RUNNING HEAD: Hope Development in Psychotherapy

Hope Development in Psychotherapy:

A Grounded Theory Analysis of Client Experiences

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October, 2008

A thesis submitted to McGill University in partial fulfillment

of the requirements for the degree of Doctor of Philosophy

Acknowledgments

There are no words to express my appreciation and gratitude to my doctoral supervisor, Dr. Marilyn Fitzpatrick, for her continued and unconditional support, guidance, and encouragement throughout all these years. Marilyn, thank you for always being available, understanding, and caring when I needed you most; for the numerous opportunities to collaborate with you on projects that helped me grow as a researcher and discover my interests; for always believing in my abilities and pointing out my strengths; and for all your generous treats to celebrate every milestone. I feel lucky and blessed to have been your student. To my advisory committee, Dr. Jack De Stefano and Dr. Martin Drapeau, thank you for your thought-provoking questions and constructive feedback, and for always making yourselves available, even during the most hectic times.

I would also like to extend my heartfelt appreciation to Jennifer Janzen, my devoted auditor. Jennifer, I have tremendous respect for the way your mind works and for your infinite intellectual curiosity. Thank you for always being up for challenging discussions and fruitful debates. To Jewel Perlin, who conducted some of the interviews while I was away, thank you for being so meticulous; I knew I could trust you. To Carole Robertson and Daria Hobeika, who performed one of the most tedious tasks, the transcription of my interviews, thank you for doing such a wonderful job and for always respecting my time limits. Fran Gauvin, you have been an endless source of moral support and encouragement for me from the time I met you till my submission day. Thank you for always cheering my efforts and successes with such genuine excitement, for reminding me the importance of self-care, and for translating my abstract in such

short notice! And to Anusha Kassan, my loyal Ph.D. companion, I would not have survived this program without you. Thank you for always being there.

To the front line staff of the McGill Counselling Service, thank you so much for managing my data collection so diligently. It was such a relief to know that I can depend on you. Also, a special thanks to all my study's participants for their time and commitment to my study, as well as to all the McGill counsellors for letting me interview their clients.

None of this would have been possible without the endless love and support of my wonderful family. Demetre, my beloved husband, your unconditional love, patience, understanding, and continuous encouragement through all these years kept filling my batteries. Thank you for giving me the strength, energy, and motivation I needed. I love you so much. Xenia and Alexia, you are the most amazing sisters in the whole wide world. You were always so far, yet so close to me. Thank you for always making me feel so special.

Dad, what can I say? You have been an exceptional father in every possible way since the day I was born. I wholeheartedly thank you for encouraging me to pursue my dream and for helping me realize it without second thought, even though it meant being away from you for so many years. This thesis is respectfully dedicated to you.

Abstract

Client hope has long been considered one of the most potent common factors accounting for positive psychotherapy outcomes. Research on the relationship of hope to successful outcome has produced promising results indicating the need to discover the processes and conditions under which hope flourishes during therapy. The present study examined the trajectory of hope development in psychotherapy based on in-depth, semi-structured interviews with 17 counselling clients presenting at a university counselling center with various concerns. Clients completed a measure of state hope before the first and after every session, and were interviewed once their responses indicated significantly higher levels of hope. Client narratives were analyzed using grounded theory methodology. Findings were synthesized into a dynamic and multifaceted theory, the *Hope as Empowerment Theory* (HET), which adopts an integrative view of hope as both cognitive and affective, and conceptualizes increased client hopefulness as a higher sense of control over the problem and as an increased sense of direction toward positive change. The compatibility of client preferences with therapist input was observed to raise clients' faith in the process of counselling, which was in some cases the stepping-stone for gaining hope in the outcome. A number of conditions, including the adaptability of client role preferences and the directiveness of hope-inspiring therapeutic strategies, were found to produce different types and varying degrees of strength of client hope. Findings are discussed in terms of the need for therapists to inquire about and consider client wishes and expectations, as well as to promote client autonomy and ownership of problem-solving attempts.

Résumé

L'espoir du client est depuis longtemps considéré comme l'un des facteurs couramment observé ayant le plus d'impact sur les résultats positifs en psychothérapie. La recherche sur la relation entre l'espoir et l'issue favorable de la thérapie a produit des résultats prometteurs indiquant le besoin de mieux comprendre les processus et les conditions selon lesquels l'espoir peut se développer pendant la thérapie. La présente étude a examiné la trajectoire du développement de l'espoir en fonction d'entrevues approfondies et semi-structurées auprès de 17 clients demandant une consultation relativement à diverses préoccupations dans un centre de counselling universitaire. Les clients ont complété une évaluation de leur degré d'espoir avant le premier et après chaque entretien, puis ont été interviewés lorsque leurs réponses indiquaient un niveau d'espoir significativement plus élevé. Le récit des clients a été analysé selon la méthode de théorie ancrée. Une synthèse des résultats fut effectuée de façon à produire une théorie dynamique à multiples facettes, la théorie de l'espoir redonnant le pouvoir (Hope as Empowerment Theory - HET), qui propose une vision intégrative de l'espoir comme étant à la fois cognitive et affective et conceptualise l'espoir accru en un plus grand contrôle du client sur le problème ainsi qu'une mise en direction vers le changement positif. La compatibilité des préférences du client avec les interventions du thérapeute fut observée comme augmentant la confiance du client dans le processus de « counselling », et dans certains cas fut le tremplin menant à la manifestation de l'espoir envers le résultat. Des conditions variées, incluant l'adaptabilité du client dans ses choix de rôles et l'utilisation de stratégies thérapeutiques plus directives afin de promouvoir l'espoir, ont donné différents types et différents degrés d'ampleur de l'espoir chez le client. Les

résultats sont discutés en fonction du besoin du thérapeute de considérer et de se renseigner sur les attentes et les souhaits du client, ainsi que de promouvoir l'autonomie et la prise en charge des démarches de résolution de problème par le client lui-même.

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Chapter 1

INTRODUCTION

This thesis examines the process of hope development in psychotherapy from the perspective of 17 counselling clients. The finding that hope is associated with positive therapy outcomes was the impetus to discover the most salient variables accounting for its growth in the context of therapy and elucidate how clinicians can best cultivate it.

The millennial issue of the *American Psychologist* was dedicated to positive psychology and aimed at catalyzing a change in the focus of psychology from preoccupation only with "repairing damage" to also building positive human qualities (Seligman & Csikszentmihalyi, 2000). Prevention researchers have discovered that certain human qualities act as buffers against mental illness; hope lies among them. Within this framework, investigating the positive role of hope in the context of psychotherapy by attempting to understand the conditions under which it flourishes seems to be indicated. A positive psychology focus is particularly relevant to counselling psychology, a field that was founded on a strength-based view of individuals and that operates within the principle of helping clients to help themselves.

Following the increasing focus of medical and nursing research on the beneficial effects of hope on human health, psychologists (Cantril, 1964; Farber, 1968; Mowrer, 1960; Stotland, 1969) and psychiatrists (Frank, 1968; Melges & Bowlby, 1969; Menninger, 1959) began to support hope as a positive force in mental health. Jerome Frank (1961, 1968, 1971, 1973) is often credited with advancing the idea that the generation of hope is a factor common to successful psychotherapy. He argued that hope is linked to other non-specific factors that have been found to account for treatment

outcome, such as the working alliance. Indeed, a review of the common factors literature by Grencavage and Norcross (1990) revealed that client positive expectancies and hope for improvement were the most frequently proposed common factors. Given that most contemporary definitions of hope integrate a number of widely researched psychotherapy constructs (i.e. expectancies, motivation, and active involvement) that moderately or strongly relate to positive therapy outcome, I will refer to and describe hope as an "umbrella" common factor in psychotherapy. A review of the linked constructs will serve to illuminate both the shared and the distinctive aspects of hope, as well as demonstrate the salience of hope in the realm of psychotherapy.

Psychotherapy researchers and practitioners (Snyder, Ilardi, Michael, & Cheavens, 2000; Snyder, Michael, & Cheavens, 1999; Snyder & Taylor, 2000; Snyder, Irving, & Anderson, 1991; Yalom, 1995) have started to observe the contribution of hope to positive client change. For example, studies have looked at the role of hope in client improvement during the early stages of therapy (e.g. Fennell & Teasdale, 1987) and have investigated the association of higher hope to positive therapeutic outcomes (Irving et al., 2004). This preliminary research has produced promising results that now call for an in-depth examination of the conditions that foster the growth of this salient therapeutic construct.

Attempts have already been made to build and apply strategies for instilling hope in clients. Lopez, Floyd, Ulven, and Snyder (2000) have recently developed a system of intervention techniques derived specifically from Snyder's Hope Theory (Snyder, 2002; Snyder, Michael, & Cheavens, 1999; Snyder, Rand, & Sigmon, 2002), and have collected early evidence for its effectiveness (Irving et al, 1997; Klausner et al., 1998). I will argue

that such theory-driven, rather than data-driven, initiatives may be useful but are not sufficient to understand and meet the needs of different clients. Research inviting clients to describe their subjective experiences of gaining hope will allow the examination of components of hope development and enrich our knowledge of what occurs in optimal therapeutic situations.

The thesis will begin with a brief historical review to portray the evolution of philosophical and psychological perspectives on the construct of hope. A number of contemporary theoretical and research-based conceptualizations of hope will then be presented, and hope's similarities and differences to several related constructs, such as optimism and hopelessness, will be identified. References will also be made to cultural differences in hoping and to the birth and growth of hope from a developmental perspective.

Subsequently, the role of hope will be examined in the context of psychotherapy. The argument that hope is a key common treatment factor will be considered from several standpoints. This will be followed by a review of the direct empirical support for the positive association between hope and successful psychotherapeutic outcome. The chapter will conclude with a presentation of the existing theoretical and empirically based knowledge of how people gain hope. This literature review identifies gaps in our knowledge of this salient therapeutic process and justifies the methodological choices of the present study, which are detailed in the subsequent chapter. The study's findings are described in detail and integrated in a theoretical proposition in the fourth chapter. The final chapter of this thesis is a discussion that reviews the gains made in light of previous research and ideas, as well as the practice and research implications of the study.

Chapter 2

LITERATURE REVIEW

A Historical Perspective on Hope

The concept of hope has been discussed for much of recorded history. There has been disagreement, however, about whether it is a blessing or a curse, as illustrated by the fable of Pandora's box in Greek Mythology. When the mortal Prometheus stole the fire from the gods, Zeus took revenge by sending the maiden Pandora to earth with a jar filled with a plague to damn humans forever. As expected, Pandora disobeyed the rule to never open the jar upon arriving at earth, which led to the release of evil forces that preyed on the body and mind. Yet, as Pandora rushed to close the lid, the only force that remained was hope (Smith, 1983). Was hope an antidote for the ills unleashed on humanity or was it just another source of suffering? The tale is representative of the philosophical and scientific debates that followed.

Sophocles believed that hope only serves to draw out human suffering, and Euripides labeled hope a curse of humanity. Yet Martin Luther and Saint Paul espoused that hope, like love and faith, should be revered as the essence of what is true and good. This sampling of perspectives illustrates the diversity of ideas about hope. Is it an illusion that eagerly seduces humankind with false promise or a gift to combat the tribulations of life? More recently, Tillich has attempted to reconcile these opposing views: "Hope is easy for the foolish, but hard for the wise. Everybody can lose himself in foolish hope, but genuine hope is something rare and great" (Tillich, 1965, p. 17).

Throughout history, theologians, philosophers, scientists, and clinicians have been interested in the concept of hope. However, early research had focused mainly on illness,

both medical and psychiatric. In psychology, hopelessness has been found to be associated with diminished life satisfaction (Beck, Weissman, Lester, & Trexler, 1974; Gottschalk, 1985) and research suggests it is a more accurate predictor of suicide than depression (Beck, Steer, Kovacs, & Garrison, 1985). Given these findings, the construct of hopelessness quickly became a popular variable in psychotherapy research. In spite of the utility of hopelessness research, the traditional pathological paradigm of psychology, which "concentrates on repairing damage within a disease model of human functioning" (Seligman & Csikszentmihalyi, 2000, p. 5), has meant that the positive power of hope in psychotherapy has been given less attention.

The fundamental importance of hope to humans as a dynamic life force has attracted the attention of researchers and professionals from diverse disciplines for more than three decades (Farran, Herth, & Popovich, 1995). Hope has recently been identified as a critical factor for promoting health and healing (Farran & Popovich, 1990; Miller & Powers, 1988). The medical field has devoted a lot of attention to investigating the benefits of hope, particularly in the area of cancer. This trend began in nursing research, as nurses witnessed patients lose or sustain hope during diagnosis and treatment of terminal illnesses (Farran et al., 1995). During the 1960s and 1970s, psychologists (Cantril, 1964; Farber, 1968; Mowrer, 1960; Stotland, 1969) and psychiatrists (Frank, 1968; Melges & Bowlby, 1969; Menninger, 1959) agreed principally that hope was based on *positive expectations for goal attainment*. During this time, Jerome Frank and Ezra Stotland described hope and its importance to mental health (Frank, 1961, 1968, 1971, 1973; Stotland, 1969; Stotland & Kobler, 1965). The work of Stotland was mainly descriptive and definitional. Possibly his most important contribution was his hypothesis

about hope: that motivation (affective experience) is directly proportional to both the perceived importance and probability of attaining a goal. Frank's work generated compelling hypotheses about the generation of hope as a core element of successful psychotherapy. His belief in the psychotherapeutic power of hope set the stage for the study of hope as an important psychotherapy construct.

Approximately 30 years later, psychotherapy researchers and practitioners (Snyder et al., 2000; Snyder, Michael, & Cheavens, 1999; Snyder & Taylor, 2000; Snyder, Irving, & Anderson, 1991; Yalom, 1995) have begun to provide empirical support for the pioneering ideas of Frank. Studies now consistently confirm the argument that hope is an important variable contributing to therapeutic effectiveness across theoretical orientations (Asay & Lambert, 1999; Hubble & Miller, 2004; Irving et al., 2004; Lambert, 1992). However, there is still a void in the literature examining the context within which hope is generated in the psychotherapeutic process. This study will attempt to fill this void by discovering psychotherapeutic processes that become fertile soil for the growth of hope in client narratives.

Defining Hope

Issues in Defining the Construct of Hope

According to Farran and colleagues (1995), the difficulty in defining hope lies in its multidimensionality. Firstly, in the English language, the term hope can be used as a verb, a noun, and an adjective. When used as a verb, there is always some object of hope. For example, one may say "I hope to get good grades this term", in which case the object of hope is academic success. As a noun, hope suggests confidence that the desired outcome will occur (e.g. "there is hope for quick recovery"). Alternatively, one can be

"hopeful" without necessarily placing hope in someone or something (e.g. "she is a hopeful person").

In addition, the concept of hope is elusive because it can be expressed affectively, cognitively, and behaviorally (Farran et al, 1995). As a way of feeling, hope is seen as functioning as an energizing force, propelling people forward when obstacles arise. As a way of thinking, hope is described as an assumed certainty that a desired possibility will happen or that a dreaded possibility will not take place. It is also seen as a creative process that produces alternative ways of dealing with negative outcomes. As a way of behaving, hope is an active process in which the individual follows the appropriate route to achieve the desired outcome. Some theorize that hope is primarily cognitive, with behavioral and affective functions as secondary (e.g. Seligman, 1992, Snyder, 2002); others classify hope as an emotion that motivates behavior and cognitions (e.g. Averill, Catlin, & Chon, 1990), or organize hope as both cognitive and affective (e.g. Staats, 1987).

A further issue in describing the construct of hope has been determining if it is stable or fluctuating. As a state, hope reflects how a person presently perceives the outcome of a particular situation. Thus, hope as a state may fluctuate over time and it is subject to influence and change. As a trait, hope is an enduring and relatively stable attitude or approach to life across time and situational contexts. Averill and colleagues (1990) described hope as an episodic disposition, stating that, "hope is a relatively short-term response tendency, usually initiated and terminated by specific environmental conditions" (p. 93). Their view on this issue is influenced by their conceptualization of hope experienced as an emotion. Although views of the functional process of the hope

construct (behavioral, affective, cognitive) have previously affected the perception of hope as a stable or non-stable factor, separate individual-differences measures, with established validity and reliability, have been developed for hope as a trait (*Trait Hope Scale*; Snyder et al., 1991) and hope as a state (*State Hope Scale*; Snyder et al., 1996).

Although the ambiguous characteristics of the hope construct present definitional difficulties, persistent attempts have been made in recent years to operationalize it, and progress has been made in formulating well-articulated theories of hope. The following is an outline of several contemporary operationalizations of the hope construct, based on a comprehensive review by Lopez and colleagues (2003), and presented in chronological order.

Theoretical Definitions of Hope

Stotland conceptualizes hope as "an expectation greater than zero of achieving a goal" (1969, p. 2). From his work on social psychological theory and cognitive schemas, Stotland holds that the degree of hope is determined by the perceived probability of achieving the goal. He also highlights the correlation between hope and the importance of the goal itself; if the significance of the goal is great, hope serves as the mediator between the desire and the actual movement toward the goal. Gottschalk (1974), like Stotland, views hope in terms of positive expectancy and defines it as optimism that particularly favorable outcomes are likely to occur. In addition, he conceptualizes hope as a provocative force that impels an individual to move through psychological problems.

Breznitz (1986) provides a cognitive definition of hope as a "fleeting thought" or a "cognitive state". He posits that, for hope to have influence on the individual, it must be strong enough to induce an action-oriented physiological response. Thus, a momentary

soothing thought (e.g. "I will be fine") has less chance of producing the same response as the thought of taking steps towards a goal, which allows people to fully experience the essence of hope.

Staats (1987) views hope as future-oriented, with affective and cognitive components based on wished-for events and the expectation of achievement or occurrence of these events. She terms hope "the affective cognition" (Staats & Stassen, 1985, p. 235). On the affective side, hope is operationalized as "the difference between expected positive and expected negative affect" (1989, p. 367). Cognitively, hope is seen as the communication or the mediating force between these expectations and the affective intensity of the wish behind them. Godfrey (1987) also perceives hope as the belief in the probability of a pleasant outcome that is guided by the person's perception of resources. Godfrey specifies that, although hope is begun by an affective jolt associated with the *idea* of a pleasant ending, it is merely a cognitive process of weighing potential outcomes.

Miller and Powers define hope as a "state of being, characterized by an anticipation of a continued good state, and improved state or a release from perceived entrapment" (1988, p. 6). An overview of the literature led them to identify ten "critical elements" of hope: caring interpersonal relations, sense of possible, avoidance of absolute (all-or-none) ways of thinking, positive anticipation, achieving goals, psychological well-being, purpose and meaning in life, freedom (i.e. confidence that there is a way out of difficulty), reality surveillance (i.e. looking for clues confirming that the maintenance of hope is possible), and mental and physical activation.

Farran and colleagues' (1995) description of hope as an experiential process, a spiritual process, a rational thought process, and a relational process underlines the complex nature of this construct. As an experiential process, hope involves some struggle or pain in a situation that challenges a person. Spiritually, hope is linked to faith. Along this dimension, it is characterized by the ability to make expectations fluid in the face of the absoluteness of the present and is likened to hoping for a miracle. As a rational thought process, hope is a learned process over time, requiring some sense of control of one's destiny, where one proactively employs physical, emotional, and social resources towards a goal that is realistically possible. Lastly, the construct of hope is defined as a relational process, which is based on the idea that hope is initially created within the developmental process of learning to trust in early relationships (Erikson, 1964). With these four central attributes of the hope construct, Farran and colleagues (1995) provide a comprehensive description of the dynamic construct of hope, accounting for the varied ways hope can be experienced.

Nunn (1996) suggests that hope is the "general tendency to construct and respond to the perceived future positively" (p. 228). Like Farran, he identifies hope as a multi-dimensional construct, encompassing three main dimensions: temporality, desirability, and expectancy. Firstly, hope is future oriented. Secondly, it is a desire for a wished-for future outcome, and the degree to which this desire is experienced relates to the value one places on the hoped outcome. The third dimension, expectancy, relates to the belief that the desired outcome is likely to happen or come true. This belief is based on a subjectively anticipated likelihood and it is occasionally distorted due to the extreme importance of, or desire for, the outcome; thus, something may be hoped for even when

the probability of the outcome is low. This is similar to some of Farran and colleagues' (1995) reference to the fluidity of hope when outcomes appear less likely.

Although the above conceptualizations of hope are theoretical, several of these ideas have received research support through studies conducted by other scholars. Specifically, there are findings endorsing both the affective and cognitive nature of hope (Averill et al., 1990; Snyder, 2002), while research has shown that factors such as the importance of a goal and the probability of attaining it may determine a person's level of hope (Lopez, Snyder, & Teramoto-Pedrotti, 2003). Similarly, the action orientation of hope acknowledged by several theorists has been shown to be an important element of hope (Averill et al., 1990; Snyder, 2002). Research-based formulations of the hope construct are outlined in the following section.

Research-Based Theories of Hope

In an attempt to identify regularities in the everyday experience of hope as manifested in representative episodes, and to explore the conditions under which hope is considered inappropriate, Averill and colleagues (1990) conducted a study using detailed written questionnaires that generated four overarching rules or *guiding principles* of hope: prudential, moralistic, priority, and action rules. Prudential rules refer to emphasis on realism; when the probability of attainment is unrealistically low, hope is "inappropriate" (p. 33). According to moralistic rules, the object of hope is also circumscribed by what is personally and socially acceptable; when the acceptability of attainment is low, hope is again out of place. Priority rules require that the object of hope is relevant to vital interests that have sufficient importance; when the priority of attainment is low, hope is inapplicable. This is not to say that people do not at times hope

for trivial events. Yet, the researchers found that this tends to be the exception rather than the rule. Finally, action rules refer to the willingness to take appropriate action in order to achieve goals, which gives a sense of some personal control.

While this study identified a set of rules that "define hope as a coherent syndrome" (Averill et al., 1990, p. 37), the same researchers conducted another study in an attempt to provide support for the hypothesis that hope should be classified among the emotions. They did this by comparing hope to two prototypic emotions, anger and love. Participants in this study identified five major similarities between hope, anger, and love, which, according to the authors, constitute the parameters of their implicit theory of hope as an emotion: a) all are difficult to control, b) they affect the way we think, c) they motivate behavior, d) they lead people to act in uncharacteristic ways, and e) they are universal experiences. Although Averill and colleagues argue that their findings offer sufficient grounds for describing hope as an emotion, they refer to hope as "an emotion of the mind" to highlight that hope differs from other emotions in being a largely "cognitive" state, if cognition is defined broadly to mean "mental" as opposed to "rational". Finally, the authors underscore the effect that the environment has on both the development and the deterioration of hope. Hence, their viewpoint relies on the norms and rules of the intended society to help define the true meaning of hope; hope can only be understood within a social and cultural context. Given that hope was conceived primarily as an emotion in the North American culture, the researchers caution us against generalizing these findings to other cultures.

Finally, Snyder's Hope Theory (Snyder, 2002; Snyder, Michael, & Cheavens, 1999; Snyder, Rand, & Sigmon, 2002) is probably the most well articulated

contemporary theory of hope and has received considerable attention in the past two decades. Snyder and his colleagues interviewed people on their goal-directed thoughts and consequently defined hope as a cognition containing *goal-directed thinking.* Goal directed thinking occurs when people perceive that they can produce routes to desired goals, *pathways thinking* (e.g. "I'll find a way to get this done"), and have the motivation to use those routes, *agency thinking* (e.g. "I can do this"). In this theory, goals may be approach-oriented (e.g. entering graduate school) or preventative (e.g. not getting laid off at work) in nature and must be of sufficient value before a person will pursue them (Lopez, et al., 2003). Based on interviews, Snyder and his colleagues also formulated the notion that hope can be dispositional; in other words, people appear to have enduring self-appraisals about their capabilities in goal pursuits.

Three individual differences scales that reflect the structure of Hope Theory were subsequently developed: The *Trait Hope Scale* (Snyder et al., 1991); the *State Hope Scale* (Snyder et al., 1996); and the *Children's Hope Scale* (Snyder et al., 1997). All three instruments have well-established reliability and validity, and have been used in research with diverse samples.

Recently, Hope Theory has been elaborated to portray the temporal unfolding of the goal-directed thought sequence (Snyder, 2002). Although the sequential model has not yet been empirically tested, it will be briefly presented here because it relates closely to the theory just reviewed. According to the model, people bring enduring and iterative pathways and agency thought processes to particular instances of goal pursuit, along with trait-like emotional sets or moods. Prior to settling on a goal, people consider the outcome value of the particular goal pursuit, which has to be sufficiently important in

order for the pursuit to be sustained. As the pathways and agency thoughts are activated

in pursuit of a goal, people may experience positive or negative emotional reactions;

positive emotions are the result of perceptions of successful goal pursuit, while negative

emotions typically reflect the perceived lack of success. In addition, positive emotions

serve as reinforcing feedback. If the goal-pursuit process is going well, positive emotions

are functional in that they cycle back and reinforce the application of effective pathways

and agency thoughts, by sustaining attention and motivation to the task at hand. In other

words, positive emotions are shaping and informing the cognitions of the person pursuing

a goal (Snyder, 2002). Although emotions have a role in Snyder's model, influencing

pathways and agency thinking, Snyder and his colleagues claim that it is the goal-directed

thinking, rather than the emotions, that drive subsequent goal-related performances

(Snyder, Cheavens, & Michael, 1999). Snyder and colleagues have put forth well-

articulated theoretical arguments for Hope Theory's potential applicability to

psychotherapy (Snyder, Ilardi, Michael, & Cheavens, 2000; Snyder & Taylor, 2000),

which will be reviewed later on in this chapter.

Summary

Within all of these theoretical and research-based conceptualizations of hope,

many commonalities exist. All of these authors view hope as future oriented, founded in

positive outcome expectancies, and predicated on goals that are attainable and significant

to the individual (Averill et al., 1990; Farran et al., 1995; Miller & Powers, 1988; Nunn,

1996; Snyder, Michael, & Cheavens, 1999; Staats, 1987). In relation to its goal

orientation, hope is explained primarily as a cognitive operation (Farran et al., 1995;

Godfrey, 1987; Nunn, 1996; Seligman, 1992; Snyder, Michael, & Cheavens, 1999;

Staats, 1987). Yet, there is also a general recognition that hope comprises an important affective element, which develops from goal orientation and feeds motivation (Averill et al., 1990; Gottschalk, 1974; Miller & Powers, 1988; Nunn, 1996; Snyder, 2002; Staats, 1987). In addition, most scholars agree that hope involves an element of action needed to achieve a desired goal, which is inherently linked to a sense of agency or partial personal control over the wished-for outcome (Averill et al., 1990; Breznitz, 1986; Farran et al., 1995; Snyder, 2002). Finally, hope is linked to previous experiences of obtaining and striving for desired outcomes that leads to a sense of possibilities derived from past outcomes (Farran et al., 1995; Nunn, 1996; Snyder et al., 1991). In essence, hope is mediated by previous experiences of striving for goals and these experiences explain how hope can be a stable trait.

From this overview of hope theory and research, it is clear that there are a number of widely researched constructs, namely expectancies, motivation, and active involvement, which are central to most definitions of hope and important in psychotherapy. When the role of hope in psychotherapy is discussed later in this review, the operational definitions of these constructs will serve to illuminate both the shared and the distinctive aspects of hope as they pertain to psychotherapy.

<center>Hope and Related Constructs</center>

<center>*Optimism*</center>

Several constructs have been examined in relation to hope, and similarities and differences have been highlighted. Optimism and hope, for example, are often used interchangeably in the literature; however, it is still unclear whether this tendency reflects the inherent conceptual equivalence of the two terms or a lack of conceptual precision.

According to Bryant and Cvengros (2004), optimism is probably the most widely studied future-focused trait. Along these lines, the most dominant theoretical perspective is Scheier and Carver's (1985) conception of dispositional optimism as generalized outcome expectancies: a stable predisposition to "believe that good rather than bad things will happen" (p.219). Optimism is hypothesized to influence psychological well being by predisposing individuals to engage in positive reinterpretation as a style of coping. There is also a clear link between optimism and physical well being that has been noted in such areas as immune functioning (Peterson & Bossio, 2002). The terms optimism and pessimism have been applied to the ways in which people routinely explain events in their lives. Specifically, Seligman (1992) argued that people are optimistic when they attribute problems in their lives to temporary, specific, and external (as opposed to permanent, pervasive, and internal) causes.

It is important to note that the absence of pessimism does not imply endorsement of optimism, and vice versa. An individual who expects his or her wishes will go unfulfilled does not necessarily expect a catastrophe to occur. Chang, D'Zurilla, and Maydeu-Olivares (1994) suggested using the term pessimism to refer to expectations of negative outcomes and optimism to refer to expectations of positive outcomes, so that individuals can be both high or low on optimism, and high or low on pessimism. Similarly, Bryant and Cvengros (2004) found support for the bi-dimensional conceptualization of optimism: people may be neither optimistic nor pessimistic, or people may be both optimistic and pessimistic.

Magaletta and Oliver (1999) found a factor solution that distinguished optimism, hope, and self-efficacy, and reported that these concepts were positively, significantly,

and moderately correlated. Bryant and Cvengros (2004) found that hope has more to do with self-efficacy, while optimism has more to do with positive reappraisal coping. Their findings also support the notion that hope focuses more directly on expectations about the personal attainment of *specific* goals, whereas optimism focuses more broadly on the expected quality of future outcomes in *general.* Moreover, optimism has stronger implications for dispositional cognitive appraisals of personal outcomes, whereas hope is more strongly tied to dispositional beliefs about personal capabilities.

Based on these findings, the authors suggested that it would be advantageous to select a criterion for hope that reflects behavior rather than belief, such as behavioral persistence or problem-solving efforts, and recommended that investigators studying the effects of future expectancies on physical and emotional outcomes would do better to model hope and optimism as separate but related constructs. A similar argument is made by Snyder and his colleagues (2001), who point out that Scheier and Carver (1985) de-emphasize the role of personal efficacy in optimism and only implicitly tap the pathways-related expectations in relation to goals, whereas Hope Theory explicitly emphasizes the pathways component.

Self-Efficacy

Self-efficacy is a construct that is related to hope and that Rosenberg (1965) explains as an overall assessment of one's self worth. According to Bandura (1982), a goal-related outcome must be important enough to capture one's attention for self-efficacy to be activated, while the cognitive processing involved must focus on situation-specific goals. Bandura (1982) described efficacy expectancy as the degree of belief in the capacity to successfully attain a desired goal, while outcome expectancy is the belief

that certain actions will result in a targeted outcome (Bandura, 1986). Capacity and action

are similar to Snyder's (2002) concepts of agency and pathways, respectively. Unlike

hope theories, however, self-efficacy theory sees personal efficacy or agency as the most

powerful predictor of behavior when examining expectancies and does not address

emotions, unlike most contemporary conceptualizations of hope.

Problem solving

Problem solving has also been conceptualized vis-à-vis the construct of hope, and

several similarities have been identified. Problem solving also involves the identification

of a desired goal, as well as the development of a route or pathway for resolving the

problem situation (D'Zurilla, 1986), which probably explains the significant positive

correlations (r = .40 to .50) found between hope and problem solving (Snyder, Harris, et

al., 1991). However, problem solving theory (Heppner & Hillerbrand, 1991) does not

necessarily attend to motivation or sense of agency in solving a problem.

Hopelessness: Not Simply the Absence of Hope

Hopelessness constitutes a widely researched construct that has received

significant clinical attention since Aaron Beck and colleagues' development of the Beck

Hopelessness Scale (BHS) that quantified a polar opposite of hope (Beck et al., 1985;

Beck et al., 1974). It will briefly be examined to illustrate how it relates to the construct

of hope and how it differs from low hope.

Hopelessness is conceptualized as generalized global negative expectations of

oneself and the perceived future (Beck et al., 1974). The BHS is widely used to measure

depression and anxiety (Abramson, Metalsky, & Alloy, 1989; Beck et al., 1985; Dixon,

Heppner, Burnett, & Lips, 1993; Lynd-Stevenson, 1997; Rholes, Riskind, & Neville,

1985) and has been found to predict suicide, even 10 years into the future (Beck et al., 1985).

When it comes to understanding the relationship between hope and hopelessness, hope is not merely the absence of despair (Nunn, 1996). Miller and Powers (1988) found a -.54 correlation of hope, measured by the Miller Hope Scale, with the BHS. Similarly, Snyder and colleagues (1991) found a -.51 correlation of hope, measured by the Hope Trait Scale, with the BHS. These findings indicate that hope and hopelessness are related but different constructs. There are people who do not hope yet are not despairing. Likewise, there are people who do not fear the worst, but also do not expect their hopes to be fulfilled. In other words, low hope does not necessarily imply hopelessness, in the same way that people may be both optimistic and pessimistic (Bryant & Cvengros, 2004). Hence, it is recommended that research methodology should not ignore the possibility that one may have both positive and negative expectations (Nunn, 1996); an individual may be experiencing positive expectations in one domain of life and negative in another.

The Context of Hope Development

Hope has its roots in intrapersonal, interpersonal, and environmental/sociological experiences (Farran et al., 1995). Erikson suggests in his theory of development that intrapersonal and interpersonal hope emerge during infancy from basic trust (1982, p. 55). Hope for infants is centered on having their basic needs met, and is largely a subconscious process at the stage of life where cognitive development is insufficient for imagination (Cutcliffe, 2004). Yet, Snyder (2000) argues that infants quickly form perceptions of "what is out there", learn that certain events co-occur temporally, and begin to focus on particular goals. As the recognition of self unfolds starting roughly at

18 months, children begin to understand that they can cause things to occur. This is when their agentic thinking becomes operative. At this point, a strong connection and a secure attachment with a caregiver who allows the toddler to navigate potential road-blocks on their own, can lead to a sense of empowerment and positive goal-directed thinking (Snyder, McDermott, Cook, & Rapoff, 1997).

Life experiences provide additional opportunities to develop, test, augment, and maintain the basis for hope. Early and continuing success in achieving goals or solving difficult problems forms the basis of a sense of confidence and ability to overcome future difficulties. Similarly, frequent failures in reaching goals or overcoming obstacles that have stood in the way remain implanted in memory and determine the perception of an individual's capacity to deal with future hardships or achieve desired goals. Social learning theory provides the primary support for the rational attribute of hope (Bandura, 1977). This theory stresses humans' self-regulatory capacity to plan, create, imagine, and engage in action. As goals appear to significantly determine motivation, self-motivation is best maintained when explicit and proximate sub-goals, as opposed to goals beyond reach, are set in order to achieve larger goals.

A spiritual perspective provides further explanation of how people develop their ability to hope. Existentialism as a philosophy identifies the transcendent themes of hope by suggesting that people find meaning through spiritual means. Erikson describes hope in its mature form as a sense of certainty about the coherent nature of life and an acceptance of life as worthwhile. If a person does not feel a sense of order or connection, hope may turn into despair (Erikson, 1982).

It is important to note that all of the above theories have been created in a western context and they may, therefore, not be readily applicable to people from other cultures. The influence of culture on the meaning and experience of hope will be discussed in the following section.

Cultural Differences in Hoping

Compared to traditional views, multicultural models of behavior offer a radically different perspective of hope (Elliott & Sherwin, 1997). Hope may be embedded in social-cognitive processes, as Snyder and colleagues (1997) described, but culture substantially "influences the way humans select, interpret, process, and use information" (Kluckhohn, 1954, cited in Triandis, 1994, p. 15). Collectivistic societies emphasize the importance of the group and its values, activities, and roles over the independent pursuits and achievements that are characteristic of individualistic societies. Furthermore, individuals with collectivist attitudes tend to be more attuned to external, circumstantial, and situational effects on personal behavior, with corresponding differences in beliefs concerning personal health, adjustment, and responsibility (Landrine, 1992; Landrine & Klonoff, 1992). Given these cultural differences, it would be reasonable to hypothesize that the development and meaning of hope in collectivist cultures may differ from western models of hope.

Averill and colleagues (1990) conducted a study to explore the meaning of hope in the United States and in Korea. Korean subjects saw hope as a socially acquired but relatively permanent part of personality, closely related to intellect and will; "ideal", "ambition", and "effort" were the most frequent synonyms for hope. Americans, on the other hand, categorized hope more as a way of coping or a feeling, and related hope more

to faith, prayer, and belief. Overall, hope was conceived by Koreans as controllable, voluntary, intellectual, and permanent; characteristics that render hope incompatible with the experience of emotion. The authors suggest that the Judeo-Christian and Confucian traditions account, to a large extent, for these observed differences. The findings highlight the idea that hope cannot be understood apart from its sociocultural context. Thus, attending to cultural background when studying the development of hope in the context of therapy is imperative.

In summary, the development of hope can be understood by attending to a variety of different factors, including past learning experiences, relationships, spirituality, and cultural background. As the effect of each of these variables on hope as a stable trait may differ from individual to individual, examining such influences in the therapy context may provide useful information for understanding how therapists can tailor their work to instill hope in different clients within the therapeutic environment. The importance of such a therapeutic intervention will be highlighted in the sections that follow by looking at several pioneering views on the role of hope in psychotherapy and the research that supports them.

<div align="center">Hope as a Common Factor in Psychotherapy</div>

<div align="center">*Theoretical Formulations*</div>

One of the most famous conclusions in the history of psychotherapy may well be the "dodo bird verdict", the conclusion that all therapies work equally well. The results of several meta-analyses (Smith, Glass, & Miller, 1980; Wampold et al., 1997) focusing on particular therapies or disorders (e.g., Elliott, in press; Robinson, Berman, & Neimeyer, 1990), specific comparison studies (e.g., Elkin, 1994; Project MATCH Research Group,

1997; Sloane, Staples, Cristol, Yorkston, & Whipple, 1975), consumer surveys (Seligman, 1995), and studies of managed care (Brown, Dreis, & Nace, 1999) have all supported this conclusion. There is little evidence that school-specific techniques or procedures have specific effects. As a result, some psychotherapy process and outcome research has shifted towards trying to identify and isolate the factors of change across the different therapy approaches and, subsequently, to find ways to amplify their influence (Bergin & Garfield, 1994; Hubble et al., 1999; Snyder et al., 2000). These factors are widely referred to as common or non-specific factors of therapy (Barker et al., 1988; Bergin & Garfield, 1994; Lambert & Bergin, 1994).

A review of the common factors literature by Grencavage and Norcross (1990) highlighted the most frequently proposed common factors. Under the category "client characteristics", which contained those suggested commonalities describing qualities and behaviors of the client, positive expectancies and hope for improvement were the most frequently cited (26% of all authors). Torrey (1972) defined this factor as the "edifice complex," describing it as "faith in the institution itself, the door at the end of the pilgrimage" (p. 49). He pointed out that the act of seeking treatment itself makes patients feel better and increases their faith that they will, eventually, get well. Interestingly, within the category "therapist qualities", the second most frequent proposition, advanced by 20% of the authors, was the therapist's ability to cultivate hope and enhance positive expectancies within the client. Neitzel and Bernstein (1987) wrote that of all common therapeutic procedures, this is "the ingredient most frequently mentioned as a crucial contributor to therapeutic improvement" (p. 196). Significantly, the experience of hope,

in terms of both client expression and therapist facilitation, emerges as a key element common to the psychotherapies.

Jerome Frank (1961; Frank & Frank, 1991) initially identified hope as the common basis of successful psychotherapies. He argued that people do not seek psychological help when they develop a problem, but when they become demoralized in their own problem-solving efforts. More specifically, Frank and Frank (1991) proposed that the four factors working to tackle demoralization in all psychotherapy approaches are a) an emotionally charged relationship, b) a therapeutic setting, c) a therapeutic myth or rationale, and d) a therapeutic ritual. In terms of the first factor, Frank and Frank (1991) argued that the presence of an emotional, confiding relationship with a therapist who is hopeful and determined to help works to "re-moralize" clients. Since Frank, others have argued that the therapist's ability to model hopeful thought and behavior may contribute to therapeutic effectiveness (Cutcliffe, 2004; Snyder, 1994; Snyder, McDermott, et al., 1997) within the context of a therapeutic relationship, which forms early in treatment (Sexton, Hembre, & Kvarme, 1996) and has a reliable relationship to outcome (Martin, Garske, & Davis, 2000).

Bordin (1976) viewed the working alliance as an integrated relationship with three components: tasks (in-session thoughts and behaviors that form the substance of the therapeutic process), goals (the desired outcome of therapy), and bond (the positive personal attachment between client and therapist, characterized by mutual trust and respect). According to Lopez and colleagues (2000), instilling hope parallels the development of all three components of the working alliance; the goals of the alliance translate to goal-directed thinking, tasks translate to pathways thinking, and the bond

provides the necessary context for the development of agency thinking. When such parallels are drawn, the two concepts appear to overlap considerably. Although this overlap has yet to be examined empirically, Lopez and colleagues (2000) have cautiously suggested that actions improving the therapeutic relationship, such as providing empathy and trust or collaborating with the client, instill hope.

With regard to the other factors proposed by Frank and Frank (1991) as common across psychotherapies and as key to combating client demoralization, settings that reinforce perceptions of the therapist as a helper who is effective in facilitating positive change strengthen a client's hope for change. In addition, a compelling myth or rationale, which is a common characteristic across therapies and explains why the client is experiencing the presenting symptoms and how the therapeutic procedure can ameliorate those symptoms, adds to clients' feelings of hope, especially when clients agree with this rationale. Finally, the actual therapeutic approach used by therapists and their confidence in and mastery of the chosen approach, which Wampold (2001) refers to as therapeutic allegiance, ultimately work by enhancing clients' belief in the potential for healing. When therapists believe in their clinical approach and they communicate that approach in a simple and convincing manner, clients perceive them as having more technical expertise, which in turn may increase their level of hope (Snyder & Taylor, 2000).

Snyder and his colleagues (1999) proposed that agency and pathways thinking, the two main components of Hope Theory, are operative in psychotherapy and that these principles explain processes that support psychotherapeutic change. Whatever the particular system of psychotherapy, Snyder, Rand, and Sigmon (2002) argue that beneficial changes occur because clients are learning more effective agentic and

pathways goal-directed thinking. In particular, the agency component is reflected in the placebo effect (i.e., the natural mental energies for change that clients bring to psychotherapy), while the particular psychotherapy approaches used to provide the client with a route for moving toward attaining positive therapeutic goals reflect the pathways component.

According to Snyder and Taylor (2000), psychotherapy clients often enter treatment because there is a major and important goal that has been blocked by their symptoms. During the early sessions, client and therapist work together to frame the presenting problem(s) in terms of a clearly defined goal or goals. Attaining early goals is likely to increase the clients' investment in therapy, as well as their hope. Moreover, agency is crucial because it provides the client with the motivation to undertake the various therapy-related activities. Because pathways thinking is directly influenced by learning history, all approaches that use skills training are imparting a form of pathways thought. Finally, Snyder (1994) argues that high-hope people tend to break down complex long-term goals into steps, a common strategy in several psychotherapeutic approaches.

Snyder and Taylor (2000) also highlight the idea that, across varying psychotherapies, clients' perceived mastery appears to be crucial for the maintenance of gains. Mastery thoughts are based on a generalized self-perception that one can find ways to deal with problems (pathways thinking) and a sense that one can have the necessary motivation to apply those pathways in the face of potential difficulties (agency). Thus, therapists need to build an enduring sense of goal-directed thought in clients so that they can remain resilient after the end of psychotherapy.

Both Frank and Frank (1991) and Snyder (1999) suggest that hope permeates

most aspects of the therapeutic process. This supports the view of hope as

multidimensional, with relational, rational, and experiential features. At the same time,

however, the above theories provide a general description of the interplay between hope

and other common factors, which need to be elaborated. Hope is a highly subjective

human experience that will develop in different ways for different clients. In that respect,

a theory of hope development grounded in clients' narratives would allow us to focus on

the therapeutic processes that support or inhibit this vital therapeutic factor.

The Role of Hope in Early Improvement

Hope has also been implicated in client improvement at the beginning stages of

therapy. Based on clinical observations, clients often experience significant improvement

following an initial diagnostic interview or after receiving a promise of treatment (Frank,

Nash, Stone, & Imber, 1963). In addition, research has shown that a substantial portion of

client improvement occurs within the first three to four weeks of treatment (Fennell &

Teasdale, 1987). Improvement so early in the treatment has been hypothesized to be a

product of the common factors - especially hope (Snyder, Michael, & Cheavens, 1999).

According to Snyder and Taylor (2000), we can safely assume that clients who decide to

enter psychotherapy have already made a choice implying hope that therapy will provide

assistance or relief. These authors argue that in the same way that the decision to seek

psychotherapy naturally raises an individual's sense of agency, so too does it strengthen

the sense of pathways; by implication, clients are capable of making plans to solve their

problems. Similarly, the positive changes that occur in these early stages of therapy have

been described as *remoralization* (Howard, Kopta, Krause, & Orlinsky, 1986), and are

characterized by improved subjective well being. More specifically, clients begin to experience relief from distress and have renewed hope that their situations will improve.

This argument does not imply that treatment is irrelevant. On the contrary, it has been theorized that both agency and pathways thinking are needed for the production and then later maintenance of change (Snyder et al., 1999). A study by Fennell and Teasdale (1987) on the treatment of depression confirmed that within two weeks of beginning treatment clients experienced changes in either CBT therapy or treatment as usual. However only those in the CBT group maintained and enhanced their gains over the course of treatment. An interpretation of these findings offered by Snyder and colleagues (1999) was that client long-term improvement was dependent on both client determination to meet goals (agency thinking) and the ability to generate ways to meet these goals (pathways thinking).

All of the theoretical arguments reviewed constitute an attempt to demonstrate how hope may be operating as a common factor across psychotherapies. An alternative route for examining the role of hope as a common factor in psychotherapy is to focus on its active ingredients, namely expectancies, motivation, and active involvement, which constitute widely-researched psychotherapy constructs that moderately or strongly relate to positive therapy outcome. A review of these constructs will serve to illuminate both the shared and the distinctive aspects of hope and to underline the salience of hope in the realm of psychotherapy.

Hope: An "Umbrella" Common Factor

Hope and Positive Expectancies

Hope has been widely defined as a positive expectancy for a future outcome. The term client expectancy refers both to client expectations for therapeutic gain and to expectations clients may have about psychotherapy procedures, the therapist's role, and the length of therapy (Garfield, 1994). The terms hope and expectancy have often been used interchangeably in the psychotherapy literature. The static nature of positive expectations differs, however, from the dynamic spirit of hope. Clients' positive expectancies about the outcome of therapy reflect their belief in the likelihood of change, but do not necessarily involve the perceived personal control or active involvement in the process, which is a significant aspect of hope. Hence, although positive expectancies are probably the most salient characteristic of hope, the two constructs are not identical.

Arnkoff and colleagues' (2002) review of 24 studies examining the relationship between client expectations for change and therapy outcome revealed conflicting findings. Specifically, half of them showed a significant relationship, while the rest presented either mixed findings or no relationship. The authors added, "most of the studies with mixed findings reflect the more recent trend toward multiple self-report measures of outcome, so that it was possible to find a relationship with one outcome variable but not another" (p. 340). Garfield (1994) had previously offered a viable explanation for this lack of clarity by noting that expectancies may play an initial role in therapy but may be altered considerably as a result of the experience of therapy itself. He also raised the issue of what different researchers mean when they employ the general term "expectancy", as it has referred to the expectations a client has with regard to a)

positive outcome, b) the therapeutic effectiveness of a particular therapist, c) the

therapeutic procedures, d) the role of the therapist, or e) the length of therapy. Yet a third

and perhaps the most potent explanation for the lack of consistency in existing findings

regarding the potential impact of client expectations on therapy outcome lies in

researchers' tendency to erroneously use the terms *expectation* and *preference* as

synonymous (Galassi, Crace, Martin, James, & Wallace, 1992; Giurelli, 2000; Van

Audenhove & Vertommen, 2000); the former refers to clients' anticipation of what will

transpire in therapy and the latter reflects what they want to receive. As a result, critics of

this empirical literature have cautioned against inferring a relationship, positive or

negative, between client expectations and therapy outcome from studies that do not

explicitly make a distinction between expectations and preferences.

Finally, indirect support for the importance of outcome expectancies is often cited

from studies or meta-analyses providing evidence of change in placebo groups (Andrews

& Harvey, 1981; Goldstein, 1960; Shapiro & Shapiro, 1982). Frank and Frank (1991)

argued that the effectiveness of placebos results from their ability to mobilize clients'

expectancies for improvement. A meta-analysis performed by Barker, Funk, and Houston

(1988), that used only those studies where the positive expectancies of the people

assigned to nonspecific factors (NSF) control groups were equal to those of people in

active treatment groups, revealed that the post-treatment outcomes of the NSF control

groups were significantly superior to those in the no-treatment control groups. Snyder

and colleagues' (1999) explanation of this finding was that exposure to the conditions of

the nonspecific or common factors groups resulted in an increase in client agency

thinking. Similarly, Tallman and Bohart (1999) argued that the placebo effect represents

the client's personal agency in action. Nevertheless, the NSF control groups were not as successful as the actual treatment groups, which supported the prediction of Snyder's Hope Theory that clients benefit by having both their agency and pathway thinking fostered over the course of therapy.

Hope and Motivation

Another core psychotherapy variable related to hope is motivation. An early description of psychotherapy motivation was presented by Sifneos (1971, 1978), who outlined a number of components: "tendency to give honest and truthful account coupled with introspection, willingness to participate actively in the treatment and to change, explore, and experiment, curiosity and willingness to understand oneself, having realistic expectations of the therapeutic outcome, and making reasonable sacrifices" (p. 295). In a recent attempt to combine a set of definitions of motivation (Klinger & Cox, 2004), the construct was conceptualized as "the internal states of the organism that lead to the instigation, persistence, energy, and direction of behavior towards a goal" (p. 4).

Like hope, motivation has been conceived both in terms of enduring dispositions and in terms of changeable states. In addition, the broadest definition of motivation refers to both the processes that determine which goals an individual will pursue and the factors that regulate how the individual carries out the pursuit (e.g. with persistence, vigor etc.). Finally, the onset of the goal pursuit process is marked by the establishment of an inner commitment by the individual, which is said to be determined by two important variables: the value that the person attributes to the incentive, that is the degree of affective change that the person expects to derive from it (Loewenstein et al., 2001; Mellers, 2000), and the person's expectancy (subjective probability) of being able to

attain it. These two variables reflect the construct of hope; therefore, hope can be viewed as an important determinant of client motivation or level of commitment to the goal pursuit process.

As in expectancy research, findings on the role of motivation in therapy outcome are equivocal. Garfield (1994) concluded that there is no strong evidence indicating a positive association between client motivation and outcome, although it may play a role in whether a person enters therapy. Orlinsky, Grawe, and Parks (1994), however, reported that 50% of 28 studies did find a relationship between motivation and outcome, and added that the significance of motivation increases if it is assessed from the client's perspective. Specifically, 80% of the studies assessing motivation from the client's point of view found a positive relationship. Likewise, Rumpold et al. (2005) reported that client motivation for psychotherapy has repeatedly been demonstrated to influence the outcome of psychotherapy and referenced both older and more recent studies (e.g. Blum, 1988; Franz et al., 1990; Kernberg et al., 1972; Schneider & Klauer, 2001; Sifneos, 1971, 1978).

Hope and Active Involvement

Bohart (2000) stressed the importance of the client's *willingness* to become involved and the *ability* to be productively involved in therapy. Yet, he argued that willingness to be involved does not necessarily equal motivation; one can be motivated to change without being motivated to engage in the tasks of therapy. In his view, willingness for involvement is partly associated with how hopeful or hopeless the client feels. Clients who enter therapy feeling demoralized may not involve themselves for several reasons. First, they may feel so hopeless they think nothing will help. Second,

they may feel personally helpless and so sit passively and wait for the therapist to fix

them. Third, helplessness and low self-efficacy can engender defensiveness and self-

protection (Bandura, 1997).

Given a willingness to be involved in therapy, clients still need to be involved

productively (Bohart, 2000). In fact, the degree of client participation in therapy has been

found to be a major variable in psychotherapy outcome (Tallman & Bohart, 1999).

Productive involvement means being able to maintain a focus on the tasks at hand, persist

in the face of temporary failure, and maintain an open learning-oriented stance in order to

confront painful material, explore, and learn from failure (Bohart & Tallman, 1999;

Tallman, 1996). According to Bohart (2000), factors that influence keeping a task focus

include self-efficacy beliefs (Bandura, 1997) and beliefs about one's ability to change

(Dweck & Leggett, 1988; Tallman, 1996), as well as feeling hopeful or optimistic

(Seligman, 1992). Clients often come to therapy when they feel unable to make changes

in their lives, or when they view the situation as hopeless (i.e., unchangeable). This may

occur either as a function of preexisting personal dispositions or as a function of

overwhelming situational stressors and personal problems. Therefore, client hope levels

seem to substantially determine the degree to which clients will actively engage in

therapy work towards reaching their goals.

Along with the alliance, client involvement in therapy is the most important

variable predicting whether therapy will succeed. Orlinsky and colleagues (1994)

reported that client cooperation, client "role investment", client openness, and client

"collaborative style" have been found to be associated with positive outcome in 69%,

70%, 80%, and 64% of studies, respectively.

In summary, existing evidence favors the argument that clients who are motivated and hold positive outcome expectations are more likely to profit from being in therapy. Beyond this, client level of involvement in therapy is one of the most important predictors of positive therapy outcome. These findings have significant implications for hope as therapeutically potent. As previously argued, hope is an overarching concept encompassing all the above factors, the force that allows their generation and development in the context of therapy. Snyder and colleagues' (1999) outlook on hope as "a psychotherapeutic foundation for common factors, placebos, and expectancies" (p. 179) clearly reflects this position.

What follows is a review of the direct empirical support for the positive association between hope and successful psychotherapeutic outcome. This will serve to illustrate the unique contribution of hope in psychotherapy and will further strengthen the need to focus on the positive experience of gaining hope accounted by counselling clients.

Hope and Positive Psychotherapy Outcome

Studies now consistently confirm that hope is an important variable contributing to therapeutic effectiveness across theoretical orientations (Asay & Lambert, 1999; Hubble & Miller, 2004; Lambert, 1992). Irving and colleagues (2004) assessed individual differences in self-reported hope before and during treatment. Clients were assigned to either a motivational orientation group or a waiting list group, and they all received 12 weeks of individual therapy. High-hope clients reported that the motivational group was significantly more helpful. Most importantly, though, higher baseline hopeful thinking was shown to relate significantly to greater client well being, regulation of emotional

distress, fewer symptoms, and better functioning across the entire course of treatment. Finally, as hypothesized, agency scores (tapping motivation) from baseline were associated with positive changes in outcome variables early in therapy, and pathways scores (tapping planfulness) from baseline were associated with positive changes in later therapy sessions. If hope plays a role in the achievement of therapy goals, it is imperative that we further investigate the *process* by which hope is gained in therapy.

The Process of Gaining Hope: Lessons from the Field of Nursing

With the exception of one qualitative study investigating the inspiration of hope in bereavement counselling (Cutcliffe, 2004), discovery-oriented approaches have not been used to study hope in psychotherapy. However, there are a considerable number of qualitative studies conducted by nurses with patients that describe circumstances and strategies that foster or hinder hopefulness (Farran et al., 1995). A review of these studies will serve to highlight our current understanding of hope as a highly subjective experience. In addition, these studies underline the importance of qualitative methods of investigating the development and maintenance of hope.

Two longitudinal studies have been conducted with adults with medical conditions. The first one explored hope in patients recovering from stroke (Popovich, 1991). Semi-structured interviews at two intervals included open-ended questions to help patients explore things that inspired hopefulness. Findings revealed six themes; family/friends/pets, spiritual beliefs/practices, and personal attitude were the most common themes. Farran and colleagues (1995) argued that the first two categories directly support the relational and spiritual/transcendent attributes of hope. The second study explored the process of maintaining hope in individuals undergoing bone marrow

transplantation for leukemia (Ersek, 1992). Interviews were conducted at three intervals and four components of the process of maintaining hope emerged: appraising the illness as a threat, allowing the emotional responses, working through them, and moving on. Two core categories describing this process were a) dealing with the problem and b) keeping in its place by using strategies like appraising the illness as non-threatening, taking a stance, and managing cognitions, emotions, uncertainty, the sense of control, the focus on future, and the view of self.

Hope has also been studied in persons with terminal illness. The first study (Hall, 1990) interviewed men with Stage II HIV infection and included questions about the specific activities that contributed to reestablishing hope. Findings suggested a view of hope as an orientation toward the future that needs to be maintained despite the uncertainty. More specifically, affective or "affect-control" strategies (e.g. 'if I get sick, I will deal with it then'; 'I can handle the situation') were more helpful in maintaining hope than mobilizing strategies, such as direct action, vigilance, and information seeking. The second study (Herth, 1990) interviewed 20 cancer patients once and 10 patients three times to explore the meaning of hope and identify strategies that hindered and fostered hope. Seven hope-fostering categories included interpersonal connectedness, attainable aims, spiritual base, personal attributes, lightheartedness, uplifting memories, and affirmation of worth. Three hope-hindering categories involved abandonment and isolation, uncontrollable pain and discomfort, and devaluation of personhood. In addition, hope was noted to change over time. The changing face of hope has not been detected in other research but lends support to the view representing hope as a process that incorporates the past, the present, and the future (Farran, Wilken, & Popovich, 1992).

Finally, older people living in three settings in the community were interviewed on their experience of hope hindering and hope fostering strategies (Herth, 1993). Hope hindrances included hopelessness in others, depleted energy, uncontrollable pain and suffering, and impaired cognition; hope-fostering strategies involved interconnectedness with self/others/world, purposeful activities, uplifting memories, cognitive strategies, hope objects, refocused time, lightheartedness, and spiritual beliefs/practices.

Collectively, nursing research supports the notion that hope is a dynamic, complex, and multidimensional construct mediated by many factors. Although there are many common themes that can be identified in the findings of these various studies of factors inspiring hope and that may have relevance to psychotherapy, the people interviewed in these studies were facing significant health problems and/or end of life concerns. While nursing research provides a useful backdrop, it may not necessarily tap the influential factors and processes that are unique to concerns of psychological nature.

The Development of Hope in Psychotherapy

Existing Qualitative Research

A study investigating if and how bereavement counselors inspire hope in clients (Cutcliffe, 2004) enriches our understanding of the implicit dynamics that may foster hope in clients in therapy. The study used a modified grounded theory method and collected data from interviews with eight bereavement counselors and four ex-clients. A core variable in the resulting theory was the implicit projection of hope and hopefulness by the therapist. Three sub-core variables also emerged: forging the connection and the relationship; facilitating a cathartic release; and experiencing a good (healthy) ending. The author noted that hope inspiration appeared to be a subtle, unobtrusive process that

was bound up with the necessary and sufficient human qualities in the counselor, namely empathy, genuineness, and unconditional positive regard, and the projection of these into the environment and the client.

These findings stem primarily from therapist perspectives, which were used as the stepping-stone to confirm the experiences of a small number of clients. In addition, the client accounts collected in this study were retrospective. It is important to consider the potential impact of the elapsed time between the end of therapy and the interviews on client memories of their sessions. The findings do indicate, however, that qualitative methodologies can be a valuable way to explore the factors that contribute to the development of hope in therapy.

Theoretically and empirically-supported hope-instilling interventions

Cheavens and colleagues have proposed ways of instilling and strengthening hopeful thinking in clients who are participating in cognitive treatments (Cheavens, Feldman, Woodward, & Snyder, 2006). Larsen and colleagues (2007) suggested that conversations about hope may be placed on a continuum in therapy from implicit to explicit. These authors offered a framework for understanding different ways in which hope can be intentionally employed within the counselling process. They proposed three differing conceptualizations for intentional hope work in counselling: instilling hope (i.e. hope is conveyed via the therapeutic relationship), finding hope (i.e. uncovering seeds of hope already present for the client), and creating hope (i.e. hope is a shared construction between the therapist and the client). While there is some research to support both implicit and explicit practices to foster hope in therapy, it is early to make definitive statements about the benefits or drawbacks of either.

Current understandings of the process of hope development in psychotherapy
also stem from the observation of the effectiveness of therapeutic techniques and
interventions derived from Snyder's Hope Theory and designed specifically to instill
hope in clients (Lopez, Floyd, Ulven, & Snyder, 2000). *Hope Therapy* is designed to help
clients in conceptualizing clearer goals, producing numerous pathways to attainment,
summoning the motivation to maintain the goal pursuit, and reframing insurmountable
obstacles as challenges. More specifically, the developers of this therapeutic approach
propose the integration of common factors, and solution-focused, narrative, and cognitive
behavioral interventions to help clients attain positive self-perceptions of their capability
for agentic and goal-directed thought. Thus, change is initiated at the cognitive level. The
hope therapist is active and directive in helping clients develop a new framework for
change and teaching them to handle the difficulties of independent goal pursuits.

There are reports of effective outcomes of hope-based interventions with
depressed older adults (Klausner et al., 1998), mildly depressed and anxious community
dwellers (Cheavens, Gum, Feldman, Michael, & Snyder, 2001, cited in Cheavens et al.,
2006), as well as depressed young to middle-age adults (Snyder, 2002). A study
conducted in a community mental health center randomly assigned clients to either a
five-week orientation group or a five-week waiting list before receiving individual
therapy (Irving et al., 1997, cited in Snyder & Taylor, 2000). The orientation group
meetings emphasized hope theory notions, such as establishing goals to handle problems
and identifying strategies to reach goals. Results showed that the low-hope clients in
particular showed increases in well-being, level of functioning, and state hope. This
finding contradicts the more recent finding that low-hope clients experienced the pre-

therapy motivational group as significantly less helpful compared to high-hope clients (Irving, et al., 2004). Hence, conclusions regarding the usefulness of motivational meetings before therapy are premature.

Klausner and her colleagues (1998) used hope theory in a group intervention for depressed older people. Half of the sample was randomly assigned to a hope-focused group, which involved identifying goals and discussing how to increase agentic and pathways thoughts related to those goals. The other half was assigned to a reminiscence-based group (control group), which emphasized individual life review to facilitate discussion. Results revealed that both groups decreased in depression, however only the hope-focused group experienced significant reductions in hopelessness, anxiety, and depression, as well as increases in state-hope.

Such evidence indicates that explicit efforts to instill hope in clients can be fruitful. However, if hope is a common psychotherapeutic factor encompassing several other non-specific therapy factors, then it ought to also be generated in various other, perhaps subtle, ways within the therapeutic situation.

Summary

The literature contains a number of theories that support the idea of hope as a common psychotherapeutic factor and that stem primarily from clinical observation. There are, however, firm relationships between hope and several widely researched psychotherapy constructs that are the basis of modern conceptualizations of hope. Nevertheless, research on hope as a unique process in the context of therapy is still in its infancy, which could be due to the complexity of the hope construct. It could also be a

result of focusing research energies on related constructs, such as expectancies, and assuming that this research illuminates the construct of hope.

The existing related studies are not trivial. In fact, research in the various components of hope (see Arnkoff et al., 2002; Barker et al., 1988; Garfield, 1994; Orlinsky et al., 1994; Rumpold et al., 2005, for comprehensive reviews) serves to illuminate the need for discovering how to best create it therapeutically. The next important step in our understanding of the development of hope in psychotherapy is to clarify the mechanisms of action that specifically contribute to it. Existing research has depended upon researchers or clinicians' understanding of what therapeutic interventions may help instill hope in clients. Allowing the positive experiences of clients to be heard will illustrate possibilities for creating the necessary conditions for its growth in the context of therapy and set the stage for the initiation of a research-based development on this topic. Qualitative research investigating actual client experiences of gaining hope is clearly warranted, as it may uncover significant unexamined components and highlight important in-session change processes.

Research Questions

The main purpose of this study is to explore the development of hope from the perspective of clients who have experienced increased hopefulness during the course of psychotherapy. The research questions to be answered are: (1) How do clients perceive and describe their experience of becoming more hopeful in therapy? (2) What specific factors do they identify as promoting hope? (3) How do they define increased hope on the basis of their therapy experiences?

Stance of the Researcher

My assumptions and biases as the primary researcher have influenced the process of collecting and analyzing my data. By articulating these presuppositions at the outset, I have increased the opportunities to observe how they influence the process and to ground the findings within the participants' experience. My main tasks involved interviewing the participants, coding the participant data, naming the categories, and choosing the vocabulary to describe the theoretical ideas that emerged from the data.

I am a 29 year-old female of Greek origin, with a B.A. in Psychology and a Masters in Counselling Psychology. My interest in the construct of hope was born while I was reviewing the literature on positive emotions and reflecting on their potentially significant contribution to beneficial psychotherapeutic processes. I had intended to implement a discovery-oriented methodology to investigate client experiences of positive emotions in therapy. Nevertheless, it soon became apparent that the construct I had chosen to examine was remarkably broad. I recognized that it would be challenging for clients to identify and describe their in-session positive emotional experiences without providing them with a focus. Around the same time, I was working on a qualitative research project looking at client perspectives on the development of the working alliance (Fitzpatrick, Janzen, Chamodraka, & Park, 2006). Our findings indicated that hope was a primary "emotion" that clients experienced following significant moments in the formation of the therapeutic relationship. Hope was also a potential source of increased client openness and engagement in therapy As a result, I became interested in the therapeutic experience of hope. In reviewing the relevant literature, I became aware that hope is not only understood as a positive emotion; rather, it is often viewed as comprising

affective, cognitive, *and* behavioral elements. This realization sparked my interest and prompted me to pay closer attention to the manifestation and role of client hope in my clinical practice.

My clinical observations have led me to believe that there is not a "one-size-fits-all" hope-inspiring therapeutic process. I have repeatedly noted that different clients respond positively to a wide array of hope-producing initiatives that lie on a continuum from the more explicit interventions aiming directly at instilling hope, to therapeutic encounters that appear to generate hope in much subtler ways. It appears to me that increased levels of hope reduce the number of cancellations and no-shows, and increase the level of engagement in the session and trust in the process. Higher engagement and trust are typically reflected in reduced hesitation to explore and become aware of the context surrounding presenting problems, as well as an increased willingness to take risks and initiate alternative ways of being in the world, or seek additional sources of help. In turn, according to both my personal experience and existing research evidence, such changes tend to be associated with better therapeutic results.

My preconceptions with regard to the meaning of hope and the conditions under which it develops also stem from my personal background as an individual with diverse learning experiences. Although I currently consider myself a relatively high-hope individual when it comes to setting goals of personal significance to me, this was not always the case. Important personal accomplishments that occurred when my primary support network was not easily accessible served to challenge my earlier doubt about my ability to control the final outcome of my goal pursuits. Once there was repeated proof that I was capable of contributing substantially to the realization of my objectives, this

became my point of reference when I am faced with a fresh challenge. The gradual shift in my personal life currently informs my understanding of the word "hope" as an endorsement of the belief that people have the power to achieve important personal goals, and that this sense of power largely depends on our perceptions and interpretations of their reality.

To sum up, the biases I bring to my research are the following: (a) hope is an important ingredient of effective psychotherapy; (b) hope partially involves a sense of personal control over the wished-for outcome; (c) the process through which hope rises is a highly subjective experience; and (d) psychotherapy can be the vehicle through which old patterns can be challenged and new perceptions can be introduced and solidified. These assumptions are reflected in the questions I ask about the development of hope in therapy.

Chapter 3

METHOD

Conceptual Framework

This research study is situated within the constructivist paradigm that emphasizes the experience of the participants in the generation of knowledge about a topic of interest (Tsoi-Hoschmand, 1989). Given that the process of hope development has not yet been studied from the perspective of clients, a discovery-oriented methodology allowed for an in depth exploration of the experiences of the research participants (Strauss & Corbin, 1998).

The qualitative method chosen for the analysis of client data was grounded theory (Strauss & Corbin, 1998). Grounded theory is a method of data collection, analysis, and reporting that aims at developing a theory directly grounded in the phenomena under investigation as perceived by the insiders; those who have personally lived the experience researchers seek to understand and who are invited to describe it in their own words. This strategy seeks to make explicit what may be overlooked or taken for granted. Grounded theory provides an opportunity to determine and articulate the external influences and internal processes that influence the development of hope in counselling clients.

Originally, proponents of grounded theory (Glaser & Strauss, 1967) warned against conducting an exhaustive literature review prior to the onset of data collection, because they believed that this served to constrain the creativity of theory development. However, as grounded theory has evolved, convincing arguments have been made by Strauss and Corbin (1994) and others (e.g. Hill, Thompson & Williams, 1997; Richie, Fassinger, Linn, Johnson, Prosser, & Robinson, 1997) concerning the need for theoretical

resources to guide the process of interpretation and representation (Pidgeon, 1996) and the interplay between how models or concepts are refined by specifying if and how theoretical ideas are upheld (Vaughan, 1992). While this work is largely grounded in the current hope literature, I have constantly endeavoured to keep an open mind and welcome the new ideas supported by the data, rather than privileging those elements in client narratives that validate existing notions.

Data Collection

Participants

For the purpose of this study, criterion sampling was used to access participants who could address the research questions (Hill et al., 1997; Morrow & Smith, 2000). Participants were recruited from an urban university counselling center that provides free personal, academic, and vocational counselling to all full-time undergraduate and graduate students. Prospective clients are first assessed briefly by an intake counsellor, who subsequently refers them to another counsellor for short-term or long-term therapy, or to the university's mental health service for a psychiatric evaluation and treatment. All participants were self-referred and they were offered brief or long-term counselling depending on the nature, intensity, and severity of the student's presenting problem and/or the counsellor's theoretical orientation.

Participants had to demonstrate a significant increase in hope over the course of therapy (see *Procedures* for the specific criteria). Of the 42 clients who volunteered to participate in the study, 20 met this criterion and were interviewed; one who did not meet the criterion was interviewed for negative-case analysis. Of the remaining 21 volunteers, 15 dropped out of therapy and three dropped out of research before their third session or before reaching significantly higher levels of hope; one dropped out of university following her first

session; one terminated therapy after her second session with significantly higher levels of hope; and one never came to his scheduled first session. Of the 18 clients who dropped out of therapy or research before completing 10 sessions, 13 had similar or lower hope levels compared to their baseline at that point in time, and 5 demonstrated higher hope but did not stay in therapy long enough to be interviewed.

Of the 20 positive-case interviews conducted, three were unsuitable for analysis due to technical difficulties that contaminated the audio taped data, resulting in a participant pool of 17 counselling clients, who had experienced increased hope during therapy, and one client who did not experience higher hope. Table 1 (p. 48) describes participants' demographics as reported on their Demographic Information Forms (Appendix C). The table also includes participants' presenting problems derived from their responses to the first interview question that asked them to describe in broad terms what type of concern prompted them to seek counselling. Some participants reported more than one concern. Based on these reports, nine participants (50%) presented with anxiety, six (33%) with relationship problems, three (17%) with depression, three (17%) with low self-esteem, two (11%) with an eating disorder, two (11%) with academic concerns, and two (11%) with problems resulting from a long-term illness.

The therapists of the study's participants were nine (6 females, 3 males) counsellors with a Master's degree in Counselling Psychology and four female interns in their second year of a Master's program in Counselling Psychology. Counsellors had 3 to 30 years of experience ($M = 13$, $SD = 9.4$). Eight of them described their therapeutic approach as integrative, informed mostly by the humanistic, psychodynamic, experiential, cognitive, and/or feminist theories. One counsellor reported using an Adlerian approach. The training of the four counsellor-

interns, who were under individual and group supervision, placed emphasis on common factors and largely adhered to the principles of the humanistic school of thought. One of the therapists saw three client-participants, three therapists saw two each, and the remaining nine therapists followed one client-participant each.

Table 1

Participants' Demographics and Presenting Concerns

Pseudonym	Age	Ethnic Origin	Religion	Relationship Status	Previous Counselling	Presenting Concern
Helen	31	Caucasian	None	Single	No	Anxiety-Relationship
Debbie	26	German	None	Common-Law	2 years	Anxiety
David	21	Caucasian	Catholic	Single	No	Academic-Relationship
Jennifer	22	Caucasian	Catholic	Single	2 months	Relationship
Bill	43	European-Canadian	None	Married	Several years	Anxiety-Self-esteem
John	24	Caucasian	Nominally Mormon	Married	No	Medical problem
Lucy	19	Caucasian	Anglican non-practicing	Single	No	Anxiety-Self-esteem-Relationship
Michelle	26	French-Canadian	Agnostic	Single	3-4 months twice	Social anxiety
Genevieve	20	Caucasian	None	Single	No	Anxiety-Self-esteem
Almira	18	South Asian-Bangladeshi	None	Single	No	Academic-Relationship
Nadia	24	Caucasian	Jewish	Single	6 months	Depression-Anxiety
Liang (M)	25	Chinese-Taiwanese	None	Single	No	Anxiety
Aaron	24	Hungarian-Polish	Jewish	Single	3-4 months	Depression
Monica	19	Caucasian	Protestant	Single	3 months	Depression-Relationship
Margaret	25	British-German	Presbyterian	Common-Law	3 years	Medical problem
Jackie	19	Caucasian	None	Single	No	Eating Disorder
Mariam	21	Maghrebian	Islam	Single	No	Performance Anxiety
Sophia	20	Caucasian-First Nations	Baha'i	Single	3 sessions	Eating Disorder

Instruments

State Hope Scale

The *State Hope Scale* (Snyder et al., 1996) was used to identify participants' pre-therapy state hope and the progressive changes in their level of hope that were used to establish the time for the interview (see *Procedures*). The scale is a 6-item, self-report inventory designed to tap temporal hope as it relates to ongoing events in people's lives and provide a snapshot of an individual's current goal-directed thinking. Responses are placed on an 8-point Likert scale (from 1 = *definitely true* to 8 = *definitely false*). Three of the six items on the scale reflect agency and three items reflect pathways. The agency and pathways subscale scores are derived by summing their respective three items (possible range of scores = 3 to 24); total state hope scores range from 6 to 48. Coefficient alphas for the *State Hope Scale* in four studies involving college students ranged from .79 to .95 (agency: .76-.95; pathways: .59-.93 (Snyder et al., 1996). The scale has also been found to have good convergent validity based on positive correlations with the *State Self-Esteem scale* (Heatherton & Polivy, 1991) and the *State Positive and Negative Affect Schedule* (PANAS; Watson, Clark, & Tellegen, 1988). This study's participants' baseline hope as measured by the State Hope Scale ranged from 8 to 41 (*M* = 23.8, *SD* = 9.5).

For the purpose of this study, the instructions on the *Pre Therapy State Hope Scale* were slightly modified in order to direct participants to think in terms of the particular problem or concern that brought them to therapy (see Appendix D). Likewise, the word "any problem" in item 3 was changed to "*the* problem". In addition, the *Post Session State Hope Scale* (Appendix E), which was administered after every session,

included the stem "as a result of this session" in front of all items, to ensure that any changes depicted in participants' level of hope mainly resulted from the preceding session as opposed to other factors.

Session Impression Questionnaire

A brief questionnaire asked participants to write brief comments on a) the session's content and b) therapy moments, thoughts, and/or feelings that stood out for them from each session (Appendix F). These responses were made available to clients during the interview to prompt memories of significant therapy experiences from their sessions.

Interview

For the purpose of this study, I developed an interview protocol that included general exploratory questions stemming from the existing literature on hope (Appendix G) and that gave participants the opportunity to elaborate fully on their experiences. In the process of data collection and analysis, the protocol underwent refinements to include confirmation questions as the theory begun to emerge and categories became saturated (Cutcliffe, 2004).

An initial version of the interview protocol was pilot-tested with three volunteer university students, two males and one female (Chamodraka & Fitzpatrick, 2005). The pilot interviews resulted in the identification and modification of problems in some of the original questions. The first question of the original protocol asked participants whether they considered themselves to be for the most part hopeful or non-hopeful. This question appeared to "force" participants to choose between two polar opposites, which may have produced socially desirable responses, and did not allow participants to perhaps place

themselves on a continuum of hope. Another question that asked participants to describe the meaning the word "hope" had for them seemed to be difficult to answer without having examples to use as reference points. Therefore, soliciting client definitions of hope was left to the end of the interviews. Finally, probing for upbringing and family values, past experiences, and cultural background seemed to force attention to these issues, so the probes were eliminated from the protocol. The data from the pilot study are not included in the grounded theory analysis, because a) the three clients who participated in the pilot interviews were not self-referred, and b) a different instrument was used to identify changes in clients' level of hope during therapy.

The questions in the refined interview protocol covered the following areas: a) client outcome and role expectancies prior to therapy, b) the experienced process of developing hope during therapy, c) significant therapy moments that enhanced hope, d) thoughts and emotions influencing and resulting from this process, e) missing elements and outside events that affected clients' hopefulness, (f) client definitions of hope, and g) client reflections about the interview.

I personally conducted 15 out of the 18 interviews over a period of 15 months (January 2007-March 2008) in the university counselling center. Following my contact with each participant, I kept "memos" (Pidgeon & Henwood, 1996; Maxwell, 1996) about the process of the interview, which I used as a tool to identify questions that needed elaboration or clarification. Although my intention was to conduct all the interviews, an extended absence from the country during the summer months of 2007 forced me to seek the assistance of a female Counselling Psychology doctoral student, who conducted three interviews. I trained this research assistant by thoroughly discussing the purpose of each

question and the places where probing would be helpful; she also studied the first taped

interview as a prototype. The length of the interviews ranged from 50 to 90 minutes ($M =$

60 min.). All 18 interviews were audio taped and transcribed verbatim by two paid

transcribers; I carefully verified the accuracy of all the transcriptions.

Procedures

Upon obtaining ethical approval for the study from McGill University's Ethics Board,

a brief electronic invitation to participate in the study (see Appendix A) was sent by the

administrative assistants of the counselling centre to all prospective clients, who had given

permission on an intake form to be contacted concerning the research, following their

assessment interview. The e-mail briefly presented the project and the procedures, and

invited interested participants to complete a secure online survey prior to their first

counselling appointment. Clients were offered $40 for their participation in the study.

Participants first read the Informed Consent (see Appendix B) and then filled out

the Demographic Information Form (see Appendix C) and the *Pre Therapy State Hope*

Scale, titled Goals Scale for the Present (see Appendix D). Upon receiving the survey

responses, I contacted participants by e-mail and invited them to complete the *Post*

Session State Hope Scale (see Appendix E) and the *Session Impression Questionnaire*

(see Appendix F) immediately after each counselling session. Following their first

counselling session, all participants received and signed a paper copy of the study's

informed consent in addition to the two questionnaires. All questionnaires were given to

participants by the receptionists of the counselling centre when they arrived for their

scheduled counselling appointment. Participants returned the completed measures to the

receptionists in sealed envelopes that were placed in a locked cabinet.

Client responses to the *Post Session State Hope Scale* were followed and checked for significant changes for a maximum of 10 sessions. The rationale for this decision was the expectation that participants would have had difficulty describing in detail the factors that contributed to their hope increase if extensive time had elapsed since the beginning of therapy. Significant change in hope was calculated by comparing participants' weekly post-session scores to their pre-therapy hope score on the *State Hope Scale* (Snyder et al., 1996). Clients were invited to the interview when a) they had reached a minimum increase of 6 points on their overall score on the *State Hope Scale*, which is considered to be "reliable change" (Evans, Margison, & Barkham, 1998) based on the original data reported by Snyder and colleagues (1996); and b) the average item score on this measure was at least 5 out of 8, indicating that, at that point in time, they mainly *agreed* with the hope statements. The first and only participant whose ratings did not significantly increase after 10 sessions was interviewed in order to collect data for negative case analysis.

Once a participant's overall score on the *Post Session Hope State Scale* indicated a significant increase in hope, the participant was contacted by e-mail on that same week and the interview was scheduled to take place before the next counselling session. I purposely started conducting interviews only after the third therapy session, even if a participant's average item score reached or surpassed the cut-off score after the first or second sessions, so that early significant increase in client hope levels were not simply due to the positive effects typically experienced after meeting with a therapist for the first time (e.g. "remoralization"; Howard et al., 1986). By conducting the interviews starting only after the third session, I aimed at increasing the chances of capturing specific

treatment effects that clients may have experienced. Nine out of the 17 positive case

interviews (53%) were conducted after the third counselling session. Notably, eight out of

these nine participants already demonstrated significantly higher hope after their second

session, while their hope was observed to increase even more following the third session.

Three interviews (18%) were conducted after the fourth session, two (12%) after the fifth

session, one (6%) after the seventh session, one (6%) after the eighth, and one (6%) after

the ninth session. The negative case interview was conducted after the client's tenth

counselling session.

Data Analysis

Client interview data were analyzed using grounded theory methodology in order

to construct a theory of hope development in therapy based on client lived experiences.

Procedures included categorization and auditing of the data (i.e. open coding), synthesis

of these categories into a few salient constructs (i.e. axial coding), and the articulation of

a theory in which the emergent constructs were detailed and their interrelationships

described (i.e. selective coding) (Glaser & Strauss, 1967). The latest version of a

qualitative data analysis software, NVivo 8, was used to facilitate open and axial coding.

The program proved to be a very helpful tool for organizing and re-organizing the large

amounts of data collected, as well as for observing patterns in the data and quickly

retrieving relevant quotes to support the findings in the later phases of the analytic

process. Throughout the process of data analysis, I kept memos of my observations and

hypotheses, in order to keep track of how my thinking about the phenomenon under study

evolved over time. For example, memos allowed for the expression and elaboration of

observations and ideas in the process of naming and defining categories, or specifying the

relationships among emerging concepts. Appendix H provides an example of a series of memos kept from the early phases of data analysis that were used to understand the function of an emerging theme in the process of hope development. Memos were also used as a way of staying aware of my assumptions and their potential influence, which I will discuss as a limitation in chapter five.

Open Coding

The first step was open coding, which consisted of a line-by-line examination of each interview transcript for information related to the development of hope. This information was then translated into concepts. Concepts developed from the first five transcripts were used in subsequent analyses; when new concepts emerged, previously coded transcripts were reexamined for these concepts.

All concepts were compared to one another for similarities, and then grouped into categories based on these similarities. A single category was identified as the *central phenomenon* of interest. Subcategories, which further specified a category, were also developed.

Audit of Open Coding

Auditor

Open coding was audited by a 35 year-old female with a Ph.D. in Counselling Psychology and 6 years of clinical experience, who was unfamiliar with the hope literature. Before she begun auditing the emerging concepts and categories, I asked her to write down her biases and assumptions regarding the development of hope in psychotherapy:

Hope is likely developed through the alliance and moderated by client

personality and/or cultural factors. Hope will be an important factor in

predicting if the client stays in therapy long enough to see an

improvement. Collaboratively developing goals that are important to the

client and working on tasks that provide relief within the context of a

comfortable therapeutic relationship will help the client to feel that the

therapy is a worthwhile endeavor. Client personality factors will likely

impact the development and maintenance of hope. Clients with few

interpersonal problems related to trust in themselves or in others may

develop hope following the first meeting – these feelings may arise from

taking charge of their situation by seeking therapy. Hope will be

maintained through client commitment to following through with the work

of therapy. Issues of control (e.g. overly dominating) may relate to lower

levels of hope and hopefulness may be related to a focus on progress made

through symptom relief. Clients with interpersonal problems related to

connectedness (e.g. problems with assertiveness) may initially leave the

first meeting feeling hopeful; however their hopefulness may wax and

wane as difficulties in the therapeutic relationship arise. These difficulties

may be related to overdependence on the therapist.

Auditing Process

 The auditor was sent the concepts extracted from the first five interview

transcripts and organized by participant code, as well as the category names in a separate

file. She first audited the concepts against the raw interview data, and then organized the

concepts under the appropriate category name as she saw fit, double coded if needed, and in some cases proposed new category names. She also noted when a category name was at first unclear, when she was uncertain about how a category was being defined, and when she had a suggestion for further dividing a category. Some feedback was integrated directly into the analysis; when I disagreed with her ideas, we discussed the issue until we reached consensus during two separate meetings. Once I had completed the analysis of the remaining thirteen interviews, the auditor was sent all the new categories that emerged with their corresponding concepts and was asked to provide her feedback, which was once again accepted or discussed until consensus was reached.

Axial Coding

Once categories and subcategories were identified, I began to develop them in terms of their specific *properties* and *dimensions*. Properties refer to the general or specific characteristics or attributes of a category or subcategory, and dimensions represent the location of a property along a continuum or range (Strauss & Corbin, 1998).

During the axial coding phase, the goal was to contextualize the development of hope in therapy, or to "locate it within a conditional structure and identify the 'how' or the means through which a category is manifested" (Strauss & Corbin, 1998, p. 127). In order to identify subtle connections among categories, I followed the organizational scheme proposed by Strauss and Corbin (1998) and coded: context (i.e. the location of events or incidents pertaining to the development of hope along a dimensional range); actions/interactions (i.e. the strategies leading up to the development of hope); causal conditions (i.e. the direct sources of increased hope); intervening conditions (i.e. the

structural conditions bearing on the strategies that pertain to hope development), and consequences (i.e. the outcome of increased hope).

Selective Coding

The final step was selective coding, which involved developing a theoretical model that visually portrays the connections between categories of information. The categories were thoroughly described and related as theoretical constructs. This process was facilitated by the creation of a table that summarized the data from each participant following the aforementioned paradigm and offered a snapshot of significant patterns in the data. The interview transcripts were then thoroughly reviewed for confirming or disconfirming incidents, in order to determine how accurately and comprehensively these observed patterns fitted the experiences of the participants.

The axial and selective codings were audited by my thesis supervisor, who examined the derived framework and the emerging theoretical model independently. Several meetings ensued where ideas about the relationships among the main categories of the model were exchanged, clarified, and refined.

Credibility and Trustworthiness

In order to enhance the trustworthiness and credibility of the work, I employed several strategies. First, I ensured the accuracy and completeness of the data by audio-recording, transcribing verbatim, and verifying all interviews. Second, I used method triangulation, collecting data through both standardized scales and an interview. The use of an auditor in the open coding phase also provided a form of triangulation and enhanced the confirmability (Lincoln & Guba, 1985) of the findings. Third, the negative case analysis was used to contrast the positive cases and offered further credibility to the

resulting theoretical framework. Fourth, by stating my biases and assumptions at the

outset and using memos to track my thinking, I was able to examine how my own

meanings influenced interpretations of the data (see *Limitations* for details). Fifth, the

interview protocol was designed with open-ended questions to systematically attempt to

learn about the participants' subjective experiences of increased hope in psychotherapy; I

refrained from asking leading questions early in the interviews and saved confirmatory

questions to verify emerging assumptions. Sixth, "member checking" (Stiles, 1993) was

employed by making the findings of the study available to all participants, who were

consulted for feedback on the emerging theory. Specifically, each participant was sent an

electronic copy of the first draft of the Results section with the quotes used from his/her

interview highlighted in yellow. In the e-mail, participants were asked to comment on

how well the findings reflect their experience, as well as whether they felt their identities

were well protected. Seven out of the 18 participants replied, all of whom approved of the

quotes used and found the findings representative of their experience. One participant in

particular elaborated on how he personally benefited from reading the study's findings:

>…It did help to see how negatively I saw counselling at first, I thought I
>
>was going into it with more of an open mind but seeing my comments
>
>made me realize that I may have biased myself and affected some of my
>
>progress, so I have been trying to change how I view counselling…I found
>
>the paper to give me a greater appreciation towards counselling especially
>
>reading how others seemed to have some similar doubts and who
>
>occasionally found it difficult to come up with topics during the session as

well as also being as uncertain as I was in what to take out of the sessions

at first.

In addition, dependability (Merrick, 1999) was facilitated by a clear and detailed

paper trail of all data, memos, coding, categorizing, and theorizing so that the process and

product of this study can be audited. I also reported quotes and examples from the data to

support obtained results. Furthermore, in order to address the issue of "transferability"

(Lincoln & Guba, 1985, p.316), I made every attempt to provide thorough descriptive

data to assist clinicians in determining if the results of this study transfer to their work

settings. Finally, the study's catalytic validity (Stiles, 1993) was verified by concluding

the interviews with an exploration of the participants' experience of the interview. Eight

participants expressed their appreciation for being asked to reflect back on their work in

therapy, as it reportedly solidified the gains already achieved, raised their self-awareness,

and/or sparked their motivation to continue participating actively in the process, like in

the example that follows:

> …it just made me realize that I have to keep on working, I have to keep
>
> that new perspective, I have to be strong and not let it go because I
>
> stopped counseling sessions (in the past). I think it would be ridiculous to
>
> talk about that, talk about hope and let it go afterwards. I guess having had
>
> this session, it's kind of - - you know wrap-up session, will just allow me
>
> to take a new step, a new start, a fresh start.

Finally, several participants highlighted the benefits of summarizing their sessions every

week and commenting on the most meaningful moments through the SIQ. In fact, one

participant requested a copy of his notes to use as a reminder of significant insights and his overall progress.

Ethics

Through the informed consent, participants learned about the purpose, procedures, and potential risks of this research. Although participants were offered a stipend of $40 as a compensation for their time, no pressure was used to solicit participation. In addition, participants were informed that they could withdraw at any time. Confidentiality was ensured by carefully maintaining participant anonymity through the use of codes. Furthermore, participants were informed that some demographic information would be attached to the presentation of the findings and they would be given the opportunity to approve of or object to it. Finally, none of the interview questions appeared to be anxiety provoking for the participants, which was expected given that clients were prompted to share their positive counselling experiences.

Chapter 4

FINDINGS

The findings of this study were derived from an in-depth analysis of seventeen positive-case interviews and one negative-case interview. Participants' experiences of gaining hope during therapy were collected, analyzed, and then synthesized and organized into a substantive theory. This thematic level of organization was achieved through a process of progressively making sense of the interview data at a more abstract level of analysis.

I will begin by summarizing the principal components of the theory, which are diagrammed in Figure 1 (p. 65). I will then introduce client experiential definitions of increased hopefulness, the core category of the derived model. Next, each major category and its subcategories will be presented in relationship to the core category. The chapter will conclude with an integration of how the categories interact, to demonstrate the most salient patterns that make up the substantive theory. Quotations of client interviews that illustrate a category, a subcategory, or a pattern in the process have been incorporated throughout. Pseudonyms have been used when quoting participants. Finally, the case of Helen, who did not experience increased hope by her 10th counselling session, has been incorporated into the results whenever applicable, as a way of providing confirming evidence to support the final theory.

The analysis yielded six higher-order categories that constitute the primary components of the process of hope development in counselling, presented next along with their respective axial codes in parentheses: 1) Sources of client beliefs about counselling (deeper context); 2) Outcome expectancies and role preferences (immediate

context); 3) Therapist and client input (strategies); 4) Outcome and meaning of strategies (causal conditions); 5) Wish fulfillment and outside events (intervening conditions); and 6) Positive change (consequences). These categories are organized around the core category, named *hope as a sense of empowerment* (top of Figure 1). The *strength* and *nature* of clients' newly acquired sense of empowerment are the products of a complex and dynamic interplay of the six main categories, which are summarized below and will be described in detail later in the chapter. The axial codes assigned to these categories are presented in bold letters.

Looking at the trajectory of hope development over the course of counselling in a sequential manner, as shown from bottom to top in Figure 1 (p. 65), the first category to emerge from the data is the **deeper context** of hope development, the sources of client views and beliefs about the effectiveness and process of counselling. These will be shown to shape the **immediate context** of hope development that is comprised of clients' outcome expectations and role preferences. Outcome expectations refer to the extent to which clients felt that counselling would help them achieve their desired goal; these range from very positive to negative expectations. Role preferences reflect clients' desired contribution from the therapist and themselves on the basis of what they think will be most helpful, and vary in terms of their level of adaptability, ranging from flexible to rigid. The factors influencing client views of counselling (deeper context) offer an explanation for the observed variation in the nature of client outcome expectancies and the adaptability of client role preferences. Therapeutic interventions and qualities in interaction with client contributions are the **strategies** resulting in new therapeutic experiences for clients that, in turn, spawn increased hopefulness. Therapist interventions

are grouped and presented under three major *types*: directive interventions, non-directive interventions, and interpersonal elements. The three types of therapist input meaningfully interacted with two levels of *influence* of client input, primary or secondary, to elicit different types and levels of strength of client empowerment.

Both the immediate effects of therapist and client actions and interactions, and the subjective meaning ascribed to those processes by the client were **causal conditions** of hope. The data contained three major causes of hope: new outlook, improvement/sense of accomplishment, and having a neutral space to talk. Throughout the analysis, the potency of all these factors was largely determined by two important **intervening conditions** acting as catalysts, protagonists, or antagonists in the process of gaining hope: wish fulfillment and outside events.

The last major component of the resulting theory of hope development is **consequences**, the aftermath of experiencing higher hope. The consequences are presented in terms of the behavioral and cognitive changes reported by the participants.

<div align="center">Higher Hope as a Sense of Empowerment</div>

Client definitions of increased hopefulness can be understood as both experience-based and cognitive; experience-based definitions were derived from the meanings participants attached to therapy processes they identified as having contributed to becoming more hopeful. Cognitive definitions stemmed from responses to the final question of the interview, which asked clients to operationalize the concept of hope. The cognitive definitions were used to verify the trustworthiness of the core category and provided further evidence of fidelity to the voices of the participants.

HOPE AS EMPOWERMENT

DISEMPOWERMENT

Positive Emotions

Negative Emotions

Strong------Tenuous

Low reliance------- High reliance

Sense of Control

Sense of Direction

Low sense of control
Low sense of direction
Low faith in counselling

Faith in Counselling

High Compatibility----------------Low Compatibility

Positive-------Negative

WISH FULFILLMENT

OUTSIDE EVENTS

CONSEQUENCE

INTERVENING CONDITIONS

New Outlook

Better Understanding/ Alternative Perspective

Having a Neutral Space to Talk

Improvement / Sense of Accomplishment

OUTCOME OF STRATEGIES & MEANING

CAUSAL CONDITIONS

Directive------------------Non-directive

Interpersonal

Primary-----Secondary

Giving Suggestions/ Offering New Perspective/ Focus on the Positive/ Psychoeducation/ Broad Exploration/ Facil. Independent Coping

Empathic/Validating Interactive Objective

Self-disclosure/ Openness to Action/ Openness to Ideas/ Ownership-leadership

THERAPIST INPUT

CLIENT INPUT

ACTION/ INTERACTION STRATEGIES

Positive---------------Negative

Flexible--------------Rigid

Honest Self-Disclosure/ Active Contribution/ Openness to Ideas

OUTCOME EXPECTANCIES

Direction/ Unbiased Listener/ Insight/ Perspective

PREFERENCES FROM THERAPIST

EXPECTATIONS FROM SELF

IMMEDIATE CONTEXT

Past Counselling

Personality Characteristics

Stories & Support

Personal Theories of Change

SOURCES OF CLIENT EXPECTATIONS AND PREFERENCES

DEEPER CONTEXT

Figure 1. Visual representation of the Hope as Empowerment Theory

Several participants re-defined hope on the basis of their experience as confidence in oneself to manage future problems and achieve personal goals, and distinguished it from optimism as the mere belief that 'things can change for the better'. Higher hope as an *increased sense of empowerment* over the presenting problem was undoubtedly the strongest common thread among all client definitions. This sense of empowerment appears to manifest itself in one or more of three different, yet complementary ways: a) as increased sense of control, b) as increased sense of direction, and/or c) as increased faith in the process of counselling.

<center>*Hope as Sense of Control*</center>

According to all 17 participants, developing hope in therapy is about gaining a greater sense of control or confidence in one's personal ability to deal with the presenting problem. This aspect of hope can be best summarized in the statement "I can manage the problem" and points to clients' perceived self-efficacy in dealing with the hardship they are presently experiencing. Issues progressively appear to shift from something all-powerful and uncontrollable to something more containable and manageable. Lucy encompassed it all in one brief statement:

> I felt really good. I felt very…I had some power that I felt that I had a
>
> greater sense of being in control. You know like 'it's okay, I can manage
>
> this' and that sense of empowerment is also good because I know that like
>
> this semester just started.

Despite the strong similarity in the nature of increased hope, the *strength* of the newly acquired sense of control varied and ranged from strong to tentative. The

following response by Aaron exemplifies a more provisional sense of control over the problem:

> …I would think about it and I'd feel like slightly better and stuff each week. So I would say I feel slightly more hopeful to that I'm able to at the very least trying to work towards some of my issues…To my ability to work through the issues as well as you know that the issues are somewhat able to be overcome, not that I'm extremely hopeful just that I feel like okay there're some strives, there were some successes.

This observed fluctuation in strength of sense of control will later be shown to be derived from interactions among different components within the model.

Everyone except two participants developed this kind of hope. Nadia and her counselor decided during the third counselling session that the time was not ideal for exploring and dealing with the roots of her anxiety and depression. The emotional turmoil that this process was generating in Nadia had begun to interfere with her ability to concentrate on her studies, so a decision was made to switch the focus of the counselling sessions and use them as a "present-focused support system". Nevertheless, Nadia still expressed increased hopefulness in the process of counselling, because the therapist heard her, validated her concern, and offered her further sessions with an alternative focus. In her own words,

> I guess I was feeling really uncertain, I was just feeling very torn about the whole issue, just feeling really, I didn't know what to do. I was really sort of lost with that decision about continuing therapy or not continuing therapy. It was a really uncomfortable feeling for me and when she sort of

helped me - - - - kind of gain a more clear perspective on things, just gain

a little bit more certainty in the way that things were going to proceed, I

think that really – that was what really helped me feel better about myself

and feel better about where we were going to go in sessions.

Hope as Sense of Direction

The second aspect of increased hopefulness as a sense of empowerment, which

was experienced by the majority (12/17) of participants, is an increased sense of

direction, or identification by the client of one or more ways to achieve the desired

therapy outcome. This can best be summarized in the statement "there is a way out" and

refers to a recognition and concretization of the steps that need to be taken in order to

overcome the problem. This is how Michelle described it:

Like it gets you to the point where you have really – you don't just hope

that something will be okay, you start to have confidence that it will and

that there is a way out and that there is some stuff you can do, and that

once you are on your own as well, you will be able to do that.

Liang used this metaphor to describe his experience of gaining a better sense of direction:

I think it gave me - - I guess, not really a clear - choice of action but more

like a guideline. It's like as if I'm in a completely dark room that's without

any guidelines and all of a sudden there is a little – in dark theatres

sometimes they have these tiny little light-bulbs that help you find your

way.

Like control, direction also differed in degrees of *self-reliance.* This was the

property that differentiated the extent to which clients relied on either the therapist or

themselves to identify ways out of their present situation. Self-reliance also pertains to the sustainability and generalizability of the identified solutions, strategies, or tools acquired in therapy; that is, the degree to which clients feel they can continue using the same tools in the future on their own, or modify and adapt them to a similar situation. Liang's experience exemplifies low reliance on the therapist, and epitomizes the notion of ownership and personal choice over the options lying ahead: "I think that last session really kind of solidified the realization I had prior to that - - - realizing that I think sometimes it's about asking myself or somebody asking me the right questions for me to actually think of the decision-making process. Instead of having somebody tell me what I *must* do (participant's emphasis)". Almira, on the other hand, clearly emphasized her need for concrete direction from the therapist:

> Well now I understand I'm not gonna get those outside answers that I was hoping for and maybe I should look somewhere else for that or like even for constructive guidance on – I mean when I talked to my counsellor about my poor study habits, she does ask me like 'well how do you study?' and 'do you think that that's the best way to study?' and 'really is that a fair expectation of yourself?' But that's not the same as a concrete study manager saying 'this is what you need to do to get this grade to pass'.

Hope as Faith in the Process of Counselling

Nine participants highlighted their enhanced trust in counselling as an effective means of problem resolution. All except Nadia (mentioned above) continued to develop a greater sense of control and most also gained a greater sense of direction.

Genevieve: I don't know exactly when I started feeling hope regarding

myself. Maybe it was at this moment that now that I knew that she'd be

able to help me, I started wanting to help myself. Because I was feeling

that there was someone who was behind me and would help me

throughout this.

It was after eight counselling sessions that Aaron's increasing faith in the process

began to instill some hope in the outcome, albeit apprehensively:

… hopeful about the process itself that this might actually be slightly

beneficial, as well as the fact that it might – not only will it be slightly

beneficial, like the sessions itself, but it might require me like taking some

active changes afterwards so it was slightly more hopeful about the

problem, not to a great extent but you know just slightly.

Sense of Empowerment Wrapped up in Positive Emotions

At a first glance, then, it appears that achieving higher hope in therapy is a

primarily cognitive function, inasmuch as the three components of client hope, namely

sense of control, sense of direction, and faith in the counselling process, reflect clients'

shifting *attitude* towards the problem and a stronger *belief* that it could be overcome. Yet,

all three components of hope were consistently portrayed by clients as emotion-laden

experiences. Becoming more hopeful was invariably coupled with feeling happier, more

confident, more relaxed, relieved, proud, and more energetic. The term 'sense of

empowerment' used in the resulting grounded theory to describe client increased hope

was in fact purposely chosen to capture this dual nature of hope as both cognitive and

affective.

Debbie described feeling more in control as intertwined with stronger positive

emotions and less negative emotions:

Interviewer: So you're not 100% confident that (the problem) is solved,

but compared to how you were feeling let's say before you came in and

how you felt after these first three sessions, how would you describe the

difference in the feeling?

Debbie: I would say I feel more confident right now than before I came in

and um - more secure, more - - what would be a good word - - - - kind of

more stable or rooted. I think that one of the effects really of coming here

and talking to the counsellor was that I took my problem from the very - -

emotive - surrounding in the experience to a more exterior, kind of

rational or just tangible level, so that gives me the feeling that it's

something that's more controllable and - just less emotively charged.

Margaret's subjective definition of higher hope as increased happiness was not

how she used to necessarily perceive hope prior to the interview:

I think it's the idea of being able to be happy for a bit of time. At the

moment I reframed my hopes for the future to next week as opposed to

three years from now. So yeah I think I probably, as a result of the

counselling experience (incomprehensible) sort of being happy and being

able to cope with the immediate future more than succeeding at everything

you want to achieve. Which I have no idea if that's how I defined it before

but it probably had something to do with accomplishing stuff. So,

accomplishments are good but being happy is also important.

Summary of the Core Category

Higher hope was defined by participants in this study both cognitively and experientially as an increased sense of empowerment that appears to manifest itself in one or more of three different but complementary ways: increased sense of control, increased sense of direction, and/or increased faith in the process of counselling. Participants consistently portrayed these components as emotion-laden experiences. While the first two inherently reflect higher client self-reliance regarding a future problem resolution, the third one implies a higher reliance on the counsellor for a successful future outcome. Later, I will elucidate how, in some cases, this reliance is an essential intermediate step for achieving one or both of the more "independent" hopeful states: sense of control and sense of direction.

The Framework of Hope Development: Relating the Categories to the Core Category

The client process of achieving an increased sense of empowerment during therapy does not appear to follow a linear trajectory. It seems more like a continuous interplay of various factors that result in a theory with a dynamic and cyclical structure. At this point, the core category will be further specified in terms of the context in which it is embedded; the action and interaction strategies that contribute to its occurrence; its immediate causes; the structural conditions that facilitate or constrain the strategies; and, finally, its direct consequences.

Deeper Context: Sources of Client Expectations

Participants were directly asked in the interview to recall how hopeful they were prior to seeing their therapist about the potential effectiveness of counselling, as well as what they had hoped their therapist's role to be and what they thought their own role

would be in achieving their desired goals. Next, the interviewer asked participants to

elaborate on what affected these outcome expectations and role preferences. The key

categories that emerged from responses to the latter question constitute the deeper context

of hope development, which is comprised of stories and support from others, past

counselling, personal theories of change, and personality characteristics. Besides

influencing the types of client outcome expectancies and role preferences, these factors

also serve to explain variations in the adaptability of clients relative to their specific

wishes from the therapist.

Past Counselling

Eight participants had previous counselling experiences that shaped their present

expectations of counselling, the therapist, and themselves. Another participant had

previous counseling, but did not refer to it in the interview. Not surprisingly, unsuccessful

past experiences yielded negative expectations or skepticism if coupled with other

positive influences, while helpful experiences contributed to higher hopes about its

potential. Sophia, for example, would probably not have pursued counselling again if her

mother had not insisted:

I've gone to various counselling sessions but never really completed them

or continued it at all. I always felt kind of silly at the beginning just kind

of talking about my negative things in my life. And to me that didn't seem

helpful at all. With one of them it felt kind of awkward, like it was just

supposed to be me talking. I never really knew like what to talk about. I

couldn't really come up with things in my life to talk about. But the fact

that the depression kept coming back and the bulimia kept coming back

obviously I had to do something about it so my mother encouraged me to

get counselling and to stick with it.

Aaron, who was counseled by an intern in the past and who reported not

benefiting from it, talked about how his present expectations automatically worsened

when he was once again matched with a counselling trainee:

They never once told me that they were putting me with an intern or

someone who was studying to be a counsellor so they made me wait a

month and a half and then I met the person and that person was a student.

And I didn't feel like waiting another month and a half – And, 'cause the

first time it didn't work so I wanted someone with more experience. So

that added to the lower expectations because I didn't want to wait another

month and a half and you know I just kind of went with it. From my last

experience I didn't think much would come from it.

Margaret's expectation that she should be adaptable and open-minded directly

stemmed from her previous therapy:

You have to be a bit flexible in terms of - if the counsellor kind of directs

you in one direction, you have to kind of go with it. That's why you're

there. As opposed to sort of resisting it 'cause if you think you know

everything, then there's no point in going to counselling.

Stories and Support from Others

Half of the participants talked about how people in their close environment

influenced their decision to seek counselling and their expectations from it in indirect or

direct ways. Indirect influences were personal stories of counselling as told by others, and

affected both outcome and role expectancies. Lucy, who reported very positive outcome expectations, had actively elicited her friends' opinions about counselling and its process, and appeared to enter therapy quite prepared for what she might encounter:

A friend of mine actually comes to counselling herself at (name of

University) and I talked to her about maybe coming in here and she said

you know, 'do it, they're really great. I find it very helpful' […] I have

another friend as well – two friends, and one of them is in counselling and

one of them really likes it and the other one finds it very frustrating 'cause

she says she always wants them to give her an answer and they won't give

her an answer. And she doesn't like that about it. She's just like 'I want

someone to fix my problems' but that's not the point of it. So I also had

that perspective and someone had told me you know how like they won't

give you the answer. They'll help you figure out an answer that works for

you but they're not going to give it to you […] I knew that they wouldn't

wave a magic wand.

Similarly, David attributed his negative outcome expectancies to hearing a few discouraging stories from friends:

I've had a couple of friends who did counselling and you know it didn't -

fix all their problems so I guess that's part of it too. They kind of go back

and forth and sometimes they like it and sometimes they don't so, but it

never really fixes everything, so that's where I was at.

Direct influences, which translated into receiving direct support and encouragement from friends and family to pursue counselling, were only reported by

three participants and were all positive in nature. As such, they contributed to clients'

positive outcome expectancies, with the exception of Sophia who, as previously

mentioned, had been in therapy before and had not walked away from it particularly

satisfied. In her case, encouragement from her mother re-opened the door to counselling,

but was not in itself sufficient to instill hope in the outcome.

Personal Theories of Change

      Ten participants spontaneously revealed their personal understandings of the

types of therapy processes required to experience positive change. Helen, who did not

reach higher levels of hope after ten weeks of therapy, believed that learning more about

behavioral "norms" would help her choose the most appropriate form of conduct in her

interactions with other people: "It's more like sort of understanding what the range of

responses that people have when they interact and sort of deciding what works best and if

I can feel better being confrontational". Debbie, who was hoping that the counselor

would adopt a rather directive approach in addressing her problem, explained her

rationale as follows:

> Sometimes I feel that - in order to change something in a client's life - just
>
> talking about it is not enough but - - there must be some concrete changes
>
> that have to be introduced in the way the client behaves and - so - it's - -
>
> but I think it has to target more the client's *behavior* (her emphasis), not so
>
> much what he (sic) thinks about his feelings or - I mean often feelings
>
> come from situations and it's difficult to change the situation by changing
>
> your feelings but it's easier to change your feelings by actually changing
>
> the reality of the situation.

Personality Characteristics

Seven participants attributed their negative outcome expectations and/or their concerns with the expected therapeutic approach to a self-identified personality characteristic, mainly pessimism or introversion. This is how John put it: "I've always been very much of an introvert so dealing with, talking to somebody about one's problem is not usually my idea of how to fix something". David described his pessimism about getting help as a character trait.

That would be affected by my pessimism, in general, I just don't expect that, I don't know, that another person could really just talk to me and be able to fix all my problems. In general it is kind of my outlook in life. I don't know, I kind of just have to get things done myself; no one else is going to be able to do for me.

Michelle hoped for an action-oriented rather than an exploratory approach, because she felt she already possessed high self-awareness thanks to her introspective nature:

I think I spend a lot of time thinking about myself, about what I need to do and who I am and what bothers me about myself. And so I'm aware of a lot of things I do and so in terms of seeking counselling it wasn't about getting more insight into who I am.

Lucy, on the other hand, saw her extroverted nature as being a perfect fit with her anticipated role as an active participant in the process:

I find talking to people extremely cathartic when I have a problem. I like to talk it out. I will, you know, when I have a problem I'll talk talk talk

talk talk. I'll talk to like the five people closest to me – I'll tell everyone

the same story five times because that's my way of like getting my release

so to speak…And so I knew that you know by coming into counselling I'd

be able to talk a lot.

Summary

Four different sources of client beliefs about the effectiveness and process of

counselling emerged from the data: stories and support from others, past counselling,

personal theories of change, and personality characteristics. These are viewed as forming

the deeper context of hope development and play a salient role in this process, since they

influence client outcome expectancies, as well as the types and level of adaptability of

client role preferences.

Immediate Context: Outcome Expectancies and Role Preferences

Outcome Expectancies

Participant responses about how hopeful they were about the success of their

sessions prior to seeing their therapist were placed on a continuum from negative to

positive expectations. Approximately half of participants admitted to having had quite

low initial expectations or to having been skeptical about what counselling could

accomplish. The rest of the group reported entering therapy with positive to very positive

outcome expectancies. The quotes that follow illustrate the differences in the language

used by participants with differing hopes regarding the potential effectiveness of

counselling.

Mariam, who presented with performance anxiety, entered therapy with highly

positive expectations: "I was pretty confident that it *will* work" (participant's emphasis).

Almira, on the other hand, who presented with academic concerns, as well as relationship problems, was questioning its potential: "I guess I was generally skeptical cause for most of the time I thought, I mean I don't know, I had the attitude that I don't need to go see a counsellor or a psychiatrist or anything like that". Others, like Aaron, who was fighting depression, were quite pessimistic about counselling: "To be perfectly honest, when I came here I really thought it was going to be pointless. I mean it was more of a last resort".

Later I will elaborate on how the nature of client outcome expectancies could interfere with the effectiveness of the methods, strategies, and interventions used by the therapist.

Preferences from Therapist

Clients were also asked to remember how they had hoped their therapist would assist them. While most participants expressed more than one type of expectation, four major types of desired input emerged: hope for direction, hope for an unbiased listener, hope for a new perspective, and hope for insight. Within each type, there was a continuum of adaptability. Some participants presented with fairly rigid and adamant input preferences, while others discussed their flexibility and openness to whatever approach the therapist deemed necessary and effective. Some had rather unclear expectations, primarily due to their unfamiliarity with counselling. Examples of the more flexible versus the more rigid client preferences from the therapist are incorporated in the description of each type to illustrate this variation.

Hope for direction. All but one participant expressed a desire to receive concrete advice, guidance, strategies, and/or answers to their questions. In that sense, the therapist

was seen as an expert-consultant; someone who could draw from their years of experience and professional knowledge to offer suggestions on effective ways of dealing with the issue at hand. On a more microscopic level, degrees of expected direction ranged from being told what to do to being prompted in the form of questions or observations during the counselling hour. A representative example of the former, which also exemplifies a rather rigid stance, is the following statement by Michelle:

> I think what I wished for my counsellor to do was to give me direct sort of steps that I could take. Like it would sort of be, well 'do this' and then I could just go out and do it, because I wanted it to be very action-based you know, to not have someone to just ask me what I think I wanted to do. Like just being this mess of confusion and trying to figure it out for myself, it's what I've been having a hard time doing.

Helen, whose hope in the outcome did not change significantly after ten counselling sessions, also had decided what would help her change her negative patterns.

> I really wanted to hear about how other people deal with situations like the one that I was in. What's normal, what's quote unquote normal or abnormal. Umm, and, also yeah, to get to learn about how I could change patterns that I think that she really helped me identify, which could be good because I couldn't necessarily have done that on my own. Umm, but once I had identified those patterns, what I was really hoping for was information on how to change them.

David, on the other hand, thought that "maybe a little guidance would be nice". A few clients were found to be somewhere in the middle of the continuum,

searching for growth through learning independent coping. Liang argued that this

was his ultimate goal: "I think the biggest thing that brought me here was the

ability (emphasis added) to make an informed decision about things between

these options".

Participants' flexibility about the therapist's approach was also depicted in

narratives of how expectations for direction had shifted as they became more familiar

with counselling. Genevieve, for example, realized after a few sessions that her original

expectations for a 'quick fix' had been unrealistic:

> I had maybe one or two maybe three expectations, and one of them was
>
> quite naïve which was like 'oh she'll come out with some great activity or
>
> something I can do, you know, to fix my problems' […] Yeah, naïve in
>
> thinking that you know, one person could have the solution.

Hope for an unbiased listener. Thirteen participants expressed a need to talk to

someone outside of their personal environment who would have no bias or judgment, and

who would understand them, support them, and validate them. On a few occasions,

clients explained feeling somewhat isolated in their lives, so that the therapist was the

only person they felt they could trust with their private issues and concerns.

> Bill: I expected a person - objective person, that would invest the time to
>
> listen to me and help me disentangle a lot of the conflicting thoughts and
>
> feelings that I found very, you know, increasingly entwined and tightened
>
> up and causing me to go into some sort of paralysis zone; so I just
>
> recognized I needed someone to help me take some time and space to sort

of unwind a lot of things […] I think it's a pattern in my life of I guess

feeling a bit isolated and needing some validation.

Others were looking forward to unleashing all their negativity in the presence of

someone who would not be personally affected by it and whose job would be to listen to

them unconditionally. Lucy was rather adamant about having a therapist who would meet

these characteristics:

I knew that by coming into counselling I'd be able to talk a lot. And that,

you know, for one hour a week I could talk about all the things that were

wrong in my life and someone would listen and someone would be

sympathetic and someone would help me and give me constructive

feedback. That's a big reason why I came in, that's a big expectation that I

had about how it would help me. I would have monopoly on someone's

time for an hour where I could just talk about whatever I wanted and no

one would get tired, no one would get mad, no one would judge me, that

sort of thing. That was a big reason why I came in.

Hope for a new perspective. Half of the participants hoped that the counselor

would provide them with a new or alternative way of looking at the problem and implied

an existing awareness of a constricted frame of mind contributing to the problem.

Monica's response exemplified this:

I guess I expected feedback, just other views and I guess someone to

discuss what the situation was and options and help me see that like

maybe there's more, that it's not so closed, it's not so hopeless, maybe

there's more to the situation.

Hope for insight. The last type of expectation from the therapist identified in the narratives of seven participants was hope to identify the problem more clearly by giving it a name or a label, and/or to understand its sources and triggers. Genevieve believed that recognizing the factors that led up to her anxiety would be the recipe to overcoming it once and for all.

> Knowing where it's coming from, I guess is the key in resolving the
>
> problem. One of the keys. And I'm thinking maybe I'm just, you know,
>
> again, born like that. …Like where did that come from? It's just so
>
> ridiculous, irrational. And if I find out where it's coming from, maybe I'll
>
> just laugh at it and then just, you know keep on without these bad thoughts
>
> I have.

Margaret based her expressed wish for a more clear identification of the problem on past experience:

> I find that counsellors tend to help structure problems. Like not necessarily
>
> give me solutions but actually just let me know what it is I'm actually
>
> upset about. Because I'm often upset without quite knowing what the
>
> problem specifically is. Even if you can't solve it, sometimes it's good to
>
> identify it.

Expectations from Self

Participants were then prompted to discuss their own contribution in the counselling process. This question seemed to catch some by surprise; not everyone had necessarily seen themselves as actually holding some power in the process. Others, however, appeared to be well-aware of the influence of their contribution. Upon

reflection, all participants came up with at least one way in which they thought they needed to participate. Three types of client self-expectations emerged from the data: honest self disclosure, active contribution, and openness to ideas.

Honest self-disclosure. All but three participants talked about expecting to have to open up as much as possible to the therapist about their problem and their true feelings and experiences, despite how uncomfortable or challenging this might be for them. For some this was more of a hope rather than an obligation, as it was inherent in their therapy goals.

David: I wanted to feel comfortable with the person and be able to talk

about my thoughts and be able to say the things that I was thinking, make

it sound right. Sometimes it's hard to express your thoughts so that was

kind of what I was hoping for me, was that I *would* (his emphasis) be able

to express them adequately, my concerns.

Bill elaborated on his understanding of the importance of self-disclosure in affecting change:

I'm aware that the more open I am and the more I can kind of work at

trying to get to the bottom of things and bringing that out and sharing and

articulating that to the counsellor, the more he can create an accurate

assessment of what's going on. So I felt I wanted to bring a lot of that in,

be very open, as much as I could anyway.

A few participants explicitly highlighted the importance of honesty on their part. "I just thought that I would have to be honest about everything that is going on and talk about as much as possible about what my concern was" (Jennifer). Jackie had already

been aware of the need to be sincere with herself and echoed the importance of

transferring this honesty to her counselling sessions:

> I just knew that I had to be as honest as possible. Like with myself it was
>
> really hard for me to even come to terms with um in myself, when I started
>
> to realize that it was becoming a bit more of a problem than it should be.
>
> And so once I kind of accepted that, that was when I decided I needed to
>
> get help. So I was kind of passed that point.

> *Active contribution.* Half of the participants recognized the need to play an active

role both within and between sessions for therapist input to be fully effective.

> Michelle: I thought my contribution would be like, after all of that to sort
>
> of go out and to do those things, to at least try them and to report back you
>
> know, to do those little assignments that I was given and to challenge
>
> myself and come back and talk to someone; that even if it didn't work out,
>
> at least to be able to discuss it. And to be able to sort of analyze like you
>
> know when I was in that situation I might have felt fear because of this or
>
> that and in the end it wasn't that bad and what were the triggers and things
>
> like that.

> *Openness to ideas.* Four participants highlighted the significance of being

receptive to therapist's questions and ideas, which involved allowing themselves to

follow the therapist's lead without questioning it or resisting it too much.

> Debbie: The other thing that's important is to try to be open-minded; I
>
> think sometimes we are caught in other problems and we've made
>
> ourselves a very - narrow - view of what exactly it is that is wrong and

maybe sometimes this is what hinders us to find solutions because we're

just – so much *obsessed* (her emphasis) with what is wrong that we don't

see how we could actually, attack it from a different perspective. So, yeah

that's important, that I try to um - - to accept other people's view on my

feelings.

Summary

The immediate context of hope development is comprised of clients' outcome

expectancies and role preferences. Outcome expectancies refer to the extent to which

clients felt that counselling will help them achieve their desired goal, and range from very

positive to negative. Role preferences reflect clients' desired contribution from the

therapist and themselves as a necessary medium for attaining positive change. Four major

types of therapist input emerged from the data: hope for direction, hope for an unbiased

listener, hope for a new perspective, and hope for insight. The degree to which these

expectations determine the process of hope development stems from their level of

adaptability that ranges from flexible to rigid. Finally, participants had three types of self-

expectations: honest self-disclosure, active contribution, and openness to ideas.

Action/Interaction Strategies: Therapist and Client Input

After discussing their outcome and role expectations prior to beginning

counselling, participants were informed that their scores on the *Post-Session State Hope*

Scale had increased. They were asked to verify the accuracy of this observation and

comment on the extent to which it reflected their subjective experience. Everyone, except

Nadia, who explained that her increased score was an effect of having modified the focus

of her counselling sessions, endorsed the scale finding. They were then asked to describe

how this experience had unfolded for them and what had primarily contributed to their increased hopefulness along the way.

All seventeen clients reported a wide range of therapist interventions, strategies, and qualities as the medium for hope generation. In the majority of the cases, the outcome of these interventions or the subjective meaning attached to them were the *causal condition* of clients' increased sense of empowerment, which constitutes a separate category. Therapist actions were grouped under three major categories: directive interventions, non-directive interventions, and interpersonal elements. This grouping was done for two reasons: Firstly, the action/interaction strategies category generated the largest number of subcategories and the richest data; this grouping serves to organize and better illuminate the different types of strategies. Secondly, during selective coding, it became obvious that the *interaction* of therapist and client in-session behaviors significantly influenced the type and strength of client increased sense of empowerment. The above grouping was also intended to make these lines of interaction more clear. For the sake of simplicity, therapist and client inputs will be presented separately; however, an attempt has been made to provide quotes that actually illustrate this interaction whenever applicable.

Directive Interventions

The term "directive" was chosen to group four different types of therapist input that reportedly involved a higher level of therapist activity: giving suggestions, offering a new perspective, focus on the positive, and psychoeducation. Such strategies seemed to aim at either modifying client maladaptive behaviors through an action-oriented approach

to tackling the presenting problem, or modifying client perceptions of their problematic
situation by providing an alternative outlook.

Giving suggestions. Twelve participants nominated incidents where the therapist
offered them a direct suggestion, advice, or technique as having significantly contributed
to their increased hopefulness either directly or indirectly through the outcome of those
interventions. This first example by David illustrates a therapist input/client input
interaction and focuses on how the usefulness of therapist suggestions was largely
dependent on client input:

> … with time as I became more comfortable I was able to say things that I
> wanted to say more clearly I guess. And it was a lot of her suggestions that
> helped out I guess, she would say something and then I would think about
> it and I'd say "ok, I'll go try it". And I didn't really see it working at the
> time, but eventually it did help quite a bit. So it was just being able to talk
> I guess and open up and say things and then get the response back – just
> new things that I didn't really think of really.

Offering a new perspective. For more than half of the participants, increased
sense of empowerment resulted from the therapist putting things into context, helping the
client see things through a different lens, or normalizing the problem. Liang described an
attempt from the therapist to place his experience into context and how he worked with
that input.

> I think there was the fourth or maybe fifth session where my counsellor
> actually offered some suggestions, not on what to do in making the
> decisions, but I remember one time he said 'this is actually, it resembles

more and more a maturing process when one kind of grows up and learns

to make difficult decisions, more and more difficult decisions than before'.

I think that was really the first time that I truly experienced myself what

the word meant. Before sometimes the word gets thrown around but this

time I actually realized that all of these decisions - there's not a clear,

better one or a worse one.

Focus on the positive. Seven participants nominated times where discussions

with the therapist focused on their strengths and accomplishments, or simply what was

going well in their lives. These clients underscored the importance of their therapist's

encouragement, positive reinforcement, and acknowledgment of their successes both for

gaining trust in the process of counselling and for experiencing an increased sense of

control over their problem. Lucy felt particularly empowered after her therapist pointed

out a significant change in the way she handled a stressful situation, which she had not

recognized in herself:

(Therapist) identified that, you know, 6 months ago I wouldn't have done

that. I would have cried about it for two hours and called everyone I knew

and talked about how terrible life was that my paper was gone. But this

time around I didn't do that, I didn't focus on that […] She was the one

who was like 'this is a change.' And I was going 'oh you're right, this *is* a

change. I wouldn't have done this before.' So that was actually really

profound for me because I didn't even identify it, but once I did it's really,

to me it has been an example of how I changed.

Psychoeducation. In only three cases, clients described the impact of having their

counselor share with them their professional knowledge, often in the form of explaining

to them the causes of certain maladaptive behaviors.

> Monica: I guess he used a lot of - I'm guessing he's read a lot so he used
>
> a lot of what he's read to explain why certain people act certain ways and
>
> you know. So I found that helpful to, I guess to understand them, instead
>
> of just you know being upset about the situation.

Non-Directive Interventions

Therapist interventions were termed "non-directive" when the therapist seemed to

guide the sessions in more subtle ways to help the client to better define the problem,

identify its roots, or become an independent problem-solver. Two different types of non-

directive interventions emerged from twelve interviews: broad exploration and

facilitating independent coping. Based on client narratives, both of these approaches to

addressing the client's problem were primarily carried out through questioning,

clarifying, and making observations.

Broad exploration. Eight participants described a process of further exploring

their issue through either revisiting past experiences in an attempt to identify the roots of

the problem; probing into client's subjective emotional experiences; or examining it as

part of a bigger problem that manifests itself in different ways and in different areas of

the client's life. Exploration in Debbie's case took the form of being encouraged by the

counselor to reflect on and voice her emotions, as well as draw connections between

them:

I think that the one moment was actually last session towards the end and

that, again comes back to what I wrote after last session when the

counsellor asked me a couple more questions that pushed me to really - uh

at the same time analyze and put together how exactly I feel about, or

what exactly - - are the emotional aspects of my problem and how they

relate to each other. And that was a little bit of a; it was a moment of -

more profound understanding of my own problem and that was very

satisfying to me.

Helen, did not report increased hopefulness at the time of the interview and

sounded somewhat disenchanted by the intense focus on her childhood experiences

during her sessions, although she still appreciated the positive outcomes of this process:

Instead of evaluating my situation at the time all this was happening, she

would just continue to probe deeper into things about my past and my

family. And initially I found that kind of irritating because it wasn't

helping me. But now I can kind of see why, why she did that, because I

think reveals a lot about like how they are constructed. Umm, I feel like

it's been a useful sort of reflective process for me but it hasn't given me

answers to like my big questions.

Facilitating independent coping. Four participants described a process by which

the therapist showed them how to identify ways of coping with the problem

independently, or prompted them to spell out more clearly the steps they felt they needed

to take. Lucy, who had to switch counselors after the summer because of scheduling

difficulties, explained in detail how both therapists helped her, through open- and closed-ended questions, discover ways of tackling her problem that would best suit *her* needs:

> I was offered, you know, not constructive solutions but you know I was
> offered a way of finding solutions and dealing with stuff. It was really
> helpful […] I mean it wasn't exactly advice. I used the word advice but
> it's not really the word for it. 'Cause it's not like they said 'you should do
> this to manage this.' They don't say that, right? Basically I would just talk
> about something that had happened and how I'd handled it and they'd say
> like 'how does that make you feel?' like 'do you feel that that was the
> right approach?' you know. 'Could you have done it differently?' And it
> was just kind of like they helped me, sort of guide me into figuring out the
> best strategies that work for me.

Interpersonal Elements

The third major category of therapist action strategies, "interpersonal elements", pertained to the development of a stronger and more trusting relationship between the therapist and the client. These positive interpersonal experiences invariably enhanced client feelings of security, comfort, pride, confirmation, and confidence in the therapist, which in turn increased clients' faith in the process of counselling. Twelve participants referenced one or more of three types of therapist approaches, traits, or ways of being in the session: empathic-validating, objective, and interactive.

Empathic-validating. The times when therapists communicated or demonstrated deep understanding of the client and his or her feelings, as well as times when they acknowledged the legitimacy of client struggles or the validity of their goals, were

significant for half of the participants in the study. Such interventions significantly alleviated clients' anxiety and instilled hope both within and outside of sessions.

> Bill: I identified (on the Session Impression Questionnaire) that there was some special significance of that session and you know realizing that, getting a stronger sense that the counsellor is appreciating that amongst all the other issues I have being a returning mature student, I'm still struggling daily with some problems at home between my wife and myself.

Finally, it was rather meaningful for Nadia to hear her therapist legitimize her internal conflict of whether or not to continue with counselling:

> Nadia: I think she just really helped me to gain more clarity and make a more clear decision about what I wanted to use the sessions for and I think that made me feel a lot better. I wasn't feeling as confused and so I think in terms of you know getting clarity and just having her understanding, having her sort of validation, helped. Validation of umm - - the fact that I wasn't sure of what to do and the fact that I was feeling uncertain about that and you know validating the fact that that's an understandable position to be in.

Interactive. Four clients talked about the positive effects of having a therapist who was interactive during the sessions. These participants seemed to appreciate the "give-and-take" of therapeutic conversation, with the therapist guiding the sessions through probing and asking questions, rather than "expecting the client to come up with everything". Aaron spoke rather extensively about his therapist's increasing efforts to be

more interactive during their sessions as the reason that kept him from dropping out of

counselling and the main source of his slowly developing hope in the process and

outcome of therapy.

> She seemed to be taking a more active role, I just felt like I was being
>
> listened to so it made it easier for me to talk, and that's pretty much, yeah
>
> as I said, later on I started speaking more about some issues that I
>
> normally find slightly difficult to talk about […] it basically felt a little bit
>
> more human than kind of like a robotic thing where you just sit there and,
>
> you know, someone stares at you with kind of a blank face […] I think
>
> there were one or two times that I showed more optimism, like there was a
>
> more pleasant discourse; and those were typically the times when I felt
>
> more like the person I'm speaking to, like there's something of an actual
>
> conversation taking place, that's when I felt I guess the most hopeful
>
> 'okay I could start discussing my problems, I don't have to feel too much
>
> like the spotlight is shining on me'.

Objective.   Three participants underscored their positive experience of working

with a therapist, who listened to them without bias and who refrained from passing

judgment on them, which seems to have facilitated the work of therapy. John found his

therapist's unbiased and objective stance "refreshing" and the sine qua non of effective

counselling, following a previous negative experience:

> The essential thing about therapy is that it's not judgmental. The
>
> experience, um, when I had that accident and just trying to deal with it
>
> through the (other type of) counselling, I felt that, and I still feel that I

can't completely trust the people who are in the leadership position in that

sort of counselling. So having somebody neutral is, and somebody who I

can have confidence in, has really been extremely significant. That was

really important for me, that there would be talking to somebody outside

of the situation.

Summary

Therapist contributions to the process of hope development as seen from the

clients' viewpoint were diverse. For the sake of clarity, they were grouped during

selective coding under directive interventions, non-directive interventions, or

interpersonal elements, depending on the level and type of activity performed by the

therapist. Giving suggestions, offering a new perspective, focus on the positive, and

psychoeducation were the four types of directive interventions that emerged from the

data, while broad exploration and facilitating independent coping were the two non-

directive types of interventions, typically carried out through questions, clarifications,

and observations. A third type of therapist contribution was the interpersonal elements,

namely empathic-validating, interactive, and objective, which contributed to the

development of a more trusting therapeutic relationship and increased clients' faith in the

process of counselling.

Client Contributions

In the interviews, client responses to how the therapist contributed to increased

hopefulness were followed up by the question of how participants perceived their own

role in this process. Most participants focused on the interaction between their therapist's

interventions and their personal contribution. However, the level of *influence* of their own

input was portrayed as either primary or secondary. In the first case, client contributions were recounted as the main ingredient of success with regard to feeling more empowered, and appeared to determine the nature, focus, and direction of the sessions according to clients' wishes, which paved the way to the therapeutic encounters that clients found most effective. In the second case, the focus was predominantly placed on the therapist interventions. Four types of client contributions to the process of hope development emerged: self-disclosure, openness to action, openness to ideas, and ownership/leadership.

Self-disclosure. All but one participant, who experienced higher hope during the course of therapy, commented on the contribution of their detailed, honest, and accurate description of their personal situations, thoughts, and feelings. This input had impacts on the therapy process or the working alliance, as well as the experiencing of in-session outcomes related to gaining a sense of control and/or a sense of direction. An example of the former was provided by Michelle, who felt that her openness with the counselor about her expectation of a more behavioral approach to overcoming her social anxiety allowed for this to happen:

> I think with the counsellor I think probably the best thing that I did do was
> to be from the get go, sort of explain what was bad about my previous
> experience and be honest, you know try to really communicate clearly
> what I needed. And then like you know when she was responding to that,
> really sort of be specific about what I was hoping to achieve and what I
> needed.

Openness to action. Thirteen participants identified their openness and willingness to take certain risks by trying out their therapist's suggestions, advice, or exercises as having offered proof of their ability to create change, as well as evidence of the value and efficacy of the proposed strategies to producing this change. Jennifer attributed much of her increased hopefulness about the future of her romantic relationship to her readiness to implement her therapist's recommendations:

I think, well I tried to be really open to the advice she gave and listening

and actually doing stuff when she'd say 'you should talk about this with

him'. I tried to actually do that instead of just saying 'I'm going to go

home and not…' So I think that made a big difference; it actually made it

more effective outside of counselling. So I think that was the most

important thing, actually listening to the things she had to say.

Openness to ideas. According to nine of the participants, being open and receptive to the therapist's questions or new perspective, as well as giving new ideas further thought, partially contributed to get the ball rolling. The following quote by Margaret was part of her answer to the general question of how her experience of gaining hope had unfolded, and illustrates an openness to adopt an alternative view of her situation:

When I thought about making the decision to take time off school, I

thought back a lot to what my counsellor had been saying - - umm about

how, what I'd been talking about and definitely thinking this perspective is

not helping. So she sort of clarified that for me.

Ownership-leadership. Almost half of the participants saw themselves, not merely as active participators in the counselling process, but as protagonists who would decide the key issues and experiences that needed to be addressed and assume responsibility for bringing about change in their lives. John best exemplified the latter in the following response:

> I've recognized that there would be; I'm very aware that, you know, somebody else can't solve my problems. So the whole reason behind coming to therapy was looking for someone to bounce ideas off of. But I am now very aware that I'm the one who has a problem, I have to internalize this, I have to take care of myself. I mean this is an hour once a week, it's not for the rest of my life. So I've had to take, you know, I take responsibility for the rest of what happens, I had to do that.

Summary

When asked about their personal contribution to the process of developing higher hope, most participants focused on the interaction between their therapist's interventions and their own actions; significant variation was observed in the level of perceived influence of their own input. Four types of client contributions to the process of hope development emerged: self-disclosure, openness to action, openness to ideas, and ownership/leadership.

Causal Conditions: Outcome of Strategies and Meaning

The preceding section was a detailed analysis of the therapist and client actions and interactions that emerged in the analysis of *what* clients felt contributed to their increased hope in the process and outcome of therapy. Some of the quotes that were

interspersed throughout the presentation of these factors have already shed light on the

reasons *why* some strategies became core generators of hope. Participant responses

yielded three major sources of hope: new outlook, improvement/sense of

accomplishment, and having a neutral space to talk. A close examination of each of these

fundamental therapeutic experiences will reveal that different strategies or in-session

events generated rather similar hope-inspiring outcomes, and vice versa. That is, similar

actions and interactions had the potential of impacting clients in different ways.

New Outlook

Client narratives provided overwhelming support for the notion of obtaining a

new outlook on their problem as a typical trigger of increased sense of empowerment.

Specifically, sixteen participants identified acquiring a better understanding of their

problem or an alternative viewpoint as the starting point for perceiving themselves as

more capable of managing the problem or recognizing ways to deal with it.

Better understanding. Fourteen clients partially or entirely attributed their

increased sense of empowerment to a more clear identification of their problem, either in

terms of better understanding its different aspects and emotional components, and/or

understanding the problem's etiology. This new clarity often shifted the original outlook

that had been associated with negative emotion. Such in-session outcomes resulted from

both direct and indirect therapist interventions, like offering a new perspective and broad

exploration, and at times from predominantly client actions, such as honest self-

disclosure or leadership. What follows is a long quote extracted from Almira's interview

in response to a question about what was meaningful to her. The quote has been chosen

to illustrate this process of change, as initiated at a moment in therapy where Almira

remembered something from her past:

> … to me what was important about that was that it was a *very specific*
>
> event that really I think explains a lot of my problems now that I had never
>
> thought of it. I had always thought of my problems in organization as like
>
> a personal failure and I hadn't realized where they date back from and I
>
> thought I should just have them, but then I saw that - what had been
>
> happening with organizing my schoolwork was that somebody was doing
>
> it for me and then - wasn't […] And it was very simple and
>
> understandable and less oppressive and awful than I had been used to
>
> thinking of that problem […] Just the way that I used to think about my
>
> problem with my schoolwork always used to be in comparison with other
>
> people um and like 'why can't I be like them' and not understanding or
>
> realizing that it's not that I can't be like them, it's because I've fallen into
>
> this pattern and *that* (her emphasis) was the cause of this pattern that I had
>
> never thought much of before, so it was really just making the problem a
>
> lot less like oppressive and unmanageable and mysterious, like it reduced
>
> the mystery of the problem. Suddenly I understood 'oh wow that makes so
>
> much sense. That's why, that's where it came from. And that's why I felt
>
> at a loss for so long'. So yeah it was just simplifying and demystifying the
>
> situation. So that's why that connection that I made in conversations with
>
> my counsellor was so significant […] Having the causal connection for
>
> that specific example or other connections that arise in our discussion with

my counsellor - helps me think my problems are more manageable, which

makes me more hopeful about them being solved even if there's other

issues for them not being solved. So I think yeah *there is a very direct link*

between understanding myself better and being more hopeful (emphasis

added).

Alternative perspective. Fourteen participants ascribed their increased sense of

control to having internalized a more balanced perspective on their problem, mostly as a

result of the therapist offering suggestions, introducing new angles, or placing the client's

experience within a larger context. In a few cases, interpersonal elements, such as

empathy and validation, seemed to be sufficient for this shift in perspective to occur.

Resulting perspectives typically resembled sentiments such as "things are not all bad", "I

am normal", or "I am not crazy". Jennifer explained what it meant for her to hear from

her counselor that "all couples fight" and that "there are ways to deal with arguments".

It was having her make it seem like everything wasn't so bad. Because

yeah just making me feel; just the way she was talking about things and

you know everything that came up, it was like there was a solution for it.

There was a reason for it. And it made me really feel like things weren't so

bad. I think that was the biggest thing. Feeling more normal, you know? It

wasn't like, I wasn't going through a huge crisis. I was just going through

some problems like everybody has problems.

The same outcome was experienced by Lucy, but more as a result of being

listened to without judgment by her therapist:

I also felt very supported in it. I felt like - it made me feel like I wasn't

insane and that you know my problems were manageable and the sky

wasn't falling and that kind of thing. So yeah that was very helpful.

Improvement – Sense of Accomplishment

Increased sense of empowerment, both as higher sense of control and higher sense

of direction, was experienced by fourteen participants as a direct result of early successes

in meeting their original goals. All of these clients underscored their fruitful attempts to

implement desired behavioral change, while several emphasized the significance of

having these improvements identified and validated by the counselor during sessions. An

increased sense of accomplishment was a common experience among these clients, who

consequently perceived themselves as more capable of managing their problems. In

addition, the experienced positive change served to confirm the effectiveness of the

suggestions or tools offered by the therapist and, hence, to strengthen clients' sense of

direction. Mariam noticed that she had not dwelled on a negative event that in the past

would have probably caused her high levels of anxiety and distress.

> I had a fight with a friend on that week I remember, and I didn't see her
>
> for the weekend and I was just like 'well, if I don't see her I'm not going
>
> to spend time thinking of it 'and this I remember was like 'okay now
>
> maybe I can do it' – I don't know if it helps or not (giggles) but I
>
> remember that this made me feel better and it made me feel more
>
> confident.

David nominated the last session with his counselor as the most hope-inspiring

one, as a result of hearing his therapist review and highlight this progress for him.

We just sort of did a recap so, 'ok you came in with these problems, and

we did this, and we talked' and that session I felt pretty good because it

made me feel like we had done something. I didn't realize that things were

getting that much better I guess, it really kind of hit home when we talked

about everything and how I came in - I started remembering how I felt

when I came in, so there's that, but that was more like a recap and a

realization that things were better now than they used to be.

For Margaret, who has been coping with the effects of a long-term disease,

progress translated into increased acceptance of her new limitations.

Again, I am sort of reluctant to say hopeful but - yeah I guess hopeful is

right - I mean hopeful's also being able to deal with the next day. You

know it didn't look that much better for the long term, but it's certainly

not as hard to get up in the morning.

Having a Neutral Space to Talk

For twelve participants, simply having someone with a distance from their

personal lives to talk to freely and honestly, to reveal their "secrets", and to expose their

internal emotional conflicts and struggles, emerged as a very significant element in the

process of gaining hope. Several clients expressed relief at not burdening people in their

lives. Overall, therapists' empathy, validation, and impartiality appeared to considerably

contribute to clients' increasing sense of comfort to open up about their private thoughts

and feelings. Michelle explained it as " being able to confide in someone openly about

lots of things that you don't necessarily want to tell all at one time to any given person",

while Monica underscored the undivided attention and interest she was finally getting

from someone.

> I would say definitely that I was finally focusing on myself. So like I
>
> wasn't focusing on my boyfriend's problems or my mother's problems but
>
> focusing on me as a person, so it allowed me to gain strength in myself
>
> […] It was like I don't have to bear it alone anymore, you know there's
>
> someone who can help me with this, I guess to go load off, like that
>
> feeling.

Margaret's response exemplified the importance of talking to someone who

would not be ultimately affected on a personal level by her disclosures:

> … I think it takes a bit of the pressure off my fiancé because he is
>
> amazing, we live together and he's there all the time and stuff like that,
>
> and he knows what I hesitate about, but you know I don't want to talk
>
> about it ad nauseam to him because that's just depressing. I don't really
>
> worry about depressing my counsellor (giggles)…In a way feel free to be
>
> miserable there so you can be more hopeful in the rest of your life.

Summary

The immediate outcome of therapist and client actions and interactions, or the

subjective meaning attached to them by the participants of this study, yielded three major

sources of hope: new outlook, improvement/sense of accomplishment, and having a

neutral space to talk. Similar actions and interactions were shown to have the potential of

impacting clients in different ways, while client narratives provided overwhelming

support for the notion of obtaining a new outlook on their problem as a typical trigger of increased sense of empowerment.

Intervening Conditions: Outside Events and Wish Fulfillment

The process of hope development in psychotherapy as presented thus far from eighteen clients' perspectives has been somewhat linear. However, analyses revealed two important conditions that seem to have the power to either enhance or block the process of hope development. With respect to *outside events*, clients were asked in the interview to comment on whether anything had occurred between sessions that contributed to their feeling more hopeful. *Wish fulfillment* emerged during the open coding phase of the analysis, and revealed its potency during the axial and selective coding phases. The missing elements that clients identified from sessions prior to attaining a significant increase in their overall score on the *Post Session State Hope Scale*, or from sessions after which their gradually increasing score on the scale suddenly dropped, helped unravel the salience of *compatibility* between hoped-for and actual in-session processes as a powerful mediating condition that determined the degree of effectiveness of therapist and client actions and interactions.

Outside Events

The parallel unfolding of significant outside events seems to have both obstructed and facilitated the process of hope development for twelve participants in this study. These clients also attributed fluctuations in their hope scores to incidents that occurred between their counselling sessions and that affected their confidence and energy to deal with their issue. Most of these events or factors directly related to the problem

participants were working on in therapy; in a few cases, hopefulness was affected by unrelated events that ended up influencing the work of therapy.

Positive events. Several participants ascribed their increased sense of empowerment to a positive change in their situation, to having received valuable support by friends, or to unrelated positive experiences. The latter was exemplified by David, whose score on the hope questionnaire increased on a certain week because he was anticipating a happy event: "Right there at session four, that was right before reading week, I was really excited because I was going home, and I was visiting a friend in NY". Sophia talked about the dual significance of her new leisure pursuit:

> I started a choir for girls and we've been practicing twice a week and I
>
> think we are each other's support systems in a way. We've been
>
> performing a lot and *that* (her emphasis) has really helped in a way to,
>
> definitely be a positive part of my life but also that I'm contributing to
>
> something, that I'm actually doing something with my life rather than just
>
> going home and studying.

Negative events. Additional stressors, academic challenges, and receiving bad news were the most commonly reported external reasons for clients experiencing a decrease in hope, despite the productivity and effectiveness of their sessions. Debbie admitted having a hard time separating the effects of another big stressor in her life on her ability to deal with her presenting problem:

> I think that maybe part of the reason for this problem to have become
>
> bigger over the past year is that professionally I am very unhappy right
>
> now and it's not directly related to it but it just - - it just puts me in a very

stressful situation and I think that for sure that impacts on how I'm able to

cope with these things. And this is something I don't really talk about

with the counsellor because it's really a different problem but at the same

time - - - well – since it affects me it's difficult to tear them apart.

For Margaret, however, a negative incident actually contributed to her increasing

acceptance of the physical limitations caused by her long-term illness, as it solidified the

realization that she arrived at in her sessions:

My best friend's mother died and I spent a week just being sort of by her

side all the time. I moved back to that neighborhood and stayed with my

parents and stuff. At the end of the week I was just exhausted and I sort of

- - figured out that there wasn't anything I wasn't going to do for my

friend and yet I couldn't help being tired and I couldn't help not being

effective. And I couldn't help hearing me say 'no I can't do that' 'no I

can't have it' and I sort of realized well if I can't do that for my friend,

right? It's not surprising that I can't do it for schoolwork, which takes a bit

of personal motivation.

Wish Fulfillment

High compatibility. Twelve out of the seventeen participants explicitly and

spontaneously highlighted the significance of having their original wishes and needs met

by their therapist. In four more cases, although participants did not explicitly comment on

their needs and wishes being fulfilled by their therapist, it was observed that therapist

interventions and/or their impact substantially matched client original expectations. Nine

of the 12 participants who spontaneously shared their appreciation for receiving from

their therapist what they wanted and needed experienced increased faith in the process of

therapy or the abilities of the therapist that mediated the development of hope in the

outcome. Michelle repeatedly emphasized during the interview the importance of having

had her therapist listen and respond to her needs.

> To have that person direct you to specific actions… I think I was very
>
> clear as well that that's what I was hoping for in the beginning and so I
>
> really like that she respected that […] I think like for me it was really
>
> simple and it was just the fact that someone understood what I said that I
>
> needed something specific, that they, even if it might not be typically how
>
> they interact with other people, that they adapted to me and that they sort
>
> of really made the effort to help me with what I said I needed. That was
>
> really really like - that I really appreciated and that certainly gave me - that
>
> certainly gave me I guess hope; like I'm trying to think if hope is really
>
> what I got out of that or just simply - - definitely encouragement and I
>
> think like just being encouraged by a situation that you're doing, that sort
>
> of made you to be hopeful I think because, you know, it obviously puts
>
> you in a better positive frame of mind and I think just - she really did cater
>
> to what I needed and you know like it already satisfies your expectations
>
> and is really there to help.

Aaron did not seem to be getting what he wanted from the therapist in the first

couple of sessions and decided to communicate his dissatisfaction. The counsellor heard

him and adapted to his request for higher input:

Pretty much it got slightly better but I still discussed some issues of

getting able to like, issues I had with the session itself and of course she

took this into account and you could visibly see it by her reaction and stuff

- - so I mean it was more of a back and forth thing. And so it felt like I was

having more of a discussion, I mean a laugh or a joke here. Even though I

realized that the person is just trying to act more, like part of my doubts

was that the person is just acting this way to help out, it still makes it a lot

easier when the person you're talking to is acting engaged […] That

changed stuff and it was more of a back and forth thing and she seemed to

be acting more attentive, I felt slightly more hopeful like this might be

getting somewhere and I was able to talk more openly.

When asked towards the end of the interview about their future expectations from

their counselling sessions, most of these participants expressed a wish to continue

receiving from their therapist the same type of input, namely direction, insight, and/or

support, or hoped to continue to show improvement until they felt confident enough to

fully rely on themselves.

Low compatibility. When clients were asked to comment on whether there was

something missing from their sessions with unimproved or deteriorated hope scores,

thirteen of them pointed to the absence of therapist actions or in-session outcomes that

they had hoped for. In most of these cases, unmet expectations temporarily decreased

participants' hope in the process and/or the outcome, and generated feelings of

frustration, anxiety, discomfort, confusion, and sadness. For a few clients the

consequence was a lack of motivation to actively work on their problem. Mariam, who

had been looking for direction in the form of concrete suggestions from her therapist, left

one of the sessions feeling down and less hopeful than before due to the absence of

direction:

> …there is one where we started to talk more about family, and time, and
>
> how much time I had to have fun and take time for me and yeah, after that
>
> session I remember I was really really, this session put me more
>
> down…Well it's just that I knew; I already knew it, I was really aware of
>
> it but I didn't see any solutions like time-wise to make the situation better.

A few clients, who had hoped to challenge themselves by trying new behaviors,

assumed responsibility for the lack of progress on certain weeks. Michelle was one of

them.

> I had such a big leap I felt the week before and I would have liked to
>
> sustain that momentum, and then it was kind of like 'well you know I
>
> wasn't able to do it' and I think it wasn't as speedy as I would like it to be.
>
> I think I was just after my second meeting which went so well where I had
>
> done stuff and I was really proud of myself. I think that it was just because
>
> I hadn't accomplished as much and I probably got disappointed about that
>
> - but in that sense I was really stressed that it wasn't because of the
>
> counsellor. It was really more just cause I hadn't necessarily achieved my
>
> active stuff during that week.

Unmet expectations interfered with the effectiveness of the work of therapy and

slowed down or temporarily halted the development of clients' hope in the outcome.

However, 12 of the 13 clients 'recovered' from these set-backs and experienced a

renewed sense of hope as a result of having these or other needs met in later sessions that

followed the discouraging events. Helen, on the other hand, whose scores on the hope

questionnaire increased marginally over the course of ten counselling sessions, was an

exception. She reportedly never received from her therapist the direction and answers she

was fervently looking for, which proved to be a more permanent obstacle in her

developing hope in the outcome.

> I thought that she would maybe help me make decisions. And that didn't
>
> happen either. Euh, and that's kind of *really* (emphasis added) what I was
>
> hoping for because I was having trouble making decisions. And I *really*
>
> (emphasis added) wanted guidance. And instead I got reflection, you
>
> know?

Later on, she elaborated on the positive but inadequate impact of exploring the

sources of her behavioral patterns with the counselor:

> It was interesting to go through this at the time I was problem-solving in my life
>
> because it made me think of the way I deal with situations and why I feel
>
> uncomfortable with the way I deal with situations. And how it's coming out and
>
> what's legitimate and what not legitimate…It didn't help me change, what I
>
> wanted see was change in the way I interact with people. And it didn't help me do
>
> that.

During the process of selective coding, it became apparent that the *adaptability* of

client expectancies may serve to explain this variation in participants' experiences. This

idea will be examined more closely later on in this chapter.

It is important to note that, despite clients' 'recovery' from episodes or sessions that did not meet their original expectations, they continued to long for what they needed but had not yet received. Five participants expressed still hoping to discover the roots of their problem, while four more emphasized their need for suggestions and advice from their therapist in future sessions. In fact, Jackie presented as somewhat fearful that her improvement may be temporary, if her and her therapist fail to find the answer to the 'why' question:

> I feel like although I'm doing well right now and I'm positive right now,
>
> it's *very* (her emphasis) much on the surface. And I could kind of; I don't
>
> mean fall back into a rut but I could get back into that pattern, if I don't
>
> really figure out why I'm doing what I'm doing.

Summary

The data analysis revealed two important factors that seem to have the power to mediate the process of hope inspiration during therapy: wish fulfillment and outside events. The compatibility between hoped-for and actual in-session processes emerged as a powerful mediating condition that significantly affected the degree of effectiveness of therapist and client actions and interactions.

<center>*Consequence: Positive Change*</center>

The main rationale and impetus for studying the process of hope development in psychotherapy was the finding that there is a positive association between hope and positive therapeutic outcomes. Although the present research did not follow clients until the end of therapy, some participants still reported positive changes resulting from their increased sense of empowerment. It appears that these clients had already summoned

adequate confidence, energy, and knowledge to adopt a different attitude towards their struggles or alter their behaviors through the use of the tools acquired in therapy. Hence, positive change in some cases took the form of implementing new behaviors, while in others it was about replacing negative, maladaptive thoughts with more positive and rational perspectives.

Behavioral Change

Although it was at times difficult to discern whether positive behavioral changes as experienced and reported were a cause or a consequence of increased hopefulness, half of the participants appeared to view these changes as the aftermath of gaining a higher sense of control and a higher sense of direction over their problem. Lucy talked about her efforts to keep applying what she learned in therapy: "I've really been trying to change and to be a more calm person and to be frankly a less sensitive person. Not to over-react to everything and not to assume the worst in situations". Even Margaret had started developing her own ways of making the most out of each day despite her pervasive symptoms:

> Now I've started keeping diaries of my fatigue and my medications, as
> opposed to just rushing through the day and feeling like; it means that for
> the things I can do, I get more out of them and I stop trying to do the
> things I can't do which I wasn't getting anything out of anyway.

Cognitive Change

Eight participants discussed positive change in terms of working on shifting their maladaptive thought patterns. Bill explained how he has been making a consistent effort to recognize and change his negative self-talk:

To re-acknowledge that I think just made me more able to I guess control it, contain it, or you know keep it in mind I guess. So that I can pay attention to that voice and I've been doing it ever since. And I try, you know, and I even check out what my wife is talking - - whether she's saying things that actually might be undermining her.

Since improvement in the form of behavioral or cognitive change also emerged as an important *source* of hope for several participants in this study, the question of the relationship between hope and change has a chicken or egg quality. This study revealed that clients experience it as both: hope facilitates positive change *and* positive change instills hope. Only one participant was explicit about the cyclical quality of hope and change:

Genevieve: I was feeling more hopeful so therefore I started myself to make efforts to apply what we had been talking about and just being more positive. You know, in my everyday life. So it's a circle. It's some kind of a chain of; *because I became more hopeful, I started you know making efforts and thinking more positively, and then because I was thinking more positively, 'yeah you can do it, you'll be able to think that way more often'* (emphasis added).

Summary

Several participants reported positive changes resulting from their increased sense of empowerment up until the time of the interview. These changes were behavioral or cognitive in nature, and served to validate the finding that there is a positive association between hope and positive therapeutic outcomes.

The Process of Hope Development: Integrating the Categories

To this point, I have outlined and illustrated the most salient dimensions of the process of hope development as an increased sense of empowerment, based on the experiences of seventeen counselling clients that can be summarized as follows. Higher hope as an increased sense of control was experienced at different levels of strength by all participants who were actively working on their presenting problem with their therapist. The majority also developed a greater sense of direction with differing degrees of self-reliance. In addition, increased faith in the therapist and the process of counselling was often a stepping-stone for developing a sense of control and direction. Higher control, direction, and faith in counselling were all emotion-laden experiences. Moreover, obtaining a new outlook on the problem by gaining insight and/or approaching the situation from alternative viewpoints emerged as a typical trigger of hope. Finally, the fulfillment of client initial hopes and preferences was a salient parameter in the development of hope for the entire sample of participants in the study.

Although presented as independent categories, the processes of hope development were in fact intricately interwoven in these data. What follows is an initial understanding of the relationships among these factors that indicate the dynamic structure of the resulting theory.

The Impact of Nature and Adaptability of Expectations on the Role of Wish Fulfillment

As mentioned, client wish fulfillment served to cultivate several clients' faith in the process of counselling as the stepping-stone for developing hope in the outcome. A closer look at this finding revealed a rather important pattern pertaining to the notion of compatibility between wished-for and actual therapy processes. The nine participants

who spontaneously shared and deeply emphasized their appreciation for receiving from their therapist what they wanted and needed and who then showed increased faith in the process of therapy, also presented at the beginning of the interview with negative or moderate expectations from counselling, as well as with rather firm preferences regarding the process of achieving their desired outcome. Figure 1 (p. 65) illustrates this relationship by presenting the relevant components of the model in red color. These components have been extracted from the diagram in order to provide a more elaborated visual reference for the process in Figure 2 below. The case of Michelle was randomly selected to exemplify this pattern; her relevant statements from different points of the interview illustrate the process.
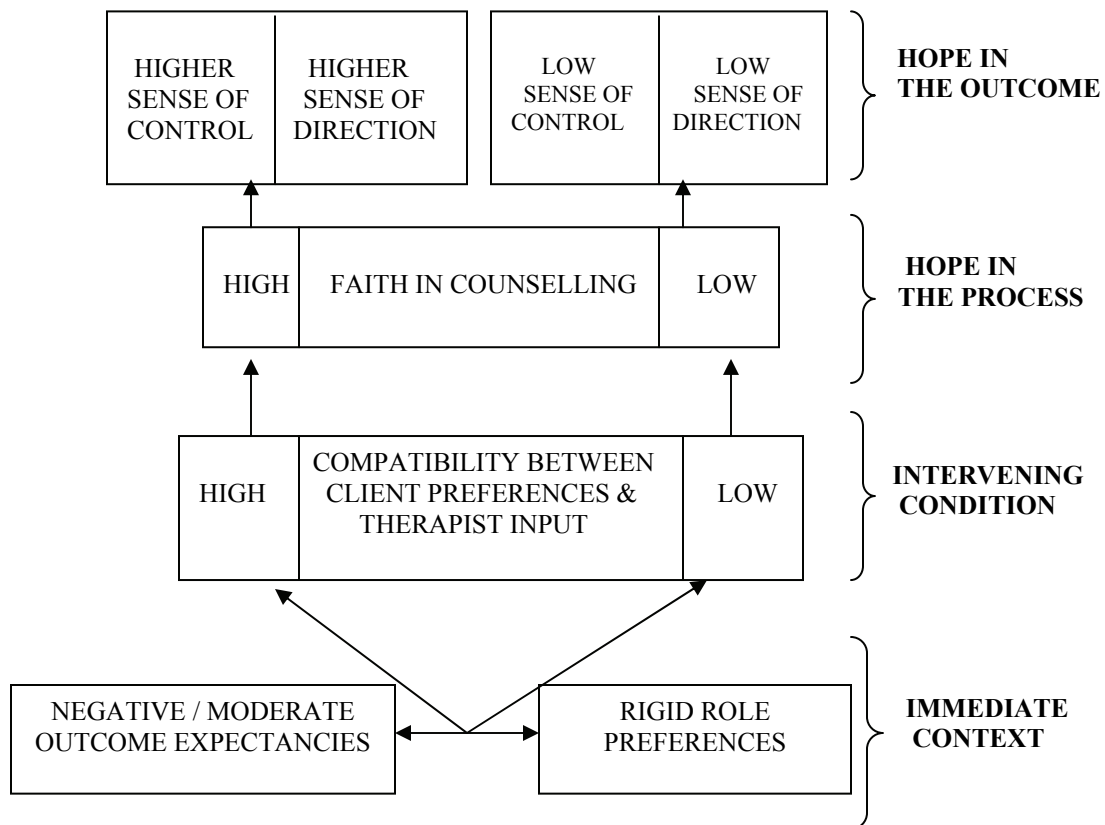

Figure 2. Visual representation of the impact of expectations and preferences on the role of wish fulfillment.

Michelle entered therapy being rather skeptical about its potential usefulness, as a result of a previous negative experience: "Just having had that bad experience and all that stuff I felt like I was stagnating a bit, so part of me felt discouraged too". Similarly, she was rather insistent about receiving specific suggestions and advice from her therapist, which was reportedly never offered from her previous counsellor: "I wanted it to be very action-based, you know, to not have someone to just ask me what I think I wanted to do". The expectation was met: "I was impressed by how well she adapted to what I asked and what I needed and she sort of, you know, she very much worked within that". The fulfillment of her original wish increased her faith in the counselor's ability to help her: "I really did like my counsellor's disposition and how she was willing to go with it. I did have some faith in her". Later on, she explained how this in turn contributed to her increased sense of control and sense of direction: "Just to have her understand and help and having that process be successful is obviously like giving me more faith in the fact that I can change, and that even when things are done like you know it's helped me see like it's also given me certain tools that I can use after". This is an illustration of how under conditions of negative or moderate outcome expectations and rigid role preferences, client wish fulfillment operated as a requirement for having more faith in the therapist and/or in the process of counselling, which in turn spawned clients' increased hopefulness about the outcome of therapy.

The property of adaptability of client role preferences may similarly serve to explain the opposing experiences observed in the cases of two participants, Helen and Debbie, whose hopes remained unfulfilled at the time of the interview. Helen reported never receiving from her therapist the direction and answers she was *strongly* hoping for,

which proved to be a permanent obstacle in her developing hope in the outcome. The firmness of Helen's original hopes seems to be the factor that differentiated her experience from Debbie's, whose original preference for direction and for an action-oriented approach to tackling her problem was also seemingly unmet at the time of the interview. Debbie was the only participant who, despite her negative outcome expectations, had reported purposely aiming not to let her specific wish for direction get in the way of the process.

> I try not to - think too much about what he could suggest me. I try to um –
>
> let it be kind of a surprise because I feel that if I – want him too badly to
>
> do exactly certain things, I would be disappointed or I wouldn't want to
>
> follow him – to other suggestions.

This flexibility of Debbie's preferences is a plausible explanation why this incompatibility did not become a barrier in any significant way up until that point. Debbie did not even mention it when asked about potential missing elements from her early sessions and appeared to value her therapist's 'alternative' input, talking about having gained a renewed sense of control over her presenting concern as a result of acquiring a better understanding of her problem.

The data suggest that, under conditions of negative outcome expectations and firm role preferences, the lower the compatibility between hoped-for and actual in-session processes, the lower the chances that clients will experience higher hope. Flexibility however, is a plausible moderating influence on the incompatibility of preferences with actual input.

Influence of Therapist-Client Interaction on the Nature and Strength of Hope

All seventeen clients reported a wide range of therapist interventions and strategies, as well as a variety of personal contributions to the process, leading up to substantial in-session experiences that instilled in them a higher sense of empowerment. When I investigated the processes connecting these factors, I observed that different *types* of therapist input meaningfully interacted with different levels of *influence* of client input, and this interaction had the potential to elicit different *types* and levels of *strength* of client increased sense of empowerment.

Specifically, when participants underscored their own contribution to the process as the primary vehicle for arriving at new insights, new perspectives, and new behaviors (*primary influence*), and described primarily non-directive therapist interventions, their resulting sense of control over the problem appeared to strengthen. Subsequently, for those who also developed a higher sense of direction, this aspect of hope tended to be more self-reliant and sustainable in nature. In Figure 1 (p. 65), the above properties of therapist and client input, and of the core category of the model are marked in blue color to illustrate their relationship. These components are once again presented separately in Figure 3 (p. 123). In elucidating this pattern, I see clients highlighting processes whereby they themselves played a protagonistic role in achieving important in-session outcomes through their extensive self-disclosures, their openness to take risks and try new behaviors, and their willingness to assume the leadership of the sessions and the ownership of change. At the same time, therapists are assuming a less directive stance by employing strategies such as broad exploration, facilitating independent coping, empathy, and validation. The case of Lucy will be used to illustrate this pattern.

Lucy identified the time when she shared with her counselor that she had successfully coped with a very stressful situation as a rather pivotal event that contributed to her increased sense of control: "Basically my trying to be more calm and more focused about things was actually better because like it feels way better, you feel like you're in control of something […] You know like 'it's okay, I can manage this' ". When asked if she could pinpoint what in particular had helped her adopt a different attitude in the face of stress, Lucy revealed a process of relying primarily on herself for discovering what works best for her:

> A lot of the change I feel has come from basically going into session and
>
> talking about stuff that has been affecting me or problems I've been
>
> having and really just exactly what I said you know, my counsellor asking
>
> me about how I felt about situations, what did I do, what could I do
>
> differently, that kind of thing. So a lot of it has just been for me essentially
>
> the time spent thinking about - like thinking deeply about my behaviour
>
> and how I can change it.

Variations to this pattern were also observed. In some of the cases where sense of control appeared to be stronger, therapists reportedly used more directive types of interventions, such as giving suggestions, offering a new perspective, or focusing on the positive; however, clients still placed considerable emphasis on their own readiness and zeal to receive and internalize the new ideas or implement the proposed actions, which resulted in their feeling more in control of the issue at hand. What seems to differentiate this type of therapist and client interaction from the one mentioned previously is the degree to which clients appeared to be willing or able to assume direction. Although

participants in the latter case still reported seeing one or more ways out of their presenting problem, the acquisition and sustainability of these ideas or tools tended to be more dependent on the therapist's lead, when he or she was more inclined to share his or her expertise in the form of suggestions or advice.

On the other end of the spectrum, a corollary pattern emerged, in which directive therapist interventions coupled with client contributions that were more receptive in nature and less emphasized by the participants (*secondary influence*) still produced the necessary conditions for the generation of client sense of control. The nature of this control was, however, somewhat more tenuous. Moreover, when clients placed most emphasis on the usefulness of their therapists' suggestions and ideas, an increased sense of direction was a key part of these clients' experience, although this direction seemed more reliant on the therapist and perhaps less generalizable to potential future situations. This interaction effect is shown in Figure 1 by marking the properties of the relevant categories in green; it is further elaborated visually in Figure 3.

Jackie, for example, appeared to be quite receptive to her therapist's suggestions on how to modify her eating habits: "She started giving me suggestions that maybe a little something every day would help satisfy these little cravings and it wouldn't get excessive, and so I started doing that and that really helped". When asked what she feels more hopeful about as a result of the work of therapy, she replied: "I feel more in control again. I feel like I'm starting to find a balance". Yet, she later qualified this statement "on the surface I'm controlling (the problem) right now […] I'd like to start talking about the deeper issues instead of, like 'I eat a lot sometimes', 'so, don't'. It's not about eating anymore, it's about the reason why".
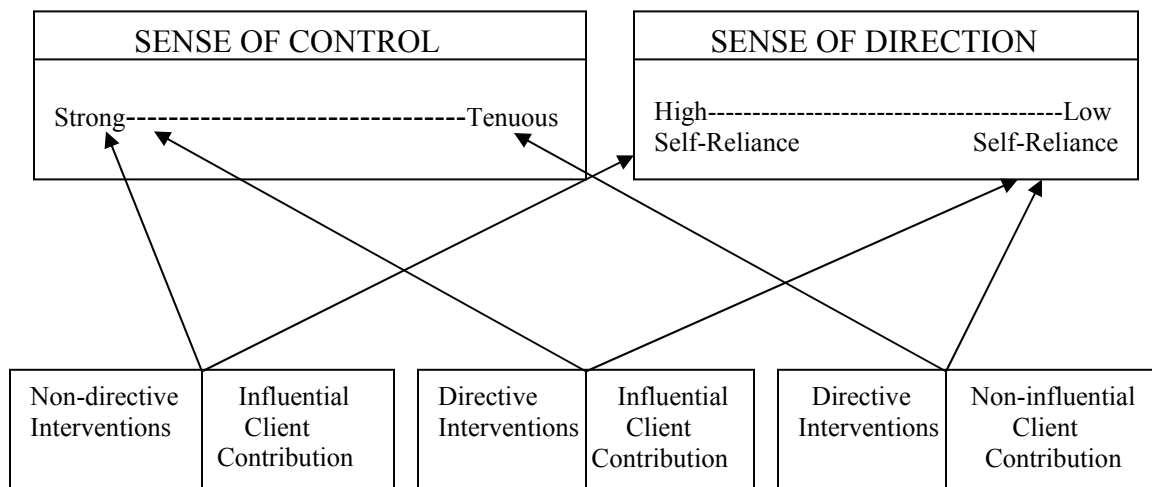
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┌─────────────────────────────┐   ┌─────────────────────────────┐
│      SENSE OF CONTROL       │   │     SENSE OF DIRECTION      │
│                             │   │                             │
│  Strong----------------Tenuous│ │  High------------------Low   │
│                             │   │  Self-Reliance    Self-Reliance│
└─────────────────────────────┘   └─────────────────────────────┘
```

Figure 3 diagram with boxes:

| Non-directive Interventions | Influential Client Contribution | Directive Interventions | Influential Client Contribution | Directive Interventions | Non-influential Client Contribution |

Figure 3. Visual representation of the influence of therapist-client interaction on client hope.

To sum up, an interesting pattern emerged from the data; under conditions of non-directive therapist interventions and influential client contributions, client sense of control tended to be stronger and sense of direction tended to be more self-reliant. While sense of control could remain relatively strong with more directive therapeutic approaches, these seemed to somewhat lower client self-reliance. For the most part, then, under conditions of directive therapist interventions and less influential client contributions, sense of control appeared to be more tenuous and sense of direction was more reliant on the therapist and more present-focused.

Relationship between Sense of Control and Sense of Direction

When examining the two primary aspects of hope - sense of control and sense of direction - I asked the following question: Why was higher hope as increased sense of control present in all cases, while hope as sense of direction was not representative of everyone's experience? What is the relationship between these two facets of hope in the

context of counselling? A more in-depth examination of the data led to the observation that clients' increased sense of direction always begot a higher sense of control, while the reverse was not always the case; the achievement of a higher sense of control did not necessarily yield an increased sense of direction. This is illustrated at the top of Figure 1 through a unidirectional arrow connecting these two components of the core category.

All therapeutic strategies and in-session outcomes were found to instill a stronger sense of control in the study's participants, but not necessarily a better sense of direction. Although most clients spoke about both feeling increasingly able to manage their problem and seeing more ways out, a few of them had not yet accomplished the latter by the time of the interview. A closer look at these cases led to the following observation: The clients who did not develop a sense of direction had wished for direction from their therapist in the form of concrete suggestions and advice, but none of them had received it (see Figure 4). These participants had expressed the need to be closely guided in shifting their maladaptive behaviors by hearing about effective ways of coping and being in the world, and believed that problem resolution might not be feasible without this type of direction from the therapist.

To conclude, clients' increased sense of control appeared to be a requisite and essential element of a higher level of hope for a potential resolution of their problem. An increased sense of direction was somewhat harder to achieve, yet constituted a key complementary element of hope for clients to feel empowered enough to believe that their difficulties could eventually be surmounted once and for all.
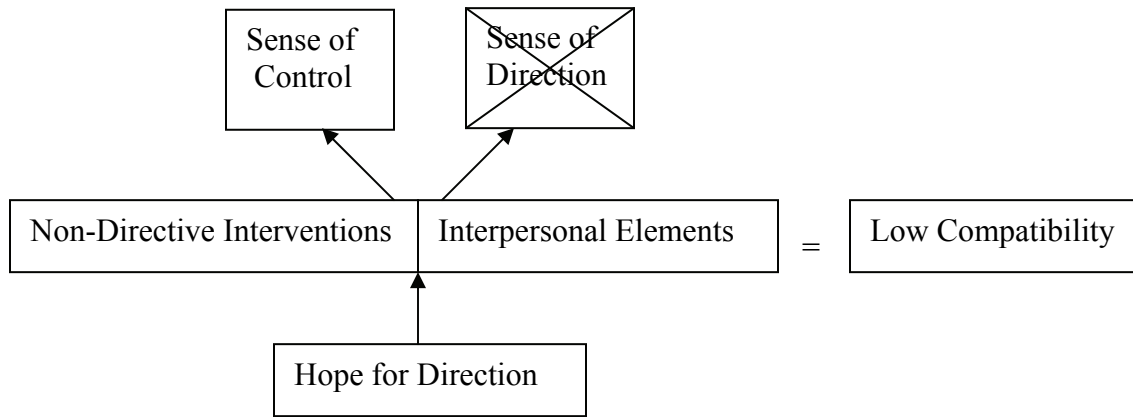
Figure 4. Visual representation of pattern observed when hope as sense of direction was

absent.

Chapter 5

DISCUSSION

Linking the Findings to the Existing Knowledge Base

While the importance of hope in counselling practice has been endorsed

theoretically for many years, research into hope and the counselling process is in its very

early stages. The proposed theory of hope development, which has been named *Hope as*

Empowerment Theory (HET), is the first to be grounded in counselling clients' subjective

experiences of gaining hope. As such, it qualifies and clarifies prior primarily theoretical

attempts to understand how this salient process unfolds in the context of counselling. The

theory departs from a uni-dimensional, dichotomous portrayal of how hope develops

towards a more complex, dynamic theory. The aim of this discussion is to situate HET

within the ongoing discourse on hope, in order to verify, elaborate, and challenge existing

views and ideas. Finally, recommendations are made for counselling practice, training,

and future research.

Defining Hope

Based on participants' experiences and operational definitions, hope emerged as a

multifaceted and dynamic construct that shifts over time and that is primarily cognitive in

nature. This is reflected in the participants' belief that they can manage their problem;

that there are ways out of their difficulties; and that the therapy can be helpful in

overcoming them. Yet, these cognitions were consistently intertwined with a wide range

of positive emotions. These findings provide further research support to recent theoretical

and empirical arguments pertaining to the dual nature of hope as both cognitive and

affective (Averill et al., 1990; Gottschalk, 1974; Miller & Powers, 1988; Nunn, 1996; Snyder, 2002; Staats, 1987).

The fact that some participants re-defined hope on the basis of their experience by distinguishing it from optimism or the mere belief that 'things can change for the better' provides data to support Scheier and Carver's (1985) conception of dispositional optimism as a stable predisposition to "believe that good rather than bad things will happen" (p. 219). More specifically, participants' increased hopefulness was not simply equal to a general positive outlook of the future, but reflected perceptions of their ability to achieve specific and desired positive changes. This finding extends to the context of counselling Bryant and Cvengros' (2004) research conclusion that hope focuses more directly on expectations about the personal attainment of specific goals, whereas optimism focuses more broadly on the expected quality of future outcomes.

One of the strongest contributions of HET is the support that it offers to the increasingly endorsed operational definition of hope as *agency* and *pathways thinking* (Snyder, 2002). Snyder and colleagues have performed extensive research on hope outside the context of therapy and have recently advanced theoretical arguments about the healing role of hope in psychotherapy (Snyder & Taylor, 2000; Snyder et al., 2000; Snyder et al., 1999). In their work, hope is defined as goal directed thinking that occurs when people perceive that a) they can produce routes to desired goals (pathways thinking, "I'll find a way to get this done"), and b) they have the motivation to use those routes (agency thinking, "I can do this"). HET's hope as sense of control is quite similar to the concept of agentic thinking, since they both reflect people's perceived capability of achieving their desired goals. However, there is a conceptual gap between pathways

thinking and HET's hope as sense of direction. Pathways thinking implies a higher degree of self-reliance, as it pertains to individuals' *ability to find ways out* of their difficulties. On the contrary, a sense of direction or thinking that 'there is a way out' does not necessarily mean that clients rely on themselves to find that way. The similarities and differences between the two main aspects of hope as portrayed in Snyder's theory and in *Hope as Empowerment Theory* will be further highlighted when looking at their unique role in the process of hope development in psychotherapy.

Hope Development: The Deeper Context

The deeper context of hope development in HET firstly comprises clients' successful or unsuccessful past experiences with counselling. The data support existing ideas that hope is linked to and mediated by previous experiences of striving for and achieving desired outcomes (Farran et al., 1995; Nunn, 1996; Snyder et al., 1991) that shape individuals' dispositional hope. In addition, the reports of these participants of their influential experiences with culture, family, and friends on the development of hope support the theory that hope is fostered within caring relationships (Farran et al., 1995; Frank, 1968; Snyder et al., 1997) and is affected by socio-cultural learnings (Averill et al., 1990; Farran et al., 1995; Nunn, 1996; Stotland, 1969; Snyder et al., 1991). Finally, personality traits perceived by participants as compatible or incompatible with the work of therapy were found to influence client expectations about the process and outcome of therapy, which in turn affected the potential for the rise of hope. This finding provides data to support Snyder's (1994) proposition that it may be more difficult for individuals with low trait hope to change in psychotherapy, as their sense of uncertainty and failure leads them to be more lethargic in the pursuit of goals.

Hope as Empowerment Theory indicates that client prior experiences in attempting to achieve goals and overcome barriers, influences from their familial and cultural environment, and certain personality traits largely determine their expectations about the outcome of counselling, as well as their hopes about the particular therapy processes and therapist roles necessary to achieve the desired goal. These preferences and expectations were the immediate context for hope development among these participants and the most salient conditions that clients bring to counselling. As such, they are a potent influence on the process of developing hope in sessions. Comparing HET to existing research on the influence of client expectations and preferences on therapy process and outcome can elucidate the ways in which the new data-based theory elaborates, clarifies, or contradicts existing findings.

Expectancies, Preferences, and Wish Fulfillment

The present study revealed that when clients entered therapy with moderate or negative outcome expectations *and* rigid preferences regarding their therapist's role and the tasks of therapy, having their hopes met was a requirement for gaining trust in the process of counselling. This in turn led to increased hopefulness about the outcome of therapy. This is an important finding that clarifies and expands existing research on both compatibility of client preferences with clinician treatments and the impact of client expectations for change on therapy outcome.

Research on the relationship between client role preferences in therapy is sparse and somewhat inconclusive. Three early studies did not support the hypothesis that client role preferences significantly relate to outcome (Gladstein, 1969; Goin et al., 1965; Pohlman, 1964). On the other hand, research focusing on the effects of disconfirmed

client preferences reveals that such incompatibility can in fact have negative

consequences for the process of change (Bush & Gasner, 1986; Goldstein, 1962;

Ziemelis, 1974; Duckro, Beal, & George, 1979; Tracey & Dundon, 1988), especially in

the early stages of psychotherapy (Kelly & Strupp, 1992; Silberschatz, Fretter, & Curtis,

1986; Van Audenhove & Vertommen, 2000). Likewise, it has been shown that clients

who receive a treatment they prefer and believe in are more likely to engage in early

therapy (Elkin et al., 1999), work harder (Devine & Fernald, 1973), and remain longer in

treatment (Hardy, Barkham, Shapiro, Reynolds, & Rees, 1995), leading to better

outcome. Similarly, a number of researchers have investigated the relationship of client

expectations of change to therapy outcome but the results have been equivocal. Twelve

studies found a significant relationship between the two constructs, 7 found no

relationship, and 7 reported mixed findings (Arnkoff et al., 2002). Arnkoff and colleagues

(2002) concluded, "if such a causal link does exist, the mechanisms by which

expectations could mediate change are still largely unknown" (p. 345).

     Hope as Empowerment Theory advances a data-based explanation for these mixed

findings and offers a rather promising hypothesis in response to Arnkoff's statement.

Both client outcome expectancies *and* the compatibility between preferred and actual

therapeutic processes appear to be especially significant only when considering the

degree of *adaptability* of client original wishes. If client preferences are flexible,

regardless of the nature of outcome expectations, their realization is still appreciated by

clients but not necessarily required for a positive outcome. But, if client preferences are

rigid *and* they are coupled with negative outcome expectancies, then the response to

those preferences will largely determine clients' hopefulness about the outcome and, in

turn, their engagement in the process. A promising area for future investigations is the study of preference adaptability as a mediator between expectations and outcome.

To conclude, the emergence of *Hope as Empowerment Theory* from these client accounts of gaining hope in therapy confirms and advances current understandings of the potency of client expectations and preferences in affecting positive change. Specifically, it is the first study to highlight the notion of *adaptability* of client preferences coupled with client outcome expectancies in understanding the significance of fulfilling client wishes and its relationship to positive therapeutic outcomes. HET proposes that the negative effect of unfulfilled client preferences in early therapy may in fact be due to a decrease of clients' hope in the therapist and the process of counselling. Likewise, the positive effect of confirmed client wishes is due to clients' increased hope in the process and, thus, in the ultimate outcome of therapy.

<div align="center">

The Generation of Hope in Counselling

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Sources of Hope

The present study revealed that different therapeutic strategies or in-session events generated rather similar hope-inspiring outcomes and vice versa: similar actions and interactions impacted clients in rather diverse ways. Ultimately, three major sources of hope emerged from the data: obtaining a new outlook on the problem, making improvement, and having a neutral space to talk. Achieving a new outlook on the problem in the form of gaining insight into its components and understanding better its roots was found to be a typical trigger of clients' increased sense of empowerment. This finding supports and advances Frank and Frank's (1991) proposition that an important therapeutic factor serving to combat demoralization across psychotherapy approaches is a

therapeutic myth or rationale for the client's problem. Specifically, HET elaborates this suggestion by proposing that clients feel more hopeful about the potential resolution of their problem when they identify more clearly its sources and triggers because they begin perceiving it as something more controllable and manageable. Such an empowered perspective on the problem as a generator of hope may additionally stem from placing it in context and considering alternative viewpoints, which in turn deflates the perceived supremacy of the problem by the client.

Having a neutral and objective listener for internal emotional conflicts and struggles is another significant source of hope for clients in the proposed theory. The capacity to be open about private thoughts and feelings was directly linked to therapists' empathy, validation, and impartiality, fostering a relationship of trust, safety, and unconditional acceptance. This finding is widely endorsed both in the hope and working alliance literatures (Bohart, 2000; Frank & Frank, 1991; Lopez et al., 2000; Phillips, 1984). In HET, this particular source of hope becomes salient when clients enter therapy with negative outcome expectancies and rigid role preferences. The presence of an emotional, confiding relationship with a therapist who is hopeful, open, caring, and willing to adapt to their needs was a requisite for participants in this study for gaining trust in the process of counselling and a stepping-stone for beginning to think more positively about the outcome of therapy.

The *Hope as Empowerment Theory* indicates that the interplay of therapist and client actions has a differential impact on client experiences of hope. In the next section, I will compare HET's perspective on therapist and client dynamics to existing literature on the roles of each party in producing positive change.

Clients as Primary Agents of Change

An important pattern that emerged from the data pertains to the way in which different combinations of therapist and client in-session behaviors influenced the nature of the resulting sense of control and sense of direction experienced by clients. Specifically, non-directive therapist interventions coupled with influential client contributions appeared to instill in clients a stronger sense of control and a greater self-reliance for direction. This sense of control remained relatively strong with more directive therapists if clients continued to value their own contribution to the process, although there was more reliance on the therapist to show them which pathway to take. Lastly, in cases where therapists were directive and clients did not particularly emphasize their contribution in the narrative, sense of control seemed to be more tenuous; the sense of direction was always present, though mostly reliant on the therapist and strictly present-focused. These data draw attention to the role of client empowerment and autonomy in the process of change in therapy.

According to HET, clients view themselves as more autonomous and capable, and in turn feel more empowered to conquer their difficulties, when they perceive their own contribution as most influential. This aspect of the theory echoes existing literature that endorses the client as the primary agent of change. The following statement by Bohart (2000) strongly exemplifies this idea:

> Clients are the active self-healing agents in therapy, aided and abetted by
> the therapist, who supplies the chair. Techniques are tools or prostheses
> clients use in their self-healing efforts, and therapy is ultimately the

provision of support and structure for naturally occurring client self-

healing processes. (p. 130)

Similarly, Rennie (2000) has shown in a series of qualitative studies that clients

do not merely receive corrective therapist input, but covertly think about it and ultimately

draw their own inferences. Elliott (1984) found that clients are active in selecting out

what they want from therapists' interpretative statements and discarding what they do not

want. On the basis of such arguments, Bergin and Garfield (1994) concluded,

It is the client more than the therapist who implements the change process.

If the client does not absorb, utilize, and follow through on the facilitative

efforts of the therapist, then nothing happens. Rather than argue over

whether or not 'therapy works,' we could address ourselves to the question

of whether or not 'the client works'! (p. 825)

The findings of the present study provided further elaboration of these

ideas by identifying the impact of different levels and types of therapist

interventions and client contributions on the strength of client hope.

These findings also advance the ongoing dialogue about whether hope

should be addressed implicitly or explicitly in therapy. Some researchers and

practitioners believe that while it is important to be intentional about hope, it is

not advisable to speak of hope explicitly due to the inherently hierarchical nature

of the counselling encounter (Cutcliffe, 2004; Hanna, 2002). Specifically, the

imposition of the therapist's agenda on the client is seen as possibly counter-

therapeutic and insensitive to clients' actual needs. On the other hand, proponents

of addressing hope explicitly in counselling suggest that hope can be a clearly

stated and effective focus of therapeutic conversation (Herth, 2001, Lopez et al.,

2000; Ripley & Worthington, 2002; Wright & Duggleby, 2006). HET points to

the need for future research on this topic.

Snyder's Hope Theory and HET: Similarities & Differences

As mentioned earlier, significant parallels can be drawn between the meaning and

role of HET's principal components of client hope, namely sense of control and sense of

direction, and the concepts of agency and pathways thinking that are at the core of

Snyder's well-established and widely referenced *Hope Theory* (Snyder, 2000). Because

Hope Theory was not derived specifically from psychotherapy research, HET offers a

more advanced and intricate perspective on the process of hope development within the

therapeutic environment.

The stories of these participants indicated that hope as sense of direction has a

reliance component that depends on the types of action and interaction strategies

employed to help the client identify ways out of the problem. On the contrary, the

pathways component of *Hope Theory* presumes that individuals have the *capability* to

generate effective routes to desired goals (Snyder, 2000). Therefore, Snyder's pathways

thinking implies client self-reliance, while *Hope as Empowerment Theory* suggests a

dynamic perspective on the notion of direction in the therapy context. These counselling

clients developed hope when they saw a way out of their problem, whether or not they

discovered this way themselves.

If we further consider the sustainability of client empowerment, Snyder and

colleagues (1991) proposed that successfully raising agency in regard to one therapy goal

should *generalize* to agentic thinking in other problematic issues and applied the same

logic on pathways; the success with one therapy goal should generalize to other therapy goals. Several years later, Snyder (2000) also hypothesized that clients' perceived mastery may be crucial for the *maintenance* of the gains that they have made. Although the present study provided evidence to support these propositions, it also introduced an important caveat: the generalizability of clients' sense of control and sense of direction, or the degree to which clients feel self-confident and self-reliant regarding the maintenance of gains seemed to be affected by therapist directiveness, coupled with how influential clients perceived their own contribution to the process to be. In other words, HET posits that client ownership of therapy gains is instrumental for securing those gains.

HET also validates Snyder's finding that increased hopefulness or, in Snyder's terms, effective goal-directed thinking requires both the perceived capacity to envision workable routes (i.e. pathways) *and* goal-directed energy (i.e. agency) (Snyder et al., 2000). Indeed, the present study revealed that clients who appeared to develop the strongest sense of empowerment regarding their problem had gained both a stronger sense of control and a stronger sense of direction; a finding that underscores the two constructs' complementary nature. An important elaboration within HET is the continuum of hope development. Specifically, the proposed theory claims that the absence of a sense of direction does not necessarily imply a lack of hope. Rather, when clients acquire a stronger sense of control over their presenting concern while still searching for direction, they can experience higher hope. This hope may be less strong or long lasting than that of clients who also feel confident about how to proceed.

Moreover, both theories attempt to make sense of the relationship between the two major components of hope. Snyder theorized that agency and pathways thinking are reciprocally and causally related, which means that a therapeutic intervention that increases one component would also enhance the other component (Snyder, 2002). HET provided evidence that this relationship is not as straightforward. Data revealed that clients' increased sense of direction automatically produced a higher sense of control; however, the achievement of a higher sense of control did not always lead to an increased sense of direction. This aspect of the theory cannot be understood separately from the notion of compatibility of client preferences with the actual roles and tasks of therapy. The participants who developed a higher sense of control but not a sense of direction had strongly hoped to receive concrete suggestions and advice from their therapist, but this hope was not realized. Therefore, HET presumes that clients need to be *willing* to engage in more collaborative and less passive ways of identifying effective routes for overcoming their barriers in order to develop a stronger and longer-lasting sense of empowerment. Surely, it also presumes that it is largely up to the therapist to promote the client's active involvement in the process of change.

Finally, the two theories largely converge on how they approach the role of positive and negative emotions in the process of hope development. HET found support for Snyder's (2002) proposition that positive emotions result from the unimpeded and successful pursuit of goals and provide reinforcing feedback that sustains motivation to achieve the desired outcome. Similarly, the present study offered evidence for the argument that blocked goals generate negative emotions that lower individuals' hopefulness and, in turn, their motivation and energy to continue the goal pursuit.

The comparison of the two theories of hope allowed for the identification of significant common threads, but also pointed to salient areas where HET emerges as a much more elaborate, comprehensive, and intricate theory of how hope is generated in the context of psychotherapy. Most importantly, *Hope as Empowerment Theory* introduces a number of conditions that constantly interact to produce varying levels of client hopefulness in the outcome of therapy.

Limitations

Two limitations inherent in all grounded theory research pertain to the 'actuality' and the generalizability of the findings. Firstly, a theory is considered to be "an interpretation made from a given perspective as adopted by a researcher" (Strauss & Corbin, 1994, p. 279). As such, the theory makes no claim to being infallible; in fact, the methodology used rejects the positivistic claim that there is one 'reality' and bears witness to a truth that is constructed and enacted. Secondly, data were collected from 18 participants, most of whom were white, female undergraduate students in their 20s. Hope as Empowerment Theory may not directly apply to clients who are male, older, less educated, and/or from non-western cultures. Similarly, it is important to consider the potential impact of this population's resilience and resourcefulness on the conceptualization of hope as a sense of control and the role of client autonomy in generating effective pathways to deal with the problem. It is possible that the process of gaining hope may differ for individuals who are less privileged and have less external support in their personal lives.

Having stated at the outset of the study my biases and assumptions with regard to the phenomenon of hope development in therapy, I was able to recognize how two of my

preconceived ideas may have influenced my interpretation of the data. Specifically, I had

stated, "I have repeatedly noted that different clients respond positively to a wide array of

hope-producing initiatives that lie on a continuum from the more explicit interventions

aiming directly at instilling hope, to therapeutic encounters that appear to generate hope

in much subtler ways" (p. 43). Since this observation was confirmed by this study's

findings, it is possible that I "looked" for it both when interviewing my participants and

when analyzing their narratives. Similarly, I had originally stated my belief that "hope

partially involves a sense of personal control over the wished-for outcome" (p. 44). Given

that the concept of "control" constitutes a core component of the *Hope as Empowerment*

Theory, I cannot be certain that this belief did not in some way influence the

"objectivity" of my coding. Although my personal definition of hope may have

influenced my interpretation of client accounts in ways that I am unaware of, I purposely

refrained from embracing this perspective early on and discussed it with my auditor,

whom I informed of this bias. The example of a memo that was elaborated on at different

stages of the analysis (see Appendix H) provides evidence to support this claim, as it

reveals that "sense of control" was nominated a component of the core category of HET

after having explored several other hypotheses.

Another limitation is that data analysis did not begin until 12 interviews had been

completed. While this procedure permitted a review of the original protocol and the

addition of specific probes, open coding illuminated areas worthy of further attention that

were not fully elaborated on in early interviews. This may have limited the richness of

some of the original interview data. Nevertheless, memos were still kept throughout the

entire interview process, which allowed for the early identification of some patterns in the data and the addition of questions in later interviews aiming at confirming these patterns.

The absence of perspective triangulation in the process of data collection constitutes another limitation of the study. All data were client self reports; therapist perspectives or session records would have served to elaborate participant reports. In the process of data analysis, however, the use of two auditors allowed for additional perspectives to be brought to these data.

Finally, during the last phases of analysis, cases were grouped based on type of client concern and were examined for similarities and differences, but no patterns emerged. Nevertheless, the size of the sample is too small to support the conclusion that client problems do not influence the hope development process. Client presenting concerns and their intensity varied among participants and it is possible that important problem-related information was inaccessible through the analytic strategy employed. Future studies might focus on comparing client experiences on the basis of presenting problem and/or distress level distinctions.

Implications for Practice and Training

The *Hope as Empowerment Theory* has important implications for counselling practice. A number of salient variables related to the process of hope development have been identified and can be transferred to therapy settings with the goal of facilitating this process.

First and foremost, the present study elucidates the importance of inquiring about clients wishes and expectations (Arnkoff et al., 2002; Elkin et al., 1999; Van Audenhove and Vertommen, 2000). While all participants desired direction, only some of them

adapted well to other forms of help. Encouraging clients to voice their preferences and preconceived ideas of what may be helpful would allow clinicians to assess the flexibility of these preferences, which is a crucial component of the HET, and determine the degree to which it would be therapeutic to incorporate them in their work, especially in the early stages of therapy. Certainly, this is not to suggest that clients are always aware of what is in their best interest. Therapists may at times need to educate clients about their respective roles and help them formulate realistic expectations in order to facilitate clients' active engagement in therapy.

Building on the previous recommendation, HET suggests that, while hope is generated in a multitude of ways, the strength of clients' empowerment may depend on the degree to which they are given the opportunity to become *active agents of change*. Clinically, this means therapists 'taking a step back' and handing the lead to the client, in order to strengthen their sense of ownership of the perspectives or strategies for implementing change. This recommendation is situated on the 'implicit' side of the spectrum of proposed hope-fostering strategies, since it assumes that it is through adopting an empathic, objective, and supportive stance, and employing less directive strategies that the therapist can pass the torch of leadership to the client. Based on HET, such practices may strengthen and maintain clients' sense of control and direction in effectively dealing with their presenting problem.

Hope as Empowerment Theory has the potential to become a useful and important educational tool for counselors-in-training. The role of hope as a common psychotherapy factor is seldom elaborated in counselling textbooks, and training on effective methods to instill hope in clients is in its infancy. Trainees could benefit from an early exposure to

literature on hope, client characteristics, particularly client expectancies and preferences, as well as client-therapist matching. In addition, as novice counselors tend to be more apprehensive of clients who appear to be more 'resistant' and hesitant to engage in the process of counselling, it may be important to educate them about the positive effects of discovering the nature of their clients' preferences. By encouraging them to explore and openly discuss the roots of their clients' skepticism early in the process, this skepticism can be gently challenged by introducing new or alternative viewpoints.

<div align="center">Research Implications</div>

The proposed *Hope as Empowerment Theory* has elucidated areas that require further research attention. Firstly, future research could confirm the veracity of the components of the theory and their relationships through the use of a quantitative methodology and a much larger sample. More specifically, the adaptability of client preferences and the fulfillment of client hopes by the therapist emerged as two potentially strong mediators between client expectancies and increased hope. Similarly, data suggest that clients' level of ownership of the gains of therapy coupled with non-directive therapeutic approaches may act as predictors of the strength and sustainability of client hope. Participant responses suggested these relationships in mostly indirect ways; therefore, further studies are needed to test the interpretation of these findings.

Future research could subsequently expand the theory beyond this sample. For example, reproducing the findings using a less 'psychologically-minded' group, a less privileged group, or a sample with more severe psychopathology would enlarge the substantive area addressed by the theory. Having a wider range of applicability would also enhance the theory's appeal as a teaching tool.

Finally, although Snyder's *State Hope Scale* indicated changes in clients' level of hope during therapy, it may not have assessed specific counselling-based experiences of hope. Several participants commented on the elusiveness of the measure's statements, which at times made them difficult to rate. Hence, HET could become the basis for developing a psychotherapy-based research instrument to measure hope development in counselling. The *State Hope Scale* could be used to establish the new measure's convergent validity, given the degree of similarity identified between HET and Snyder's *Hope Theory*.

<div align="center">Contribution to Knowledge</div>

The present study aimed to enhance our understanding of the processes by which hope is generated in counselling by employing a focused, phenomenological approach to actual client experiences. A dynamic, pan-theoretical, and multifaceted theory, the *Hope as Empowerment Theory*, summarizes the detailed and novel information gathered on this topic. It is among the most elaborate, comprehensive, and empirically grounded theories to date on the topic of hope development, and the first to examine this phenomenon within the context of psychotherapy.

A unique contribution of the proposed theory is its attention to a number of conditions that produce different types and varying degrees of strength of client hope. HET is the first theory looking at the interaction between adaptability of client preferences and client outcome expectancies, and its effect on the role of fulfilling client needs when attempting to instill hope in clients. This aspect of the theory offers a viable explanation for the equivocal results on the impact of client expectations on therapy outcome. Another factor influencing the nature of hope experienced by clients according

to HET pertains to clients' perceived ownership of the gains made in the process. The theory argues that client sense of empowerment is stronger, more self-reliant, and longer-lasting when clients work with therapists who follow a non-directive approach and when they attribute positive changes mostly to their own active participation in the tasks of therapy. This parameter of the theory advances our knowledge about the inner world of the client and provides a magnified, first person perspective on what has proven to be a highly subjective human experience; the experience of gaining hope.

To conclude, *Hope as Empowerment Theory* is the first theory of hope to be grounded on the accounts of counselling clients who became increasingly hopeful during therapy and sheds light on the nuances and variations of this experience by closely attending to moment-by-moment therapy interactions and felt emotions. Ultimately, it perceives the phenomenon of hope development in therapy through several spectrums that qualify the adaptability of client preferences, the directiveness of hope-inspiring therapeutic strategies, the primacy of client contributions, the resulting strength of client sense of control, and the resulting degree of client self-reliance for achieving a higher sense of direction.

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Appendix A

ELECTRONIC INVITATION TO THE RESEARCH PROJECT

Dear Student,

We would like to inform you of a new doctoral research project currently being conducted at the McGill Counselling Service. Please read the message below sent to you by the principal researcher.

_____

Hello! My name is Martha Chamodraka and I am a doctoral student in the Department of Counselling Psychology at McGill University. This is an invitation to consider becoming a participant in my doctoral research that looks at individuals' experiences of their counselling sessions to identify what is most helpful from their perspective.

WHAT IS INVOLVED?

If you agree to participate, a) you will be asked to fill out a brief online survey titled "Pre-Therapy Survey", which should take you about 10 minutes. Following this, b) you will be asked to fill out two very brief questionnaires after each of your first 10 counselling sessions, and c) you MAY be invited to participate in a 70-minute interview with me that will take place anywhere between your third and your tenth session. The interview will focus primarily on your experiences of your counselling sessions up until that point.

HONORARIUM

If you remain in the study until the 10th session and/or if you participate in the interview, you will receive a check for $40 as an honorarium for your participation in this research project.

If you are interested in taking part in this study, please press on the following link:

http://www.zipsurvey.com/LaunchSurvey.aspx?suid=10294&key=6C8F7B2C

This link will bring you to a secure website, which provides more detailed information on my doctoral study and describes all the ways in which the information you provide will be kept **strictly confidential.** If you consent to the conditions of the study, you will then be asked to complete the online survey. Please note that it is important to fill out the online survey **BEFORE** your first appointment with your counsellor.

If you have questions at any time, please do not hesitate to contact me at # 514-824-8284 or at martha.chamodraka@mail.mcgill.ca. Thank you for considering participating in my doctoral study.

Sincerely,

Martha Chamodraka, M.A., Ph.D. Candidate
Department of Educational and Counselling Psychology
McGill University

Appendix B

INFORMED CONSENT TO PARTICIPATE IN RESEARCH

1. Purpose

The goal of this project is to study client positive experiences of counselling. Your
participation in this study will be an important contribution to this venture and may also
contribute to your understanding of the counselling process, as well as your personal
needs and expectations from counselling. There are no foreseen risks entailed in your
participation in the study.

2. Procedures

You will be asked to complete three short forms before your first session takes place: a)
this consent form, b) a demographic information form, and c) the Goals Scale For The
Present. Following this, you will be asked to complete the Goals Scale For The Present
and the Session Impression Questionnaire, after every session for 10 sessions, and
participate in one interview of approximately 70-90 minutes in length with the researcher,
with the goal of discussing your experiences in counselling. If you remain in the study
until the end and/or if you take part in the interview, you will be offered a cheque of $40
for your time.

The interview will be audio-taped and transcribed so that the dialogue can be coded. To
ensure anonymity and confidentiality, all personal identifying information will be deleted
or altered to conceal your identity in the transcription process. Auditors will be
professionally trained counsellors, bound by a code of ethics that regulates their
professional conduct relating to all matters in the conduct of research, including
confidentiality. Moreover, all information will be treated as private and privileged even
after identifying features have been removed. Tapes, transcripts, and questionnaires will
be kept in a locked file and the code keys will be stored in a reference file separate from
the data set. You may withdraw from the study at any time without any penalty.

The results of this study will be compiled as a doctoral dissertation, and may be presented
at research conferences or published in scholarly journals. As a participant you will have
the opportunity to verify the accuracy of how your information has been portrayed, and to
approve of any citations made.

If any further information is required, please contact the principal researcher:

Martha Chamodraka, Counselling Psychology Program, Faculty of Education, McGill
University, 398-4240, or by email: martha.chamodraka@mail.mcgill.ca

3. Conditions of Participation

I understand the purpose of this study and know the risks, benefits and inconveniences it entails.
I understand that I am free to withdraw at any time from the study without penalty or prejudice.
I understand how confidentiality will be maintained during this project.
I understand the anticipated uses of the data, especially with respect to publication and communication of results.

Name (please print)_____

Signature_____Date_____

Appendix C

DEMOGRAPHIC INFORMATION FORM

Contact Information

1) Phone-Number : _____

2) E-mail Address : _____

3) Preferred means of contact : _____

Demographic Information

4) Sex: _____

5) Age: _____

6) Nationality: _____

7) Ethnic origin: _____

8) Religion: _____

9) Relationship Status

_____ Single
_____ Married
_____ Common-Law
_____ Widowed
_____ Divorced/Separated

10) Education: _____

11) Occupation: _____

12) Any visible or non-visible disability: YES _____   NO _____

13) Past counselling or psychiatric experience: YES _____   NO _____

   - If YES, how long did the treatment last for: _____

Appendix D

THE PRE THERAPY STATE HOPE SCALE*

Directions: Read each item carefully. Using the scale shown below, please select the number that best describes *how you think about your problem/issue/concern <u>right now</u>* and put that number in the blank before each sentence. Please take a few moments to *focus on the issue that brought you to therapy*, and then answer each item according to the following scale:

1. = Definitely False
2. = Mostly False
3. = Somewhat False
4. = Slightly False
5. = Slightly True
6. = Somewhat True
7. = Mostly True
8. = Definitely True

_____ 1. If I should find myself in a jam, I could think of many ways to get out of it.
_____ 2. At the present time, I am energetically pursuing my goal(s).
_____ 3. There are lots of ways around the problem that I am facing now.
_____ 4. Right now, I see myself as being pretty successful.
_____ 5. I can think of many ways to reach my current goal(s).
_____ 6. At this time, I am meeting the goal(s) that I have set for myself.

* When administering the State Hope Scale, it is labeled as the "Goals Scale For The Present".

_____

Modified from its original version in C.R. Snyder, S.C. Sympson, F.C. Ybasco, T.F. Borders, M.A. Babyak, & R.L. Higgins, 1996 ©

Appendix E

THE POST SESSION STATE HOPE SCALE *

Directions: Read each item carefully. Using the scale shown below, please select the number that best describes *how you think about your problem/issue/concern right now* and put that number in the blank before each sentence. Please take a few moments to *focus on the issue that you are working on in therapy*, and then answer each item according to the following scale:

1. = Definitely False
2. = Mostly False
3. = Somewhat False
4. = Slightly False
5. = Slightly True
6. = Somewhat True
7. = Mostly True
8. = Definitely True

_____ 1. As a result of this session, I feel that, if I should find myself in a jam, I could think of many ways to get out of it.
_____ 2. At the present time, I am energetically pursuing my goal(s).
_____ 3. As a result of this session, I feel that there are lots of ways around the problem that I am facing now.
_____ 4. As a result of this session, I see myself as being pretty successful.
_____ 5. As a result of this session, I can think of many ways to reach my current goal(s).
_____ 6. At this time, I am meeting the goal(s) that I have set for myself.

* When administering the State Hope Scale, it is labeled as the "Goals Scale For The Present".

_____

Modified from its original version in C.R. Snyder, S.C. Sympson, F.C. Ybasco, T.F. Borders, M.A. Babyak, & R.L. Higgins, 1996 ©

Appendix F

SESSION IMPRESSION QUESTIONNAIRE

Dear Participant,

At a future point, you may be invited to participate in an interview about your experiences in your counselling sessions. Please describe in a few lines something that will help you remember *what happened* in the session you just had (e.g. central topic, how the session ended etc.).

_____

_____

_____

_____

_____

_____

If there is anything that *stands out* or has a *special significance* for you from the session you just had (e.g. interaction, feeling, thought, process, outcome etc.), please use the space below and write a couple of sentences that may help you to remember it at the time of the interview.

_____

_____

_____

_____

_____

Thank you for taking the time to answer these questions.

Appendix G

INTERVIEW PROTOCOL

Remind the participant of how confidentiality will be ensured.

The purpose of this project is to learn about clients' experiences of developing hope in and outside of counselling.

A. COUNSELLING

I. *PRE-THERAPY EXPECTANCIES*

1) Before coming for the first time, to what extent did you feel that you would get what you hoped for as a result of your counselling sessions?

2) What affected this expectation?

3) What did you expect/hope your therapist's contribution to be in getting what you hoped for?

4) What did you expect your contribution to be?

II. *CHANGE IN LEVEL OF HOPE*

After every session, you have been filling out the same questionnaire, the "Goals Scale For The Present" that is often used in research to measure hope. From the time you started counselling until now, your weekly ratings on this scale indicated that there was a an increase in your level of hope. Would you say this is accurate?

1) Could you talk to me about how this experience has unfolded from the beginning until now? What has played a role in your gradually becoming more hopeful? (*Probe for details re: therapist & client contribution*).

2) Has there been anything that occurred <u>in between</u> sessions that contributed to your feeling more hopeful?

III. *SIGNIFICANT EVENTS*

    1) Has there been a time, in your sessions so far, where you felt the most hopeful? Was there **a moment** that made a difference for you, a point when you felt "*Ok, now I feel more hopeful about this*"? (*If no, go to 2*)

    a) As much as you can remember, please describe the interaction (*use session impression questionnaires as reminder*).

    b) How do you feel your therapist contributed to making this experience come alive?

    c) In what ways do you feel you contributed to making this happen?

    d) What was particularly meaningful to you about this incident?

    e) How were you feeling in the session right after this incident occurred?

    f) What were you thinking?

2) **If client cannot think of a moment, say the following**:

After session X your ratings indicated you were feeling more hopeful compared to before. This is what you wrote following the session. (*Show client the corresponding Session Impression Q*). Do you remember anything in particular about this session that may have made a difference for you / that may have contributed to your feeling more hopeful afterwards?

3) Looking back to the sessions preceding this incident, how would you best describe what was <u>missing</u> from those sessions / what were they lacking perhaps?

IV. *IMPACT*

What are your present expectations about the remainder of counselling?

    B. GENERAL

So, you have been talking about _____ as having had contributed to your feeling more hopeful in therapy.

1) In what way has this experience been *similar* to other experiences you may have had outside of therapy?

2) In what way has this experience been *different* from other experiences you may have had outside of therapy?

3) Having gone through this experience in counselling, how would you describe the meaning that hope has for you personally? How would you define *hope* ?

C. PROCESSING THE INTERVIEW

1) How did this interview go for you?

2) Was there anything that stood out for you, anything that surprised you, anything that you learned?

Thank you for agreeing to participate in this interview. When all the interviews are done and all the analyses completed, I would like to share the study's findings with you to verify that your experiences have been well represented, and also to get your approval of how your case is portrayed. How would you feel about that?

Appendix H

THE EVOLUTION OF A MEMO IN DATA ANALYSIS

March 15, 2008

"New perspective" appears to be <u>the effect / outcome</u> of a therapeutic intervention (e.g. *Suggestions*) or a therapeutic process (e.g. *talking* to the therapist) – this seems to be a <u>core category</u> at this point, because it is <u>the thing that actually made clients more hopeful</u> – in other words, this is what hope in counselling is about (i.e. it is about gaining a sense of control, it is about seeing a solution, it is about gaining a sense of normality etc.) I wonder if this category involves client **definitions of hope** presented in an indirect way. Often clients would start with "I realized that…" They all seem about **gaining some type of insight**.

April 23, 2008

"New perspective" is replaced by the term "Meaning" in an attempt to identify what it is that clients refer to when talking about a new sense of control etc. At the same time, "seeing solutions" and "gaining clarity/better understanding" (merged with "seeing connections") are removed from this category, as it turns out that they constitute <u>a more direct OUTCOME of a therapeutic intervention or an interaction</u>, which THEN clients attach a personal meaning to (e.g. I gained a better understanding of my problem which gave me a sense of control).

May 18, 2008

I am replacing the term "meaning" again with the term "new perspective" which is the actual data-based finding and the umbrella category for all the different types of new perspective that clients talked about (e.g. sense of control, sense of balance etc.). Before seeing again the original memo, I started thinking again that <u>this category seems to define hope,</u> and is therefore the core category of the model.

After checking client definitions of hope, the majority of them (13) define hope, among other things, as "confidence in own ability to achieve" which seems to be the same as the New Perspective = "sense of control". One more talked about the idea of "keeping perspective". The rest of the participants defined hope primarily as an emotion. This is important in deciding whether the category "Positive Emotions" is also a core category (Increased Hope) or a "consequence" of that.

June 07, 2008

I am in the process of axial coding and verifying my hypotheses of how categories relate against the data. ALL clients refer one way or another to having a SENSE OF CONTROL over the problem, confidence that they can manage it AS WELL AS seeing

ways out. THIS IS WHAT HOPE IS ABOUT - so up to this point is appears to be the core category emerging. The rest of the categories that used to be under New Perspective were found to actually PRECEDE the experience of gaining control - e.g. gaining a better understanding, being validated, making progress etc. These are the direct OUTCOMES of the STRATEGIES involved - AND the CAUSAL CONDITIONS OF HOPE. It appears that is some cases, STRATEGIES directly lead to the SENSE OF CONTROL - it looks like that is when the therapist is **most directive.**

In addition, it becomes more and more evident that IN SOME CASES the HOPE is more about the counselling process <u>as having the potential</u> of helping with problem resolution. So it looks like an intermediate factor that in some cases is actually giving rise to hopefulness about a positive outcome.

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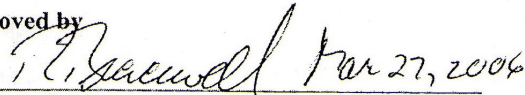**Project Title :** *The development of hope in psychotherapy: A qualitative study*

Applicant's Name: Martha Chamodraka   **Department:** ECP

Status: PhD student   **Supervisor's Name:** Marilyn Fitzpatrick

Granting Agency and Title (if applicable): n/a

Type of Review: Expedited ✓__   Full ____

This project was reviewed by: Shariff/Derevensky

Approved by

Bracewell   Mar 27, 2006
Signature/Date
Robert Bracewell, Ph.D.
Chair, Education Ethics Review Board

Approval Period: March 27/06 to March 27/07

All research involving human subjects requires review on an annual basis. An Annual Report/Request for Renewal form should be submitted at least one month before the above expiry date. If a project has been completed or terminated for any reason before the expiry date, a Final Report form must be submitted. Should any modification or other unanticipated development occur before the next required review, the REB must be informed and any modification can't be initiated until approval is received. This project was reviewed and approved in accordance with the requirements of the McGill University Policy on the Ethical Conduct of Research Involving Human Subjects and with the Tri-Council Policy Statement on the Ethical Conduct for Research Involving Human Subjects.

3/24/06