

**HOPE-FOCUSED STRATEGIES FOR COUNSELLORS**

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A Project  
Submitted to the School of Graduate Studies  
of the University of Lethbridge  
in Partial Fulfillment of the  
Requirements for the Degree

**MASTER OF EDUCATION**  
**(COUNSELLING PSYCHOLOGY)**

**FACULTY OF EDUCATION**  
**LETHBRIDGE, ALBERTA**

June 2011

## **Dedication**

I would like to dedicate this project to my mentor and dear friend, Dr. Cal Botterill. You have always been there to cheer me on and offer kind words of wisdom and support, regardless of the challenge I was facing, be it academic, health, or personal. You taught me the difference between hoping and believing and challenged me to continue fighting when I had nearly given up. I was able to reach my goals because you allowed me to stand on your shoulders and gave me a boost when I needed it most. Thank you for never closing the door on possibility and for teaching me that to approach success is to live with purpose. Most importantly, because you believed in me, I believed in me.

## **Abstract**

The purpose of this project was to develop a comprehensive workshop manual, by synthesizing existing research related to practical applications of hope-focused counselling skills. Hope-focused counselling requires a conscious decision on the part of the therapist to incorporate hope into counselling sessions. Tools and techniques found to be particularly beneficial when exploring hope with clients were discussed and outlined in this project. Hope-focused counsellors rely heavily on narrative interventions with the goal of improving therapeutic outcomes and increasing client hope by broadening clients' perspectives when options are limited by feelings of hopelessness. The first part of this project includes an introduction to the study, a comprehensive literature review on hope, applications of hope in counselling, a detailed outline of the manual, project development methods, and a synthesis of the information. The second part of the project is a stand-alone document, located in the Appendix, consists of a facilitator guide for conducting the workshop, and the Hope Toolbox containing handouts necessary for participation in the workshop.

## **Acknowledgment**

It has been a long journey, and without my parents as pillars of support I would not have had the foundation to build this project. I would like to thank the Bank of Frank, which allowed me the financial freedom to focus on my studies without having to take on the added responsibility of working.

My parents have helped me to pace myself throughout this project and learn to accept my limitations. Thank you for always encouraging me and believing in me, no matter what project I was working on. I love you both and feel like the luckiest girl in the world to have you as my parents.

I would also like to thank my project supervisor, Dr. Blythe Shepard for her patience, creativity, and support.

Lastly, I would like to thank Dr. Denise Larsen, whose kind words of encouragement and expertise in the field of hope-focused counselling helped to make this project what it is today.

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## Chapter 1: Introduction

*“A rainbow is a prism that sends shards of multicolored light in various directions. It lifts our spirits and makes us think of what is possible. Hope is the same—a personal rainbow of the mind”* (Snyder, 2002, p. 269).

Hope is an emotion driven by a specific desired outcome, which is unlikely to occur. What is unique about hope is that it causes people to remain committed to their goals and take actions toward achieving them despite setbacks and obstacles. This results in better outcomes for clients whether they are battling physical or mental illness. The healing power of hope has been underestimated and understudied for nearly 50 years, and just recently its important role within the therapeutic relationship has begun to emerge in academic research. The manual and workshop attached to this project serve to offer counsellors an opportunity to learn ways of incorporating positive psychological strength-based hope interventions into their practice. The materials included in the manual cover a wide variety of therapeutic orientations and will be applicable for a range of therapists due to the open-ended, culturally sensitive, integrative manner of the interventions in the manual. As therapists we play a critical role in the process of recovery. Hope therapy should be used more frequently because by fostering hope we can help clients to maintain a focus on positive possibilities and a better future, instilling in them a sense of purpose, meaning, and engagement, which in my opinion is the most powerful gift helpers can give.

Words matter. And words coming from you especially matter. We cannot be a party to a collapse of all hope. Equally we have a capacity to preserve and

maintain hope. Toward a homecoming. Toward a journey's end. (Brennan, 2010, p. 261)

Chapter 1 of this Master of Education project provides a rationale for applying the construct of hope to practical interventions. The goals for creating a manual are outlined and my motivation for creating this manual is explained. The last section of this chapter is devoted to overall outline of subsequent chapters.

### **Project Purpose**

The purpose of this project is to create a manual to be used as an educational tool for workshops on the topic of hope-focused counselling. The goals of the manual are to: (a) educate counsellors about the concept of hope and its critical role in the therapeutic relationship; (b) outline the implications of incorporating a hope-focused approach during counselling sessions; (c) provide applied strategies and interventions to be used as tools for counsellors during therapeutic interactions; and (d) create a user-friendly workshop intended for counselling professionals.

### **Project Rationale**

The rationale for the creation of a hope-focused counselling manual is to increase knowledge and application of hope as a therapeutic intervention. After conducting an extensive literature review on the topic of hope in the counselling process, a large deficit in research became apparent. An abundance of research exists related to defining the construct of hope, but limited research is available in applying the theoretical construct of hope to practical interventions. Therefore, this project will synthesize the existing research on hope into one user-friendly manual. Such a manual will assist counsellors to incorporate a hope focus into their practice, regardless of their underlying therapeutic

orientation. The exploration of hope is an important skill set for counsellors to develop, as hope has proven to be a powerful factor in recovery (Snyder, 2000; Udelman & Udelman, 1985). The manual includes a variety of hope interventions that have the potential to appeal to a large audience of counsellors.

### **Statement of Interest**

My personal motivation for creating this manual arose from my own experience of the dramatic effect of hope on recovery. A mentor and very close personal friend challenged me to consider believing in a positive outcome during a difficult struggle in my life. A change in my perspective led to a dramatic physiological response, resulting in a spontaneous recovery from a life-threatening illness.

I feel very strongly that many people underestimate the power of their emotions and thoughts on their physiology, mood, and engagement in life. All humans possess the ability to believe in infinite positive possibilities for their future. Therapists who operate from a hope-focused counselling orientation help clients to realize this potential and are able to positively influence the quality of life of their clients. Approaching success involves picturing the future full of positive possibilities and believing in the ability to create a life one wants. This process requires an underlying sense of hope. Hopeless individuals can be trapped in a closed perspective fuelled by fear of failure and the belief that the future will not bring happiness. Therefore, my justification for this project lies in my values and my personal belief system. I believe that hope is a fundamental, universal human characteristic that is all too often overlooked. The use of hopeful language in therapy has massive potential for influencing recovery in spiritual, emotional, physical, and cognitive domains. Research has pointed to the therapeutic relationship as an

important factor influencing recovery and client improvement, above and beyond the therapeutic orientation or intervention being used by the counsellor (Levitt, Butler, & Hill, 2006). Inspiring hope in a client can be a powerful tool for improving the therapeutic alliance and its positive influence on therapeutic outcomes is clear.

Another personal motivator for creating this manual is the limited exposure to hope-based interventions I received during my training as a Master's level counsellor. I would like to influence improvements in counsellor education programs by creating and disseminating a reference guide and practical manual of hope-focused tools for therapists and trainees.

### **Project Structure**

The first section of this project includes an introduction to the study, a comprehensive review of the construct of hope, practical applications of hope in counselling, project development methods, a synthesis of the project, and an overview of the workshop manual. Following the introduction to the project, offered in Chapter 1, Chapter 2 provides an outline and a detailed description of the construct of hope based on existing research. The history of hope research is reviewed, and the construct of hope is distinguished from similar constructs such as optimism and wishing. The functions of hope are explored from the clinical counselling perspective and from a medical perspective. Noteworthy internal and external threats faced by clients and counsellors are discussed. To end the chapter, criticisms of hope research are explored and the existence of false hope is disproven.

Chapter 3 addresses the applied practice of hope-focused counselling in an effort to educate counsellors about practical methods for incorporating hope-fostering

interventions into their clinical practice. Specific emphasis is placed on the importance of counsellors becoming self-aware of what strengthens their own hope. Additionally, empirically supported hope-fostering techniques are discussed. Interventions from a variety of therapeutic orientations are presented, highlighting the diverse options for applying hope into clinical practice.

Chapter 4 outlines the process of project development that I undertook when conducting this research. The overarching themes of the project are listed and primary sources used to find references are identified. Methods used for gathering empirically supported research are outlined, including online database searches, buying books online, and visiting libraries. Chapter 5 is the synthesis of the project, walking the reader through the motivation behind the project, a brief literature review, project application to practice, the strengths and weaknesses of the project, and suggestions for future hope research. Chapter 6 is an outline of the workshop manual, found in the Appendix. It provides a detailed description of the contents of the manual in addition to the objectives of each section. Lastly, it describes the strengths and weaknesses of the manual.

The second part of the project (the Appendix) is a stand-alone document containing the workshop manual titled “Hope-Focused Strategies for Counsellors: Workshop and Toolbox.” The workshop manual is split into two sections; the first section is titled “Facilitators Guide to Hope-Focused Counselling,” and contains detailed facilitation instructions for all workshop activities. The second section is titled “The Hope Toolbox” and contains the participant handouts, including pre and post workshop evaluations along with other hope resource materials. I designed this workshop for me to facilitate with the supervisory assistance of an expert in the field of hope-focused

counselling. The intention of the Hope Toolbox is to provide participants with activities that can be used to enhance their own understanding of hope and improve their knowledge and skills in the area of hope-focused counselling interventions. This workshop is designed to be delivered to counsellors from diverse therapeutic orientations who wish to learn skills for incorporating hope into their clinical practice.

The following chapter is a comprehensive review of the existing literature on the construct of hope. Hope is defined and differentiated from similar constructs, its functions are highlighted, and common threats to hope are explored. The chapter concludes with a discussion around common criticisms of hope, including a discussion about false hope.

## Chapter 2: The Construct of Hope

*“To hope is so intimately bound to human life, that like the air we breathe, it can easily escape our notice”* (Smith, 2007, p. 81).

Although people have been speaking about hope for a very long time, a common understanding of this construct has been difficult to define over the years. Within society hope is known to be a very personal experience that differs between individuals and can be difficult for people to describe. Jevne and Miller (1999) explained that hope is illusive because, “You can’t touch it, but you can definitely feel it. You can’t physically see it by itself, but you can hold it and carry it. Hope doesn’t weigh anything, but it can ground you and anchor you” (p. 6). What is universally accepted and understood is the value and positive impact hope has on human life. People often speak about hope accompanying them in their darkest hours and carrying them through seemingly insurmountable circumstances. Hope is unique and special because it is resilient, and it helps people stay committed to the possibility of a better future. Hope gives people a reason to continue fighting and believing that their life will improve, despite the unpredictable nature of human existence.

In this chapter I outline and describe in detail the construct of hope based on existing research. The history of hope research is reviewed and numerous differing viewpoints of researchers are presented. The construct of hope is then distinguished from similar constructs such as optimism, wishing, and dreaming. The functions of hope are explored from the clinical counselling perspective and also from a more general medical perspective. Noteworthy internal and external threats faced by clients and counsellors are

discussed. To conclude the chapter, criticisms of hope research are explored and the existence of false hope is disproven.

### **A Brief History of Hope**

Research on hope began with Karl Menninger (1959) and Victor Frankl (1959) who paved the way for hope research in the field of psychiatry over 50 years ago. Within the medical community, Menninger challenged professionals to look at the concept of hope as an essential component of clinical practice. On the other hand, Victor Frankl drew upon personal insights gained during his imprisonment in concentration camps to develop the notion that the absence of hope results in hopelessness and loss of meaning in life. Within a few years a research trend began, which was initiated by Marcel (1962), who placed hope on a continuum with despair as its opposite

Lynch (1965) and Stotland (1969) led the way for hope research in the area of psychology, with Stotland's (1969) conceptual framework creating the backbone for further research advances relating to hope as a goal-focus endeavour. Lynch (1965) and In fact, Stotland (1969) presented a theory that portrayed hope as an expectation of goal attainment in the future, driven by the importance of the goal and motivating action within the individual to achieve the desired outcome. Lynch's (1965) contribution to the field included the assertion that the expectation of what is desired is also possible for the hopeful person.

Hope research continued to expand and develop across diverse contexts, including those of the chronically and critically ill, cancer patients, HIV/AIDS patients, and the terminally ill (Nekolaichuk, Jevne, & Maguire, 1999). Numerous assessment frameworks were developed, exploring patients' experiences of hope (Hinds, 1984) and

exploring hope-enhancing strategies (Beste, 2005; Herth, 1989; Turner & Stokes, 2006). Hinds (1984) described hope as a universal concept and intrinsic element, necessary for human life.

Over the next 50 years, researchers continued to work towards a common understanding of the construct of hope. Using a grounded theory approach, Dufault and Martocchio (1985) came to define hope as “a multidimensional dynamic life force characterized by a confident yet uncertain expectation of achieving future good which, to the hoping person, is realistically possible and personally significant” (p. 380). In a review of research on hope, Stephenson (1991) further supported this definition and offered a broad definition of hope, which included: (a) anticipation, (b) a positive future orientation, and (c) what is personally meaningful for the hoper. Additionally, Nekolaichuk et al. (1999) presented an integrative model of hope outlining personal spirit, risk, and authentic caring as essential defining features of this construct. This structure is uniquely sensitive to the meaning of hope generated by individual experiences within health and illness. This research was fundamental in adding breadth and depth to our understanding of hope as a multidimensional concept as can be seen in more recent research.

Simpson (2004) agreed that hope is more complex than previously understood and listed important aspects of hope including: (a) the role of desires or wants, (b) the connection to values or goals, (c) the role of imagination and its link to uncertainty, and (d) the action component of hope. Additionally, Simpson helped us understand that to talk about one’s hopes introduces personal vulnerability into a conversation, which is another important awareness for counsellors working with hope. Flaskas (2007)

expanded upon these findings by stating, “To frame hope and hopelessness as (simply) internal emotional states, intimate and powerful as they may be, makes it harder to see the force of the thinking and doing of hope, alongside the feeling of hope” (p. 190).

Larsen, Edey, and Lemay (2007) have summarized elements common to a multidimensional definition of hope as being:

- dynamic (Dufault & Martocchio, 1985; Hinds, 1984);
- essential to life, which is to say that life loses purpose or meaning without hope (Beste, 2005; Duggleby & Wright, 2004; Elliott, 2005; Frankl, 1959; Herth, 1989, 2000; Marcel, 1962; Miller, 1983; Morse & Doberneck, 1995);
- future oriented (Morse & Doberneck, 1995);
- personally significant and subjectively understood (Dufault & Martocchio, 1985; Hinds, 1984; Morse & Doberneck, 1995); and
- goal oriented (Hinds, 1984; Morse & Doberneck, 1995; Snyder, 2000).

From a multidimensional perspective, hope is a complex, dynamic construct involving an interplay between emotion, cognition, behaviour, and interpersonal relationships. Other theories of hope also exist such as goal-focused theory and discursive-oriented understandings of hope. Goal-focused theory describes hope as a unidimensional construct, existing on a continuum ranging from low to high hope and involves a specific focus on goal setting. Discursive-oriented understandings of hope draw attention to the powerful relationship between language and hope. All of these theories are discussed in greater detail later in the chapter. As counsellors we must learn to listen for and work with these unique understandings of hope between clients.

The construct of hope is illusive and difficult to define because hope is experienced differently by each individual. After reviewing the essential characteristics of hope, its important role within the therapeutic relationship becomes glaringly obvious. To have hope, as indicated above, is to live a life with purpose, meaning, and direction. Additionally, the existing research indicates that hope is essential to optimal human functioning.

### **Differentiating Hope from Related Concepts**

Words such as optimism, wish, and hope are often used interchangeably in the English language. While these constructs share some similar characteristics, researchers have shown that these constructs are different in many ways. How is the construct of hope unique? Bruininks and Malle (2005) teased apart the concept of hope from related concepts, moving beyond the folk-conceptual perspective to a psychological construct that is definable and more clearly understood. Bruininks and Malle achieved this by having participants describe how they used words such as hope, optimism, and wishing in everyday language. Participants then went on to compare and contrast these and other related constructs to hope. The results generated by Bruininks and Malle paved the way for future research contributing to our current understanding of the construct of hope.

To understand what makes hope unique it is important to compare it to similar constructs. Optimism and hope are often used as synonyms for one another in everyday language; therefore, it is important to discuss what characteristics these two constructs share and how they differ, to gain a clear understanding of them both.

Bruininks and Malle (2005) highlighted the most distinct differentiating feature between hope and optimism is that optimism is a trait whereas hope is an emotion. A

trait refers to a general attitude, and Bruininks and Malle argued that optimism represents a “positive outlook, looking on the bright side, or thinking positively” (p. 336). This optimistic attitude does not strongly influence emotions because people report feeling optimistic about general outcomes (i.e., life will get better). Beste (2005) supported this argument and stated that optimism is vague whereas hope involves specific, significant goals for the future. According to Bruininks and Malle (2005), these hoped for specific outcomes (e.g., remission from illness) illicit strong emotions, which keep people committed to their goals and oriented toward their desired particular event or object. Hope involves feelings, thoughts, and action, Aldridge (1993) argued, and is more enduring than optimism because it does not fade in the face of adversity (Hollis, Massey, & Jevne, 2005).

Another notable difference is that optimistic people experience a sense of control over life events because they assess their desired future as likely to occur (Arnau, Rosen, Finch, Rhudy, & Fortunato, 2007; Bruininks & Malle, 2005; Seligman, 1998). This perspective results in optimism being easier for people to hold than hope because it is more rational. Seligman (1998) noted that people who are optimistic tend to view setbacks and difficult life events as challenges, and they tend not to assume personal responsibility for such defeats. This gives optimistic people a continued sense of control, regardless of situational influences. Hopeful people often experience less personal control because the outcomes they desire are much less likely to be realized (Bruininks & Malle, 2005).

Optimists are sometimes accused of having a Pollyanna attitude; for example, suggesting that a person not worry because everything will be alright without

acknowledging the seemingly insurmountable challenges that the person is experiencing. A Pollyanna attitude differs from hope, which often includes the awareness of difficulty and acknowledgment of the improbability that the desired future outcome will be reached. Interestingly, hopeful people continue to expect the unlikely outcome to occur (Bruininks & Malle, 2005). This understanding about hope is important for counsellors because it demonstrates that hope is not solely rational. Clients often enter therapy feeling demoralized, assessing the likelihood of their desired outcome as low, hence the introduction of hope can be a powerful therapeutic tool.

As you can see, optimism and hope often work in harmony, with an underlying positive attitude providing the backbone for remaining hopeful, despite challenges and setbacks in life. An important shared characteristic between hope and optimism, echoed by numerous researchers, is that they both imply a positive future orientation (Bruininks & Malle, 2005; Miceli & Castelfranchi, 2010).

In summary, optimism and hope share the similarity in that both involve a positive future orientation. The difference is that optimism is a positive attitude about a future event, which is probable and, therefore, likely to occur. Conversely, hope leads to actions directed toward possible, often unlikely, outcomes that hold personal significance for the hopeful person (Miceli & Castelfranchi, 2010).

When comparing hope to wishing, another related construct, hoping is less fleeting and involves, “a great commitment to representing and seeking out the outcomes” (Bruininks & Malle, 2005, p. 349). Wishing, defined by Merriam Webster, is “to have a desire for” (“Wish,” 2011, para. 1), representing a general want for something in the future. Hollis et al. (2005) described hope as an active process and wishing as a

vague, passive process because wishing does not involve a plan of how to accomplish change. Bruininks and Malle's (2005) research indicated that that hope is unique because it combines the difficulty of affecting the outcome through one's own efforts, the outcome's valued importance, and the continuing investment of energy despite poor odds.

To further understand the construct of hope, Bruininks and Malle (2005) explained that hope is a basic emotion with four fundamental rules: prudential, moralistic, priority, and action. These rules indicate that hope exists when a person believes the probability of attainment is realistic, the hoped for outcome or event is considered important, it is socially and personally acceptable, and the person is willing to take action to achieve their goals. Factors such as importance, likelihood, and perceived personal control define the framework for understanding the subtle differences between related concepts such as optimism, wishing, and hoping. Interestingly, if the outcome is strongly valued, people continue to hope even when they realize that a hoped-for outcome is not likely to occur (Bruininks & Malle, 2005). This phenomenon can be attributed to the shift in focus within the person from what is probable to what is possible.

According to the discourse-related research reviewed here, hope can be distinguished from similar constructs in that it is an emotion, which is related to a specific future-oriented goal that holds significance for the hopeful person. Hope is not solely rational because the desired outcome is often improbable, yet the hopeful person remains committed to the pursuit of the outcome. This behaviour results in committed actions directed towards the ultimate goal and is unique because it assists people in maintaining resiliency in the face of adversity and obstacles.

## **Functions of Hope**

Hope is a resource. We hoard it at our peril. The effects of hope are profound, as are the effects of hopelessness. It is a human rights issue. Just as food, water, and security must be equitably distributed, so, too, must hope. Whether we offer or receive, co-create or imagine, we can all participate in doing hope. (Weingarten, 2007, p. 22)

Research on the functional qualities of hope within the therapeutic relationship has been growing over recent years, however, it is still limited. Edey (2000) explored hope in therapeutic interactions and found that it serves to sustain energy and facilitate change. When studying high risk behaviours, Harris and Larsen (2008) found that hope has protective qualities because it is part of a “positive feedback loop” (p. 406): as hope increases high risk behaviours decrease. This evidence supports previous findings by Arnau et al. (2007) who reported that hope has both protective and resiliency qualities. The presence of hope decreased the severity of depression and anxiety symptoms.

Overall, the research in this specific area is sparse but it is obvious from these few studies that the impact of hope within the therapeutic relationship is powerful and significant. Further attention to and investigation of the functional qualities of hope is required in order to build upon existing research. Hope scholarship presented over the past 12 years indicates that hope improves resilience and mental health (Arnau et al., 2007), sustains energy, and facilitates positive changes for the client (Edey, 2000).

The existing research in the area of medicine sheds light on topics that could be explored in greater detail within the therapeutic relationship. For example, in their study on the discursive properties of hope in terminal cancer patients, Elliott and Olver (2007)

found that hope is a resource, a motivator, and a reason to continue with medical treatment. Specifically, it was found that hope encourages active patient engagement in and compliance with treatment without total subjugation to medical advice. In a study on hope and hopelessness, Raleigh (2000) found similar results stating that people are motivated to act in the face of uncertainty because a positive outcome is expected.

Hope provides benefits in coping with and adjusting to health problems (Cheavens, Michael, & Snyder, 2005). Benefits have been found related to both primary prevention techniques or before problems occur as well as with secondary prevention techniques or in the reduction or elimination of existing problems (Cheavens et al., 2005). Hopeful thinking during the secondary prevention phase results in minimizing the impact of the problem, more successful psychological adjustment, and more effective coping with barriers between the person and their goals. “Higher hope virtually always is related to more beneficial life outcomes” (Cheavens et al., 2005, p. 127).

Numerous studies in the medical field (e.g., Moon, Snyder, & Rapoff; Seaton & Snyder, as cited in Cheavens et al., 2005) have found that health-care professionals also benefit if clients have higher hopes because they are more likely to adhere to therapeutic intervention. Therefore, when clients believe in a positive future for themselves they are more likely to take action toward recovery, which helps to improve their situation.

In summary, a large amount of the research related to the functions of hope has been generated in the area of medicine; however, it is likely that the same results exist within the therapeutic relationship. Hope functions as a resource and motivator, assisting clients in sustaining recovery-related behaviours, and in improving treatment compliance and positive treatment outcomes. Hope has been shown to decrease the severity of

psychological symptoms, improve resiliency, and serve to protect people against setbacks and obstacles. Overall, hope is incredibly complex and multifaceted, which makes it “crucial for enhancing the quality of our lives” (Snyder, 2002, p. 268).

### **Threats to Hope**

Clients and counsellors both face countless threats to their hope including but not limited to: lack of support, inability to envision a positive future, repeated failures or setbacks, mental illness, and personal limitations. A majority of research related to threats to client hope has been generated by the insights and experiences of nurses within the medical community. Miller (1989, 1991) discovered numerous external threats to hope including: physical setbacks, seemingly unrelieved pain, uncertainty about successful treatments, abandonment, isolation, and a devaluation of personhood. Internal threats included adjustment problems (e.g., inadequate social activity, financial inadequacy, impaired communication, anxiety, depression, and hyper vigilance), and negative affect (Miller, 1991). Additional threats to hope involve sharing statistical odds with the patient, probability of survival, and being told that a good outcome is not likely (Harris & Larsen, 2008). The focus on probability versus possibility results in negative effects on mood and on a personal sense of control.

When people perceive that they can no longer control the outcome of a situation, hopelessness may result. Hope is jeopardized in a number of situations from job loss, health crisis, financial crisis, and relationship strain to traumatic events (Miller, 1991). Yeasting and Jung (2010) recommended increasing client involvement in decision making regarding the therapy process, and encouraging clients to engage in more

frequent self-care activities as methods of improving the clients sense of control and ultimately hopefulness.

Grief related to the loss of a loved one puts people at high risk for losing hope because couples often define goals together (Snyder, 2002). When one partner dies, the other is left in a state of confusion and depression. In a society that places high value on relationships, being single can be just as immobilizing as losing a partner. The inability to make connections to other people can put single people at risk for diminished hope (Snyder, 2002). In order to combat feelings of isolation and loneliness, Adams and Partee (1998) suggested that the people surrounding the suffering individual could provide inspiration in times of need. Adams and Partee argued that having someone who believes in you could help you to imagine new, positive possibilities. Recommendations included sharing success stories that the person can relate to, verbalizing a belief in the recovery of the individual, having a physical presence such as the therapeutic relationship, and helping clients learn to manage their illness (Adams & Partee, 1998).

Unfortunately, hope often acts as a silent factor within the therapeutic relationship with the problem becoming the focus of discussion. In contrast, Edey and Jevne (2003) argued that hope could be consciously tracked in sessions and could form the basis of discussions. Key elements of building hope within the therapeutic relationship involve coconstruction of expectations by the counsellor and client for a good future and the willingness of the counsellor to participate in that future (Edey, 2000). Without these elements in the counselling relationship, hope can become threatened.

Edey and Jevne (2003) brought attention to the fact that counsellors and clients must both possess hope to enhance the therapeutic process. This can be a daunting task,

as Edey and Jevne pointed out, “We all want to be effective in our work, and it is difficult to be hopeful in the presence of those clients who don’t change, don’t try, and won’t take advice” (p. 46). These client traits are often associated with underlying mental health concerns such as depression, helplessness, and grief.

Imagining the possibility of a positive future becomes very difficult for people suffering with mental, physical, emotional, social, and environmental limitations (Adams & Partee, 1998). People who have experienced the successful attainment of goals and wishes find it much easier to hope, whereas those who have suffered greatly and experienced numerous failures and defeats may need someone to help them look to the future with hope (Edey & Jevne, 2003). Edey and Jevne (2003) asserted that people who are structurally disadvantaged (by class, gender, race, poverty, discrimination, and occupation) require support in generating and maintaining hope.

Markus and Nurius (1986) brought attention to how these social factors could threaten hope when they examined the relationship between motivation, self-concept, and possible selves. Possible selves are our imagined future selves, those we very much would like to be and those we fear becoming. Possible selves “represent specific, individually significant hopes, fears, and fantasies” (Markus & Nurius, 1986, p. 954). According to the theory of possible selves, hope for the future is intimately tied to individual self-concept, as possible selves are “cognitive manifestation of enduring goals, aspiration, motives, fears, and threats” (Markus & Nurius, 1986, p. 954). The goals people set for themselves, based on their self-concepts, are intimately tied to their life experiences; therefore, repeated negative events can increase fear and dampen hope. Conversely, overall good health and limited exposure to threats and negative life

experiences can lead to enhanced sense of optimism and hope for specific valued outcomes.

Finally, to gain a comprehensive understanding of factors that threaten hope, hopelessness must be discussed. Hopelessness is defined by Miceli and Castlefranchi (2010) as “the persistence of the desire, coupled with the belief of impossibility” (p. 258). Hopelessness is the perspective held by most people suffering from depression that manifests as an inability to see a positive future for oneself (Hollis et al., 2005; Stone, 1998). Stone (1998) explained that “hopelessness is an essential, defining condition of depression” (p. 431) in which individuals see the world through a dark lens. Unfortunately, depression is on the rise and, according to Stone (1998), recapturing hope is the best way to fight back against depression.

In brief, humans face many obstacles when attempting to remain hopeful. From personal limitations and crises such as living with a mental illness or losing a loved one to financial crises such as experiencing a job loss, everyone is susceptible to feelings of despair. Weingarten (2007) affirmed that this is a normal and expected life process and proposed that hopeful people sometimes despair and feel discouraged. Weingarten argued that hope is a journey, and it is the process of arriving at a goal that is most important. “As long as despair doesn’t descend into isolation, devolve into indifference or foster fear and hatred, it is just another feeling that may accompany us along our path” (Weingarten, 2007, p. 24).

### **Criticisms of Hope**

Criticisms aimed at hope research commonly involve the potential dangers of raising a sense of false hope. In addition, there is fear that clients will act unwisely if

they focus on possibility, argued to be based upon illusions, instead of probability based upon statistical evidence. Related to this argument is the belief that it is unethical to raise a client's hope when the desired outcome is unlikely or improbable. Clients often struggle with feeling stuck and search for growth and movement in life. This common concern places counsellors in the position of working with challenged hopes. Fostering hope within the therapeutic relationship offers the energy for engagement, even though the outcome that the client specifically hopes for may change or be refined over time in the course of therapy.

Exploring false hope is an integral part of understanding hope because it is addressed so often in the literature. Only a handful of researchers have attempted to prove the presence of false hope. One such researcher, Kwon (as cited in Snyder, 2002) defined false hope as the state of having a desired goal and the requisite motivation (i.e., agency), but not having the plans to reach the goal. To prove that false hope resulted in negative consequences, Kwon needed to demonstrate that high hope and an immature defence style related to maladjustment. With numerous research studies, Kwon was unable to prove this false hope hypothesis. Instead his research findings indicate that high hope is related to better adjustment regardless of the defence style of the individual (Snyder, 2002).

Snyder (2002) listed and dispelled three common false-hope claims, including: “(a) the expectations rest on illusions rather than reality; (b) unsuitable goals are being pursued; and (c) the strategies to achieve the desired goals are poor” (p. 264). Numerous other researchers offer additional supportive counterarguments to false hope based on these claims.

In response to the first argument, Edey and Jevne (2003) pointed to numerous research studies (e.g., Herth; Jevne; Perakyla, as cited in Edey & Jevne, 2003), which stressed the importance of acknowledging hope while de-emphasizing its relationship to realistic goals. Elliott and Olver (2007) agreed and stated that what the patient hopes for is irrelevant, as hope functions to value both the desired object and the one desiring it. Simpson (2004) de-emphasized the role of realistic goals pointing out that “not every hope is realized . . . hope comes with the possibility of disappointment” (p. 442).

Snyder's (2002) second claim for false hope stated that people with high hope pursue unsuitable goals. Snyder argued that people who set extreme, unattainable goals are actually low in hope. In contrast, people with high hope set difficult goals that they see as challenges and are invigorated by them. Additionally, those individuals with high hope display persistence even under stressful conditions. These individuals tend to be more flexible and often imagine numerous strategies of goal attainment (Snyder, 2002, p. 266). Snyder noted that people with high hope appear to thrive in solving dilemmas faced in the pursuit of their goals. “Even if high-hope persons find their hopes dashed, they appear to arise phoenix-like again so as to try another strategy for effectively pursuing their goals” (Snyder, 2002, p. 265). Jevne (2005) stated that hope can exist even when we do not attain our desired outcome and things do not work out as we had planned. Hope supports engagement in life, and the person with hope actively works toward recovery rather than giving up.

The following short story, taken from Buchholz (as cited in Snyder, 2002), is an example of instilling hope in clients and its powerful effect on physiology:

As I was eating breakfast one morning I overheard two oncologists discussing the papers they were to present that day at the national meeting of the American Society of Clinical Oncology. One was complaining bitterly:

“You know Bob, I just don’t understand it. We used the same drugs, the same dosage, the same schedule, and the same entry criteria. Yet I got a 22% response rate and you got 74%. That’s unheard of for metastatic lung cancer. How do you do it?”

“We’re both using Etoposide, Platinol, Oncovin, and Hydroxyurea. You call yours EPOH. I tell my patients I’m giving them HOPE. Sure, I tell them this is experimental, and we go over the long list of side effects together. However, I emphasize that we have a chance. As dismal as the statistics are for non-small cell cancer, there are always a few patients who do really well.” (p. 266)

Finally, in response to the third criticism that false hopes represent bad planning, Snyder (2002) argued that even in situations of high stress, hopeful people select effective routes to their goals. Conversely, people who score low in hope often become confused, avoidant, and ineffective in finding routes to their goals (Snyder, 2002).

When comparing false hope to false despair, it becomes very clear that false despair is much more detrimental to overall health, commitment to therapy, and emotional wellbeing. Generally speaking, people with false hope look to the future positively whereas false despair causes people to avoid planning for the future, due to feelings of hopelessness (Jevne, 2005). Edey and Jevne (2003) argued that people are more prone to false despair than false hope, which results in unrealistic hopelessness and prevents them from seeking solutions, becoming actively involved in treatment regimes,

complying with treatment recommendations, and listening to medical advice. Therefore the presence of despair challenges engagement in therapy. Additionally, Edey and Jevne found that people with false despair confuse possibility with probability and view situations based on the past, not looking at the future from a hopeful perspective. On the other hand, people who experience false hope are able to separate hope for the condition from hope for themselves as a person, allowing them to retain hope, based on the possibility of a positive, unlikely outcome (Jevne, 2005).

Using hope as a verb allows people the freedom to simultaneously assert their commitment to a positive, yet unlikely, outcome while recognizing their limitations to achieving this (Elliott & Olver, 2007). Hope positions clients as believing that they harness the potential to influence outcomes, with goals that may be achievable, in contrast to their position as relatively helpless to effect change when assuming a hopeless perspective.

In conclusion, Edey, Jevne, and Westra (1998) put it best when they stated, “Clients are adamant and we now agree that there is no such thing as false hope. For any individual, there is only hope” (p. 20). To label a hope false threatens engagement in counselling by negatively labelling the client’s desired outcome, rather than recognizing that hope is a process that is likely to shift and change over time. Weingarten (2007) added that “more worrisome than false hope is not stepping on the path at all. After all, it is not the arrival but the journey that matters” (p. 21).

## **Conclusion**

Defining hope is a difficult task, as can be seen by the various theories and definitions proposed numerous over the years. Consensus has still not been reached.

Simpson (2004) noted that research related to the description and understanding of hope has generally been lacking. Capturing the elusive, intangible qualities of hope that are often difficult to describe in words and that are grounded in the uniqueness of an individual's experience is a major conceptual challenge in hope research (Nekolaichuk et al., 1999).

In the next chapter, I review the application of hope-focused counselling techniques in clinical practice. Common threats to hope are outlined, and existing research related to empirically supported hope-focused interventions are presented. The purpose of Chapter 3 is to demonstrate a variety of applied methods for incorporating hope into therapy, regardless of the therapeutic orientation of the counsellor.

### **Chapter 3: Application of Hope**

*“Every human communication has the potential to influence hope, positively or negatively” (Jevne, 2005, p. 273).*

Hope-focused counselling takes a unique approach to client care because it “emphasizes hope and broadens the client’s perspectives when options are limited by hopelessness or diminished hope” (Edey et al., 1998, p. 1). This is accomplished by adhering to the fundamental guiding principles of hope therapy. To adhere to these principles counsellors can: (a) use intentional hope language and encourage the client to do the same, (b) incorporate a collaborative client-centred approach, (c) allow clients to tell their story as if this were the first contact with someone in their situation, (d) take a nonexpert role, (e) listen to stories, (f) work with images, (g) foster creativity, (h) participate in hope rituals, (i) encourage clients to teach us what they know, and (j) consult with other professionals (Edey et al., 1998; Larsen & Stege, 2010b).

This chapter addresses the applied practice of hope-focused counselling in an effort to educate counsellors about practical methods for incorporating the hope fostering behaviours listed above into their clinical practice. Specific emphasis is placed on the importance of counsellors becoming self-aware of what strengthens and threatens their own hope. Additionally, scholarship on hope-fostering techniques is discussed. Interventions from a variety of therapeutic orientations are presented, highlighting the diverse options for applying hope into clinical practice.

#### **Understanding Your Hope as a Counsellor**

As professionals, when we think of hope, we often think of ways that we can work to inspire, repair, or maintain the hope of those who come to us seeking help.

Before this can be achieved, counsellors must first begin to understand how hope functions within the lives of clients. This involves careful examination and ongoing monitoring of our own sense of hope and hopelessness, our belief in the client's ability to improve, our judgments and preconceived ideas about mental illness, and our cultural biases.

Jevne (2005) reminded the therapeutic community that helpers are not immune to hopelessness and often find themselves searching for lost hope. Jevne argued,

We are not exempt from hopelessness, or from defences that protect us from it. Failure to examine our personal working assumptions about hope and hopelessness places us at risk for imposing our template of hope on those who seek our help. (p. 271)

Russinova (1998) drew attention to the intimate connection between client and therapist emotions and stated that professionals carry the responsibility of believing in better outcomes for the client, even when clients are experiencing hopelessness. Flaskas (2007) highlighted the difficulty of this task and stated, "To hold hope in the face of witnessing the family's hopelessness and carrying our own hopelessness, can be a difficult task" (p. 196). At the root of protecting your sense of hope is self-awareness. Recognizing that your personal hope is being threatened and you are struggling to continue believing in positive outcomes for your client (or clients) is only possible if you have taken the time to understand your working assumptions about hope.

Another important area for counsellors to pay close attention to is their unconscious biases about cultural definitions of hope. Counsellors should make a concerted effort to be culturally competent and sensitive to differing values and needs of

all clients. Averill and Sundararajan (2005) highlighted the importance of considering the culture and ethnic orientation of each client when working with hope. In comparing Eastern and Western perspectives on hope, important similarities and differences emerge. From an Eastern perspective hope is an enduring personality trait, whereas in the Western world it is viewed as an emotion. Eastern perspectives (Averill & Sundararajan, 2005), therefore, emphasize the development of personal characteristics such as endurance, patience, and acceptance, with a focus on “courage” (p. 161) or “fortitude” (p. 161). The Western emphasis is on overcoming environmental obstacles with a focus on “optimism” (p. 161) or “problem solving skills” (p. 161). For counsellors who prefer a more open-ended approach, LeMay, Edey, and Larsen (2008) offered examples of culturally sensitive questions counsellors could use to explore the individual cultural influences of each client including: (a) what can you tell me about your family or culture to help me better understand your hope, (b) what does hope look like in your family or culture, and (c) what does hopelessness look like in your family or culture?

Cultural awareness extends beyond ethnicity to encompass personal values, beliefs, and lifestyle choices. Discrimination and oppression result from cultural ignorance. To demonstrate cultural competency, counsellors must be particularly self-aware of their individual cultural influences by confronting their own preconceived ideas about mental illness, disability, despair, spirituality, and recovery (Minkoff, 1998). This process involves learning to empathize with the shame and despair of living with chronic mental illness, learning to accept new definitions of success, and learning to appreciate the spiritual value of recovery. When it comes to imparting hope, everyone can share in

the success, as hope begets hope and its transfer from helper to client is plausible (Snyder, 2000).

In summary, it is an ongoing challenge for counsellors to remain self-aware of their own experience of hope in addition to approaching client interactions from a culturally inclusive, nonjudgmental stance. Taking time to explore personal values and gain a thorough understanding of your own biases provides a strong framework for approaching hope-focused counselling.

**Hope within the therapeutic relationship.** An overview of the existing literature identifies hope as an essential part of the change process in counselling. Practitioners can begin by exploring their own hope and then progress to learning methods of incorporating hope into therapeutic interactions.

Why use hope in counselling? Change is inevitable in life, and hope provides an orientation for approaching that change (Larsen & Stege, 2010a, 2010b). Most importantly, Edey and Jevne (2003) found that maintaining a hope-focused approach to counselling was preferred by clients. Additionally, counsellors and trainees have found that their own ability to work with clients was enhanced when they consciously drew attention to hope (Edey & Jevne, 2003).

It has been argued historically that caregivers are not living up to their duty to care for clients if they fail to inspire hope (Vaillot, 1970). This ability to inspire hope originates in the therapeutic relationship. Edey, Larsen and LeMay (2005) agreed that the therapeutic alliance is of utmost importance and stated that individuals need to feel that they matter to others and feel worthy of being heard. Often, it is this relationship that sustains people when their hopes for a positive future are threatened (Edey et al., 2005).

Clients have identified specific aspects of the counselling relationship that they found particularly hope-inspiring including: empathy, trust, caring, authenticity, support, feeling connected, sense of belonging, being inspired, feeling empowered, encouraged, and understood (Beste, 2005; Harris & Larsen, 2008). Larsen and Stege's (2010a) research supported these findings and emphasized that when practitioners enter a relationship from a stance of acceptance and nonjudgment, clients experience a sense of hope in the moment, and a framework for exploring options for a more positive future. Additionally, when clients feel supported and cared for, they start to believe in positive possibilities for their future and to begin the journey toward regaining purpose in their lives.

From this foundation, therapists have the freedom to challenge and collaboratively refine the client's goals from the basis of a solid therapeutic alliance. Larsen et al. (2007) agreed that collaboration within the therapeutic relationship is of utmost importance and stated that hope is a cocreated experience between individuals. From this perspective the therapist and the client are both actively involved in the process of coconstruction, which is a shared and mutually influencing experience (Edey & Jevne, 2003). This process is very similar to the traditional person-centred client relationship; however, incorporating hope involves conscious intention on the part of the therapist to focus on the theme of hope and to foster hope through the use of hope-fostering language.

In conclusion, drawing conscious attention to hope is often preferred by clients, and it has been shown to improve the ability of counsellors to work with clients. Hope inspiration begins within a collaborative relationship and grows from a foundation of empathy, trust, respect, and the intentional use of hopeful language.

**Applying hope in counselling.** Hope can be the spark that brings the client in for help, the fuel that keeps the client going, the thrust that helps the client trying, and the outcome of a successful effort. “It can also be the seed that blossoms into interesting and inspiring . . . interventions” (Edey & Jevne, 2003, p. 45). Once counsellors have closely examined their own experience of hope and understand the guiding principles of a hope-based therapeutic relationship, they move to learning ways of applying hope into their counselling sessions.

As practitioners it is important to be aware of the most effective treatment modalities for each presenting problem. Edey et al.’s (1998) work indicated that hope-focused therapy is a valuable intervention style for treatment of clients with four main presenting concerns: “The skidding effect, the bruising effect, the boomerang effect and the alien effect” (p. 7).

The skidding effect represents clients whose health is failing in spite of treatments; these clients experience a loss of control, similar to when a car is skidding on the ice. In these circumstances, traditional therapies may focus on previous unsuccessful treatment attempts. In a hope-fostering approach to healing, Edey et al. (1998) recommended asking questions such as, “What has maintained your hope during this long struggle?” (p. 8). This intervention increases hope because it moves the discussion from a problem focus to a strength-based exploration of resilience while acknowledging the client’s ongoing struggles.

The bruising effect is used to describe the experience of repeated failures, losses and/or negative life events, which lead to an overwhelming sense of hopelessness. In this case, instead of asking the person what they can do to improve their situation, Edey et al.

(1998) suggested using a hopeful intervention such as, “What is the smallest change that could increase your hope?” (p. 8). According to Larsen and Stege (2010a), this technique is effective because it maintains a focus on what is within the client’s control, while simultaneously recognizing and considering many possibilities with the client. Jevne and Miller (1999) agreed with this intervention stating that “hope is not about changing the world . . . it’s about making a little difference in one part of the world” (p. 33). Edey et al. (1998) encouraged the use of hope language and stated that it allows people to focus on possibilities, chance, and exceptions.

The boomerang effect occurs when a person has tried repeatedly to change something about their life, only to feel as though they are back where they started. An example of this might be a client who repeatedly tries to get a promotion without success, or someone who suffers from addiction and has been unsuccessful at maintaining sobriety. These types of experiences result in feelings of failure, self-blame, and hopelessness. Edey et al. (1998) recommended drawing upon exceptions to this experience by asking the client, “Can you recall several occasions when you felt hopeful at work, and tell me about them?” (p. 9). By focusing on exceptions, clients’ perspectives shift to their strongest moments and their capabilities, instead of only seeing their repeated failures. Larsen and Stege (2010b) supported the use of explicit hope language during therapeutic interactions because it turns the conversation “away from problem-saturated talk” (p. 298) and onto more positive elements. This approach fosters hope by reminding clients of their small successes and ability to overcome adversity.

The final category is the alien effect, which refers to clients who feel that no one understands them (Edey et al., 1998). These clients often feel different from others,

struggle to connect with health care professionals, and may have been unable to make meaningful connections with counsellors in the past. A client in this category might be a man with breast cancer who stopped attending support meetings and counselling because he was the only male. Edey et al. (1988) stated that hope could be a very powerful tool for building a relationship with people who suffer with the alien effect, because “any two people can start a conversation about hope” (p. 9). Sharing success stories and readings about hope are recommended to strengthen the therapeutic alliance (Edey et al., 1998; Larsen & Stege, 2010a). These activities are particularly hope inspiring because clients experience investment from the therapist and they feel heard (Larsen & Stege, 2010a). The client feels validated which strengthens the bond between counsellor and client, and ultimately intensifies hope.

Edey et al.’s (1998) four categories (the skidding, bruising, boomerang, and alien effects) related to people who are generally low on hope. These clients typically present with a “lack of energy, a feeling of being alone, a sense that anything they do will be futile, [and] a hesitancy to try” (Edey et al., 1998, p. 10). People with high hope also seek counselling. Hope-focused counselling could also be used with this population; however, the counsellor’s role changes to encouraging the clients to educate the counsellor about their hope, while at the same time focusing on their presenting problem. Although hope-focused interventions are commonly used with clients who are experiencing a sense of hopelessness, hope can also be incorporated into other therapeutic interactions.

When examining the integration of hope into therapy from a more general perspective, the desired relationship qualities and interventions are very similar to

existing research in other areas of psychotherapy. One very basic and yet powerful hope-enhancing technique, according to Bryne et al. (1994), is believing in the client's abilities. Stearns (1998) supported this and added that clinicians who hold hope for their clients spend more time with them, resulting in better quality client care.

In a qualitative study related to therapist client interactions, Larsen and Stege (2010a) discovered that therapists use specific hope-fostering techniques. These skills included witnessing hopelessness, highlighting client resources, encouraging clients to reframe their problems, using metaphors to describe the client's circumstances, sharing personal success stories, externalizing the problem, and incorporating humour.

Several other authors echoed the finding that humour could be used to enhance hope, as it has been applied to help treat depression (Edey, 1999; Yeasting & Jung, 2010), decrease stress (Vilaythong, Arnau, Rosen, & Mascaro, 2003), and treat fear and anger (Yeasting & Jung, 2010). Using humour in therapy requires good timing based upon intuition, good insight, and a strong relationship, as inappropriate humour could cause relationship ruptures. When used effectively, the impact of humour on improving hope can be dramatic.

These research findings paint a picture of quality client care and improved therapeutic outcomes, originating from a belief in the client's potential to improve. Simple, common techniques such as reframing and highlighting resources combine with more advanced skills such as the use of humour to influence positive outcomes and build a strong relationship. These hope-promoting experiences and techniques demonstrate the simplicity of hope-based interventions and the universality of their applicability.

**Hope refinement.** At times, therapists report being unsure of how to proceed when they do not share a particular hope manifestation with the client (Larsen, Edey, & LeMay, 2005). When seemingly unrealistic hopes are shared within the therapeutic environment, hope refinement assists clients through the process of letting go of old hopes and replacing them with new ones (Larsen et al., 2005). In this collaborative process clients share their hopes and the helper offers his or her perspective on what might be hoped for, while respecting the client's vulnerability. Together, new more realistic hoped for objects or outcomes emerge through the process of hope refinement as the client gains new information, insights, and actions. A similar approach used in medical settings, is described it as, "A conscious decision to change or transform their [client's] hope" (Duggleby & Wright, 2004, p. 76). This shift in focus often involves refocusing on family and quality of life (improvements are possible) rather than focusing on finding a cure (low probability of achieving desired outcome).

When working with hope refinement, Simpson (2004) stressed the importance of clients having their expressed hopes mirrored back to them, even if the therapist does not agree with the hoped for outcome. Simpson's research in the medical field highlighted the need for professionals to acknowledge the client's hopes and respond empathically because "an offhand comment . . . may reinforce or destroy a patient's hope" (p. 445). Simpson's findings pointed to a need for specialized training for counsellors in hope-focused intervention techniques.

Overall, hope refinement is a process, within which the client's own understandings of hope shift and grow. The focus of hope refinement is not on ensuring that the client's hoped-for outcome is realistic from the perspective of the counsellor.

Instead, the focus is on ensuring that the client's hopes are heard and witnessed by the therapist, allowing the client and counsellor to hold differing hopes simultaneously. Most importantly, hopes are most often intimately connected to something deeply meaningful for the client in the present; therefore, ensuring that the client feels heard and understood is of utmost importance in the process of hope refinement.

In summary, hope has the potential to positively influence all therapeutic environments when it is intentionally incorporated into interactions. Expressing a belief in a positive future for a client, managing your own personal biases, collaboratively refining hope with clients, and remaining genuine and supportive are all hope-enhancing behaviours that can be easily incorporated into therapy sessions. These skills have been proven to increase client engagement in therapy and improve therapeutic outcomes by increasing treatment program compliance.

### **Therapeutic Orientations and Hope**

The goal of hope-focused counselling is to make hope visible and to broaden the perspective of clients whose feelings of hopelessness and diminished hope have limited their options (Edey et al., 1998; Yeasting & Jung, 2010). Historically, therapy often focused on dysfunction and diagnostic psychopathology in an effort to find solutions to the client's presenting problems. Conversely, hope therapy moves away from a problem focus; hope therapy is directed at exploring the client's virtues, options, and natural strengths. Cheavens, Feldman, Scott, Michael, and Snyder (2006) supported hope-focused therapy and clarified that it aims to reinforce and instill strengths. In addition to the treatment of current symptoms, hope therapy buffers clients against future struggles and stressors. Hope-based interventions are used to enhance virtues and tasks the client

is doing well, determine what the clients wants more of in his or her life, and specify what the client aspires to do in the future (Cheavens, Feldman, Scott, et al., 2006).

Hope is a fundamental human experience, and it is not tied to a specific theory. Therefore, regardless of the therapeutic orientation being used, hope-focused counselling skills could enhance therapeutic relationships and improve therapeutic outcomes. Snyder (2000) suggested that integrating solution-focused, narrative, and cognitive-behavioural techniques with hope is the best approach. By combining these therapeutic modalities, Snyder argued, the result is a therapy that is designed to help client set clear goals, offer numerous options of goal attainment, and reframe difficult obstacles as challenges to be overcome (p. 123). Table 1 contains a summary of numerous therapeutic modalities and hope scholarship (including research, theory, clinical observation) pertaining to each.

Table 1

*Hope-Focused Techniques Used Within Differing Therapeutic Orientations*

Therapeutic Orientation	Hope Scholarship
Positive psychology	Bergsma (2008); Cheavens, Feldman, Woodward, and Snyder (2006); Edey (1999); Jevne and Gurnett (2002); Jevne and Miller (1999); Larsen and Stege (2010a); Riskind (2006); Vilaythong et al. (2003); and Yeasting and Jung (2010).

Narrative therapy	Beste (2005); Bowman (1999); Edey (2000); Edey and Jevne (2003); Edey et al. (1998); Edey et al. (2005); Elliott and Olver (2007); Harris and Larsen (2008); Jevne and Miller (1999); Larsen (2004); Madigan (2007); McDermot and Snyder (1999); Perkins and Dolbin-MacNab (2008); Shade (2006); Sowards, O'Boyle, and Weissman (2006); and Wood (2006).
Solution-focused therapy	Corey (2009), Snyder (2000).
Cognitive behavioural therapy	Cheavens, Feldman, Woodward, and Snyder (2006); Edey et al. (2005); Green, Oades, and Grant (2006); Matt, Sementilli, and Burish (1988); Riskind (2006); and Snyder (1989, 1994, 2002).
Existential	Bryne et al. (1994); Diessner, Rust, Solom, Frost, and Parsons (2006); Dufault and Martocchio (1985); Duggleby and Wright (2004); Elliott and Olver (2007); Frankl (1959); Fry (1984); Harris and Larsen (2008); Herth (1989, 2000); Larsen and Stege (2010a); Lynch (1965); Riskind (2006); Snyder (2000); Stone (1998); and Yeasting and Jung (2010).
Expressive Arts therapy	Aldridge (1993); Appleton (2001); Boisvert (2003); Jevne (2005); Kennett (2000); Miller and Happell (2006); Perkins

	and Dolbin-MacNab (2008); Spaniol (2005); and Turner and Cox (2004).
Group therapy	Cheavens, Feldman, Scott, et al. (2006); Edey (1999); Nedderman, Underwood, and Hardy (2010); Snyder (2002); Sowards et al. (2006); Stearns (1998); and Vugia (1991).
Health care	Clayton et al. (2008); Herth (1989, 2000); Simpson (2004); Turner and Stokes (2006).

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The scholarship presented in Table 1 illustrates the scope of documented applied hope-focused counselling interventions. The following sections explain each reference listed above and provide examples of academically-supported intervention ideas.

**Positive psychology.** Martin Seligman (2002), a leader in the area of positive psychology, explained that positive psychology is fundamentally about “positive subjective experience: well-being and satisfaction (past); flow, joy, the sensual pleasures, and happiness (present); and constructive cognitions about the future – optimism, hope, and faith” (p. 3). Seligman’s explanation clarifies the strong bond between positive psychology and hope which both focus on drawing attention to personal strengths and exploring possibilities for a better future. Cheavens, Feldman, Woodward, et al. (2006) added “optimal functioning, flourishing and resiliency” (p. 135) to the list of characteristics and processes that are active in this sub-speciality of psychology.

Reflecting on personal and societal strengths, the hallmark of positive psychology is an important tool used by therapists, which not only increases client hope but also

serves to strengthen the therapeutic alliance (Cheavens, Feldman, Woodward, et al., 2006). Encouraging clients to volunteer in their community doing activities that are focused on others not only positively impacts the client but also improves the lives of the people they choose to help. This altruistic type of intervention not only increases confidence and self-esteem but it also fosters hope (Yeasting & Jung, 2010).

According to Bryne et al. (1994), clients are empowered by therapists who communicate their belief in hopeful possibilities. Edey (2000) supported this technique, stating that counsellors are able to lend hope to clients without depleting their own supply by predicting positive outcomes for clients. Supporting this research, Riskind (2006) encouraged counsellors to empower clients by humanizing and normalizing them. Empowerment is achieved by exploring with clients how they are similar to other people, increasing hope by fighting back against ingrained stigmatizing beliefs that they are abnormal or odd.

Interventions from the perspective of positive psychology involve determining a person's natural strengths and encouraging growth in those areas (Cheavens, Feldman, Woodward, et al., 2006). Building upon this argument, Yeasting and Jung (2010) recommended bringing attention to "any improvements or progress the client makes during counselling" (p. 312). This shift in focus helps clients to recognize small achievements and maintain a process focus, enhancing hope that they will ultimately reach their specific desired outcome goal.

One of the most popular interventions used in positive psychology are self-help books that optimize personal functioning and enhance strengths (Bergsma, 2008). In his research on the positive effects of bibliotherapy, Bergsma (2008) analyzed 57 best-selling

psychology self-helps books centred on topics such as emotional literacy, fighting depression, improving communication, and accepting yourself. Bergsma (2008) discovered that self-help books maintain and strengthen hope by encouraging the reader to focus on what is possible and what traits and natural abilities they possess, which can assist readers in reaching their goals. Interestingly, Bergsma (2008) drew attention to the research indicating that self-help books are much more effective when used in conjunction with ongoing talk therapy.

More specifically, in the area of self-help literature related to hope, Jevne and colleagues contributed two self-help books titled *Finding Hope: Ways to See Life in a Brighter Light* (Jevne & Miller, 1999), and *My Hope Journal* (Jevne & Gurnett, 2002) which assist people in developing and strengthening hope through relatively obvious and modest activities.

In brief, positive psychology and hope-focused interventions are a seamless fit. Refocusing clients away from a problem focus and shifting the therapy onto discovering personal strengths, assists clients in beginning to imagine positive possibilities for the future and results in increased hopefulness.

**Narrative therapy.** Narrative therapy focuses on unique outcomes or when things turned out well regardless of the problem. The intention is to create more positive experiences and exceptions in the future. As such, narrative therapy is often used as a strength-based therapy, focusing on what the client did to succeed in overcoming obstacles (Perkins & Dolbin-MacNab, 2008). In the book *Key Elements of Hope-Focused Counselling*, Edey et al. (1998) argued that “hope-focused counselling is a narrative style of therapy” (p. 5). Edey et al. reported that questions asked during hope-

focused narrative therapy are what distinguish this therapy from other narrative approaches. Implicit and explicit hope-focused language skills are used in conjunction with stories. Interventions may include writing or rewriting stories, or perhaps telling or retelling stories or the hearing and sharing of stories. Language-based interventions involve learning, using, and incorporating mindful hope-focused language into therapeutic and casual interactions.

The process of using hope language in practice begins with each therapist becoming aware of his or her own beliefs about hope. McDermott and Snyder (1999) outlined an excellent narrative method for developing an understanding of hope patterns. In this article, the reader is walked through the process of developing his or her own story of hope. In doing so, the reader becomes more aware of his or her own hope language, self-talk, and high-hope messages. Upon completion of this activity, the counsellor is more astute at identifying high-hope and low-hope statements as they listen to the client's stories, ultimately helping the client to begin recognizing these statements for themselves.

Within the therapeutic relationship, Shade (2006) stated that stories are valuable because they can transmit a sense of hopefulness and provide insight into the process of hoping. Stories have additional benefits such as helping people become aware of the complexities involved in hoping, offer opportunities for self-reflection and knowledge, and help people to imaginatively consider possible responses to problems (Shade, 2006). Simply put, hope is transmitted through stories (Harris & Larsen, 2008).

Bowman (1999) described the narrative interventions of "storying" (p. 180) and "restorying" (p. 180). Storying provides clients with an opportunity to hear the inspirational stories of people who rediscovered lost hope. Stories from other people who

had been through similar challenges with a positive outcome, offered current clients hope because they began to see possibilities for a good future (Harris & Larsen, 2008; Sowards et al., 2006). Stories also serve the purpose of planting the seeds of hope when they are shared with others and reinforced (Larsen, 1999). Restorying gives people an opportunity have their own stories of shattered dreams heard, promoting resiliency in the face of losses, and enhancing hope. Wood (2006) supported this approach, reflecting on a personal experience in which she was able to rekindle hope from the process of hearing herself articulate her own story. Taking time to tell your hope story helps people to put all the pieces together and make sense of their difficult life experiences (Jevne & Miller, 1999).

Another narrative intervention involves the retelling of a more positive outcome to a troubling story. This activity may serve to reinforce new behaviour and result in positive actions taken by the person (Larsen, 1999). Engaging in the retelling of stories involves shifting the focus from the problem to the positive exceptions located in the personal narrative of the client. Madigan (2007) highlighted the central role of “bringing forth re-remembered ‘alternative’ selves . . . and tracking alternative actions/thoughts/responses these selves took outside the realm of a specified problem identity” (p. 104). Clients come to recognize that the problem identity is not fixed and it is not located within them, resulting in a hopeful future orientation.

To be effective at exploring alternate selves and envisioning more positive outcomes to painful memories of life events, people often require external support. This activity requires imagination and people often look to support people such as family,

friends, and care-providers for assistance in considering new possibilities of hope (Beste, 2005).

When stories are broken down to their fundamental elements, they are made up of a series of words. Individual words can have a dramatic impact on clients; therefore, therapists have a responsibility to pay careful attention to the words they use and choose them intentionally (Edey & Jevne, 2003). Carefully honed and directed language can be a very powerful, hope-inspiring tool and a “catalyst for change” (Edey et al., 2005, p. 2; see also Edey & Jevne, 2003). In a review of numerous psychological theories, Larsen (1999) highlighted Skinner’s notion that reinforcement has the power to shape individuals’ behaviour and that language has the potential to reinforce others as well as ourselves. Therefore, the way a therapist speaks to a client can have a direct impact on both the client and therapist experiences of hope. Incorporating hope into therapy is as simple as using hopeful language with intention and making it explicit by using it more frequently in speech, making it a conversational leader. Larsen and Stege (2010a) recommended speaking with clients early in therapy about the benefits of talking directly about hope. Larsen and Stege (2010a) suggested that counsellors request permission to speak directly about hope because doing so lays the foundation for the exploration and incorporation of hope language within therapeutic exchanges.

An abundance of applied hope-focused narrative interventions aimed at increasing the frequency of hope talk in therapy are explained by Edey (2000) in *The Language of Hope In Counselling*. Edey encouraged therapists to support hope in client stories by acknowledging the things the client hopes for and predicting that they will happen. Sentence stems such as: “When,” and “I believe...because” (Edey, 2000, pp. 8–9), are

useful implicit hope language for conveying the message of belief in the client's ability to accomplish their desired goals. Additionally, explicit questions incorporating hope language are suggested (Edey, 2000, p. 3) including: "How would you define hope? . . . What would you say about the importance of hope? . . . What things or people in your life tend to diminish your hope?" Edey stated that hope language serves to "draw hope from stories, to support hope in stories and to inject hope into stories" (p. 3).

When discussing the importance of using hopeful language in therapy it is also important to explore the client's perspective and determine what he or she finds helpful. In their study of the discursive use of hope as it arose spontaneously with cancer patients, Elliott and Olver (2007) found that clients support and strongly value the incorporation of hope in healing. From the clients perspective, "presence of hope means life, absence means death" (Elliott & Olver, 2007, p. 141).

In conclusion, the impact of narrative interventions is immense, providing people with the freedom to imagine infinite positive outcomes and reframe negative life experiences. Additionally, narrative interventions give people an opportunity to share their unique experiences of shattered dreams and hopes for the future with others, resulting in a feeling of being heard and understood. Listening to inspirational stories and creating optimistic narratives about the future foster hope and create meaning for clients. The language used by therapists and clients can have a direct impact on hopefulness (Edey, 2000). Becoming aware of our beliefs about hope and learning hope-inspiring techniques can serve to inspire and build hope in those with whom we work.

**Solution-focused therapy.** Similar to narrative therapy, solution-focused therapy is not a problem-focused approach. Instead, it "emphasizes solutions to problems rather

than the problems themselves” (Snyder, 2000, p. 156). According to Corey (2009), solution-focused therapy is unique in that it has little or no interest in gaining an understanding of the problem. Instead of focusing on the past, solution-focused therapists focus on the present and future, and similar to hope therapy, solution-focused therapy also focuses largely on possibilities.

Snyder (2000) linked solution-focused therapy to hope therapy and outlined the process of each, comparing their similarities. The first step in solution-focused therapy involves the client identifying a problem or concern that they would like to change. This is consistent with hope-therapy because it begins with a goal-focused thought. After deciding upon a goal, clients are asked to identify barriers to achieving this goal and they are then helped to generate alternate pathways around the obstacles (Snyder, 2000). This is common practice in hope therapy, as clients are encouraged to generate a large number of possible solutions and outcomes to the presenting problem. Both therapies work to inspire a belief that the client can succeed at overcoming their previously insurmountable obstacles, resulting in increased hope and positive actions toward goal attainment.

**Cognitive behaviour therapy.** Cognitive behavioural approaches are very diverse; however, they do tend to share some core characteristics. Corey (2009) explained that from a cognitive behaviour therapy (CBT) perspective, problems arise because people suffer from cognitive distortions, which negatively effect their behaviour and emotional health. CBT is a collaborative process that focuses on reorganizing negative self-statements resulting in improved emotional functioning and behaviour.

Snyder (1989) argued that hope is fundamentally cognitive in nature and stated that cognitive behaviour therapy is a highly effective method of fostering client hope.

Snyder asserted that the emphasis in CBT is on breaking the ultimate goal down into small workable pieces, which results in increased pathway and agency thinking. Snyder (1989) built the foundation for future hope research by defining it as “goal-directed thinking, in which people appraise their capability to produce workable routes to goals (pathway thinking), along with their potential to initiate and sustain movement via a pathway (agency thinking)” (p. 143). This definition has helped to bring validity to hope interventions by aligning them with CBT, a highly regarded, empirically supported therapeutic intervention style.

Later in his career, Snyder teamed up with Cheavens, Feldman, Woodard, et al. (2006) to closely examine the application of hope in cognitive psychotherapies. Strategies for utilizing hope concepts within therapy were explored within three phases of therapy: assessment, active treatment, and termination. Examples were provided of ways that hope theory can be used in each phase.

During the initial assessment phase, clients often enter therapy feeling hopeless, depressed, and demoralized. Traditional methods of assessment often focus on the presenting problem and ways that the person is suffering. Cheavens, Feldman, Woodward, et al. (2006) explained that hope therapy is different, because it includes a “thorough investigation of strengths and successes” (p. 139). This is an important step toward remoralization and can provide the therapist with information about client resources. Additionally, during early sessions Snyder (2002) encouraged practitioners to assist clients in setting “stretch goals” (p. 253), which are easy enough to achieve but difficult enough to be challenging. This pushes clients to grow and to continue

improving beyond what they previously believed was possible, serving not only to decrease symptomatology but also to increase feelings of satisfaction and hope.

Once the foundation of setting goals has been established, the next step is to begin the difficult work of pursuing those goals. As the client transitions into the active treatment phase, Cheavens, Feldman, Woodward, et al. (2006) reported that from a cognitive behavioural perspective self-talk and automatic thoughts should be monitored and challenged (p. 141). Similarly, hope therapy emphasizes the dramatic effect that self-talk can have on an individual. For example, statements such as, “I am going to get better,” versus “I am getting worse,” result in dramatically different emotional responses and actions toward goals. Riskind (2006) agreed and stated that encouraging clients to frequently use positive words can have dramatic effects on frequency of positive thoughts and hope.

Setting subgoals in pursuit of end goals is another recommended technique for use during the active treatment phase (Cheavens, Feldman, Woodward, et al., 2006). Subgoals are used as building blocks to reinforce ongoing successes throughout therapy and to keep clients working toward their end goals. Interestingly, the use of stretch goals and subgoals has been demonstrated to be effective and frequently used by high-hope individuals (Snyder, 1994).

Hopeful thinking continues to be important in the termination phase, just as it was in the assessment and active phases. Cheavens, Feldman, Woodward, et al. (2006) reported that there are two main objectives during the termination phase, to review gains and to prevent relapse. Reviewing gains involves spending time discussing skills learnt during therapy and improvements the client has made. Preventing relapse is a process of

exploring maintenance techniques for sustaining positive changes made during therapy (Cheavens, Feldman, Woodward, et al., 2006). Preventing relapse also involves imagining obstacles, which are likely to arise in the future and discussing coping mechanisms, which can be used to overcome difficult situations. Both of these activities are consistent with hope therapy. Reviewing gains is similar to exploring positive exceptions. Relapse prevention planning involves imagining numerous alternate possibilities in the future as positive responses to negative life events. These interventions result in increased hopefulness and feelings of self-confidence.

To highlight how cognition plays a role in hope therapy, Edey et al. (2005) drew a connection between hopeful emotions and planning for the future. To make this concept more tangible, Edey et al. encouraged people to imagine a personal life circumstance that gave them hope. The example offered is of a parent who is told by a teacher that their child who has a learning disability will be receiving specialized support, to potentially increase their reading skills. Encouraging people to reflect upon stories similar to this one helps people to be hopeful in the moment and to increase resilience in the future. When hope is threatened in the future, people who have consciously engaged in this exercise will be able to refocus on past hopeful experiences and positive exceptions which will help to protect their hope during difficult life events.

Another intervention proven to increase client hope is cognitive-behavioural, solution-focused life coaching group therapy. Green et al. (2006) conducted a 10-week group therapy experience in which participants chose a specific and measurable goal that was attainable in 10 weeks. Group members worked toward their goal by completing

group and individual assignments. The results indicated that this type of intervention increased client hopefulness through goal-directed behaviour.

In summary, Snyder (1989, 1994, 1995, 2000, 2002) is the leader in producing empirically supported goal-focused hope research built upon the foundation of cognitive behavioural therapy. Snyder (2000) demonstrated repeatedly the ease with which hope-focused techniques could be interwoven into cognitive interventions. By incorporating a hope-focus within CBT, counsellors refocus clients on strengths, past and present successes, and positive self-talk. Clients feel a greater sense of satisfaction, have more productivity in life, maintain the positive changes they make during treatment, and feel more hopeful about their future.

**Existentialism.** Fundamental to existential therapy is the underlying belief that we have the freedom to choose our responses to any situation and the responsibility to be accountable for our actions. Existential therapy addresses human suffering and issues related to life purpose and meaning, freedom and responsibility, spirituality, and mortality. Similarly, the intentional use of hope in therapy has been shown to positively impact these areas and complements existential therapy very well.

Initially, in 1959, Victor Frankl began to see that people believing in positive outcomes for others fostered hope, and he coined this behaviour transcendent hope. A few years later, Lynch (1965) found supporting evidence that offering help to others can enhance the experience of hope, and these findings were once again echoed in Dufault and Martocchio's research in 1985. Holding hope for others and offering help to others assisted the hoper in recapturing lost hope because these behaviours provided people with a sense of meaning and purpose in life. More recently, Harris and Larsen (2008), in

addition to Yeasting and Jung (2010), offered further support that one's hope is fostered through the hope held for others as well as in the context of relationships. Harris and Larsen recommended connecting HIV clients with volunteer organizations and other altruistic social outlets to increase their sense of purpose and meaning.

The most profound link between hope and existentialism is the relationship between hope and meaning (Duggleby & Wright, 2004; Frankl, 1959; Herth, 1989, 2000; Yeasting & Jung, 2010). With the presence of hope comes the possibility that a productive, meaningful life can become realized. Yeasting and Jung (2010) reported that during the process of internalizing hope, the client begins to generate and reflect upon their own personal meaning of life. Counsellors can contribute to this process by assisting clients to look beyond their difficult circumstances and help clients draw meaning from the situation. Bryne et al. (1994) stated that the clinicians' ability to understand what is important to the client and what gives their life meaning are essential in the process of hope enhancement.

Beyond finding meaning and purpose in life, existential therapy also helps people to understand the intricate relationship between accepting responsibility for one's actions and exercising the freedom to choose our responses to any given situation. Stone (1998) argued that to assist clients in applying their freedom of choice, and to instill hope, we must encourage them to take action. An action-orientation shifts their focus from the past into the future, creating hope. Clients experience a sense of control in the freedom to make choices when they are involved as active participants in decision-making processes. Stone (1998) listed specific techniques that help clients to take action and enliven hope including: "(a) searching for exceptions, (b) reframing, (c) focusing on people's

strengths, and (d) creating future goals as a way to move away from preoccupation with the past” (p. 433). Stone argued that these techniques could be particularly helpful in treating the hopelessness associated with depression. Stone explained that depression which he saw as dwelling on negative past events, involves no longer believing in a positive future. In short, hope has been lost.

Existentialism addresses the issue of human suffering and attempts to help enhance meaning in life through activities in which people feel connected and engaged. Herth (1989) found that spiritual faith fostered hope by providing a sense of meaning for suffering that transcended human explanation. Numerous studies have found a significant relationship between affirming spiritual beliefs and empowering hope (Gaskins & Forte; Herth as cited in Yeasting & Jung, 2010, p. 314). Spirituality can represent a variety of activities such as: spending time in nature, meditating, praying, going to church, artistic endeavours, and so on. Another spiritual activity, suggested by Diessner et al. (2006) is to engage people in the exploration of beauty. Diessner et al. found that writing weekly beauty logs and engaging in weekly discussions related to naturalistic, artistic, and moral beauty resulted in a significant rise in hopefulness.

Existential theory argues that as humans we must all face the imminent reality that our lives will end—a fact that can be particularly daunting and anxiety provoking for many people. Instilling hope works to counteract the prevalent fear of death in Western culture. Patients reported that this increase in hope helped them to “fight against their disease and ultimately . . . fight against death” (Elliott & Olver, 2007, p. 142). When treating depression and hopelessness in the elderly population, Fry (1984) found that strengthening spiritual faith was their primary existential concern. Elderly people also

reported a need to “know their own worth, be useful and worthwhile to others, restore their declining energy, and feel that they will be remembered and cherished after death” (Fry, 1984, p. 329).

In conclusion, hope is fostered within the therapeutic relationship simply by addressing existential concerns. Shifting the focus of therapy onto what is within a person’s control, discovering what is meaningful for the client, exploring spirituality, encouraging altruistic activities, and openly discussing mortality all serve to increase hope.

**Expressive arts therapy.** Expressive arts are used as a creative medium, which often results in feelings of safety for clients who participate in activities such as expressive arts, photography, drawing, painting, collages, and poetry. Aldridge (1993) stated that creative arts therapies are a powerful modality for fostering hope because of their focus on personal contact and the value of the client as a creative productive human being.

Palliative care has been an area in which treatment has been limited. Kennett (2000) investigated the effects of incorporating art therapy into treatment for palliative care patients and found that it enriched their lives by increasing “self-esteem, autonomy and social integration” (p. 424). Spaniol’s (2005) research supported these findings, stating that art therapy focuses on the needs and hopes of individuals versus disabilities by collaborating with clients to coconstruct new visions of the future. Aldridge’s (1993) research also supported these findings, indicating that creative arts are beneficial because they encourage clients to focus on quality of life topics such as joy, release, satisfaction, and simply being.

Photography has become a popular art-therapy-based modality for exploring and expressing hope. The Hope Foundation developed a project titled Images of Hope which included hundreds of photographs taken by amateur and professional photographers depicting images that convey hope (Jevne, 2005). Similarly, Turner and Cox (2004) used photography in conjunction with in-depth interviews to prompt revelations about hope. Turner and Cox found that photographs have the power to create passionate discussions about the hopes and dreams of the photographers. Miller and Happell (2006) echoed this finding in their research, stating that photographs provide an invaluable strategy for encouraging discussion of experiences and abstract concepts. Additionally, photographs have been found to encourage storytelling (Miller & Happell, 2006) and create an opportunity for “deeper and more reflective positions about hope to be unveiled than had been previously expressed” (Turner & Cox, 2004, p. 20).

Boisvert (2003) found similar results in her case study of an anorexic women’s experience of hope during her recovery. The participant used photography, journaling, and poetry as creative healing mediums and reported that photography “gave [her] a reason to hope for a more liberating existence” (p. 31). Additionally, poetry written about the photographs helped the participant to gain a deeper appreciation for and understanding of the images (Boisvert, 2003). Poetry has been found to be a powerful medium for exploring and fostering hope because it allows people the flexibility and freedom to express their thoughts and feelings creatively and expressively (Dahlberg, 1994; Rea, 2006). When creative arts are combined the potential for self-reflection and healing increases exponentially.

Perkins and Dolin-MacNab (2008) suggested another form of art therapy to facilitate the exploration of strengths, resources, and skills through the creation of collages. This activity provides opportunities to examine ideas for the future, which fosters a sense of hope. Similarly, Appleton (2001) used numerous art therapy methods (drawing, building creative boxes, etc.) with trauma survivors and found that expressive arts are an excellent method for processing and resolving trauma because trauma is stored in the memory as images. Appleton provided an example of a client who used creative art as a vehicle to explore hope, reveal his inner resources, and create new avenues of hope. The premise behind these activities and many other forms of expressive arts is that the actions involved in the activity will have a greater impact on client than is possible in traditional talk therapy methods.

In brief, expressive arts interventions are a valuable modality for exploring hope through creative projects. The use of mediums such as photography, poetry, and collages create an opportunity for clients to explore their feelings on a deeper level. Expressive arts allow clients to interpret their feelings and experiences in safe, imaginative ways, which promote healing and inspire hope.

**Group therapy.** Irvin Yalom (1995), an expert in group therapy, listed the instillation of hope as the first of 11 primary factors in group therapy. The other 10 factors include: “universality, imparting information, altruism, the corrective recapitulation of the primary family group, development of socializing techniques, imitative behaviour, interpersonal learning, group cohesiveness, catharsis and existential factors” (p. 1). Group therapy offers opportunities for renewal, empowerment, and hope to group members. “Support group theory rests on the humble notion that people with

similar afflictions can imbibe healing and relief through their mutuality” (Vugia, 1991, p. 104). The experience of mutuality experienced during the group experience sends a message of caring and esteem to the individuals involved, resulting in expansion of each client’s support system (Vugia, 1991).

A majority of the existing research on hope-based group therapy has been conducted with clients diagnosed with depression and/or anxiety. An overview of this literature indicated that hope-themed group therapy participation resulted in decreased symptomatology and increased feelings of connectedness to others (Cheavens, Feldman, Scott et al., 2006; Klausner, Snyder, & Cheavens, 2000; Sowards et al., 2006; Stearns, 1998). Interestingly, the available research encompasses many different group therapy themes of psycho-educational, life-skills, laughter, cognitive-behavioural solution focused, and peer modelling.

Participation in group therapy has been shown to increase life purpose and meaning, hopeful thinking and self-esteem and to decrease the severity of psychological symptomatology. Stearns (1998) conducted a 3-month group skills training program in which clients reported increased sense of life purpose and hope in addition to decreased experiences of anxiety and depression. Similarly, depressive symptoms were decreased and activity levels increased in seniors who participated in 10 sessions of hope-based group activities (Klausner et al., 2000). In addition to decreasing symptoms of depression and anxiety, Cheavens, Feldman, Scott, et al. (2006) found that participation in an 8-week group therapy treatment program resulted in increased hopeful thinking, life meaning, and self-esteem. These three studies show strong evidence for the support of

hope-based group therapy interventions demonstrating improvements in mental health concerns, activity levels, and hopefulness.

Sowards et al. (2006) provided evidence that peer modelling within group therapy is an important mechanism for instilling hope and improving engagement in treatment programs. Participants in this study experienced increased motivation and hope by identifying and connecting with a peer who was further along in the process of recovery. Peer support resulted in expanded images of possible alternative futures for themselves. Hope was increased when participants found themselves strongly relating to the stories of other people who had similar experiences and had already begun to experience positive changes. This recognition, according to Sowards et al. (2006), is an important factor in changing pessimistic attitudes and in increasing engagement in the treatment program.

Group therapy is often used in conjunction with an underlying therapeutic orientation. Examples of themes for these groups include a cognitive-behavioural psycho-educational group or an art therapy laughter group. Green et al. (2006) found that participants in a 10-week cognitive-behavioural, solution-focused group program experienced increases in well-being, quality of life, and positive emotions. These results indicated that this type of program may promote increased hope in clients. Nedderman et al. (2010) offered an example of combining group therapy with existentialism and cognitive behavioural therapy when they investigated the impact of hope on female prisoners through involvement in a spirituality based psycho-educational group. Nedderman et al. argued that instilling hope in group therapy is a key therapeutic factor. Edey (1999) combined art therapy with group therapy and highlighted the incredible

healing power of laughter in group therapy for people suffering with depression. Edey's work supported the hypothesis that humour could positively influence hopefulness.

Overall, group therapy has been proven as a hope-facilitating form of therapy. The experiences of mutuality, feelings of connectedness, peer modelling, laughter, skill building, and sharing of stories all contribute to increases in self-esteem and hope.

**Health care.** A majority of the studies have been in health care settings where much has been learned about the helper–client relationship from exploring the client's perspective. When interviewing terminally ill clients, Clayton et al. (2008) found that client hope was fostered from relationships, beliefs and faiths, symptom control, maintaining dignity, finding peace within themselves, maintaining a sense of humour, and reflecting on meaningful events in their lives. More specifically, clients requested that care providers emphasize what can be done including controlling physical symptoms, emotional support, and practical support. Discussing day-to-day living and exploring realistic goals were also mentioned as important ways of nurturing hope (Clayton et al., 2008).

Turner and Stokes (2006) reported that most nursing studies related to strategies and tactics used to promote hope are qualitative studies, based chiefly upon the practice backgrounds of nurses. Herth (1989, 2000) has been leading the way for research-based findings in this area and has conducted research on enhancing hope with cancer patients. Qualitative interviews with nurses reveal common hope-facilitating characteristics of practitioners as: (a) an ability to touch the lives of others, (b) an ability to connect with the inner being of the patient, (c) ability to establish a relationship of trust and journeying with patients, and (d) the way you do things rather than the things you do (Herth, 2000).

Turner and Stokes (2006) built upon these findings, describing hope-facilitating behaviours of practitioners in acute care situations, which included: (a) talking to patients and offering them choices, (b) listening to them, (c) offering them encouragement, and (d) maintaining a positive attitude during patient interactions. These findings paint a vivid picture of personal characteristics and behaviours that promote hope and enhance healing. This information is based upon research with nurses; therefore, hope research could benefit from an investigation of these skills being incorporated into the therapeutic counselling relationship.

### **Conclusion**

“By conceptualizing a framework for practitioners to integrate hope in their practice, the intentional use of hope can be expanded and incorporated into treatment with most clients regardless of the issues they face” (Yeasting & Jung, 2010, p. 315).

The material presented in this chapter illustrates the adaptability of hope-focused counselling. It has been successfully integrated into numerous interventions by counsellors from a wide variety of therapeutic orientations. The underlying message is that hope is easy to incorporate into practice and the benefits are enormous. Research into the effectiveness of hope-focused interventions is still in its infancy, but the existing research provides strong empirical support for its positive influence on client improvement and therapeutic outcomes.

Chapter 4 addresses the process of project development. It explains the various methods used for gathering the information presented in this project. Activities involved in locating resources, including online materials, books, and journal articles, are

discussed and a rationale is provided for why this particular format was chosen for the project.

## **Chapter 4: The Process of Project Development**

*“Courage is a feeling that helps us stay engaged in the hoping process”*

(LeMay et al., 2008, p. 23).

This chapter addresses the process of project development undertaken in developing the manual and workshop found in the Appendix. The overarching themes of the project are listed and primary sources are identified. Methods used for gathering empirically supported research are outlined, including online database searches, buying books online, and visiting libraries.

The research gathered was extensive and examined both counselling and medical hope-related articles. The studies fell into two main categories, the construct of hope and the application of hope. “The Construct of Hope” (Chapter 2) related to the refinement and definition of hope in academic literature, from its inception 50 years ago to our present understanding. A majority of the references related to the construct of hope were from American sources, most notably work by Snyder (Cheavens, Feldman, Woodward et al., 2006; Cheavens et al., 2005; Snyder, 1989, 1994, 1995, 2000, 2002; Snyder, Rand, Kind, Feldman, & Woodward, 2002) and Bruininks and Malle (2005). Snyder’s work added credibility to the construct of hope by demonstrating its similarities to and application within cognitive behaviour therapy, a popular empirically supported treatment method. Bruininks and Malle contributed clarity to the definition of hope, by differentiating it from similar constructs such as optimism and wishing, making hope a more tangible, measureable construct.

Following the explanation of hope as a construct, the “Application of Hope” (Chapter 3) focused largely on research regarding intervention strategies for

incorporating hope within the therapeutic relationship. This research was substantiated by additional data from within the field of medicine, chiefly related to insights gained from nurse–patient relationships. A majority of the articles used to develop the application of hope were of Canadian origin (Dahlberg, 1994; Edey, 1999, 2000; Edey & Jevne, 2003; Edey et al., 1998; Edey et al., 2005; Harris & Larsen, 2008; Jevne, 2000, 2005; Jevne & Gurnett, 2002; Jevne & Larsen, 2003; Jevne & Miller, 1999; Larsen, 1999, 2004; Larsen et al., 2005, 2007; Larsen & Larsen, 2004; Larsen & Stege, 2010a, 2010b; LeMay et al., 2008). The literature review demonstrated a common theme that approaching counselling from a hope-focused orientation results in higher quality client care, better treatment outcomes, and a stronger therapeutic alliance.

The Hope Foundation of Alberta (2010) was used as the primary resource for Canadian literature, particularly related to the application of hope. “An old house on the campus of the University of Alberta is home to the Hope Foundation of Alberta, a unique partnership of the academic and greater community, dedicated to the study and enhancement of hope” (Jevne, 1994, p. 45). The “Hope-Lit Database” (Larsen, 2010, para. 1), which I found as a link on the Hope Foundation of Alberta’s webpage, was rich with international resources; however, some of the articles and materials listed could only be accessed directly at the Hope Foundation’s Library located in Edmonton, Alberta. After exhausting the online material, I drove to The Hope Foundation and met briefly with Rachel Stege, MEd, R. Psych (who works as a researcher and counsellor at the Hope Foundation) and spent one day conducting research at the Hope Foundation Library.

The search parameters for the literature review were published in the English language between 1949 and 2010, with preference given to articles published since 2002.

The initial search was done using the online databases available through the University of Lethbridge Library. Electronic databases accessed were PsychINFO and Academic Search Complete. Search terms included “hope,” “hope counselling,” “hope interventions,” “hope therapy,” “belief,” “false-hope,” and “hopelessness.”

Many fundamental books necessary for an exhaustive literature review on the construct of hope were not available through the University of Lethbridge Library, so I purchased these books online via Amazon.com (2011). No interviews were conducted during the completion of this project, and no research data were collected; therefore, a human subjects application was not required. Throughout the creation of this project, I adhered to American Psychological Association (2010) writing standards and the Canadian Psychological Association’s (2000) *Canadian Code of Ethics for Psychologists*.

The following chapter is a synthesis of this project, highlighting key aspects of the research on hope in addition to outlining the strengths and weaknesses of the project. The chapter ends with recommendations for future research in the area of hope and specifically in hope-focused counselling.

## Chapter 5: Synthesis

*“Hope is not the conviction that something will turn out well, but the certainty that something makes sense, regardless of how it turns out”*

(Havel, as cited in BrainyQuote, 2011, para. 8).

In this chapter, I provide a personal background of how my interest in hope therapy was sparked, moving on to a concise synthesis of the existing research on hope. Following an explanation of the applicability of the project, I provide an overview of its strengths and limitations. Finally, I highlight personal insights about future research considerations, supported by academic literature.

My personal history of the role of hope in healing is relevant as the impetus and motivation behind the development of this applied project because hope changed my life. Hope gave me a reason to get up in the morning and helped me to believe that my life would get better. My hope was severely threatened when I was told at the age of 23 that due to the damage caused by my Lupus I would be on dialysis for the rest of my life. I wanted to give up and stop fighting because I could not imagine my future being attached to a machine, reliant on it to live. Hopelessness resulted in feeling of a total loss of control, purpose, and meaning in my life. I felt isolated, I lost my appetite and my self-esteem plummeted, leaving me feeling as though I had nothing meaningful to contribute to my interpersonal relationships. In my mind, I was now just a burden to my family and society. So how did I regain my hope from this pit of despair? I reached out to my friend, a person I could be completely honest with about my experience of total hopelessness. He helped me to recapture my hope by listening to my story and by challenging me to believe in my ability to heal myself, despite the statistical

improbability of recovery given my circumstances. He fostered my hope that day by expressing his belief in me. For the first time in over a year I felt as though I was not alone and I was not crazy to continue hoping despite poor odds of recovery.

Here's how my friend challenged me to continue to believing in myself. He said to me,

You have two choices. Either you believe in a better future for yourself, which will result in you taking positive actions toward your goals, or you can choose to focus on being "realistic" and believe what the doctors have told you, that your body won't heal itself. (Dr. Cal Botterill, personal communication, July 16, 2003)

My friend continued to challenge me by implicitly communicating his belief in my ability to get better. He asked "Is there a possibility that they don't know you as a person? Is there a possibility that miracles happen or that you have the capability to heal yourself?"

I started to cry and said, "Yes, that's exactly what I want to believe, but how do I embrace that when everyone is telling me that I'm in denial?"

"What feels better to you?" he asked. "Being in denial or being realistic? How do you want to live your life? Do you want to approach success or live paralyzed by fear?"

The answer was obvious. I had nothing to lose. Continuing to believe in a better future for myself despite unlikely odds that my kidney function would improve resulted in a more positive outlook, commitment to treatment, increased energy, better nutrition, and a renewed interest in reconnecting with friends and volunteer activities. Three months after the conversation and six months after starting home dialysis I received a call from my doctor: "I can't explain to you how this happened," he said, "but your kidney

function has improved dramatically . . . to the point that we can take you off dialysis indefinitely” (Dr. Mauro Verrelli, personal communication, October 2, 2003).

“I told you I’d get better,” was all I could say. Never stop believing. No one knows what you are capable of, not even you.

This project was built upon a solid and exhaustive literature review; if it was out there, I probably read it. The scope of research related to hope was wide (including studies from medicine) because specific materials related to hope-focused counselling interventions were limited. The literature review, found in Chapter 2, was a comprehensive review of the construct of hope, taking the reader on a journey through time as our understanding of this construct grew, changed, and developed.

Hope research began in 1959 with Victor Frankl and Karl Menninger bringing attention to its powerful psychological and physiological effects; these researchers concluded that without hope life loses meaning and purpose. We now understand hope to be a multidimensional (Dufault & Martocchio, 1985), future-oriented (Morse & Doberneck, 1995), and dynamic (Hinds, 1984) construct. Bruininks and Malle (2005) contributed greatly to our current understanding of hope by adding that hope is an emotion, which is distinct because it assists people in maintaining resiliency in the face of adversity due to a focus on personally significant, specific, future-oriented goals.

Chapter 2 then moved on to the medical and psychological functions of hope. When combined, the results indicated that hope has very powerful healing properties. Hope functions as a resource and motivator, improving treatment compliance, and assisting clients in sustaining recovery related behaviours (Elliott & Olver, 2007; Good, Good, Schaffer, & Lind, 1990). Cheavens et al. (2005) attested that the presence of hope

results in more beneficial treatment outcomes because it helps people to cope with and adjust to health problems (Cheavens et al., 2005). Arnau et al. (2007) found that hope has been shown to decrease the severity of psychological symptoms (depression and anxiety), improve resiliency, and protect people against setbacks and obstacles. It is an essential element of treatment because it sustains energy and facilitates change (Edey, 2000). Overall, hope is incredibly complex and serves many functions, which make it “crucial for enhancing the quality of our lives” (Snyder, 2002, p. 268).

For both counsellors and clients, hope is fragile and people face numerous threats to their hope, which were thoroughly explored in Chapter 2. Threats can originate from other people, be circumstantial, or can come from within. Clients report commonly experienced threats such as: lack of support, hearing poor statistical odds, personal limitations (mental or physical illnesses), and personal crises and grief (Adams & Partee, 1998; Miller, 1991; Snyder, 2002). Counsellors indicated that their hope for clients could become threatened when they repeatedly heard stories of hopelessness and when they were surrounded by people who were not engaged or invested in therapy (Edey & Jevne, 2003). In short, any experience that results in feelings of hopelessness and despair can threaten hope for both counsellors and clients alike.

I was also mindful of criticisms of the use of hope and dedicated energy to discussing counterarguments. Empirical evidence was presented to support the positive effects of incorporating hope into practice in addition to research, which disproves the existence of false hope (Edey et al., 1998). This was accomplished by clarifying that low hope—previously known as false hope (Snyder, 2002)—can be detrimental, whereas high hope leads to better goal setting (Snyder, 2002), more persistence and resilience (Jevne,

2005; Snyder, 2002), improved therapeutic outcomes, better engagement in treatment (Edey & Jevne, 2003), and stronger therapeutic alliances.

Chapter 3 addressed the applied practice of hope-focused counselling in an effort to educate counsellors about practical methods for incorporating hope-fostering interventions into their clinical practice. An explanation of hope-focused counselling was offered, explaining that it “emphasizes hope and broadens the client’s perspectives when options are limited by hopelessness or diminished hope” (Edey et al., 1998, p. 1). Specific emphasis was placed on the importance of counsellors becoming self-aware of what strengthens and threatens their own hope. Highlights of this chapter were findings that hope-focused counselling is preferred by many clients and counsellors and that counsellors found their ability to work with clients was enhanced when they drew conscious attention to hope (Edey & Jevne, 2003). Additionally, the work of Larsen and Stege (2010a, 2010b) was explored, drawing attention to the importance of incorporating both explicit and implicit hope interventions into therapy. Interventions from a variety of therapeutic orientations were presented, highlighting the diverse options for applying hope into clinical practice.

Overall, the material presented in the literature review of this project highlighted the universality of hope as an intervention tool. The construct of hope was thoroughly defined and criticisms of hope were discussed. Hope-focused therapy was explained and specific therapy tools were explored. This section of the project provided a strong argument for the necessity of hope-focused training for counsellors and provided academic evidence that the intentional use of hope in therapy results in better treatment outcomes.

## **Project Applications**

My graduate studies have taught me the importance of using the academic literature as a guide for my clinical practice. Although literature related to the application of hope-focused counselling techniques is still in its infancy, the available research demonstrates a powerful argument for the incorporation of hope in therapy. Unfortunately, there are currently very few resources or workshops dedicated to improving counsellor knowledge of and confidence with hope-fostering interventions. As a practitioner, I often see clients arrive in therapy with very low hope and a focus on problems. Recent research on hope indicates that introducing hope implicitly and explicitly into therapy serves to shift the focus from the problem onto hopeful possibilities, enhancing client hope, and strengthening the therapeutic relationship (Larsen & Stege, 2010a, 2010b). Participating in a workshop, such as the one attached to this project, assists counsellors in developing the skills to understand their own hope and to begin using hope as a therapeutic tool with clients.

## **Project Strengths**

In this section I list four project strengths. These are: (a) the project meets the need for formalized training in hope; (b) the counselling interventions provided in the manual apply to a wide range of client needs; (c) the workshop delivery is cost-effective; and (d) the project includes an interactive, hope-focused skill workshop.

**The project meets the need for formalized training in hope.** Hope is an important construct for therapists to understand and to implement. Unfortunately, many counsellors lack a clear understanding of the construct of hope and have never been given the opportunity to receive formalized training on how to incorporate hope into their

practice. This project and manual meet this need by providing counsellors from diverse backgrounds with an empirically-based explanation of the construct of hope, followed by a practical workshop for learning hope-enhancing counselling skills. During the workshop participants learn about their own experience of hope, practice hope-focused counselling skills, and learn techniques that are applicable to all therapeutic relationships.

**The counselling interventions apply to a wide range of client needs.** The project offers counselling intervention suggestions for a wide range of clients that require effective support. One of the ways that this project demonstrates inclusiveness is the exploration and integration of cultural differences in the definition and understanding of hope. Unfortunately, research in this area remains sparse; however, the project currently explores cultural differences in hope from both Western and Eastern perspectives (Averill & Sundararajan, 2005) in addition to teaching participants more general, culturally-sensitive, open-ended hope questions (LeMay et al., 2008). An opportunity is available for workshop participants to offer insights about their knowledge of how different cultures experience and understand hope. This strengthens the workshop section, which deals with culture and hope because participant insights will be added to the existing project and workshop, resulting in specific cultural differences being shared and better understood. Additionally, hope-focused counselling skills taught during the workshop could be used with a diverse client population because they are open-ended in nature, using both explicit and implicit hope interventions (Larsen & Stege, 2010a, 2010b).

**The workshop delivery is cost-effective.** In addition to meeting a clinical need, this project offers a workshop that is both inclusive of diverse participants and cost-effective in its delivery. The project draws attention to the existing publications

highlighting hope-based interventions from many different therapeutic orientations and provides readers with ideas about how they can begin to incorporate hope-focused activities into their counselling sessions. The majority of the information presented in the Chapter 3, “The Application of Hope,” is based upon Canadian resources. The delivery of the workshop is inexpensive because the materials required for facilitation are minimal. Additionally, because I will be conducting the workshop under the supervision of an expert in the field of hope counselling, the participants will not incur the cost of bringing in an external hope counselling specialist.

**The project includes an interactive, hope-focused skill workshop.** Finally, within this project, I created a hope-focused skill workshop (see Appendix), which strengthens this project by serving as a practical guide for facilitating a workshop and disseminating the information presented in the project in an interactive, applied manner to counsellors. Counsellors who wish to implement the use of hope into their therapeutic practice may note the following strengths of the workshop. It involves interactive learning activities to ensure participant engagement and enjoyment. The workshop integrates hope therapy with numerous theories and demonstrates creative interventions. Most importantly the workshop offers participants an opportunity for self-reflection and provides them with the necessary tools to begin using hope-focused counselling with clients.

### **Project Limitations**

A review of the research identified hope as an essential part of the change process in counselling (Bryne et al., 1994; Edey & Jevne, 2003; Larsen & Stege, 2010a).

Regrettably, there remains limited available research related to strategies for applying

hope within psychotherapy (Larsen & Stege, 2010a, 2010b). Within medical research, hope-fostering activities and traits of hope-inspiring nurses have been studied extensively (Duggleby & Wright, 2004; Herth, 1989, 2000; Turner & Stokes, 2006). Therefore, to substantiate interventions suggested in this project, hope-fostering techniques used by nurses in the treatment of chronically and terminally ill patients were referenced. This project could have been stronger if more research was available within the field of psychotherapy, specifically related to applied methods of hope-focused counselling.

### **Future Considerations**

There are substantial opportunities for further research in the area of hope-focused counselling, as it has only been gaining popularity within the past 20 years. In 1989, J. F. Miller wrote, “The importance of hope is universally accepted. However, despite its wide acceptance, the domains of hope and how persons maintain hope while confronting adversity are not well-known” (p. 23). Recently, researchers added that there are still many unanswered questions about hope, such as the nature of hope, the value of hope, and how hope is fostered in a variety of demographics (Larsen et al., 2007; Nedderman et al., 2010).

Edey et al. (2005) have tackled the initial inquisition about the domains of hope by outlining the six dimensions of hope, including: affiliative, affective, contextual, cognitive, behavioural, and temporal. This framework provided initial insights for how hope can be incorporated into therapy; however, this area still requires additional attention from the research community.

Larsen and Stege (2010a, 2010b) recently took on the challenge of studying the ways counsellors foster hope through the examination of implicit and explicit hope-

fostering techniques used by hope-focused counselling professionals. Disappointingly, this was some of the first research projects exploring the counsellor's perspective of how hope is inspired in therapeutic relationships. The field of counselling would benefit from more qualitative research looking at hope in therapeutic relationships by exploring clients' perspectives (Larsen et al., 2007), counsellors' experiences of their own hope, and counsellors' perceptions of client hope.

To make hope a valid and reputable intervention this specialization requires additional research involving the incorporation of hope outcome measures to provide empirical evidence of its efficacy. Within the medical field, Cheavens et al. (2005) found that the presence of hope results in more beneficial treatment outcomes; however, within the field of counselling, no such results are available.

Within the field of medicine, Roberts et al. (as cited in Clayton et al., 2008, p. 641) who studied oncologists, surprisingly found that over half of the physicians felt that they lacked the skills to help patients sustain hope. This study would be worthwhile repeating in the counselling field to determine if a need exists for further education in the realm of applied hope enhancing interventions. If similar results are discovered with counsellors, recommendations could arise for improvements in counsellor education programs related to teaching students hope-enhancing interventions.

Based upon an exhaustive review of the existing research on hope, there appears to be no literature available on the construct of belief. I believe that the research on hope could be strengthened by differentiating hope from belief and from studying the ways that belief impacts emotional, psychological, and physiological recovery from illness.

In this chapter I provided an overview of my project, including my personal story of hope, a concise literature review, the strengths and weaknesses of the project, and finally I identified numerous large gaps in the existing hope research. I am certain with the positive results generated by the recent and ongoing research in this area, hope-focused therapy will continue to gain popularity and credibility as a successful intervention in the near future.

The following chapter addresses an overview of the workshop manual, located in the appendix. Chapter 6 walks the reader through the contents and objectives of the workshop manual, followed by an exploration of its strengths and weaknesses.

## Chapter 6: Overview of The Workshop Manual

*“To desire, in short, is to hope”* (Snyder, 2000, p. 25).

In this chapter I explain the motivation behind the creation of this workshop, and I provide details about the overall objectives, structure, and methods of evaluating the workshop. The workshop manual is titled *Hope-Focused Strategies for Counsellors: Workshop and Toolbox*, and it can be found in the appendix, attached to this project.

Over the past decade, hope-focused counselling has grown as an area of clinical practice as the inclusion of hope has demonstrated recurrent positive therapeutic outcomes. The approach has been widely used in the counselling of patients suffering from cancer and other illnesses (Edey & Jevne, 2003; Edey et al., 1998; Jevne, 2000); however, hope-focused counselling has not been widely used by therapists in a more general sense. Unfortunately, there are very few resources that counsellors can turn to for information on the concept of hope and its application, with the exception of materials available through the Hope Foundation of Alberta (2010). When I began to read about hope-focused therapy and the positive implications of incorporating hope into therapeutic interactions (for both counsellors and clients), in addition to the lack of research and education in this area, I began to wonder what I could do to contribute to this particular field of study.

This inspired me to begin creating a workshop with the objectives of disseminating hope research to practitioners while simultaneously teaching the counsellors applied skills to begin incorporating hope-focused techniques into their clinical interactions. I strongly believe that applied educational workshops are of great value for counsellors and it is unfortunate that hope-focused workshops are severely

lacking in availability across Canada. My vision is to personally conduct workshops across the country, educating counsellors about creative ways to incorporate hope into their therapeutic interactions and daily lives.

This hope-focused counselling workshop was designed to be conducted by me, the author of the project, under the supervision of an expert in the field of hope-focused counselling. I intend to use the manual found in the appendix to facilitate the workshop. This manual contains all the necessary teaching materials and participant handouts. Ethics were taken into consideration during the creation of the workshop in the following ways. Participants will be fully informed during their first session about the limits of confidentiality related to group activities involved in the workshop. Additionally, I will ensure that a hope-focused counselling expert supervises the delivery of the workshop until I have been approved as a competent facilitator of hope-focused counselling skills. The target population for this workshop are masters-level students and counsellors from diverse therapeutic orientations who wish to learn skills for incorporating hope into their clinical practice.

The overall structure and organization of the workshop was designed with the intention of providing participants with an interactive learning environment based upon empirical evidence. The activities in the workshop are sequenced in such a way that the participants begin by exploring their own hope, learning about the construct of hope, and eventually progress to learning about hope-focused interventions and practicing using these skills in role-play situations. All activities and handouts presented during the workshop serve the dual purpose of assisting participants in exploring their own

experience of hope while simultaneously providing them with the necessary tools for hope-focused counselling with clients.

The format for the workshop was chosen with the intentions of promoting learning, mentally and physically stimulating participants, and maximizing engagement and enjoyment. The interventions taught in this workshop were all developed based upon research and suggestions available from the leading Canadian hope-focused counsellors (Dahlberg, 1994; Edey, 2000; Edey & Jevne, 2003; Edey et al., 1998; Edey et al., 2005; Harris & Larsen, 2008; Hollis et al., 2005; Jevne & Gurnett, 2002; Jevne & Miller, 1999; Larsen & Larsen, 2004; Larsen & Stege, 2010a, 2010b; LeMay et al., 2008).

The manual begins by introducing the facilitator of the workshop. The manual then goes on to the facilitator's guide to hope-focused counselling. This section includes seven sessions laying out instructional information for the facilitator including: advanced preparation activities, supplies needed, objectives, time allotted for each activity, description of each activity, instructions, and facilitator notes. Additional detailed instructions and answer keys are provided at the end of each session. The sessions are divided into four parts and are labelled: Part One Sections A and B, Part Two Sections A and B, Part Three sections A and B and Part Four.

The morning begins with Part One, which seeks to increase trust within the group, engage participants, provide structuring for the workshop, and begin to explore the construct of hope. Section A, titled "Exploring Your Hope," includes three activities designed to identify participant goals for the workshop, facilitate group engagement, to increase comfort with hope language, and to increase participant self-awareness about hope. Section B, titled "Understanding Hope," includes four activities designed to

demystify the construct of hope, identify common threats to client and counsellor hope, and experience an example of hope-focused creative arts (i.e., a poem).

The workshop then transitions into Part Two, which was designed to improve self-awareness related to hope, explore cultural influences, and begin building a repertoire of hope-focused interventions. Section A, titled “Function and Culture of Hope,” educates participants about the numerous functions of hope through engagement in a team activity, followed by a group discussion about how cultural values impact our understanding of hope. Additionally, Section A includes an applied component of discussing and brainstorming culturally sensitive therapy questions. Section B, titled “Introduction to Hope Tools,” transitions participants into the application of hope-focused counselling tools into clinical practice. The participants begin by discussing the role of hope within counselling and move on to two narrative exercises and one creative arts exercise. Upon the completion of Part Two Section B the participants take a break for lunch.

The afternoon begins with Part Three, which was created with the objectives of re-engaging participants following their break while continuing to learn about hope, hopelessness, and interventions. In Part A, titled “Hope-Focused Interventions,” participants learn about the six dimensions of hope by playing a game of Family Feud. The next part of the session is dedicated to recognizing hopelessness by answering questions about hopelessness following a family therapy role-play, demonstrated by the participants. Participants read a hope poem as a wrap up for this lesson. Part B, titled “Hope as a Therapeutic Orientation,” introduces participants to numerous strategies for applying hope interventions into therapy. Participants engage in small group

brainstorming sessions and generate hope-focused questions for the different stages of counselling sessions. The participants then work as a large group to learn more hope-focused interventions including practicing sentence stems such as: “When,” and “I believe . . . because . . .”

The final session is Part Four, which provides participants with time to practice the skills they have learnt during the workshop, with the intention of increasing participant confidence and skill in the area of hope-focused counselling. Participants are encouraged to take turns playing the role of therapist and client to experience what it is like to discuss hope from different perspectives. Finally, the “Hope Toolbox” is reviewed including the additional materials following the seven lessons.

The workshop manual then transitions into The “Hope Toolbox” designed to provide workshop participants with the tools necessary to participate in the workshop. The “Hope Toolbox” is particularly applied in nature because all materials included are transferrable into clinical practice and can be used to increase self-awareness. The handouts are organized in the same order as the sessions located within the *Facilitators Guide to Hope-Focused Counselling* (see the Appendix). Additionally, at the end of the manual is a section titled “A Few Extra Interventions for Your Hope Toolbox” that contains extra hope tools for participants to use in their clinical practice.

The effectiveness of the workshop in increasing participants’ knowledge and skills in the area of hope-focused counselling will be measured at the beginning and the end of the workshop through self-report pre- and postworkshop questionnaires. At the end of the workshop, participants will also be asked to provide feedback regarding the strengths and weaknesses of the material presented and the format used. The feedback

will be used to measure the effectiveness of the workshop and to improve upon existing activities and interventions.

The outcome of this project was the creation of a workshop that (a) provides academically-supported information to counsellors about the construct of hope and its role within the therapeutic alliance; (b) highlights the implications of incorporating hope into counselling sessions; (c) teaches participants applied hope-focused strategies and interventions; and (d) provides opportunities for engagement (i.e., group activities, debriefing, discussions, etc.) and practice of hope-based skills (i.e., role-plays, partner activities, etc.) within the workshop.

### **Manual Strengths**

This workshop will appeal to a wide audience of counsellors due to its educational, interactive, practical, and engaging format. Regardless of the therapeutic orientation of the counsellors who attend the workshop, the hope-focused counselling skills taught and the individual insights gained will be universally applicable.

In an effort to address to complexity and multidimensional aspects of working with hope a majority of the interventions taught during the workshop were inspired by the leading hope researchers in Canada—Wendy Edey, Ronna Jevne, and Denise Larsen (The Hope Foundation)—who all support the use of narrative interventions as a foundation for hope therapy.

Most importantly this workshop fills a gaping hole in the resources currently available to counsellors across Canada in the area of hope-focused counselling interventions. Well-known researchers and practitioners such as Irvin Yalom (1995) have emphasized the necessity of incorporating hope in counselling for a very long time;

however, hope remains an underutilized skill set among counsellors. One explanation for why hope skills are not typically utilized within therapy is that the use of both implicit (Larsen & Stege, 2010a) and explicit (Larsen & Stege, 2010b) hope language by counsellors requires specialized training. A lack of opportunities for training in this area results in a high demand within the counselling community for workshops in hope-focused counselling. I am predicting that this will result in excellent attendance at the workshops I plan to facilitate, which will be based upon the appendix attached to this project. To spread the word that training will be offered, promotional materials such as advertisements will be e-mailed to universities and to counselling-related associations across the country. Therapists who complete this workshop will feel confident incorporating hope-focused interventions upon the completion of the lessons and will learn how simple and effective the interventions are to integrate into therapy.

### **Manual Limitations**

The activities presented in the workshop are largely interactive and involve group participation, partner work, reading aloud, sharing insights, role-plays, and active involvement. This approach was chosen to create an engaging environment; however, it may not be the preferred method of learning for all participants. Due to the interactive style of this workshop it will appeal to a variety of practitioners, and the skills taught will be especially helpful for therapists with a specialization in narrative, existential, and creative art therapy. Specific interventions for therapists from other therapeutic orientations (Adlerian, Feminist, Family systems, etc.) are not presented because literature related to the application of hope-focused counselling within these specializations is not currently available. The *Facilitators Guide to Hope-Focused*

*Counselling* workshop will become stronger when further research becomes available in these areas and is added to the workshop. As it is, the material can still be helpful for practitioners from all therapeutic orientations, provided they incorporate the fundamental hope skills into their practice.

The material and interventions presented in the manual were purposefully chosen based on current academic literature in this specialized area of therapy. This helps to strengthen the validity and efficacy of the workshop; however, this workshop has not yet been delivered. To ensure that the information and interventions taught during the workshop has been critiqued, an expert within the field of hope-focused counselling, specifically, Dr. Denise Larsen, a leading researcher and practitioner in the field of hope-focused counselling, has reviewed this master's project workshop manual.

Unfortunately, the workshop lacks refinement at this time, which will occur once it has been conducted and feedback has been obtained through postworkshop questionnaires and incorporated into the workshop materials. Pre- and postworkshop questionnaires will be completed by all workshop participants to measure the effectiveness of the material at teaching participants about the construct of hope in addition to applied hope-focused counselling skills. There will also be opportunities for the participants to provide feedback in an open-ended fashion with the intention of receiving suggestions for improvements on the current workshop.

This manual is geared toward therapeutic interventions with adults; therefore, the use of hope-focused counselling with children is not discussed. If participants request specific information related to working with children they will be referred to *Nurturing Hopeful Souls* (LeMay et al., 2008).

In summary, the workshop manual located in the appendix attached to this project provides participants with an interactive, engaging, educational experience, which will help them to better understand their own hope and provide them with the tools to begin incorporating hope into their private and professional lives. This workshop will help counsellors to incorporate hope-focused therapies into their practice and may lead to higher job satisfaction. A proven benefit of using hope-focused techniques in therapy is that clients who are hopeful work harder, are more resilient to setbacks, and follow treatment plans (Elliot & Olver, 2007). Most importantly, by learning the skills to increase their own hope, therapists are likely to increase their quality of life, improve their health, and increase their ability to deal with adversity.

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## Appendix

### Hope-Focused Strategies for Counsellors Workshop and Toolbox



Photo credit: Ashleigh Mutchler, 2008.



## **Introduction**

Hope is a critical factor in healing because it helps people to maintain recovery-enhancing behaviours, and to remain focused on the possibility of a better future, especially during times of great distress. The purpose of this manual is to: (a) educate counsellors about the concept of hope and its critical role in the therapeutic relationship; (b) outline the implications of incorporating a hope-focused approach during counselling sessions; (c) provide applied strategies and interventions to be used as tools for counsellors during therapeutic interactions; and (d) create an educational and engaging workshop intended for counselling professionals.

This manual was created with the intention of being delivered as a workshop, which will be facilitated by me, the author of this project, under the supervision of an expert in the field of hope-focused counselling. This workshop was designed to be delivered to counsellors from diverse therapeutic orientations who wish to learn skills for incorporating hope into their clinical practice.

The Appendix contains two sections. Section one provides detailed outlines of seven one-hour instructional segments intended to be used by the facilitator of the one-day workshop. Section two contains the “Hope Toolbox,” which provides participants with handouts necessary for the workshop, in addition to further hope resource materials. The intention of the “Hope Toolbox” is to provide participants with activities that can be practiced during the workshop and applied in their clinical practice environments.

## Author Biography

The *Hope Focused Strategies for Counsellors* manual was conceived and created by Ashleigh Mutcher to partially fulfill the requirements for the Master's of Education (Counselling Psychology) University of Lethbridge.

Ashleigh will be graduating in 2011 with a Master's of Education (Counselling Psychology). She also holds a Bachelor of Arts with double majors in Kinesiology and Applied Health and Psychology from the University of Winnipeg, 2002. Ashleigh has significant experience working with people from diverse backgrounds and presenting concerns. Her counselling specialties are concurrent disorders (addictions and mental health), crisis counselling and sport psychology. Fostering hope in all interactions, regardless of the situation, is of utmost importance to her.



Photo Credit: Michael J. Steen, 2010

*“There are only two ways to live your life...one is as though nothing is a miracle. The other is as if everything is.”*

Albert Einstein

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**Part One**

**Sections A & B**

102 **Part One, Section A:** 1 hour

Advanced Preparation

- ✓ Purchase and prepare break refreshments and snacks
- ✓ Arrange chairs in a circle
- ✓ Write morning outline on Chart Paper
- ✓ Prepare Jenga Activity by writing questions on blocks with a sharpie
- ✓ Determine location of the bathrooms and nearest exits

Required Supplies	√	Objectives
Statement of Intentions		To increase feelings of trust and safety among workshop members.
		To foster accountability for individual goals.
Overview of Workshop (on Chart Paper) Sharpie Markers		To provide structuring for the workshop.
Wooden Jenga Games (3)		To better understand one's beliefs about hope.
		To provide participants with a tool that they can use to foster hope with clients.
The Power of Language		To better understand how language can threaten or strengthen hope.

103 **Plan for Part One, Section A**

<b>Time</b>	<b>Objective</b>	<b>Activity</b>	<b>Supplies</b>	<b>Instructions</b>	<b>Facilitator's Notes</b>
5 min	Introduce Yourself Review Confidentiality	Introduction		Introduce yourself to the participants. Speak to the group about the limits of confidentiality in the group setting.	Talk about your academic credentials. Tell a personal hope story, and explain to the group why you think hope counselling is important and unique.
15 min	Outline Goals and Expectations	Check-in	Statement of Intentions	Ask participants to open their Hope Toolbox and complete the first handout titled "Statement of Intentions." Once everyone has completed the handout, go around the room, and request that everyone state their name and share one goal for the workshop.	If members have difficulty starting, the facilitator can model by providing one response and then ask the participant to their left to begin and proceed clockwise.
5 min	Review agenda for the day and provide pertinent information	Agenda	Chart Paper	Provide participants with information about bathrooms, breaks, etc. Show the participants the agenda for the day, written on chart paper and also provided in the Hope Toolbox.	See Answer Key titled, "Overview of Workshop."

<b>Time</b>	<b>Objective</b>	<b>Activity</b>	<b>Supplies</b>	<b>Instructions</b>	<b>Facilitator's Notes</b>
25 min	To begin the process of thinking about hope and what it means for individual participants.	Explore Beliefs about Hope	Wooden Jenga Games (x 3)	<p>Players will take turns removing one block from the stack without knocking the tower over.</p> <p>Once a player has removed a block the player must read aloud the question and answer it.</p> <p>Then the player must carefully place the block on the top of the tower without knocking the tower over.</p> <p>If the tower falls down before everyone has a chance to answer a question, the tower is reconstructed and the game begins again.</p> <p>If a player chooses a block with a question he or she has already answered, then block is placed on top of the tower and the player pulls another block.</p>	<p>To Create the Game:</p> <p>Use a sharpie marker to write hope-focused questions onto each Jenga Block.</p> <p>Divide the group into the three smaller groups by numbering off participants from 1 to 3.</p> <p>Give each group a Wooden Jenga Game and a flat, level playing surface.</p> <p>Walk around the room as the groups are playing the game to provide modeling of responses and positive reinforcement for participation.</p> <p>Inform participants that the questions from this activity can be found in the Hope Toolbox on the handout titled, "Exploring Your Hope."</p>

<b>Time</b>	<b>Objective</b>	<b>Activity</b>	<b>Supplies</b>	<b>Instructions</b>	<b>Facilitator's Notes</b>
5 min	To provide participants with an opportunity to gain insights from fellow participants and to reflect on their own experience.	Gaining Insight into Hope Beliefs		Request that the group come back together as a whole and share their reflections.	Ask participants to share reflections about what it was like to engage in this exercise: <ul style="list-style-type: none"> <li>• What was difficult about it?</li> <li>• What was fun about it?</li> <li>• Any other insights or reflections?</li> </ul>
5 min	To distinguish between hope facilitating and hope threatening language.	Self-Reflection Exercise		Request that participants turn to the page titled, "The Power of Language" and complete this form individually.	

**Facilitator Answer Key**

- Overview of Workshop

**Part One (2.25 hours)****Section A**

- Statement of Intent
- Exploring Your Hope (Activity)
- The Power of Language

**Section B**

- True or False: Group movement and debate activity
- Compare and Contrast: Hope, Optimism, Wish
- Threats to Counsellor and Client Hope
- Video – Hope for clients with limitations
- Take Heart: Words That Get Us Through

**Break (15 minutes)****Part Two (1.5 hours)****Section A**

- Functions of Hope – Group Activity
- Culture and Hope

**Section B**

- Introduction to Hope Tools
- Role-Play: The Story of Sarah
- Recognizing Hopelessness: Discussion Questions
- Angel

**Lunch Break (1 hour)****Part Three (1.5 hours)**

- Dufault and Martocchio's (1985) Five Dimensions of Hope
- Hope as a Therapeutic Orientation/Stages of Counselling

**Break (15 minutes)****Part Four (1.25 hours)**

- Activity (Role-Play With Tools)
- Debriefing and Sharing
- Increasing Confidence Using Hope Tools
- Review Activities in Hope Tool Box
- Evaluation

107 **Part One, Section B:** 1 hour and 15 minutes

Advanced Preparation

✓ Connect to the Internet and cue video to ensure it is ready to play

Required Supplies	√	Objectives
Chart Paper & Markers (Compare and Contrast)		To understand the construct of hope.
		To build group cohesion and foster engagement through active participation.
Chart Paper & Markers (Common Threats to Hope)		To increase understanding about threats to hope.
Video <a href="http://www.ted.com/talks/lang/eng/aimee_mullins_the_opportunity_of_adversity.html">http://www.ted.com/talks/lang/eng/aimee_mullins_the_opportunity_of_adversity.html</a>		To sensitize participants about culturally engrained values regarding success, illness, and limitations.
		To increase ability of participants to hold hope for clients who present with limitations.
Take Heart: Words That Get Us Through		To introduce participants to a creative arts intervention.

108 **Plan for Part One, Section B**

Time	Objective	Activity	Supplies	Instructions	Facilitator's Notes
10 min	To dispel myths about hope and educate participants about false hope.	Group movement and debate.	Answer Key	<p>Ask all the participants to stand in the middle of the room.</p> <p>Instruct participants that you will be reading true or false questions related to hope and request that they take a stance on either the left (True) or right (False) side of the room, depending on their answer.</p> <p>For each question, once participants have all decided where they would like to stand, have the participants discuss with their group why they chose the answer they did.</p> <p>Allow approximately 1 minute per question for small group discussion.</p> <p>Ask the groups to choose a different spokesperson for each question and ask the teams to quickly state an argument for why they chose either True or False.</p>	Following each debate, provide the class with the correct answer and an explanation based on the research provided in the answer key below titled "Answer key: True or False?"

<b>Time</b>	<b>Objective</b>	<b>Activity</b>	<b>Supplies</b>	<b>Instructions</b>	<b>Facilitator's Notes</b>
20 min	To clarify characteristics that make hope unique.	Compare and contrast: Hope, optimism, and wish.	Chart Paper and Markers	<p>Break the participants into three groups.</p> <p>Provide each group with a piece of chart paper and some markers.</p> <p>Request that the group designate a person to record the group's answers on chart paper as the group discusses the construct in relation to the questions on the left-hand column of the handout titled "Compare and Contrast."</p> <p>Allow 10 minutes to discuss answers and complete the chart paper in small groups.</p> <p>Request that the group take turns sharing their responses with the larger group and that everyone complete the handout as the group responses are shared.</p>	Clarify and offer corrective feedback for any incorrect answers using the answer key below titled, "Answer Key: Compare and Contrast The Following Constructs."
10 min	Increase participant knowledge about hope threats.	Brainstorm	Chart Paper and Markers	<p>Request that the participants turn to the handout titled "Common Threats to Hope," and record answers on this form as the activity progresses.</p> <p>Brainstorm as a large group and record responses on chart paper so that the group can see all the answers.</p> <p>On a clean piece of chart paper record the participants responses to the question, "As a therapist, what threatens your hope for clients?"</p> <p>On a fresh piece of paper, record the participants' responses to the question, "What are some common threats to hope that clients face?"</p>	<p>Record participant responses on chart paper as the brainstorming session progresses.</p> <p>Use the information in answer key titled "Hope Threats" to guide the discussion.</p>

Time	Objective	Activity	Supplies	Instructions	Facilitator's Notes
20 min	<p>To explore culturally engrained values about success, illness, limitations, and hope.</p> <p>To increase ability of participants to hold hope for clients who present with limitations.</p>	Watch Video	Computer and Internet Access	<p>Watch Aimee Mullin's (2010) <i>The Opportunity of Adversity</i> video (<a href="http://www.ted.com/talks/aimee_mullins_the_opportunity_of_adversity.html">http://www.ted.com/talks/aimee_mullins_the_opportunity_of_adversity.html</a>)</p> <p>Stop the video after 5 minutes.</p>	<p>Use the following questions to guide the debriefing session following this video:</p> <ol style="list-style-type: none"> <li>1) What emotions are people feeling after hearing Aimee speak?</li> <li>2) What culturally instilled values did you become aware of as you listened to her speak?</li> <li>3) How can we redefine success based on the teachings Aimee has given us?</li> <li>4) How can your beliefs about limitations and success influence your ability to be hopeful for a client in a session?</li> </ol>

Time	Objective	Activity	Supplies	Instructions	Facilitator's Notes
5 min	To gain additional clarity on any outstanding concerns.	Questions/ Comments		Allow 5 minutes for participants to gain additional clarity on any outstanding concerns.	
10 min	To introduce participants to a hope-focused expressive arts intervention.  To transition into morning break.	Read Poem as a Group	"Take Heart: Words That Get Us Through" poem	Ask the participants to take turns reading pieces of the poem titled "Take Heart: Words That Get Us Through."  This will serve as a transition into the break.	If participants are reluctant to start, read the first phrase of the poem and then request that one of the participants continue with the next phrase.  Discuss suggestions for creative arts interventions. Discuss the importance of using creative mediums during hope-therapy.
15 min		Break	Snacks/ Beverages	Inform participants of 15-minute break.  Encourage participants to have a snack/drink.	Remind participants of the location of the bathrooms.

**Facilitator Answer Keys**

- True or False?
- Compare and Contrast The Following Constructs
- Hope Threats

<b>Answer Key: True or False?</b>		
<b>Q1</b>	<b>Hope is harmful because it rests on illusions rather than reality.</b>	
<b>A1</b>	<b>False</b>	We need to de-emphasize the relationship between hope and realistic goals (Jevne & Larsen, 2003). Emphasize possibility versus probability and explore numerous options. “Part of what makes hope hope is the awareness that not every hope is realized or that hope comes with the possibility of disappointment” (Simpson, 2004, p. 442).
<b>Q2</b>	<b>Hopeful people pursue unattainable goals.</b>	
<b>A2</b>	<b>False</b>	Extreme, unattainable goals are set by low-hope individuals (Snyder, 2002, p. 266). Difficult, challenging, & invigorating goals are set by high-hope individuals (Snyder, 2002, p. 266).
<b>Q3</b>	<b>Hopeful people use good strategies to achieve their desired goals.</b>	
<b>A3</b>	<b>True</b>	“Even if high-hope people find their hopes dashed, they appear to arise, phoenix-like, again so as to try another strategy for effectively pursuing their goals” (Snyder, 2002, p. 265). In highly stressful situations Snyder (2002) found that: High-hope people found effective routes to their goals. Low-hope people displayed confusion, avoidance, and chose ineffective routes to their goals.
<b>Q4</b>	<b>Having false-hope is dangerous to people’s health and well-being.</b>	
<b>A4</b>	<b>False</b>	When compared to false hope, false despair is more harmful. False despair prevents clients from: (a) seeking solutions, (b) becoming actively involved in treatment regimes, (c) complying with treatment recommendations, and (d) listening to medical advice (Edey & Jevne, 2003). False hope has never been proven. Research indicates a continuum of high hope individuals to low hope

		<p>individuals (Snyder, 2002).</p> <p>People with high hope have been shown to set achievable goals and to believe that they harness the potential to influence outcomes. In contrast, low-hope individuals feel relatively helpless to effect change and assume a hopeless perspective (Jevne, 2005).</p>
<b>Q5</b>	<b>It's more beneficial for the client to focus on possibility than probability.</b>	
<b>A5</b>	<b>True</b>	<p>Weingarten (2007) stated that “more worrisome than false hope is not stepping on the path at all. After all, it is not the arrival but the journey that matters” (p. 21).</p> <p>Hopelessness results when a person is no longer able to imagine creative possibilities for a positive future. Focusing strictly on probability can create these feelings of false-despair (Edey &amp; Jevne, 2003).</p>
<b>Q6</b>	<b>Hope is a complex, multidimensional experience.</b>	
<b>A6</b>	<b>True</b>	<p>Hope is “a multidimensional dynamic life force characterized by a confident yet uncertain expectation of achieving future <i>good</i> which, to the hoping person, is realistically possible and personally significant” (Dufault &amp; Martocchio, 1985, p. 380).</p> <p>Hope includes: (a) anticipation, (b) a positive future orientation, and (c) what is personally meaningful for the hoper (Stephenson, 1991).</p> <p>Flaskas (2007) stated, “To frame hope and hopelessness as (simply) internal emotional states, intimate and powerful as they may be, makes it harder to see the force of the thinking and doing of hope, alongside the feeling of hope” (p. 190).</p>

<b>Q7</b>	<b>Hoping involves only the future.</b>	
<b>A7</b>	<b>False</b>	The past, present, and future are all involved in the experience of hope (Jevne, Nikolaichuk, & Boman, 1999).
<b>Q8</b>	<b>Hope is strengthened in communities.</b>	
<b>A8</b>	<b>True</b>	Support is essential for fostering hope. Isolation has been linked to feelings of hopelessness and depression.
<b>Q9</b>	<b>Hope is a dynamic that comprises a continuum of possibilities in spite of uncertainties.</b>	
<b>A9</b>	<b>True</b>	Jevne et al. (1999) conducted a qualitative study on the dynamic experience of hope.
<b>Q10</b>	<b>Hope is experienced in all kinds of relationships.</b>	
<b>A10</b>	<b>True</b>	Jevne et al. (1999) examined unique individual and group experiences of hope.

<b>Answer Key: Compare and Contrast The Following Constructs</b>			
	<b>Hope</b>	<b>Optimism</b>	<b>Wish</b>
<b>Certainty of Desired Outcome?</b>	Uncertain outcome	Outcome more certain	Vague Outcome
<b>Specific Goals?</b>	Yes	No. General goal	No. General goal
<b>Planning Involved?</b>	Yes	No	No
<b>Outcome Possible or Probable?</b>	Possible	Probable	Possible
<b>Emotion, Trait, Idealistic?</b>	Emotion	Trait/Attitude	Idealistic
<b>Personal Significance</b>	Highly significant	Not as significant	Significance varies
<b>Enduring or Fleeting?</b>	Enduring	Fleeting	Fleeting
<b>Action Oriented?</b>	Creates action	Not action oriented	Not action oriented
<b>Positive Future Orientation?</b>	Yes	Yes	Yes

*Note.* The Answer Key: Compare and Contrast The Following Constructs table was created by A. Mutcher and is based on information from Bruininks and Malle's (2005) work.

**Answer Key: Hope Threats****Questions #1) As a therapist, what threatens your hope for clients?**

The counsellor may find his or her hope is jeopardized by clients who “don’t change, don’t try and won’t take advice” (Edey & Jevne, 2003, p. 46). Maintaining a hope-focused approach to treatment helps to instill and foster hope. Approaching therapy from a problem-focused lens leads to further rumination about the past and the barriers the client is facing.

**Question #2) What are some common threats to hope that clients face?**

**Lack of Control:** When people perceive that they can no longer control the outcome of a situation, hopelessness may result (Yeasting & Jung, 2010). The biggest threat to hope is an inability to affect the kinds of changes people desire in their lives.

**Counsellor Lacks Hope:** The counsellor and client must co-construct a hopeful future (Larsen, Edey, & LeMay, 2007). Hope and hopelessness are both contagious.

**Grief:** There is pressure from society to be in a partnership. Feelings of hopelessness arise during periods of loneliness and isolation, and can be caused by losing a loved one or being single (Snyder, 2002).

**Lack of Support:** Support has been shown to be a critical factor in hope inspiration. It is important to be surrounded by people who believe in you and help you to imagine positive possibilities (Adams & Partee, 1998). Support involves physical presence, sharing success stories, educating clients about their illness, and helping the person learn to live with their illness or loss (Adams & Partee, 1998). A lack of support leads to isolation, tunnel vision, hopelessness, and lack of motivation.

**Suffering and Numerous Failures:** People who have experienced the successful attainment of goals and wishes find it much easier to hope, whereas those who have suffered greatly and experienced numerous failures and defeats may need someone to help them look to the future with hope (Edey & Jevne, 2003).

**Probability:** Other common threats to hope include being told that a good outcome is not likely based on poor statistical odds and low probability of survival, recovery, or success (Harris & Larsen, 2008).

**Limitations:** Living with limitations makes it more difficult to imagine a positive future. External threats to hope are: (a) physical setbacks, (b) seemingly unrelieved pain, (c) uncertainty about successful treatments, (d) abandonment, (e) isolation, and (f) a devaluation of personhood (Miller, 1991).

**Social Threats:** Social threats such as health crises, financial crises, relationship strain, and traumatic events also reduce hope (Miller, 1991).

**Internal Threats:** Internal threats to hope are: (a) social isolation, (b) financial inadequacy, (c) impaired communication, (d) anxiety, (e) depression, (f) hypervigilance, and (g) negative affect (Miller, 1991).

**Part Two**  
**Sections A & B**

**Part Two, Section A: 45 minutes**Advanced Preparation

✔ Create an open space for the Family Feud Game

Required Supplies	√	Objectives
Small Plastic Ball (Family Feud)		To improve group cohesion.
		To engage the participants through movement and critical thinking.
Culture and Hope		To improve cultural competence of participants.
		To provide participants with a culturally sensitive tool that they can use to foster hope with clients.

### Plan for Part Two, Section A

Time	Objective	Activity	Supplies	Instructions	Facilitator's Notes
20 min	<p>To learn the numerous functions and benefits of hope.</p> <p>To educate participants about outcomes they can expect incorporating hope into their practice.</p>	Family Feud Game	Small plastic ball	<p>Ask for an assistant who is willing to write the answers on chart paper as they are guessed correctly by the teams.</p> <p>Split the group in half.</p> <p>Have one member from each team come up to the front.</p> <p>Have a small plastic ball placed on the table between the contestants.</p> <p>Instruct the contestants that you will read a question and the first one to grab the ball and answer the question correctly will get to choose if they want to play or pass.</p> <p>If they choose to play the game, their team will begin guessing the answers and must successfully guess ALL the correct answers before getting 3 wrong answers. If they accomplish this, they win the game. If they get three answers wrong, the opposing team gets a</p>	<p>To begin the game, ask the following question, "Based on Hope literature, name one function of hope." Use the list below as a guide for academic hope findings.</p> <ul style="list-style-type: none"> <li>• Protective</li> <li>• Increases Resiliency</li> <li>• Increases Quality of Life</li> <li>• Increases Motivation</li> <li>• Sustains Energy</li> <li>• Facilitates Change</li> <li>• Creates a Positive-Feedback Loop</li> <li>• Increases Treatment Compliance</li> <li>• Increases Ability to Cope</li> </ul>

Time	Objective	Activity	Supplies	Instructions	Facilitator's Notes
				<p>chance to steal the win. At this point the opposing team huddles together to decide on one final answer and if their answer is correct they win the game.</p> <p>If the player who picks up the ball first chooses to pass, the opposing team must answer all the questions correctly before guessing 3 incorrect responses.</p>	
10 min	To emphasize the differences in hope across cultures.	Brainstorm	Answer Key	<p>Request that participants turn to the handout titled, "Culture and Hope" in the hope toolbox.</p> <p>Work through the sheet as a large group, filling in the answers and guiding responses with the answer key listed below.</p> <p>Request further ideas/information about other cultural beliefs related to hope to increase knowledge in this area, as research is limited.</p>	To facilitate the activity refer to the answer key titled "Culture and Hope."

10 min	To provide time for discussion to generate ideas that might be lacking in the current (limited) research in this area.	Share Insights Record Insights of other participants	Answer Key	Request that each participant generate one culturally sensitive hope-focused question. Go around the room inviting participants to share their questions and record the questions of others that resonate with them.	LeMay, Edey, and Larsen (2008) offered suggestions for culturally sensitive hope questions which can be used to facilitate discussion: <ul style="list-style-type: none"> <li>• “What would I have to know about your family or culture to understand your hope?”</li> <li>• “What would hope or hopelessness look like in your family or culture?”</li> <li>• “Is there any aspect of your family or culture that makes it difficult to hope?”</li> <li>• “What are sources of hope in your family or culture?”</li> <li>• “If there was one symbol that would describe hope or hopelessness in your family or culture what would that symbol be?”</li> <li>• “Can you draw it for me?” (p. 41)</li> </ul>
5 min	To gain clarity on any outstanding questions.	Questions/ Comments		Ask the participants if there are any remaining questions or comments?	

123 **Facilitator Answer Key**

- Hope and Culture

The following table is a summary of information presented by Averill and Sundararajan (2005) regarding the relationship between hope and culture.

<b>Answer Key: Hope and Culture (Answer Key)</b>		
<b>Cultural Orientation</b>	<b>Beliefs About Hope</b>	<b>Implications for Interventions</b>
Western	<ul style="list-style-type: none"> <li>• Hope is an emotion</li> <li>• Emphasis on overcoming obstacles</li> </ul>	<ul style="list-style-type: none"> <li>• Focus               <ul style="list-style-type: none"> <li>○ Optimism</li> <li>○ Problem Solving</li> </ul> </li> </ul>
Eastern	<ul style="list-style-type: none"> <li>• Hope is an enduring personality trait</li> <li>• Focus on Personal characteristics of               <ul style="list-style-type: none"> <li>○ Endurance</li> <li>○ Patience</li> <li>○ Acceptance</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Focus               <ul style="list-style-type: none"> <li>○ Fortitude</li> <li>○ Courage</li> </ul> </li> </ul>

124 **Part Two, Section B:** 45 minutes

Advanced Preparation

- ✓ Connect to the Internet and cue video to ensure it is ready to play
- ✓ Pull out cue cards for role-play so that they are easily accessible

<b>Required Supplies</b>	√	<b>Objectives</b>
Counsellors Introduction to Hope Tools		Increase knowledge about Hope Tools.
Role-Play Cue Cards		To foster engagement through active participation.
		To provide an example of how hopelessness impacts clients, counsellors, friends, and family members.
Recognizing Hopelessness: Discussion Questions		To better understand defining characteristics of hope and hopelessness.
Music of “Angel” (McLachlan, 1997)		Learn an expressive arts hope intervention.

**Plan for Part Two, Section B**

<b>Time</b>	<b>Objective</b>	<b>Activity</b>	<b>Supplies</b>	<b>Instructions</b>	<b>Facilitator's Notes</b>
5 min	To get the participants to start thinking about how hope tools can be used in counselling.	Read Aloud with the Group	Counsellors Introduction to Hope Tools	Have the class read through the handout titled "Counsellors Introduction to Hope Tools" as a group.  Answer questions as they arise and at the end of this part of the workshop.	Instruct the participants to take turns reading.
20 min	To illustrate how hopelessness can impact client and counsellor functioning.  To build group cohesion and foster engagement through active participation.	Role-play a counselling session with Sarah and her family.	Role-play Cue Cards	Ask the group for 4 volunteers to engage in a role-play: "The Story of Sarah."  Give each volunteer one character's role description.  Tell the characters that they will be role-playing a family therapy session.  Characters: <ul style="list-style-type: none"> <li>• Sarah (Client)</li> <li>• Otto (Sarah's unsupportive Father)</li> <li>• Emily (Counsellor)</li> <li>• Kathy (Sarah's supportive friend)</li> </ul>	Before starting this activity be sure that you have photocopied the answer key titled "The Story of Sarah," that outlines the character role-plays.  Also, cut out the individual character roles so that you can hand them out to the volunteers.

Time	Objective	Activity	Supplies	Instructions	Facilitator's Notes
				<p>Instruct the volunteers to read about their roles and get into character.</p> <p>Execute the role-play.</p>	
10 min	To teach participants how to identify hopelessness in clients and within themselves.	Exploration of Hopelessness	Recognizing Hopelessness: Discussion Questions	Request that all participants (volunteers and observers) individually fill in the handout titled, "Recognizing Hopelessness: Discussion Questions."	<p>Read the questions aloud and request participation from the group in answering the questions.</p> <p>Use the answer key located below as a guideline during discussion. The answers are based upon findings by Edey (2000).</p> <p>1) Lack of engagement in therapy/life, incomplete homework, tardiness, suicidal ideations, hopelessness, depression, involvement in risky or harmful behaviours, and</p>

<b>Time</b>	<b>Objective</b>	<b>Activity</b>	<b>Supplies</b>	<b>Instructions</b>	<b>Facilitator's Notes</b>
					<p>lack of responsibility for their actions in general.</p> <p>2) Taking on more responsibility than the client and working harder than the client.</p> <p>3) Lack of belief that interventions will make a difference for the client and a lack of interest in investing energy (i.e., lost cause).</p> <p>All the counsellor's best suggestions and ideas will not be followed through on. Therapeutic goals will not be met. Clients will remain feeling hopeless.</p>

<b>Time</b>	<b>Objective</b>	<b>Activity</b>	<b>Supplies</b>	<b>Instructions</b>	<b>Facilitator's Notes</b>
5 min	To gain clarity on any outstanding questions.	Questions/ Comments		Ask the participants if there are any remaining questions or comments?	
5 min	To introduce participants to another expressive arts intervention idea for hope therapy. Transition into lunch break	Large Group Discussion	Angel Video	Invite participants to discuss ways that music can be used as a hope fostering activity. Request that participants get comfortable, close their eyes and listen to the song "Angel" by Sarah McLachlan (1997). Note: A written copy of Lyrics will not be provided to participants.	This will serve as a transition into the break.

**Facilitator Answer Key**

- The Story of Sarah

**STEP 1: Photocopy these role-plays and cut them and paste them onto cue cards****Volunteer #1****Sarah – Client experiencing hopelessness**

You are a 52-year-old mother and wife who struggles with celiac disease, depression, and poor overall health. Your family is seeking help for you because you recently began expressing a desire to end your life. Due to your digestive problems, you find it difficult to eat meals away from home and have begun isolating yourself from family and friends for this reason. Your hope is **very low** and you are considering suicide because you no longer see a positive future for yourself. You feel very stuck and although people try to cheer you up, nothing seems to help improve your hope.

Some low-hope behaviours you are exhibiting include:

**Lack of engagement in therapy/life**

**Hopelessness**

**Lacking of purpose/meaning in life**

**Incomplete counselling related homework**

**Tardiness**

**Lack of responsibility for actions**

**Involvement in risky or harmful behaviours**

**Depression**

**Suicidal ideations**

*Note. The terms in bold are from *The Language of Hope in Counselling* (p. 1), by W. Edey, 2000, Unpublished paper. Copyright 2000 by W. Edey.*

**Volunteer #2****Otto – Father of Sarah**

You are the father of Sarah, a woman who struggles with celiac disease, depression, and poor overall health. Your family is seeking help for Sarah because she recently began expressing a desire to end her life. For years now, you've watched Sarah suffer and seen her health progressively deteriorate. You are struggling to feel hopeful for her and you've started to believe that a positive future is improbable. Most recently you've begun withdrawing from her because you do not know what to say or how to help. Your hope is also **very low**.

Your behaviours exhibit low hope such as:

**Lack of belief that interventions will make a difference for Sarah**

**Lack of interest in investing energy (lost cause)**

130 *Note. The terms in bold are from The Language of Hope in Counselling (p. 3), by W. Edey, 2000, Unpublished paper. Copyright 2000 by W. Edey.*

### **Volunteer #3**

#### **Emily – Counsellor of Sarah**

You are the counsellor of Sarah, a woman who struggles with celiac disease, depression, and poor overall health. Her family is seeking help for her because she recently began expressing a desire to end her life. Based on Sarah's presenting concerns and her poor prognosis for the future you are struggling to feel hopeful for Sarah and you've started to believe that a positive future is improbable.

Your hope is also **very low**. Your behaviours exhibit low hope such as:

**Lack of belief that interventions will make a difference for Sarah**

**Lack of interest in investing energy (lost cause)**

*Note. The terms in bold are from The Language of Hope in Counselling (p. 3), by W. Edey, 2000, Unpublished paper. Copyright 2000 by W. Edey.*

### **Volunteer #4**

#### **Kathy – Friend of Sarah**

You are a very close friend of Sarah, a woman who struggles with celiac disease, depression, and poor overall health. You are attending a family counselling session because you are an important support person in Sarah's life. Sarah has recently begun expressing a desire to end her life to you, and you are very concerned for her. Although Sarah is facing difficult circumstances and has struggled for a long time you continue to hold hope that her health and quality of life will improve. You refuse to believe the doctors, never giving up on Sarah or her future. Sadly, no matter what you say, it seems Sarah continues to expect poor outcomes for herself. This despair is difficult to deal with, but yet you **continue to hope** for Sarah.

You exhibit numerous high hope behaviours such as:

**A belief that interventions will make a difference for Sarah**

**An investment in therapy and supportive involvement with Sarah**

**Telling stories of other successful people similar to Sarah who beat the odds**

**Telling Sarah that you believe in her and her ability to improve**

*Note. The terms in bold are from The Language of Hope in Counselling (pp. 3–7), by W. Edey, 2000, Unpublished paper. Copyright 2000 by W. Edey.*

## Part Three

**Part Three:** 1 hour and 30 minutesAdvanced Preparation

- ✓ Display hope counselling resources
- ✓ Put out snacks and refreshments
- ✓ Attach Paper title markers to the wall in 3 separate locations
- ✓ Write out afternoon outline on chart paper
- ✓ Pull out ball of yarn and construction paper

<b>Required Supplies</b>	√	<b>Objectives</b>
Ball of Yarn		To improve group cohesion.
		To increase engagement and participation through mentally- and physically-stimulating activity.
Agenda		To provide structuring for the afternoon.
Construction Paper (cut into large pie shapes)		To practice using hope-focused language and generate hope-focused questions related to all 5 domains of hope.
Paper Titles to Organize Stations		To build hope-focused counselling skills.

133 **Plan for Part Three**

<b>Time</b>	<b>Objective</b>	<b>Activity</b>	<b>Supplies</b>	<b>Instructions</b>	<b>Facilitator's Notes</b>
10 min	Check-in Re-engage Participants	Group Hope Story	Ball of Yarn	<p>Ask the group to stand up and form a circle.</p> <p>Put a ball of yarn in the hands of a participant.</p> <p>Explain that the group will be collectively creating an inspirational story of hope. The person with the yarn begins by adding a few words to the sentence stem provided by the facilitator. Then the yarn is tossed to another member and the story is repeated from the beginning with one more piece being added by everyone until everyone has had a chance to add something.</p>	<p>Begin with the sentence stem, "There once was a boy named Bobby..."</p> <p>This activity is complete when everyone has had a chance to add to the story. Have everyone repeat the whole story in unison at the end as a large group.</p>
2 min	Review Afternoon Agenda and provide pertinent information	Agenda	Flip Chart	<p>Inform people that there is a break in the afternoon, lasting 15 minutes and that the workshop will finish at 4:00 pm.</p>	<p>Read over the afternoon agenda.</p>

Time	Objective	Activity	Supplies	Instructions	Facilitator's Notes
35 min	<p>To educate participants about the six dimensions of hope.</p> <p>To illustrate numerous ways that hope can be incorporated into therapy.</p> <p>To build group cohesion and foster engagement through active participation.</p>	Group Hope-Question Generation	<p>Six large, colourful pieces of construction paper cut into large pie shapes.</p> <p>Markers</p> <p>Tape</p>	<p>Number the participants off from 1-5, creating 5 groups.</p> <p>Give each group a large piece of pie shaped, colourful construction paper and some markers. (Allow 5 minutes for the groups to get organized)</p> <p>Assign one dimension of hope to each group (affiliative, affective, temporal, contextual, cognitive, and behavioural).</p> <p>Ask the group to turn the handout titled "Dufault and Martocchio's (1985) Five Dimensions of Hope."</p> <p>The groups will be given 5 minutes to generate 1-2 hope-focused questions related to the dimension on their piece of pie. The pieces will then be passed clockwise at 5-minute intervals until all five groups have written on each piece of pie.</p> <p>A spokesperson from each group will share the responses with the entire group, bringing all the pieces together to form one large pie.</p>	<p>Once the activity is complete, the entire pie will be taped to the wall where it can continue to be viewed.</p> <p><u>The Six Dimensions of Hope</u> (Dufault &amp; Martocchio, 1985):</p> <ul style="list-style-type: none"> <li>• Affiliative</li> <li>• Affective</li> <li>• Temporal</li> <li>• Contextual</li> <li>• Cognitive</li> <li>• Behavioural</li> </ul> <p>Participants can be invited to take a few minutes at the end of exercise to record hope-focused questions from the 5 domains in their pie shaped diagram titled "Dufault and Martocchio's (1985)</p>

<b>Time</b>	<b>Objective</b>	<b>Activity</b>	<b>Supplies</b>	<b>Instructions</b>	<b>Facilitator's Notes</b>
35 min	<p>To provide participants with tools they can use in their sessions with clients.</p> <p>To learn ways hope can be used in the different stages of counselling interventions.</p>	Brainstorm	<p>3 laminated pieces of paper with the words: Stage 1 Stage 2 Stage 3</p> <p>Chart Paper (x 3) Markers</p>	<p>Create three groups of participants by numbering people from 1-3.</p> <p>Request that participants move to their designated station, generating hope-focused intervention ideas at each station.</p> <p>Request that participants turn to the page in their toolbox, which aligns with the stage of counselling they have been assigned to.</p> <p>Request that each group complete a summary of their discussion on chart paper to share with the class.</p> <p>Allow participants approximately 25 minutes to complete their responses.</p> <p>Allow 10 minutes for groups to share their responses with the entire group.</p>	<p>Once the participants have broken into groups, walk around the room to answer questions of individual participants and ensure that everyone understands the activity.</p> <p>Encourage participants to be creative and use their imaginations, incorporating activities, questions, phrases and props.</p> <p>Encourage the participants who are listening to the presentations to record insights that are helpful and meaningful for them.</p>
5 min	To provide a chance to gain additional clarity on any outstanding concerns.	Debrief		Bring the participants all back to the large group to debrief the activity.	<p>Use the following questions as a guide for debriefing questions:</p> <ul style="list-style-type: none"> <li>• Was there a particular question or skill you learnt during this exercise that you could see yourself using in practice? Which one and why?</li> <li>• Did anything surprise you?</li> </ul>

<b>Time</b>	<b>Objective</b>	<b>Activity</b>	<b>Supplies</b>	<b>Instructions</b>	<b>Facilitator's Notes</b>
3 min	To gain clarity on any remaining questions or concerns.	Questions/ Comments		Ask the participants if there are any remaining questions or comments?	
15 min		Break	Refreshments Snacks Hope- Counselling Resources		Encourage participants to look at the hope-focused counselling resources (set-up near the refreshments and snacks).

## **Part Four**

**Part Four:** 1 hour and 15 minutesAdvanced Preparation

None

<b>Required Supplies</b>	√	<b>Objectives</b>
Chairs and quiet spaces		To practice using hope-focused skills.
Hope Toolbox		To ensure participants are familiar with all the tools provided in the workshop.
		To clarify any remaining questions.
Evaluation of the Workshop		To get feedback on the strengths and weaknesses of the workshop so that improvements can be made.
		To gather data related to the effectiveness of the workshop as a hope-focused counselling teaching aide.

**Facilitator Answer Keys**

- Discussion Questions: Stage 1
- Discussion Questions: Stage 2
- Discussion Questions: Stage 3

The information in the answer keys below are based upon material presented by Edey, Larsen, and LeMay (2005, pp. .3-10) and Edey (2000, pp. 1-10).

**Discussion Questions: Stage 1 (Edey et al., 2005, pp. 7-8)****1) What are the benefits of using this approach to exploring the presenting problem?**

Examine the problem in its current state.

Speculate on how the situation might improve.

Envision the situation as the client would like to see it.

Create an opportunity to explore elements, which were previously never discussed.

Create opportunities to view the situation in a new way.

Start the ball rolling early by exploring possibilities of how the situation might be different.

**2) What is your role as the counsellor in this situation?**

Ask questions that link hope to the presenting problem.

Ask questions that link hope with the idea of changing the situation.

**Discussion Questions: Stage 2****1) What do these activities achieve? (Edey et al., 2005, p. 9)**

Bring the experience of hope in the present moment.

Allow people to move freely through time, drawing on past hopeful experiences, and projecting hopeful ideas into the future.

Create cognitive pathways with ideas and situations that trigger hope.

Sensory/object interventions make hope explicit by connecting it to a person, place, or thing and drawing in the five senses.

Thematic interventions draw attention to the tension between possibility and expectation. They bring attention to times when possibility exceeds and expands beyond expectations.

Activity interventions move beyond talking and into action. Hope is made explicit through actions.

**2) Why are symbols (music, pictures, items, songs, etc.) important and successful interventions? (Edey, 2000, p. 5)**

Positive associations are formed when we label symbols as hope facilitating and discuss their significance to the client.

When people are low on hope, it can be VERY powerful for them to recall symbols of hope.

(a) For example, if Uncle Harry is a symbol of hope because he coped with adversity by overcoming illness, he can be introduced into a conversation involving coping with adversity.

**Discussion Questions: Stage 3**

- 1) Participants provide an example
- 2) Participants provide an example
  - (a) According to Edey et al. (2005, p. 9) the intended impact of conveying confidence is to share hope the client that you believe successful adjustment is possible. This serves to improve the therapeutic relationship because the client will begin to see you as a hopeful person.
- 3) The following responses are suggestions offered by Edey (2000, p. 7).
  - (a) What are the worst and best possible outcomes of this situation? (Ask as 2 questions.)
  - (b) What are ALL the possible outcomes?
  - (c) Can you tell me some things we don't know about this situation?
  - (d) Who might have information that could be helpful for us to better understand this situation?

**Plan for Part Four**

<b>Time</b>	<b>Objective</b>	<b>Activity</b>	<b>Supplies</b>	<b>Instructions</b>	<b>Facilitator's Notes</b>
35 min	<p>Practice using hope counselling skills.</p> <p>To experience what it is like to be asked hope-focused questions.</p>	Role-Plays		<p>Ask participants to choose a partner.</p> <p>Engage in partner role-plays using the interventions taught throughout the workshop.</p> <p>Request that participants take turns as the counsellor and the client.</p> <p>Instruct the client to choose a current issue (that is moderately affecting them) to discuss.</p> <p>Instruct the counsellor to use the worksheets as guidelines for practicing hope-focused interventions.</p>	<p>Make your way around the room checking on the groups to ensure people understand the activity, and provide clarification as necessary.</p>
10 min	<p>To share insights and experiences.</p> <p>To gain further insight by hearing the experiences of others.</p>	Large Group Debrief		<p>Come back together as a larger group to discuss the activity.</p>	<p>Facilitate Discussion by asking:</p> <ol style="list-style-type: none"> <li>1) What was it like to use hope language? (Both as the counsellor and the client)</li> <li>2) How did you feel as the client, talking about hope?</li> <li>3) What interventions felt most powerful?</li> </ol>

<b>Time</b>	<b>Objective</b>	<b>Activity</b>	<b>Supplies</b>	<b>Instructions</b>	<b>Facilitator's Notes</b>
10 min	To Learn ways of increasing self-confidence in using hope tools.	Group reading		Ask participants to turn to handout titled "Increasing Confidence Using Hope Language." Take turns reading the information one paragraph at a time.	Following this exercise, allow an opportunity for questions and comments.
10 min	To familiarize participants with additional hope resources. Clarify questions. Provide opportunity to share insights.	Small group discussion.		Ask participants to break into small group and review the contents in the toolbox, discussing their favorite activities and creative ways they intend to use the activities with clients.	Take time to walk around the room and answer any questions regarding interventions taught during the workshop. Take a few minutes at the end to briefly explain additional handouts included at the end of the hope toolbox.
5 min	To gain clarity on any remaining questions or concerns.	Questions/ Comments		Ask the participants if there are any remaining questions or comments?	
5 min	To get feedback on the effectiveness of the workshop. Find out what went well and what areas can be improved.	Complete Post-Workshop Questionnaire		Ask participants to complete the "Evaluation of Workshop" forms and ask to get them back immediately.	Thank everyone for their participation, remind them of your contact information for any follow-up question which arise.

## Hope Toolbox

The following pages are the start of your hope toolbox. Selected materials have been added for you to become familiar with during the workshop. Additional handouts and activities have been included, which you are encouraged to use in your practice. It is strongly recommended that you continue to add to your toolbox as you continue incorporating hope into your counselling sessions.



Photo Credit: Lori Veenstra, 2010

**Handouts for Part One: Sections A and B**

## Overview of Workshop

### Part One (2.25 hours)

#### Section A

- Statement of Intent
- Exploring Your Hope (Activity)
- The Power of Language

#### Section B

- True or False: Group movement and debate activity
- Compare and Contrast: Hope, Optimism, Wish
- Threats to Counsellor and Client Hope
- Video – Hope for Clients with Limitations
- Take Heart: Words That Get Us Through

#### Break (15 minutes)

### Part Two (1.5 hours)

#### Section A

- Functions of Hope – Group Activity
- Culture and Hope

#### Section B

- Introduction to Hope Tools
- Role-Play: The Story of Sarah
- Recognizing Hopelessness: Discussion Questions
- Angel

### Lunch Break (1 hour)

### Part Three (1.5 hours)

- Dufault and Martocchio's (1985) Five Dimensions of Hope
- Hope as a Therapeutic Orientation/Stages of Counselling

#### Break (15 minutes)

### Part Four (1.25 hours)

- Activity (Role-Play With Tools)
- Increasing Confidence Using Hope Language
- Review Activities in Hope Tool Box
- Debriefing and Sharing
- Evaluation

**Part One – Section A**

### Statement of Intentions

Date: \_\_\_\_\_

Welcome to Hope-Focused Strategies for Counsellors! Please take a few moments to answer the following questions related to your goals for the workshop.

On a scale of 1 to 5, reflect on how you feel about the following statements:

1 = None	2 = A little	3 = Some	4 = A lot	5 = Expert
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I would currently rate my hope-focused counselling knowledge as: 1 2 3 4 5

I would currently rate my hope-focused counseling skills as: 1 2 3 4 5

The reason I chose to participate in this workshop is:

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My Top 3 Goals for this workshop are:

1) \_\_\_\_\_

2) \_\_\_\_\_

3) \_\_\_\_\_

### Exploring Your Hope<sup>1,2</sup>

The following questions can be written on Jenga Blocks or just simply asked to clients to initiate a conversation about hope.

- What do you believe about hope?
- What would I need to know about you if I wanted to understand your hope?
- In your opinion, what does a hopeful person look like and sound like?
- What drew you to learn about hope?
- Whose example would you follow if you wanted to behave in a more hopeful manner?
- What questions do you have about hope?
- Who diminishes your hope?
- Please describe a hope mentor. What made this person a good role model?
- Are there other things and people in your life who boost your hope?
- How have you used hope in your own life?
- How have you used hope in your counselling practice?
- What would you say about the importance of hope?
- If a picture on your wall could remind you of hope every morning, what would that picture be?
- What fragrance (colour, sound, song) reminds you of hope?
- Rate your hope on a scale of 0 to 10, with zero meaning no hope and ten meaning a lot of hope.
- Can you tell me about a time in your life when you felt particularly hopeful?
- When you think about your situation? What is it that most threatens your hope?
- What is the smallest possible change that could increase/decrease your hope?
- If I wanted to know a hopeful you, where in your history would I need to look?
- What would a hopeful person do in circumstances like yours?
- Name an activity, event, or person that tends to increase/decrease your hope.
- What might you do to make hope visible at times when you don't see hope?
- If you wanted to increase your hope in the next few days, what could you do?
- Do you have any drawings (writing, pictures, quilts, or other creative items) that would show me more about your hope?
- What changes in your actions would send a message to people that you had become more hopeful?
- What can you do to help yourself remember hope?
- Is there anything we've talked about that increased/decreased your hope?

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<sup>1</sup> From *Nurturing Hopeful Souls: Practices and Activities for Working with Children and Youth*, by L. M. LeMay; W. Edey; and D. Larsen., 2008, Edmonton, AB, Canada: Hope Foundation of Alberta. Copyright 2008 by The Hope Foundation of Alberta. Adapted with permission.

<sup>2</sup> From *Key Elements of Hope-Focused Counselling: The Art of Making Hope Visible*, by W. Edey, R. F. Jevne, and K. Westra, 1998, Edmonton, AB, Canada: Hope Foundation of Alberta. Copyright 1998 by The Hope Foundation of Alberta. Adapted with permission.

- How would you be different if you were more hopeful?

### The Power of Language

In *My Hope Journal*, Jevne and Gurnett (2002) encourage counsellors to examine their own experience of hope by keeping a journal, tracking hopeful experiences through the use of creative arts activities and self-exploration. The activity below is recommended by Jevne and Gurnett (2002, p.32) as a way to become aware of words or phrases that strengthen or weaken hope.

My hope is strengthened with the following words or phrases:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

My hope is weakened with the following words or phrases:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

**Part One – Section B**

<b>True or False? Group Movement and Debate Activity</b>	
1) Hope is harmful because it rests on illusions rather than reality.	T or F
2) Hopeful people pursue unattainable goals.	T or F
3) Hopeful people use good strategies to achieve their desired goals.	T or F
4) Having false-hope is dangerous to health and well-being.	T or F
5) It is more beneficial for the client to focus on possibility than probability.	T or F
6) Hope is a complex, multidimensional experience.	T or F
7) Hope involves only the future.	T or F
8) Hope is strengthened in communities.	T or F
9) Hope is a dynamic that comprises a continuum of possibilities in spite of uncertainties.	T or F
10) Hope is experienced in all kinds of relationships.	T or F

<b>Compare and Contrast</b>			
	<b>Hope</b>	<b>Optimism</b>	<b>Wish</b>
<b>Certainty of Outcome?</b>			
<b>Specific Goals?</b>			
<b>Is Planning Involved?</b>			
<b>Outcome Possible or Probable?</b>			
<b>Emotion, Trait, Idealistic?</b>			
<b>Personal Significance</b>			
<b>Enduring or Fleeting?</b>			
<b>Action Oriented?</b>			
<b>Positive Future Orientation?</b>			

*Note.* The *Compare and Contrast The Following Constructs* table was created by A. Mutcher and is based on information from Bruininks and Malle's (2005) work.



**Take Heart: Words That Get Us Through**

There is a brokenness  
Out of which comes the unbroken,  
A shatteredness out of which blooms  
The unshatterable.  
There is a sorrow,  
Beyond all grief which leads to joy  
And a fragility  
Out of whose depths emerges strength...

There is a cry deeper than all sounds  
Whose serrated edges cut the heart  
as we break open to the place inside  
which is unbreakable and whole,  
while learning to sing. (Rea, 2006, p. 25)

**Handouts for Part Two: Sections A and B**

**Part Two – Section A**

### **Functions of Hope**

Hope is a resource. We hoard it at our peril. The effects of hope are profound, as are the effects of hopelessness. It is a human rights issue. Just as food, water, and security must be equitably distributed, so, too, must hope. Whether we offer or receive, co-create or imagine, we can all participate in doing hope. (Weingarten, 2007, p. 22)

*Please record the numerous functions of hope following the group activity in the space below.*

### Culture and Hope

<b>Cultural Orientation</b>	<b>Beliefs About Hope</b>	<b>Implications for Interventions</b>
<b>Western</b>		
<b>Eastern</b>		

<b>Culturally Sensitive Hope Questions</b>
<ul style="list-style-type: none"> <li data-bbox="297 1297 1101 1329">○ <b>“What would hope look like in your family or culture?”</b></li> </ul>

*Note.* The culturally sensitive hope question listed above is from *Nurturing Hopeful Souls: Practices and Activities for Working with Children and Youth* (p. 41), by L. M. LeMay, W. Edey, and D. Larsen, 2008, Edmonton, AB, Canada: The Hope Foundation of Alberta. Copyright 2008 by The Hope Foundation of Alberta.

**Part Two – Section B**

### Counsellors' Introduction to Hope Tools<sup>3,4</sup>

#### **Start thinking dynamically about hope!**

- Everyone defines hope differently based on his or her personal life experiences.
- In general, hope is defined in terms of what it means to the hoping person.
- **Realism** drastically narrows the field of possibilities while hope expands possibility and nourishes motivation. For this reason it is important to be **hopeful first** and **realistic** second.
- Hoping and setting goals are not synonymous.
- Hoping allows more room to move and provides alternate routes to the desired outcome than does a concrete goal.

#### **What do you need to know if you want to incorporate hope into your counselling?**

- Get to know the hoping self within you (what does it feel like to hope, to have your hopes dashed by others, to know the experience of hope in your life?)

#### **How will this help?**

- You will begin to recognize when hope is absent.
- You will begin to recognize hope cues and foster them in clients.
- You will begin to understand hope from a multidimensional perspective, which will help you to successfully guide therapeutic conversations about hope.

#### **How are hope tools used in counselling?**

To examine a problem	To activate a client's hope	To express/convey hope to client
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#### **Why use hope tools?**

Uncovers hope within the story	Gives emphasis to the client's hope for the future	Allows the client to tell their story freely
Encourages the counsellor to listen	Makes hope visible for the counsellor and the client	Allows for an exchange of hope
Sustains energy and facilitates change		

#### **What are hope tools/interventions?**

Questions	Statements	Your hope	Body language
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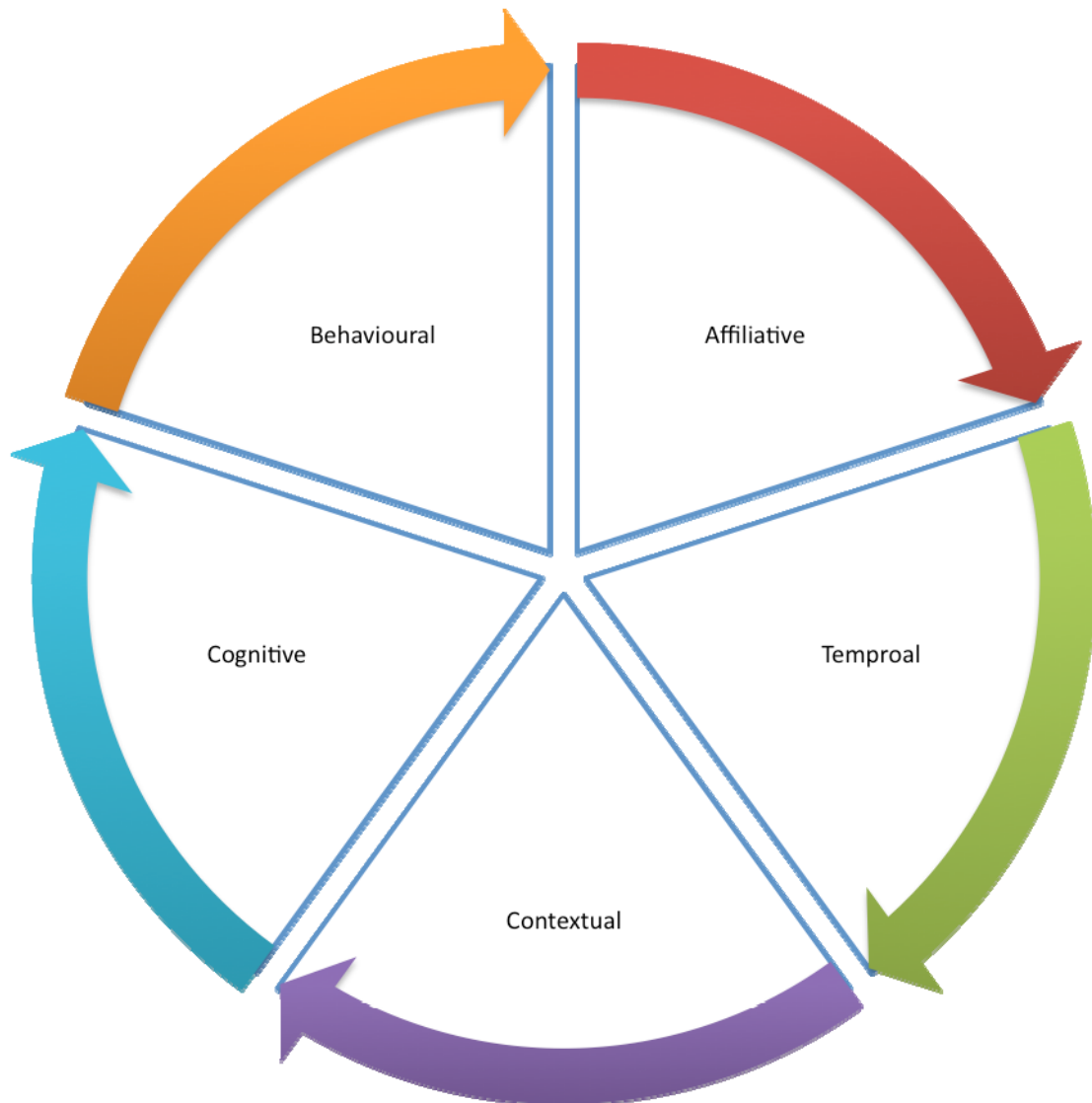
<sup>3</sup> From *The Language of Hope*, by W. Edey, 2000, Unpublished paper. Copyright 2000 by W. Edey. Adapted with permission.

<sup>4</sup> From *The Counsellor's Introduction to Hope Tools*, by W. Edey, D. Larsen, and L. LeMay, 2005, Edmonton, AB, Canada: The Hope Foundation of Alberta. Copyright 2005 by The Hope Foundation of Alberta. Adapted with permission.



## **Handouts for Part Three**

### Dufault and Martocchio's (1985) Five Dimensions of Hope



*Note.* The *Five Dimensions of Hope* figure was created by A. Mutchler and is based on information from Dufault and Martocchio's (1985) work.

## **Hope as a Therapeutic Orientation**

### **Stage 1:**

The first stage of therapy involves the intake process, followed by an examination of the problem. This exercise is designed to get you thinking about how to initiate the counselling process from a hopeful orientation.

Please brainstorm creative ways of incorporating hope in the early stage of treatment. Be creative and use your imagination to generate activities, questions, phrases, and other interventions.

Important areas to consider listed by Edey et al. (2005) include (a) linking hope to the intake process, (b) linking hope to features of the situation, (c) inviting speculation about change, and (d) developing personal hope statements (p.7).

**Discussion Questions: Stage 1**

1) What are the benefits of using this approach to exploring the presenting problem?

2) What is your role as the counsellor in this situation?

## **Hope as a Therapeutic Orientation**

### **Stage 2:**

The second stage of therapy involves activating the experience of hope with the client. This stage involves facilitation of hopeful feeling in your clients.

Please brainstorm creative ways of incorporating hope in the second stage of treatment. Be creative and use your imagination to generate activities, questions, phrases, and other interventions.

Important areas to consider listed by Edey et al. (2005) include: (a) linking hope to the five senses, (b) linking hope to objects, (c) exploring positive exceptions and times when things turned out better than expected (p. 8).



## Hope as a Therapeutic Orientation

### **Stage 3:**

In the third stage of therapy you must count on your hoping self as a resource as you work to instill hope in your clients. But how? For starters, you must step into the role of a hopeful person, communicating your belief that hope is an appropriate emotional response given the situation.

Please brainstorm creative ways of incorporating hope in the final stage of treatment. Be creative and use your imagination to generate activities, questions, phrases, and other interventions.

Important areas to consider listed by Edey et al. (2005) include: (a) conveying possibility, and (b) conveying confidence (p. 9).



## **Handouts for Part Four**

## **Increasing Your Confidence Using Hope Language**

***You have to feel confident using hopeful language before you can believe it, to communicate it.***

Edey et al. (2005) listed several suggestions for increasing your confidence using hopeful language (p. 10):

- 1) Start with nurturing and strengthening your hoping self  
Review the 6 dimensions of hope and decide which area(s) you need to pay attention to strengthening in yourself.
  - a. Try to see possibilities, learn from success and failure, and elevate hope out of silence.
  - b. Complete some of the activating interventions yourself (this will add to the contents of your hope tool box).
    - i. Stories of positive exceptions
    - ii. Things that became possible which seemed impossible
    - iii. Take a walk and then journal about what inspired hope in you within nature.
- 2) Find hopeful statistics and success stories related to your field of interest.
  - a. These stories are often not the central theme of the research and require careful attention to find, so watch closely as you read!
  - b. Look in biographies and autobiographies for stories of people who have overcome adversity.
  - c. These stories give people a reason to hope.

### Evaluation of Workshop

Date: \_\_\_\_\_

On a scale of 1 to 5, reflect on how you feel about the following statements now that the workshop has ended:

1 = No way!	2 = Not Really	3 = Neutral	4 = Kind of	5 = Totally!
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I would recommend this workshop to others.	1	2	3	4	5
I felt respected by others in the group.	1	2	3	4	5
I felt understood by the group facilitator.	1	2	3	4	5
I feel like I met my goals.	1	2	3	4	5
The learning environment was engaging.	1	2	3	4	5
The assignments were meaningful.	1	2	3	4	5
I feel I benefited from participating.	1	2	3	4	5

1 = None	2 = A little	3 = Some	4 = A lot	5 = Expert
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I would currently rate my hope-focused counselling knowledge as: 1 2 3 4 5

I would currently rate my hope-focused counseling skills as: 1 2 3 4 5

One aspect of this program I would change for the future: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What was most useful to me in this workshop was: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Anything else? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_