research agenda. In the field of philosophy, the English translation of *Homo Viator: Introduction to a Metaphysic of Hope* by famous existentialist Gabriel Marcel was already available in 1962. In a paper dated 2005, psychologist Jaklin Eliott reported that the numbers of hope-related research amongst various disciplines had grown so rapidly in the last half decade to the extent that we could hardly come to a unique consensus on the nature of hope itself (Eliott, 2005). Nevertheless, there is a big, good pool of resources that can be used to inspire our thinking about the role of hope in recovery from mental illness before it is too late. This is my second reason.

Amongst various mental illnesses, schizophrenia has the most devastating and destructive kinds of mental problems in society. The first sign of schizophrenia could occur in adolescence, but the course of illness could be life-long. People with schizophrenia will have experiences of alienation, such as delusions and hallucinations that result in a marked decline in overall social functioning. My personal observation is that over 80% of the service users in various long-term residential services for the mentally ill in my city are suffering from schizophrenia, and there is a general belief that schizophrenia is a severe mental illness that is hard to deal with. Hopelessness is not a diagnostic criterion of schizophrenia, but the concept of hope is no doubt totally relevant in discussing recovery from schizophrenia. With my background as a psychiatric social worker and now as a teacher at a university, how to link up recovery, hope and schizophrenia became my third reason to take up this research topic.

Research Aims and Purpose

As inspired by what has been introduced above, the present study aims to investigate the lived experience of hope amongst people with schizophrenia in their recovery process. It is an explorative research and, by using qualitative methodology, the data collected by in-depth interviews is interpreted to form a general picture of the phenomenon. This study especially focuses on how individuals with mental disability interpret their own recovery from schizophrenia.

Preliminary Research Questions

1. What is the individual recovery process of those people with schizophrenia in the community?
    1a. What is their personal experience of psychiatric recovery?

1b. In what way do they perceive and describe their own recovery process?

2. What is the lived experience of hope in the process of recovery?
    2a. What is hope? What is the nature of hope in their view?
    2b. What is the lived experience of hope? How would they name it?

Organisation of Chapters

Chapter 2 will introduce the concept of schizophrenia as a whole. The term “schizophrenia” was created more than 100 years when it first appeared in the literature. In Chapter 2, the historical roots and recurrent discussion of the epidemiology will be presented. Thereafter, we review some major, but not all, theories of schizophrenia as well as the traditional permissive view of the recovery outcome. It is worth noting that under the new recovery movement, a more positive expectation of schizophrenia recovery is being advocated. The chapter will end with the discussion of hope as an important component of recovery from schizophrenia.

Chapter 3 is a comprehensive review of the basic concepts of hope in general. A broad review of hope literature and related theories shows that there are two common agreements in the articulation of hope in the history. Firstly, hope is basically articulated as a verb and as a noun in various research. Secondly, hope is commonly articulated in terms of two different types of hoping, i.e. hoping with specified goals and hoping without specified goals. The present dissertation will basically expand the relationship between hope and recovering from schizophrenia in line with the mainstream articulation.

Chapter 4 incorporates discussion on the method and methodology being used in the present dissertation. Inductive thematic analysis and its implementation in handling narrative data are introduced. A thematic map is produced to provide a visual representation of the six overarching themes and seventeen sub-themes that are discovered from the data.

Chapter 5 is the introduction of the research participants of this study. In total, we have eight participants: three females and five males. Their stories of having schizophrenia and their recovery will be introduced briefly.

Chapter 6 contains a detailed report on the contents of the 6 overarching themes, 17 sub-themes and 52 first-order themes. The first theme, *Ups and Downs of Illness,* provides direct answers to the first research question concerning participants' account of their recovery from schizophrenia. Two sub-themes were included: (1) Good Times and (2) Bad Times. The second theme, named as *Modes of Hope*, contains data that provides answers to the second research question concerning the actual hope experience related to their mental illness. From the analysis, four sub-themes were identified: (1) Hope as Believing, (2) Hope as Hoping, (3) Hope as Feeling, and (4) Hope as Acting. The third theme, *Hope Effects*, focuses on the three effects that hope can bring into the participants' living world. This theme comprises the following sub-themes: (1) Comforting Effect, (2) Motivating Effect, and (3) Transcendent Effect. The fourth theme, *Strategies of Hope,* uncovers the strategies that the participants utilised to bring themselves a better sense of hope. The following sub-themes emerged from the analysis of the data: (1) Adjustment, (2) Staying with Others, and (3) Empowerment. The fifth theme, *Relationship Quality*, focuses on those important relationship factors that affect the experience of hope. This overarching theme contains the following sub-themes: (1) Family Care, and (2) Professional Care. The last overarching theme, *Environment Opportunities*, contains the participants' description of how the social and economic environments affect their hope experience. This overarching theme contains the following sub-themes: (1) Housing Availability, and (2) Employment Availability and (3) Welfare Availability.

In Chapter 7, on Discussion and Conclusion, a model is suggested to illustrate the intertwining relationship between the themes and sub-themes that are identified. The limitations of the study and a suggested research direction for the future will also be discussed.

CHAPTER 2: SCHIZOPHRENIA AND RECOVERY

Chapter Introduction

This chapter serves to provide a general background relating to schizophrenia and the concept of recovery, as discussed in the dissertation. Schizophrenia has been described as an illness of doom, where those who suffer from it would experience hopelessness rather than hopefulness. During the last century, based on the anti-permissive point of view, mental health service users have sparked a social movement in Western countries and called for the reformation of the societal attitude towards mental illness. Through this movement, the old clinical model of recovery has been replaced by a social recovery model, where the recovery of those with mental illness is no longer measured in terms of psychopathology; rather, self-directed and participatory recovery is stressed instead.

Schizophrenia

Generally speaking, schizophrenia is one of the most prevalent mental disorders. It is described as a mental disorder that causes various disturbances in social life and has a poor recovery rate. In terms of symptom descriptions, schizophrenia is mainly characterised by distortions in thinking, perceptions and consciousness, as well as inappropriate affective responses. According to the *Diagnostic and Statistical Manual of Mental Disorder* fifth revised edition (DSM-V), the following diagnostic criteria for schizophrenia are suggested:

Characteristic symptoms: Two (or more) of the following, each present for a significant portion of time during a one-month period (or less, if successfully treated):

1. Delusions
2. Hallucinations
3. Disorganised speech
4. Grossly disorganised or catatonic behaviour
5. Negative symptoms, such as affective flattening, and alogia or avolition.

Epidemiology

Schizophrenia is a mental illness with a low incidence rate across the world, with only approximately 1 in every 10,000 individuals diagnosed. However, because of the devastating experience the illness brings to the patient, schizophrenia is the most frequently reported cause of psychiatric hospitalisation when compared with other kinds of mental illness. High rates of re-hospitalisation during the course of illness are also reported, and prevalence studies have shown that normal people have a 1% risk of ever suffering from such a disorder during his or her lifetime (Jones & Cannon, 1998). For most people with schizophrenia, the onset of illness usually occurs during early adolescence and up to the age of 45 years; most often, men have an earlier onset (18–25 years) than women (25–35 years) (Angermeyer & Kuhnz, 1988).

In an earlier study, Holmboe and Astrup (1957) reported that approximately 40% of those with schizophrenia had recovered after two or more episodes and were then considered to be socially well-adjusted. A further 20% were reported as having improved and were well adapted with merely residual symptoms; notably, however, 40% were seen to suffer from moderate-to-severe mental deterioration. In another study (Harris *et al.,* 1956), similar findings were reported, with only 25% of discharged patients eventually able to earn a living independently in the community. Comparing different cohorts of schizophrenic patients who were diagnosed in 1950, 1960 and 1965, Niskanen and Achte (1972) examined the periods patients spent in hospital, along with their social outcome. Whilst there appeared to be a reduction in the need for hospitalisation for each successive cohort, with fewer patients actually hospitalised, there was no overall improvement in the social outcome between the groups.

In an attempt to define prognostic factors in schizophrenia, Marinow (1986) studied the outcome of 280 schizophrenics discharged during the period spanning 1946–1950. Marinow considered 'symptomatology', working ability and social integration as variables, and combined these to produce an overall prognostic picture. Marinow reported that favourable prognosis was recognised in 50% of the cases, a relatively favourable response in 22% of the cases, and an unfavourable prognosis in 28% of the cases (Marinow, 1986).

In summary, early research findings all suggest a poor prognosis when there is the presence of a schizoid premorbid personality, along with negative responses.

When there is an unfavourable illness prognosis, long-term medication is expected and the basic life of those people with the illness will not usually be independent. Within the mental health service system, schizophrenia has always been recognised as the most common type of mental disorder, with a high service utilisation rate ranging from normal outpatient clinical services to long-term institutionalised service.

When describing schizophrenia, the common notation is centred on designating its symptomology via the terms “positive symptoms,” “negative symptoms”; and “disorganised symptoms” (Strauss, Carpenter, & Bartko, 1974). Positive symptoms of schizophrenia are mainly psychotic in nature, meaning the exaggeration or distortion of normal experiences, including delusions and hallucinations, etc. Negative symptoms refer to an absence or complete deficiency of normal thoughts, feelings and behaviours that would normally be presented. Disorganised symptoms — the third notation — refers to the presence of general confusion, incoherence, non-directness and non-reality-based thoughts and behaviours, generated by the illness. In other words, in general, schizophrenia with positive symptoms will induce an alienated experience; on the contrary, negative and disorganised symptoms as a whole are less dramatic but could be more damaging in terms of their deteriorating impact in terms of social functioning. In actual fact, the illness experience not only affects the individual diagnosed with the illness but also their carers through causing a significant caring-related burden. Overall, without question, the social and economic impacts related to the disorder, as felt by families and society, are significant.

Schizophrenia Throughout History

Historically speaking, “schizophrenia,” as a term to describe a particular mysterious mental experience, was first used by Swiss psychiatrist Eugen Bleuler in 1911. Before this time, schizophrenia was conceptualised as early dementia. The renowned French psychiatrist Benedict Augustine Morel (1809–1873) introduced the word “dementia praecox” or ‘precocious dementia’ when describing the illness experiences. Nowadays, however, the illness is referred to as schizophrenia. With this foundation, German psychiatrist Emil Kraepelin (1856–1927) formulated a more comprehensive notion of dementia praecox, which encompassed the descriptions of catatonia, hebephrenia, paranoid psychosis and his own ‘dementia paranoia’ into a single entity. This new conceptualisation of dementia praecox was said to have poor clinic features and was described as a disorder without a specific aetiology. In fact, the contribution of Emil Kraepelin in understanding schizophrenia did not only rest in his clustering of symptoms; rather, his effort centred on distinguishing dementia praecox and manic-depressive disorder into separate illnesses, which eventually formed the present psychiatry landscape. In the seventh edition of the textbook, Kraepelin (1923) described 10 different possible general remission outcomes of the illness

Later on, Swiss psychiatrist Eugen Bleuler (1857–1939) followed Kraepelin's systematic classification work on psychoses but he subsequently reformulated dementia praecox as "schizophrenia," which is the term commonly used in current mental health practice. From the Greek, schizophrenia can be defined as 'a splitting of the mind' (schizin: 'to split'; phren: 'mind'). Bleuler used the name "schizophrenia" because it literally meant mind-splitting, thus representing the overall 'fragmented' and disturbed associations normally integrated. For Bleuler, schizophrenia was a single disease comprising fundamental symptoms and accessory symptoms, which would be presented in all patients with the same illness. Fundamental symptoms were recognised as "ambivalence, disturbance of association, disturbance of affect, and a preference for fantasy over reality" (Walker *et al.*, 2004:403). On the other hand, hallucinations and delusions were conceptualised as secondary or accessories to the core disturbances. Because of including affective domain in diagnosing schizophrenia and advocating a more positive view of the illness, Bleuler's approach was widely shared by other psychiatrists at that time (Berrios, Luque & Villagran, 2003).

In 1959, almost 40 years after the term "schizophrenia" became widely used in psychiatric practice, German psychiatrist Kurt Schneider (1887–1967) further proposed that first-rank symptoms should be emphasised in the understanding and diagnosis of schizophrenia. He identified eleven first-rank symptoms, which could be grouped into three categories, namely passivity experiences, auditory hallucinations and primary delusions (Peralta & Cuesta, 1999). Schneider claimed that such *pathognomonic* symptoms were key features of schizophrenia, and the presence of any one of them should be considered sufficient enough to make such a diagnosis. Second-rank symptoms, according to Schneider, included disturbances in writing, motor activities, language and affective responses; however, these types of symptom were also recognised as occurring in other mental illnesses, not only in the case of schizophrenia (Tsuang & Stone, 2014).

As a short conclusion, it would be accurate to state that Kraepelin, Bleuler and Schneider — the three most pivotal pioneers in this field — made attempts to conceptualise schizophrenia in very different ways: for Kraepelin, his definition mainly centred on the onset, course and prognosis; for Bleuler, his contribution was mainly based on his articulation of the affective deficits and negative symptoms of the illness; whilst for Schneider, the emphasis was placed upon the manifestation of positive symptoms in the illness (Tandon *et al.,* 2008, 2009). Importantly, all of these three early formulations of schizophrenia have had a very long-lasting influence until the present time — especially in terms of the formation of the present *Diagnostic and Statistical Manual* (DSM) by the American Psychiatric Association (APA) as well as the International Classification of Diseases by the World Health Organization (WHO). Despite the two diagnostic systems used globally (the current versions of the DSM-V and ICD-10) carrying different criteria in defining schizophrenia, with variations recognised in identifying subtypes of schizophrenia, they basically and mainly “incorporate Kraepelinian chronicity, Bleulerian negative symptoms and Schneiderian positive symptoms” (Tandon *et al*., 2009:2).

Major Theories of Schizophrenia

Although numerous schizophrenia theories and studies have been formulated during the past century, the exact cause of this devastating illness remains unknown. Nevertheless, in past schizophrenia literature, several major theories seem to have received wide-ranging discussion and attention and are commonly accepted as the sound causes of the illness. Some of the major theories will be presented here.

Primary Narcissism Theory

Within the psychodynamic perspective, psychological disorders were assumed to be the manifestations of, firstly, the imbalance between id, ego and superego and, secondly, unconscious attempts to deal with unacceptable and repressed internal drives. In line with this psychodynamic thinking, schizophrenia was generally viewed as the conflict between the ego and the aggressive id. Impulses from the id were believed to have threatened the ego and then induced intensive inner conflicts. Under such threatening condition, people tended to regress into a state of “primary narcissism” (Sandler *et al.*, 2012:61), in which the boundary between inner world and outside environment was not so clear to the individual (Cluley, 2008).

Genetic Theory

According to genetic theory of schizophrenia, the closer the genetic relationship between family members and a person with schizophrenia, the greater the likelihood the family members will also suffer from schizophrenia (Kallmann, 1946). For example, identical twins whose genetic structure is identical are found to have an extra risk of having the same illness compared with non-identical twins (Kringlen, 1968; Fisher, 1973). In addition, first-degree relatives of people with schizophrenia, including parents, siblings and children, are also recognised as being at greater risk of developing schizophrenia than other family groups with healthy relatives (Hutchinson *et al.*, 1996). However, as family members used to share very common living environments beyond only sharing common genes, the hypothesis of connecting genetic factors with onset of schizophrenia never come to a full conclusion (Joseph, 1999).

Dopamine Theory

Dopamine theory is a leading biochemical model of schizophrenia falling under the neurobiological perspective. The theory states that the cause of schizophrenia was an “over-reactivity of dopamine transmission in the brain” (Littlejohn, 2003:453), resulting in the experience of psychotic symptoms. The dopamine theory has been validated with the use of a dopamine agonist in the treatment of Parkinson’s disease, in which the administration results in an accidental schizophrenic effect amongst some people (Joseph, Frith, & Waddington, 1979; Carlsson, 1987). In modern psychiatry, in fact, dopamine theory is widely recognized by psychiatrists as the primary theory in explaining the causation of schizophrenia as well as some other types of mental illness such as attention deficit hyperactivity disorder (ADHD) (Levy & Swanson, 2001).

Expressed Emotion Theory

The expressed emotion theory originated from family communication research in schizophrenic families, in which studies found that different forms of expressed emotion, as a pattern of responding to the illness, could be identified amongst family members. Some forms of emotion responding were hostile, critical and indifferent, resulting in an even worse family atmosphere surrounding the individual with schizophrenia. Schizophrenic individuals from high expressed emotion family backgrounds reported a higher relapse rate than those from a more supportive family atmosphere. Importantly, it was held that high EE relatives typically showed less empathy, tolerance and flexibility than low EE relatives (Mintz, Mintz, & Goldstein, 1987); Kavanagh, 1992).

Existential Phenomenological Theory

In the book *Divided Self,* psychiatrist Ronald Laing argued for an existential phenomenological explanation of schizophrenia (Laing, 1965). The book is indeed full of philosophical delineations with clinical observations. Laing believed that understanding people with schizophrenia was far more possible than it was believed. As stated in the first few pages of the book, Laing emphasised that the book was aimed at enlightening an approach in which the process of madness could be comprehended existentially. Without doubt, this classic work of Laing's centred on his insightful understanding of schizophrenia as based on phenomenology and existentialism.

According to Laing (1965), people strove for security, preserving aliveness, and safeguarding autonomy. Dealing with people was always a challenge to human ontological security: wish fulfilment and meeting inner desires and needs together created supportive criteria for building up healthy ‘self’, adding ‘weight’ to the ‘being’. On the other hand, however, unfulfilled needs and suppressing the developing process of the self — including both being suppressed or through self-suppression, commonly translated as compliance — were a pre-requisite for formulating the path of being ‘divided’.

Human beings have always been ambiguous and equivocal. Absurdity and contradiction are often found in the thinking process and appear clearly in the ways in which we act. According to Laing (1965), people forgo their autonomy just because they wanted to safe it.; to consume oneself by one’s own love prevented the possibility of being consumed by another; to die was to prevent oneself from being killed (p. 51). These contradictory self-protecting mechanisms were manifested in people’s behaviours. These seemed to be incomprehensible to most people — and were particularly incomprehensible to those who did not want to invest effort into understanding these ‘trouble-makers’. They simply surpassed the time-consuming process of understanding and were satisfied with the simplified conclusion by merely labelling these people as insane.

The misfortune of having mental distress was terrible, but failing to be understood and be sympathised could be even worse. Laing (1965) advised a humanistic perspective towards mental illness through the concept of existentialism and phenomenology to help us gain understanding of the schizoid. Understanding as a continuous process was the key expectation sought by Laing.

For Laing (1965), traditional psychiatry tended to isolate the patient from society. Mental illness was the problem of individual: in this case, the person was treated as an object that needed to be repaired, as a broken machine needing to be fixed or to simply be disposed of. On the contrary, existential psychology insisted on the point that the person was a part of society, that he was “being-in-the-world” (p. 17). Laing cared very much about the comprehensive transition from sane to becoming psychotic. It was a process involving the context of the person, the interpersonal interactions, and unfulfilled needs. Neglect, improper response and even deprivation in the upbringing of these insane persons were easily found from their stories. Isolation implied alienation and marginalisation; however, it could not help in solving problems.

For Laing (1965), ontological insecurity developed in infancy. It deterred a person from a “sense of his presence in the world as a real, live, whole and, in a temporal sense, continuous person” (p.39). He became unable to establish normal self-identity and was unable to maintain a normal connectedness and build up his uniqueness. He was preoccupied with preserving rather than gratifying himself. He withdrew into himself, lived in a world of his own, and lost contact with reality. The external world, however, still existed: external events were still affecting, although they did not affect him in the same way as they did in others — they were distorted and magnified. The world of his experience came to be one that he could no longer share with others. Laing stated that the person encountered three forms of anxiety: of being engulfed, imposed and petrified, or depersonalised.

For a person with the anxiety of being engulfed, any and every relationship threatened the person with a loss of identity. Engulfment was felt as the risk of being understood, being loved or even being seen. The main way of preserving his own identity was self-isolation: he was self-constrained into a narrow world so as to prevent him from losing himself and to preserve his existence.

Depersonalisation was a universal technique adopted in an effort to deal with disturbing or tiresome people. One did not allow oneself to be responsive to others and one treated others as objects with no feeling. He tended to depersonalise others; meanwhile, he tended to feel himself as more or less depersonalised, of which the person was afraid. As such, subjectivity drained away from him. He then may come to anticipate that a relationship with others might result in deadening and impoverishment. Therefore, any other was then a threat to his ‘self’. Sometimes, to petrify someone, i.e. to turn someone into ‘stone’, was an easy way of disconnecting with others and of preventing the ‘self’ from being contacted.

Laing (1965) pointed out in his book that if the person suffered from ontological insecurity, his true self could not endure the external world, which was full of risks and threats, meaning that the true self was then gradually detached from the body; it shrank into an unembodied inner self, and the sense of a holistic person diminished. The self was detached from the body: “The body is felt more as one object among other objects in the world than as the core of the individual’s own being” (p. 69). At first, the body no longer manifested the true self body, and then second it turned to become the part of the embodied self, and. This person has lost livelihood. The interaction with the other was just meaningless role playing; no true emotionality was interchanging. As a result, the true self was trapped in the false system. In this scenario, one could not nurture oneself or energise oneself through daily interpersonal encounters. The realness and aliveness drained away until total emptiness grew. On the other hand, he disliked or even hated himself for the unreal behaviours of the false self-system. The only way of soothing this desperate form was through illusion through creating a set of systems of thinking in which he felt safe but detached from reality. This condition only worsened and, finally, a schizophrenic pattern was formed in this course of protecting himself.

Ontological insecurity made one doubt one’s own existence. The above two forms of awareness were enhanced in a compulsive nature; it was magnified to the extent that one was anxious about being seeable and, more so, was afraid of the mental self being penetrable. The self was then alienated through this compulsive awareness, and the false identity was maintained. Meanwhile, in an effort to protect his existence, he became cut off from direct relatedness with others, and once again was left self-isolated from the environment.

In the human society domain, there were many anxieties centred on being obvious, being distinctive, and drawing attention to oneself; therefore, in contrast, people attempted to merge with the environment to make it difficult for anyone to see them as a distinctive individual. Depersonalisation was ultimately a defence analogous to hiding oneself. All in all, for a person with schizophrenia, the self was a divided one: the body was disconnected from the mind and the spirit.

Pessimistic View of the Illness and Recovery

As long as the term “schizophrenia” has been widely used in describing and diagnosing mental illness, there is a classical and general belief that the course and the outcome of this illness would be quite negative and distressing. Schizophrenic individuals are often expected to be quite withdrawn, would experience a one or many relapses and hospitalisation during the course of their lifetime, and have to deal with various co-morbidities that seriously induce life disturbance. This particular pessimistic view of schizophrenia is merely ideas; however, a concrete message is shared and can be witnessed in our daily lives. For example, in 1988, schizophrenia was described by *Nature,* which is a renowned international weekly journal of science, as the “worst disease affecting mankind” (Editorial, 1988, cited in Tandon *et al*., 2008). Moreover, according to the World Health Organization (WHO), schizophrenia is still recognised as one of the top ten diseases — the term “disease” assigned to this illness implies severe disability in the world (World Health Organization, 2001). Furthermore, schizophrenic individuals are the population most commonly identified in the various forms of long-term psychiatric service. Last but not least, it is not uncommon for schizophrenic patients to be educated to expect a chronic and deteriorating life course (Deegan, 1988). In consideration of such a pessimistic tradition, recovery from schizophrenia generally is not fully expected. However, the question remains: what is the outcome when diagnosed with schizophrenia? What is the course and what are the outcomes associated with the illness? What is the meaning of recovery in the context of schizophrenia? Does it really suggest and support such a pessimistic view?

Schizophrenia Recovery: Findings Throughout History

A general definition of the word "recovery" states 'to get back: regain' or 'to restore [oneself) to a normal state' (Webster's Dictionary, 1984). Alternatively, it might be defined as "the restoration or return to a former, usual, or correct state or condition, as health, prosperity, stability, etc. ... the cure of an illness, wound, etc." (Brown, 1993). Within these general definitions, recovery seems to occur in a time after 'something happened', and implicitly implies a return to a formal 'state' or a return to a formal 'standard' of something. Regardless, however, the term "recovery" seems to have various definitions and carries different meanings in various schizophrenia literature throughout history. The only consensus relating to the meaning of recovery in various schizophrenia literature actually is a lack of consensus, resulting in different reports about recovery. Fortunately, recent discourses on schizophrenia recovery more or less favour a rejection of the pessimistic view of having schizophrenia in one’s life. In actuality, they agree that the results of most outcomes are heterogeneous, but that the general picture of those suffering from schizophrenia is not really consistent with the chronicity, as suggested by Kraepelin, the founder.

The earliest traceable original concept of recovery in mental health literature can be traced back to the 18th century. In this period of time, institutional care was the main form of treatment for the mentally ill in the West. In actual fact, it was an era where the terms “lunatics” and “madness” were used to describe mental illness, with modern psychiatric notions still lacking. Despite this, however, there was some emphasis placed on separating mental patients from society, with a certain portion of hospitalised patients able to live in the community again. According to a classic publication in 1885 named *The Curability of Insanity,* the recovery rate of those major asylums in

North America was around 30%. In this earliest study, recovery directly referred to the discharge from mental hospitals. Perhaps the reported findings of the 1885 publication might be far from satisfactory and lack any effective and established bio-psychosocial intervention.

The founder of schizophrenia as a recognised concept, Kraepelin (1902), considered dementia praecox to be a deteriorating illness leading that could lead to poor cognitive and social functioning. His own findings, whilst using his Kraepelinian definition of schizophrenia, provided the first coherent set of clinical findings on the outcome of the illness. As reported, no more than 17% of patients showed clinical improvement during follow-up (Kraepelin, 1899, cited in Hegarty *et al*., 1994). Such a pessimistic view was further supported by another study that was carried out by Warren Stearns in 1912, in which a sample comprising 395 hospitalised schizophrenic patients was diagnosed with the 'apparent hopelessness of the disease dementia praecox' (Stearns, 1912, cited in Hegarty *et al*., 1994). During this period of time, treatment methods, such as adrenaline injection and inducing fever, were most often ineffective.

Figure 1: Percentage of ‘improved schizophrenia’ throughout the early 20th century decades

Decade of Studies	Weighed Percentage
1895–1925	27.6%
1930s	34.9%
1956–1985	48.5%

Figure 1 shows a convenience table with data sourced from a paper penned by Hegarty *et al*. (1994). In their report, which reviewed all outcomes studied for a whole century from 1895–1992, it was found that the average ‘improved’ rate of schizophrenia was 40.2%. According to the paper, early outcome studies indeed showed a relatively lower ‘improved’ rate; however, when there was a broader conceptualisation of schizophrenia introduced by different scholars, such as Bleuler (1950), and with more treatment alternations, the ‘improved’ rate appeared to be less bleak. Nevertheless, these earliest outcome results in the mental health field formed an ‘unmovable impression’; these pessimistic ideas, however, have remained influential in current conceptualisations.

Although the earlier studies on schizophrenia were quite discouraging, more optimistic result of those outcome studies was noted after the last mid-century. Bellack (2006) stated that the pessimistic view had, in fact, changed as of the late 1980s, following a series of long-term outcome studies demonstrating that many schizophrenic individuals could achieve very good outcomes — even, in some cases, without any maintenance medication (Bellack, 2006). The first most cited positive outcome study that championed social recovery amongst schizophrenics was the 1974 report published by Manfred Bleuler, the son of Eugene Bleuler. In his study, 208 patients of Burgholzli Hospital had been followed for a decade. The observation and investigation mainly focused on patients' daily lives outside of the hospital wall. The study found that 23% of the first admission group in 1942 and 1943 had achieved full recovery, and another 43% had sustained significant improvement for the five years prior to the end of the study period. For Bleuler, recovery, in this context, referred to a person's capacity to partake in sensible conversation, where overall behaviour was seen to be normal, and where the individual was recognised as having the ability to perform useful work.

The Vermont Longitudinal Study was also one of the earlier influential studies in forming contemporary understanding about the course and outcomes of schizophrenia. This 32-year prospective follow-along study was conducted by Harding *et al*. of a cohort of 269 patients from Vermont State Hospital, 213 (79%) of whom were matched with the diagnosis of schizophrenia. The latest follow-up investigation was conducted in 1984; the results were finally published in 1987 through different papers. When discussing recovery, the study primarily adopted the Global Assessment Scale (GAS) and Strauss–Carpenter Levels of Functioning Scales to define good outcomes. The result of this study was quite encouraging, showing that a large portion of people with the illness were “neither downward nor marginal, but an evolution into various degrees of productivity, social involvement, wellness, and competent functioning” (Harding *et al*., 1987). More precisely, 34% were found to have achieved full recovery, and a further 34% were seen to have achieved significant improvements in their psychiatric status and overall social functioning. Although some patients would face difficulties in some areas of community living, they could function well and could not be considered sick people by most untrained people.

Also, in another paper published in 1987, Harding *et al*. reviewed the Bleuler study and Vermont study together with three other long-term studies, which had been conducted before 1980. The three studies were the Iowa 500 by Winokur's team (1972), the Bonn Study by Huber *et al*. (1975) and the Lausanne investigations by Ciompi (1980). The result of this meta-analysis found that schizophrenia chronicity was, in fact, the exception in most cases, and this assumption was far too inadequate to become the rule. An overall picture relating to the longitudinal studies on schizophrenia can be found in Figure 2.

(Adopted from a conclusive paper by Harding, 2005)

Study	Sample Size (*n*)	Average Length of the Study (year)	Percent of Subjects Recovered or Significantly Improved	Percent of Subjects Socially Recovered
M. Bleuler 1972, 1978, Switzerland	208	23	53-68	46-59
Hinterhuber 1973, Austria	157	30	75	77

Huber *et al*. 1975, Germany	502	22	57	56
Ciompi and Muller 1976, Switzerland	289	37	53	57
Kreditor 1977, Lithuania	115	20+	84	NA
Tsuang *et al*. 1979, United States	200	35	46	21
Marinow 1986, Bulgaria	280	20	75	NA
Harding *et al* 1987a, 1987b United States	269	32	62-68	68
Ogawa *et al*. 1987, Japan	140	22.5	56	47
DeSisto *et al*. 1995a, 1995b	269	35	49	NA

Figure 2: Selected long-term studies of schizophrenia

Source: Harding (2005:29)

These positive findings were further supported by more and more recent research. Harrison, Hopper and Craig (2007), for example, examined the outcomes of 644 schizophrenic subjects included in the WHO's International Study of Schizophrenia. In this study, patients' outcomes were assessed in the 15th and 25th years. By using the Bleuler's symptoms recovery scale (1978), 48% of the 15th year incidence cohort and 54% of the 25th year cohort were rated as recovered, stating that the subjects could resume their formal roles and ready to be assigned fully employed jobs. As another example, in a prospective study that focused on functioning recovery, Harrow *et al*. (2005) examined the outcomes of 274 young adults diagnosed as psychotic. Although the authors found that the recovery from schizophrenia was more problematic when compared with other types of psychotic disorders, 50% of the schizophrenic group did not have a disorder that was chronic and continuous but rather was only episodic. In a more recent study, Menezes *et al*. (2006) reviewed a couple of longitudinal outcome researches concerning first-episode psychosis. In the review, the research team carefully analysed thirty-seven outcome studies on first-episode psychosis, as published between 1966 and 2003. The thirty-seven outcome studies represented 4,100 mental patients. The authors concluded that the outcome of first-episode psychosis was more favourable than previously expected, and both methodological variables and available treatment could be considered important contributors to such favourable outcomes.

Other Outcome Studies Demonstrating Heterogeneity

Nevertheless, not all outcomes studies have suggested a positive outcome in schizophrenia recovery; some negative voices have been heard as a result of those outcome studies widely shared by most scholars, professionals and frontline practitioners as influential, with positive voices rooted in consumer groups. For example, in 1994, Hegarty *et al*. processed a more comprehensive review of the schizophrenia outcomes studies spanning the past 100 years (Hegarty *et al.*, 1994). The general purpose of this comprehensive meta-analysis, as stated by the authors, was to assess the changing views on the overall prognostic of schizophrenia across different years. Altogether, 320 studies of 821 identifiable sources were selected for meta-analysis; they covered almost 51,800 subjects in 368 cohorts. In their study, as an overall picture, only 40.2% of patients were, on average, considered to have improved after follow-ups averaging 5.6 years (Hegarty *et al.*, 1994). Furthermore, if implementing narrow criteria of recovery, only 27.3% were considered improved. Better outcome results were recognised when patients were diagnosed with the use of the broad criteria (46.5% improved) or the undefined criteria (41.0% improved). The study also showed that schizophrenic patients displayed better improvements after the 1950s (1956–1985 amounted to 48.5% whilst 1895–1955 amounted to 35.4%), with such favourable results potentially accounting for improved treatment and rehabilitation services as well as a broadened concept of schizophrenia. In conclusion, Hegarty *et al*. claimed that overall outcomes of schizophrenia throughout history did not favour a positive conclusion in illness outcome, with less than half of patients diagnosed with schizophrenia showing substantial clinical improvement after follow-ups averaging almost 6 years (Hegarty *et al.*, 1994).

The Persistence of a Pessimistic Prognosis

Despite the new evidential data relating to recovery, as considered in the various outcome studies, a pessimistic view of schizophrenia remains surprisingly common. In fact, although some scholars accept the heterogeneous results in schizophrenia outcomes, they remain unable to move far enough away from a pessimistic perspective implying chronicity and poor outcomes. Throughout literature on schizophrenia, there is an apparent lack of systematic discussion on how such pessimistic views have been sustained. However, certain important points have been suggested by different scholars that are worth mentioning here.

The first explanation was provided by Cohen and Cohen (1984) using a concept called ‘clinical illusion’. In their theory, clinical practitioners who used to work with ambiguous and prolonged illnesses would have a greater tendency to assume that the ways in which “such illnesses present in clinical care settings represent the ways these illnesses look both over time and among the broader population of persons” (Cohen & Cohen, 1984:1179). Simply put, chronic cases used to be the frequent service users of clinical services, and the biased perception of their chronicity formed by daily interaction created a prejudiced understanding of the illness. It formed the ‘clinician’s illusion’.

The second explanation of the permissive view towards schizophrenia and the recovery from it was given by Kruger (2000). As discussed earlier, the official language of hopelessness and doom for schizophrenia was established through the process of self-fulfilling prophecy in making a diagnosis. According to Kruger (2000), however, people who successfully recovered from the symptoms in less than 6 months, even having symptoms of schizophrenia would be re-diagnosed again for other psychotic illness (Kruger, 2000:31). Simply put, recovery rate determined the diagnosis and then confirmed the chronicity assumption of schizophrenia.

In an early paper penned by Harding *et al*. (1992), this circularity in psychiatric diagnosis was named as “prognosis confirmed diagnosis. If the person who had all the symptoms of dementia praecox improved, then Kraepelin routinely considered the patient to have been originally misdiagnosed — an interesting tautology”(p.27).

Schizophrenia in Hong Kong

In Hong Kong, there are an estimated 200,000 people diagnosed with severe mental illness, and around 40,000 people diagnosed as suffering from schizophrenia (Hospital Authority, 2011:16). Most often, people with schizophrenia are the major population utilizing the mental health services in Hong Kong, especially in using sheltered workshop services and residential care services and.

Mental Health Services for Schizophrenic Patients in Hong Kong

Generally speaking, the history of mental health services in Hong Kong can be divided into the following five periods (Yip, 1997):

1. The stage of ignoring psychiatric rehabilitation (1841–1924)
2. The stage of awareness of psychiatric rehabilitation (1948–1965)
3. The initial rehabilitation period (1966–1973)
4. The centralised rehabilitation period (1974–1981)
5. The stage of controversial psychiatric rehabilitation (1982–1996) (Yip, 1997:8–27).

With reference to a chronological review of historical events in Hong Kong, Yip (1997:10) asserted that the local psychiatric service started to become aware of the importance of psychiatric rehabilitation in 1948 as a result of some enthusiastic professionals who formed a study group and mutual aid club in running small-scale experiential rehabilitation services. Although mental health professions started to recognise psychiatric rehabilitation as a workable practice model in dealing with mental illness, Yip (1997:11) claimed that not until the fourth stage, the centralised rehabilitation period, was the concept formally addressed by the government in local papers and policy. Starting from there, various psychiatric rehabilitation services have been fully funded by the Hong Kong government and were gradually established in the community. However, the growth of the services were, to some extent, inhibited by a violent psychiatric incident in 1982, which started a community-driven demand to re-institutionalise mental patients who were considered dangerous in society (Yip, 1997:15). In this stage of controversial psychiatric rehabilitation, rehabilitation services occurred in a form of segregated community institution, where a relatively large number of mental patients were confined to small service units to receive rehabilitation services. For example, hospital-discharged patients would be referred to 40-capacity halfway houses, with vocational rehabilitation taking place in 200-capacity sheltered workshops. In 2002 the Hong Kong government started to develop more community mental health services on a trial basis, and in 2010 a new integrated community mental health caring service was launched. Figure 3 shows a simple chart identifying the different categories of mental health services in Hong Kong.

When reviewing the causation of such development of psychiatric rehabilitation services in Hong Kong, Yip (1997) stated that the ideologies of psychiatric rehabilitation in the local area were one of the factors that needed to be taken into account bearing in mind the mentioned changes (Yip, 1997:6). He asserted that psychiatric rehabilitation in Hong Kong tended to underestimate the patients of the services, and the focuses of rehabilitation work usually centred on stabilising impairment as opposed to capacity development (Yip, 1997:17).

Major Categories	**Examples**
Medical Service:	Mental hospital service Psychiatric clinic service Day hospital service Youth mental health service Discharge follow-up management services Community psychiatric nurse service Patient resource centre service
Rehabilitation Residential Service:	Long-stay care home services Halfway house services Supported hostel services

Vocational Rehabilitation Service	Integrated vocational rehabilitation service Supported employment service Youth employment service
Community Support Service	Integrated community care for mental wellness Family resource centre service

Figure 3: The different categories of mental health services in Hong Kong
Note: non-subverted or pioneer services by NGOs are not included.

In another literature, Yip (2004) continued to reveal that tended to ‘keep themselves at a distance from the client’s subjective feeling, inner experience and personal problems’, and even the medicalisation of social workers in mental health services in Hong Kong was noted (p.413). In other words, the focus of psychiatric treatment in Hong Kong was primarily centred on medication (Cheung, 1986:209; Yip, 1997). Moreover, the personal experiences of those with mental disability were not adequately attended. In actual fact, sparse literature has been published in relation to the concern of the recovery process and the personal experiences of recovery from mental illness.

In recent years, apart from the provision of residential-based and sheltered-based mental health services, a new series of community mental health service hass developed in Hong Kong (Leung & Yip, 2009). Since 2002, a dozen of community-based mental health centres have established in different areas of Hong Kong with specific focus in supporting mental health recovery in the community (Leung & Yip, 2009; Chui *et al*., 2012). Such changes of the basic ideology of mental health services in Hong Kong have brought forth tremendous increase in service utilization and user participation in past 20 years (Tse *et al*., 2012). Despite all these improvements, community rejection of mental illness remains the significant obstacle of further provision of mental health services in Hong Kong (Tse, Ng & Lam, 2015).

Stigma and Public Attitude

There are a number of research studies that have been conducted in Hong Kong in an effort to explore public attitudes towards those with schizophrenia and mental illness. The results showed that although the public had become more compassionate in recent years, those with mental illness continued to face various levels of labelling, discrimination and stigma. In this domain, stigma was referred to as a "social devaluation of a person because of personal attribution leading to an experience of sense of shame, disgrace and social isolation" (Thara & Srinivasan, 2000). Furthermore, Gabe and Monaghan (2013) suggested that stigma was "a societal reaction which singles out certain attributes, evaluates them as undesirable and devalues the persons who process them."

In the following sections, the major findings amongst existing research in regard to public attitudes and the stigmatisation of people with mental health problems in Hong Kong will be discussed.

Unchanged Attitude

Several research studies have come up with a similar phenomenon in which the stigma of older age is greater and more impermeable. People who were more experienced with the patient experienced fewer misunderstandings and were less likely to hold negative attitudes towards those with mental health problems (Chiu & Chan, 2007). The negative identities of stigma held by the public built up in people with mental problems negative imaginations and behaviours relating to them. Overall, such stigmatising appeared in regard to the aspect of basic knowledge of mental health, healthcare and employment.

Inadequate Knowledge Relating to Mental Illness

Knowledge of illness requires the recognition of associated symptoms and behaviours. Research findings suggested that people in Hong Kong tended to describe those with mental health problems as quick-tempered, unpredictable, introverted and as having low self-esteem (Tsang *et al*., 2003). The general public was seen to be quite concerned about whether there would be unpredictable violence from a mentally ill person. People usually thought that those with mental health problems were dangerous, with such a situation not improving for the rest of their lives. For the sake of safety, the general public seemed to prefer to maintain distance from people with mental health problems. Although they agreed that patients would recover much better in an acceptable context, they generally resisted having mental health facilities in their community. On the other hand, however, it was found that the general public did not know how to recognise different types of mental illness but could hold only a single impression. Over half of them thought that only autism and depression were defined as psychiatric conditions, and excluded anorexia nervosa, ADHD and Parkinson’s disease. These findings showed that their major impression towards those with mental health problems involved such individuals being ‘crazy and weird’ and displaying abnormal behaviours.

Moreover, when dealing with illness, the respondents tended to think that they should consult a psychiatrist instead of a general practitioner, which implied that all mental illness was recognised as a serious illness. Whilst agreeing that mental patients should have their own rights as normal citizens, the general public tended to agree that most people in this situation should stay in hospital or restricted mental health facilities until they recovered. For example, according to a study conducted in 1996 (Chou *et al.*, 1996), approximately 40% of respondents disagreed with having mental patients live in their neighbourhoods. In addition, there were more people who agreed that the rehabilitation facilities should be far from the community than those who disagreed. In addition, a study conducted later (Tsang *et al.*, 2003) found similar results, in which 40.1% of the respondents agreed that rehabilitation facilities could stay in the community. However, 28.8% of the respondents stated that they would strongly oppose any suggestion for the government to propose setting up halfway houses in their neighbourhood (Tsang *et al*., 2003). This showed that the general public was actually unconsciously marginalising those with mental health problems. All of these misunderstandings lead to a relatively negative attitude towards mental illness in Hong Kong.

Discrimination in Employment

Research findings have shown that employers usually exclude applicants with a history of mental illness, with such individuals less likely to be employed or promoted. Moreover, the general public believed that those with mental health problems were less reliable and less competent than others. In this regard there was a phenomenon of ‘tokenism’, in which some employers would employ ex-mentally ill individuals to build up an image of an inclusive environment beneficial to the running of the business. However, the overall negative attitude in the workplace was not beneficial to recovery at all, and working in such an environment could prove to be even more stressful.

It was generally agreed that the mass media played an important role in spreading negative images and ideas of mental illness in the community

(Wahl, 1992; Philo et al, 1994;). In this regard, repeating reports of a particular kind of news would build up negativity in the minds of the observers. In the case of reporting mental illness, unfortunately, the continuous reports of psychiatric violence and aggression would induce only fear and hostility. In this regard, it was easy for readers/viewers to associate and link mental illness with extreme danger, with this type of stereotype not easily removed; ‘filtering’ and ‘exaggeration’ would unconsciously take place in society, with the phenomenon of selective attention potentially maintaining the stereotype by ignoring contradictory evidence. This would further intensify the labelling by the public of those people with mental health problems.

According to Yip (1991), people used to show an interest in discussing the topic of mental illness. When people lack knowledge on this topic, it is common for them to discuss according to their subjective emotions, but not in consideration of the evidence. This is referred to as the effect of rumour. This involves the rumour gradually going further away from the truth, in which the stereotype and labelling are further internalised towards those with mental health problems.

Mental Health Recovery Movement

In the 1980s, the concept of recovery started being seriously considered amongst mental health service consumers with the publication of personal accounts of recovery from serious mental illness. The general beginning of this recovery movement was basically an assertion in rejecting the pessimistic view of the course of mental illness. With such a pessimistic view, improvement and success were outcomes generally neglected and denied, with such individuals being marginalised in society. Many consumers felt that they were given a ‘prognosis of doom’ (Deegan, 1997) and became hopeless on unreasonable grounds. Moreover, they found that such negative labelling did not match their experiences, in which most of them figured out to defeat the disability and the problems induced by the illness and could have successful and joyful lives. Such experiences supported their views that severe mental illness, including that of schizophrenia, did not need to have a long-term deteriorating outcome as expected. With this as their starting point, mental health service consumers actively worked for re-conceptualisation of recovery in the field.

In fact, the recovery movement started off after several mental health service users publicly disclosed their first-hand experiences and advocated their right for more humane treatment. Schiff (2004) asserted that the ‘spoken out’ adopted by those pioneers in fact matched the consumer-survivors tradition in Britain, France and America, which could be traced back to the earliest work by Elizabeth Packard and Clifford Beers. Nevertheless, this new recovery movement of the 1970s did not fall mainly in this historical tradition, but nonetheless appeared to be a mixture of other disadvantaged groups, such as blacks and gays, in bringing political influence (Schiff, 2004). Only patients with first-hand illness experiences were gathered and they largely focused their role in increasing consciousness (Chamberlin, 1990). Mutual helping behaviours between mental health service users were appreciated and highly emphasised in the recovery movement; in actuality, the recovery notion was started by those professionals who were also mental health service consumers, and their voices were heard eventually. Frese and Davis (1997) named such pioneers in the 1980s as “prosumers” (professional consumers), who have both types of experiences to educate professionals about the lived experiences of consumers.

Early First Accounts of Recovery

The earliest first-person account in the recovery movement, which started around the 1980s, came from Joan F. Houghton (1982). Houghton was a research analyst at the National Institute of Mental Health in Rockville, USA, and a doctoral student in counselling. Although her personal account did not clearly present the concept of recovery, her sharing was so deeply personal and unique and her process of change was clearly identified. This meant there was a great effort made in making her life fuller. In actual fact, her personal introduction of the paper *Maintaining Mental Health in a Turbulent World* also showed that she struggled for a life, just like the readers, and that these changes were valuable enough to be revealed.

> *"This is a preview of a tragedy in my life which I find difficult to remember 5 years later. The difficulty is a function of the fact that my reality is your reality — that I, like you, struggle to cope and survive each day in a turbulent world. The difference between us is an experience which has changed every aspect of my life. It is the changes and not the experience that I want so much to share with you." (Houghton, 1982:548).*

In the same year, the personal recovery story of Ms Marcia Lovejoy

(1982), the director of Project Overcome in Minneapolis, USA, was published in *Schizophrenia Bulletin.* The title was *Expectations and Recovery Process.* Lovejoy was once diagnosed as having chronic schizophrenia and actually experienced several hospitalisations as a result of the prolonged experience of hallucinations. By carefully delineating her recovery process after joining a halfway house and making new friends, the author critically discussed how a self-fulfilling attitude and pessimistic labelling would only induce a poor outcome. In her articulation, recovery was not only a final outcome but was a progress involving her personal growth and coping methods.

> *"I have finally learned how to survive, and have not seen the inside of a psychiatric hospital for 4.5 years. But although I now feel that my life is under control, I know that thousands of others have not been so lucky and are still facing the same struggles with mental illness that I fought for most of my life. My experiences, as well as the experiences of others from the halfway house, have taught me that regardless of the cause(s) of mental illness, progress toward recovery cannot occur when there is no hope." (Lovejoy, 1982:608)*

Following the path of Houghton (1982) and Lovejoy (1982), another well-known service consumer, Patricia Deegan, publicly disclosed her personal recovery experiences. At the age of 17 she was diagnosed as having schizophrenia and there was no hope of recovery; she referred to this labelling as like suggesting a ‘prognosis of doom’. Nevertheless, Deegan refused to passively accept the diagnosis and instead decided to become a psychologist to prove that she was still a person with dreams and hopes, but such initiatives were, in turn, treated as delusions of grandeur by her psychiatrist. Deegan eventually received her doctorate in psychology and named the persistence of hope for a better life as a ‘survivor vision’ (Deegan, 1988). Notably, the paper of Deegan’s did not simply describe her personal experience of recovery but also actively discussed the concept of recovery. According to Deegan (1988), recovery was defined as:

> *“A process, a way of life, attitude, and a way of approaching the day’s challenges. It is not a perfectly linear process. At times our course is erratic and we falter, slide back, regroup and start again … The need is to meet the challenges of the disability and to re-establish a new and valued sense of integrity and purpose within and beyond the limits of the disability, the aspiration is to live, work, and love in a community in which one makes a significant contribution.” (Deegan, 1988:15)*

Recovery, in Deegan’s definition, was different from rehabilitation. In her words, people with psychiatric disability were not passive service recipients. In overcoming their disabilities, they could regain a new self beyond their limitations. , Recovery, instead of rehabilitation, referred to “the lived or real life experience of persons as they accepted and overcame the challenge of the disability”(Deegan, 1988:11). Nowadays, Deegan is still active in publishing recovery papers and promoting the recovery notion in the field. In actuality, her paper, in 1988, was the most cited publication in recovery literature.

Beyond these three classical narrations by Houghton (1982), Lovejoy (1982) and Deegan (1988), two other popularly cited first-person accounts were subsequently published by Leete (1989) and Unzicker (1989). These five earliest self-narrations by mental health service users clearly favoured the description of recovery from illness as a process. Obstacles of various sizes were obvious in the journeys of recovery; nonetheless, their personal struggles championed a more positive outcome, which was more than others had expected.

More Consumer Voices on Recovery

Once the recovery movement was started in the 1980s, more and more efforts were directed by consumers to present their voices on the illness, treatment and services, and their individual recovery stories. Efforts were invested and voices were heard. The voices from the consumers not only echoed within themselves but also in the editorial boards of academic journals; leading journals in the mental health service field, such as *Schizophrenia Bulletin, Hospital and Community Psychiatry Psychiatric Services* (renamed as *Psychiatric Services* in 1994), and *Psychosocial Rehabilitation Journal* (renamed as *Psychiatric Rehabilitation Journal* in 1992), etc., all started to publish first-hand narratives from mental health service consumers in various aspects.

In reviewing the first-hand accounts of schizophrenia and recovery for this thesis, a preliminary electronic search has been done. Various keywords, such as “recovery,” “schizophrenia,” “narration,” “first-hand account,” “psychosis,” “stories,” “consumers,” “recovery movement,” etc., were used to search available electronic databases, such as PsycINFO, ScienceDirect, Academic Search Premier and Social Science Citation Index. This broad search resulted in more than 100 records and encouraged further re-categorisation.

Eventually, a list comprising almost 40 articles was made and regrouped into *Consumer Recovery Experiences* and *Consumer-led Recovery Discussion*. In the first group, personal *recovery experiences* were the key components of the articles, and thick descriptions were available. In the second group, obvious discussions on the *recovery concept* were noted instead.

Conceptual Development of Recovery

After the 1980s, the word “recovery” moved beyond a shared language amongst consumers and instead became recognised as a common notion amongst all mental health-related literature. More specifically, hundreds of papers that emphasised theoretical discussions, conceptual reflections, reporting of research findings (both quantitatively and qualitatively) and services re-engineering, etc., were published around the theme of recovery. At that moment, a detailed review of each related area became impossible because it would involve producing a number of books. In fact, some influential textbooks that focused on recovery have been published in recent years. In the following parts, a brief summarisation of the conceptual development process will be provided.

Through the use of a qualitative analysis method, Ridgway (2001) reviewed in depth a number of published personal recovery stories as given by consumers. At the beginning of his review, 25 recovery stories were identified. Nevertheless, focus was centred on the four seminal personal accounts from Lovejoy (1982), Deegan, (1988), Leete (1989) and Unzicker (1989), with such narrations explicitly relating to the recovery notion and therefore able to provide rich data for further conceptualisation. Ridgway (2001) found that various distinguishing recovery themes could be identified amongst the classical pieces:

1. Recovery is a reawakening of hope after despair;
2. Recovery is breaking through denial and achieving understanding and acceptance;
3. Recovery is moving from withdrawal to engagement and active participation in life;
4. Recovery is an active coping rather than passive adjustment;
5. Recovery is reclaiming a positive sense of self and no longer viewing oneself primarily as a mental patient;
6. Recovery is a journeying from alienation to purpose;
7. Recovery is undertaking a complex journey; and

8. Recovery involves support and partnership rather than working alone.

Another comprehensive qualitative review of the lifeworld of chronic mentally ill individuals was conducted by Hayne and Yonge (1997). In addition to the personal accounts by Lovejoy (1982), Deegan, (1988), Leete (1989) and Unzicker (1989), 36 more consumer stories (total = 40) were involved in the qualitative analysis. The results showed that four common lifeworld experiences — namely corporeality, spatiality, relationality and temporality — were noted in the personal stories (Hayne & Yonge, 1997). Nevertheless, the results of the study mainly focused on analysing commonality amongst the subjective experiences of those consumer authors, and thus it merely provided insight towards the recovery process, as per that what Ridgway (2001) did in his project.

Recovery Literature and Common Themes

Various types of recovery literature were published after the 1980s. Starting from this time, the concept of recovery, which had originated from the consumer side, was becoming enriched by various parties, including clinicians, scholars, practitioners, service organisers and politicians. Literature appeared in various forms, including research reports, conceptual debates, conference papers, papers on models development, papers on measurements development, outcome studies, service reviews, as well as policy papers (Ralph, 2000). Instead of reviewing them in a purely chronological but individual description, the types of literature are grouped under a discussion on the common theme or issues related to recovery.

Key Theme: Recovery as Process

Generally, recovery was viewed as a process — not as an outcome (Deegan, 1988, 1993) — and was almost an personal process of searching as opposed to an end point (Stocks, 1995). In this personal journey, individual experiences were so unique and different from one another, and usually involved a reconnection of one’s life (Dillon, 2012:18). Anthony (1993) acknowledged recovery as a continuing and deeply personal journey leading to personal growth and discovery. It was not a state of being, but was a becoming, a path, rather than a destination.

> *“This assumes there is no end point that can be achieved now and forever. Rather it is a process by which individuals work continuously to maximize the satisfaction of their needs even when a serious brain disorder makes it a formidable adaptive challenge.” (Hatfield, 1994:6).*

> *"It is so important to remember that recovery is a process … We live through the vicissitudes of hope and despair and above all we learn to survive, not just as victims but as people who can turn reaction into action that is self-directed. Thus, we never get recovered. We are always on the way." (Deegan, 1994:19).*

According to the people with experience in severe mental illness, recovery was always said to be a non-linear process "by which people with psychiatric disabilities rebuild and further develop important personal, social, environmental and spiritual connections" (Spaniol & Koehler, 1994:1). This journey was unique and individual, including improvement, growth and setbacks. Ralph (2000) also suggested that the idea of the 'upward spiral' was a best fit for describing the original ideas presented by consumers. In the general upward movement of recovery, most often, turning points could be witnessed and personal growth should be celebrated.

Key Theme: Recovery is Not about Symptoms but the Person

In the traditional medical model, mental illness was fundamentally perceived as a physical disease, and recovery referred to a return to a former state of health in which the person was said to be cured (Whitwell, 1999).

Generally speaking, the term “recovery” implied the absence of disease. In most outcome studies of schizophrenia and other mental illnesses, this traditional perspective was the dominant ideology, which was also the case in those studies reviewed in previous paragraphs. Outcome indicators, such as symptom reduction, re-hospitalisation rate and functioning level, therefore were extensively used. Nevertheless, the definition of recovery in the consumer side was never rooted in this perspective.

> *“One of the biggest things I’ve had to accept is that recovery is not the same thing as being cured.” (Deegan, 1997:11).*

Consumers’ rejection of such a medical definition of recovery was understandable, especially when they were experiencing the medical symptoms for a long time. In the system, they were perceived and referred to as patients, and what would be observed were their diagnoses and symptoms but not themselves as individuals. Their illness or disease was described as the manifestation, accumulation or declination of symptoms, and it would be written down in medical records. Especially when the ‘form’ rather than the ‘content’ of their symptoms was the basic criteria for making a psychiatric diagnosis, their personal stories were seldom heard and respected. More specifically, an implicit but primary ideology behind the consumer-led recovery movement was to alter this clearly inhumane orientation towards mental patients. However, most importantly, most mental health service consumers reported that they could find their way of having a life worth living even if symptoms never disappeared. In this vein, as supported by real stories, a good living after having a mental illness has nothing to do with symptoms reduction or the curing of symptoms. From a more radical point of view, consumer advocators claimed that it was truly the medical view, placing an over-emphasis on symptoms reduction in defining recovery, that made recovery impossible — and they were the true victims.

Tooth *et al*. (1997) further stated that only 14% of the participants would interpret recovery as having no more symptoms; instead, it might involve an active self-management of the illness, although such definition is far from a full description of recovery. Certain consumers held the view that their treatment was even more harmful than their illness in their process of recovery (Frese, 2000; Mead & Copeland, 2000). Others also concluded that their intended withdrawal from anti-psychotic drugs was the starting point of recovery.

> *"Being in recovery means that I don't just take medication … I used medications as part of my recovery process. In the same way, I don't just go to the hospital … I used the hospital when I need to." (Deegan, 1997:21)*

Hope and Components of Recovery

In recovery literature, various efforts have been made to further conceptualise the components of recovery. From my perspective, three sources of information can be seen as worth mentioning in this thesis; these are included because they provide a unique contribution to identifying the basic components of recovery. They are:

- The definition of recovery from Davidson *et al*. (2005)
- The definition of recovery in National Consensus Statement (2004)
- The definition of recovery from Onken *et al*. (2007).

In order to avoid another lengthy introduction of the components identified, Figure 4 provides a comparison of the recovery components suggested by the three important sources. As shown in Figure 4, 'hope' is repeatedly included as a key component of recovery, meaning its clear importance warrants further exploration and discussion.

However, a closer examination of the concept of hope, as suggested in the recovery literature, would be disappointing because there is a lack of information centred on establishing a clear picture of hope as an element of recovery. Nonetheless, there follows various summarised texts relating to the concept of hope in the recovery model:

> *"Renewing Hope and Commitment: Having a sense of hope and believing in the possibility of a renewed sense of self and purpose, accompanied by desire and motivation, is essential in recovery. This sense of hope may be derived spiritually and/or from others who believe in the potential of a person, even when he/she cannot believe in him/herself. The emotional essence of recovery is hope, a promise that things can and do change, that today is not the way it will always be." (Davidson and colleagues, 2005)*

National Consensus Statement (2004)	**Davidson *et al.* (2005)**	**Onken *et al.* (2007)**
Hope	Renewing **Hope** and Commitment	**Hope**
Responsibility	Assuming Control	Sense of Agency
	Being Involved in Meaningful Activities	Meaning and Purpose

Self-direction		Self-determination
Strength Based		Awareness and Potentiality
	Incorporating Illness	Coping
Person-Centred Treatment	Redefining the Self:	Healing
Holistic Wellbeing		Wellness

Figure 4: Comparisons drawn between various definitions of recovery

> *"Hope: a condition 'characterised by an anticipation of continued good state or release from perceived entrapment in health related literature' (Miller & Powers, 1988:8), including optimism in achieving goals. The two dimensions of hope are general hope (an expectation of positive future development), and motivational hope (an expectation that one will make efforts to accomplish valued goals)." (National Consensus Statement, 2004)*

> *"Hope: Hope is central to recovery, as people must have hope for themselves and their own futures in order to rally resources necessary to face the challenges of the psychiatric disability. It is often the expectation of better things that propels a person toward an improved life situation and incites the desire to take in that direction." (Onken and colleagues, 2007)*

From the perspective adopted by this research, however, the above information is insufficient to support a good discussion about hope and recovery, meaning that a much more thorough discussion of hope is required.

Social work and recovery

Social work as a care profession has a long history of commitment to working with people with severe mental illness. In North America, formal training has been offered in psychiatric social work in hospital settings since the very beginning of the 20th century (Reisch, 2012). In England, a huge number of social workers were involved in helping mental patients to regain a successful social life under the promotion of the community mental health movement between the 1950s and 1960s (Timms, 1998). In Hong Kong, social workers have been employed to work with mental patients in outpatient clinics and hospitals as well as in the community since the 1960s (Mak & Gow, 1996; Yip, 1998). By adopting a humanistic, empathic and anti-oppressive approach in mental health practice, social workers provide valuable contributions towards promoting the general well-being of people with mental illness (Yip, 1998, 2004, 2005).

In social work literature in the past 40 years, there are three obvious types of discussion about social work practice and the concept of recovery. In the first type of discussion, the focus is on reviewing the role of social workers under the concept of recovery in general (Aviram, 2002; Bland, 2014; Carpenter, 2002; Starnino, 2009). The second type of discussion is about applying strengths-based social work practice as a means to promoting mental health recovery (Barry et al., 2003; Graybeal, 2001; Rapp & Goscha, 2006; Yip, 2008). In the third type of discussion, emphasis is placed on advocating patients' rights as a key component of recovery in constructing user-led services and user-led research (Beresford & Wallcraft, 1997; Beresford, 2002, 2004; Faulkner & Thomas, 2002). But, as a whole, no matter how the concept of recovery is defined, social workers are always expected to uphold an enabling and empowering attitude when working with people with psychiatric disabilities. In the face of a huge number of people with mental distress, social workers have the ethical obligation to foster a recovery-friendly society and non-oppressive mental health policy. I totally agree with Saleebey (2006) that social workers should not hesitate to offer a helping hand to those who need or ask for it during their darkest times in life, for we have been chosen to do so.

Chapter Summary

Over the past 100 years, a lot of attention has been given to improve our understanding of schizophrenia as a severe mental illness. At the very beginning, schizophrenia was supposed to be a deteriorating illness with limited hope for recovery. Nowadays, people around the world are more willing to accept the fact that people with schizophrenia could have a positive outlook than what was once expected. This chapter begins by introducing the historical concepts of schizophrenia and is followed by an extensive review of the literature on recovery. In the next chapter, the concept of hope is further explored. This exploration will set the stage for forming the theoretical background to my qualitative research.

CHAPTER 3: A LITERATURE REVIEW OF HOPE

What is Hope?

The definition of the term “hope,” as provided by the Merriam-Webster Dictionary (1996), is detailed as follows:

Hope as a verb : to want something to happen or be true and think that it could happen or be true.

Hope as a noun: : the feeling of wanting something to happen and thinking that it could happen : a feeling that something good will happen or be true
: the chance that something good will happen
: someone or something that may be able to provide help : someone or something that gives you a reason for hoping

The Christian Notion of Hope

Through this definition, we will find hope as a positive and is always highlighted on the good side of the future. For myself, as a Christian for more than 20 years, this spirit of hope is quite familiar as it matches the religious ideas of Christianity, where hope is a belief (in terms of faith) in the Holy Father in Heaven, who always provides the best for us. According to the Bible, hope is a virtue, and based on his hope against hope (Rom 4:1-8), Abraham became a father of many nations and was blessed (Bowman, 2001:38). In introducing his theology of hope, Jurgen Moltmann (1993) asserted faith in a coming God and the hope of a resurrection that will relieve. For Moltmann (1993), our openness to a better future was always the best reaction that we could have in facing present suffering.

Ancient Greeks’ Notion of Hope

The ancient Greeks’ idea of hope was introduced by the great poet Hesiod in his poem *Words and Days* around 700 BC. In the poem, there was a story about hope and Pandora — the first made woman. Zeus was the father of the gods that ruled the universe. However, when the clever and foresighted Prometheus stole the fire, i.e. the flames of Olympus, from heaven to the mortal world, Zeus was angry. In order to achieve retribution, Zeus ordered the creation of Pandora, who was the first mortal woman on Earth. This beautiful woman was presented to Prometheus’ foolish brother Epimetheus. Pandora was then given an attractive box and was asked not to open the box under any circumstances. Motivated by her curiosity, as expected by Zeus, Pandora opened the box and all evils contained inside were released to the world. When Pandora managed to close the box, only hope remained.

In the modern world, in popular English, the opening of Pandora's box relates to the onset of something bad; however, the interpretation of the ancient Greeks in regard to the poem was quite controversial, with the argument centred on whether hope was the good evil that remained for mankind in times of difficulty, or whether it was the bad evil left to fool mankind in times of suffering. Generally speaking, the positive view was the dominant version shared by most people in society.

Hope, Wishes and Optimism

In the literature, the term "hope" has been used quite interchangeably with terms of similar meaning, such as 'wish' and 'optimism', and different writers, although only a few, have attempted to distinguish the three concepts from one another (Pruyser, 1963).

The difference between the concepts of optimism and hope was the first to have reached a conclusion in hope literature (Lavalley, 1973). Early scholars suggested that the selective perception of reality was a characteristic of optimism, whereas hope involved the acceptance of reality — regardless of whether good or bad — with hope for the best to come (p. 39). In 1985, Scheier and Carver asserted that optimism was a generalised positive outcome expectancy in which the individual utilised his good wish to expect something to happen positively (p. 219). In recent years, and in greater detail, Bruininks and Malle (2005) have claimed that optimism differed from hope in two essential aspects. Firstly, optimism could be experienced as being free from contextual reality in which an optimistic individual could believe in positivity not only in regard to one but amongst various different realities. Hope, on the other hand, was generally considered to be contextually bonded. Secondly, optimistic individuals tended to experience feelings of optimism when they had good control over the result. Hope, in contrast, became more obvious in situations where people had lost control of the outcome. With this in mind, I am more inclined to agree with the first point made by Bruininks and Malle (2005) in which, in reality, optimism is comparable with a personality trait as opposed to a contextual response.

However, the difference between hope and wishing is not that obvious

(Bruininks & Malle, 2005). For example, according to Marcel (1962), hope was not wishing as, by definition, hope involved no specified wished objects but only referred to global objects, such as freedom, justice and salvation. In addition, according to Korner (1970), wishing was different from hope as the former was merely a mental activity and did not necessarily imply actual action (for example: “I wish you a Merry Christmas”). In this case, giving up a wish was easier than giving up hope, which involved affective components (p. 136). However, psychologist Menninger (1959), who introduced the concept of hope in the domain of psychology, described hope as the consciousness of a realisable wish. In Webster’s Dictionary (1999), hope is defined as a ‘wish’ or desire accompanied by the expectation of its fulfilment. Another recent article by Miceli and Castelfranchi (2010) was titled *Hope: The Power of Wish and Possibility.* Phenomenologist Martin (2011) asserted that there was no clear-cut distinction to be made between hoping and wishing in the superficial meaning, but that only the underlining frame of reference in use determined the difference.

Nevertheless, despite hoping, wishing and optimism being described as having quince meanings, it was also agreed that, in reality, it was possible for one activity to preclude the possibility of others (Lavalley, 1973:41). We wish, we hope and then we become optimistic on the same subjects; there is no need to assume that they will be identified in a sequential manner; more often than not, they arise in a pair.

Major Perspectives and Theories of Hope

In the following section, major hope theories from different perspectives will be introduced. It is worth mentioning that many hope theories have been devised in the field of nursing, in which the concept of hope is implemented in daily practice in a number of life and death situations.

Psychology: Cognitive Perspective

Stotland: Possibility Theory of Hope

Ezra Stotland (1969) is said to be one of the earliest cognitive hope theorists in the field, and his book *Psychology of Hope* is said to be the most classical cognitive theory of hope to have been born from the 1960s. When analysing a wide range of empirical research conducted during this period, Stotland conclusively provided in his book a suggestion of his cognitive definition of hope and seven propositions regarding the relationship between hope and motivation. Throughout the course of the book, Stotland discussed his concept of hope by emphasising the importance of cognitive paths in formulating the level of hope, and its interlocking relationship with human motivation in regard to goal attainment. In the first page of the book, Stotland wrote, “With hope, man acts, moves, achieves” (Stotland, 1969:1). In other words, in this theory, hope was seen to be related to motivation for action, with some scholars (such as Schrank, 2011), even referring to Stotland’s hope theory as Motivational Theory.

According to Stotland (1969), hope was defined as a one-dimensional construct that was “an expectation greater than zero of achieving a goal” (Stotland, 1969:2). With this definition, hope existed only when three following conditions were realised: firstly, there needed to be the presence of a goal; secondly, there should be the expectation of goal attainment; and thirdly, the expectation should be greater than zero. In this model, expectation was characterised by possibility calculation (greater than zero), which suggested the involvement of certain cognitive processes. Regarding this definition of hope, which was seen to involve cognitive processes, Stotland's hope theory was generally said to be a cognitive hope theory or cognitive-behavioural theory if the motivational element was counted. For the writer of this thesis, it should be a cognitive-behavioural theory since the concept of motivation is also stressed in Stotland's theory.

Snyder: Cognitive Hope Model

Following the path of Stotland, Snyder *et al*. built up their own cognitive theory of hope; without doubt, their hope theory is one of the most influential and most commonly cited theories in the field.

In 1991, Snyder *et al*. first defined hope as "a positive motivational state that is based on an interactively derived sense of successful agency and pathways" (Snyder *et al*., 1991:287). This was named as the two-component hope theory. A few years later, in his new paper *Hope Theory: Rainbows in the Mind*, 'goals' were added to the full hope model as a third key component of the theory. This new trilogy theory of hope — comprising goals, agency and pathways — was formed (Snyder, 2000, 2002:249). According to Snyder and his colleagues, these components of hope were reciprocally related to one another as opposed to merely standing alone independently. For Snyder, the more likely an individual was to realise these three components, the more likely he or she was to achieve a sense of hope and a positive psychological state.

In this model, the relationship between cognitive thinking and affection were clear: cognitive thinking was seen to generate affective response; simply put, cognition came first and was more important than reactive affections. Essentially, the more a person thought cognitively in this way, the better hope was attainable. When goals came together with the will and the pathway, this led somewhere desirable and sought after.

In the following paragraphs, closer focus will be directed towards the three components of Snyder's hope theory.

In regard to goals, Snyder stated that human actions were goal-directed, and human beings were goal-directed in nature (Snyder *et al.*, 1991). Goals were important in human life as they were the targets of mental action sequences in hoping (Snyder, 2002:250). However, it was important to recognise that goals varied in terms of their temporality ranking, from short-term goals relating to the near future to long-term goals for which a longer period of time was needed for materialisation. For Snyder, goals could be positive (a positive outcome was expected) or negative (a negative outcome was not expected to happen). Regardless, however, a goal was the cognitive component that fastened Snyder’s hope theory (Snyder, 2002:250), as the two other components — namely pathway and agency — were meaningful only when a desired goal should be achieved. As stated by Snyder, “goals can be the objects, experiences or outcomes we imagine and desire in our minds” (Snyder, 1994:8). Moreover, there was much variation in terms of their temporality and achievability, which might be either short-term goals or long-term goals, or could be highly achievable or very difficult to achieve in terms of actualisation. Importantly, though there could be different types and combinations of goals, irrespectively, however, one point was certain: goal attainment was always found to be associated with positive emotions (Snyder *et al.*, 1996).

In regard to agency, this was the level of goal-directed willpower possessed by an individual who was willing to move towards the goal and was centred on the energy, the wilfulness and the motivation to take actions in mind of the desired goals. Without the motivation to move, plans would not be executed, and what remained was merely dreaming. For Snyder, willpower was the driving force to initiating and executing goal-directed behaviours. Sometimes, the willpower for the desired goal would be particularly important when foreseeable obstacles were there in reaching the goals, and only strong willpower would lead an individual to overcome the barriers. Snyder found that high-hope individuals were always able to maintain a responsible sense of agency by knowing that he or she was the one who was going to take action. It is the ‘I’ that became the agency in goal attainment.

Regarding pathways, this was the level of goal-directed willpower an individual believed he or she held over the possible pathways to achieve the desired goals, with emphasis placed on the route towards achieving the goals — not the motivation. Goals without a possible pathway or pathways were unable to be achieved. If an individual positioned desired goals in his or her mind, even when there was a strong motivation to act, pathways were needed. People with good waypower always knew ‘the path’ for working out their desired outcomes; in other words, those with waypower possessed a route, or even several different routes, to bring the future to the present. According to Snyder, waypower was affected by previous successful experiences in achieving desired outcomes, and (social) learning from others' successful experiences could bring about the same effect.

Lazarus: Emotional Theory of Hope

Richard Lazarus made two important contributions to our present understanding of hope. Firstly, he asserted that hope was an emotion, and secondly, hope could be a coping resource when an individual experienced stress. These two ideas are actually commonly found in hope literature, although not all theorists would introduce ideas of hope with such elaboration.

Lazarus was a renowned emotion theorist. However, the cognition-based emotion theory introduced by him differed from classical theories in terms of emotion, which emphasised biological responses. For Lazarus, cognitive appraisal was involved in the formation of emotions for individuals to make sense of their situation. His earliest idea in this arena can be found in his paper *Thoughts on the Relations between Emotion and*

Cognition, published in 1982, in which he discussed basic emotions, such as anger and fear, in conjunction with their related cognitive processes. In 1994, twelve years later, Lazarus co-authored a book, *Stress, Appraisals and Coping*, with his colleague Susan Folkman, which introduced a transactional model of stress and coping in which stress was treated as an emotion. In the model, hope, as an emotion, had a particular role to play.

In consideration of the argument posed, in the model of stress and coping, as introduced by Lazarus and Folkman (1984), emphasis was placed on interaction between people and their environment, where stress was not a direct response to stimulus; rather, stress was the result of the cognitive appraisals of a situation in which demands exceeded the availability of resources (Lazarus & Folkman, 1984). However, individuals under stress were not passive receivers: they could deal with stressful situations through various means of coping, with such coping affecting the appraisals of the situation in the present view of the future. This provides the basis for why the framework is recognised as a transaction or interaction model. In this regard, Lazarus and Folkman (1984) claimed that hope was a kind of emotion-focused coping mechanism aimed at dealing with the emotions of the problematic situation, but not primarily aimed at alleviating the problems. In this way, hope seemed to be a “positive attitude” (p. 665), which had been found useful in the coping process and which elicited positive re-appraisal of the situation, accordingly initiating some “uplift” (p. 670) behaviours that assisted the individual in temporarily releasing the stressful feelings. As a result, the individual who could be released from the negative emotion with a positive attitude could act in a more direct way to try to solve the problem and turn events into positives in an effort to sustain his or her coping.

As hope was generated as a reaction to a strong desire to alleviate faced difficulties, just as other emotions were generated after the appraisal of a situation, hope was typically recognised by Lazarus and Folkman (p. 663) as an emotion.

Averill: Rules of Hope

In 1990, psychologist James Averill and colleagues George Catin and Kyum Koo Chon finished a book titled *Rules of Hope*. This seminal work is one of the earliest and complete examples of literature centred on hope treated as an emotion. By adopting a social constructionist perspective, Averill *et al*.

argued that hope, as an emotion, was not only a biological and physiological response but socially constructed by norms and rules of the culture. The authors claimed that the traditional approach to emotion, which placed an emphasis on the stimulation-reaction model of thinking, could not encompass complex intellectual emotions such as hope. They stated that the only way of understanding hope as an emotion would be to carry out 'social level analysis' (Averill, 1980; Averill *et al.*, 1990:309). However, this book was not simply about hope, but emotions in general.

In the book, Averill *et al*. reported four interrelated studies that explored and discussed hope as an emotion in society. All studies were conducted by the authors in America. In the first study, the focus was directed towards 'the social norms and rules that help constitute and regulate hope' socially (Averill *et al.*, 1990:7). In the second study, the focus was directed towards examining the similarities and differences between hope and other basic emotions, such as love and anger. Based on the results provided through the completion of the first two studies, the third study examined the generalisation of the results through analysis of the metaphors of hope in American society. Finally, the fourth study encompassed a trial comparing the experience of hope between the United States and Korea. The results of these studies provided a foundation for analysing the concept of hope at the individual level, as well as at the social level. Amongst the four studies reported in the book, as stated by Averill *et al*. (1990), the first study was the most important one that presented the scholars' ideas about the rules of hope, i.e. the rules that created hope as an appropriate emotion in a situation, and how appropriate hope could be differentiated from inappropriate hope. The following provides details of the studies.

In the first study, as opposed to exploring the hoped-for contents of the university students, Averill's team asked the participants to talk about their experiences of hope and the development of such experiences. Ultimately, four overarching 'rules' of hope — which generated hope as an appropriate emotion — were identified. In other words, an emotion of hope that satisfied all four rules should be referred to as appropriate hope (as an emotion) and vice versa. In this context, rules were basically rigid regulations that could not be violated: whether or not hope was an appropriate emotion depended on the regulations. The four overarching rules were named by the authors as follows:

1. Prudential rule
2. Moralistic rule
3. Priority rule
4. Action rule

Firstly, hope was appropriate when the probability of attainment was realistic (prudential rule). On the other hand, when the probability of attainment was low, hope was considered “inappropriate” (p. 33). Secondly, hope was appropriate when the object of the hope was personally desirable, socially acceptable and subject to moral constraints (moralistic rule). For example, hoping for the death of a rich relative was inappropriate; simply put, it could be referred to as a personal desire (Averill & Sundararajan, 2005). Thirdly, hope was appropriate only in relation to those outcomes and events that were weighted as essentially important (priority rule). When the priority of attainment was low, the notion of hope was inappropriate. Fourthly, hope was appropriate when the one who hoped possessed good willingness to take action for his desirable goals if that action was available (action rule).

Importantly, hope without actions should not be named as hope. According to Averill and his colleagues (1990), such rules were, in fact, cognitive rules shaped by social values of the culture. Different cultures would indeed hold different values when assessing the importance, priority and available actions for the hoped-for objections.

Whilst this study identified a set of rules that "define hope as a coherent syndrome" (Averill *et al*., 1990:37), Averill and his team conducted another study in an attempt to provide support for the hypothesis that hope should be classified as an emotion. They did so by comparing hope with anger and love, which are prototypic emotions. Participants in this study identified five major similarities between hope, anger and love, which, according to the authors, constituted the parameters of their implicit theory of hope as an emotion: they were all difficult to control, they affected the way we thought, they motivated behaviour, they led people to act in uncharacteristic ways, and they were universal experiences. Although the scholars believed that their findings offered sufficient grounds for describing hope as an emotion, they nevertheless referred to hope as 'an emotion of the mind', highlighting that hope differed from other emotions in being a largely ‘cognitive’ state, if cognition was defined broadly to mean ‘mental’ as opposed to ‘rational’.

Nursing Theory

Farran’s Summary of Hope

In 1995, nursing scholars Carol Farran, Kaye Herth and Judith Popovich published the book *Hope and Hopelessness: Critical Clinical Constructs*. The book provides a good ensemble of discussion and knowledge on hope and hopelessness in the field of nursing. By extensively reviewing empirical research on hope conducted before or during the 1990s, the authors made two important claims: firstly, hope was a disposition that expected the best possible outcome, or where emphasis was placed on the positive aspects of a situation; and, secondly, there existed a dialectic relationship between hope and hopelessness, where the former could not be without the latter (Farran *et al.*, 1995).

The authors did not generate their own theory of hope in their book but rather suggested that there were four essential attributes of hope, in which hope was an experiential process, a spiritual or transcendental process, a rational thought process, and a relational process (Farran *et al*., 1995). In the experiential process of hope, human beings, by our very experiential nature, were recognised as capable of hoping, and trial mode imagination played an important role for us in locating life possibilities. In the spiritual or transcendent process, the forming of hope did not go without personal beliefs and faith in which material reality — mainly constraints — could be transcended. The rational process of hope stressed cognitive thinking on goals and attainment in firm life directions. Finally, in the relational process of hope, we found our connectedness and dynamic relationship with others in the generation of a desirable future, and, most of the time, the influential effect of having a hopeful significant other was essential (Farran *et al*., 1995).

This scholarly book is one of the most widely cited in hope literature in the field of nursing; however, their suggested framework relating to the process of hope has not attracted serious followers and has rarely been developed in knowing about hope. One possible reason that I suggest for this is that by its very nature the scholarly book simply aims at reporting empirical knowledge on hope during those decades, during which the three authors had their own empirical focus on hope and hardly came up with a real meta-concept to guide their collective efforts. This claim is obviously true as one of the authors, Kaye Herth, a dean of nursing at different universities, was the founder of the Herth Hope Scale and who advocated the use of her measurement in different areas. Importantly, the primary purpose of this work was not conceptual building.

Dufault & Martocchio: Two Spheres of Hope

In the field of nursing, the hope model proposed by Dufault and Martocchio (1985), both of whom are nurses, is recognised as being quite popular and widely used as a reference in papers; in fact, the model was a product combining the results brought by the two authors from their individual doctoral dissertations. In Dufault's dissertation, 35 cancer patients aged over 60 were followed over a two-year period for their experience of hope with terminal illness. In Martocchio's dissertation, on the other hand, a group of young but dying patients were evaluated for two years on their way of living with hope against various illnesses. In 1985, the two scholars worked together and published their renowned paper, *Symposium on Compassionate*

Care and the Dying Experience. Hope: Its Spheres and Dimensions, after confirming a multidimensional model of hope with the data from their studies.

In their paper, Dufault and Martocchio (1985) described hope as a "multidimensional life force characterised by a confident yet uncertain expectation of achieving a future good" (p. 380). In short, the nature of hope, in this context, was defined as a type of expectation with a certain confidence, which kept people moving forward. By reviewing their data, the two scholars reported that hope, or expectation, encompassed two spheres (particularised hope and generalised hope), along with the inclusion of six distinctive but related dimensions (i.e. affective, cognitive, behavioural, affiliative, temporal, and contextual). This 2x6 mixture (12-cluster areas) model is shown in Figure 5. The authors stated that the experiences in any of these areas contributed uniquely to the total experience of hope, as held by the individual (p. 381). In their paper, a justification of their hope model was provided:

> *"Hoping is not a single act but a complex of many thoughts, feelings, and actions that change with time. Hope is multidimensional and process-oriented; it is not unidimensional or trait-oriented. There are*

> *many manifestations of hope. Based upon empirical data, hope is conceptualised as being composed of two spheres having six common dimensions." (Dufault & Martocchio, 1985)*

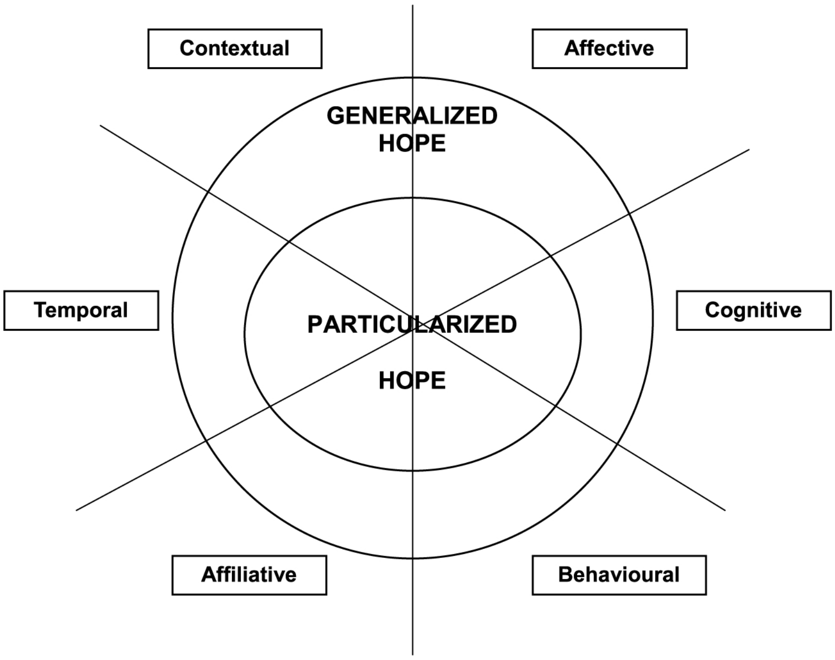

Figure 5: Two spheres of hope

In their hope model, Dufault and Martocchio stated that there were two different types of hope: a particularised hope and a generalised hope. The difference between these two hopes was seen mainly in terms of the hope objects they aimed to attain in various contexts. Firstly, for particularised hope, the hoped-for objects were quite specific, expressed in the form of 'I hope that …' People with particularised hope could reveal the specific outcomes they were hoping to achieve. For example, a patient in a hospital might hope that he could go home for Christmas, or a pregnant woman would hope that her labour would be smooth. Furthermore, as the hoped-for goals were so specific, people with particularised hope were able to recognise, organise and prioritise their goals consciously. Secondly, on the contrary, people with generalised hope did not tell a specific hoped-for object, but rather hoped for a better future, for example. This type of hope is best illustrated by some of our daily expressions, such as ‘nothing left without hope’ or ‘I only hope’ or ‘hope keeps me alive’. In terms of this type of generalised hope, Dufault and Martocchio (1985) described it to be like an “umbrella that protects hoping persons” (p. 380), such as protecting them from despairing in the case of adversity, and, in the case of clients, facing terminal illness. Dufault and Martocchio (1985) expressed that particularised hope and generalised hope were related but distinct and it seemed that the two spheres of hope did not have priority over one another; however, as will be seen in later paragraphs, the two authors seemed to illustrate the overriding nature, as well as the function, of generalised hope. It was stated that “generalised hope provides the climate for the development of particular hopes” (p. 380), which subsequently could protect hoping individuals from despairing if the materialisation of the particularised hope became unrealistic. In other words, generalised hope served as a background for particularised hope and could be sustained — even if the latter disappeared.

Six Dimensions of Hope

In addition to the two basic spheres of hope, Dufault and Martocchio (1985) also identified six different dimensions of hope, namely affective dimension, cognitive dimension, behavioural dimension, affiliative dimension, temporal dimension and contextual dimension.

To elaborate further, the affective dimension focused on the sensations and emotions (both positive and negative) contributing to the hope experiences. Hope, defined by the two authors as a confident but uncertain expectation, always came with feelings but not with cool blood. For example, in their words, a hopeful person would emotionally long for, yearn for, or feel good when anticipating the attainment of a desirable outcome, or would just generally feel good about his or her future. The cognitive dimension of hope was anything related to the thinking, interpretation and evaluation of hoping. The basic components of this cognitive side of hope included the identification of objects, the reality assessment of achievability and the calculation of probability. In the thinking process, the imaginative uses of the here-and-now, in addition to past experiences, were crucial in forming hope beliefs and their corresponding boundaries. In this regard, Dufault and Martocchio (1985) stated that people would give up specific hope, i.e. particularised hope, when the possibility of materialisation was rare, but would keep such hope as a wish. For the two authors, a wish "is not perceived as within the realm of possibility in the present of future" (p. 385).

The behavioural dimension of hope was recognised as the action orientation of the hoping individual. As mentioned, behavioural actions were taken to achieve the desired outcome; these might be psychological, physical, social and/or religious (Dufault & Martocchio, 1985). Interestingly, the two authors stated that hoping individuals did not always carry out actions related to direct goal attainment; some actions were actually generated just because of holding hope. In short, the hoping individual did more than just achieving the desired outcome but also showed greater engagement in meeting the "daily demands of living, expanding or revitalising interests, extending self to others, caring for others, and altering their personal outlook" (p. 385).

From my point of view, the affiliative dimension is related to connection, relationships, trust and belongingness. As reported by Dufault and Martocchio (1985), their research subjects were asked to describe hope: either their friends or families were involved in the actualisation of certain outcomes, or the hoped-for outcomes were related to the well-being of friends or families. In simpler terms, the act of hoping was not a singular act; rather, it was situated in the web of relationships with others.

In specific consideration to the last aspect, temporal dimension, Dufault and Martocchio (1985) recognised that the action of hope was not necessarily confined to the future, but, in the case of some relationships, was related to the hoper's experience both in the present and in the past. For example, people with successful hope experiences in the past would know how to hope again and how to get rid of failure, and a better future would be expected as an alternative (or as a comparison) to the present situation.

Finally, the contextual dimension of hope focused on the life situation and circumstances where hope or hoping should be “brought to the forefront of awareness and experience” (p. 388). The two authors proposed that various contextual factors were more closely related to hope and hoping, the first of which was the situation of loss whilst the second was the situation of hope exchange. In the situation of loss, such as when there was failure in fulfilling the role’s expectation or there was disappointment in physical independence, the affected individual would sometimes carry hope or would be hoping for an alternative. In the situation of hope exchange, where the “physical and emotional suffering and pain or joys of others … about one’s own hope and others’ hope” (p. 389) could be a natural or created situation to generate hope. For the care professions working in the health sector in particular, attention should be directed towards the latter situation, which is related to hope intervention.

Miller and Powers’ Elements of Hope

Judith Fitzgerald Miller and her colleagues provided an early construct of hope in 1988. Influenced by Stotland (1969) and Marcel (1962), the authors provided the following definition of hope:

> *“Hope is a state of being characterized by the anticipation for 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 based upon: mutuality (relationships with others), a sense of personal competence, coping ability, psychological wellbeing, purpose and meaning in We, as well as a sense of 'the possible.” (Miller & Powers, 1988:6)*

Under this definition, Miller and Powers (1988) argued that there were 10 critical elements of hope: mutuality-affiliation, sense of the possible, avoidance of absolutising, anticipation, achieving, psychological well-being and coping, purpose and meaning in life, freedom, reality surveillance-optimism, mental and physical activation. The 40-item Miller Hope Scale was constructed in mind of the aforementioned definition of hope.

The Miller Hope Scale has been used in various instances when exploring the level of hope amongst a psychiatric population. For example, Holdcraft and Williamson (1991) conducted a hope research utilising a sample of 192 hospitalised patients with different diagnoses (notably not limited to schizophrenia). The results showed that mental patients reported lower hope levels than the general population. However, the level of hope improved at their date of discharge. Another recent example has been provided by Landeen *et al*. (2000), in which 55 mental patients with schizophrenia were involved in the research. The research findings showed that the level of hope did not have a correlation with symptoms severity, although there was a link between the level of hope and the level of life satisfaction. The authors concluded that a supportive environment, such as good housing and stable financial security, would be more helpful to maintain hope for people with schizophrenia.

Philosophy Theory

Marcel: Metaphysics of Hope

Gabriel Marcel was a famous existential phenomenologist. In the last century, no other philosopher has written as systematically as Marcel when discussing the nature of hope. In fact, the concept of hope is pivotal in Marcel’s general philosophy, in which he related the concept of hope to many areas of his work. In 1964, Marcel received the German Peace Prize for his contribution towards world peace.

In 1945, Marcel published his metaphysics of hope in French, and the English translation later became available in 1962. This book is an outstanding phenomenological analysis of hope in which Marcel examines the nature of hope with his first-person experience in the First World War and the Second World War. The philosophical concern of Marcel's in the book was the meaning and value of life, i.e. the questions centred on the meaning of the human being's existence in the world. In the book, Marcel (1962) claimed that hope was the human mystery of the surrounding environment. Nevertheless, we have to abandon our original understanding of hope as a desire in order to establish the meaning of hope as introduced by Marcel.

Marcel used a French word "esperance" — 'to hope', in English — in his book (Marcel, 1962). In French, the word "esperance" as a noun implies a meaning of capacity and, in this way, when talking about hope, according to Marcel, we should take the concept as a human capacity. However, if we were to do this, a question arises: what is this human capacity for? For Marcel (1962), this human capacity was the aptitude allowing us, as human beings, to live in the present. Hope, for Marcel, was a mystery. Put simply, hope was a way of living in the mystery of its own ‘Being’ in an ontological sense. According to Marcel, there was no non-Being; the denial of ‘Being’ was non-having, not non-Being. Existentially speaking, having could be a problem of Being, but non-Being could never happen. As a Being, we have a soul, i.e. the ability to think and reflect, and it was this that lived through hope, presenting itself in this world. For Marcel, the soul did not exist alone but was open to the existence of others; it was this viewpoint that provided the foundation for Marcel’s (1962) assertion that hope was always an association with a communion with others (p. 58).

According to Marcel, our soul, through hope, was a mystery of ‘Being’, living in the world with the knowledge that there was another. This immediacy experience of others, as Marcel referred to it, constituted an I-Thou relationship. The other presented to me as a Thou, and I presented to him as a Thou as well. Through love and openness, the soul entered the world at an intersubjective level. Marcel (1962) stated:

> *"Hope is essentially … the availability of a soul which has entered intimately enough in to the experience of communion to accomplish the transcendent act — the act established in the vital regeneration of which experience affords both the pledge and the first-fruits." (p. 10)*

To sum up in a simple way, we could consider the following line of thinking: hope was the human capacity to live in the world. Our Being was an existential one that could not be non-Being. The soul in our 'Being' firstly acknowledged the existence and secondly showed the love of others (intersubjectively), and men with this soul entered into our Being. Conclusively speaking, through hope we entered our Being, we entered our world, and we opened up to the world. To hope meant living passionately and participating in our world. Accordingly, hope might be described as the connection of human beings with their purpose. Essentially, hope meant participation.

Parse's Lived Experience Research of Hope

Nursing scholar Rosemarie Rizzo Parse (1999) developed his human becoming theory in response to his disagreement with nursing theories based on a normative bio-medical approach. Inspired by various European philosophers, such as Dilthey and Heidegger, Parse developed his human science nursing theory, and this human becoming theory received certain attention in the field of nursing. In his theory, human beings were a combination of biological, psychological, sociological and spiritual elements, and were a unitary being continuously interacting with the environment. Moreover, according to his assumption, the human coexisted whilst constituting rhythmical patterns with the universe. There was a symbol representing the human becoming theory: this was a group of swirls intertwining together to form a centre-joined grass ball. Three different colours of swirl could be identified, each of which carried a particular meaning. For Parse, green represented hope, and black and white represented an opposite paradox to the ontology of the human being. This nursing theory has been recognised as applicable in terms of guiding nursing practice towards desired health outcomes, and, most importantly, it can be used as a methodology in nursing research to explore the lived experience of patients. Parse is now a professor and Niehoff Chair of Nursing at Loyola University Chicago. The edited book *Hope: An International Human Becoming Perspective*, published in 1999, was an attempt to explore the lived experience of hope across nine different countries by the Parse scholar group. Although the aforesaid human becoming perspective was originally a nursing theory related to nursing practice, this scholarly book reported so-called lived experience research not limited to health topics, but with the general population as the research subject. At the end of the book, Parse made the following observation on the findings obtained from the thirteen studies

> *"Evidence from the participants' stories shows hope as an ever present expectance enduring all-at-once with the arduous, reflecting paradoxical changing health patterns co-created as individuals live the meaning of their situation in moving beyond the moment. The meaning of hope described by participants is their structure realities arising in confirming-not-confirming cherished beliefs with speaking-being silent and moving-being still. Unique rhythmical patterns of …" (Parse, 1999:23)*

Hope Research and Mental Illness

Despite the recognition of hope as an essential component of recovery from mental illness, very limited efforts have been directed towards understanding the relationship between them. In the literature, there were five major qualitative papers related to the topic of hope and mental illness, as will be discussed briefly here.

The first paper was published by anthropologist Van Dongen in 1998, who performed a Dutch ethnographic study during the period 1988–1993 in a psychiatric hospital in the Netherlands (Van Dongen, 1998). Through presenting the life stories of 13 mentally ill patients and after reviewing the data gathered after conducting in-depth interviews with 12 mental healthcare staff, the author described the discrepancy between the two parties in the articulation of hope in the ward. Simply put, professional staff expressed their hope in relation to the operation of the caring system in which the author claimed that such hope was not a positive force (p. 189). Mentally ill patients, unfortunately, were circled by the cultural assumption of chronicity and the negative beliefs relating to their illness, thus resulting in the expression of narrow-minded hope as a mere cultural being. The author called for a critical review of the negative attitudes recognised at the cultural and system levels in an effort to achieve benefit for the mental patients residing there but not for the people at the end of the road (p. 176)

The second hope research was carried out by Kirkpatrick *et al*. (2001) with a special focus directed towards long-standing schizophrenia. In this qualitative research on hope, 10 participants were purposely selected to reveal their notion of hope. The research findings showed that there were four major themes generated by the qualitative data, as provided by the people with schizophrenia, namely maintaining relationships, experiencing success, taking control, and finding meaning in life (Kirkpatrick *et al*., 2001). For the research participants, good interaction with supportive staff provided the sources of hope. Moreover, simple task completion under self-directed behaviours was seen to be effective enough to generate a feeling of hope amongst patients. Furthermore, those with long-standing schizophrenia could only generate hope with their own active control of life but not a passive waiting attitude. Finally, those who were recognised as mentally ill but were hopeful were seen to embrace life and actively engage with their living environment.

In 2007, Perry *et al*. (2007) investigated the personal experiences of hope of those identified as being in the first episode of psychosis. In the study, a semi-structured interview method was used to explore the lived experience of hope amongst five male participants within the first 8 months of their illness

(Perry, Taylor, & Shaw, 2007). The research data showed that three themes emerged, namely ‘What’s it all about?’, ‘Banged up’ and ‘Belonging versus alone’. The authors pointed out that the experiences of hope, as held by the participants, matched the psychological status of frustration and shock after being identified as mentally ill. The paper concluded in this stage of frustration that a sense of belonging was critical in maintaining the experience of hope for further development. A helping hand, as well as an empathic and non-judgmental attitude, could be more than helpful in working with people with mental illness during this initial stage.

The fourth qualitative research was carried out by a group of Korean nurses headed by Noh in 2008 (Noh, Choe, & Yang 2008). The study adopted a qualitative interviewing method in exploring research participants’ responses to three main questions: the meaning of hope, what is hoped for, and sources of hope. A total number of 25 Koreans, all diagnosed as having schizophrenia, were interviewed in the study, with the respondents reporting that the meaning of hope was equal to the meaning of life with a sense of happiness. Moreover, it was also equal to the anticipation of a better future, where hope was a basic energy of life. The research participants reported that they were merely seeking a normal life without trouble, the restoration of human family relationships, freedom and spiritual fulfilment. This group of Korean people with schizophrenia also reported that a significant other, as well as good self-beliefs, would provide a source of hope in their journey towards recovery. Furthermore, in conclusion, the authors asserted that the research participants hoped for nothing more than an ordinary life, equal to that of other Koreans.

Last but not least, the fifth qualitative study on hope in a mental health setting was performed by Herrestad and Biong (2010), the purpose of which was to understand the lived experience of hope amongst patients being hospitalised for self-harming behaviours. In the study, patients admitted to mental hospitals for self-harming behaviours were interviewed in an attempt to narrate their experience of hope. By adopting a Ricoeurian approach of interpretation, the authors found that the research participants reported three dominating narrations on hopes for life, hopes of death and the act of hoping. The study concluded that the research participants were in a situation with definite and indefinite relational hopes for life and death. In regard to those people displaying self-harming behaviours, indefinite hope could function well in helping to avoid the experience of failure and hopelessness; however, in regard to the medical professions, the expression of indefinite hope would raise questions about the likelihood of fulfilment and its possible negative effect on vulnerable patients in mental hospitals.

Hope as a Common Factor in Effective Psychotherapy

Through intensive reviews of various empirical outcome studies on psychotherapy, Lambert (1992) asserted that hope, expectancy and placebo were common factors accounting for 15% of the therapeutic change in the process of therapy. According to Hubble, Duncan and Miller (1999), this type of hope and expectancy, as recognised in the counselling process, was not specifically related to the counselling techniques of individual therapy but rather to an overall belief about the presenting problems and the outcome in the foreseeable future. Lambert (1992) claimed that hope was a powerful therapeutic factor under three different conditions. Firstly, during stages of therapy in which the help-seeking behaviours already presupposed the hope and expectation of the individual to face and accordingly solve the problems encountered; put simply, help-seeking behaviour was, by its very nature, the actualisation of the hope of the individual. Secondly, in the process of therapeutic intervention, a trustful relationship with perceived credibility of the counsellor created another sense of hope whereupon changes would be possible. This kind of hope was based on the trust of the counsellors, who would always ensure genuine and non-judgmental comments about clients and their problems. Thirdly, a sense of hope relating to the therapeutic process would be subject to experience by service users if positive outcomes were generated by intended therapeutic actions.

Chapter Summary

This chapter offers a review of major theories of hope in psychology, nursing theory, and philosophy theory. A small section is devoted to introducing empirical research that related to hope and mental illness. It is found that scholars varied on how to define the concept of hope as well as the way to know how people describe their hope experiences. By adopting an interpretive approach in conducting qualitative enquiry, the present research will focus on the understanding of the lived experiences of hope among people recovering from schizophrenia. In the next chapter, I will address the methodology of the present study and introduce the process of enquiry, data collection as well as data analysis. Topics will include the rationale for adopting a constructivist approach, in-depth interviews, sampling approaches to recruit participants, and applying thematic analysis to analyse the data.

CHAPTER 4: METHOD AND METHODOLOGY

Chapter Introduction

This chapter will introduce the research methodology and research design, including sampling issue, data collection, interviewing process, research rigour and data analysing method.

The word “research” can be literally divided into two syllables, i.e. “re” and “search”. The syllable “search” represents an act to find out something carefully and the syllable “re” implies a repeated action or over again. The two syllables together form the word “research,” meaning a patient, thorough, systematic and repeated investigation to look for knowledge. In exploration of new knowledge and new ideas in new areas, a research project can also bring modification, amendment and expansion of existing knowledge. Research is indeed an endlessly creative career (Denzin & Lincoln, 2000:23).

In conducting research, we basically need both research methods and research methodology in that methods and methodology are different. Research methods are the means how we carry out the research. It could be a laboratory virus test, psychological experiments, public surveys, a face-to-face interview in a café or a silent observation in a rural community. A research method is the way we act to find out answers to our research problems and it is the question of "how". Research methodology, however, is far more complicated than that. It involves a thoughtful explanation of "why" the research should be conducted in that way and the theoretical positioning that the researcher lays down. It is a question of "why." This theoretical position is not just related to the research questions that we are facing but also our positioning on the nature of knowledge and the nature of the world. In research textbooks, they are referred to as epistemological and ontological questions, and the discussion of epistemology and ontology, generally speaking, should go together.

This study is about the "lived experience of hope" amongst people recovering from schizophrenia. The term "lived experience" ("*Erlebnis"*) was first introduced to the social sciences by German philosopher Wilhelm Dilthey in the early 19th century (van Manen, 2007). For Dilthey, lived experience ("*Erlebnis"*) was our immediate and pre-reflective experience of something. Simply put, this is the experience that people live through every day beyond and before reflection. It is our direct contact with our lived word. Lived experience is the starting point and the end point of most qualitative research that have a specific interest in investigating human subjectivity and the life world of others (Ellis & Flaherty, 1992). In this study, my field work involves interviews and observations that seek to learn about the meanings that participants place on their lived recovery process. In so doing, I interpret how hope is related to the participants and the meaning of it.

Choosing a Research Paradigm

According to Guba and Lincoln (1994), there were four competing paradigms in qualitative research, namely positivist, post-positivist, constructivist and critical theory. Each paradigm was philosophically and ontologically different from the others. This qualitative study, which aims at exploring the lived world of others, basically follows the ontological and epistemological position of a constructivist paradigm. The basic ontological assumption of a constructivist paradigm was relativism; that there was no absolute truth but relative, subjective value caused by different perceptions. In other words, there is no objective truth and our world and knowledge are generated by contextual understanding. The basic epistemological assumption of a constructivist paradigm was transactional subjectivism; that the emphasis rested on how we came to understand others' worldviews. As a social worker who, firstly, believes in reflective practice and, secondly, has worked with people with mental health problems for years, I find myself drawn to a constructivist worldview that equally stresses the process of understanding in forming knowledge. Choosing a constructivist paradigm for this qualitative research is my conscious act.

Merriam (1998) defined qualitative research as "an umbrella concept covering several forms of inquiry that help us understand and explain the meaning of social phenomena with as little disruption of the natural setting as possible" (p. 5). According to Denzin and Lincoln (2000), the defining characteristics of qualitative research include its ability to capture the individual's perspective. It is concerned with the richness of data and allows for the examination of the constraints of everyday life. Qualitative methods provide the chance to build up a descriptive, insightful comprehension and understanding into an individual's beliefs and concerns in their context

(Needleman & Needleman, 1996). Elliott, Fischer and Rennie (1999) stated that "the aim of qualitative research is to understand and represent the experiences and actions of people as they encounter, engage, and live through situations" (p. 216).

The use of quantitative methods dominated social science research for many decades and it was not until the I980s and 1990s that qualitative methods emerged to challenge the positivist approach (Howitt, 2010). Quantitative approaches are generally based on the view that observed phenomena can be represented by mathematical relationships and the conditions under which the phenomena are observed are controlled as much as possible to eliminate influencing variables. This present dissertation allowed participants to provide their lived experience of hope in recovery from mental illness in detail and in a holistic context.

Research Rigour

Lincoln and Guba (1985) suggested that it was inappropriate to use validity and reliability in examining the quality of qualitative research. Similar ideas have been asserted by various qualitative scholars (e.g. Leininger, 1994) that we should use qualitative criteria to evaluate qualitative paradigms.

Within a qualitative paradigm, research rigour, which means integrity and competence of a study (Milne & Oberle, 2005), is emphasised. Qualitative research rigour should be demonstrated by showing the trustworthiness in terms of credibility, transferability, dependability and conformability (Lincoln and Guba, 1985) Credibility is concerned with ensuring that the research topic and subjects are accurately identified and described. Transferability refers to the extent that the knowledge generated by a particular research can be transferred to another context. Both dependability and confirmability are concerned with how research data and research findings can be subjected to audit checking and procedure analysis (Lincoln and Guba, 1985).

To address the issue of credibility in this study, I have used prolonged engagement with all participants to make sure adequate time was spent in hearing their recovery stories that related to lived experience of hope. In addition, member checking, as a second method, has been used to invite the participants to review the research progress and research findings actively. To establish transferability, as a researcher, I tried my best to record the research progress and research context precisely. Every interview, transcript, coding notes, etc., has been kept properly for further usage of data and findings. To address dependability and confirmability, a detailed audit trail has been made to show the whole methodological flow and process of data analysis.

The Field: Hong Kong

I was born in Hong Kong and it is my hometown. In Chinese, Hong Kong is written as “香港” (Xiang Gang). The word “香” (Xiang) means ‘fragrant’ and “港” (Gang) means ‘harbour port’. According to local legend, Hong Kong was named as such because it was once a famous trading point for fragrance in southern China in the early Ming Dynasty.

When I was young, I was told that my father came from mainland China in the 1950s, just like those who wanted to run away from communist China to make a living. Here, my father started a family, with 3 children including me. Although I knew nothing about sovereignty when I was just a junior primary school student, I knew that my hometown was ruled by the British government since 1842 under the Nanking Treaty signed after the Opium War. The cession of Hong Kong to the British government brought a new era of change to all walks of life in this small fishing village. Today, Hong Kong is one of the most modernised cities in the world, and it was famously nicknamed the Pearl of the Orient, which means a beautiful and shining city. This city is now a forest of concrete with surroundings of tall buildings, and main streets are usually decorated with colourful lighting displays. To be honest, the night scene in Hong Kong is still one of the best in the world and it is always good to enjoy an evening walk along the harbour side during weekends.

Because of its special colonial background and its geographical privilege in southern China, Hong Kong is often named as a place where “East meets West.” Such a claim is partially true, but not the whole truth. From a glance at the city life, we can truly say that Hong Kong is such a globalised city, in which we can see a good mixture of shops, products and companies from various parts of the world. However, we can also see that Hong Kong, culturally speaking, remains essentially Chinese. In this place of more than 7 million residents, 90% is ethnic Chinese and people usually speak Chinese, mainly Cantonese, in daily life. For most people in Hong Kong, the Chinese calendar, which is the lunar calendar, is still deeply influential on their day-to-day activities, especially for those in their old age. Modern coffee shops such as

Starbucks are now everywhere in the city, but Chinese teahouses are the good places for family gatherings during Sundays. In this Chinese society, human relationships and interactions are basically affected by a combination of cultural beliefs sourced from Confucianism, Buddhism and Taoism as well.

Sampling and Research Participants

The methodology chosen for this study is qualitative thematic analysis, which is generally referred to as a search for themes that best describe the research phenomenon (Daly, Kellehear, & Gliksman, 1997). In the present study, people recovering from schizophrenia are the population of interest. As mentioned by Deegan (1988), the recovery experience is crucial to every person with a mental problem. Nevertheless, in order to ensure that the recruited subjects are actually people with a mental disability and become valid cases to provide information on recovery, all subjects were recruited through a local mental health service unit. In other words, they were actual service users of existing psychiatric rehabilitation services.

In this exploratory research, non-probability sampling method has been used to recruit cases. To fit the research objectives in exploring hope experience in psychiatric recovery, purposive sampling (also called judgement sampling) was to be employed instead. Patton (1990) asserted that purposive sampling was effective for researchers to bring suitable cases that could provide rich information on the topic of interest concerned. Most of the time, purposive sampling method is the common form of non-probability sampling that is widely used in exploratory research that employ a qualitative research method (Patton, 1990). In undertaking purposive sampling, the research studies are active in locating cases, groups and organisations that hold relevant information and can provide the greatest insight into the research question, but not a random selection of cases within a targeted research population (Devers & Frankel, 2000).

Patton (1990) identified that there were 16 types of purposive sampling, including homogeneous, deviant case, intensity, criterion, maximum variation, quota, theory-based, snowball, chain referral and convenience. In this study, both convenience (purposive) sampling and snowball (purposive) sampling have been used to collect data from whatever available cases could be reached or could be referred. Altogether, eight participants who have schizophrenia whilst living in the community were recruited to be the research participants of this study. Seven of them were living on their own or with their family; only one of them was living in a psychiatric halfway house. Two out of the eight participants were married whilst the others were single. Appendix 1 describes the overall demographic information of the research participants. Under the principle of anonymity (Parry & Mauthner, 2004), all research participants have been renamed with some simple English names, and the true identities of the participants are not identifiable.

Interview Guide and Semi-structured Interview Format

The present research utilises a semi-structured interview format to collect data from the research participants. A semi-structured format interview (Carruthers, 1990) is a kind of interview that allows a natural dialogue with the subject that is being investigated. Pre-planned interview questions are needed before going into a real interview, but the flow of the interview should not be conducted in a specific order with specific questions. Tutty *et al.* (1996) stated that the semi-structured interview format has an advantage in allowing interviewer-interviewee dialogue with respect to specific topics in an open-ended manner. All in-depth interviews and joint interviews were to be carried out by the researcher and would be tape-recorded.

In order to ensure the covering of important materials during the semi-structured interview, an interview guide (Appendix 2) has been used. This interview guide is a list of questions that consists of sequencing questions that I wished to explore in the interview. In the present study, the questions' contents and the order of sequence have been specially designed to fit the research aims and objectives. All in-depth interviews of this study usually began with warm rapport-building biographical questions, followed by the introduction of the research theme through questions designed to inspire conversations detailing the respondent's view of the identified areas of interest. The medium of all the interviews was Chinese, which is the mother tongue in Hong Kong. All interviews were audio-typed to facilitate the transcription of the interviews and subsequent data analysis, for which audio-typing is the best way to ensure data accuracy (Tutty, Rothery, & Grinnell, 1996). In addition, I also wrote notes to capture additional valuable information well, such as special facial expressions and body language that the interviewees with that information expressed.

Altogether, thirty-one semi-structured interviews were conducted for data collection. Almost all of the participants were interviewed for at least three times within twelve months after their first interview. Some of them were interviewed four times for clarification of information or exploration of relevant ideas. Some participants showed initiative by providing data for me and some interviews were suggested from their side before action was taken from the research. Most of the interviews lasted from 60 minutes to 70 minutes and our participants were quite comfortable for the duration of the conversations.

Inductive Thematic Analysis

Data analysis in qualitative research is an ongoing and creative process. According to Polit and Beck (2004), the purpose of data analysis in qualitative research is to make sense of some latent pattern in the a substantial volume of data. In this study, thematic analysis is employed as a method of data analysis. General speaking, thematic analysis is a qualitative analytic method that focuses on analysing and identifying themes and patterns within data (Braun & Clarke, 2006, p.79). A simple process of thematic analysis is to identify codes, and, by a process of abstraction, meaningful units can be grouped into various sub-themes and then major themes of a research phenomenon.

By definition, a code is the very basic meaningful unit that represents an initial idea of data. A theme, however, is a label that can summarise the essence of a number of codes that are generated by initial coding (Morse, 2008). According to Boyatzis (1998), a theme was a pattern found in the data that could organise and describe observations and, at the most, show us single or different aspects of a particular phenomenon and could provide answers to corresponding research questions. In recent years, thematic analysis has become one of the most popular analysing methods in conducting qualitative research because it is a flexible and useful tool that can provide a rich description of data.

Altogether there are two different forms of thematic analysis, i.e. the inductive thematic analysis and the deductive thematic analysis. Inductive thematic analysis is a bottom-up analysing method in that the data should be coded and analysed as closely as possible to the original data without preconceptions. The main purpose of this inductive analysing method is to let the data speak for itself. Deductive thematic analysis, on the other hand, allows the use of an existing coding framework or theory to guide the abstraction progress. It mainly serves the function to enhance in-depth theoretical understanding of the research process (Braun & Clarke, 2006). Figure 6 outlines the six analysis steps suggested by Braun and Clarke (2006) in conducting thematic analysis.

Figure 6: Six steps of thematic analysis

Step 1	Getting familiar with the data
Step 2	General initial codes
Step 3	Searching for themes
Step 4	Review themes
Step 5	Defining and naming themes
Step 6	Writing the report

Step 1: Getting familiar with the data. The first step of doing the analysis involves becoming familiar with the data. After the interviews, observations are made with regard to the initial impressions of the interviews and of the

respondents. Time should be spent in listening again and again to the recorded audio files.

Step 2: Generate initial codes. In this stage, after getting familiar with the data, initial codes should be given by the researcher next to the transcript to identify important key points and ideas presented by the data. For Boyatzis (1998), codes were important labels that carried and represented important meanings from the data. In addition, it was the “the most basic segment, or element, of the raw data or information that can be assessed in a meaningful way regarding the phenomenon” (Boyatzis, 1998, p. 63). According to Braun and Clarke (2006), coding was analytical in nature and it served as an important fundamental for the analysis to come afterwards.

Step 3: Searching for themes. In the third phase, the researcher should search for themes. By definition, a theme is “a pattern found in the information that at minimum describes and organises the possible observations and at a maximum interprets aspects of the phenomenon” (Boyatzis, 1998.p. 4). The researcher then analyses the codes and combines them to form overarching themes.

Step 4: Reviewing themes: This stage of work comprises of reviewing the themes and verifying if themes work in connection to the coded materials. The review process should include the whole data set, and should generate a thematic map if possible.

Step 5: Defining and naming themes: In the fifth phase, themes should be defined and named through repeated analysis to refine the details of each theme and the general story that the data tells.

Step 6: Writing the report. In this final phase, a reiteration should link up all the analysis and the research questions in order to produce a full analysis report.

Ethical Considerations

The confidentiality and the rights of the research participants were emphasised during the whole process of research. All interviews were on a voluntary basis and the research participants had the right to withdraw from the research and their decisions were respected. All respondents were given full notice about the aims and objectives of the study before the interviewing, and a consent form was explained to and signed by them to join the research.

The researcher undertook to keep proper records and storage of the collected data. Identifiable personal information about the research participants were made anonymous for the present study. The related information was destroyed after the research was completed. Appendix 3 is the letter of informed consent that was used in this study.

Data Analysis

In the following sections, I will report the various steps that I have gone through in performing inductive thematic analysis for this study. The overall purpose of such data analysis is to organise and explore the data set in good detail and to identify important themes to describe the lived experience of hope amongst people with schizophrenia in Hong Kong.

Preparing the Data

Before commencing the data analysis, all verbal data were transcribed into written form in Chinese and then translated into English. Before everything was translated into English, the researcher listened to each audio recording and looked at the Chinese transcript carefully and repeatedly (at least four times) to make sure that they matched with each other. In translating all prepared excerpts into English, I implemented the process carefully to make sure the English excerpts could capture the real meanings of those Chinese excerpts. Although the whole transcription and translation were quite time-consuming, it was an excellent way for me to familiarise myself with the data and acquire a feeling for it.

Generating Initial Codes

The coding process began after all the interviews were transcribed and translated. Some other researchers would then extract significant statements from the raw data so as to create a smaller data set for manipulation (e.g. Xyrichis & Lowton, 2008). However, I made reference to the whole data set in the process of coding and did not want to extract codes from their surrounding interview context and dialogue contents. In order to facilitate the process of coding, I underlined all significant statements with a red pen and important meaningful units were marked with a highlighter. In most cases, I tried to use the exact wordings from the excerpts as much as possible for the meaningful units. The process of coding was done manually all by myself. I worked systematically through each data set giving an equal amount of attention to all data items, coding for “as many potential themes/patterns as possible” (Braun & Clarke, 2006, p. 89). In total, I highlighted more than 700 meaningful units at this stage out of the five hundred pages of transcripts.

Building Up Themes

By using all the meaningful units that were generated from the transcripts, I tried to search for themes that could group the units into a cohesive and meaningful way. Finally, I came up with 52 first-order themes and then 17 second-order themes and 6 overarching themes by repeatedly comparing the meaningful units, codes and various themes. This process of analysis took months and finally a thematic table came from it. Figure 7 outlines the final formulation of all first-order themes, sub-themes and the 6 overarching themes.

Defining and Naming Themes

In this final stage of thematic data analysis, I defined the names of all the themes and sub-themes with reference to the research purpose and proposed research questions. For me, the challenge of this naming process was to keep close to what the original data told me whilst at the same thing providing a

Figure 7 : Overview of first-orderthemes, sub-themes and main themes

52 First-order themes		17 Sub-themes (second-order theme)	6 Main themes (third-order theme)
Free from symptoms	In good health	Good times	Ups and downs of Illness
Keep functioning	Enjoy normal living		
Knowing the diagnosis	Mental distress	Bad times	
Physical discomfort	Hospitalisation		
Believing in no dead-end	Believing bad things will go away	Hope as believing	Modes of Hope
Believing good things will come			
Keep on hoping	Hope for symptoms-free	Hope as hoping	
Hope for a normal life	Hope for self-actualisation		
Bodily expereince of hope	Metaphors and Images	Hope as feeling	
Planning	Doing	Hope as acting	
Psychological ease	Bodily ease	Comforting effect	Hope Effects
Spark interest	Willing to try	Motivating effect	
Continuous involvment			
Hang-on	Tolerated dislike	Transcendent effect	
Make new meanings			
Lower expectations and be realistic	Focus on personal strengths	Adjustment	Strategies of hope
Appreciation	Wish fulfillment		
Adjustment to age			
Being alone is risky	Learn from others	Staying with others	
Seek help from others			
Speak up for yourself	Speak up for ourselves	Empowerment	
Family Security	Family belonging	Family care	Relationship quality
Attitude	Information and Guidance	Professional care	
Availability	Consistency		
limited housing choices	limited housing space	Housing availability	Environmental Opportunities
limited chance for independent			
Only low-level jobs	Only law salary	Employment availability	
High competition	Job prospects		
Financial assistance	Transport supplement	Welfare availability	

readable understanding of the phenomenon. The names of the overarching themes that contribute to our understanding of the lived experience of people recovery from schizophrenia are:

Ups and Downs of Illness: This theme provides direct answers to the first research question concerning participants' accounts of their recovery from schizophrenia.

Modes of Hope: This theme contains data that provide answers to the second research question concerning the actual hope experience related to their mental illness.

Hope Effects: This theme focuses on the three effects that hope experiences can bring to the participants' living world.

Strategies of Hope: This theme uncovers the strategies that participants used to give themselves a better sense of hope.

Relationship Quality: This theme focuses on those important factors that were named as affecting the experience of hope.

Environment Opportunities: This theme contains participants' descriptions of how the social and economic environments affected the hope experience.

Chapter Summary

This chapter describes the methodology and method of how this qualitative research has been conducted. Inductive thematic analysis, as suggested by Braun and Clarke (2006), has been used to analyse interview data. Altogether, 52 first-order themes, 17 sub-themes and 6 overarching themes have been identified to represent the lived experience of hope amongst people recovering from schizophrenia. A detailed description of each individual theme is provided in next chapter.

CHAPTER 5: STORIES ON HOPE, RECOVERY AND SCHIZOPHRENIA

Sunny's Recovery Story

Sunny was diagnosed with schizophrenia in 1994, when he was at the age of 40. Sunny was a lover of the Chinese language and has read a lot of Chinese fiction, poems as well as some classical texts. Actually, Sunny looked like a 書生, meaning that you could tell he was somewhat well educated. Sunny was born in a normal family and he was the youngest of 4 siblings. The siblings used to have a good relationship with others and they grew up together. These supportive relationships were a contributing factor towards Sunny's recovery from his mental illness.

Sunny was educated up to Form 5 and then he started to work as a general clerk in a university. When holding a daytime job, he attended Form 6 and Form 7 as a part-time evening student, with a hope that he could eventually get into a university. In 1989, his dream came true when he was offered a university studentship with Chinese language as the major. Because of his talent in language and his hardworking attitude, he was offered various scholarships during the course of his study. The scholarships did not only serve as recognition but the money left him with no worries about the school fees. Sunny thought that the money was quite helpful to him as a mature student with limited resources.

The year 1992 was a very stressful time for Sunny. His parents passed away within 6 months due to ill health. Sunny and his siblings were totally shocked by these tragedies and the family was filled with grief and sadness. “That year was really a hard time for us, especially for me,” he said. Actually, Sunny was the one whom the parents loved the most in the family. The departure of the parents suddenly made Sunny feel so much pain and sorrow. Thereafter, he became extremely sensitive and experienced a lot of unwanted anxiety, causing him difficulties in concentrating during the daytime. In 1993, Sunny broke up with his girlfriend to whom he had been engaged for many years. Subsequently, Sunny experienced a mental breakdown. “I remember having my first psychotic attack, which was absolutely distressing,” he said. “I had been out of touch with reality. I had so many delusions about my parents, my girlfriend and then everything around me. Those were the days that I really could not move myself for any purpose. I was so confused and self-dreaming," he added.

Sunny had no idea about what schizophrenia was. What he knew was just what he read in the papers. During his first admission to a mental hospital, he did some research on his own by asking around people. Sunny alleged that he found a volunteer who visited their psychiatric ward and who was quite supportive and he learnt a lot from him. From this volunteer, Sunny learned that schizophrenia was related to the stress of life and he needed to keep his life less stressed thereafter. Sunny said that his mental condition was not so stable during his first hospitalisation. During the daytime, he merely engaged in ward activities and just wanted to stand alone somewhere in the open garden. As he recalled, he hardly concentrated to do simple things and felt sleepy most of the time. "Sometimes the side effects from the anti-psychotic drugs made you feel so sleepy, but sometimes I just wanted to hide out myself and find some place to sleep," said Sunny. "It was a state of hopelessness, if I have to put a name to it." Sunny's brothers and sisters were busy in their own lives and would approach the mental hospital during weekends for Sunny. The family gatherings in the mental hospital were the single joyful activity for Sunny during hospitalisation. “It was all I looked for and hoped for every single day,” he said. Sunny had raised a request to be discharged but in vain. Not until he had spent almost 8 months in the mental hospital that he was allowed to leave and live with his siblings at home.

Sunny found that his road to recovery was not as easy as expected; in fact, it was full of challenges. Whilst taking the anti-psychotic drugs, Sunny found that his talent had been “washed away.” Although he did not lose his memories, he was not that interested in language anymore. Reading a Chinese fiction was now a heavy task for him as he needed to “push up” his concentration power to his upper limit, and he felt truly exhausted after doing so. Sunny did not reject the idea of using anti-psychotic drugs, but they caused him to feel so tired and experience muscular discomfort in his body. “You felt like a robot and moved like a robot too,” he said. During this initial stage of recovery, Sunny could not take up a post as a part-time Chinese language teacher as before. Actually, he felt he could do nothing in the future. He lost his strengths and a career that he was once committed to. He felt he was nothing at that time and he had no direction for himself. “Once on the bed you can sleep, then you can be unaware of those [conscious] thinking,” he said. Sunny spent few years like this and he said that it was a stage in which he was useless. During that period of time, he was admitted to a mental hospital for treatment at least once a year.

Fortunately, after a difficult period of coping with uneasy feelings in the mind and the side effects of drugs, Sunny felt his illness was under control. Sunny experienced some changes after he became a volunteer in a patient resources centre. He was there because he was referred by a medical social worker to offer some help. Knowing that Sunny was good in the Chinese language, the centre kindly invited him to provide some ideas on forming a small library. Sunny found that the assignment was quite interesting for him and he was glad to go there regularly for help. “Things started to be more positive after I went there regularly, because I made some friendships there,” he said. Sunny found himself becoming happier in the daytime, not only because he was able to offer some help but also because he opened up more when he had a supportive relationship with other mental health service users.

“They never judged you,” said Sunny. ”You felt no pressure there; we were all in the same boat,” he added. Most importantly, Sunny was appreciated for his contribution in forming a small Chinese corner in the centre and that gave Sunny a sense of satisfaction. One day, when Sunny was going to the centre for a group gathering, he met a girl named Cindy who was his friend years before. Sunny felt no shame to tell Cindy that he was on his way to the patient resources centre and the latter showed a lot of understanding about his difficulties. ”It was so lucky that I talked to her like that at the very beginning, no secret, and then I started to date her few months later,” Sunny said. After spending several months developing a friendship, Sunny and Cindy became boyfriend and girlfriend. ”There was no planning at the very beginning; we just thought that we were okay to be together,” Sunny said. Allegedly, Cindy showed some empathy for Sunny since her family also experienced some painful times years before and Cindy hoped that Sunny could aim for a better life too. Thereafter, Cindy became a very powerful source of hope for Sunny and he became more active than before. He started to work as a part-time Chinese-language tutor in a children’s education centre, and a few months later he worked as a programme assistant in a youth service centre near his living place. Sunny named that this was a stage of “doing” as he found himself motivated to pick up his own life again under the encouragement of Cindy. Sunny and Cindy got married in 2008 after a few years of engagement, and Sunny said that it was the most wonderful day in his life. In 2009, under the encouragement of his wife Cindy, he attended a challenging job interview for a full-time executive post at a local charity fund. Interestingly, Sunny found that the interviewer was once a volunteer who taught computing at the patient resources centre, and the interviewer also recognised Sunny. Sunny eventually got this full-time post — it was the first full-time post after his mental illness and Sunny thought that it was also the luckiest day in his life. With this full-time post, Sunny revealed that he could make good planning for the coming few years with his wife Cindy. Now at the age of 49, Sunny started to plan for his retirement. “Because of my ill [physical] health, it was good to have some planning before it’s too late,” he said. Sunny told me that he started to execute a savings plan a few years before and he hoped that he could have a certain amount of money that was enough for a simple retirement life with Cindy, who was also at the age of 40-plus. Sunny said that he still kept going to the patient resources centre if there was free time, and he started to write down his recovery story for sharing. Sunny was once invited to deliver a talk about recovery at the centre and he felt great to have such changes. Regarding his own recovery, Sunny said that he has 好過來了, literally meaning “recovered.” Sunny attributed the support of his wife to be a great source of motivation in his going through all this. He also admitted that the road to recovery was full of challenges and life will also have ups and downs. Sunny said that with all that he has gone through, he was now a hopeful person, with concrete planning and also dreams. Sunny has confidence that he can make a good way in the following years and he hoped that all other mental health service users could experience the same in their roads to recovery. “I will not really retire after 60; I will still go to share my story with people with mental health problems and let them see the bright side of the world. People with schizophrenia should know that they are not alone, and they are in the same direction to live with the illness,” Sunny concluded.

Eddie's Recovery Story

I can't remember when I started to know Eddie, and neither did he. In the first interview, whilst I was inviting him to be one of my participants, we spent a couple of minutes finding out under what circumstances we first met each other. Eddie is now an outspoken advocate for schizophrenia and mental health self-help groups in Hong Kong.

Eddie was now at the age of 47 and was still single. He had been diagnosed with schizophrenia and had been taking anti-psychotic drugs for more than ten years. Nevertheless, despite there being some hard times living with the illness, Eddie was quite successful in living a very normal life. Eddie never felt shy in telling that he was once schizophrenic, but you really can't distinguish him from other, ordinary people by his appearance and behaviour. Indeed, Eddie is smart, clever and has a bright character. Eddie's prominent features are his openness, calmness and self-confidence, and you can feel all of them when you meet him once. But, most importantly, Eddie is quite enthusiastic and committed to fighting for the rights and advantages of the mentally ill in Hong Kong. With all these positive characteristics, Eddie is one of the most well-known spokesmen for mental patients to the mass media. In addition, he was an often invited guest speaker at mental health conferences with a special focus on recovery, patients' rights or the self-help movement. Eddie is quite humble in denying his accomplishments and contributions to local self-help activities. He was already well known in leading effective meetings. When participating in policy meetings with government representatives, Eddie was always one who could clearly express his ideas and, most importantly, assist other mental health service users to voice out concerns and wishes. In Hong Kong, Eddie is a figure of mental health recovery.

Eddie once showed me a passport-type photo which was taken at the age of 20. In the photo, Eddie looked like an ordinary young man, with large round eyes, black glasses, full lips and a slim face. Eddie asked if he looked like a scientist. I simply replied 'yes' because he really looked like one. Eddie told me that he loved science and mathematics, but being involved too much in thinking might be the reason for causing the mental illness.

After graduating from secondary school and attending the HKCEE open examination, Eddie started to work in various companies at the age of 20-plus. “I don’t have a specialty or any special skills, so I go anywhere if there was a chance or the salary was higher,” said Eddie. Around the age of 30, Eddie began to show signs of *grandiose* delusions. He believed that he had some controlling power over some public events, such as the appointment of government officers, the occurrence of a crime, and even the result of the Mark Six charitable lottery, which has a huge prize of millions. Eddie also got a constant belief that he was, or should be, a king. In addition, he believed that he had some unusual power that could make him solve most science problems. Eddie thought that the ideas were not harmful, and he decided to accept the delusions. In the beginning, they did not affect his life, and he was not totally convinced of their veracity. He did love thinking with those ideas, because they were a funny world for him. “You know, I once believed that I could control the outcome of the Mark Six (六合彩) if I wanted to. So funny. If I could do that, I would be rich,” he said. When recalling his experience of delusion, however, Eddie looked a little anxious but excited. I could read it from his face from a pair of stunning eyes.

Eddie said it was his close friend who brought him for psychiatric assessment. Eddie agreed to do so because he knew part of his delusional world was fake (but not all of them). Thereafter, he was requested to attend medical follow-up every two months in a psychiatric clinic. Eddie still had a daytime job in a factory and he frequently missed the dates of the follow-ups, but he thought that it was no big deal. In 1989, Eddie experienced an acute attack from the delusional ideas in which he could not control them anymore. ”They flew into your brain so strongly, I could not stop them,” he said. Eddie was found having disorganised speech and poor self-care at home, and his mother called his close friend for help. Eventually, he was hospitalised for almost 3 months.

In the hospital, Eddie started to think that he got something wrong mentally. He thought that he had been involved too much in excessive thinking and now he had become schizophrenic. He said he had lost control of his thoughts as the good ideas and bad ideas popped up involuntarily and they made him so “unhappy.” He said that the medication could make him calm down from an irritated mood but it could not stop the thoughts. “They still come up occasionally. The situation has already lasted for 30 years," he said.

Eddie was able to take up some daytime jobs between 1990 and 2000. However, he lost his spirit (一團火) to work hard. He could not stay long in any of the daytime jobs, with the longest being six months. When struggling, regardless of whether or not he was mentally ill, Eddie preferred to have a simple life that could give him some good space for isolation. Insomnia was a big problem for Eddie, which meant he could rarely sleep when thinking. "I felt so tired if I couldn't sleep at night, and the problem was that I hardly slept at night during those years," said Eddie. Starting in the year 2000, Eddie stopped working as he found no meaning in working. Eddie used to live with his mother when all other siblings had already moved out.

Eddie said that he never had an idea to try any mental health services. He even couldn't imagine that after attending a short-term computing course in a day centre, he would spend the past 15 years closely working with different mental health agencies. "I just made a phone call to ask for some information about a computer training course. Once I stepped into the service, a new era started," he said.

After feeling good after joining some daytime training courses at the psychiatric day centre, Eddie became a frequent visitor who always looked for new classes. "Not all the classes were very interesting, but they helped me in killing time and the worker used to be so nice to me. I liked that feeling," said Eddie. In fact, because of his high calibre with documentation, Eddie was asked to work as a volunteer at the centre to help with some administrative work. "You felt no pressure there, and the tasks were super easy for me," Eddie revealed. A few years later, Eddie was elected by other members to become the chairman of their self-help group and he felt great from being recognised. As the chairman, he was invited to join a lot of meetings in the unit, and once he represented Hong Kong to deliver a speech at a local conference on mental illness. Eddie said he treated all this work just like a kind of volunteering, but he felt good when their voices were heard by the policymakers. "Now, as people with a mental disability, we can use the MTR for just two dollars. I was involved in that negotiation meeting with the director of MTR," Eddie said proudly.

Eddie alleged that the delusional ideas never stopped in past years but at a level that he could manage. “Now, I have some tricks to cope with the delusional ideas,” he told me. “For example, if I found myself being delusional again, I would write down some Mark Six numbers on paper and then I would throw it away: after the real lottery numbers came out, I would know if I was being delusional or not and I would throw the idea away,” he laughed. However, insomnia was still a problem for Eddie and many times he missed the chance to join overseas mental health conferences because he could not sleep well away from home.

Regarding his experience of recovery, Eddie said that for a few years he refused to believe he was suffering from schizophrenia because such a denial prevented him from thinking about the problem seriously. “Everyone should have a way to get through those crazy days, and luckily I found my own way,” said Eddie. “You should learn to live with the symptoms and be easy,” he added. Eddie said that our society puts too much expectation on people with schizophrenia without knowing the actual experience of it. Eddie advocated that “maximising the potential” should be the mission of recovery as every one of them had their problems to face. Eddie smokes but not very seriously. He told me that cigarettes were important to his recovery. “Every time you breathe in some fresh air, you can feel some seconds of peacefulness (平靜). It is important to me,” said Eddie.

Yuki’s Recovery Story

Yuki is an active community organiser. She is now working as a clerk in a labour union, which aims to fight for the benefit of working people in various aspects. Yuki said that she was working in an empowering condition and thus she was very conscious of the welfare issues related to mental health recovery. Knowing that she was invited to be a research participant of this study, she said, ”My memory is not good and I cannot recall all the past events, but I am fine to talk to you.”

As told, Yuki was now 42 years old. She was born in a middle-class family and used to live in decent apartments located on Hong Kong Island before the age of 20. Yuki was good in English, showing that she got a very good education during her childhood. In fact, she attended a traditional Catholic school that was formed in the 19th century and has a lot of famous graduates in Hong Kong, such as government officers, council members, movie stars, doctors, etc. However, Yuki said that she did not like the school because it was too traditional that it erased creativity amongst students and it also wanted to be a prestigious school for upper-class families only.

Yuki suffered from an early onset of schizophrenia when she was young, but she forgot the exact year. “I was mentally ill because I experienced a lot of auditory hallucinations before I finished secondary school education,” she said. “The voices were too disturbing but now I am used to them. I treat them as a puff of wind (耳邊風). I cannot pay attention to them now that I am too busy (唔聽得太多，我好多野做),” she added.

Yuki has been hospitalised frequently in the first few years after the onset of illness. Whilst she was staying at the hospital, the best thing she could hope for was to get rid of the hallucinations but she could do nothing about it. The repeated hospitalisations made Yuki marginally complete Form 7 in school with some delay. Yuki’s family was not happy with that delay and they thought it was just Yuki’s weak personality that was making her far from recovery. Nevertheless, Yuki was not very proud of being one of the graduates of the girls' school. She said that the school was no more than a human factory to train up idiots, like girls with the same characteristics and appearance.

After her secondary school education, Yuki did not go for tertiary education. Instead, she joined a private school for a certificate as a secretary, and there she learned some skills that she still finds useful today. However, it was also a hard time for Yuki to get her certificate as a secretary as sometimes the voices made it hard for her to concentrate on finishing auditory typing, which is an important secretarial skill. "It was funny. I heard two voices at the same time and I didn't know which conversation I should type," she said.

Yuki said the death of her father brought big changes to the family. "He passed away because of ill health whilst I was living in a mental hospital voluntarily to adjust my medication," said Yuki. "I could not even attend his funeral since my mother did not tell me for fear of making me become unstable in the mental hospital," she added. Yuki felt so sad about her father's passing, but she did not know that it also affected her discharge planning. "My family asked me to move into a halfway house because my mother was depressed due to the death of my father and would not be able to take care of me," said Yuki.

The first admission to a halfway house was not very smooth for Yuki because she experienced a lot of stress in adjusting herself to this new accommodation. Living in that stressful condition with more frequent experiences of hallucinations, Yuki was readmitted to the mental hospital for another 9 months. After that, she was referred to another halfway house for admission, and this time it was much more successful. "The house staff were very caring and able to give me more flexibility in being alone without pushing me too much," said Yuki.

In the following years, Yuki was able to put herself back into the community. She started attending day training service and was able to develop some friendships there. Under the recommendation of an occupational therapist, Yuki was employed as a sales girl in a supported employment unit located next to the halfway house. Because of her English proficiency, most often Yuki was chosen to present the services to visitors. Yuki thought that it was not difficult for her, but the sense of achievement and sense of recognition made her feel better most of the time. In 2008, Yuki was elected by the house residents to become the chairwoman of the self-help group and she became more active in her daily life. 2009 was a good year for Yuki because her dream came true: she had been offered a part-time job from a labour union to work as a community organiser. “I am so happy for that, because it was my first taking a post in the open market by myself,” she said. In 2010, she was promoted to be a full-time community organiser with a higher salary. Yuki said that she enjoyed this job very much because in the post she needed to work with different people and it motivated her to become more open to others. Besides, the job was quite meaningful in a sense that it fights for a better future for others. Being a person suffering from schizophrenia, Yuki deeply understood the feeling of being marginalised and being abandoned. She agreed that the issue of discrimination was a social problem and people with mental illness should not be ashamed of the label.

Yuki hardly agreed that she was a successful case of recovery from schizophrenia. The main reason was that she was still suffering from auditory hallucinations without knowing when they would become worse. Yuki said that she had some hopes for her future but she was not very hopeful. “I have a lot of worries. I am not sure about my future,” she said. “Being a girl without a family [her parents had both passed away], my life is still vulnerable,” she said. Yuki said that she seldom hoped for something very far away, but she was able to set goals for something for the near future.

Michelle’s Recovery Story

Michelle was born into a big family, and she was the youngest amongst 8 siblings. As told, her eldest sister and eldest brother were almost 20 years older than she was and were now aged over 60. Michelle’s father passed away when she was just a little child and she only got a limited idea about her father. In the family, after the father had passed away, Michelle’s mother and the eldest sister became the main caregivers for the young kids and those big brothers were the breadwinners. Allegedly, the family never had to worry about their financial condition in those years when some elder brothers had already started to work in the labour force. Some of them were professionals as well.

As reported, Michelle grew up normally with her brothers and sisters and they used to have a good relationship with each other. Her schizophrenia started slowly when she was 18. At that time, she was just a student and living with the family. As revealed, Michelle started to have obvious self-muttering in school, where she was also teased by others on her appearance. Her family members found that Michelle’s active self-muttering involved a certain amount of religious notions that she had learned in primary school and they thought that it just might be a minor problem. However, the situation became worse as Michelle spent more time self-muttering and became confused and out of touch with reality, and she hardly talked to the family. She was then referred to a governmental psychiatric clinic for assessment. She was given the diagnosis of schizophrenia at the age of 22.

During the interviews, Michelle did not want to talk too much about her first psychotic experience. “Those old days are too far away from now. I can’t remember either,” she said. However, she once talked about it during another research interview but she requested to keep the content confidential and I duly respected her decision. She told me that once she knew that it was a delusional thought, she stopped thinking about it to avoid sinking (沉淪下去).

Nevertheless, she told me more about her daily experiences after having the diagnosis of schizophrenia. Michelle was lucky enough that her mother and sisters agreed to let her take rest in the family home but not hospitalisation. Michelle appreciated the acceptance shown by the family and she tried hard to regulate herself to not make trouble at home. As told, during those “bad days,” she said that when she was overwhelmed by the delusional thoughts, she stopped eating and bathing but idled somewhere in her own house. It could be a heavy task for her to go out because she did not know where she wanted to go. She would experience some auditory hallucinations sometimes, but she was able to manage them. Michelle used to keep walking in the house when her mother got her out of bed to avoid too much sleeping in the daytime. Michelle found it very hard to deal with daily activates in the daytime, and she rarely talked to her mother who was caring. Her incoherent speech, which was affected by the experiences of delusions, affected her relationship with her brothers and they all found it very hard to communicate with Michelle at that time. Michelle said that it was her “moratorium stage” (迷惘期). Luckily, Michelle found some “relief” when she spent some time with some good friends in the community. Although that kind of “happy hours” in a restaurant or cafe did not last too long every time at maybe just 45 minutes, Michelle revealed that the happy feeling made her feel better during the day.

In the past 20 years when having the mental illness, Michelle said she was so “lucky that no single hospitalisation was needed” (一次住院都唔駛) and she just needed to attend regular medical check-ups at a governmental public clinic. “I am so lucky to have a good family, a caring mother and sister who encouraged me to try my best in recovery,” she said. She added that her mother was a good therapist:

> *“My mother never let me idle and do nothing (唔俾我停下來) … my mother always urged me and supervised me to help do some housework in the house or some volunteer work outside in the community …. every day I had to read newspapers and take down some short notes for mother.”*

Actually, her mother and sister had trained her up to comply with a stable daily living schedule in which she still keeps those habits. These two lovely carers did not pay lip service but they complied with the plan together. As told, they woke up early in the morning and then started with some basic housework. Then they would go out for yum cha (Chinese morning tea) and then they would start to prepare lunch and dinner. Every day, clothes would be washed. Also, the floor would be mopped regularly. In 2011, Michelle's beloved mother passed away peacefully at the age of 80. Michelle said that she was still able to keep a healthy daily living schedule and she appreciated what her mother did for her in the recovery from mental illness. "I am not talking recovery with lip service; I am acting on it," she said. "Some people with mental problems are so pitiful (可惜) because they give up on themselves," she added.

At the age of 30, almost 8 years after the onset of illness, Michelle thought that she should not spend her life idling at home. She told her medical social worker the idea and she was referred to attend a vocational assessment. Thereafter, according to the recommendation provided by the assessor, Michelle applied for a store assistant post in a supported employment project at a general hospital. There, she worked as an assistant at the beginning and then was no sooner promoted to senior sales. Michelle was quite happy to have that job because it was what she had dreamed of for years. “I hoped I could have a job, and now I have a job,” she proudly told me. Because of her smart outlook and good communication skills, Michelle was able to stay in that unit for a couple of years before moving to the next step. In joining that programme, she started to make some friends who were also mental health service users. Michelle treasured knowing some new friends there as she started to know more about how the people faced their mental illness and the stories behind it. “They taught me a lot of things about the illness and again it let me feel so lucky about my recovery,” she said.

In 2006, Michelle successfully secured a job in the open market on her own. The new job was an office assistant post in a mainland China/Hong Kong company (兩地公司) for which she needed to work in Shenzhen occasionally. “I got this job because I had started work for three years, and with that experience I got the job,” she said. As alleged, the salary was quite attractive, and by working in that post, she saved some money, though not too much, to prepare for the future. Time flew and Michelle spent another four years in the company until it closed down in 2010.

This time, Michelle was not able to find a job on the market so easily as she was already approaching 40. Without thinking too much, she attended an employment retraining programme for 6 months and eventually got a licence as a security guard (保安員証). Two months before our first interview, Michelle was signed as a part-time security guard by an outsourcing company. In this new job, she needed to work 8-hour shifts for 5-6 days per week. As told, her monthly salary was around HK$7000-8000, so she was earning slightly higher than the statutory minimum wage per hour in Hong Kong. Michelle added that she was satisfied with the workload and corresponding reward. “I am again able to save some money for future usage,” she proudly described to me.

Hubert’s Recovery Story

Hubert was now at the age of 30. He was the 4th of 4 siblings in a normal family. His father was a factory worker and his mother was a housewife. Hubert said that he used to have a good relationship with his brothers and sisters, especially his eldest brother who was a significant supporter in his road to recovery.

After secondary school education, he started to work as a security guard in a big shopping mall and the salary was good enough for him with a Form 5 education level. However, the illness derailed his life. “Maybe I was too shy for that post. I needed to use a walkie-talkie and speak openly, and I felt uneasy and pressure in using them,” he said. “I was not a talkative person in secondary school anyway; I used to hide myself (收埋自己) and did not often speak so publicly,” he added. In addition, Hubert found that he could not mix well with other colleagues and felt isolated. “I can’t remember quite exactly what happened in those years, but I knew I was not happy at all and found no one to talk to,” he said. “Maybe my mother and sisters had already reached out a hand to help me and I just did not take it (唔領情),” he added regretfully. All in all, a group of negative feelings overwhelmed Hubert at that period of time.

> *“Until one day, I left my post suddenly and wandered aimlessly in the street. I didn’t know how long I walked on the street, and eventually I was caught by police after midnight. My family ran to the police and*

> *tried to help me, but I exploded like a volcano with all my negative feelings and became aggressive towards my parents. A few hours later, I had been locked up in a mental hospital and was restrained."*

Hubert reported that it was not easy for him to stay in the hospital in that way and he needed time in persuading the psychiatric nurses that he was no longer aggressive and could be relieved from his bed restraints. The medication made him feel better and he started to calm down and think about what had happened. However, he found that thinking was now a very difficult task for him (腦根唔好) and sometimes he could think of nothing even if he wanted to. He was told by the psychiatrist that he was suffering from schizophrenia during that hospitalisation. Hubert did not reject the diagnosis of schizophrenia because he personally felt that he really had a mental problem (我都覺得自己有問題) and he needed some help from others.

Hubert's first admission to the mental hospital was his only hospitalisation after having the mental illness. Hubert felt lucky and proud to speak about it to me when compared with what he knew about other mental patients. After he was discharged from the mental hospital, he spent a few months sleeping in his bed and did nothing. Eating and bathing were problems for Hubert, and his parents were exhausted from supervising him in basic self-care. He made the following reflection on that period.

> *"It seemed that the sky had fallen down (天塌了下來), my world had collapsed (崩潰了). I was out of my job; in fact, I didn't have face (面子) to go back to the post again, so shameful (好醜). Suddenly, you found that you didn't belong to this world. There was no hope anymore, nothing could interest me at that time."*

Hubert then attended a day training programme in a rehabilitation centre and would go to a psychiatric clinic once a month. Hubert revealed that he had mixed feelings about the training at the day centre. "I appreciated that some social workers were so empathic to me and were quite supportive when you needed someone to talk to. I am a shy boy, you know, and they never left me alone and would give me some encouragement," he said. "However, that kind of artwork (串珠仔) was very insulting. It made you feel just like a fool," he added angrily. "Doing those kinds of training really made your life hopeless," he said. Hubert appreciated that I agreed with him.

Hubert alleged that the support from his brother was the turning point in his recovery. Hubert was not a good swimmer but he enjoyed swimming. His brother was a registered swimming coach. Knowing that Hubert was suffering from a mental illness and idling at home, the brother asked Hubert to work as an assistant in his swimming class with the main hope that Hubert could open up himself to the world. Such an attempt was indeed quite successful. “That gave me a chance to let me see that there was still some opportunity and hope for me,” said Hubert. At the beginning, Hubert just worked on a part-time basis. Thereafter, he found himself loving to swim again as swimming made his body feel more comfortable. “The drugs made me so tense, but swimming was a good way to relieve that tense feeling and train up your body,” he said. Most importantly, Hubert could join the other swimming coaches, who worked for his brother, as a big family, where he felt support and acceptance. “They all knew that I have such an illness, but they just didn’t mind,” he said.

A few years later, Hubert became a registered swimming coach himself, around the age of 25. In order to prepare for the registration examination, he trained up himself gradually with the support from his brother and other coaches. Hubert thought that the training was indeed hard for him, but eventually he went through it and the intensive training made him become stronger and healthier. In the examination, he spent 40 seconds to finish the 50 metres freestyle swimming, which was a very proud personal record and even faster than other candidates who were aged 20.

Hubert said that there were many reasons for him to keep good health. “It includes being healthy, happy, keeping a body in good shape and being more energetic in daily life,” he said. Hubert thought that Hong Kong was not a health conscious city and people with mental health problems usually ignore how a healthy body could be beneficial to personal recovery from illness. In doing different kinds of sports, Hubert said he met a lot of friends who were fitness lovers and that pool of friendships was what he treasured the most. “Sometimes when you are down, doing some simple exercises can quell that feeling immediately,”’ he said.

Then Hubert worked as an assistant officer in a private fitness clubhouse located on a luxury housing estate in Hong Kong. In this job, he needed to serve the residents (mainly foreigners) in the usage of the fitness equipment and swimming facilities. He would also give private swimming classes for the residents individually or in a group. Hubert loved this job as he loved swimming and the job was not so stressful. Last year, Hubert was recruited by Hong Kong’s Leisure and Cultural Services Department (LSCD) to launch healthy swimming classes for cancer patients. He tried his best to serve that patient group and felt that it was a kind of job that was really meaningful. In 2012, Hubert was once asked by a head-hunting company to take a higher post in another private clubhouse in Sai Kung. However, Hubert rejected that invitation and provided the following answer to me:

> *“It was my belief that, in recovery, everything should go step by step, at least for me. If I can’t afford to go for that job and have no confidence in attaining it, I would not push myself for it. This is my motto. Remember my attempt to be a registered swimming coach that happened years before? In fact, my brother asked me to do it at the beginning, but I didn’t go for it when I felt that it was not the right time. After I started to teach swimming in his class and gained more*

> *satisfaction, then I tried it. This was my experience of recovery."*

When reflecting on his own recovery experiences, Hubert said he would like to say thank you to all his family members who were supportive from the very beginning. He thought that he was very healthy now and he coped well with the illness. He lived his life like a normal person at the age of 30, nothing was missing. Herbert alleged that his recovery looked like a staircase with different steps, that he stood on one and then looked for a higher step naturally. A sense of self-satisfaction and self-appreciation were important in keeping him moving. Regarding his future, Hebert provided the following statement, which I thought was quite suitable and appropriate for describing this young man.

> *"My future is bright (光明的) with opportunities (有機會的) and is hopeful (有希望的)."*

May's Recovery Story

I first met May during a winter. She was referred by another participant in this study as my interviewee. That participant proudly said that May was very suitable to tell about the experience of hope since she was known as a hopeful person. In order to arrange the first meeting, I tried to make phone calls to May but was not very successful. Then I sent her some text messages, and no sooner she replied in a short text in English asking who I was. After some introduction through texts and some follow-up phone calls, May agreed to participate in my study. “Sorry for asking you so many questions, I just wanted to identify who you are. I should say sorry for my roughness,” May explained to me during the first interview.

May was impressive as a beautiful woman in her middle age. She dressed sharply and clearly and looked comfortable and smart. Her voice was so sincere that you could easily feel warmed to chat with this lady, and she always had a lovely smile on her face. ‘I am 58 now and approaching my retirement,” she laughed. I was stunned at her face and really couldn’t believe what she told me. What a surprise to me.

May said that she suffered from schizophrenia 30 years ago, around the age of 25. “It was my mother who took me to a psychiatric clinic for a consultation,” she said. May was born into a family with 5 kids and she was the 3rd child. As told, May never had to worry about money since she was born as her father was said to have been a landlord with some property assets since the 1960s. May reported that during her most troubled days of schizophrenia, she was able to live in her house with a Chinese helper to take care of her and the family as well. “Yes, I was lucky that my family helped me a lot financially,” she said. “Without the shelter [house] they provided for me, I couldn’t imagine how worse I would be,” she added.

May attended a normal girls’ school in Hong Kong. May did not want to reveal the name of the school but by reading her style of presenting herself to me I interpreted that it should be one of the most renowned girls’ schools in Hong Kong. May once told me that her hobbies during weekends were listening to music and joining some concerts. This answer confirmed my interpretation. Actually, May did not think that she suffered a lot from the schizophrenia. “I just needed to take some pills, which is not really heavy for me. The pills just made me sleep at night and they had no influence on my daily life," she said. May attributed the illness (mainly as hallucinations) to her introspective personality formed in childhood. "I was at peace to keep my feelings to myself, and I was too keen to be a good student and a good person to everyone. It brought stress to me,"' she said. Even though she was diagnosed as having schizophrenia, she was able to complete a self-financed diploma in management and secured a job in a big company. Years later, she was promoted to be a senior general manager and was able to work with some famous businessmen in Hong Kong.

2003 was a critical year for May — it was the year that she faced a severe panic attack and mentally broke down. "I don't know the reason why I started to feel so scared and panicked in the office, but I can remember what was going on in the office. Maybe it was due to work stress. I functioned poorly in my workplace, my thinking stopped, I felt so scared in front of my desk. The world started to fall down before me, and only I alone stood there,' she said. "It was not a feeling — I saw the pictures. Maybe you can name it as a delusion or hallucination," she added. After spending a few days in her house with acute anxiety and confusion, May was sent to a mental hospital for observation. “The doctor told me that I had an illness called schizophrenia, but I didn’t care. I didn’t even care what was going on outside,” May said. During the hospitalisation, May said she could hardly maintain reasonable self-care. She was speechless and demonstrated clear negative symptoms. “It was not easy for me to make a simple decision, not even in deciding what kind of food I wanted to eat,” she said. May had no interest in watching television in the hospital ward and she knew nothing about what was happening outside the hospital walls. “It was my mother who told me what was happening around the world, but soon I forgot the news,” she said. May never asked for a discharge because she thought that the hospital ward provided her with good shelter. She felt safe there but not in the real world. As reported, delusions and self-muttering were noted occasionally during her hospitalisation. It was the decision of May’s mother to bring her home. The family hired a helper to take care of May in the house they owned. May was aggressive, but she was over-dependent on others and would feel extremely anxious when she was left alone in the house with the helper. May said that the only enjoyable moments in the house were when she listened to classical music that she loved. Otherwise, her bad memories would come out occasionally in which she was not able to stop them, resulting in a panic attack.

May revealed that there was one day that she got some new insight on living. When she walked to a primary school near her living place, she witnessed some lovely children lining up and waiting to go into the school. May said that she suddenly became aware that even if she were a child, a learning opportunity should still be available somewhere. Then she said she looked for some information seminars about mental illness. At the very beginning, she attended some psycho-education activities in a mental health clinic, and then she took every opportunity to attend seminars, workshops and programmes amongst various community mental health agencies. May said that it was her new primary and secondary education period. With that thinking, she felt no shame in identifying herself as being mentally ill as there should be nothing to be ashamed of. May alleged that in the beginning she felt tired easily and her mind could not function so well too. However, after she knew more about her illness and the recovery stories of others, she felt more energetic to know more. “Learning became meaningful to me. I felt no tiredness,” she said. As told, May found herself able to function much better under self-encouragement. She was able to attend those talks on time and have good concentration in learning. The more she knew, the more questions she was able to ask. Since May was a frequent visitor to different seminars, she was invited by various social workers to become someone who could share a message, not just as a listener. May kindly refused to adopt this role as she felt that she was not ready yet.

Starting from 2011, May felt that she was ready to look for some part-time jobs to train herself up. May would not look for full-time jobs because she was already 55 years old. By reading the advertisements in the newspapers, May applied for a helper job at a local university which conducts Hong Kong community surveys. As May was good in English, she was offered a post as a telephone surveyor on a part-time basis. She needed to attend the telephone survey centre twice a week and conduct a certain amount of telephone interviewing. May said that almost 45 minutes was needed to complete one single telephone interview, and it was a little bit hard for her.

However, she thought that it was a good chance to try new things that were challenging, otherwise she could not overcome her problems. Whilst working at the university, May also started to work as a volunteer in peer counselling. Again, May found this opportunity whilst she went to that centre for attending a seminar about interpersonal relationships. There, she knew there was a volunteer peer counsellor to be recruited and she expressed a wish to try. “I thought it was time for me to pay back. I have attended a lot of seminars and workshops for free and it was time for me to contribute back to the community,” she said. Because May was now a happy person with a smile on her face, she was welcomed by others in conducting simple peer counselling. “It was just simple encouragement for them, not really a counselling I think,” she said. “But I enjoy this kind of sharing, because every time I recall my experience, I feel grateful for what I have now,” she said. “I have spent too many years doing nothing and lived like a baby under family care, and then I started to move and face my life bravely again. I hoped they could make their life grateful too,” she added. May claimed that drug compliance was never a problem for her because she just needed to take a limited dosage only and no obvious side effect was noted. Now, May enjoyed her life every day and she hoped that the enjoyment would go on. As alleged, May showed some worries about the age of 60 because that is normally the age of retirement. However, she was told that retirement was just for people with full-time jobs but not for volunteer work. Financially, she would retire from the labour market, but there was no need to stop her spiritual work. May could not agree more.

May told me that she was 90% recovered (好番九成) from her schizophrenia; the remaining 10% was just some uncertainty about the future. “You just can’t be sure about what will happen next, right? Otherwise, I am totally recovered from that experience of schizophrenia,” she said. When talking about recovery from mental illness, May stressed that the acknowledgement of having some problems was the very first beginning, then people with the illness could call for help and help from others would come. “I thought I could try getting out from the medication. It was a dream, but I never tried,” she said. May said that she was not a good role model according to the above principle because she spent too many years living in her own shelter and being “too late” in waking up herself. May said that if she could have such awareness a little bit earlier, she could have had more time to share her recovery stories.

Charles’ Recovery Story

Charles said that he was mentally “sick” whilst he was attending Form 7 education. “It was nothing related to bullying before, but after the breakdown, it was,” he said. Charles had a mental breakdown a few months before a public examination, and he thought that it was all due to the examination stress. During his school life, Charles felt compelled to be one of the best in his class but he was also in fear of failure. As alleged, that open examination in Form 7 was really too stressful for him. “I felt so nervous inside, my mood became irritable, and I needed some place to release my bad mood inside,” he recalled. One day, and without reason, Charles suddenly left his house and started walking with nowhere to go. It was a panic journey as he believed that all pedestrians were trees and someone was always tracking him on the way. When he stopped walking, he felt that someone was inputting some hostile messages into his head and even took some thoughts out from the brain.

Then he kept walking and walking and got wet in the rain during the night. “My mother told me that I was speechless and looked totally crazy in the morning when I was standing outside the house door and did not even press the doorbell,” he said.

“The doctor told me that I had a thought disorder called schizophrenia and he would put me on medication. He said the medication would help me to relax myself,” said Charles. “I knew I had something, but just didn’t know it was called schizophrenia,” he added. In the following months, he stayed in a hospital ward and joined the day training programme in the hospital. Although he didn’t like to carry out artworks every day, at least it gave him a break to leave the ward with a certain amount of “freedom.” Furthermore, he could pass through the open area of the hospital where he could buy himself something to eat or a cup of coffee. “The open area was for discharge-ready patients in the open ward. They gave them a small open area to live in the daytime,” he explained. Originally, Charles had hoped that he would be discharged from the mental hospital soon but in fact he wasn’t. “My mother and my psychiatrist asked me to try a halfway house,” he said. “It was all because of my father," he added.

Charles revealed that his father used to put high expectations on him, just as what he expected for Charles' brother and sister. As told, both Charles' brother and sister were professionals. They graduated from university with different specialties and thus could engage in some gainful jobs thereafter. Charles' father also put the same expectation on Charles, and so he was a little bit disappointed towards Charles in having some mental illness. Actually, as told, Charles' father once claimed that there was nothing (mentally) wrong with Charles and it was an excuse by him to escape from pressure. "He thought I was not sick but a failure. He seldom came here (to the hospital) for me," said Charles. "He was the one who introduced the idea of putting me into a halfway house for some training," he added. Charles did not know what a halfway house service was since he had never imagined that he was to try one at his age — before 20 and still a student. However, he agreed to have an agency visit first to get some idea of the service. As alleged, to a certain extent, Charles' willingness to try the halfway house was due to his relationship with his father, who said he had not been so good in recent years whilst at secondary school. “Sometimes he would put too much pressure on me and we had nothing to say to each other. He would just be concerned with my school performance, nothing else,” said Charles. In a later research interview, Charles reflected that the reason behind his having a mental illness was somehow related to the stressful relationship with his father and the high expectations put on him. Fortunately, Charles’ brother and sister were supportive towards a recovery from the illness and they kept close contact with Charles frequently.

Charles did not need to wait too long from discharge to halfway house. He was at a young age without marked functional impairment caused by the illness. As told, most of the time he could have a clear mind and knew what was happening around, but occasionally he would have some manic moods and talked too much in a loud voice. “It was just my style, the style that I used to take to face my father,” said Charles. It was the mother who brought Charles to a halfway house that chose after an agency visit. The house was 30 minutes away from Charles’ family and located in a small but new public estate. There was a big shopping mall not far away from the house, and it became a good place for Charles to visit daily. Under the recommendation of an occupational therapist at the hospital, Charles joined the youth training scheme of a supported employment project in which they provided intensive support for adolescents in their first episode of schizophrenia. The training was quite comprehensive and included social skills training, interviewing skills, computer skills, etc. For Charles, the training was not so useful to him since he knew all the stuff already. However, he felt good about joining a sharing group in which he could learn more about the illness by listening to others' stories. "By listening, you would know more about your future," Charles said. "However, you know more and then your worry will also increase," he added.

Charles spent more than 2 years at the halfway house, more than what he had expected. In the beginning, he had hoped he would go home in 6 months. However, the father rejected the idea and wanted his young boy to spend more time in training. Charles' mother passively supported the idea as she did not want to see some conflicts happening between the father and son if they were not ready to live under the same roof. Charles felt angry towards this authoritative decision without considering his voice and rejected to go home even after the completion of the training at the house.

Charles told me that he was referred to try some outreaching crew teams of the supported employment unit in which he could work in a normal setting, such as a library, swimming pool, or garden. “The job was not heavy for me since most often I was the team leader distributing the work duties. But, of course, I would not make people angry. I needed their cooperation,” Charles said. In the workplace, this young boy interacted with a female service user of the same age. They became lovers just a few months after they met at the supported employment unit. The girl came from a divorced family; her carer, the father, used to work in mainland China. Charles said that his own parents had reservations about accepting his girlfriend out of certain discrimination, especially the father. Time flew and Charles was discharged to a youth supported hostel near the halfway house, and in the same year he was referred to take up a full-time office cleaning job in a big commercial building. “The job was quite challenging, with a lot of work to do with very limited manpower. But I was okay with that,” Charles said confidently. A few years later, Charles got married to the female service user and the new family moved into a public housing unit recommended by the medical social worker. In the meantime, both Charles and his wife were able to work in the open job market and their financial condition was just enough for them to have a short trip to mainland China every year for vacation. The family planned to have babies but just have not done so at this moment.

Regarding his recovery from schizophrenia, Charles experienced the problem of discrimination. He was glad that he was a person who always acted to live in the world and was not isolated. He always wanted to try new things and enjoy self-satisfaction. However, he admitted that life did not give too much space and opportunity for people with schizophrenia. Most often, they were told to do something they didn’t want to with the reason that there were no better alternatives. For example, Charles originally wanted to be a taxi driver but that idea was turned down by the psychiatrist, since Charles would not get a taxi licence with a record with mental illness. “Once you get a label of mental illness, not many things are left in front of you,” he said. Charles agreed that he was lucky in getting a job that he was interested in, but he also witnessed that still many people with schizophrenia were working in day training centres or sheltered workshops, which barely gave you general satisfaction in life. “Joining that kind of service, your life was stable, but it would not take you to new ground. You would be stuck there,” he said. In view of his present mental health condition and his commitment to life, Charles said that he was a “recovered schizophrenic.”

Leo’s Recovery Story

Leo was now at the age of 38. He was a little above medium height and usually dressed casually.

In the first 27 years of his life, everything was fine for Leo. He was born into a small family with two children, and he was the youngest, with an elder sister. Leo completed Form 5 education in a normal school and then he started to work as a general clerk in a trading company. In order to have a better career development, Leo applied for a position as a technician trainee in a famous elevator service company. In the following years, he had been trained up by his company to be a qualified elevator technician. Leo thought that his life orientation was good and he had a very clear picture about his future and good promotion opportunities. However, he never imagined the work stress and the relationship problems with his supervisor.

Leo said that his mental illness was triggered by work stress 12 months before 2002. “I had a serious problem but my immediate supervisor — he was so mean to me — left me alone,” he recalled. “I don't know why he always targeted me,” he said.

Leo started to become so stressed once he had to work with this supervisor and the situation was unavoidable. Having an introverted personality style, Leo kept all the stress and secret inside him and said nothing to the family about the stressful year. Eventually, in the summer of 2002, Leo experienced his first psychotic episode characterised by acute confusion with persecutory ideas.

“I was in an acute state of confusion ... the feeling was quite mixed, but I can still remember what happened,” said Leo. Without a good reason, Leo went to Cheung Chau and loitered for almost 2 days. He slept on the beach and only took some garbage to eat. Fortunately, out of his conscious thinking, he went to a food store and made a phone call to his mother. “My mother said that I spoke irrelevantly (亂講野) without telling them where I was before

I hung up the phone," said Leo. Leo's family quickly reported the case to the police and successfully found out that Leo had made the call from Cheung Chau. A few hours later, the family met Leo at the Cheung Chau police station with the help of the local police force. Leo looked messy and terrible when he met his family. He could not stop talking something that was really difficult to understand. Leo felt great to meet his mother again but at the same time he thought that he was being followed by someone who wanted to do something bad to him. Hospitalisation was needed at that moment and he was restrained on a bed for at least 3 days.

In the hospital, Leo felt extremely guilty for being mentally ill. He repeatedly blamed himself for his failure to handle the work stress and his relationship with his immediate supervisor. He thought that he was just too stubborn in trapping himself in this stressful relationship for too long and now he had a breakdown. Leo also experienced delusional ideas and hallucinations during this onset of illness. "The voices said that I was being followed and monitored and something bad would happen to me," said Leo.

Fortunately, Leo was able to leave the hospital within a few months.

However, he lost his job because of his mental illness. He became depressed because of this unwanted consequence. “I saw my dreams fly away. No more future, not anymore,” he said. From 2002 to 2008, Leo had tried different work posts in the open market but all the jobs ended with poor interpersonal relationships. Leo said that 2002–2009 was not a good period for him as he hardly adapted to other new working environments from doing elevator service. In 2009, Leo experienced another episode of acute confusion and he was re-hospitalised. This time, he spent a longer time in recovering from the confusion. With a hope to live a better life, Leo initiated an application for a halfway house service. “I hoped that I could face my problem there with some little help from the professionals,” said Leo. “My parents also supported my idea,” he added.

Leo found living in a halfway house too easy for him. In fact, he didn’t need special training in the house since he was able to manage his life independently. The only difference was that there was no need to cover up his experiences of mental illness and it made him more relaxed. After taking down the mask, he slept well at night and could be more energetic in the morning. Under the recommendation of the house’s social worker, Leo attended a re-employment programme to learn to be a bar assistant (水吧助理). He completed the training course with a good performance and was able to find a real job on the market with his boss knowing that he was once mentally ill. Leo felt that a trustful relationship in the workplace was the thing that he missed in the period of 2002–2009. He was so afraid to be discovered by others as having a mental illness. Now, working in a trustful environment made him feel easy to deal with others and, of course, he appreciated the acceptance shown by his colleagues. With this new insight, Leo was willing to reveal his identity as a recovered schizophrenic when relating with others. He hoped that he could prevent a further relapse and hospitalisation. Last year, Leo was invited to work as a mental health peer counsellor, which is a non-subsidised welfare post attached to different mental health agencies. Leo was chosen as the representative of the halfway house because he was young and energetic with good functioning in all aspects. Leo thought that the job was quite meaningful for him as he could share his experiences as a person from amongst mental health service users.

Regarding his recovery from the mental illness, Leo said that it was his way out of self-stigmatisation and negative image. “Self-blame is not effective in letting you go through the illness. It brings a harmful effect instead,” he said. “Accepting your illness and knowing your own weaknesses are the key to opening up new possibilities for yourself,” he added.

Leo said that he now had good hopes for the future. He shared with me a lot of big plans for the future, including marriage, new jobs, etc. As told, he spent each day peaceful and full of happiness. “I think I have found the tricks to make me healthy,” he laughed.

Chapter Summary

This chapter provides an overview of the research participants’ backgrounds and their recovery stories. Each story is unique and personal, showing that their lived experiences of hope intertwined with their illness as well as their living context. Their stories of hope not involve their past but also a positive anticipation of the future. Chapter 6 will outline in detail the main findings of my research arrived by thematic analysis. Altogether, there are six overarching themes constituted by their own sub-themes and first-order-themes. Relevant quotations from interview transcripts will be provided to support the identification of the themes.

CHAPTER 6: RESEARCH FINDINGS

Chapter Overview

Altogether, six overarching themes have been uncovered by thematic analysis. The first theme, the ups and downs of illness, provide direct answers to Research Question 1 concerning participants' accounts of their recovery from schizophrenia. Two sub-themes are included: (1) *Good Times* and (2) *Bad Times.*

The second theme, referred to as hope experience, contains data that provide answers to Research Question 2 concerning the actual hope experience related to their mental illness. From the analysis, these sub-themes are identified: (1) *Hope as Believing*, (2) *Hope as Hoping*, (3) *Hope as Acting* and *(4*) *Hope as Feeling.*

The third, hope effects, focuses on the three effects that hope experiences could bring into participants' living world. This theme comprises the following sub-themes: (1) *Comforting Effect*, (2) *Motivating Effect* and (3) *Transcendent Effect.*

The fourth theme, strategies of hope, identifies the strategies participants would use to bring themselves a better sense of hope. The following sub-themes emerged from the analysis of the data: (1) *Adjustment*, (2) *Staying with Others* and (3) *Empowerment.*

The fifth theme, relationship quality, focuses on the important factors recognised as affecting the experience of hope. This theme contains the following sub-themes: (1) *Family Care* and (2) *Professional Care.*

The last theme, environment opportunities, details participants' descriptions of how the social and economic environments affect the hope experience. This theme contains the following sub-themes: (1) *Housing Availability,* (2) *Employment Availability* and (3) *Welfare Availability.*

This chapter provides a detailed report of each major theme and its respective sub-themes.

Theme One: Ups and Downs of Illness

The first overarching theme, the ups and downs of illness, mainly addresses participants' descriptions of their process of recovery from schizophrenia. As mentioned previously in Chapter 1, establishing the individual recovery process from mental illness is the primary research question. Throughout the course of the thematic analysis, it was found that it was the first overarching theme, observable at the very beginning of the analysis. The participants' transcripts show that recovery experiences are revealed in a different way; however, their experiences of recovery can be grouped into two different sub-themes, namely (1) *Good Times* and (2*) Bad Times*. Each sub-theme is discussed with the support of essential meaningful units generated from the transcripts.

Sub-theme 1: Good times

Despite being diagnosed with schizophrenia, all participants reported that they do experience good times during the recovery process. Four first-order themes best group the data and support the name of this sub-theme, namely (a) *Free from Symptoms,* (b*) In Good Health*, (c) *Keep Functioning* and (d) *Enjoy Normal Living.*

Free from Symptoms: Almost all participants revealed that they had some good times free from symptoms. Charles made the following statement:

> *"Free from symptoms is good. You can feel that you are free and comfortable, with peace in your heart. It was such a good feeling when you know you are no longer being bothered*." (Participant Charles)

Nevertheless, data show that they reported different symptom-free situations. Participants Charles, May and Sunny stated that they were 'totally free' from their symptoms for 'a long time' and they were quite happy with that. Sunny further stated that he was deeply knowledgeable about his own symptoms and was quite sure that he was 'totally free' from them. He stated:

> *"That kind of anxious feeling, restless mood and striking hands had bothered me for a long time at the beginning of the illness and now I am out of these. It was good*." (Participant Sunny)

Participant Sunny recognised the importance of training and increasing his levels of fitness, as well as maintaining a constant relationship with his family, both of which allowed him to experience free time for years. Participants Yuki, Michelle and Eddie also admitted that they had periods in which they were ‘totally free’ from their unwanted symptoms.

Nevertheless, whilst reading through their transcripts, I found that they also considered having various types residual symptoms that she could control as a good day. Both Yuki and Michelle stated that they would have various minor strange thoughts and sometimes were not sure if they were related to their mental illness. Yuki stated that “everyone would have some crazy thoughts, right? Ha ha, and so do I.” Michelle considered that having this kind of residual symptom was a part of her life for a long time and so she did not feel strange about this but became used to it. As a result of her ‘good times’, she embraced her experiences of being partially free from symptoms. Participants Eddie and Leo stated that they had experienced alternative ‘totally free from’ symptoms, but were disturbed by symptoms like a roller coaster. Eddie reported that every time he had the opportunity to read some news about the Mark Six lottery, he would have some interesting ideas. Leo made a similar expression, stating: “Sometimes I walked around and was concerned about nothing, but sometimes I just doubted if someone was following me. I have tried to control that thought and it was just so effective.”

All participants agreed that ‘medication’ was somehow helpful in providing relief for their unwanted symptoms. For those who were free from symptoms for years, claims were made that ‘medication’ was an ‘insurance plan for them’ to prevent a relapse. Participant May stated this point clearly: “I would not ask for a total stop of medication but a fine adjustment only. This insurance plan was fine for me.”

In Good Health: In addition to being symptom-free, participants revealed that they loved to experience a stage of good health, which contributed to their feelings of having a good time throughout their recovery. All participants attributed their concept of ‘in good health’ as being ‘free from physical illness’ or other ‘physical discomfort’. Participants Eddie, Sunny, May and Charles shared the common view that the statement ‘no need to see a doctor’ best represented their concept of good health; all participants agreed with ‘no need to take other drugs’ as another sign of good health amongst them. Perhaps the following transcript of Charles best represents the idea. He stated: “no illness, no pain and out of drugs (無病無病，唔駛食藥).”

Keep Functioning: According to Herth (1989), hope level was positively correlated with good functioning in daily life — in both the family and at a job. The concept of ‘functioning’ in this context refers to participants doing as they please and doing so ‘continuously’ without any great problem. For participants Sunny, Michelle, Yuki and Charles — all of whom were employed on the open job market — the claim was made that a good time in recovery is ‘having a job’ and experiencing ‘good functioning’ is handling work duties during prolonged employment. Sunny stated that “having a stable job and in which you can stay working in it are already too good.” For those participants with a part-time job, rehabilitation job or taking rest at home, they attributed the concept of ‘good functioning’ to ‘being able’ to complete non-vocational skills, such as making friends, go shopping, cooking, etc. Female participants, such as Michelle and May, placed great emphasis on their functioning in the ability to take care of themselves during menstruation and daily tidiness. May stated that “as a female, you should be able to function all rounded and it was our duty to take care of ourselves.” Michele also stated that “the ability to prepare a good meal for yourself is an important skill in daily life. One day if you are no longer able or not willing to cook for yourself, your bad day was not far.”

Enjoy Normal Living: The last first-order theme encompasses having a good time in recovery, which centres on participants’ experiences in ‘enjoying’ their lives. Participant Charles explained that to “*enjoy* means that you can really feel good about living and you’ve found happiness in daily life.” Participants used a lot of examples to highlight their enjoyment in normal living, such as having tea, watching movies, shopping, joining in various activities, going hiking, etc. Participant Leo stated that enjoying normal living means ‘no problems’ in living and ‘no problems in solving problems’, where worry-free living allows you to be happy in life.

All participants alleged that, during their good times, they felt a higher sense of hope for their future, which allowed them to aspire to achieve more meaningful goals for themselves. In fact, all participants agreed that, when psychotic symptoms reduced, hope increased.

Sub-theme 2: Bad times

This sub-theme, bad times, deals with participants’ descriptions regarding their bad times. It also reflects the fluctuating course of their schizophrenia and how the associated negative illness experiences shaped their experience of hope in their recovery process. From a first-person perspective, all participants thoughtfully referenced different qualities of the bad times under this sub-theme. Four first-order themes within this sub-theme are valuable for understanding: (a) *Knowing the Diagnosis*, (b) *Mental Distress*, (c) *Physical Discomfort* and (d) *Hospitalisation*.

Knowing the Diagnosis: All participants shared the view that the day they learned of their diagnosis was a really bad time in their life. Some of them were told by their psychiatrist during their first admission to a mental hospital (participants Eddie, Leo and Hubert), whilst others learned of this when attending a medical follow-up in a mental health clinic (participants May, Michelle and Yuki); whilst another, in contrast, learned of his diagnosis gradually after starting treatment (participant Sunny). Both participants Sunny and Michelle reported that they were ‘shocked’ by the news. “I was not ready for this at that time,” stated Sunny. Michelle said that she ‘stopped’ herself for a few seconds to calm down, and then she started to ask about the diagnosis and the meaning of schizophrenia. Participant Eddie provided the following statement about learning of the diagnosis:

> *"I quite remember when I really knew I was schizophrenic. Well, after passing through a lot of things happening to me, medication, hospitalisation, I started realising that I was having a mental problem, [sigh] I couldn't believe it … I felt that there was no meaning in my life anymore, totally meaningless. I didn't know what should I do in the future and where I wanted to go. I was a little bit lost at that time."* (Participant Eddie)

The following is a statement from Charles, who stated that he felt he had been sentenced to a lifelong label upon learning of his diagnosis:

> *"That data was a court day for you, when you got your hearing in a court and was sentenced for having a mental illness in your life. The worst was that in a court you can speak up for yourself but in a treatment room the psychiatrist takes charge."* (Participant Charles)

Mental Distress: Participants in the study all agreed that being in a state of mental distress is a bad time in the recovery from mental illness. Leo stated the following:

> *"No matter what the time, it is a bad time when your mental condition is not good at all. Well, we have a mental illness, and being affected by the illness is really not a good thing*." (Participant Leo)

Experiencing hallucinations is a core symptom of schizophrenia. Within schizophrenia literature, auditory hallucination is the most commonly reported form of mental distress. For some people with schizophrenia, the experience of auditory hallucinations is reported during life stress and creates feelings of anxiety. Participant Yuki provided the following passage, emphasising how she wouldn't like to revisit hallucinations:

> *"Sometimes I would hear some male voices with no contents; it was pretty like the first day when I started to hear that. Sometimes there would be no more voices, but sometimes the voices came again. I didn't want to hear that kind of voices, they made me so anxious and nervous. Hearing those voices made me feel that I seemed to have some relapse*." (Participant Yuki)

In an interview, participant Eddie stated that his delusional thoughts would occur occasionally, making him feel sad and affecting his usual way of living. He remarked:

> *"My thoughts of being a king and powerful man sometimes really affected me. A long time before, at the very beginning of my illness, maybe I still liked that feeling [to be a king]. However, after I knew my illness, I didn't like it. It made me become very alert of my thinking in order to control the thinking, in hopes that it would not get worse. Sometimes, when having some delusional thoughts, I had to stop my social life for a while."* (Participant Eddie)

A depressive mood was highlighted as another form of mental distress by some of the participants, namely May, Michelle, Yuki and Sunny. When facing life's difficulties, disappointments and setbacks on the road to recovery, for example, a depressive mood can be a foreseeable reaction. In the following excerpt, participant Yuki reported how a depressive mood made her feel bad for a whole day:

> *"Sunday should be a happy day for me. However, in a depressive mood, I felt really sad. I cried occasionally, was full of negative thoughts, kept asking myself why bad things always happened to me … Some negative thoughts are really not necessary but keep thinking those things made me feel more inferior … having such a depressive Sunday is really a bad thing."* (Participant Yuki)

Participant Sunny provided the following excerpt, which highlights a sudden depressive episode that occurred a few years ago at a time when he thought that he had almost recovered from the illness:

> *"It was a sudden attack; I was not expecting that. I had experienced a lot of depressive moods at the beginning of my illness, but was free from it for many years. That depressive mood was triggered by a minor conflict with a friend [about money]. However, I didn't stop it at once and then I started to think negatively afterwards. The negative mood went on and I became worried about my uncontrolled mood … Fortunately, I cheered myself up by doing something else and before dinner I felt much better. I really don't want myself going down like that, it was too risky."* (Participant Sunny)

Physical Discomfort: Michelle was the only participant who never needed to stay in a mental hospital for in-patient treatment; however, she had many complaints about her physical discomfort. She stated that "my bad times during my illness were related to my uncomfortable body. For example, I would easily have headaches, physical exhaustion and dizziness." Female participants Yuki and May shared the view of Michelle that physical discomfort is the 'sign' of their going to have some bad days, or having physical discomfort itself was already the bad day. Participants Leo and Charles reported that physical discomfort could be caused by drugs' side effects. Participant Sunny said that it was "interesting that they were treating your mental problems but they bring you a prolonged physical problem." Sunny further emphasised that, in the old days, it was his mental discomfort that came first, which then elicited a physical reaction of feelings of exhaustion, tension, anxiety and pain. Participants Eddie and Yuki, however, revealed that having some 'uncontrollable residual symptoms' were a bad time in terms of recovery.

Hospitalisation: For some people, schizophrenia goes up and down, with hospitals often becoming familiar places when re-hospitalisation is needed. For such individuals, how often they go back to the mental hospital depends on the 'severity' of the symptoms experienced and how 'often' these symptoms flare up. For all participants, hospitalisation added a feeling of 'loss of freedom'. The following passage from participant Leo illustrates this point:

> *"There was a closed area and you were locked inside. You would have your own bed and that's all. You could walk inside the [hospital] ward but*

> *just that certain limited space. Sometimes, sitting on my bed made me feel like I was living in a prison and my freedom had been taken away."* (Participant Leo)

Participant Eddie stated that "in the ward you should follow orders and regulations and there were not so many things you could choose for yourself." Participants Yuki, Charles and Sunny emphasised that wearing a 'patient uniform' not only caused them to feel like they were losing their 'freedom' but also their 'identity'. Participant Yuki hated the 'uniform', remarking:

> *"You needed to put away all your clothes and wear that kind of clothing in the hospital. I knew it was a must, but wearing that clothing made us look very much the same … and the size and cut of that kind of clothing were another big problem. It didn't fit anymore, especially on me. Wearing that uniform made you feel unhappy and I found myself looking ugly*." (Participant Yuki)

All participants considered hospitalisation 'too boring', meaning that they could only take various steps in a very space-limited garden during an 'assigned schedule'. Participant Eddie was a smoker, and he found hospitalisation extremely 'unbearable' as he was unable to smoke as frequently as he wished. Participant Leo asserted that re-hospitalisation was dually another bad time for them — not only because they did not want to be locked up but also because of the consideration of the fact that re-admission to a mental hospital for them meant that they had 'failed' in coping with the illness. Participant Sunny expressed the following:

> *"Re-admission is special. It meant that all your efforts in coping with the illness have failed and you are a loser. I felt a little bit hopeless on the night that I was re-admitted to a psychiatric ward."* (Participant Sunny)

Participant Leo provided a very similar view that re-hospitalisation carried a special meaning as it meant that "no matter how hard you want to be normal, now you go back to the same place."

Theme Two: Modes of Hope

The second overarching theme, hope experience, mainly contains participants' answers to the second research question, which concerns the nature of hope and what hope constitutes. From the analysis, participants described four different inter-related modes of hope in their transcripts, which became the four sub-themes: (1) *Hope as Believing,* (2) *Hope as Hoping,* (3) *Hope as Feeling* and (4) *Hope as Acting*. Participant Yuki stated interestingly that different modes of hope are quite normal as “we also have different modes of water: the gas, the ice and the liquid.”

Sub-theme 1: Hope as Believing

Hope as believing is the first sub-theme of the hope experience. Believing is more than thinking, with participant Charles noting that “it should be a kind of thinking with confidence, a real confidence that you owned.” And for participant Hubert, this kind of confident believing “need not be confined by reality, otherwise it is not hope.” The following first-order themes have been found from abstracting the codes uncovered in the analysis: (a) *Believing In No Dead-end*, (b) *Believing Bad Things Will Go* A*way* and (c) *Believing Good Things Will Come*.

Believing in No Dead-end: This first-order theme, believing in no dead-end, has been extracted from the data in an effort to represent participants’ notions on hope as a belief. Participant Charles stated his personal definition of dead-end:

> *"Dead-end is an end, a final stop … an end point, maybe the ending of a story. Believing it is a dead-end means that there is no future. I once had that kind of feeling … trust me, it was a belief that you should never have*." (Participant Charles)

For all the participants, hope is not believing in a dead-end; rather, as participant May stated, the world will not stop and there is always a future:

> *"You don't have to believe that it is the end of life. Having a mental illness, well, is not the end of your life. For me, my life goes on for years after I have been diagnosed with schizophrenia. Time will not stop and life will go on."* (Participant May)

A similar notion of hope surrounding possibilities was provided by participant Sunny. He stated:

> *"Despite our having the illness, we still have a lot of life possibilities … we could have differences possibly in the future, and the endings are not yet fixed."* (Participant Sunny)

For some participants, hope meant not believing in a fixed present, but rather in a future with different alternatives. Participant Eddie remarked:

> *"You should not just focus on a fixed present, you should focus on the future and alternatives will come … For many years, we [mental patients] have been rejected for [disability] travelling supplements, but now we can just spend 2 dollars to use public transport and maybe we can have more welfare benefits in the coming years. Who knows."* (Participant Eddie)

Believing bad things will go away: All participants stated that they had good times and bad times during their illness. As someone diagnosed with schizophrenia, it was quite 'normal' to experience some bad times related to the illness. During the bad times, as stated by participant Michelle, the only 'weapon you have' is to keep believing, to believe that bad 'times' and bad 'things' will 'go away' or 'end'. For example, participant Yuki said that during a stay at the mental hospital, she believed that the bad time would come to an end sooner or later and she could leave the hospital walls. For participant Eddie, the bad ward staff would 'go away' a few hours later. Participant Hubert alleged that he had experience to believe that his 'short period of unemployment', 'adjustment to drugs' side effects', 'relationship problems with colleagues', being 'out of money' and experiencing 'some bad luck in daily life' would eventually come to 'an end' and would not 'last very long'. Participants Yuki and Michelle also experienced believing that their 'residual symptoms', 'crazy thoughts', 'anxious feelings', 'bad moods' and 'quarrels with friends' would end soon. Participant Charles experienced believing that his 'temper' would go away and 'a short period of vocational training' would come to an end, allowing him to find a gainful job later.

Believing Good Things Will Come: This first-order theme is the other side of the coin: when bad times and bad things come to an end, 'good times' and 'good things' will appear. Most often, 'good times' and 'good things' have been mentioned in the previous section under 'good times'. Participant May once used a meaningful expression to represent the coming of good times, stating: "Old happy days will come when bad times go away." For participant Charles, believing good times and good things will come was equal to 'having a better job', 'will see the supportive halfway house a few hours later', 'will get my salary soon and end my poverty', and 'my son's fever will go down and everything will be alright'. For participant Leo, good times and good things will come were equal to ‘my auntie will come to visit me in the hospital’, ‘I will be discharged soon’, ‘they hired me as a peer counsellor and will end my idling’, and ‘the resident who used to bully others will soon leave the house’. For participant Sunny, bad times and bad things included his ‘father’s death and grief’, whereas the good times and good things included ‘regaining an old period of positive mood’ and the ‘ability to love again’. For participant Michelle, bad times and bad things go away, meaning ‘a long period of rainy days will eventually stop and I can go for some cycling with friends very soon’.

Sub-theme 2: Hope as Hoping

In addition to the last sub-theme, hope as believing, hope as hoping is the next mode of hope experience highlighted by participants in the interviews. This sub-theme emerged through the analysis of participants’ descriptions of their various experiences of hoping in relation to their various hopes of recovering from their illness. This kind of hope is different from the hope of believing in that participants often gained more experience and confidence in believing that some good things would come during their bad days. Notably, all of the experiences grouped under this sub-theme, hope as hoping, captured the subjects' general desire and thoughts about their future and not only good times out of bad times. The data analysis developed the following first-order themes of the sub-theme: (a) *Keep on Hoping,* (b) *Hope for Symptoms-free*, (c) *Hope for a Normal Life* and (d) *Hope for Self-actualisation*.

Keep on Hoping: All participants agreed that 'keep hoping' was important for them as mental patients. They all agreed that it was quite 'rare for them to have nothing to hope' for. Participant Eddie said that normal people used hope to 'want something' or 'get something' in various aspects. However, he stated that experiencing a period of 'no hoping' was the time he 'most suffered' from delusional thoughts. Participant May also stated that in the very first year of having the illness, she had some time of 'no hoping' as she was 'trapped by symptoms'; for her it was her depressed mood and feelings of anxiety. Both participants May and Yuki described that their 'no hoping' period was mainly characterised by a stage of 'total isolation'. During this time, they said 'nothing was wanted', 'food was not wanted', 'bathing was not wanted', 'communication was not wanted', and that they did not want to re-experience the period again. Participant Charles said that continued hope ‘makes you come close to the world, quite alive’, ‘no dying’, and only ‘a dead man will have no hope’. Moreover, it was stated that it was also important to ‘keep on hoping’. Participant Sunny said that new hope brought ‘new challenges’, ‘expectations’ and a ‘sense of interest’. He shared the hope of buying a new mobile phone in order to allow him to become ‘close to the world’. He stated:

> *“I read the news, I ask somebody for an opinion, I do some window shopping … arrange the budget, make a decision. It is normal living and everything is so exciting.”* (Participant Sunny)

Participants Michelle, May, Yuki and Charles agreed that, with something to hope for and expect out of life, you could ‘stop just standing’ and ‘keep on moving your body’, which is good for mental health. Finally, participant Leo said hoping would let ‘you know where to go’ — ‘a direction for you’. Leo also alleged that “it would never be too many hopes at a time. The only thing to do is just to prioritize what you hope — you can’t get them all at one time’.

Hope for Symptoms-free: The naming of this first-order theme, hope for symptoms-free, is quite self-explanatory as it groups all descriptions around the hope of being symptoms-free. This is quite normal as all participants wanted to avoid all types of schizophrenic- and psychotic-associated thoughts, such as ‘thought disturbance’, ‘bodily dizziness’, ‘anxious feelings’, ‘anxiety and panic’, etc. The following excerpt provided by participant Leo illustrates this point:

> *“I think all people who have schizophrenia, or another mental illness, would hope for a life without symptoms, and so do I. I have experienced bad days in my illness, with confusing ideas, poor self-hygiene, negative thoughts, anxious feelings, and I don’t want to have them anymore. If you have had my experience, you would have the same wishes and hopes.”* (Participant Leo)

Hope for a normal life: All participants expressed their desire to live normally; simply put, to hope for normalcy. For them, ‘marriage’, ‘friendship’ ,’kinship’, ‘normal job’, ‘travelling’, ‘entertainment’ and ‘housing’ were all components of a normal life they hoped to live. This finding is not surprising at all: firstly, the word “normalcy” is self-explanatory, implying that everything will revert back to normal, and, secondly, the same finding has been reported in various other hope research with other patient groups. Dabbs *et al*. (2004) reported a very similar finding in the recovery experiences of lung transplantation, in which patients deeply 'hope for normalcy' (p. 1475). In that research, normalcy simply meant free from symptoms, discharge from hospital and breathing normally (Dabbs *et al*., 2004). In this present dissertation, participants reported making comparisons with a reference group when talking about their hopes for normalcy. When talking about his hope for normal living and normalcy, participant Charles highlighted the concept of same age-group comparisons. The following statement best illustrates his attribute of normalcy:

> *"To live normally is to live just as similarly as those other people my age and in this place [Hong Kong]."* (Participant Charles)

He further elaborated on this concept by stating the following:

> *"For example, my best friend is my classmate from secondary school. To live normally means that there should be no huge difference between the*

> *ways we live our lives … of course, I am not saying that we should live exactly the same, but to a certain extent very alike each other: family, marriage, jobs, house, etc."* (Participant Charles)

Participants May, Michelle and Sunny also believed the same, stating that they would make reference to the way of living by their significant others and friends and relatives who were almost at the same age. Participant Yuki stated that she has cousins similar to her age and she recognised what is meant by 'normal living', more or less, for her in Hong Kong. In talking about her hope to get married, the concept of age comparisons became more explicit. She stated:

> *"I think I am just a normal girl with a normal hoping for a good marriage. It is not hard to understand this hope, right? At my age, normally most girls in Hong Kong would think about love and marriage. I keep hoping for that too*." (Participant Yuki)

In addition, participant May told a slightly different story relating to normalcy, making reference to the way of living by 'other recovered mental patients' and not referencing those similar in age:

> *“Normalcy doesn’t mean you totally get rid of the illness, but you can make a life just like hers [a recovered mental patient who functions quite well]. She can do it and so maybe I can do it too.”* (Participant May)

When May shared more about what she thought normal life was for her, it was found that her life planning included the active use of rehabilitation services and her concept of normalcy came close to the experience of ‘normal pathway of rehabilitation’.

Hope for Self-actualisation: This first-order theme, hope for self-actualisation, contains rich information centred on how participants wished to ‘take the lead in their life’. During most interviews, participants explicitly expressed very similar statements related to different forms of self-actualisation, such as to do what ‘I want to do’, do things ‘not told by others’ and do things ‘not planned by others’. Participants Yuki, Eddie and Charles could not agree more with this kind of hope as they used to be so over-protected and under-estimated in making life choices by themselves. Participants Charles and Leo further emphasised that the illness, to a certain extent, caused their lives to stop for a while, which caused them to live under another’s care and arrangements. If possible, they wanted to do what ‘they used to do’ and do things they were ‘originally good at’. Eddie said that, in actual fact, he was good at sales, and he hoped from the bottom of his heart that he could work in a related field. For participants Leo and May, who attended a certain type of rehabilitation programme, they hoped to do something ‘fun’.

Sub-theme 3: Hope as Feeling

Two first-order themes best group the data and support the name of this sub-theme, namely (a) *Bodily Experience of Hope* and (b*) Metaphors and Images.*

Bodily Experience of Hope: Interestingly, when telling their bodily experience of hope, male participants provided more valuable information than female participants. However, when communicating their visual image of hope, both male and female participants articulated their own answers to the question. One participant stated the following:

“I knew I have hope because I felt something inside, something

> *pleasurable and happy. The feeling is not a hallucination, I knew that."* (Participant Eddie)

In talking about the bodily experience of hope, participants Leo and Sunny shared the view that the 'chest up' feeling is common. Leo stated:

> *"It's just like when you take a deep breath and that breathing cheers you up and makes you ready to go. Taking a deep breath will make you feel like full of air, full of energy, and it is a positive feeling."* (Participant Leo)

Participant Sunny, who is a fitness trainer, provided some professional sharing on chest up and deep breathing. He stated:

> *"Deep breathing is needed to let the body fill with air and air generates energy as it carries oxygen for the body's consumption. Usually, we will take a deep breath before we want to do something, just like when you start to swim … Secondly, deep breathing [chest up] could regulate your heart beat as well as provide a relaxed feeling and a calming down effect when you pump out the air from your lungs … yes, chest up could either be motivating or relaxing."* (Participant Sunny)

Participant Yuki used the words "fuel" and "engine" to describe what she could feel in her body when she was hopeful:

> *"Yes, you feel it. When I am hopeful, I feel pleasure and when I feel pleasure, I want to eat more … Being hopeful is just like knowing that you have a car engine inside your body and you can feel the power [to move] inside."* (Participant Yuki)

Similar statements were made by participant Charles:

> *"The engine inside you is now fully fuelled and then you are ready to go for what you want [hope] … That energy can last as long as it can unless you get what you want."* (Participant Charles)

Metaphors and Images: Interestingly, participants used very similar visual images to represent the meaning of hope in their experience. The first common visual image used to represent the idea of hope was 'light'. Participants Leo, Sunny, Charles, Michelle shared the idea of 'light' in the darkness or just 'light' as representational of hope. Michelle used 'light' in the darkness in her statement: "It is just like being on a very dark road and you see some light, and then you know where you are and the direction of hope. It is hope." Participant May, who was good at language, preferred to use the image of 'twilight' to represent her idea of hope, which was more-or-less the same as Michelle. Both felt that ‘twilight’ elicits hope with the rising of the sun. She said, “it is why the old saying is that we hope in the morning.”

Another common visual image participants used to represent the idea of hope was ‘road out there’. That visual image of a ‘road’ could be a straight road or full of bends; it didn’t matter. Participants Eddie and Yuki agreed that a ‘road’ could take you somewhere but did not block you or stop you in your tracks. Yuki stated: “You can be hopeful when there is a way out of trouble.”

Participant Charles added his own description of a ‘sunny day’ to represent hope, stating that “you will be more hopeful on a good sunny day rather than on a grey rainy day.” In addition, Yuki also mentioned that a big piece of ‘grass’ below a sunny day also carried the meaning of hope, as grass generally infers growth and hope.

Sub-theme 4: Hope as Acting

In reviewing their recovery process, the participants revealed many problematic situations that they found to be challenging, in which actions could be taken to cope with the problems. It should be remembered that problematic situations are not necessarily related to the temporality of recovery; by definition, recovery is a non-linear progress involving ups and downs in all aspects of life. Facing a relationship problem at the present time does not imply that it represents a problem in other aspects. The proposition here is that, when the problem is subjectively acknowledged and actions are available to solve the problem, a specified goal would elicit coping and problem-solving behaviours.

The analysis of data suggests that the participants were not only passive agents who hoped for better, but rather those who could ‘act out’ something in order to attain their goals or solve their problems. When faced with problems throughout the recovery process, they had a great deal of dissatisfaction and disappointment, and this raised a desire for the hope of change. The experience of hope appeared in a form of hoping with specified hope for goals. This logic sounds reasonable: for example, when facing ill health, you hope for better health; when faced with a housing problem, you hope for a more decent living environment. Here, problems and hope become two sides of the same coin, i.e. hoping objects are the desired outcomes when the problems can be solved.

This sub-theme emerged when participants discussed hope but which needs to be supported by actions. Two important first-order themes have been uncovered from the analysis of the descriptions, namely (a) *Planning* and (b) *Doing*.

Planning: According to the participants, having a plan is of considerable significance in forming a mode of hope. For participant Charles, for example, planning is ‘the starting point of everything’. Before taking actual action, planning is of fundamental importance for deciding the working direction. Participant Leo stated that planning was the stage that put hope into conscious thinking:

> *“You can hope and then you got some ideas in your mind. For example, I want to have a job, it is an idea. To put this hope into action, I need a plan and I need to have more actual thinking rather than just an idea.”* (Participant Leo)

In addition, planning is not only a thinking process but also an extensive decision-making process involving the setting of directions and goals. Participant Sunny provided the following passage:

> *"I am now trying my best to prepare adequate resources for my retirement, which is years later. I started planning a few years before. In making that [retirement] plan, I set up different goals together with my wife to guide our actions*." (Participant Sunny)

In the process of planning and the development of various goals for actions, information gathering is the key activity to be performed:

> *"Every time when I wanted to get a new job … with more salary, I would do some market research by myself. I would like to know the nature of the jobs' availability on the market and the up-to-date suggested salary. Usually, I got that kind of information from the web, from my friends and by visiting a nearby Labour Department office."* (Participant Michelle)

Participant Yuki also conveyed a similar experience when planning a short trip in an effort to realise her hope of a relaxing summer. She added information sorting as one important task in information gathering:

> *"I got a lot of ideas in my mind, perhaps too many [laughing]. Then, the first step is to get as much information as possible. I read magazines and pamphlets and sort out possible options and impossible options … and finally I come up with 2 possible options that fit my dreams and [most importantly] my budget."* (Participant Yuki)

Doing: Here are two stories about how the participants coped with the problem of 'isolation' in the context of schizophrenia. For those with schizophrenia, isolation causes them to feel out of touch with reality and rather more attached to their own inner world. Knowing this, they hoped to experience changes. Participant Sunny stated:

> *"During the 2nd hospitalisation, I hoped that I could get well soon, just didn't want to stay there for too long. With the experience learned from the first time, I knew that I could not give up and isolate myself. Then I started not to be passive. I offered some help to other patients and kept talking with someone who was kind and willing to chat. That made my life not so boring and I am glad that I took that move to save myself."* (Participant Sunny)

Another participant, Charles, expressed how he acted and did something to avoid being 'too idle' at home: He stated:

> *"My parents sometimes would leave the house early in the morning. They have their own activities, maybe going the Chinese restaurant or maybe going shopping. I am not the kind of person that needs to be surrounded by friends. However, sometimes feeling too alone and isolated is not easy, especially when you wake up and find out that you didn't sleep well last night. The best thing to do is to find something to do. Sometimes I will go to the Chinese restaurant with my parents. I knew and I hoped it could help."* (Participant Charles)

Another participant, Eddie, also agreed that being bored would give too much 'space' for unrelated or aimless thoughts, and as a person diagnosed with schizophrenia, it was easy to end up in a 'though-loop'. When he felt bored in the daytime or during weekends, he would arrange different activities for himself in the daytime, such as a regular visit to the self-help group to which he belonged. There, he might not have regular things to do and could 'chit-chat' with workers or even provide some help with paperwork. He stated that "at least I felt more easy there than being alone."

Theme Three: Hope Effects

The third overarching theme, hope effects, mainly details participants' experience on what hope could provide them in the recovery from mental illness. From the analysis, the participants described three different hope effects, which became the three sub-themes (1) *Comforting Effect,* (2) *Motivating Effect* and (3) *Transcendent Effect*.

Sub-theme 1: Comforting Effect

This sub-theme, comforting effect, focuses on how participants could experience some sort of feeling of comfort when having a sense of hope or making hope. This experience of psychological comfort in hoping was quite obvious amongst all participants, and the related conversations were explicitly noted during various research interviews. Two important first-order themes have been uncovered from the analysis of their descriptions, namely (a) *Psychological Ease* and (b) *Bodily Ease*.

Psychological Ease: Participants reported that, when believing some good things will come or when already acting for good things, the hope experience could induce various forms of psychological ease. Participant Eddie stated that psychotic ease meant a ‘clear mind’, when he could ‘enjoy a cigarette peacefully’ and without stress. Participant May said that, when feeling hope in her life, her mind would look ‘like a peaceful lake’. Participants Charles and Leo both emphasised that being ‘able to sleep well’ was also psychological ease. Participant Sunny revealed that peace could bring ‘more smiles’.

Bodily Ease: Besides the feeling of psychological ease, participants could also enjoy some forms of bodily ease when feeling hopeful during life’s difficulties. Participant Sunny stated that, when feeling relaxed, he would have ‘shoulders down’ and ‘would not feel pushed to the ground’. The most common words the participants used in relation to bodily ease included ‘muscles relax’ and ‘not being tense anymore’.

Sub-theme 2: Motivating Effect

Generally speaking, motivation is defined as the tendency to return to and continue working on something. In our daily life, people are usually motivated by goals and desires, which are beneficial and preferable. With hope and motivation, we tend to work harder. This sub-theme, motivating effect, captures the experiences of participants in being motivated to act and move on after having something to hope for in the situation of hoping for something significant. From the analysis of their descriptions, the following first-order themes are used to summarise the representative meanings of the sub-theme: (a) *Spark Interest*, (b) *Willing to Try* and (c) *Continuous Involvement*.

Spark Interest: According to our participants, a phenomenon connected with motivation is their hope for something, in which something sparks their interest in something. Sometimes, they would restore interest in something they used to enjoy; sometimes, it would be a brand new interest in something never experienced. Research participant Eddie reported his registration for a new interesting class on drawing last year. During the interview, he stated:

> *"I like drawing, an old personal interest, but I never had time to have formal training in it. In order to avoid being bored in the daytime, I hoped to spend some time joining some interest classes. On that particular day, Susan [the worker] told me that there would be an interest class on*

> *drawing that was specially designed for people with mental illness. I felt so excited and then I immediately wrote down my name for programme registration."* (Participant Eddie)

Research participant May also shared her stories on rediscovering an old interest in music appreciation a few years after the onset of her illness. Whilst spending a lot of the daytime in various skills retraining programmes, May wanted to spend some time relaxing. Accordingly, she restored her interest in music appreciation, and stated the following:

> *"I love music, especially classical music. It was because I grew up in a traditional girls' school in which many classmates could play musical instruments … I did not play any instruments but I loved to be an audience member … I then started to pay attention to various musical performances. I would go to the Cultural Centre to look at posters, I would go to City Hall or a concert hall for some free evening [performance] sessions. I would also bring some CDs as well … Now, I have a small CD case in my bedroom for storing recordings … I feel my life is more balanced now … I love classical music. It is so wonderful and peaceful."* (Participant May)

Besides sparking old interests, motivation can also be seen in the form of sparking new interests. Participant Leo, as a young adult in his early 30s, has no experience in balloon-twisting activities. With a desire to become a centre volunteer for a Christmas programme, he planned to learn funny handicrafts so that he could play with the audience in the Christmas programme. He stated the following:

> *"I never thought that I could do some balloon twisting. I used to think that balloon twisting was just for young children … One day, the [halfway] house staff showed me something about twisting objects and I was so surprised. Then I started to learn it myself, and twisting became my new interest … In order to improve my twisting skills, I would go to YouTube for some clips that could tell me how to make funny objects, such as Mickey Mouse."* (Participant Leo)

Willing to Try: The second phenomenon the participants revealed about hope and motivation was willingness to try. For those with mental illness, sometimes the most obvious weakness is giving up; giving up prematurely would not bring about success but failure. Goals and motivation, however, could mobilise better willpower to try something new, and a better 'yes' to their life. Participant Sunny stated the following:

> *"When I hope for something, then I would like to have a try, even if I don't*

> *know what the result will be."* (Participant Sunny)

Participant Leo once shared his story about becoming a peer counsellor for other mental health service users:

> *"At the beginning, I simply just wanted to have a job other than sheltered work, and they [a worker] often suggested to me to become a peer counsellor. I never thought about this as I didn't know if I was able to do so or if I would like to do so. However, I thought, 'Why don't I have a try first? At least it was a paid part-time job that matched what I was looking for'."* (Participant Leo)

Not only did Leo agree that willingness to try is motivated by hope, but participant Hubert also shared a similar story. Hubert stated how hope to work as a lifeguard like his brother motivated his willingness to take the first step. Hubert stated:

> *"After becoming a certified swimming coach, I started to teach swimming individually by myself. One day, when I walked around the swimming pool, I saw a lifeguard who looked a little bit like my brother. Suddenly, I hoped I could be a lifeguard too … I didn't know if it would be beneficial to my present job, but why not have a try. Then I took action to fulfil that dream … It was because I was already a swimming coach that I eventually*

> *passed the lifeguard examination a few months later without great difficulty."* (Participant Hubert)

According to our participants, hope-related motivation not only generated the willingness to try but also the inclination to try again when experiencing failure. Most often, the motivation to try again is equally as important as being willing to try in mental health recovery. The following excerpt was given by participant Charles:

> *"I always had a wish to complete my high-school education, but the onset of mental illness pulled me off from education. I once tried to retake Form 7 and the open examination a few years ago but failed. However, I thought I should not give up [my dream]. Then I retook the examination and finally got a full pass."* (Participant Charles)

A similar story was also shared by participant Michelle about learning a Chinese input method for the computer. She stated:

> *"If you want to work as a clerk, you need to know Chinese input for a computer. At the beginning, it was too difficult for me; I needed to memorise a lot of radicals (部首) and type them correctly. The training was indeed too far advanced. There were too many reasons for me to give it up. However, I just kept trying and retrying."* (Participant Michelle)

Continuous Involvement: In psychology literature, the best-known consequence of motivation is persistence. Participants in this study also reported similar experiences about how their motivation and hope-related goals resulted in their continuous involvement with something. The following excerpt is given by participant Eddie:

> *"I have joined the self-help group for many years … it is my determination to keep on assisting the centre to carry out empowering actions to fight for the rights of people with mental illness. Running a self-help group is not easy but it is the only way we can speak up for ourselves."* (Participant Eddie)

Participant Yuki is one of the participants who remained in a paid open-market job for many years. As stated, credit should be given to her boss and colleagues who created a supportive working environment for her. However, she proudly asserted that half of the merit of this continuous involvement came from her own persistence and effort. She stated:

> *"At the very beginning, it was really not an easy thing to take up the job,*

> *and in your middle [years], you have a lot of excuses to quit work and live on welfare money again. What motivated me to go through these years was my effort and simple wish at the very beginning: to get a job."* (Participant Yuki)

Sub-theme 3: Transcendent Effect

This sub-theme centres on participants' descriptions of being able to go through difficult moments related to illness, as well as their normal life stress. Frankly speaking, a major proportion of the transcendent-related experience induced by hoping was found to be related to recovery from mental illness. Literally, the word "transcendent" means to go beyond limits and to surpass. Through the analysis of their expressions, the following first-order themes within this sub-theme emerged: (a) *Hang On*, (b) *Tolerated Dislike* and (c) *Make New Meanings*.

Hang On: This first-order theme, hang on, centres on participants' experiences of 'just stay there' whilst having hope in the form of believing that something good would eventually come. Simply put, believing something good will come is the source of our ability to 'just stay there'. As mental patients suffering from schizophrenia, most participants reported that they experienced a lot of bad times in the recovery process and, most of the time, there was nothing that could be done with the situation. According to participants, the most common unchangeable bad times for them were the symptoms episodes — either in exaggerated or residual form, as well as hospitalisation and being discriminated against, etc.

Participants Sunny, Michelle and Yuki agreed that ‘just stay there’ referred to a non-fighting but non-surrendering attitude in facing the bad times. Michelle described her ‘just stay there’ experiences quite clearly: “It is just like you grasp something when you fall down and you just hang on there. You are able to climb up and so you stay there, but at the same time you don’t give up holding something.” Participant Sunny agreed that the transcendent effect brought on by hoping and believing would not lead to actively striving against the situation. In contrast, you just stay there. Michelle placed more emphasis on the concept of ‘don’t give up’ than just staying there. For her, giving up was surrendering herself to the difficulties. For her, ‘don’t give up’ meant everything would continue despite difficulties. By using her own experience of working with her psychotic symptoms, Michelle illustrated what is meant by ‘don’t give up’:

> *“I used to have some crazy thoughts [delusions] going on in my head and sometimes they were quite annoying. By having hope that the ideas or voices would go away, I kept on doing what I was doing, for example, cleaning my house. The ideas and voices did not go away immediately, but I stayed there too … to fight meant that I should find a way to stop them [thoughts], and to surrender myself meant that I should stop my cleaning work.”* (Participant Michelle)

When discussing their experiences of dealing with hardships, participants May and Sunny emphasised the experiences of ‘waiting’ and of hanging on. May reported that in the very first year of having schizophrenia she experienced a lot of abnormal subject experiences and felt very anxious. By having the hope that “it was already the worst time of my life, why don’t I wait for something good to come.” May emphasised that:

> *“I tried to tell myself that everything would be okay in the end, maybe in half an hour, maybe minutes later. All I had to do was to wait for that peaceful moment to come*.” (Participant May)

Tolerated Dislike: The second first-order theme of the sub-theme transcendent effect is the ability to tolerate dislike. The ability to tolerate dislike is amazing because you can still keep disliking something but you 'just don't mind' if it appears in front of you. For example, you might dislike dogs and cats but you don't mind walking with a close friend who brings his pet with him; you just 'don't mind' it. Participant Eddie described his 'just don't mind it' experience when recalling an unhappy hospitalisation experience and how he went through the hard time. He stated:

> *"No one wants to be restricted in the hospital. Life was so boring there. Even though sometimes I was quite confused by my delusional thoughts and thinking, I would have a clear mind some of the time, then I felt so bored. You can do nothing there unless you are permitted to do so. The ward nurses — some of them were good, but some of them were bad — made the final decisions about your living in the ward. As a patient, you could hardly reach the doctor to discuss your situation; all information was directed to the nurses' station; the environment and system were so restricting and closed; and living in such a place for months could make you really crazy and aimless. The toilet was smelly and dirty as well. Of course, I didn't like that situation but there was nothing I could do for that as well. Nevertheless, by believing that my symptoms would eventually go down and knowing that the short-term hospitalisation was needed at that time, I just didn't put those things into my mind and just*

stayed there." (Participant Eddie)

One participant, Michelle, shared that good strategies for facing her dislikes during bad times were to keep them 'out of your sight'. She stated: "It was very effective if you just couldn't get them out; then make it out of your eyesight." She shared a negative experience about a big family gathering and finding out that someone was not friendly; Michelle felt that the person had made fun of her mental illness. Michelle said:

> *"Sure, such a feeling was not from my paranoid ideas as my mother felt the same way. She asked me if I was okay on our way home … That guy just kept asking me something about my job, my illness and planning so loudly and publicly. He had a lot of comments about welfare benefits in Hong Kong, and implicitly looked down on me as a person with mental illness who was wasting too much welfare money. I was so embarrassed and so was my mother, I think. If it were a big family gathering and I could not get out from that roughly, I would just turn away and walk towards somewhere far from him a little bit. When we started to eat, I got a seat at another table with my mum*." (Participant Michelle)

Make New Meanings: This first-order theme contains expressions of the participants in terms of how they were able to make new meanings associated with having mental illness. In fact, as revealed, the relationship between hope experiences and meaning-making behaviours is reciprocal, where hope experiences uplift participants' ability to establish new meaning from their situation and vice versa. Participant Eddie stated the following:

> *"If we are not so sad and hopeless, we can think in a positive way and be able to see the world from different perspectives."* (Participant Eddie)

In a similar way, participant Sunny stated the following:

> *"If I feel hopeful about my future, I am able to accept myself and my illness … and sometimes I am able to view things in a new way and not be fixed by negative thinking. In fact, I don't like negative thoughts anyway — they keep me sick."* (Participant Sunny)

Almost all participants shared their meaning-making experiences in recovery from their mental illness. Participant Leo used the word "challenge" to make sense of his experience during the illness. He stated:

> *"My [mental] illness is a challenge for me and I have to face it. Actually, we have different challenges in our lives, right? And my illness is one of them only and I should not give up and be beaten."* (Participant Leo)

In establishing new meaning towards her difficulties whilst having a mental illness, participant May provided the following excerpt relating to family:

> *"Maybe … I think it was a chance for me to see my family in a different way. Before I got the illness, I used to keep myself too busy in work and was distanced from my family. When I got the illness, I felt caring from my family and they were so lovely … It was a chance for me and my family to go hand in hand. I never forgot their care for me."* (Participant May)

Leo stated something related to having a new understanding of his family:

> *"I never thought that we could be so close … and thanks to my sister who cared for me and supported me in the last few years. I used to be a rough guy with limited emotions, but now I have changed … [my] illness has given me a chance to get close to my family and have a new era of family life."* (Participant Leo)

Two participants, Charles and Yuki, used the word "holiday" to describe their experience of mental illness and hospitalisation. Charles stated:

> *"When looking back, being a person with schizophrenia is not easy … It is just like having a long holiday in your life … 'holiday' means that you are out of your busy life for a while and then you come back and then go on … thinking in this way makes me less stressed and less sorrowful, as the holiday will pass one day."* (Participant Charles)

Yuki used the word "holiday" in the following way:

> *"For me, living in the hospital could be viewed as having a holiday. In the hospital, I didn't have to work and had nothing to worry about. I would watch television and sleep peacefully. Actually, if you take it easy, you can see that hospitalisation is not really a bad thing in recovering from the [mental] illness."* (Participant Yuki)

The following is an excerpt provided by Eddie, who stated that he acknowledged a new meaning of his life as a mentally ill person. The new meaning of his life is to help others:

> *"I think I got a new mission in my life: to help others, mainly people with mental illness. It is a new mission [assigned] to me, a calling, that I should use my experiences to help others who have the same illness … they need me and I need them too … Someone needs to be the first one to help and*

now I think that mission is assigned to me." (Participant Eddie)

Theme Four: Strategies of Hope

Strategies of hope, the fourth overarching theme, address participants' descriptions of how people diagnosed with schizophrenia could improve their sense of hope through their own actions. All participants agreed that hope could be nurtured and instilled through dynamic interaction between their behaviours and the surrounding environment.

Sub-theme 1: Adjustment

The following first-order themes seem to be important in giving details about the concept of adjustment as strategies of hope: (a) *Lower Expectations and Be Realistic*, (b) *Focus on Personal Strengths*, (c) *Appreciation*, (d) *Wish Fulfilment* and (e) *Adjustment to Age*.

Lower Expectations and Be Realistic: All participants stated that making adjustments by lowering their own expectations is a must in order to have more hope. Participant Eddie stated that "you can't aim too high now. You should be realistic or else you gain nothing." Eddie explained that he used to have a lot of personal dreams about his future; now, however, whilst living with the illness for years, he has learned about 'not aiming so high'. For example, in order to avoid insomnia, which would in turn elicit a bad mood, he gave up the idea of having long visits. Now, paying a weekend visit to a rural park would make him very happy. With a similar experience in lowering expectations, another participant Michelle stated the following:

> *"Originally, I was very eager to get married and have my own family. However, it is not a must now. It is good to be realistic about this matter … Years ago, I still hoped that I could get married before the age of 40, but I don't have that hope now. Even if I remain a singleton for a long time, it's okay."* (Participant Michelle)

Participant Leo shared a similar experience in lowering his expectations of 'job nature' when finding a job on the market. After being discharged from the mental hospital, Leo originally opted to apply for office jobs, meaning he could stay off the street, have his own seat and be responsible for some clerical work. However, due to keen competition in the market, it was not easy for him to make it. Leo then became more realistic in 'opening up' himself to any ‘nature of job’ that was available to him and which could keep him busy in the daytime. He stated: “Having a job means that you are still valuable and idling is boring.” In fact, Leo was quite satisfied with his current job as a mental health peer counsellor, which has flexible working hours and touring around different service centres. Participant Charles revealed his experience in being a realistic guy in terms of ‘job salary’. Charles agreed that finding a job with a high salary was becoming more and more impossible at his age and with the illness. Being a father of young children, Charles agreed that ‘stable income’ was more realistic than wasting time looking for a job with a high salary. He stated: “It is just a game of calculation: a stable income for 12 months is better than a high salary for just for 3.”

Focus on Personal Strengths: Living with the mental illness for years, our participants agreed that they had already spent a great deal of time coping with the illness and got used to it. As a result, they all agreed that they had lost their golden age for personal growth, and that such opportunities would never come back. Participant Hubert alleged that people in similar circumstances should not waste time in aiming for something too high and which is not attainable. The better solution is to develop ‘what you have’, which should be ‘your personal strengths’. Personal strengths mean you are ‘good at something’. He stated: “I should thank my brother who inspired me to work as a swimming coach, which fits my ability. I started swimming for years and I love swimming too … Things will become easier if your expectations and wishes fit what you can do and are able to do.” Another participant, May, claimed that she was a good listener and excellent with documents before she suffered from schizophrenia. She said that, luckily, the illness did not take away her capabilities in these ways, and now she was “proud to work as a mental health peer counsellor, which requires both skills I am totally capable of.”

Appreciation: All participants agreed that appreciation involved ‘appreciating what you have’. Participant May said that it was an attitude worth having; with this attitude, you can find that you are already lucky or rich in some aspects, which is worthy of appreciation. For her, it was not until two or three years after she became ill that she started to appreciate what she had. She gave her examples:

> *"I should be thankful for what I have at present. For example, I am living in a flat owned by my family and it was free for me. I told myself that I am already too lucky in having such as stable living place, which is good for my mental illness."* (Participant May)

Participant Michelle also shared her appreciation of what you own helps you to 'remember' what you already have, and how it worked in making her feel more satisfied with her life. May shared a very similar experience in 'remembering' and appreciating that she has a good family. She stated: "It was so lucky to live in the house with them as they gave you a lot of support." Participant Herbert also appreciated that he had 'a supportive brother' who guided him and taught him to come out of isolation. Likewise, participant Sunny strongly appreciated that he 'owned' a family and was supported by his wife in many aspects. He stated: "It is the greatest gift to my life. I ask for no more."

Participant Yuki added the concept of appreciation of the 'present moment', reflecting her attitude towards daily living. In different interviews, Yuki stated how you should love to appreciate every present moment. She stated:

> *"Besides the appreciation of what you own in your life, I also try to appreciate little moments of living every day. For example, I will be happy to have a cup of good Chinese tea, or spend some happy hours with a friend just for some window shopping (I have no money), or even I am happy to talk to you [the researcher] today."* (Participant Yuki)

In line with the attitude shared by Yuki, participant Herbert expressed the experience of 'appreciating yourself' in making his mind peaceful. He stated: "You are the only one you can love and appreciate yourself, then why hate yourself? I did not intend to have schizophrenia; I don't want it too. Out of this misfortune, what I can do is to appreciate myself and do something good for myself." Actually, Herbert was a young man who ate and dressed well so as to keep himself comfortable and healthy. A similar self-appreciation attitude was reported by participant May. May was a lady with an elegant and tidy appearance. May admitted that she showed her appreciation of herself by buying beautiful but not expensive clothes. She loved to have a good, healthy outlook, and most often she could earn appreciation from others too. Participant Yuki performed her self-appreciation by eating. She loves delightful desserts and she used to go and buy some for herself for appreciation and reinforcement.

Wish Fulfilment: In order to ‘create a feeling of success’, participants alleged that they had to ‘create chances for fulfilment’ by adjusting their wishes. The condition of wish fulfilment was possible ‘when goals are concrete’, ‘when goals are attainable’ and when ‘they are able to’ make the fulfilment occur and happen in real life. Good experience in wish fulfilment ‘will bring satisfaction’. Most importantly, it will ‘bring self-satisfaction’ and was down to the participants themselves in making it happen. The ‘sense of urgency will increase too’. An increased sense of urgency will make you ‘believe that you are capable’ of bringing about changes; this self-belief is closely linked with hope experience. Participant Eddie was a smoker and not good at art; however, he was invited to join a drawing class and began to love drawing. He once shared that he felt happy and proud when completing a good painting. He appreciated himself for making this happen, and he ‘knew that he was a capable person’ and he was ‘ready for a new challenge’.

Adjustment to Age: Our research participants were of different ages, and they needed to ‘take the age factor’ into account when adjusting themselves to different personal goals. For example, participant Sunny, who is 50, claimed that he tended to slow down his pace and expectations because he was approaching the age of retirement — it was time to time: “to prepare for life after 60 since there could still be 10–20 years of life to come before I stop breathing.” Participant Charles said that he needed to ‘adjust his plans to his family life cycle’ instead of his age because he put great emphasis on family plans beyond his personal interest. All participants agreed that at a ‘young age they could hope more’ as it was a period full of energy, and when they approach their old age, they were less inclined to hope in order to ‘preserve energy for major goals’ only.

Sub-theme 2: Staying with Others

The following first-order themes have been found to be good enough to explain the sub-theme, staying with others, and its benefit for hope experience: (a) *Being Alone is Risky,* (b) *Learn from Others* and (c) *Seek Help from Others.*

Being Alone is Risky: All participants were open-minded and happy; none of them would have significant difficulties in being with others. They agreed that being with others was good, as being alone was too risky, especially for those with schizophrenia. Participants expressed that being alone was just 'fight alone' (單打獨斗) and had 'high chances of failure'. In actual fact, individuals would be 'too exhausted' to do things alone without help from others. In addition, various life challenges and personal difficulties 'could not be solved alone'. Participant Sunny, who was quite educated with a master's degree, said that:

> *"It is never possible to know the whole world. Impossible. The more I have studied, the more I have found that I don't know. You can never work alone, it's better to have somebody next to you. In fact, there is no need to be so alone in the world."* (Participant Sunny)

In addition, some of them agreed that their mental health condition would get worse if they were alone. For example, participant Eddie stated that he would 'have more time for irrational thoughts' when alone, and participant Yuki, who suffered from residual hallucinations, stated that in a ‘too-silent world’, she would have high chances of ‘hear[ing] some strange voices’ and therefore preferred to stay with others if at all possible.

Learn from Others: From the data analysis, it could be found that participants would like to learn from others to solve their problems, to know more and to increase their sense of hope. There were two kinds of learning from each other: ‘direct learning’ and ‘indirect learning’. ‘Direct learning’ includes the directive ‘asking how’ and ‘asking what’. For example, participant Hubert stated that he found a new coach for fitness, which involved some good physical moves that were quite useful for his further teaching. He would ‘copy’ those actions first and then finally ask how to do them. Similarly, when participant Charles had problems in childcare, he would seek help from someone and ‘ask how’ to apply a better method. Participant Leo once shared an experience that he found himself in a ‘situation and did not know what to do’ in the new halfway house, and so he opted to ‘observe’ what other residents did and how they arranged their daily activities in the house. Once, however, he needed to double-check how he could go to the nearest health clinic and he directly asked others how to get there. Participant Sunny also stated that 'for a better life we should 'learn from others' successes' as well as to 'learn from others' failures'. Learning from others' successes would give hope; and you learn from others' failures to allow you to 'avoid making the same mistakes'. Participants Michelle and Yuki both mentioned that, in order to remain hopeful, they should also 'learn others' hopes'. For example, Michelle has some very close friends who also suffer from mental illness, and sometimes they just chatted with each other about daily living, dreams, plans and hopes.

Seek Help from Others: For those with mental health problems, help from others is very important; they would seek help just because they are not able to deal with the situation. For example, they would 'ask for physical help' for house removal. Participant Charles, a father of two children, would occasionally 'ask for financial help' from good friends or relatives if needed. Participant May, who loved artwork and had no idea how to paint new things, would go and 'seek comments' from others in order to widen her perspective. Almost all of them had experience in 'seeking others' comments on making choices' and they would ask for comments on various things, ranging from ‘clothes choices’, ‘job choices’, and even ‘drugs choices’ in the process of mental illness recovery.

Participant Yuki stated that those like her who were suffering from mental illness were sometimes ‘too shy’ or ‘ashamed’ of staying with others or maybe just ‘afraid of being rejected’.

Sub-theme 3: Empowerment

This sub-theme reveals participants’ experiences of empowering themselves in order to avoid feeling hopeless and have a better sense of hope in recovery. The experience of self-empowerment and self-assertiveness was widely shared by all the participants in different research interviews. As reflected by the data, the relationship between hope and empowerment is reciprocal: if you hope for something significant, then you will be more willing to take self-empowering acts or assistive acts to actualise that hope. The more you can actualise your hope through the use of assertive behaviours, the more you think life is hopeful, and you are more willing to hope more. Participant Eddie once made a very good statement on empowerment and its relevance to mental health recovery. He remarked the following:

> *"Empowerment is a lifelong business for all people with schizophrenia, including me. I can hardly imagine that if we the patients did not speak up for ourselves, who will?"* (Participant Eddie)

From the data, the following first-order themes emerged to represent the ideas of empowerment and their relationship with hope experiences: (a) *Speak Up for Yourself* and (b) *Speak Up for Ourselves*.

Speak Up for Yourself: This code focuses on participants' self-empowering or assertive behaviours that occurred during their recovery from mental illness. In the research interviews, all participants shared their valuable stories on how they acted in order to be self-empowering or assertive in their real life, but not all shared episodes were specifically related to their individual recovery experience. As a result, only related conversations and expressions were coded for analysis.

All participants reported that they have had experiences in making complaints or various other assertive requests to somebody relating to their illness and recovery. The concept ‘right some wrongs’ was quite explicit, which gave the rationale as to why assertive acts were needed: you are expecting something or hope for something, and eventually you find that something goes wrong or goes in a different direction than expected, which forms a reason for being assertive. As stated by participant Herbert: “As mental patients, we are okay about avoiding too many conflicts. However, in some situations you should speak up for yourself to right some wrongs because those wrongs will affect you.” For Herbert, as expressed, being a mental patient already had high chances of encompassing too many ‘wrong’ things in life, meaning that he should learn to do something to right some wrongs that, in nature, could have been avoided. Participant Leo shared a personal story of making a complaint, where some wrongs should be corrected by using the voice.

> *“I was once told by my case nurse at the mental hospital that I had been recommended to move to the discharge unit the next week as I was fit for pre-discharge training. What he [the nurse] would do was to put my name on the transfer list, and once there was a vacancy, I would be the first one to move to the discharge unit. However, later I found out that this was not the case as one of my roommates in the*

> *ward had moved to the discharge unit a few days later, not me. It was not what I had hoped for. I tried to contact the case nurse for an enquiry and he reported that my name was mistakenly missed in arranging the transfer and it was his personal fault for not making the proper documentation. I was not really angry about that as the case nurse is a good man. However, I eventually made a complaint to the case medical officer to right this wrong. There was nothing that they could do to change the situation as that vacancy was filled, and all I had to do was to wait. The case medical officer replied that their team would be more careful in handling this kind of issue in the future and would not make the same mistake again."* (Participant Leo)

Participant Yuki also agreed that people tended to become hopeless when too many 'wrong' things happen in their lives, meaning individuals need to do something to right the wrongs. She was once promised a certain salary adjustment in her second contract and was hoping for it to materialise; however, the new supervisor forgot and Yuki acted to achieve the promised salary. Yuki stated: "Though it was just a few hundred [dollars], as a mental patient who was scared of recourses, that kind of mistake should be avoided."

In line with what participant Eddie mentioned, participants Charles and Leo asserted that 'actual changes' were only possible when you spoke up for yourself or else nothing would happen; issues would be missed and ignored, and would go unaddressed. They both asserted that individual rights were highly vulnerable in any bureaucratic system. For example, in the medical system in which different parties work in separate manners, if you want to make ‘actual changes’ to right a wrong, you are only an agent presenting your interests. Participant Charles shared a personal story about his request to use new psychiatric drugs years earlier. He stated: “I heard about the use of new drugs in public psychiatric clinics and, in fact, some pamphlets were available at the patient resources centre. However, no one talked to you about this; all you had to do was ask. However, based on many reasons, the psychiatrist would tell you that you might not be eligible for using the new drugs as they had a policy governing the prescription. After making several enquiries and initiating discussions with my attending psychiatrist, I am now using [the new drug] Risperidone with limited side effects, and I am happy for that.” Likewise, participant Leo reported that actual changes could only be brought about by action but not through passive waiting. In applying for the halfway house service for discharge, Leo said that he was the one who actively expressed his views and sought to plan his rehabilitation plans but did not wait for arrangements to be made by others. He stated: “If you don’t ask for yourself, they would just plan for you in their own way.” Leo also revealed that in the halfway house he was the first one to raise his hand as being willing to work as a peer counsellor, and now he was quite happy with what he chose for himself. He added: “It was a little bit, as some mental patients were still willing to wait and see what would be arranged by others.”

In relating their assertive experiences with their hope experiences, participants also stated that assertive behaviours could bring about ‘positive effects in increasing self-belief’. As alleged, self-belief is a belief in one’s own capabilities and in the ability to make changes. Both participants May and Sunny described how their assertive experiences enhanced their self-belief. May stated that, as a mental patient, she was too scared to try new things at the very beginning; however, after joining an interest class that she enjoyed very much at a community centre, she started to ask for more and became more assertive in utilising a disability job retraining course to equip her. May stated that she once asserted her rights by discussing the course refund policy, and eventually they made some amendments to the attendance requirements and became more flexible in allowing trainees to attend multiple medical follow-ups if needed. As stated, May became a woman with more confidence and more self-belief in her own abilities; now, she has become a peer counsellor. She said, “You believe in yourself and you hope before you can help others.” Sunny agreed that to ‘speak up for yourself’ and ‘actual changes’ were good stepping stones for building up self-belief amongst mental patients. Sunny described his improvement in self-belief after seeking to take the initiative in planning his study path in Chinese. He said that the more successful experiences he had in initiating a progress in his life, the more self-belief he had, and he could have more hope about the future. He admitted that it was a ‘learning process’.

Speak Up for Ourselves: This first-order theme, speak up for ourselves, encompasses the participants’ overall experience of joining various self-help groups or collective actions to speak up for the rights of people with mental health problems. Half of the participants reported that they have a history of joining self-help groups or similar self-help activities. Participant Charles said that various types of self-help activity were launched by different welfare agencies in Hong Kong, and it was not too difficult to join any of them. Participants Eddie, Yuki and Michelle were members of different established self-help groups in Hong Kong. Eddie emphasised that the experience of ‘speaking up for ourselves’ and ‘speaking up for yourself’ are just the two sides of a coin; however, personally he recognised that self-empowering behaviours would never be adequate enough to ‘strive’ for benefits for mental patients as a disadvantaged group. He stated: “You just can’t expect those policy makers would spend good time in learning about your situation and give you a helping hand. For example, you can see how many years we [service users] have spent in striving for welfare discounts for public transportation.” Eddie further admitted that some hopes or dreams were ‘too big’ for individual actions and thus collective efforts were needed.

Yuki and Michelle described their experiences, and stated that ‘social consciousness is learned by joining’. They both shared experiences of ‘learning’ to be more conscious about their own welfare rights in society. Yuki made the following statement: “I have opened my eyes by joining those mutual help activities or collective actions. At the very beginning, I was not used to it. But through the years I started to learn that participation is important and we, people with mental illness, should stay together to change the social [macro] environment.” Michelle reported that she also learned to be more aware of policies related to mental recovery and her own (patient) rights in the welfare and medical system. She stated: “Learning is gained by my participation in those mutual-help activities and by learning from each other in the group.“

Theme Five: Relationship Quality

Relationship quality — the fifth overarching theme of thematic analysis — is significant in highlighting how the relationship quality experienced in the stage of recovery from mental illness shaped the total experience of hope. The following sub-themes have been identified during analysis in an effort to describe the relationship between relationship quality and hope experiences: (1) *Family Care* and (2) *Professional Care.* Individual sub-themes will be thoroughly discussed in the following paragraphs.

Sub-theme 1: Family Care

For the participants, family plays an important role in their experience of hope in recovery from their mental illness. Participants Hubert, Eddie, Michelle, May and Yuki were all single, whereas participants Sunny and Charles were married; however, all of them used to live with their family and had no doubts that family interaction and family communication inevitably affected their recovery from mental illness, as well as the related hope experiences. From analysis, the participants all agreed that ‘supportive family relationships are preferred’ and ‘conflicting family relationships bring more harm.’ Altogether, there are two important first-order themes that can enrich the sub-theme of family care: (a) *Family Security* and (b) *Family Belonging.*

Family Security: For all participants, good family relationships are most preferable in enhancing their mental health condition as well as their sense of hope. Supportive families provide a sense of security that the family is a ‘safety net’ for its members. Participant Michelle stated the following:

> *“In there, you always feel safe because there is nothing you are unfamiliar with. And vice versa: you know everything about the family and the family knows everything about you too*.” (Participant Michelle)

Participant Leo, who lives in a halfway house, was always eager to be with his family because, when entering the door, ‘there are all known faces’. Participant May had the same experience:

> *“You always know whom you are talking to, there is no stranger and you have nothing or anybody to avoid or to worry about.”* (Participant May)

Participant Sunny has been married for a few years and moved away from her family. She expressed family security in this way: ‘house move, but family is always here’. Participant Charles said that family was a place ‘with permanent relationships until you die’. He remarked:

> *“In my family, we all share the same family name [surname], we are all family members, and this relationship will stay forever. I am the father of my sons and my sons are always my sons*.” (Participant Charles)

Participant May, who has lived with her family for a long time, described how family serves as a ‘place for you to hide from rainstorms’. She stated: “My family protected me starting from the first day I got my illness and I am deeply grateful to be so loved there.”

Family Belonging: For our participants, good family relationships provide them with a good sense of belonging. Participant Leo said his family gave him a sense of belonging as the family is a place to which ‘he already belonged’. Participant Michelle alleged that belonging ‘means there is a place for you’ and there will ‘always be an open door for you’. Participant Eddie expressed that family members ‘have the same last name’ and this ‘inevitable relationship’ provides a ‘shared identity’. Participant May provided a good statement about the domain of belonging:

> *“[Family] belonging means when you go home — whatever time you go home and however long you have gone — no one will question why you are there.”* (Participant May)

She also expressed that family will ‘never give up on you’ if you need them. She stated: “My case is a good example to illustrate this point.” Participants Sunny, Hubert and Leo also revealed that their families could provide a sense of togetherness when they felt lonely or isolated. Sunny remarked:

> *"When we [the family] sit together, like watching television, there is a sense of togetherness in the house. We are a team and we stay together."* (Participant Sunny)

Commenting as a husband and a father of two children, Charles stated that what family can give you, 'friendship can never give you'.

Sub-theme 2: Professional Care

This second sub-theme of relationship quality reveals participants' experiences of receiving professional care during their process of recovery from mental illness, as well as the sense of hope and how this would be affected. Four first-order themes emerged from the data, namely (a) *Attitude*, (b) *Information and Guidance*, (c) *Availability* and (d) *Consistency*.

Attitude: All participants had adequate experience in working with different professional staff in the mental health system and the welfare system. The professionals may be psychiatrists, family doctors, psychologists, nurses, social workers and personal helpers, etc. According to their experiences in working with the helping staff, the participants all agreed that a ‘caring attitude’ is important. Participant Eddie said that caring means he or she ‘wants the best for you’ but not the best for themselves. As stated, he had witnessed a lot of care staff in the mental health setting who ‘cared about their procedures, system and duties but not your situation’. Participant May said that a caring and positive staff member is better, and only in this case can a patient ‘learn hope from them’. As a patient diagnosed with schizophrenia, Leo said that he found helpful staff with ‘non-discriminating attitudes’ could earn cooperation from service users, and stated that for most of the time ‘our attitude was our response to their attitude’.

Information and Guidance: Participant Charles hoped that all helping staff would have ‘updated information’ and their ‘own quality information’ for their work. He also stated that he had a very good feeling with social workers, and he would always ask them to ‘tell more to inspire me’ for more thinking, resulting in his learning a lot. He especially remembered a moment they shared concerning the new function of a modem mobile; starting from then on, he would occasionally buy mobile magazines for self-reading. Participants

Yuki, May and Michelle shared the same feeling, stating that a helpful professional should speak to service users in a way that ‘information should be understandable’.

Availability: Participants Leo, Eddie, Charles and May all had frequent contact with professional staff, and they all found that they were too busy and this made them not always available to hospital patients when needed. Eddie spoke of an experience in the hospital ward:

> *“When you were being hospitalised, it was hard to reach your social worker who was in charge of your service application and welfare application. What you could do was to leave them messages, but you couldn’t expect that there would be a reply shortly.”* (Participant Eddie)

Participant Leo also conveyed a similar in-patient experience, adding the concept of duration of availability:

> *“Throughout the whole period I was living in the mental hospital, I just met my social worker two to three times. He was a good man, but I could not reach him until he came to find me for some purpose. Nevertheless, he could only stay with me for 10-20 minutes and then he needed to do some other duties … There was no time for us to get to know each other well.”* (Participant Leo)

Consistency: This first-order theme, consistency, reflects participants' desire to have a continuous relationship with their corresponding care staff. Care staff could be psychiatrists, psychologists, nursing staff, social workers or any other allied health professionals. The following definition of care consistency was provided by participant Michelle:

> *"Continuity is having a stable working relationship with someone [care staff] without frequent changes. For example, I can see the same doctor [psychiatrist] for a long period of time."* (Participant Michelle)

Another definition was provided by participant May, using her relationship with a family doctor as an example. She stated:

> *"Continuity means that my case has been followed up by the same person through the years. For example, I have a family doctor who has a clinic next to my building and I used to go to see him for minor health problems. It has lasted almost ten years."* (Participant May)

Continuous relationships with care staff could bring about many advantages for those people with mental illness, especially for those people with schizophrenia who are relatively vulnerable to relational stress. Participant Eddie provided the following statement:

> *“As for me, I was so lucky to see Dr. Chan continuously for a few years after the onset of illness. Seeing and talking with a familiar face in the out-patient clinic made me feel safer mentally.”*(Participant Eddie)

Participant May also stated that she had experienced this psychological benefit by seeing the same female psychiatrist for years, especially when her mental condition was not very stable. She added:

> *“When you are quite confused about everything, about yourself and about the illness, you hope to see the same doctor continuously. It could at least give you some sense of stability and security.”* (Participant May)

Participant Yuki conveyed a similar expression on the advantages of the continuity and consistency of care:

> *“For me, a sense of being understood is the advantage of having someone [care staff] to rely on. Whilst I was living in the halfway house years before, I was so glad to have a prolonged relationship with the [female] officer in charge. She knew me so well, everything.”* (Participant Yuki)

For those who are recovering from their mental illness, having a stable and continuous working relationship with a rehabilitation professional is beneficial for going through ups and downs and complicated situations. Participant Michelle stated that:

> *"By having my social worker who knows me so well throughout the process, at least I could have consistent advice from the same person."* (Participant Michelle)

Sometimes, the advantages of having continuous care could be applied to the relationship with a care team, not only narrowly with a single care professional. The following citation was provided by participant Charles:

> *"In the halfway house, there was a team of workers, including social workers, nurses and wardens. Not all of them would stay with me throughout those years, but I got used to that team of people and had a good relationship with them as a team."* (Participant Charles)

In addition, continuity of care also safeguarded the continuity of information and understanding between those with mental illness and the care professionals. Participant Sunny reported a bad experience of working with an unfamiliar doctor, who was newly assigned to him. He stated:

> *"First of all, I had to tell my stories and experiences again and then we started to have some discussions which have already been gone through a few months ago. By the end of our time, when I came out from the consultation room, I didn't think he knew whether I used to take oral medication or an injection."* (Participant Sunny)

Sunny also expressed his view of continuity of care:

> *"I knew a lot of external factors would affect the care relationship inside the medical system. However, a continuity of care is indeed desirable for people with mental illness."* (Participant Sunny)

Theme Six: Environment Opportunities

The sixth overarching theme mainly addresses participants' descriptions of their experience of environment opportunities in Hong Kong, and how this works in affecting their recovery from mental illness and the experience of hope. Three sub-themes are included (1) *Housing Availability*, (2) *Employment Availability* and (3) *Welfare Availability.*

Sub-theme 1: Housing Availability

Most participants reported that they were not very satisfied with their housing conditions, and in Hong Kong there were ‘limited housing choices’ and ‘limited housing space’. Participant Yuki was an exception as she was living alone in a singleton housing unit. For those participants who were living with their family, they all thought that the house was too small to contain all family members. Two concepts are elaborated here: firstly, they all experienced that the house was too small, but at the same time, society provides inadequate housing choices. As a result, all family members had to live together in a small house. Participant Leo, who was living in a psychiatric halfway house, admitted that his own situation was because he couldn’t live with his family but he had no other options, meaning that he had to opt for the halfway house service. He said: “In fact, I have to think about my housing arrangement for the coming years. You know, the house rent is too high and you can only get a deprived environment’. He alleged that ‘over-crowded living’ conditions were not a contributing factor to recovery. All participants agreed that they could ‘only dream of having a good living place’.

Sub-theme 2: Employment Availability

Employment availability is the second sub-theme of environment opportunities. Altogether, four first-order themes best group the data and provide support for this sub-theme, namely (a) *Only Low-level Jobs,* (b) *Only Low Salaries,* (c) *High Competition* and (d) *Job Prospects*.

Only Low-level Jobs: Hong Kong is a society for those who are highly educated. For those individuals with lower educational levels and without professional status, it is not easy to get a job with gainful payment. Regarding the relationship between job nature and job availability and those with schizophrenia, participant Yuki remarked:

> *"When you are not a professional or you haven't gone to university, you can only look for manual work such as cleaning or a low-level clerical job that requires not so much skill. Without a good education, you can hardly find a place to stand safely in the [Hong Kong] job market. You can't hope for too much."* (Participant Yuki)

The following passage was given by participant Michelle, who told of a similar situation to those with mental illness and limited job choices. She stated:

> *"Now you need a licence or registration for doing everything. For example, you have to get a security guard licence before you can work as a watchman [security guard]. Then you have to join some courses and pay high training fees. I don't think people with mental illness have such big resources to go for the training, resulting in a very limited choice of jobs. There is limited hope for us."* (Participant Michelle)

Two of the participants, May and Leo, now work as peer counsellors at various mental health agencies. They were very happy with their present jobs, which are meaningful. However, they also noted that it was a type of voluntary job that could not be counted as formal employment. Leo stated:

> *"I am happy to work as a counsellor. However, by its nature, it is not a full-time job and we just work on a part-time basis, 2-3 half-days per week only … It is the only job available to me right now*." (Participant Leo)

Only Low Salaries: All participants conveyed that having a job with a reasonable salary was important in their road to recovery. For participant Yuki, whose income mainly came from her job but not welfare supplement, a reasonable job salary is important:

> *"If you get a job and have to live on it, you should be paid at a reasonable level. It is your own resource for real-life living."* (Participant Yuki)

Participant Sunny alleged that his monthly salary determined the resources level and choices he had available. He stated:

> *"My monthly salary determines how much I can spend on daily living. In addition, my salary level determines the choices available to me on the market. The more money I can have, the more material choices I can have for my life — unless everything is free."* (Participant Sunny)

All participants stated that those with mental illness should 'enjoy the right to have a reasonable salary' and 'no exploitation should be allowed'. Participant Michelle expressed that a reasonable salary should be able to cover the costs of doing the job plus the cost of basic living. She recalled a bad experience in working as a security guard at an old building with very a limited salary.

> *"The salary was so unreasonable; it was just enough to cover the*

> *transportation cost and meal cost of doing the job. Nothing was left. In such a case, you cannot earn a living by yourself."* (Participant Michelle)

According to the participants, beyond material advantages, a reasonable job salary could also elicit psychological advantages, such as an increased sense of self-worth, life satisfaction and job satisfaction. For participant Hubert, who used to have a full-time job in recent years, a reasonable and stable salary provides a sense of security in community living. He stated:

> *"For us [with illness], we need to have a stable living in the community. With adequate resources [from a salary], we can have a better choice of food, clothes and leisure without great worries and anxieties. That contributes a lot to our [mental] health condition."* (Participant Hubert)

The following excerpt was also given by Herbert, who referred to the core disadvantage of having a low salary. He stated:

> *"The obvious result would be low motivation to do the job, and resignation from the job is foreseeable."* (Participant Hubert)

All participants agreed that people with mental illness in Hong Kong could only reach out for jobs with a low salary confined by their job nature.

High Competition: When talking about their hope for securing employment, most participants expressed that they preferred a job not only with a reasonable salary but with certain stability. For example, the following passage is provided by Charles:

> *"It is good to have a job that you can work in for 12 months a year, but not two 6-month jobs … I used to have this kind of thing even if I joined the supported employment project a few years before."* (Participant Charles)

Participant Sunny stated that he preferred a job with prolonged employment opportunity:

> *"It is not easy to settle yourself into a job, you need to adjust to new colleagues and new job duties. It is not easy for us to make frequent adjustments."* (Participant Sunny)

Participants Yuki and Michelle also reported that they used to hope for a job that could allow them continuity. Yuki stated that job continuity could provide security in life. Michelle also stated that:

> *"If I can stay in a job for a few years, I will feel valued and respected. Having a stable job will give me better self-feeling and esteem. At least I will get out early in the morning and go home after the job, just like a normal person."* (Participant Michelle)

However, all participants agreed that it was not easy to get a stable job on the market as most companies only offered jobs on a contract basis lasting from 3 months to 12 months only.

Job Prospects: For the participants, job prospects referred to a foreseeable job future that they could work in. Charles expressed the following:

> *"I prefer a job with a good future, meaning that you know where to go and how to develop yourself, and then you can always hope for a better job position."* (Participant Charles)

With a similar meaning, participant Hubert made a similar point:

> *"I am a man who doesn't want to stop. I want to hope more in my job.*

> *When you can see the [job] prospects, you can have a goal, a personal goal that you want to work on."* (Participant Hubert)

Participant Sunny, who had a long history of open employment, provided the following passage in linking job prospects and a good future:

> *"As a general clerk, I can hope to become an executive officer with more salary and related benefits. As an executive officer, I can aim for the post of senior executive officer, with a better salary, of course. When I know that there is a chance out there — even if it is not possible at this stage — there is a goal to work on and there is hope."* (Participant Sunny)

Participant Leo, who was working as a part-time peer counsellor, also expressed concerns about his job:

> *"My job is meaningful, but it is just a part-time job and temporary job. I am okay with this job right now, but the future is still uncertain. The project will just last for three years, and then nothing. I love this job, but after I finish this one, I will find a job with a better future and more money."* (Participant Leo)

Sub-theme 3: Welfare Availability

Welfare availability is the third sub-theme of environment opportunities.

Altogether, two first-order themes best group the data and provide support for the sub-theme, including (a) *Financial Assistance* and (b) *Transport Supplement.*

Financial Assistance: All participants agreed that financial assistance was an important factor for successful community living. As alleged, all participants received either disability allowance (DA) or comprehensive social security assistance (CSSA) for living. Sunny, Charles, Yuki and Hubert used to live on welfare assistance before getting a full-time job. Meanwhile, Michelle, Leo, Eddie and May now live on CSSA whilst attending various kinds of rehabilitation services. Eddie provided the following passage related to financial assistance:

> *"It is a safety net for us, ensuring that we can have money to spend on basic living. It is important to us as people with mental problems, especially when we are in a state of difficulties."* (Participant Eddie)

Leo also stated the relationship between assistance and hopelessness:

> *"You can't face two life problems at one time. Firstly, you have to handle*

> *your illness and, secondly, you have to live a life. Without some financial support in that period of time, it can be really hopeless."* (Participant Leo)

In addition to the availability of financial assistance, participant Charles also alleged that the level of financial assistance affected their way of living and their sense of hope:

> *"The present level of financial assistance is just good enough to keep you from dying, but it is not a life with some quality. For example, you can just spend less than a hundred [Hong Kong] dollars per day for everything and it makes you feel stressed, but not peaceful or hopeful."* (Participant Charles)

Leo also revealed that:

> *"Living on CSSA is just better than nothing, it keeps you living. But you should carefully plan your spending. For me [living on CSSA], buying a good coffee in the afternoon means that I have to eat less for dinner. Sometimes I feel hopeless in this situation."* (Participant Leo)

Almost all participants expressed that the amount of financial assistance should support basic living plus extra resources for learning, which can lead to new experiences, new skills and then new hope. May stated the following:

> *"I went for a computer course on which I thought I could learn more. But at the rehabilitation unit there was a course fee. I was lucky to be supported by my sisters. Some of my classmates needed to pay by themselves if they were not supported by welfare money."* (Participant May)

Transport Supplement: All participants alleged that travel expenses were too costly in Hong Kong, meaning that going out into the community was not possible:

> *"Compare the situation in Shenzhen: the people there just need to spend one to two dollars for a public bus and five dollars for a whole MTR [Mass Transit Railway] journey. Travelling in Hong Kong is too expensive."* (Participant Leo)

Other participants stated that expensive travelling fees in combination with a lack of choice in public transportation further worsened the situation:

> *"When I have to go out from Tin Shui Wai to Tuen Mun for a peers gathering, there is in fact no other choice but only the MTR … the government withdrew bus services when the bus routes overlapped with*

> *the MTR service … The MTR is the single service provider in many [Hong Kong] areas*." (Participant Yuki)

Almost all participants stated that they enjoyed normal community life. By going here and there, they were able to mix with others, including mental health staff.

> *"I enjoy travelling alone on the bus as you can have good sightseeing of this city. I especially enjoy travelling by bus in the morning whilst the bus is not so crowded … I used to visit my aunt by bus and I loved that journey."* (Participant Michelle)

All participants agreed that travelling supplements were important for those with mental health problems who have limited resources.

> *"If community integration is so important for us [as people with mental health problems], we should be adequately subsidized for our hope to take part in society … Now, we can enjoy some discounts when using some but not all transportation methods in Hong Kong. I hope such a privilege for us could be further expanded to all transportation services."* (Participant Leo)

Chapter Summary

The six overarching themes of the ups and downs of illness, hope experience, hope effects, strategies of hope, relationship quality and environment opportunities have all been examined and elaborated thoroughly throughout this chapter. For each overarching theme, corresponding sub-themes, related first-order themes as well as transcripts have been presented. In writing this chapter, attempts have been made to articulate, as clearly as possible, the relevance of each theme and sub-theme in order to develop understanding of the experiences of hope in the recovery from schizophrenia, as told by research participants.

CHAPTER 7: DISCUSSION AND CONCLUSION

This thesis aims at exploring and understanding the lived experiences of hope of people in their recovery from schizophrenia. Eight participants were purposively invited for semi-structured interviews. All interviews were transcribed and translated for data analysis. Inductive thematic analysis was used to identify major themes and related sub-themes. This chapter will integrate the findings with hope literature, and major findings will be introduced and discussed, followed by support from hope literature. Practice implications and recommendations for further research will be detailed in the latter part of this chapter.

Summary of Findings

The most significant result of this study was the identification of six overarching themes, which were central to participants' experience of hope in their recovery from schizophrenia. The major themes identified were *the ups and downs of illness*, *modes of hope*, *hope effects*, *strategies of hope*, r*elationship quality* and *environmental opportunities*. These six overarching themes were all abstracted from the 52 first-order themes and 17 sub-themes identified from the data. In this chapter, a detailed description of the formation of each theme and sub-theme was provided. Figure 8 provides a model reflecting the association between themes and sub-themes.

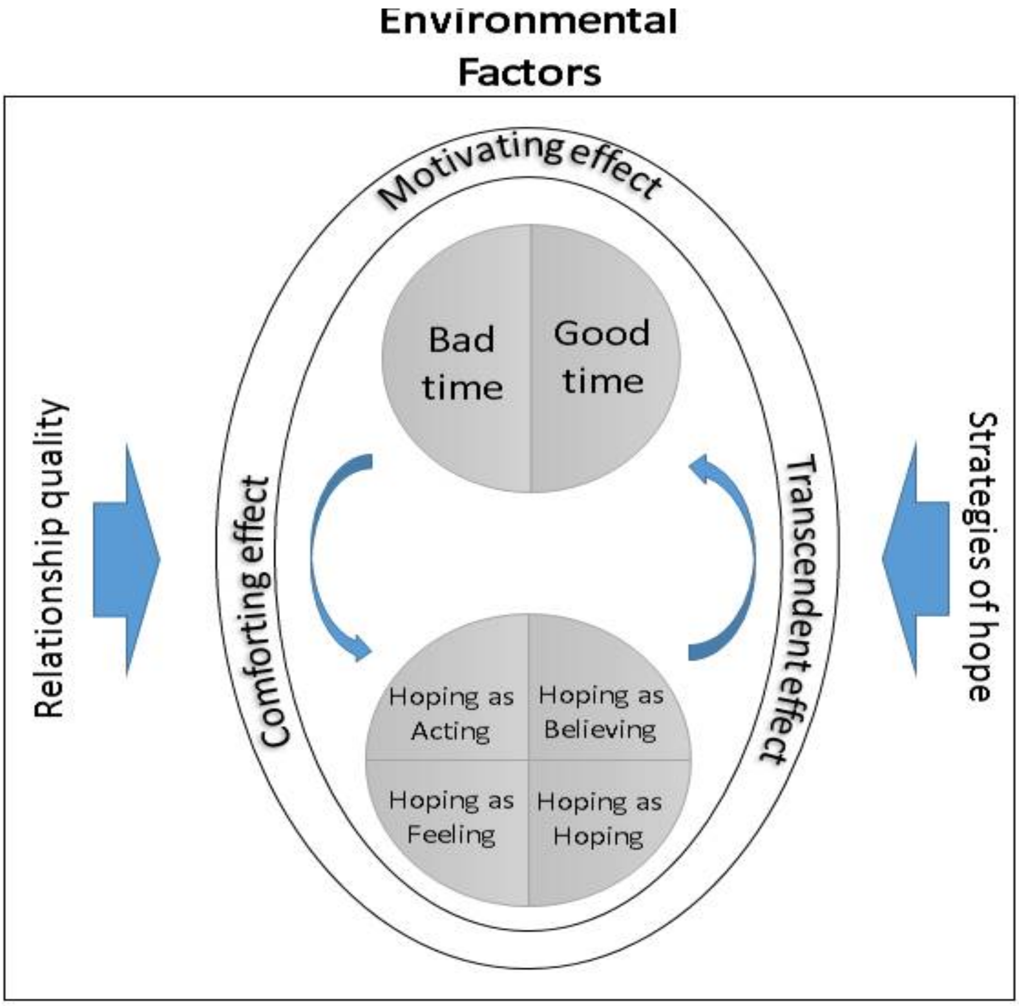

Figure 8: Theme model of hope in this study

The model illustrates the main themes, the *ups and downs of illness* and *total hope experience,* and how they are intertwined with one another and form the core of the model, known as the atom. This atom is surrounded by a running ring formed by the three *hope effects*, including comforting effect, motivating effect and transcendent effect. Using a running ring to represent the various hope effects was applied as it is dynamic and changes according to our lived experiences of recovery and hope. The outermost triangle and arrows represent the outer factors contributing to the dynamic interaction in the middle; these contributing factors are *strategies of hope, relationship quality* and *environment opportunities.* In actual fact, all themes and sub-themes are well interconnected and become a holistic model representing the findings of the analysis. In fact, this theme model of hope cannot be read by itself without referring to the research findings that are listed in Chapter 6. In organising Chapter 6, I have tried to introduce the overarching themes one-by-one, moving from basic definitions of hope and recovery towards hope effects, hope strategies, relationship factors, and finally the connection with external environments. Thus, this theme model of hope is better read from the 'inside' to the 'outside' in accordance with the flow established in Chapter 6. I believe that one important contribution of the present study is the identification of a hope model that relates psychological and environmental aspects of hope.

In the following paragraphs, research findings will be discussed in relation to existing literature of hope as well as recovery.

Discussion of Findings

Ups and Downs of Illness

The theme *ups and downs of illness* was quite explicitly overarching when participants discussed their recovery from schizophrenia. As all participants have been diagnosed with schizophrenia for years, they are all well-qualified candidates to tell of their experiences. Most of the participants described a sense of having no hope during the early phases of the mental illness. This experience of hopelessness is deeply associated with their beliefs in a negative future — a future where everything is unsure and uncertain. Most often, negative beliefs are mixed with stigmatised messages from the mass media or indigenous ideas. As a result, their world has been shattered and their life crushed into the ground.

Research findings show that the different modes of good times and bad times reported distinguished their course of illness: some of them experienced explosive episodes but were still able to live steady lives with medication. For some, however, their recovery from illness was just like a roller coaster: even with a period of good times under treatment or rehabilitation training, their schizophrenic symptoms returned, and whether or not their daily lives would be affected was dependent on the severity of the symptoms and their own ability to cope. Nevertheless, a symptoms relapse was not the only way in which participants defined their bad times in recovery; narration of negative bodily experiences, such as physical exhaustion and dizziness, was also provided. Participants alleged that, during their good times, they were able to hope, to hope more and have high hopes; however, during times of deterioration, on the other hand, the only striving power came from a hard belief that ‘bad times will go away, and good times will come’. Whether or not their daily lives would be affected was dependent on the severity of the symptoms and the effectiveness of their own coping skills. This phenomenon matched the central theme of the recovery movement, where recovery is, in fact, a non-linear and individualised process. Participants also reported physical discomfort in the form of physical exhaustion and dizziness.

Modes of Hope

The findings of this study are consistent with other hope research, in which the concept of hope is multifaceted and multidimensional (Morse & Doberneck, 1995; Cutcliffe, 2004; Holtslander & Duggleby, 2009). Hope has never been a single concept, but “rather as a phenomenon, the phenomenon of hope” (Levi *et al.*, 2012. p. 1672). Hope is a dynamic experience that provides the courage to continue living by having a positive view of the future. Simply put, it is a source of life. Hope can play an important role in the process of recovery amongst those individuals with schizophrenia. The present thematic analysis results support the notion that hope is not a unitary experience; rather, according to our participants, hope is experienced differently depending on different times and different situations; in other words, no single mode of hope has an overall representation of the experience. The plurality of modes of hope reflects the complexity of the interactions of the participants, their illness experiences and the surrounding world. All in all, four distinct modes of hope are revealed in the study: hope as believing, hope as hoping, hope as feeling and hope as acting. By and large, this finding is in line with those of Dufault and Martocchio (1985), Godfrey (1987) and Webb (2007), all of whom never viewed hope as an undifferentiated experience but rather who suggested different modes of hope.

Almost all of the participants in this study reported that hope, for them, existed as a mode of believing; however, surprisingly, the connection between hope and believing has not been adequately elaborated in the literature. The only exception can be seen in Hinds' research on the hopeful thinking of adolescents on health, during which hope was defined as a belief that personal tomorrow exists (Hinds & Martin, 1988). Indeed, the Oxford English Dictionary (1989) defines 'believing' as having a confidence or faith in the truth of something, having a firm persuasion of something, and to expect with confidence. When coping with their mental illness, individuals should be better filled with beliefs that could empower them in the process. Beliefs have the power to enrich us but also the power to destroy us. In our daily lives, limiting beliefs are those that can cause life to be less satisfactory; on the contrary, positive beliefs can lead to a more promising life than what can be expected. Beliefs not only filter our perceptions of the outer world, but also motivate our bodies and actions towards those believed directions. Most of the participants in this study reported that their hope sometimes existed in believing that good times would come and bad times would go away. Nevertheless, the most overarching and powerful belief regarding their mental illness and recovery process was the belief that there was not yet an ending: for them, things would change and there was still a possibility and alternatives out there.

In this study, it was found that hope also exists in a mode of hoping. Many of the respondents alleged that their hope experiences contained thinking towards something that was desired. Two important elements are reported here: firstly, hope appears as a verb; and secondly, their notion of hope involves certain hoped-for goals, which, as reported in the interviews, are not necessarily a concrete object (e.g. a car, a dress) but may be social situations and circumstances that implicitly embrace a hoped-for goal. For example, one respondent alleged that he hoped that he could have more self-actualisation in recovering from mental illness, and having a gainful job that matched his personal strengths featured in his description of self-actualisation. This finding is consistent with that suggested by Eliott and Olver (2002, 2007) in discussing that hope is a verb, as compared with hope as a noun. Accordingly, hope as a verb normally indicates clearly desired objects.

Also consistent with other hope studies is the identification of hope of normalcy amongst participants. The study participants seldom hoped to be cured; rather, thematic analysis showed that the respondents hoped to be free from symptoms and to get back to normal. These two notions of hope were often the very first things that could be heard in the interviews. As people recovering from mental illness, they hoped for normal things, normal activities, normal paid jobs, normal community living and normal interactions with others. Slight differences between respondents on the allegation of normalcy were observed. However, the differences did not affect the categorisation of this theme. Findings from this study in this area are consistent with other similar studies (e.g. Godschalx, 1989). In discussing normalcy desire along with living with mental illness, Pickens (1999) asserted that, in many respects, such desires were common amongst all human beings; however, when struggling with their devastating and long-lasting illness, such desires of normalcy are found to be much more important in maintaining a personal spirit of recovery.

In this study, another dominant discourse of hope as hoping is the wish to have a life free from symptoms. For the participants, to be free of symptoms is an important indicator, ultimately proving their recovery or process of recovery. The longer the period participants are free of symptoms, the more they could hope for and the more hopeful they could feel about recovery.

Another interesting finding in the present study is the notion of hope as feeling amongst the participants. More specifically, from the researcher's own interpretation, hope appears to be a mode of embodied feeling that involves bodily feeling and mindedness. Being affected by the current dominant cognitive view of hope, suggested by Snyder (2000, 2002), hope as a feeling has seldom been discussed adequately. The most exceptional examples come from Staats and Stassen (1985) in discussing hope in an empirical context as an affective cognition, and Godfrey (1987) who delineates the concept of hope as a feeling from a philosophical perspective. Through this study, the participants felt the pleasure of hope. Hope appears to them with bodily sensations, such as through lightened shoulders and a fuelled body, etc. As stated, the participants not only knew that they had reasons to be hopeful, but they had bodily cues to facilitate their own understanding of hope as a total experience. In a recent piece of work, MacDonlad (2011) reported a very similar phenomenological finding between hope and bodily experiences; future research, however, should be carried out in an effort to examine the relationship between hope, experiences and bodily feelings.

The theme modes of hope revealed valuable answers to the second research question. Altogether, it was reported that there are three different types of hoping, including hoping, acting and believing. A careful examination of their descriptions of their hope experiences easily identified that the told hope stories intertwined with the ups and downs of illness, and is the reason why these two intertwining themes become the atom of the hope model suggested. This finding makes sense as it matches with our own common understanding that we need different energy to do different things in different periods: we need shelter and a peaceful mind during rainstorms but we need a boat for moving. It is also true for the participants in that they needed different forms of hope in different periods. On some occasions, one needs to go ahead, one needs big goals and to act, but sometimes just a dim light is needed in one’s heart in order to give peace of mind.

Hope Effects

Previous hope literature identified that hope used to serve two primary functions; however, my data analysis shows that hope provides three different effects amongst participants, namely the comforting effect, the motivating effect and the transcendent effect. Each hope effect experience was supported by real descriptions and stories. For most of the respondents, hope represented an optimistic state of mind characterised by urgency for ongoing living along with actions. It was the drive behind their daily lives and prevented them from sinking back into passivity.

The understanding that hope is motivational has been widely addressed in hope literature. For example, Synder *et al*. (1991) described hope as a motivational state that was driven by agency thinking and pathway thinking. With hope-generated motivation, we would divert our energy and resources towards the hoped-for future (McGeer, 2004). A similar view was expressed by Stajkovic (2006), who distinguished active hope from passive hope, whereby individuals with active hope would adopt an active position and determination in goal planning and goal attainment. In actual fact, planning as an action in itself is energising as it could mobilise actions (Koehn & Cutcliffe, 2012). In connecting motivation and goal setting, Levi and colleagues (2012), for example, asserted that hope was a means to accomplish personal goals. When the respondents aspired to do something, they set goals for themselves and tried their best to realise their hope. During the process, they saw goal attainment as a mission; for them, hope was something they owned and which motivated them from the inside — not from the outside. It was not surprising to hear that hope was merely the fuel in their body and drove them towards what they desired.

Strategies of Hope

In this study, the second theme, strategies of hope, examines participants' experiences in helping themselves to maintain a better sense of hope. The majority of the participants in the study were quite assertive in knowing that hope is so fragile during their daily lives. Actually, whilst facing difficulties, they referred to different hope strategies employed in recovering from illness.

The first hope strategy identified in this study involves making adjustments in expectations, goal formatting and self-demands in an effort to preserve an easy life with the illness. The majority of the respondents alleged that they became more realistic in making choices and would consciously lower their personal expectations in order to avoid striving for something impossible. As reported, their life with mental illness was already filled with too many hope-endangering factors. For them, being wise in moving forwards gradually was much better than falling backwards. As stated, with appreciation and re-appreciation of what they owned, they could lead a peaceful life and preserve energy to deal with challenges. Almost all participants revealed that making personal adjustments was an effective strategy to foster hope in recovery. Similar findings had been reported by Saleh and Brockopp (2001), who stated that those who face chronic bone diseases were keen to foster accomplishments in the recovery from the illness so as to avoid difficult personal feelings. Furthermore, Ersek (1992) also reported that maintaining control and focusing on personal strengths were important hope strategies in dealing with chronic illness.

The second hope strategy described by participants in the present study was to stay with supportive others; by doing so, they learned the success of others. By staying with supportive others, they also gained emotional and actual support in solving problems. For the participants, supportive others could be friends and peers but also other people with mental illness. The active utilisation of social support networks is commonly seen as an effective strategy for hope maintenance. For example, Saleh and Brockopp (2001) reported that those with chronic diseases who utilised social networks were able to access social and material support and tended to suffer less distress, sadness and hopelessness. In addition, in a qualitative research investigating hope-fostering strategies amongst older adults, Duggleby and Wright (2004) asserted that remaining with supportive friends was one individual strategy that was the most often reported by participants.

The third coping strategy employed by participants in this study is their engagement in empowerment. For them, the process of empowerment was a double-sided sword. By standing up and speaking up for themselves, as shown in the last chapter, participants manipulated their surrounding environment in an effort to facilitate hope attainment. In return, successful experiences reinforced further assertive acts, as well as better self-beliefs, which led to the experience of hope. The correlation between self-esteem and hope experiences is not new in mental health literature (Davidson & Strauss, 1992; Corrigan & Watson, 2002; Lysaker *et al*., 2007); nonetheless, the findings of this study add new and important explicit evidence connecting empowerment and hope experience. Without question, it is a topic that warrants further exploration and discussion.

Besides all the individualised factors mentioned, participants also highlighted various external factors affecting their hope experience. Family care was the first most commonly mentioned factor seen to be directly related to their recovery from illness and the experience of hope. Family acceptance and the sense of togetherness, as well as the sense of belonging, formed the cornerstone of survivorship. Nevertheless, in Hong Kong, we all live under the same roof and are affected by its macro economy. All participants seemed to have good feelings and accordingly focused on their surrounding environment, but nevertheless they desperately considered Hong Kong as being no longer a city of hope: they faced only limited housing choices, limited employment opportunities and deprivation, which affected their process of recovery and their sense of hope.

Relationship Quality

This theme examines participants' hope experiences in connection with other supportive relationships. Having a relationship with others has long been recognised as a major source of hope. Within this sub-theme, relationship quality manifests in two ways: firstly, the relationship with family; and secondly, the relationship with professional staff. Regarding their family, most participants reported that, through acceptance and a sense of belonging, they became hopeful again. They also reported that, during times of crisis and when mentally unstable or even in a bad mood, the idea of going home always became the first thought on their mind. The role of family support in fostering hope experiences is well reported by previous studies. Koehn and Cutcliffe (2012), for example, asserted that non-judgmental family members and peers were crucial in hope building. Moreover, Hong and Ow (2007) also reported that open communication with family members was important in formulating hope experiences amongst people with terminal illness. They also affirmed that decreased hope came from the absence of support from family members when needed. Similar conclusions were drawn by Reb (2007) in discussing relational aspects of hope. Sometimes, hope expressions are placed in the context of human relationships. Below is a direct quotation from Herrestad *et al*. (2010):

> *"For example, hope of gaining acceptance from others, hope for community with others, and hopes of being remembered."* (p. 4562)

Thematic analysis of the data also suggests that another aspect of relational hope is the relationship quality with mental health professionals. Almost all participants conveyed first-hand experiences of working with mental health professionals, and they asserted that a caring, non-judgmental and supportive attitude meant a lot to them in the clinical setting. When supported as a ‘normal’ person, identification by the illness diminished. When supported by self-initiated ideas, the sense of worthiness increased. The research participants further pointed out that information and guidance from mental health professionals were important sources of hope. With concrete ideas, information, training or actual service referrals, chances were therefore possible and hope was there. The role of helping professionals in hope inspiration is a very attended-to research topic in nursing; however, most of the research have focused on how nursing professionals contribute to hope building, whilst others provided stories through narrations from mental health service users.

Environment Opportunities

In the past, hope scholars have interpreted hope from a biological or psychological perspective. For them, hope was something that occurred within an individual or, to a certain extent, to the immediate human environment. Even when discussing the various sources of hope, it was quite common to anticipate that the focus of discussion rested on connections with peers, friends, families and professionals. However, the findings of this study suggest that hope and hoping cannot cause the social environment, public systems, economic environment and welfare policy to be disregarded. This connection between hope and the larger environment is quite logical and reasonable. As citizens and situated in our living space, we actively interact with different social parties in our daily lives. Every human behaviour in this living space is interactive, and our behaviour is undoubtedly partially affected by the structure of the environment. Almost all participants of the study reported what they could reach and take as alternative experiences of hope. For example, the desire to secure a job would assume at least that there was a healthy labour market out there in which job vacancies exist, or the desire to visit a friend could be affected by the availability of appropriate and affordable transportation.

The findings of this study, however, reveal that the participants were quite critical towards the availability of resources in assisting a hopeful recovery. Many of them asserted that they were in an unfavourable position in terms of social inclusion. Similar findings have been reported by mental health scholars in connecting mental illness with poverty and freedom. Boardman (2011), for example, asserted that those with mental health problems were being marginalised by mainstream society through means of poverty and inequality. In discussing the situation of exclusion, he stated:

> *"The rich are at the front, those on low income at the back. Whilst the whole train is moving forward, those at the front move at much faster pace than those at the rear, as the rises in their incomes have increased at a much greater rate. People with disabilities and those with mental health problems are over-represented in those traveling at the back of this train."* (Boardman, 2011. p. 114)

Social exclusion is indeed a social disadvantage (Silver, 1995). Those with lower social economic status (SES) could have less than satisfactory recovery from mental health problems if they became mentally ill (Gallo & Matthews, 2003). For people with mental health problems, social inclusion is beneficial, but not social exclusion. According to Charles Rapp, the advocate of strengths-based social work practice, environmental strengths were, in fact, equally as important as individual strengths in overcoming life difficulties (Rapp, 1998). As a result, critical attention to structural constraints and related social problems, such as poverty, housing shortage, insufficient employment, etc., was crucial in promoting mental health recovery as well as hope experiences. According to Blau (2004), real freedom was not only a lack of compulsion on rights but also having the necessary resources for such actualisation.

Overall Reflection

This dissertation has been carried out in an effort to explore the lived experience of hope of people recovering from schizophrenia. Eight participants recovering from schizophrenia were invited to join the researcher on this journey of exploration. Many related topics, such as illness experience, recovery experience, the nature of hope, the articulation of hope, the language of hope in Chinese, and the concept of hopeful persons, etc., were examined. Research participants were all welcome to express their ideas and stories from their own perspectives without pressure, and the researcher was careful to align with their pace during the telling of their stories. Interviews were never carried out when time was limited. However, by repeatedly having conversations, we were able to exchange our ideas deeply and reflectively, and facilitated the interpretation of data in the stage of analysis.

The findings of this dissertation echo the mainstream disclosure that there are two forms of hope, namely specified hope and non-specified hope; in other words, it is the first dimension of hope. In addition, by analysing the narration of hope of the research participants, the present dissertation asserts that the quality and functions of hope vary in different situations, depending on the subjective awareness of the life situation as either positive or negative. Simply put, hope experiences interact with the awareness of situations in producing different hope effects on our life situations. Being in a negative life situation, a general hope can help us to relieve ourselves from pain and distress, and hope can act to elicit our coping behaviours in solving problems. Being in our position in a life situation, a specified hope can motivate us for further development, and a general hope can create openness to our future.

The present dissertation has found that, despite facing challenging life situations in their recovery process, people with schizophrenia never give up hope for a good future. Without hope, there is no future, which would mean they cannot move on. The traditional negative view about the passivity of individuals with schizophrenia is not true; in fact, they are doing their best to hope for the future, take small steps to solve the problem, try to be self-motivated in searching for a better tomorrow, and strive to become hopeful people who can share their life stories with others. Every successful hope realisation can provide strength in forming new hope and direction for the recovery from illness. People with schizophrenia usually start by holding a general hope and progress towards a stage in which they can embrace hope. In the beginning, experiences of despair are unavoidable and they have a hard time securing support and care. Unfortunately, however, people tend to believe that people with schizophrenia should work on their own to foster hope in their own lives without recognising that we all can have a role to play, just by being supportive and empathic. Moreover, an active sharing of hopeful experiences amongst the network of mental health services users is also important — nothing is more convincing than shared first-hand experiences.

Contribution to Knowledge

The findings of this study add to the body of existing knowledge and are relevant to future researchers and mental health clinicians seeking to develop an understanding of hope experiences, their impacts on individuals and clinical practices, and their relation to recovery in working with people diagnosed with schizophrenia. As far as I am aware, this is the first qualitative research to explore the experiences of hope amongst those who are recovering from schizophrenia.

Six overarching themes have been identified and a model has been devised and suggested to capture the intertwining relationships between the different themes to form a whole picture. As discussed, the research findings are more-or-less in line with previous studies', showing that hope is a dynamic life force and an essential component in the recovery from mental illness. Nevertheless, the present research sharply points out that the core intertwining effect between recovery experience and hope experience is a non-divisible whole phenomenon. Another major contribution of this study is the identification, by the participants themselves, of effective strategies in nurturing hope; such findings can also install insights into our practices.

Practice Implications

Given all the findings reported and discussed here, implications for social work are quite clear in the following aspects:

1. There is a need for us to give time to understand the intertwining link between recovery from schizophrenia and the hope experience as a non-divisible whole. Hope is always there in any period of time.
2. During bad times in recovery, family support, encouragement, believing in personal potential, and providing alternatives are all good steps to getting through those rainstorms.
3. Assisting people with schizophrenia to achieve wish-fulfilment by themselves and for themselves and self-led successful actualisation impact the total hope experience.
4. Social workers themselves should be hopeful and optimistic, and share goals, wishes and themes. Hope talking is found to be beneficial for all

parties involved.

5. The missions of macro practice — of seeking a discrimination-free, just and welfare-adequate city of hope — should not be dismissed or pushed to one side.

Study Limitations

The first limitations of this study are the purposely selected sample and the selection of a qualitative research method, which do not allow for results generalisation (Babbie, 1995; Coyne, 1997). The results apply only to the sample's characteristics employed for this study. The second limitation of this study is the potential problems in translation between Chinese and English. As stated in Chapter 4, attempts have been made to minimise the problems in translation by using appropriate words and phrases in order to adequately communicate the meanings expressed; however, there remains the chance that some important expressions may have been missed, thus potentially creating possible misunderstanding amongst readers. Another potential limitation of the study is the process of implementation of thematic analysis and the interpretative nature of the study. Although a lack of research rigour in qualitative research and thematic analysis can be avoided by adopting measures to enhance credibility and trustworthiness, the potential weakness should not be missed. For example, within available hope literature, friendship and peer support were proved to have playing an active role in creating hope (Barilian, 2012; Mclntyre & Chaplin, 2007). However, despite with the fact that interviews did mentioned about friends and peers in the present inductive research, it is discovered that they neither did not emerge as a notable theme, non they became the components in the existing theme 'relationship quality' in the thesis. In other words, during the process of coding, data abstraction and 'recontextualization' their importance as an overarching theme was not lost (Braun & Clarke, 2006:19). By nature, inductive thematic analysis is indeed interpretative and there is no fixed rule in guiding data analysis but depends on the theoretical sensitivity and reflective ability of the research (Guest *et al.*, 2011).

Recommendations for Further Research

After completing this study, various recommendations can be made for additional research. Firstly, more in-depth qualitative research could be conducted in the same area with different specific age groups of schizophrenic patients. Secondly, hope research work could be extended to encompass other mental illness groups, such as those with depression or those suffering from personality disorder. As mentioned before, one interesting but so far unexplored topic is the impact of research interviews on the sense of hope amongst participants. My research interviews occurred in the community in a natural way, and during the interviews I came across many hopes, worries, dreams, and ups and downs. In various situations, participants reflected that this kind of hope-centred talk made them more hopeful. However, the way in which research interviews can bring hope is a question that has not yet been asked. This area could be explored.

Conclusion

Whilst conducting the present thesis, I realised that most people recovering from schizophrenia are just hoping for an ordinary life as a 'normal', i.e. undiagnosed, person. For them, recovery is not merely confined to symptoms remission but should be their active and practical involvement in daily life. People with schizophrenia want to love and be loved in supportive human relationships. They all have strong inner strengths and desires to live their lives more happily through ensuring hope for their future and interactions with their social environment. The target and content of hope are not necessarily related to only personal interests but could be an interest of others as well as of communities. We should not lose hope because we never know what tomorrow will bring.

Appendix 1

Demographical Information of Participants

Name	Gender	Age	Education	Marital status	Illness duration
Sunny	Male	49	University	Married	20
Eric	Male	47	F.7	Single	19
Yuki	Female	42	F.7	Single	20
Michelle	Female	47	F.5	Single	25
Hubert	Male	30	F.7	Single	11
May	Female	57	F.7	Single	35
Charles	Male	39	F.7	Married	21
Leo	Male	38	F.5	Single	11

Appendix 2

Semi-structured Interview Guide

Can you tell me something about your illness?

After having the illness, what aspects of life have changed?

What is recovery to you? What is it for?

What keeps you going in your process of recovery?

How do you feel today?

How do you define or describe hope?

What thoughts do you have about hope?

What is the difference between hope, a wish, an expectation, or a want?

Is hope important to you? Why?

Do you have hope? What is it?

Is there anything that can make you feel hopeful?

Where do you get your hope?

Where do you find your hope?

How do you know that you have hope?

How do you know you do not have hope?

How does it feel to have hope?

How does it feel to not have hope?

Tell me about a specific time when you had hope.

When life is hopeful, how do you describe it?

When life is not hopeful, how do you describe it?

What influences your hope?

What influences the presence or absence of hope?

What influences your hope to go up or down? What drains your hope?

What can other people do to change your hope?

Since having the illness, has anyone or anything made you feel hopeful?

Since having the illness, has anyone or anything made you feel less hopeful?

Tell me you hope for?

What is your hope for today?
What is your hope for the future?
What is the opposite of hope?
When you lost your hope?
What happens if you don’t have hope?
What are the sources of hope?
Can you teach someone else to have hope?
How do you help each other to hope?
What can social workers do to bring hope to people with schizophrenia?

Appendix 3

知情同意書
（中文版）

研究題目：「希望」在香港精神分裂個案復原過程上的角色
研究人員：梁詩明

研究內容簡介：

在西方文獻中，「希望」這個概念一向被視爲精神病患者的重要復原動力，它可以是一種情緒、一種感受、又或是一種思維。本研究之目的是透過研究本地（香港）精神分裂症（一種爲喻爲在復原上較悲觀的精神病患）康復者的生活經驗，對「希望」這個概念及其在復原路上所扮演的角色有一個深入的描述及認識。研究人員將會透過文獻回顧、深度訪談、參與觀察來收集研究資料。本研究希望得到數位精神分裂症康復者提供個人背景資料、復原故事及個人見解以作研究資料分析之用。研究成果將會輯錄成爲博士論文交予香港理工大學應用社會科學系，或以其他學術文獻方式發表。

參與研究細節：

- 參與這項研究只是自願性質，參與者在研究過程中有權隨時終止、暫停或繼續參與研究而不會有任何損失。
- 本研究將採用質性研究法收集資料，訪談對話將會被錄音以方便分析。所有通過對話、或透過觀察所得取的研究資料將會保密處理。
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- 本對研究有所查詢，你可以隨時與研究員梁詩明 (852) 9102- 或其指導老師葉錦城教授 (852) 2766-5733 聯絡。

本人 ____________________________ 已完全了解上述所有要點，並同意自願參與這項研究。

同意參與研究者簽署：__________________________

簽署日期　　　　　：__________________________

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