Hope: The Essential Therapeutic Factor

In Partial Fulfillment of the Requirements for
the Degree of Master of Arts in
Adlerian Counseling and Psychotherapy

By:
Sarah Jane Winger

May 2010
Acknowledgements

I would like to give thanks to everyone who has been a part of this endeavor and everyone who has helped and supported me throughout my life. Without you I would not be where I am today.
I said to my soul, be still, and wait without hope
For hope would be hope for the wrong thing; wait without love
For love would be love of the wrong thing; there is yet faith
But the faith and the love and the hope are all in waiting

Abstract

Hope is an essential factor in psychotherapy as it's possession by client and therapist alike is required for positive movement in therapy. This paper examined hope as a common factor, the importance of hope in the therapeutic setting, its role in early therapeutic change, and techniques for creating and fostering hope in both group and individual therapy. This paper also examined the consequences of hopelessness, depression, despair and hopelessness' ultimate danger: suicide. This paper also looked at hope through an Adlerian lens by examining the connection between Individual Psychology and encouragement.
Table of Contents

Hope: The Essential Therapeutic Factor 6
Hope in Mythology 6
Hope in Philosophy 7
Hope in Psychology-- an Introduction 9
Hope as emotion and cognition 10
Hope as a Common Factor 12
Hope in early therapeutic change 15
Creating Hope in Group Therapy- The Instillation of Hope 16
Building Hope in Individual Therapy 18
Keeping Hope Alive- In the eyes of the therapist 22
Keeping Hope Alive- In the eyes of the client 24
Snyder's Hope Scale 25
Alfred Adler, Hope, and Encouragement 27
Hopelessness 30
The Hopelessness Theory 31
The Helplessness-Hopelessness Theory 32
Suicide 33
Conclusion 35
References 37
Hope: The Essential Therapeutic Factor

Hope, as defined by the Webster's new Universal Unabridged Dictionary, is a desire accompanied by an expectation or belief in fulfillment or success. Hope is one of the oldest vehicles of human development and through an interdisciplinary examination, hope is defined in the many contexts through which it surfaces including, but certainly not limited to, mythology, philosophy, and psychology.

Hope in Mythology

Hesiod was a Greek poet that was believed to live in the eighth century. In his poem, *Works and Days*, he tells the myth of Pandora. Pandora was a woman Zeus ordered created by Hephaestus to punish men. Hephaestus molded her out of earth and each god contributed to her completion by giving her a unique gift. Athena taught her needlework and weaving; Aphrodite “shed grace upon her head and cruel longing and cares that weary the limbs” (Hawthorne, 1967) Hermes gave her a shameful mind and deceitful nature and the power of speech, putting in her lies and crafty words. Athena clothed her and then she, Persuasion and the Charites adorned her with necklaces and other finery. Then Horae adorned her with a garland crown. Finally Hermes gave her the name Pandora, meaning “all gifted” as all the Olympians gave her a gift.

According to the myth Pandora and a jar, said to contain more gifts, are given to Epimetheus from Zeus. Against caution by his brother Prometheus, Epimetheus accepted Pandora and her jar as gifts from the gods. One day, out of simple curiosity Pandora, against Zeus' instruction, opened the jar releasing all the evils of mankind. Instantly sickness, poverty, jealously and revenge, along with disease and plague were released into the earth. Realizing what she had done, Pandora quickly resealed the jar. Everything except hope was released from
the jar. It is thought that hope was left to comfort the humans in the face of the evils that were now loose in the world (Hawthorne, 1967).

**Hope in Philosophy**

Hope is a virtue that has been historically discussed in the context of uncertainty. Although hope originated as a virtue, by definition meaning an attribute of moral good, the twentieth century has seen the evolution of hope as an attitude stripped of moral content (Elliot, 2005). Augustine of Hippo (354-430 BCE) assumed hope to be future oriented and thus based on uncertainty. He regarded the notion of good as intrinsic to the notion of hope and claimed, “Hope...deals only with things that are good and which lie in the future and which have a relevance to him who is said to entertain it.” (Elliot, 2005).

Aristotle (384-322 BCE), the founder of virtue ethics, did not address hope specifically but his writings (and those of Augustine) were expanded upon by Aquinas. Faith, hope and love (charity) were added to the Greek list of virtues and Aquinas used and appropriated Aristotle's writing on virtue to develop his own theories. To distinguish the “newer” virtues (faith, hope and love) from the Aristotle's cardinal virtues of justice, prudence, courage and temperance, Aquinas labeled these theological virtues. The theological virtues were said to be based on God, rather than anyone or anything else, thus faith was faith in God, hope was hope in God and Love was love in God. Aquinas identified hope as a morally good disposition and believed that hope was connected to the future and to uncertainty. Aquinas thought that this enabled a believer to avoid the morally bad attitudes, or vices of despair and or fear.

Baruch Spinoza (1632-1677), a 17th century Dutch philosopher disagreed with Aquinas and believed that hope and fear were interdependent. He defined hope as “simply an inconstant
pleasure which has arisen from the image of a thing that is future or past, about whose outcome we are in doubt,” and “Fear, on the contrary, is an inconstant pain which has also arisen from the image of a thing that is doubtful.” Spinoza explained their co-existence: “When someone is hoping for something and doubts whether it will occur, he/she feels the pain of fear. When he/she is fearing something and doubts whether it will occur, he/she feels the relief of hope. Spinoza was likely unimpressed with both hope and fear and argued that they, like other states that arise from them such as confidence, despair, and joy are indications of ignorance and weak-mindedness. Spinoza much preferred reason and certainty to mere hope, and implicit in his thought was the idea that reason will deliver certainty whereas hope in God is uncertain. The power in reason would give human beings the power to get certainty, thus eliminating the need for hope. Spinoza was rejecting of the uncertainty that according to Augustine and Aquinas was essential for hope.

David Hume (1711-1776), an 18th century Scottish philosopher, considered fear and hope to be the most important instances of what he called direct passions and labeled hope as fear's opposite. Hume claimed “when either good or evil is uncertain, it gives rise to fear or hope, according to the degrees of uncertainty on one side or the other.” Hume believed that certainty of good or evil would give rise to grief or joy; the mere possibility of good or evil coupled with uncertainty, would give rise to hope and fear. When the chances were equal both fear and hope might arise.

Central to living a moral life, Immanuel Kant (1724-1804), an 18th century German philosopher asked “For what may we hope, given that we do our duty?” Kant regarded moral duty as something to be done irrespective to and even in the face of (possibly oppositional)
emotions. By the power of our wills, using our reason, human beings were to obey the Moral Law, irrespective of how they felt. Kant argued that, “All the interests of my reason, speculative as well as practical, combine in three following questions: What can I know? What ought I to do? What may I hope?” (Elliot, 2005). For the question theoretical and practical, “What may I hope?” Kant derives his answer from his concept of the highest good and ultimately from the idea of God. A human being may only hope for happiness on the grounds that God will make the necessary casual connection between mortality and happiness so that individual human beings get the happiness they each deserve. Again uncertainty is crucial for hope as all human beings can do is hope for their reward, they cannot be certain of it.

**Hope in Psychology-- an Introduction**

Hope first received attention from the fields of medicine and psychology in the 1950's and 1960's when Karl Menninger (1959) and others defined it as positive expectancies for goal attainment. In his 1959 address to the American Psychiatric Association, Karl Menninger exhorted his colleges to recognize the power of hope- their own as well as their patients' in understanding and treating mental illness. He wrote,

> Are we not now duty bound to speak up as scientists, not about a new rocket or new fuel or new bomb or new gad, but about this ancient but rediscovered truth, the validity of Hope in human development. Hope, alongside of it immortal sisters, Faith and Love (Menninger, 1959, p. 491).

Although people seek counseling and psychotherapy for a number of different reasons, each and every client seeks help with one factor in common, hope. Hope, present in even the smallest of degrees, involves the desire and belief that things can be different. Hope contains the
belief that by seeking some sort of help, assistance, or outside influence, change is possible. Hope is the one factor that extends across all demographics: all cultures and ethnicities, religions, ages, genders and sexual orientations and between all clinical presenting problems: from substance abuse to depression, domestic violence to anxiety, relationship issues to developmental concerns.

The presence of hope, be it in large amounts or small, is important in every stage of any change process and is requirement for movement in therapy. The absence of hope, or hopelessness, among people seeking change can lead to consequences as small as stuck-ness in the therapeutic process or as great as successful suicide. This paper recognizes hope as emotion and cognition and examines the importance of hope as a common factor in therapy and examines the importance of hope in early therapeutic change, instilling hope in group therapy, building hope in individual therapy, keeping hope alive for both therapists and clients and discusses the dangers of hopelessness. This paper also recognizes hope through an Adlerian lens, as compared to encouragement.

**Hope as emotion and cognition**

Clark in his 2003 article entitled Faith and Hope, defines hope as a longing for something that may not be certain but is at least possible. Clark goes on to discuss the problem of demoralization that often occurs among people who are struggling to come to terms with mental illness and its impact on their lives. Clark believes that this demoralization is characterized by a loss of hope and noted that people without hope have far poorer health outcomes than those who do. Because hope is a factor that relates to an individual's view of the future, it is inevitably related to outcome's of one's life. Clark notes that hope is not just a cognition or thought but is
Hope is a common part of coping processes used by most people to deal with daily life and extraordinary circumstances and is often experienced in situations of both adversity and success (Snyder et al., 2006; Yoani, 2008). Hope, like despair, anger and love is often viewed as a powerful emotion that emerges from within a person and acts as the “fuel” that drives interactions between people and their environment (Yoani, 2008). Jevne and Miller (1999) believe that hope exists because “it is essential to the quality of our life- as essential as is breath to physical existence.” (p. 10) Jevne and Miller explain that when people hope, they are able to keep going regardless of what life offers. With hope, individuals can find meaning, begin to see a future and cope with losses and other life challenges (Yoani, 2008). Hope also assists with adjustment processes in the aftermath of or during stressful life experiences and is used intentionally in counseling and psychotherapy to assist people in healing, recovery, and life transitions (Yoani, 2008).

Irving et al. (2004) identifies hope as a construct that focuses on individuals' goal-directed thinking. Irving reviews the relationship of hope to the presence of positive expectancies for goal attainment and claims that positive expectancies are essential to good mental health and that psychiatric disturbance reflects deficits in such goal-directed expectations.

**Hope as a Common Factor**

Although the exact cause of the effectiveness in psychotherapy is unknown, it is known that 80% of people that receive psychotherapy treatment are better off than those who do not (Snyder, Michael, and Cheavens, 2006). It is also unknown what the beneficial effects of
Hope

psychotherapy can be attributed to, but it is assumed that they largely result from processes shared by the various models and their associated techniques (Snyder et al., 2006). Research shows that most psychotherapy approaches affect change in clients with few differences in effectiveness. Common factors such as client factors, relationship factors, placebos and therapeutic techniques have been examined in the change process as a key to change. Snyder and colleagues believe that the beneficial effects of psychotherapy largely results from processes shared by the various models and their associated techniques.

Snyder (1994) asserts a new model of hope as a conceptual framework for achieving a better understanding of common factors, early improvement in therapy and placebo and expectancy. This model, The Psychology of Hope, examines the way that people think about their goals and proposes that these goals are thought about in two components. The first component contains the thoughts that people have about their ability to produce one or more workable routes to their goals. The second component involves the thoughts that people have regarding their ability to bring about continued movement on selected pathways toward those goals (Snyder, 1994). These two components are known respectively as pathways thinking and agency thinking and Snyder believes that both types of thinking must be present for a person to experience hope.

In this Snyder's cognitive model of hope, stress, negative emotions and difficulties in coping are considered a result of being unable to envision a pathway or make movement toward a desired goal (Klinger, 1975). Snyder et al. (2006) believes that this view is supported by both correlation and causal research that shows that people experience negative emotional responses when blocked from achieving their goals. Concurrently, research also shows that people are
likely to experience positive emotional responses and maintain hopefulness when they are able to both pursue their goals and generate alternative pathways when needed (Snyder et al, 2006).

Frank (1973) believed that people do not seek psychological help in response to a developed problem, but instead when they have become demoralized in their own problem-solving efforts. Frank and Frank (1991) noted such individuals are “conscious of having failed to meet their own expectations or those of others, or of being unable to cope with some pressing problem and feel powerless to change the situation or themselves.” Snyder's cognitive model of hope would dictate that these feelings of powerlessness to change indicate a lack of agency thinking. That is, the person without thoughts of being able to begin and continue movement successfully on a selected pathway toward his or her goals. As a result, the determination necessary to attempt goals is missing (Snyder et al., 2006).

Frank and Frank (1991) theorized that four factors work together to combat demoralization in all psychotherapy approaches. The four factors are (a) an emotionally charged relationship, (b) a therapeutic setting, (c) a therapeutic myth (or rationale) and (d) a therapeutic ritual. In the case of the first factor, Frank and Frank (1991) argue that the presence of an emotional, confiding relationship with a therapist who is both hopeful and determined to help, works to “re-moralize” clients. Snyder (1994) found that therapists must have hope for the clients to change. Therapists who are burned out or otherwise fail to convey hopefulness to their clients implicitly model low agency and pathways thinking. Related theory and research on the role of the therapeutic alliance and client's views of the therapy process further demonstrates the importance of clients being able to rely on and trust the therapist to guide them on the journey characterizing successful psychotherapy (Horvath & Greenberg, 1986).
The second factor set forth by Frank and Frank, is that of a therapeutic setting and includes a setting in which therapeutic encounters occur. Frank and Frank (1991) argue that settings reinforce perceptions of the therapist as a helper who is effective in facilitating positive changes and strengthen a client's hope for change. Settings that send either implicit or explicit messages that the client can expect successful change increase the opportunity for critical agency and pathways thinking (Snyder, 1994). The client must sense that this therapist-helper, working in this particular setting has helped other to reach their goals (Snyder et al. 2006).

The third factor set forth by Frank and Frank (1991) is the therapeutic explanation for why the client is experiencing the presenting symptoms. Equally important is an explanation for how the therapeutic procedure will help to alleviate the symptoms. Every school of therapy has a clearly defined theory regarding the origin, maintenance and resolution of difficulties that clients bring to the therapeutic process. Snyder and colleagues (2006) found that successful treatment depends, at least in part, on the plausibility of a particular school's theory to the client. Clients who agree with the rationale of a particular therapeutic approach are likely to experience an increase in agency thinking that ultimately translates into increased determination to move toward improvement-related therapy goals. Such thinking also serves to reinforce the resolution to continue trying, which decreases the chances of early termination from therapy. Snyder and colleagues also found that a compelling theory or therapeutic rationale also invites pathway thinking by providing an explanation for how movement toward desired goals can occur especially in the face of current and future obstacles.

The fourth therapeutic factor, which Frank and Frank (1991) assert as a requirement to combat demoralization in all psychotherapy approaches, is that of the therapeutic ritual or the
actual procedures used by therapists. Frank and Frank (1991) argue that in spite of the hundreds of different and sometimes contradictory, treatment procedures in use today, therapist's confidence in and mastery of a chosen method ultimately works by enhancing the client's belief in the potential for healing. Snyder (1994) believes that effective therapists model both agency and pathways thinking through their confidence in and mastery of the techniques they use.

An emotionally changed relationship, the therapeutic setting, the therapeutic explanation of symptoms and the therapeutic ritual all combine to produce cognitions that make the client's therapeutic goals more viable. Generally, the therapeutic relationship and setting in which psychotherapy occurs foster agency thinking, i.e. “I can do it!” The particular rationale and therapeutic ritual act to enhance pathways thinking i.e., “Here's how I can do it!” As the agency thinking and pathways thinking combine, the resulting hope is predictive of more favorable therapeutic outcomes (Snyder et al., 2006).

**Hope in early therapeutic change**

Research consistently shows that a substantial portion of client improvement occurs within the first three to four weeks of treatment (Fennell & Teasdale 1987; Ilardi & Craighead 1994; Howard, Kopta, Krause, and Orlinsky, 1986). For example, clients have been observed experiencing significant improvement following an initial diagnostic interview or after receiving a promise of treatment. In a series of treatment studies, researchers find that 40% to 66% of clients reported positive, treatment-related improvement before attending their first session (Howard et al., 1986). Similar studies suggest that 56% to 71% of the variance related to total client change can be accounted for by change occurring in the early stages of treatment (Fennell & Teasdale, 1987; Howard, Lueger, Maling, and Martinovich, 1993). Such dramatic
improvement occurring so early in the treatment process can hardly be the result of specific
treatment effects or a particular therapeutic technique. Ilardi and Craighead (1994) claim that
clients have usually not even learned the supposedly “active” mechanisms for change by the time
improvement occurs in these early stages of treatments. Rather, the rapid response of clients
must be the product of the common factors - especially hope.

Early changes in psychotherapy may be viewed as a reflection of increases in agency
thinking by the client or a renewed determination to accomplish their goals. Clients are often
bogged down and seem unable to formulate goals or mobilize themselves toward their goals
when they first enter psychotherapy. The very act of deciding to enter psychotherapy can
represent a new determination to achieve a specific goal of “getting better” and as such cause
spark in agency thinking that propels the new client toward the goal of improvement (Snyder et
al, 2006). This is not to say that treatment of psychotherapy is unimportant or irrelevant, as gains
are even more evident when treatment is added to these early improvements. Both agency and
pathway thinking is critical in the productions and then later maintenance of change.

**Creating Hope in Group Therapy- The Instillation of Hope**

Yalom (2005), through his research and practice of group therapy suggests that
therapeutic change is an enormously complex process that occurs through an intricate interplay
of human experiences. Yalom refers to these human experiences as “therapeutic factors” claims
that there is a considerable advantage in approaching the complex through the simple when
examining the therapeutic experience. Through basic component processes, Yalom has
accordingly divided the therapeutic experience into eleven primary factors. Appropriately, the
first primary factor is Instillation of Hope (followed by universality, imparting information,
altruism, corrective recapitulation of the primary family group, development of socializing
techniques, imitative behavior, interpersonal learning, group cohesiveness, catharsis, and
existential factors.) Yalom states that the distinctions among these factors are arbitrary and
believes these factors are interdependent, neither occur nor function separately.

Yalom asserts that the instillation and maintenance of hope is crucial in any
psychotherapy. Not only is hope required to keep the client in therapy so that other therapeutic
factors may take effect, but similarly to what Frank and Frank (1991) believe, Yalom claims that
faith in the treatment mode itself is therapeutically effective. Also similar to Frank and Frank's
four factors to combat demoralization, Yalom believes that a positive outcome in psychotherapy
is more likely when the client and the therapist have similar expectations of the treatment.
Yalom (2005) asserts that a high expectation of help before the start of therapy is significantly
correlated with a positive therapy outcome.

In group therapies, Yalom (2005) believes that group therapists can capitalize on the hope
factor by doing whatever they can to increase the clients' belief and confidence in the efficacy of
the group mode. According to Yalom, this task begins before the group even starts, in the pre-
group orientation, during which the therapist should reinforce positive expectations, correct
negative preconceptions and present a lucid and powerful explanation of the group's healing
properties (Yalom, 2005).

Yalom (2005) asserts that group therapy not only draws from the general ameliorative
effects of positive expectations, but also benefits from a source of hope that is unique to the
group format. Therapy groups invariably contain participants who are at different points along a
coping-collapse continuum. Each member thus has considerable contact with other individuals,
Hope typically with similar problems, who have improved as a result of therapy. Yalom notes that clients often remark the end of their group therapy how important it was for them to have observed the improvement of others. The group therapist should by no means be above exploiting this factor by periodically calling attention to the improvement that members have made. Hope is flexible, as it defines itself to fit the immediate parameters it transforms, becoming hope for comfort, for dignity, for connection with others, or even for minimum physical discomfort.

Many self-help groups place a major emphasis on the instillation of hope. A major part of Recovery Inc (for current and former psychiatric patients) and Alcoholic Anonymous meetings is dedicated to testimonials (Yalom, 2005). At each meeting, members give accounts of potentially stressful incidents in which they avoided tension by the application of Recovery Inc. methods, and successful Alcoholic Anonymous members tell their stories of downfall and then rescue by AA. One of the great strengths of AA is that fact that the leaders are all alcoholics, a living inspiration to the others (Yalom, 2005). Substance abuse treatment programs commonly mobilize hope in participants by using recovered drug addicts as group leaders. Members of these groups are inspired and expectations are raised by contact with those who have trod the same path and found the way back.

**Building Hope in Individual Therapy**

Horowtiz (2008) examines hope and expectation in the psychotherapy of the long-term mentally ill and poetically defines hope as “something that is nurtured and cultivated and grows out of the transformation of dimly imagined possibilities into realities” (p. 238). Like Frank and Frank's four factors and Yalom's view on instillation of hope, Horowitz explains that hope exists
not in the abstract but in the relationship that comes to life over the course of therapy. Hope is indissolubly tied to expectation. It is not a blind faith in the promise of the future but rather a sense of genuine possibility born of deep struggle and mature recognition of life's limits and prospects.

If a client leaves his or her first session of psychotherapy with a sense of expectation or genuine possibility, or simply hope, the odds of his or her attending another session are likely to be much higher (Hanna, 2001). Building hope involves directly empowering a client, helping her or him to become more capable and confident as part of perceiving a favorable, realistic future. The therapeutic process is largely dedicated to helping a client become more stable in the face of adversity and better able to focus on positive outcomes with the realistic expectation that problems and situations will turn out well. The client who is hopeful and has sufficient coping skills is better able to deal with problems and issues. The hopeful client also has the capacity to see beyond the problems toward a bright future.

Hanna (2001) claims that by strengthening and empowering the client, hope can be instilled, and that hope can serve as a precursor toward change. When a client has hope, the other precursors can be positively affected by its pervasive influence throughout the range of that person's life. Hanna claims that the gift of hope is the gift of a desirable future. Thus, Hanna believes, hope building is done through any approach that can make the future more tolerable.

Hanna claims that the therapist's positive expectations of a client can be highly influential on the client's success in therapy, as a therapist's confidence is contagious. When working with a client to build hope through empowerment, a therapist simply believing in a client can help the client get through an issue or successfully solve a problem. Many clients have told their
therapists they have successfully handled a problem because of the faith of confidence the therapist had in them. In this way, Hanna believes that hope is contagious.

To build hope through empowerment, Hanna (2001) presents two modes as especially helpful: reframing negative behaviors as skills and converting a threat into a challenge. One of most helpful ways of empowering clients is to demonstrate to them that their dysfunctional, negative behaviors can be reframed into positive skills, available to them through their own choosing. All too often, the message received by people who have negative behaviors is that the behaviors are “bad” and are something that no good or worthy person would ever do. The key is to reframe negative behaviors as skills. For example, rather than inform a manipulative client that her or his behavior is destructive, the therapist can reframe it as a kind of skill that involves accurate perception and persuasiveness in getting people to do what they want.

Clients are far more willing to talk about their manipulative behavior when it is framed as a skill. The therapist can admire it as a skill, hard earned and well practiced. The therapist can suggest that the skill is actually underused and can be used in other, more positive ways. If one is a selfish manipulator, one can redirect or reverse that very same skill and become a helper. The same perception that is used to exploit a person also be used to help a person. Thus, the therapist can inform the client that up until now, the skill of manipulation was being used for selfish purposes. When the client realizes that he or she already has the blueprint of positive skills, it builds hope by making the refinement of those skills seem a realistic possibility.

When a client is threatened by a set of circumstances, problems, or general conditions, hope can be adversely and sometimes seriously affected (Hanna, 2001). The greater the perceived threat, the lower the level of hope will be for a positive outcome. The key to this
strategy is to reframe that perceived threat into what looks more like a challenge, thus rendering it more likely to be successfully handled. If a threatening problem is perceived as a challenge, hope will not only remain intact, it may also be enhanced.

The reframing procedure comprises two steps. The first step is locating and identifying the client's skills, of which he or she may be even be aware. If the client was a victim of oppression, for example she or he may be highly perceptive of others, even if easily exploited. Similarly, being a survivor of abuse can be reframed as an ability to endure hardship as part of solving a problem. Ingratiating or “people-pleasing” behaviors require the skill of perception as part of knowing what people want. A host of skills can be recognized in clients ranging from patience and strength to assertiveness and intelligence. A skill is a skill, no matter how little or well developed it may be. If a client recognizes it as a skill, hope may be enhanced.

After skills are identified, the problem itself can be addressed. The therapist can suggest that the client's skills are especially suited to the problems at hand and are what is needed to solve it. When clients see that the skills they possess in other domains can be transferred to the current problem, hope can be increased and the effort precursor may be enhanced as well (Hanna, 2001).

Basset, Lloyd and Tse (2008) also examine ways of instilling hope in individual therapy through their research on spirituality and hope in recovery from mental health problems. They present several practical steps the therapist can take to instill hope, such as emphasizing the importance of establishing a vision of the future, finding out what clients want to become and simply highlighting the fact that the development of hope is an evolving process. Basset et al. also emphasizes the importance in honoring the process of helping individuals develop hope
when none seems to exist, and the importance of acknowledging grief and despair. Lastly, one of the most powerful tools available to therapist Basset et al. believes, is to help clients find hope through the experience of engaging in meaningful activities and achieving small goals leading to more possibilities in the medium or longer term. This in turn creates a belief in possibilities, which were thought lost or were never imagined. Having taken these simple steps, Basset et al believe that the therapist can then help to equip the client with specific problem solving skills to combat obstacles.

**Keeping Hope Alive- In the eyes of the therapist**

As discussed previously, there are four factors that Frank and Frank believe to work together to combat client demoralization across all psychotherapy approaches - the therapeutic relationship, the therapeutic setting, the theoretical orientation and the therapeutic ritual. It is the therapist's responsibility and obligation to make sure that these factors are present. Flaskas (2007) reinforces this belief by claiming it is the job of the therapist to hold on to hope for their clients in seemingly hopeless situations.

The heavy yet essential responsibility of holding onto hope falls onto the shoulders of the therapist. Pentecost and McNab (2007) stress the importance of therapists continually monitoring the extent to which to which they feel drowned in the depression themselves, mentally overwhelmed and useless. Through their research on keeping company with hope and despair, Pentecost and McNab (2007) draw attention to the therapist that frequently finds themselves working on the edge between hope and desolation, and at times is witness to the stultifying effects of depression on people's lives yet at other times amazed by client's ability to take the modest flickers of optimism from a therapeutic session and return next time reporting
new changes they have made.

Horowitz (2008) also warns of the polarization of hope that clients may have and claims that hope alternately surges and fades as ambitions crystallize and dissolve. Horowitz proposes deriving gratification from even the most incremental change is essential, lest a therapist plunge deeply into questions about her or his own worth and competence. When therapy continues over a vast period, but movement of almost any kind comes to a halt, therapists inevitably question their efficacy. No one engaged in psychotherapy will avoid this dilemma, whose resolution lies in the maintenance of what Horowitz declares a precarious and fragile balance. Only through establishment of an understanding of what to hope for can a therapist come close to achieving such a balance (Horowitz, 2008). The therapist's hopefulness must remain attuned to the client's expectation, forever reworked over the course of a lengthy relationship (Horowitz, 2008).

Munchin and Fishman (1981) describe a process in work with families whereby the therapist gets pulled into the interactional pattern of the family and in turn gains a unique perspective on the dynamics operating therein. To combat this enmeshment and to address a possible need to increase the therapist's sense of hopefulness Pentecost and McNab (2007) discuss the advantages of a co-therapy approach. Pentecost and McNab believe it is helpful to recognize that one member of the client family may become inducted into the despair which may show itself as frustration, lack of curiosity, a feeling that minimal or no change is happening. Co-therapy provides the opportunity to for one member of the therapeutic team to become inducted into the same depressive position (Pentecost & McNab, 2007). As challenging fixed narratives about the futility of change is such a crucial aspect of the therapy process, Pentecost and McNab identify the value of the second member of the co-therapy team needing to occupy a
role in cheering on the smallest change, positively connoting family stories of entrenched behavior and immutable personalities.

Pentecost and McNab (2007) note that the binocular approach provided by co-therapy allows therapists to notice and expand the sparkling moments in working with clients. In many cases working towards “preferred futures' rather than dwelling in hopeless pasts” has become the preferred path and helps to instill hope back into the family system. Setting small goals and seeing them successfully achieved has the ability to spur on a co-therapy team, and enviably transforms the therapists into “cheerleaders for change” (Pentecost & McNab, 2007).

Another crucial aspect for keeping hope alive in the eyes of the therapist is the necessity for a therapist to build dependable and encouraging networks (Pentecost & McNab, 2007). In considering what keeps hope alive for clients and for therapists and how these threads interweave, it is important to appreciate that in order to provide a safe and hopeful environment for clients, therapist must pay attention to making themselves as safe as possible in their surroundings.

**Keeping Hope Alive- In the eyes of the client**

Snyder (1995) notes the common process among interventions to promote positive change or growth is an “attempt to increase the sense of agency and pathways that people have for the goals in their lives” (p. 570). Snyder and his colleagues at the University of Kansas-Lawrence have discovered ways to measure hope, and have found strong correlations between one’s belief in their abilities to reach goals. According to Snyder (1996), “high-hope individuals” typically: (a) can clearly conceptualize their goals, (b) can envision one major pathway to a desired goal and can generate alternative pathways, especially when the original one is blocked,
Hope

and (c) perceive that they will actively employ pathways to their goals.

Snyder (1996) studies what high-hope people tend to say and tend to do and based on these observations, combined with research aimed at changing agency (willpower) and pathways (waypower), he gives the following suggestions for enhancing hope.

1. Learn self-talk about succeeding
2. Think of difficulties encountered as reflecting wrong strategy, not lack of talent
3. Think of goals and setbacks as challenges, not failures
4. Recall past successes
5. Find stories about how others have succeeded (i.e. movies, books, tapes)
6. Cultivate friends with whom you can talk about goals
7. Find role models that you can emulate
8. Exercise physically
9. Eat properly
10. Rest adequately
11. Laugh at oneself
12. Re-goal (persistence in the face of absolute goal blockage deflates agency and pathways)
13. Reward oneself for small subgoal attainments on the way to larger, long term goals
14. Educate oneself for specific skills as well as learning how to learn

**Snyder’s Hope Scale**

In his attempts to measure hope as a cognitive set, Snyder (1994) developed an individual-differences measure called the Hope Scale. The scale is a 12- item questionnaire that
Hope asks the taker to rate with a number the extent to which a statement is true for them, ranging from definitely false to definitely true. Eight statements are actually measured and the sum of the answers provides the Hope Score. The designation of each question is listed and included are the four distracter questions.

1. I can think of many ways to get out of a jam. (Pathway)
2. I energetically pursue my goals. (Agency)
3. I feel tired most of the time. (Distracter)
4. There are lots of ways around any problem. (Pathway)
5. I am easily downed in an argument. (Distracter)
6. I can think of many ways to get the things in life that are important to me. (Pathway)
7. I worry about my health. (Distracter)
8. Even when others get discouraged, I know I can find a way to solve the problem. (Pathway)
9. My past experiences have prepared me well for my future. (Agency)
10. I’ve been pretty successful in life. (Agency)
11. I usually find myself worrying about something. (Distracter)
12. I meet the goals that I set for myself. (Agency)

When administering the scale, it is called the Future Scale. The agency (willpower) subscale is derived by summing items 2, 9, 10, and 12; the pathways (waypower) subscale score is derived by adding items 1, 4, 6 and 8. The total Hope Scale score is derived by summing the four agency and the four pathway items.

Snyder et al. (1991) through studies with college students and patients finds that the Hope
Scale demonstrates acceptable internal consistency, test-retest reliability, and the factor structure identifies and agency and pathway components of the Hope Scale. Snyder et al. also finds that the Hope Scale scores augment the prediction of goal-related activities and coping strategies beyond other self-report measures.

**Alfred Adler, Hope, and Encouragement**

The aim of Alfred Adler's Individual Psychology is always to increase an individual's courage to meet the problems of life (Ansbacher & Ansbacher, 1956). Encouragement techniques used to increase an individual’s courage are so foundational in Individual Psychology. Alder stated, “Altogether, in every step of the treatment, we must not deviate from the path of encouragement.” (Ansbacher & Ansbacher, 1956, p. 342). Adler's definition of encouragement may be taken as activating social interest, as he equates courage with activity plus social interest. Encouragement techniques are used by Adlerian therapists to foster client responsibility and increase client courage.

Adler believed that psychotherapy is an exercise in cooperation and a test of cooperations (Ansbacher & Ansbacher, 1956). Adler states:

“We can succeed only if we are genuinely interested in the other and we must be able to see with his eyes and listen with his ears. He must contribute his part to our common understanding and we must work out his attitudes and his difficulties together. Even if we felt we had understood him, we should have no witness that we were right unless he also understood. A tactless truth can never be the whole truth; it shows that our understanding was not sufficient. We must cooperate with him in finding his mistakes, not for his own benefit and for the welfare of others.”
Demonstrating concern for the client, instilling hope, showing the client that there are answers to problems and emphasizing the positive, are all Adlerian encouragement techniques. Helping the client to redefine goals in order to lessen over ambition and decrease fear of failing is another encouragement method, and the use of these methods often results in the client actively accepting responsibility for herself or himself (Carlson & Slavik, 1997).

The first phase of an Adlerian intervention, and for almost all other approaches as well, is the establishment of a meaningful therapeutic relationship with the client (Oberst & Stewart, 2003). This relationship, in fact becomes the vehicle through which the significant attitudinal and behavioral changes occur (Rogers, 1961). The therapeutic relationship does not develop and evolve in a completely freestyle manner, and in Adlerian psychotherapy, attention is paid to the clients attempt to instantiate previously dysfunctional interpersonal patterns with therapist to maintain the status quo of their problems and relationships (Oberst & Stewart, 2003). Adlerian practitioners attend to several issues that frame the ground rules of treatment and that orient them and their clients to the work that lies ahead. Similar to both Frank and Frank's four components and Yalom's ideas, three components create the frame for Adlerian interventions; (a) parameters of the therapeutic contact, (b) relationship with the client, and (c) agreement on goals for treatment.

The first component of an Adlerian intervention essentially defines how treatment will occur for a particular client and includes considerations about the length of the treatment, frequency of the session, contacting the therapist between sessions, therapist reimbursement, and so forth (Oberst & Stewart, 2003). The second component pertains to the establishment and maintenance of the relationship with the client. More than other components of the frame, the
therapeutic relationship occupies a central role in fostering both encouragement and a renewed sense of co-operation in clients (Oberst & Stewart, 2003).

The third component in the frame for Adlerian interventions is agreement on goals for treatment, during which the client and therapist must come to some agreement about the goals of the treatment so that the therapeutic relationship can be put to its best use (Oberst & Stewart, 2003). The Adlerian therapist can move this process along by directly inquiring about the events of experiences that occasioned the scheduling of the first appointment (i.e. “What brings you in to see me today?”). Further inquiries along the lines of “What kind of person would you like to be six months from now? How about a year from now?” will also reveal something about the client's expectations for personal transformation through the therapy (Oberst & Stewart, 2003).

Adler cautions against instilling a false amount of hope within the client by warning the therapist against promise or even strong hint that complete recovery or the client's image of an ideal self will be realized by the therapy (Adler, 1968). Adler claims that providing such assurances effectively give the balance of power to clients who, in moments of safeguarding and depreciation, may frustrate the therapists desire to produce “success.” Leaving open the possibility that they client may feel worse before feeling better or that another therapist may provide more rapid results and so forth, will disarm some of the high expectations that clients and therapist may unwittingly develop. In addition, retaining the options for evaluating progress and renegotiating therapy goals periodically also keeps therapist from over-committing.

**Hopelessness**

Hopelessness is the expectation that highly desired outcomes will not occur, that highly aversive outcomes will occur and that one cannot change this situation (Haeffel, Abramson,
Hopelessness theory and the approach system: Cognitive vulnerability predicts decreases in goal-directed behavior, examines a hypothesized etiological chain of cognitive vulnerability-stress, hopelessness, goal-directed behavior, and depressive symptoms.

Haeffel et al. find that cognitive vulnerability interacts with stress to predict changes in goal-directed behavior, importantly the relationship between the cognitive vulnerability-stress interactions and goal-directed behavior was mediated by hopelessness. Participants in the Haeffel et al. study who experienced a decrease in goal-directed behavior had higher levels of depressive symptoms than those who did not experience a decrease in goal-directed behavior. In other words, hopelessness is thought to cause a decrease in motivation towards an individual's pursuit of goals and rewards (Haeffel et al., 2008).

In examination of hopelessness and its connection to demographic factors in the community, Greene (1981) found that hopelessness levels were connected with increasing age and low socioeconomic status. Greene (1981) also found that hopelessness was associated with decreases in life satisfaction, poor subjective health, depression, suicidal ideation, and alexithymia. Soares, Macassa, Grossi, and Viitasara (2008) reviews studies of the general population that connects hopelessness and depression and anxiety while finding hopelessness to be stable over time and independently connected to a poor financial situation (which was also associated with
depression). Tanaka, Sakamoto, Ono, Fujihara and Kitamura (1996) observed in a community-based sample that hopelessness was negatively linked to subjective physical fitness and self-confidence.

**The Hopelessness Theory**

The hopelessness theory of depression suggests that the attributional style for negative events is deemed a distal cause of depression in an individual who displays the tendency to attribute negative outcomes to internal, stable, and global factors, or a tendency to interpret positive events as being external, unstable, specific and unimportant (Abramson, Metalsky & Alloy, 1989). More simply put, individuals who have a tendency to attribute events to stable and global causes, and infer both negative consequences and negative self-characteristics following the occurrence of these events. Based on the cognitive-vulnerability-stress model for understanding the development of depression, these individuals should be vulnerable to developing symptoms of and diagnoses of depression in the presence, but not absence of negative life events (Gibb, Beevers, Andover & Holleran, 2006).

According to Haefel et al. (2008) the hopelessness theory underscores the importance of cognitive process in the etiology, maintenance, and treatment of depression. According to the hopelessness theory of depression, some individuals have a cognitive vulnerability that interacts with stress to produce depression. Specifically, the hopelessness theory posits that people are vulnerable to depression because they tend to generate interpretations of stressful life events that have negative implication for their future and for their self-worth. People who generate these negative interpretations develop hopelessness, which is a proximal and sufficient cause of hopelessness depression (a theoretically derived subtype of depression characterized by
Hope symptoms such as retarded initiation responses, lack of energy, sad affect, and apathy) (Haeffel et al, 2008).

**The Helplessness-Hopelessness Theory**

The helplessness-hopelessness theory is an extension of the revised hopelessness theory of depression and follows a series of increasingly complex formulations that describe the role of attribution and life events in the etiology of depression (Swendsen, 1997). According to the helplessness-hopelessness model, once negative life events occur, an individual then determines the degree to which the event is within his or her control, as well as the degree to which the cause of the event is internal (due to self), stable (enduring over time), and global (affecting outcomes in many life domains). The helplessness-hopelessness model views anxiety and depression as both being characterized by helplessness (i.e. the expectation that future negative outcomes, should they happen, would be uncontrollable), but differing in that only depression is characterized by hopelessness (an expectation that future negative outcomes will occur due to attributions that the causes of negative events are stable and global) (Swendsen, 1997).

The high frequency of pure anxiety is explained by the helplessness-hopelessness model in that hopelessness (which causes anxiety) can occur without hopelessness or hopelessness depression. However, as hopelessness cannot occur without helplessness, depressive syndromes commonly have significant anxiety symptoms. Similarly, the evolution of anxiety into (but not the reverse) is also explained by a progression through the cognitive continuum from helplessness to hopelessness. In this way, anxiety is seen as the initial mood response to negative event and helpless attributions, but may evolve into hopelessness depression as the individual becomes more certain that the causes of negative events are stable and global (Swendsen, 1997).
Suicide

Amid dreams of happiness and achievement lurk nightmares of self-destruction especially among individuals feeling hopeless, helpless and discouraged. Suicide, although it occurs uniquely in each individual’s mind, is something that happens every day and is attributed to what Shneidman (1996) calls psychache. Suicide is caused by pain, a certain kind of pain—psychological pain and this psychache stems from thwarted or distorted psychological needs. When an individual experiences these negative emotions in some heightened degree, psychological anguish and disturbance follow and an individual may feel upset, disturbed and perturbed. Pain is nature’s great signal; pain warns us; pain both mobilizes us and saps our strength; pain, by its very nature, makes us want to stop it or escape from it.

Although Shneidman claims that each suicidal death is a multi-faceted event and biological, biochemical, cultural, sociological interpersonal, intrapsychic, logical, philosophical, conscious, and unconscious elements are always present, in the proper distillation of the event, its essential nature is psychological. Shneidman believes this constant state of anguish is caused by pain, sometimes physical pain, but more often psychological pain. Psychological pain is the basic ingredient of suicide and suicidal death is in other words is an escape from pain (Shneidman, 1996).

In attempts to create certain set of psychological characteristics that are present in all suicides, Shneidman (1996) developed 10 commonalities of all suicide. By “commonality,” it is meant a feature that is present in at least 95 out of 100 committed suicides—an aspect of thought, feeling, or behavior that occurs in almost every case suicide. By “all suicides,” it is meant to span across age, sex, ethnic status, and psychiatric diagnosis. Shneidman (1996) found that the
common emotion in suicide is hopelessness-helplessness. At the beginning of life, an infant experiences a number of emotions (rage, bliss) that quickly become differentiated. In adolescence and adults of a suicidal state, the pervasive feeling is that of helplessness-hopelessness: “There is nothing I can do [except commit suicide], and there is no one who can help me [with the pain that I am suffering].” The early psychoanalytic formulations about suicide emphasize unconscious hostility, but today it is assumed that there are other deep basic emotions. The underlying one of these is the emotion of active, impotent ennui, the despondent feelings that everyone is hopeless and I am helpless, in other words, “the rays of hope are lost” (Shneidman, 1996). Below are Shneidman's Ten Commonalities of Suicide:

1. The common purpose of suicide is to seek a solution.
2. The common goal of suicide is cessation of the consciousness.
3. The common stimulus of suicide is unbearable psychological pain.
4. The common stressor in suicide is frustrated psychological needs.
5. The common emotion in suicide is hopelessness-helplessness.
6. The common cognitive state in suicide is ambivalence.
7. The common perceptual states in suicide is constriction.
8. The common action in suicide is escape.
9. The common interpersonal act in suicide is communication of intention.
10. The common pattern is suicide is consistency of lifelong styles.

Often it is assumed that depression is the number one risk factor in suicidality, yet Soares et al, (2008) found that hopelessness may be a more important risk factor than depression in explaining suicidal ideation and in identifying suicide ideators, long term suicidality in clinical
groups, suicide in psychiatric outpatients and those who did or did not eventually die by suicide. However, in attempts to offer an opposing perspective on the dangers of hopelessness, Soares et al found that associations among depression, suicidal intent/attempt, and hopelessness are not consistent across all studies. Soares et al, in their study on psychosocial correlates of hopelessness among men, review studies that indicate that not all depressed patients experience hopelessness and found that hopelessness is not always a useful predictor of suicidal intent/attempt.

**Conclusion**

Frankl (1984) reasoned that if illness is associated with a lack of hope, then successful treatment must involve its restoration. With that in mind, this paper has discussed the importance of hope in therapy and the necessity of its possession by the therapist, client and group. It is important to remember that while hope is essential for change, the simple creation or instillation of hope will not guarantee therapeutic success or even change. Hope can be viewed as gasoline in a vehicle, without it a car will not start, let alone move. It is the job of the therapist to instill hope into hopeless clients so that they are able to start and begin movement. It is at that time that other therapeutic factors must be considered and taken into account when examining therapeutic success and or client change.

This paper has reviewed hope as a therapeutic factor and it's impact in the early stages of therapeutic changes. The paper has examined the importance of creating and building hope in group therapy, individual therapy and reviewed the necessity of keeping hope alive in both the eyes of the client and the therapist. Snyder's Hope Scale, a valid and reliable assessment for measuring hope in the therapeutic setting has been discussed.
This paper has reviewed hope through an Adlerian lens by discussing Individual Psychology, hope and encouragement. The dangers of hopelessness have been reviewed and the Hopelessness Theory and Hopelessness-Helplessness Theory have set forth its connection to changes in goal-directed behavior. The consequences of hopelessness and its potential to lead to helplessness and suicidality have been described and common factors outlined.
References


In L.S. Greenberg & W.M. Pinsof (Eds.), *The psychotherapeutic process; A research handbook* (pp. 367-390). New York: Guilford Press.


Snyder, C. R. (1996). To hope, to lose, and to hope again. *Journal of Personal and Interpersonal Loss, 1*, 1-16.


Swendsen, J. D. (1997). Anxiety, depression and their comorbidity: An experience sampling test
of the helplessness-hopelessness theory. *Cognitive therapy and research, 21*, 97-114

