



Essay

The Centrality of Hope in Psychiatry and Psychotherapy

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Abstract

In this essay, hope is presented as a key driver of psychiatric and psychotherapy outcomes, helping clients move beyond symptom relief toward meaning, resilience, and flourishing. The text integrates goal-based models with relational, narrative, and cultural dimensions. Drawing on the “standard account,” the author proposes that hope is the interplay of wishing for a valued good, believing its attainment is possible (though difficult), and trusting internal and external resources, including the therapeutic alliance. A vignette of Susanne, a young woman with partial dissociative identity disorder, illustrates how psychoeducation and small wins increase belief, while a consistent therapeutic alliance builds trust that extends to self-trust and cooperation. Clinicians play a central role as “hope carriers,” shaping realistic goals, reinforcing progress, and avoiding false hope.

Keywords: hope; wish; belief; trust

1. Introduction: The Role of Hope in Psychotherapy

Psychotherapy increasingly recognizes that healing involves more than just reducing symptoms; it also includes cultivating a meaningful and fulfilling life [1]. Developmental models highlight that therapy supports the lifelong development of identity, encouraging clients to integrate conflicting tendencies, such as trust and despair, and to strengthen core virtues like will, purpose, love, and wisdom [2,3]. This developmental approach urges practitioners to look beyond pathology and focus on clients’ capacity for growth and flourishing. Within this broader therapeutic framework, hope stands out as a vital force. As research on common factors has consistently shown, hope is a major contributor to therapeutic change [4]. Hope acts as a catalyst for resilience and growth: it helps individuals rebuild their narratives after trauma, supports goal-directed action, and facilitates recovery from setbacks [5]. When actively cultivated, hope becomes an antidote to despair and a transformative power that sustains both clients and therapists in the shared effort to imagine and create a better future [6–9]. From this standpoint, fostering hope is inherently tied to fostering human potential.

The essay examines the significance of hope within psychotherapeutic and psychiatric contexts. It first outlines major conceptualizations of hope, develops a process-oriented understanding of hoping as a dynamic phenomenon involving wishing, believing, and trusting, and then portrays it through a case vignette. Building on this conceptual foundation, the paper distinguishes between authentic and false hope, synthesizes relevant empirical findings, and discusses selected interventions to foster hope in clinical practice. Particular attention is given to the role of health care professionals, including psychiatric nurses, in supporting hope as part of therapeutic care.

For this purpose, a targeted literature search was conducted in Google Scholar and PubMed using the search terms “hope AND psychotherapy” and “hope AND psychiatry.”



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Sources were selected based on recency, scientific quality, thematic relevance, and practical applicability. Foundational contributions from medical literature, psychological research, and nursing scholarship were included in order to examine hope from an interdisciplinary perspective and to relate current findings to psychotherapeutic, psychiatric, and psychiatric nursing practice.

2. Different Conceptualizations of Hope

Contemporary research highlights hope as a dynamic, adaptable, and culturally rooted resource. This is vital across various clinical populations. Its significance extends from individuals with severe psychiatric conditions to aging populations [10], forensic settings [11], substance abuse treatment [12], and family systems managing chronic psychiatric issues [13]. Hope fosters resilience, coping skills, empowerment, and recovery in conditions like schizophrenia, depression, and suicidality [12,14,15]. It aids recovery from severe mental illness, promotes empowerment, treatment adherence, and overall quality of life, while also serving as a shield against helplessness and demoralization [16–19]. To foster hope, clinicians are encouraged to explore clients' sources of meaning and support their future orientation [20,21].

Theories of hope include both agency-focused and identity/meaning-focused concepts. Agency-focused models, such as Snyder's Hope Theory [22], view hope as a mental and motivational process that involves pursuing goals (agency) and identifying ways to achieve them (pathways). This approach highlights problem-solving, personal drive, and practical thinking, helping clients set realistic goals, take action, and perform steps that increase their sense of control. Therapeutic approaches such as solution-focused strategies, scaling questions, and recognizing past successes build agency, supporting hope as an active, self-directed process [23].

In contrast, identity, self, and meaning-oriented approaches frame hope as a relational, existential, and phenomenological experience. Drawing on philosophy, phenomenology, and developmental psychology, theorists such as Larsen et al. [24] and Nunn [21] conceptualize hope as a multidimensional human attitude tied to meaning, spirituality, and life coherence. Hope emerges through narrative continuity that integrates the past, present, and future and is reinforced by relationships, social support, and cultural context [13,15,25]. It is dynamic, fluctuating with life events, illness, and relational changes, and contributes to identity reconstruction, self-authenticity, and personal growth [26]. Meaning-making is therefore central to sustaining hope: clients draw hope from interpersonal connection, purposeful activity, intrapersonal growth, environmental engagement, and transcendent or spiritual sources [20,27].

Overall, hope in psychotherapy is dynamic, relational, and multifaceted, combining goal-directed agency with existential meaning and identity coherence. Integrating these dimensions allows therapy to enhance clients' sense of control while fostering a meaningful, connected, and resilient orientation toward the future, making hope both a therapeutic target and a catalyst for recovery.

3. Hope Is the Process of Wishing, Believing, and Trusting

Based on the standard account of hope [28], Krafft et al. [29] argued that hope involves the processes of (1) wishing for a valued outcome or state, (2) believing that its realization is possible, though not easy, and (3) trusting in the availability of internal or external resources that could help achieve it, especially when facing obstacles and setbacks. This understanding of hope includes, but also extends beyond, Snyder's dispositional hope theory. While Snyder [22] emphasizes agency and pathways thinking, a psychotherapeutic conception of hope should be broader in scope: it becomes especially relevant in situations

of crisis, suffering, and uncertainty, where positive expectations may be weak or temporarily unavailable. In this respect, hope also differs from dispositional optimism, which is typically grounded in generalized expectations of favorable outcomes [30].

In psychotherapy and psychiatry, hope may be sustained by more fundamental wishes, beliefs, and trust. These can be directed toward personal goals, thereby strengthening agency, motivation, and self-efficacy, but they may also be oriented toward others, health-care institutions, family members, or a higher power, since concrete goals can sometimes be overwhelming for patients. Significant wishes are anchored in personally meaningful values, needs, and relationships. Beliefs include assumptions about the self, others, the world, and, sometimes, spiritual or existential dimensions of meaning. Trust, finally, is central to a hope-enhancing therapeutic alliance. Through reliability, empathy, and recognition, the therapist can help clients regain confidence in their own capacities and gradually develop more hopeful ways of relating to themselves, others, and the future.

The willpower to act and persist stems from the nature and importance of the desired good and from the strength of belief and trust, which can originate from several sources held by those who hope. These key elements capture the core of hope and are broad enough to apply across different levels (individual, interpersonal, social/collective, and transcendent) and in various cultural contexts. A brief fictitious case vignette illustrates this process (Box 1).

Box 1. Case Vignette.

Before psychotherapy, Susanne (27) lived in a constant fog of fear, confusion, and exhaustion. Her partial dissociative identity disorder (pDIS) shaped every aspect of daily life: different inner persons stepped forward to manage overwhelming emotions, while others hid. These shifts often left her with major memory gaps that she could not explain to others without feeling “crazy.” She lost track of conversations, misplaced important objects, and sometimes found herself in places she did not remember going. The amnesic barriers inside made communication within her system inconsistent and fragile. Years of misdiagnoses and invalidation led her to believe the chaos was her fault. Beneath all this, a fragile wish persisted—she longed for stability, for fewer disruptions, and for the possibility of relationships that did not collapse under the weight of her symptoms.

Entering psychotherapy, Susanne expected very little. Yet small, steady experiences began shaping her belief that change was possible. Learning about complex trauma and pDIS gave language to experiences she had always hidden. Understanding that her system formed as a necessary response to repeated childhood trauma helped dismantle her chronic self-blame. As the therapist guided her to notice brief moments of cooperation between inner persons, and to celebrate small successes—getting through a day with fewer switches, remembering more, calming her body—her belief in a different future slowly grew. She began to imagine not just surviving, but living.

What truly anchored the process was trust. The therapist’s consistency, attuned listening, and willingness to engage with her inner persons created a relational space in which Susanne could gradually risk openness. Over time, trust expanded from the therapist to her internal system: parts learned to communicate, to step back or forward intentionally, to care for one another. Gradually, she discovered trust in herself—an inner steadiness she had never known.

After successful psychotherapy, Susanne experiences her inner world as more coherent and collaborative. Amnesia has lessened, daily functioning has improved, and she feels connected to others in ways that once seemed impossible. Her wish has become a lived reality: a meaningful, self-directed life supported by belief in positive change and sustained by trust in oneself and others.

In the psychotherapeutic and psychiatric context, hope arises from the interplay of wish, belief, and trust, each representing a distinct yet interconnected dimension of the client’s outlook toward a better future. The wish component pertains to the client’s desires and valued goals. Recovery-oriented approaches highlight that therapeutic progress begins with the individual’s own longing for change and meaningful participation in daily life [31]. Recovery is seen as a personal journey toward a life filled with meaning and contribution, shaped by the client’s values rather than solely by symptom relief [5]. Consequently, the

wish involves clarifying what the client finds worthwhile—whether autonomy, connection, stability, or self-growth [25]—and recognizing that, especially in later life, hopes may shift toward goals such as dignity, acceptance, or maintaining quality of life [32,33]. Therapists nurture this dimension by helping clients articulate their desires for change, validating the importance of their hopes, and adopting a recovery focus that emphasizes personal meaning and possibilities [34].

The belief dimension entails the conviction that a desired future is attainable, even when it appears difficult. Research shows that without the belief that change is possible, recovery cannot begin [5]. Many clients start therapy with deep-seated defeatist beliefs or low self-worth that erode hope. Therefore, therapy aims to challenge hopeless thoughts, foster a sense of agency, and strengthen positive expectations [35]. Belief also influences the impact of stigma: internalized stereotypes decrease self-esteem and hope, which, in turn, lower quality of life [36,37]. Conversely, cultivating positive beliefs—about therapy's value [38], about recovery [39], and about identity as changeable rather than fixed [5]—restores psychological possibility.

Finally, trust pertains to the therapeutic relationship and the resources—personal, social, and spiritual—that support change. Building a safe, attuned alliance is essential when hope is fragile [40]. Trust enhances clients' hope for counseling and strengthens their sense of belonging, a key factor associated with hope in severe mental illness [38,41]. Through consistent, dependable therapeutic presence, clients can re-experience trust and repair damaged internal worlds [42]. Trust also anchors shared decision-making and encourages realistic hope in medical and primary care settings [43]. Trust in the therapist, the method, and ultimately in oneself facilitates movement toward change [44].

Together, wish, belief, and trust create a therapeutically generative orientation: the client desires a meaningful future, believes in its possibility, and trusts in the relational and internal resources that make striving worthwhile.

4. Authentic and False Hope

Especially during times of crisis and suffering, people can be vulnerable to false hope, which can be practically, socially, and morally misleading, dangerous, and even destructive, hindering individual and social well-being and growth. To avoid further personal pain, it is important to identify the signs of false hope and distinguish it from realistic hope [45]. Essentially, the detrimental forms of hope stem from misguided goals, flawed beliefs, and misplaced confidence. One main danger is to confuse hope with wishful thinking and biased optimism [46]. This can entail losing oneself in illusory fantasies and detaching from the uncomfortable reality [47].

In a psychotherapeutic context, authentic hope can be understood as a future-oriented and reality-attuned stance that helps clients engage constructively with uncertainty, distress, and change. It does not aim to restore an idealized past or deny present suffering, but supports the emergence of new possibilities for living, relating, and acting. Authentic hope broadens clients' perspectives by fostering imagination, cognitive flexibility, and openness to alternative pathways, especially when habitual interpretations, symptoms, or relational patterns have narrowed the sense of possibilities.

At the same time, therapeutic hope is not equivalent to unrealistic optimism. It remains grounded in the client's lived reality, available resources, limitations, and social context. It involves the careful exploration of what may be possible, meaningful, and worth pursuing, even under difficult conditions. Authentic hope is also relational: it often develops within a trusting therapeutic alliance, where clients experience recognition, care, and emotional safety. Through this relationship, hope can become internalized as confidence in one's capacity to endure, learn, and change. Finally, authentic hope is active

rather than passive. It supports engagement, perseverance, and small but meaningful steps toward heartfelt desires.

5. Synthesis of Empirical Findings

A substantial body of empirical research emphasizes hope as a key therapeutic factor influencing engagement, symptom reduction, and long-term recovery across different psychotherapy approaches [48,49]. Snyder and colleagues have shown that higher hope predicts better progress in cognitive-behavioral therapies (CBT) and increases clients' ability to pursue therapeutic goals [50]. Building on this, Irving et al. [51] demonstrate that client hope before treatment and in early sessions reliably predicts later outcomes, highlighting its role as both a precursor to and an effect of effective therapy.

In psychosis treatment, Hodgekins and Fowler [31] find that increases in hope mediate the positive effects of CBT on activity and functioning, positioning hope as a mechanism of recovery rather than a mere byproduct of improvement. Increases in hope and positive self-beliefs mediate improvements in real-world functioning, suggesting that hopeful, self-affirming cognitions energize clients to re-enter work, education, and social life. Additional work by Schrank et al. [52] and Hasson-Ohayon et al. [53] demonstrates that hope in schizophrenia-spectrum disorders is strongly associated with better quality of life, reduced depression, and lower self-stigma, and it often mediates relationships between symptoms and recovery-oriented outcomes.

Across broader clinical contexts, systematic reviews by Hernandez and Overholser [10], Walsh et al. [54], and Luo et al. [55] provide convergent evidence that hope-focused, positive psychotherapy, and other structured interventions consistently boost hope and decrease distress in older adults, people with cancer, and those with chronic mental illness. In specialized settings such as infertility, studies by Rahimi et al. [56], Nazemi et al. [57], and Yanik & Kavak Budak [58] show that hope-centered group programs significantly improve mental health and emotional resilience.

Collectively, these findings demonstrate that hope is not just an aspirational idea but a clinically modifiable factor that actively supports therapy, enhances client involvement, and promotes recovery across diverse populations and therapeutic approaches.

6. Hope Interventions

Hope-oriented interventions emphasize that hope is not just a result of therapy but a core mechanism of change. They often focus on boosting future orientation. Hope-Focused Therapy (HFT) positions hope as a central guiding principle, helping clients develop their goals, pathways, agency, and identity while overcoming obstacles, maintaining motivation, and reducing distress [40,59]. Cognitive-behavioral approaches also promote hope by reshaping beliefs, supporting recovery, and decreasing hopelessness across various conditions, including psychosis and late-life depression [10,31]. Broader mental health frameworks highlight that hope is delicate and requires intentional cultivation through education, stigma reduction, and collaborative goals in therapy [5]. Brief "hope modules" provide portable, adaptable strategies to combat demoralization in different clinical settings [18]. Solution-Focused Brief Therapy (SFBT) focuses on expectancy, preferred future imagery, exceptions, and resource talk, framing hope as a deliberate therapeutic goal reinforced by the therapist's attitude and language [35]. Across various protocols—CBT, psychoeducation, narrative therapies, and holistic care—enhancing hope strengthens dignity, challenges maladaptive beliefs, and supports recovery [36,60].

Interpersonal and relational aspects of hope are equally vital. Supportive relationships—therapeutic, familial, and peer—are key sources of hope, offering validation, safety, and models of possibility [4,25]. In daily practice, hope can be reinforced through

early alliance-building, clear therapeutic rationales, small wins, and collaborative goal-setting [38,39]. Even brief, structured hope interventions can boost engagement and maintain momentum [18]. Mental-health nursing practices nurture hope through presence, meaning-making, collaborative goal-setting, and the celebration of progress [27]. Ultimately, fostering hope requires clinicians to balance possibility with realism, creating a relational space where clients feel believed in, supported, and capable of change.

7. The Role of Health-Care Workers

Healthcare workers play a crucial role in shaping both the therapeutic process and the broader care environment. Research consistently demonstrates that clinicians can either foster or diminish hope depending on how they interact with individuals and families, and whether they communicate respect, possibility, and realism [13]. Nurses, psychiatrists, social workers, and psychologists can become “hope-carriers” through presence, genuine engagement, and attention to meaning-making [27,61]. This is especially vital in complex or long-term conditions like schizophrenia, where fostering belonging, agency, and a future outlook can reduce stigma and promote recovery [25,41,62].

Hope is not just a result of treatment but an active component within it, continuously co-created through relationships, attitudes, and clinical practices. Therapists’ own hopefulness is crucial: their expectations for client improvement are linked to outcomes [63,64]. Clinicians who model hope, express belief in a person’s capacity to change, and maintain a steady, caring presence can significantly enhance client hope. Therapeutic relationships based on empathy, validation, and curiosity help clients rediscover inner resources and loosen rigid beliefs that limit growth [16]. Organizational cultures also influence hope: environments built on respect, transparency, and belief in patients’ capacity support both client and staff morale, while demoralized settings risk therapeutic nihilism [17,65].

The education and training of health professionals should place greater emphasis on the multifaceted nature and clinical significance of hope. Therapists, nurses, counselors, and other care providers need to develop a nuanced understanding not only of patients’ fears, concerns, and vulnerabilities, but also of their hopes, aspirations, and sources of meaning. Such training should enable professionals to explore what patients and their families may realistically hope for, identify the experiences and relationships that sustain hope, and communicate hope in ways that are authentic, ethically grounded, and responsive to the patient’s individual situation. Strengthening this competence may contribute to more humane, person-centered, and therapeutically effective care. Below are ten takeaways practitioners can use to enhance patients’ hope [11,27,32,39,61,66,67] (Box 2):

Box 2. Takeaways for practitioners.

1. Be present and maintain relational continuity to foster trust.
2. Acknowledge negative emotions and despair without getting stuck in them.
3. Identify different types of wishes and hope, and shift therapeutic focus when needed.
4. Involve patients in decisions to increase control and buy-in. Adjust your therapeutic style to their individual preferences.
5. Use hopeful language that stays realistic. Foster hope without giving false reassurance.
6. Boost belief in therapy and use meaning-making to reframe critical situations in a positive light.
7. Set small, achievable, and visible goals, and build alternative pathways so that setbacks do not undermine hope.
8. Help patients shape everyday life to keep hope alive day-to-day.
9. Activate relational hope through attachment to family, mentors, and community.
10. Where possible, cultivate spiritual beliefs by encouraging prayer, meditation, and other spiritual practices.

8. Conclusions

Across the literature, hope is regarded not merely as an optional component of psychotherapy but as its essential foundation—an active component that promotes agency, self-efficacy, and ongoing engagement with change [68]. Recovery-focused models describe hope as the “trunk of the tree,” supporting and energizing all other areas—identity, social connections, work, self-esteem, and daily living skills [5]. Without hope, these branches cannot develop.

The therapeutic relationship itself seems capable of fostering this vital resource. Hope can be shaped, grows stronger with a solid alliance, and uniquely influences outcomes [38]. Furthermore, hope functions both as a process and an outcome: it encourages clients toward a meaningful future and sustains their efforts in the face of adversity [16]. Clinical work, therefore, requires intentionally fostering and safeguarding hope through visualizing possible futures, demonstrating a rooted belief in change, setting small goals, and emphasizing progress [11]. For many, this process is associated with belonging, connection, and meaning, underscoring the importance of hope in recovery [41].

Yet cultivating hope requires discernment. Authors consistently warn against false hope—optimism disconnected from realistic possibilities, which can turn into despair when unmet [11,16]. Maladaptive or rigid expressions of hope may even impede therapeutic progress [69]. True hope, on the other hand, remains grounded while remaining open to possibilities: a credible, adaptable stance that recognizes limits while also activating agency [3].

The present essay does not claim to provide a systematic literature review of hope in psychiatry and psychotherapy, as has been undertaken previously by Cutcliffe and Koehn [49], Koehn and Cutcliffe [48], Kylmä et al. [14], Luo et al. [55], Schrank et al. [16], and Walsh et al. [54]. Rather, it aims to offer a conceptually informed and clinically oriented synthesis of selected literature on hope relevant to psychotherapeutic and psychiatric contexts. Furthermore, the processual hope model presented in this essay is supported by philosophical and psychological theories but has not yet been empirically evaluated.

Future research should further examine which interventions are most effective in reducing hopelessness and fostering hope among patients. Particular attention should be given to the distinction between wishes and goals, as well as to the assessment and modification of patients’ beliefs about themselves, others, and their environment, including how these beliefs influence the formation of wishes, expectations, and goals. In addition, the role of trust in shaping future-oriented perspectives warrants more detailed theoretical and empirical investigation.

In sum, hope is widely regarded as the starting point and sustaining force of therapeutic change. As evidence suggests, it can be seen as a catalyst that enables clients to reclaim agency, rebuild identities, and engage with the world. Psychotherapy must therefore treat hope not as a by-product of progress, but as the very condition that makes progress possible.

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Abbreviations

The following abbreviations are used in this manuscript:

CBT Cognitive-behavioral Therapy

HFT Hope-Focused Therapy

pDIS Partial Dissociative Identity Disorder
SFBT Solution-Focused Brief Therapy

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