

FINDING, NURTURING, AND INSTILLING HOPE IN FAMILY THERAPY

by

Joseph D. Tschudy

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Approved:

Thorana S. Nelson, Ph.D.
Major Advisor

Kathleen W. Piercy, Ph.D.
Committee Member

Scot M. Allgood, Ph.D.
Committee Member

Byron Burnham, Ed.D.
Dean of Graduate Studies

UTAH STATE UNIVERSITY
Logan, Utah

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ABSTRACT

Finding, Nurturing, and Engendering Hope in Marriage and Family Therapy

by

Joseph D. Tschudy, Master of Science

Utah State University, 2010

Major Professor: Dr. Thorana S. Nelson
Department: Family, Consumer, and Human Development

The development of a personal theory of therapy and change is an integral part of the training and educational philosophies of the Marriage and Family Therapy Program at Utah State University. This personal theory attempts to identify and explain each student's beliefs regarding the specific mechanisms by which change occurs, thus providing a therapeutic backbone from which one may integrate various interventions, ideas, concepts, and approaches to therapy. As one engages in the process of integration, it becomes critical for students to evaluate their performances. A thorough self-evaluation that includes the utilization of scientific methods leads to the development of important scientist-practitioner skills that may be difficult to obtain through any means. This study was designed to elucidate and investigate a single therapist's utilization and integration of hope theory in an effort to increase his ability to find, nurture, and engender greater hope in family therapy.

Three individuals who presented for therapeutic services at the Utah State University marriage and family therapy clinic participated in the study. Eight therapy

sessions were conducted. Each session was videorecorded and coded with an intervention checklist. The Outcome Questionnaire 45.2, Personal and Family Information Form, case notes, teammate/supervisory observation notes, personal reflection journal, DVD reflection journal, homework assignments, and a hope scaling question were used to assess hope as well as the therapist's decision-making process.

The results of this study suggest that the therapist applied and integrated interventions consistent with hope theory during the course of therapy, which appeared to be beneficial to clients. The decision-making process of the therapist and the effects of the integration and utilization of hope theory upon the therapist were revealed. Other findings, implications, and limitations are discussed.

(116 pages)

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CHAPTER I

INTRODUCTION

Marriage and family therapy (MFT) graduate programs differ greatly according to their philosophies and approaches to training and educating students (Lebow, 2007). Although some programs focus on teaching one therapy model that is clear, theoretically consistent, and easy to master, others enumerate the benefits of teaching integrative approaches (Lebow). Despite numerous benefits, it is feared that a heavy focus on learning the classic models of family therapy may only lead students to attribute therapeutic change to the models themselves (Sprenkle, 2003). The MFT program at Utah State University emphasizes the development of a personal theory of change that serves as the basis for integrating various models of therapy (USU MFT Program, 2009). This approach attempts to match the personal values, beliefs, and worldviews of therapists to the assumptions and theoretical underpinnings of various family therapies (Carlson & Erickson, 1999). This process of discovery encourages students to explore various theories of therapy and integrate them in unique, practical, consistent, and useful ways (Piercy & Sprenkle, 1986).

Educational Benefits of Self-Evaluation

The process of identifying, implementing, and integrating theories that are consistent with one's personal values, beliefs, and worldview not only helps students develop a theoretical backbone, it also helps students acquire important therapeutic skills. A particularly important set of therapeutic skills that may be gained from this process consists of the skills necessary to become an applied scientist. The scientist-practitioner

model (Chwalisz, 2003), a training and educational model, is designed to help therapists develop a pattern of continual learning and improvement. It emphasizes the importance for clinicians to use scientific methods in their practices. This includes utilizing evidence-based techniques and interventions, becoming familiar with and informing clients of current research findings, and evaluating one's own work by conducting practice-based research (Crane, Wampler, Sprenkle, Sandberg, & Hovestadt, 2002).

Evaluating and scrutinizing one's own work requires practice and a specific set of skills. Lebow (2006) noted that many practitioners desire better treatment outcomes but do not know how to evaluate their practices. Because of subjective biases, clinicians may have a tendency to see what they expect or desire to see. These biases may influence perceptions of client progress and the therapist's effectiveness. Obtaining more objective information on one's own effectiveness is also crucial to developing relationships with managed care programs and prospective clients (Lebow). For these reasons, developing consistent methods of gathering information and assessing one's personal effectiveness is important.

Because fundamental assumptions guide a therapist in what to look for and can, therefore, influence what is seen or attended to in therapy, Liddle (1982) persuasively argued that it is critical for family science researchers and practitioners to be able to articulate the personal epistemological positions that underlie their theoretical and therapeutic orientations. Conducting an in-depth study in order to evaluate the utilization of theory can provide valuable information regarding therapy practices as well as the opportunity to acquire valuable skills that are essential for development as a clinician.

Hope

Within the old proverb, “Where there’s life, there’s hope” is the idea that hope is inseparable from life (O’Collins, 1969). In a review of the contextual usage of the word, hope has been identified as part of human development; a process, a theory, and a source of meaning in life (Stephenson, 1991). The concept of hope is simple enough to find use in everyday conversation and complex enough to interest researchers and mental health professionals (Farran, Herth, & Popovich, 1995). In the last three decades there have been three identifiable theories of hope. Stotland (1969) defined hope as “an expectation greater than zero of achieving a goal” (p. 2). Averill, Catlin, and Chon (1990) defined hope as an emotion that possesses cognitive rules. Snyder and colleagues (1991) defined hope as the perceived capability to derive pathways to desired goals, and to motivate oneself via agency thinking to use those pathways. Snyder’s (2002) theory clearly identifies the interactive components of hope, defines a cognitive process, measures hope through a psychometrically sound and valid scale (Snyder et al.), and offers suggestions as to how his theory may be used to benefit others.

Integrating Hope as a Personal Value

The personal values, beliefs, and worldview that I maintain suggest that many clients that present for therapy are seeking more than solutions to their problems. Many clients lack a sense of direction, purpose, or meaning and, in the face of repeated and persistent failure, present to therapy with feelings of hopelessness and helplessness

(Norcross & Goldfried, 2003). Although I ultimately believe that clients are seeking solutions to their problems, it is my personal belief that many clients are also seeking an increase in hope.

Hopelessness is not a diagnosis found in the Diagnostic and Statistical Manual of Mental Disorders IV-TR (American Psychiatric Association, 2000) although it is commonly associated with depression, suicide, anxiety, dysthymia, post traumatic stress disorder, and other diagnoses and complaints (Arnau, Rosen, Finch, Rhudy, & Fortunato, 2007; Beck, Weissman, Lester, & Trexler, 1974; Chang & DeSimone, 2001; Cramer & Dyrkacz, 1998; Irving, 1997; Range & Penton, 1994).

If hopelessness is seen as a symptom of larger, more pressing concerns, it would be logical to conclude that hope would return as the major concerns of the client are resolved. Although this assumption is logical, I believe it persuades clinicians to “get to the root of the problem,” emphasizing the importance of identifying client pathology at the expense of attending to the immediate emotional distress of the client, which may include overlooking the importance of engendering hope. I, therefore, conceptualize hopelessness as a distinct concern that merits attention rather than a symptom of another problem.

Therapeutic Benefits of Hope

Hope has been identified as one of several common factors in therapy (Lambert, 1992) and may be an active ingredient in the change process. It is unclear how hope may enhance the therapeutic process of change, but researchers have suggested that it may assist in strengthening the therapeutic alliance or deepening a client’s commitment to and

participation in therapy (Frank, 1973; Stotland, 1969; Ward, 2006). According to the transtheoretical model of change (Prochaska, DiClemente, & Norcross, 1992), engendering hope may assist a client to progress from a stage of change known as contemplation to another stage called action. Interestingly, Prochaska and colleagues discovered that clients who progressed into action stages early in therapy experienced more successful treatment outcomes. Although the specific methods by which hope enhances the therapeutic process of change are uncertain and more research is needed, hope appears to be a promising construct of therapeutic value.

Conceptualizing hopelessness as a concern that merits special and perhaps primary attention is not uncommon in therapy (McLaughlin, Miller, & Warwick, 1996). Consistent with positive psychological approaches that focus on strengths and virtues (Seligman, Steen, Park, & Peterson, 2005; Snyder & Lopez, 2003), Frank (1973) asserted that the instillation of hope constitutes a primary intent of all psychotherapies. Therapists frequently tap into hope when assisting someone to overcome thoughts of suicide (Fiske, 2008). Research on positive emotions, including hope, suggests that experiencing positive emotions, even briefly, predicts recovery and is associated with the ability to learn new skills, behaviors, and ways of thinking (Fredrickson & Joiner, 2002). Wingate and colleagues (2006) noted that

patients' positive emotional states should render them more open to considering, learning, practicing, and implementing the skills presented in therapy, thus maximizing the likelihood of the patients' acquiring these skills and obtaining benefits from treatment. (p. 270)

These findings suggest that attending to hope in therapy is a practice that may enhance treatment outcomes.

Conclusion

Attending to the immediate emotional distress of the client by assessing and nurturing hope is important to me and constitutes a personal value. The selection and integration of a theory that remains congruent with this personal value is consistent with accepted training philosophies of the Marriage and Family Therapy Program at Utah State University. An in-depth investigation of the utility and integration of this theory promotes the acquisition of valuable scientist-practitioner skills, and is potentially useful in promoting therapeutic change (Wingate et al., 2006).

Hope theory as proposed by Snyder (2002) is congruent with my personal values and beliefs and was selected for investigation in this study. This conceptualization of hope is a multidimensional construct consisting of goals, pathways, and agency, and provided the organizing framework for the current study. In an effort to utilize and integrate Snyder's conceptualization of how one may assess and increase hope in therapy, a small case study design was used, which allowed me to select and integrate interventions early in therapy that are consistent with my theory of therapy and change. The process of utilizing and integrating this theory was carefully observed and recorded and constitutes the primary focus of this study.

CHAPTER II REVIEW OF LITERATURE

In this chapter, the concept of hope is reviewed historically, identified as a possible common factor or change mechanism in therapy, specifically defined, and then contrasted with similar concepts. Hope theory (Snyder, 2002) is then explored further and details of its usefulness in therapy are described. A systematic examination of the decision process involved in applying hope-engendering interventions was used for the investigation.

Origins of Hope

The concept of hope dates back to ancient times. According to Greek mythology, hope was considered to be as dangerous as all of the world's evils because it prolonged man's torment. When Pandora opened her box, she released all of the evils without allowing the creature hope to escape. Without hope to accompany all of their troubles, humanity was filled with despair. Pandora eventually revisited her box, and to the great relief of all, released hope as well (Athanasakis, 1983).

Although the Greeks included the concept of hope in their mythology, the origin of hope is unknown. What is clear is that hope has been a topic of interest and discussion among psychologists, philosophers, spiritual leaders, and many others for centuries (Snyder, 2000). The study of hope by social scientists has received no less attention today. Over 26 distinct theories or definitions of hope have been identified by researchers (Lopez, Snyder, & Teramoto-Pedrotti, 2003).

In psychological literature, a few of the earliest studies on hope were published in 1959 (Menninger) and 1968 (Frank) as researchers more closely analyzed the influence

of hope on initiating therapeutic change. Other studies followed that indicated a lack of hope or hopelessness was a significant risk factor in developing many psychological disorders and symptoms including depression (Beck, 1963), suicidal ideation (Magaletta & Oliver, 1999), alcoholism (Smart, 1968), and even physical illness (Schmale, 1958).

More recently, it has been proposed that hope may be one of several common factors responsible for client change in therapy (Snyder, Michael, & Cheavens, 1999). Researchers have hypothesized that the efficacy of various models of psychotherapy are more or less equal due to common factors or change mechanisms that are present across models (Asay & Lambert, 1999). Lambert (1992) was one of the first to propose a four factor model of change that included common elements from various theories. Miller, Duncan, and Hubble (1997) proposed a modified version of this model with four general categories of common factors. These factors are client/extratherapeutic factors; relationship factors; technique/model factors; and expectancy, placebo, and hope factors.

Hope as a Common Factor in Psychotherapy Change

Through extensive reviews of numerous empirical outcome studies, Lambert (1992) suggested that the common factor of expectancy, placebo, and hope accounts for nearly 15% of the improvement or change that takes place during the process of therapy. Hubble, Duncan, and Miller (1999) described this common factor as the amount of improvement that comes from a client's knowledge or belief that therapy is rational and that treatment is being provided by someone who is credible. This expectancy presupposes that both the client and therapist believe there is a curative dynamic

associated with the procedures and rituals of therapy. Non-specific to the particular methods being employed, there are positive and hopeful expectations that accompany structured treatment procedures (Hubble et al.).

The effects of expectancy, placebo, or hope may be the most influential common factor before treatment has begun and during the early stages of therapy. Upon investigating pretreatment change, researchers have theorized that the simple act of seeking therapy may lead clients to act differently and make small changes even before coming to therapy (Weiner-Davis, de Shazer, & Gingerich, 1987). In a study of 854 psychotherapy outpatients, Kopta, Howard, Lowry, and Beutler (1994) found that 5%-10% of clients improved even before the first session. These studies suggest that change occurring during this time cannot be attributed to relationship factors or technique/model factors.

Apart from pretreatment change, research has consistently found that a significant amount of improvement occurs during the first three weeks of therapy (Howard, Lueger, Maling, & Martinovich, 1993). Hubble and colleagues (1999) reasoned that this improvement generally occurs before the client or therapist is able to identify the active change mechanism or attribute the improvement to any particular diagnosis or intervention. Fennell and Teasdale (1987) as well as Ilardi and Craighead (1994) noted that among their clients receiving cognitive behavioral therapy, those that experienced an initial rapid response to treatment experienced more improvement in subsequent stages of therapy and final outcome. Because this initial improvement can be observed across a range of therapeutic approaches, many of which have diverse rationales for effecting

change, it is reasonable to suggest that this phenomenon may be attributed to a common factor that is present during the early stages of therapy such as a client's level of hope.

Hope as an Emotion

Although hope currently occupies a place in the common factors research (Hubble et al., 1999; Snyder et al., 1999), the concept of hope also finds a place in everyday conversation. This familiar word, as we generally use it, refers to a very common feeling or emotion. One theory that conceptualizes hope as an emotional construct was proposed by Averill et al. (1990). This theory maintains that hope is an emotional construct, but can only be understood within the context of culture and society because, unlike other emotional states, it is difficult to identify specific affective or behavioral components.

Through working with animals in a stimulus-response paradigm, Mowrer (1960) viewed hope with a behavioral lens and theorized that hope was an emotion that served as a secondary form of reinforcement when a goal was soon to be reached. Mowrer noted that this emotion only appeared with the onset of a stimulus that was associated with something pleasurable. Although many of us refer to hope as a feeling or an emotion, theories that maintain hope as an affective condition (Averill et al., 1990; Mowrer) are far less common than theories that conceptualize hope as a cognitive process.

Hope Defined as a Cognitive Process

Most theories regarding hope maintain that it has a cognitive basis. Among the many theorists who conceptualize hope this way is Snyder, who has developed what is known as hope theory (Snyder et al., 1991). In the early 1980s, Snyder was conducting experiments on how people make excuses when they make a mistake or perform poorly (Snyder, Higgins, & Stucky, 1983). During these experiments, Snyder often noted the comments that participants made regarding other motives they wanted to fulfill. These early interchanges led Snyder (1989) to describe hope as the “other side” of “excusing.” Upon researching the motivational literature of the 1960s and 1970s, Snyder discerned a shared theme regarding the desire to seek goals (Cantril, 1964; Farber, 1968; Frank, 1975; Stotland, 1969). After discerning this theme, Snyder conducted numerous interviews with students regarding the course of their days, from which he discovered that goals almost always emerged either implicitly or explicitly. Upon identifying goals, he also noted that people often process ways to find or develop routes to their goals and generally make it a point to talk about their motivations to use those pathways.

During this time, Snyder was heavily influenced by Craig’s (1943) classic work, *The Nature of Explanation*, where he convincingly argued that the purpose of the brain is to comprehend and anticipate causal sequences. This persuaded Snyder to consider the importance of pathways thinking in pursuing goals. As Snyder became more interested in his own hypothesis regarding hope, he met with Karl Menninger and read “The Academic Lecture on Hope,” a paper presented and later published by Menninger (1959) as president of the American Psychiatric Association. This encouraged Snyder to place thinking rather than emotions at the core of hope. Before formalizing a definition, Snyder

was left to decide whether hope was situation specific, trait-like, or some combination of the two. Based on his interviewing experience, he concluded that it was clear that hope was something more than the thoughts surrounding a specific goal. Superseding their thoughts regarding a specific goal, people appeared to have enduring, self-referential thoughts or self-appraisals about their general capabilities regarding producing routes to goals and their abilities to find the requisite motivation to utilize those routes. These experiences led Snyder (2002) to develop his theory regarding hope.

Snyder (2002) defined hope as “a positive motivational state that is based on an interactively derived sense of successful agency (goal-directed energy), and pathways (planning to meet goals)” (p. 287). *Goals* pertain to an individual’s ability to formulate specific desirable outcomes. *Pathways* refer to an individual’s ability to envision plausible routes or methods that could be employed in order to obtain the desired goals. *Agency* consists of one’s perceived capacity or competence in utilizing one’s pathways to reach goals. In other words, hope is a perceived capability to derive pathways to desired goals and motivate oneself by way of agency thinking to utilize those pathways. It is an interaction of significant goals, willpower, and waypower. Not only does Snyder maintain that cognitions provide the underlying basis of hope, but unique to his theory is a multidimensional description of hope, suggesting an interaction of three components.

Snyder’s Theory of Hope

Goals

Goals are an important element of hope theory (Snyder et al., 1991). The general belief or assumption that much of human behavior is goal directed provides an understanding of just how important goals are. Goals can be visual images, verbal descriptions, or mental representations. Goals may also vary greatly according to place and time. Hope theory specifies two general types of goals: approach goals, which reflect the desire for something positive, and avoidance goals, which reflect the forestalling of something negative (Snyder, 2002). Although goals come in many varieties, hope theory suggests that the best goals are specific and of sufficient value to produce sustained thought about them.

Pathways Thinking

As soon as a goal is envisioned, the human mind begins generating possible means or methods by which the goal may be obtained. The cognitive process that produces these thoughts is referred to as *pathways thinking* (Snyder, 2002). Hope theory suggests that we typically think of how we can connect our present to our imagined futures. An individual with high hope possesses the ability to generate many possible and plausible routes, while an individual with low hope is likely to produce few or no alternate routes. According to hope theory, an increase in pathways thinking often leads to an increase in agency thinking, which could result in an increase in hope.

Agency Thinking

Agency thinking is the final ingredient to hope theory and is sometimes called the motivational component. It refers to an individual's perceived ability to utilize a personal collection of pathways in order to obtain desired goals (Snyder, 2002). This thinking provides the energy with which one begins and continues upon a specific path. Agency thoughts sometimes take the form of motivating self-talk or statements such as, "I can do this." According to hope theory, an increase in agency thinking often leads to an increase in pathways thinking, which could result in an increase in hope.

Although pathways and agency thinking are two distinct components of the hope theory (Snyder et al., 1991), they are functionally inseparable. Snyder and colleagues theorized that these two components influence one another reciprocally so that a change in one causes a change in the other. For example, if an individual possesses a high degree of agency thinking but cannot develop pathways, his or her agency thoughts will soon deteriorate. Similarly, if a person has generated numerous possible pathways to a goal but lacks the motivating agency thinking, he or she is likely to begin rejecting many of the pathways, believing that they are not achievable.

Hope Compared to Optimism and Self-Efficacy

Although there is agreement among most researchers regarding the cognitive basis of hope, there is disagreement concerning the specific underlying processes. Hope theory, as proposed by Snyder et al. (1991), represents only one of these conceptions. Other theories that describe the underlying cognitive processes of hope involve expectancies or beliefs that a certain outcome will occur (Boone, Roessler, & Cooper,

1978). These theories, prevalent in the schools of motivation (Stotland, 1969) and social learning (Bandura, 1977), have resulted in constructs that are similar to hope such as self-efficacy and optimism. According to Snyder's (2002) definition, hope differs from these concepts and can be better understood by examining these differences.

Optimism

Scheier and Carver (1987) referred to optimism as “generalized expectations that good things will happen” (p. 171). The specific rationale for these expectations, however, is undefined. This means that a person may have optimism independent of belief in her or his abilities, perhaps because she or he believes in luck or divine blessings from God (Snyder, 1995). Further, because optimists believe that good things will eventually happen, it is reasonable to suggest that the ability to generate the means or various pathways that would enable people to actively obtain their goals could be missing entirely.

Seligman's (1991) theory of learned optimism grew out of his theory of learned helplessness, the focus of which is an attribution or explanatory style characteristic of individuals during bad or negative events. According to Seligman, people with optimism conceptualize bad events in a manner that enables them to externalize them and restrict their influence. Optimism in this sense may be thought of as an attribution strategy that allows people to separate themselves from negative outcomes. Hope theory (Snyder, 2002) differs from this concept of optimism by primarily focusing on an individual's connection to positive goals rather than negative events. Although hope differs from

Scheier and Carver's (1987) and Seligman's concepts of optimism, it is similar in that it describes a cognitive process guided by expectancies.

Self-Efficacy

Perhaps the most well-known theory of self-efficacy is that of Albert Bandura (1977). In his theory, Bandura made an important distinction between outcome expectancies and efficacy expectancies. Efficacy expectancies refer to an individual's belief that he or she can competently perform a particular behavior. Outcome expectancies refer to an individual's belief that a particular action or behavior will result in a desired outcome. The pathways component of hope theory (Snyder, 2002) differs significantly from this idea because it refers to an individual's belief that he or she is capable of generating numerous pathways rather than having confidence in one particular path (Snyder, 1995). According to Snyder (2002), it is a personal belief in one's ability to design ways to "try, try again," believing that one will eventually create or discover a successful method. Bandura's efficacy expectancies are very similar to Snyder's concept of agency thinking. The main difference is that according to Snyder, agency thinking is a global self-appraisal and not related to any particular behavior.

Although hope may be similar to constructs of optimism and self-efficacy, there are significant differences sufficient to set it apart. In a study predicting general well-being, a multiple regression analysis revealed that Snyder's (1995) hope construct predicted a significant amount of unique variance independent of self-efficacy and optimism (Magaletta & Oliver, 1999). These findings have begun to suggest that although these constructs are related, they are not the same.

Engendering Hope

Engendering Hope Through Goals, Agency, and Pathways

Once the concept of hope is clearly understood and defined, it becomes easier to understand how a theory of hope can be utilized in therapy. The concept of hope as proposed by Snyder (2002) consists of goals, pathways, and agency. Helping to engender hope in clients can occur through various interventions that draw upon or emphasize establishing and clarifying goals, stimulating and providing new pathways thinking, and recognizing/reinforcing a client's use of his or her agency (Snyder, 1995).

Utilizing Goals to Engender Hope

It is not uncommon for clients to report their goals in very vague terms such as, "I want to be happier" or, "I want to do my best." Goals such as these are not useful because they are so general and vague that they provide no indication of where to start or how to measure progress. Without the ability to measure progress, these goals provide very little in terms of motivation. Similar to solution-focused therapy (de Shazer, 1985; Miller, Hubble, & Duncan, 1996), hope theory (Snyder, 2002) is a goal-oriented approach. Constructing a vision of the future where the complaint is no longer an issue helps the client to identify what constitutes a well-defined, positive, meaningful future (Michael, Taylor, & Cheavens, 2000).

The goal element of hope theory suggests that it is essential to help clients establish concrete, measureable, and obtainable goals. Approach goals that reflect the presence of something positive rather than avoidance goals that reflect the forestalling of

something negative are preferable (Snyder, 2002). Snyder (1995) suggested breaking down long-term goals into step-by-step subgoals, cultivating friends with whom one can discuss goals, and teaching clients about adjusting goals. These suggestions have clear implications regarding the process of treatment planning. During treatment planning, therapists help clients to identify and operationally define treatment objectives.

Utilizing Agency to Engender Hope

Snyder (1995) suggested that rebuilding agency can occur in various ways. Because these techniques represent a strength-focused approach, many of his suggestions are similar to those of solution-focused therapy. Focusing on what the client is doing well and emphasizing exceptions and wellness over pathology (de Shazer, 1985) are important tenets of both hope theory (Snyder, 2002) and solution-focused therapy (Michael et al., 2000). For example, Snyder (2000) suggested that helping clients to reframe their current situations can be powerful. This can occur by helping clients to view their difficulties as reflecting wrong strategies rather than a lack of talent, or viewing setbacks and goals as challenges instead of failures. Rebuilding agency can also occur by helping clients to recall past successes or helping them to identify with the past success of others.

An important part of increasing agency is to expose and identify the self-talk being used as clients encounter difficulty or start doubting themselves. Helping clients to establish positive and empowering self-talk can help them rebuild confidence (Snyder, 1995). Assisting a client to develop positive self-talk can be aided by the use of cognitive-behavioral techniques. Identifying, challenging, and eliminating cognitive

distortions that erode agency may be the first step to establishing more positive and hopeful cognitions (Taylor, Feldman, Saunders, & Ilardi, 2000).

Finally, assigning simple homework assignments or tasks that remind clients of their abilities may help reestablish a sense of self-mastery or agency (Snyder, 1995). These homework assignments may consist of anything that is easily within control of the client, and may simply consist of the solution-focused idea of doing something different (de Shazer, 1985). Stressing the importance of eating properly, exercising, and obtaining adequate rest are examples of simple tasks that a client could be assigned to in order to increase a sense of agency and mastery (Snyder).

Utilizing Pathways to Engender Hope

According to Snyder (1995), utilizing pathways in order to engender hope can also occur in numerous ways. The choice to pursue therapy is itself an example of pathways thinking. The use of self-monitoring and modification of cognitive distortions are particularly important in the generation of pathways thinking (Taylor et al., 2000). Self-monitoring allows clients to become more mindful of their behaviors and patterns of behavior so that they may enlist the help of the therapist in evaluating the usefulness of pathways. Solution-focused techniques prompt clients to draw upon their own resources in order to generate possible solutions or pathways, which further reinforce agency thinking (Michael et al., 2000). Modifying cognitive distortions helps to eliminate destructive thinking errors around the pathways brainstorming process (Taylor et al.). For example, upon finding one unsuccessful pathway to a goal, the client may assume the goal is eternally blocked (catastrophizing) or, having successfully utilized a pathway to

reach an important subgoal, the client may ignore his or her achievement (disqualifying the positive).

Providing new pathways is another way one may stimulate pathways thinking (Snyder, 1995). Teaching new skills or providing insight through psychoeducation stimulates clients to consider new ideas and generate even more pathways (Lopez, Floyd, Ulven, & Snyder, 2000).

Providing the client with a copy of the treatment plan serves to highlight the unfamiliar yet specific interventions designed by the therapist to bring about change (Taylor et al., 2000). This road map for therapy allows a client to see specifically tailored goals and subgoals along with the associated therapeutic pathways that were previously unimaginable.

Purpose

It is theorized that engendering hope in clients may be a key process that accounts for change during the early stages of therapy (Snyder et al., 1999) and allows clients to benefit more from the therapeutic experience (Fredrickson & Joiner, 2002; Wingate et al., 2006). Hope theory (Snyder, 2002) provides a useful framework for understanding hope as well as useful suggestions as to how clinicians may engender hope in clients by tailoring the early stages of therapy to emphasize goals, pathways, and agency.

The purpose of this study was to provide a single therapist with feedback and insight into his understanding and utilization of hope theory and to determine the

usefulness of hope theory for the practicing therapist. The questions that were investigated in this study include:

1. Did I demonstrate fidelity to the specific interventions described?
2. How did I make decisions regarding the selection and implementation of hope-engendering interventions (goals, agency, or pathways)?
3. How did attending to hope theory (Snyder, 2002) affect how I performed therapy?
4. Did clients report an increase in hope?

CHAPTER III

METHOD

Design

This study utilized a qualitative research approach in order to investigate the decision-making process utilized by the practicing therapist during the initial stages of therapy. In this investigation, a descriptive multiple-case study design was used (Yin, 2009). Three cases provided differing contexts from which the primary unit of analysis (the therapist, his conceptualization of hope, and his rationale for the selection of certain interventions) was examined. In an effort to corroborate and triangulate evidence, data for the study were collected from a variety of sources (Yin, 2003). These data were then subjected to analyses both individually and collectively.

Sample

Participants

Participants consisted of two individuals and a mother and daughter pair seeking therapy from the marriage and family therapy clinic at Utah State University. Participants were not required to meet any specific standards regarding presenting problem, family constellation, or level of distress. The first case consisted of a 26-year-old Caucasian female seeking assistance with substance abuse and relapse prevention. The second case consisted of a 31-year-old, recently separated Caucasian female seeking assistance with divorce and grieving. The third case consisted of a 29-year-old Caucasian female

accompanied by her 9-year-old daughter seeking treatment for the daughter's violent anger outbursts.

Individuals were considered for participation in the study only after consenting for treatment and research at the marriage and family therapy clinic. This stipulation included reading and signing disclosure documents that describe the standard policies and procedures of the clinic regarding the reception of mental health services. These documents included statements of maintaining and limits to confidentiality as well as clients' rights and responsibilities. Separate consent was given for data to be used in research (see Appendix A).

Selection Procedures

The sample used in this study consisted of a convenience sample of volunteers who presented to the marriage and family therapy clinic at Utah State University. Clients were randomly assigned to the practicing therapist based on a rotating schedule. Because of the in-depth analysis and reflection required for each case, a small sample size of three cases consisting of at least three sessions each was considered to be adequate.

Personnel at the clinic other than the therapist checked to be sure informed consent for research had been adequately understood and approved. This consent form assures clients that such consent is voluntary and that confidentiality is maintained through numerous procedures. These provisions included limited access to clinical files through protected filing cabinets, the substitution of client names with case numbers in the clinic appointment book and on clinical assessments, and the requirement that video

recordings be used for the sole purposes of providing supervision, feedback, and research within the building, to be destroyed after use.

Site Information

The USU marriage and family therapy clinic is an on-campus facility dedicated to providing therapy services and conducting research. Mental health services offered at the clinic are provided by graduate students under the supervision of Utah State University faculty who are licensed marriage and family therapists in the state of Utah and approved supervisors of the American Association for Marriage and Family Therapy. Therapy conducted at the clinic is closely supervised through direct observation (one-way mirror), video recording, and student documentation. Services are offered to students and members of the local community and fees are based upon family size and income, ranging from 10 to 40 dollars per session.

Instruments

Triangulation of Data

The evidence collected in this study came from a variety of sources, including clinic documents, case notes, immediate personal observation notes, self-evaluative personal reflection notes, and teammate/supervisory observation notes. This design used multiple sources of evidence in an effort to establish construct validity and is consistent with credible case study methods as documented by Patton (2002). The documentation evidence was provided by records that are typically kept throughout the therapy process and reflection notes that were kept by the therapist. These documents consisted of intake

information as well as case notes that documented both objective and subjective information regarding what transpired during each session. Records and clinic documents as well as supervisory notes, teammate observation notes, completed homework assignments, and a personal reflection journal were used for corroboration and triangulation of data (Yin, 2009). Direct observation occurred through the use of video recordings and a coding checklist that allowed the therapist and an outside observer to evaluate the performance of the therapist and measure fidelity to the interventions described. Finally, a precisely-phrased scaling question regarding the clients' subjective levels of hope was asked. Such questions that ask about the level of clients' commitment to therapy, commitment to a relationship, progress toward a goal, or hope are common in therapy at the MFT clinic. Details on each of these procedures and instruments follow.

Intervention Checklist

To ensure fidelity to the hope-engendering interventions employed in this study, a checklist enabled a fellow graduate student observer to verify their occurrences and establish reliability of the instrument. This checklist describes specific behavioral markers and provides a means of documenting their frequency. Reliability was established by asking one other therapist currently enrolled in the MFT program to view DVDs of four sessions of therapy. Ratings were then compared with mine in order to establish inter-rater reliability.

To establish reliability of the instrument, four sessions of therapy were selected for coding by the second observer. These four sessions consisted of two first sessions, a second session, and a third session of therapy. For the purposes of this study calculating a

percentage of agreement score was considered to be adequate. From this examination of four sessions of therapy, an average percentage of agreement score of .86 was found.

After the first DVD recording was coded, the observations of the second observer were compared to my own in order to verify my observations, resulting in a percentage of agreement score of .88. Because this degree of agreement existed, no further action was taken. After comparing observations from the second DVD recording, the percentage of agreement score did not adequately verify the occurrence of the interventions (.72). After identifying the discrepancies, the practicing therapist and second coder discussed their differences. After this discussion, the second DVD recording was recoded by me as well as the second observer. A comparison of these scores resulted in a more acceptable degree of agreement (.85). Similar results were found for the third and fourth DVD recordings (.87 and .86). These results indicate that a degree of congruence existed between the practicing therapist and the second observer.

To further ensure fidelity to the interventions described in the study, the intervention checklist was utilized during each session of therapy as a decision-making tool. The referencing and use of the intervention checklist before and during the implementation of each intervention served to remind the therapist of the specific characteristics and descriptions of each one.

Personal and Family Information Form

Prior to receiving treatment, clients at the MFT clinic are required to provide personal information by completing an intake form. This form contains valuable client details such as demographic information, family constellation, and a personal description

of why the clients are presenting for therapy. It also provides information about previous therapeutic experience and health conditions.

The information provided on the intake is generally useful during typical assessment procedures and was thought to be of value for assessing hope. For example, a client's description of his or her problem may suggest difficulty or competence in formulating goals. Goals may appear too general or represent the absence rather than the presence of something. A client's description of previous therapy experience may provide evidence that therapy has been an effective or ineffective pathway utilized in the past. This information was collected and examined in an effort to help me answer the second research question regarding the decision-making process utilized to select specific interventions. The questions on the intake sheet that were examined were, "Briefly describe the problem for which you wish to have therapy," "Previous therapy experience," "What would you like to see happen as a result of therapy," and "The thing that concerns you most right now?" It was thought that this information could have been helpful in assessing hope, but as discussed later it was found to be of little value.

Outcome Questionnaire

The *Outcome Questionnaire 45.2* (OQ; Lambert, Lunnen, Umphress, Hansen, & Burlingame, 1994; Lambert et al., 1996) is a 45-item instrument given to all clients at the MFT clinic during the initial intake process. It is designed to provide clinicians with a standard measure of a client's current level of distress and to measure change. The OQ is typically given before the first session of therapy, during the course of therapy according to the discretion of the therapist, and upon termination. The OQ provides a total score as

well as three subscale scores that measure symptom distress, interpersonal functioning, and social role performance.

The OQ has internal consistency with a coefficient alpha of .93 and test-retest reliability with a correlation coefficient of .84. (Lambert et al., 1994). The convergent validity of the OQ has been well established by comparison with numerous measures of anxiety, depression, social functioning, and interpersonal relationship functioning with correlation coefficients ranging from .60 to .88. The construct validity of the OQ has also been established with studies that document the sensitivity of the instrument among clinical populations (Umphress, Lambert, Smart, Barlow, & Clouse, 1997).

The OQ contains specific questions regarding the client's functioning that were utilized in order to help further answer the study's second question. The questionnaire items, "I blame myself for things," "I feel weak," "I feel worthless," "I feel that I'm not doing well at work/school," and "I feel something is wrong with my mind" provided information regarding the client's degree of agency thinking. For example, clients high in agency thinking may have a tendency to attribute failure to multiple sources, maintaining a stable belief in their own competence. Furthermore, the question, "I feel hopeless about the future" helped to substantiate or challenge the hope scaling question posed to the client. In addition, subscale items often give insight as to which areas of the client's life are being most affected by the problem. This information, as well as answers to specific questions, provided useful information as item responses will be answered individually.

Case Notes

The documentation of what occurred in each session of therapy is important and

necessary for clinical, legal, and ethical practice. Case notes provide documentation of when the session occurred, who was present during the session, goals and objectives, homework assignments, a description of what occurred during the session, a description of how the client responded to interventions, and a subjective assessment of the session and client progress.

Case notes represent an invaluable source of information because they contain a summary of the information, ideas, and interventions used during treatment. This allowed me to remember relevant details of each case that were important for treatment. My observations were recorded and used for reflection. Observations of clients regarding their affect, language, and responses to questions and interventions provided evidence regarding their levels of agency, pathways thinking, and goals. For example, a client may describe a problem in a very unique way. If the therapist is unsure of its significance, it can be recorded in case notes and referred to in the future as possible evidence of pathways, goals, or agency thinking.

Homework Assignments

A common practice of marriage and family therapy is the assignment of homework. Clients are encouraged to realize small changes in their daily lives through the completion of small tasks. These tasks may include keeping detailed accounts of their behaviors, thoughts, and ideas. When homework assignments include creating tangible documents, these documents become a valuable resource to the therapist. Clients may fail to complete homework assignments for various reasons, but clients who complete their homework assignments or do so extremely well may indicate high levels of agency

thinking. The degree to which a client completes a homework assignment may be used as an indicator of agency thinking. For example, if a client says, “My assignment was just too hard,” it may indicate a low degree of belief in their own abilities.

Personal Reflection Journal

The *personal reflection journal* represents an important source of information for this project. In this journal, I recorded my personal impressions and observations regarding my decision-making process while utilizing hope theory (Snyder, 2002). Data were recorded in this journal immediately following each session. The questions that were answered in this journal were designed to expose my rationale behind the assessment of hope and the selection of specific hope engendering interventions (see Appendix B). The comparison of various journal entries across cases allowed me to discern patterns and themes in my thinking and decision-making process. These questions include:

1. What indications were present that suggested a strength or weakness of (a) pathways thinking, (b) agency thinking, or (c) goals?
2. Could the client clearly define his or her problem?
3. Could the client clearly identify goals without prompting? Were these goals specific rather than general? Was there any evidence of short-term goals, intermediate goals, or long-term goals?
4. Did the client have any expectancies regarding therapy? Were they good/bad? Were they based on previous experience?
5. What specific pathways were already used by the client and how many?

6. In what ways did the client exhibit or demonstrate use of agency thinking?
7. What hope-engendering interventions were used or prescribed and why?
8. In what ways were these interventions tailored to the client and did this affect my decision to use them?
9. What was the reaction of the client?
10. What evidence was there to suggest that the client already had sufficient levels of hope?
11. Did my observations of the client related to affect and tone match the client's self-evaluation of hope?
12. Other observations.

DVD Reflection Journal

I reviewed each session of therapy to document the occurrence of interventions as well as to provide additional information and reflection. The DVD reflection journal consisted of two separate sections that provided data in the form of general observations regarding the client and therapist. Observations that included information about the client and indications or disconfirmations of hope were separate from observations of my effectiveness and efficiency in utilizing interventions. Data collected from this reflection journal allowed for general observations regarding the organization of each session, the tone and facial expressions of the therapist and client, client reactions to interventions, other nonverbal data, and any other observations. The data provided by this reflection journal were often triangulated with other data and proved to be very helpful in evaluating my own performance.

Teammate and Supervisory Observation Notes

Observations from others often provide alternative viewpoints and feedback to the practicing therapist. Three fellow graduate students enrolled in the MFT program and one supervisor, specifically trained to observe processes occurring during therapy, provided observation notes. This information, often specific to the therapist's model of therapy, is regularly communicated to the therapist during mid-session breaks and through detailed notes that do not include any identifying data. In order to encourage a more specific focus on hope theory (Snyder, 2002), observers were asked to make notes on a specially designed form. This form (see Appendix B) provided a brief explanation and examples of pathways thinking, agency thinking, and goals, as well as a format to organize and separate these observations from general observations. The data provided by these instruments assisted me in evaluating my own performance, included contradictory evidence, and identified indicators of hope and hopelessness that I had missed.

Therapist

I am a graduate student currently enrolled in a Commission on Accreditation for Marriage and Family Therapy Education-accredited MFT program. I have received a Bachelor's degree in Psychology and am currently pursuing a Master's of Science with an emphasis in marriage and family therapy. I provided therapy to all the participants in the study.

Because the therapist represents an important instrument in this project, it is important to identify personal biases that may affect the study. My most obvious bias is

that I am accomplishing this study in order to fulfill a requirement necessary for graduation. The time and energy invested in this pursuit increases the desire to find significance and meaning in everything. The desire to find significance accompanied with a strongly focused lens of hope may have resulted in observing elements of hope in things that may be meaningless to other observers. Also, because I played a significant role in which data were collected, there is the potential that relevant information was ignored. Information that went unrecognized could significantly impact my ability to assess hope as a factor in therapy as objectively possible.

These significant biases may be reconciled or controlled, given the following rationale: First, although there is a tendency for me to find meaning in the meaningless and read too much into a client's behavior, the nature or design of this study is not intended to produce findings that are generalizable to anyone other than myself. It is my desire to understand and utilize theory in a functional and practical way. The process of researching, comprehending, and implementing a theory is in and of itself a profitable exercise. Over time and with practice, the client behaviors that are truly meaningful or indicative of hope can become more salient to me. Therefore, the purpose of this study was not to evaluate or qualify the hope variables, but to understand the role they played in my decision-making process.

It is in my best interest to investigate potential mediating or confounding variables in therapy. Although I may fail to recognize information that would be useful regarding the assessment of hope, the *personal reflection journal* and *teammate/supervisory observation notes* provided a forum for contradictory evidence to be considered.

Including contradictory evidence into the data pool is an example of “being open to contrary findings,” which is recognized as one valid method of limiting personal bias in case study research (Yin, 2009, p. 72).

Hope Scaling Question

Participants in the study provided valuable information regarding their current levels of hope and changes that occurred in hope levels by answering a hope scaling question. This scaling question was asked at the conclusion of each session. The question was phrased precisely the same every time and the client’s response was verified and documented. The question was asked, “On a scale of one to 10, one indicating I have no hope at all and 10 indicating that I am totally hopeful, how would you rate your current level of hope regarding your belief that you can overcome the difficulties for which you have sought therapy?”

Procedures of Participants

Study participants were engaged in the process of therapy, including intake, assessment, treatment planning, weekly 50-minute sessions of therapy, interventions, and homework assignments. During the first three active sessions of therapy, I utilized Snyder’s (2002) theory of hope by selecting and implementing specific interventions or procedures that emphasize growth in establishing and clarifying goals, pathways thinking, and agency thinking. Due to the in-depth nature of the study, the number of data sources, and my detailed reflection and personal observations, the number of active

sessions for each case was considered sufficient to answer the questions proposed for investigation.

Interventions

Hope theory (Snyder, 2002) offers a rationale for the use of various interventions that could effectively increase hope. Integrating interventions (Lopez et al., 2000) from narrative (White & Epston, 1990), solution-focused (de Shazer, 1982), and cognitive-behavioral (Beck, Reinecke, & Clark, 2003; Dattilio, 1998, 2001) approaches represent the most recent conceptualization of interventions that would be effective in increasing hope. There are numerous interventions that are consistent with my theory of therapy and change that can be utilized as well as many others that may be selectively borrowed. Because of the difficulty associated with identifying and defining interventions that could potentially be used, a small number were selected for use in this study. Below are the interventions and practices that I identified as particularly necessary and salient to building hope during the early sessions of therapy.

Interventions That Increase Goal Formulation

Identifying goal domains is the process of assisting clients to examine various life domains, determine their relative value or importance, and assist clients to subjectively rate their personal satisfaction in each domain (Lopez et al., 2000). This process is accomplished by asking the client questions such as, “How important is your work to you?” or “How satisfied are you with your social relationships?”

Specifying goals is the process of transforming a general idea into a concept that can be stated explicitly or in detail (Lopez et al., 2000). For example, a goal such as, “I want to be happy” is unlikely to be accomplished because it is difficult to know what it means. This goal could be *specified* or transformed into “I want to improve my interpersonal relationships” and then into “I want to improve my social skills.”

Reframing avoidance goals is the process of transforming a goal from a negative avoidance context into a positive approach context (Michael et al., 2000). Although a goal may be specific, its negative avoidance context makes progress difficult to identify. Reframing avoidance goals transform them into observable behaviors. An example of *reframing goals* would be transforming the goal of “arguing less” to “spending more time together and discussing areas of common interest.”

Envisioning goals and recognizing goal achievement is the process of assisting clients to visualize and describe their goals (Michael et al., 2000). It also includes assisting clients to establish specific methods of recognizing progress towards their goals and final goal attainment. It may include identifying thoughts, feelings, and behaviors or anything noticeable that would be associated with goal achievement (Michael et al.). This is often accomplished by directing thought-provoking questions or instructions to clients regarding their goals, for example, by asking a client, “How would you reward yourself for making progress towards your goal and how would you know when you have made that progress?”

Interventions That Increase Agency Thinking

Positive reframing is the process of altering the meaning of a specific situation or statement in order to reflect positive or desirable characteristics (Lopez et al., 2000). It often allows a client to change the attribution of failure from a personal one (e.g., “I’m a failure”) to an external one such as circumstance, an ineffective pathway, or other variables. For example, a client’s belief that he or she is a failure for seeking therapy because of a distressful marriage may be positively reframed to reflect a belief that he or she is wise for seeking therapy, that marriage is an exciting challenge, and that with the proper skills, he or she could achieve success.

Identifying strengths is the process of identifying competence, power, control, wisdom, capability, or accomplishment (Michael et al., 2000). It may be accomplished by identifying and complimenting the past success of the client, the present success of the client, or the past and present success of others who are similar to or in similar circumstance as the client. This process is most helpful when noticing a personal attribution of the client. For example, a therapist may say, “I think you made a very good decision to come in and speak with me; it tells me that you realize the importance of healthy relationships.” A therapist could also ask, “What is the hardest thing you have overcome in your relationship?”

Establishing positive self talk is the process of assisting clients to develop specific thoughts regarding the appraisal of themselves or their abilities (Taylor et al., 2000). It is accomplished by directing questions to clients that will assist them to identify negative self-talk and replace it with more constructive thoughts. For example, a therapist could

ask a client, “What do you tell yourself when you start to doubt your ability to reach your goal?” or “What could you tell yourself instead that would motivate you to continue pursuing your goal?”

Assigning a small task is the process of instructing a client to carry out a specific task that is in his or her perceived ability to perform (Lopez et al., 2000). The first step in this process may involve asking clients to identify something themselves. The second step is to establish accountability for accomplishing the task. Asking the client, “What is one small thing you can do differently this week that you believe will help you in the pursuit of your goal?” is an example of the first step. Asking the client, “Getting an extra hour of sleep each night this week sounds like a great idea; will you be prepared to report back next week and explain what difference that has made for you?”

Anticipating and preparing for roadblocks is the process of assisting a client to identify the most threatening obstacles that are likely to stand in the way of goal attainment (Lopez et al., 2000). It also involves preparing clients by assisting them to feel capable of coping with those situations should they arise. This is also done by asking the client questions such as, “Once you begin to change, where or from whom are you most likely to meet with resistance?”

Interventions That Increase Pathways Thinking

Providing pathways is any process that involves teaching a client new behavioral or perceptual skills (Taylor et al., 2000). This may include education regarding parenting, communication, problem-solving, or other skills training. It may also include techniques or skills required to record or alter thoughts and behaviors.

Identifying social support and role models is a process of assisting a client to identify others whose interactions may stimulate pathways thinking (Lopez et al., 2000). This may include friends, family members, coworkers, or anyone who, if made knowledgeable of the client's difficulties, could offer new pathways by way of personal advice or experience. This is done by asking a client questions designed to stimulate his or her thinking regarding social support. For example, a therapist may ask, "Who else knows about this?" or, "I'm sure some of your closest friends have already told you what to do about your situation, but who else in your life might understand what you are going through?"

Exploring past pathways is a process of assisting clients to identify the specific strategies and pathways that they have previously used in order to achieve their goals (Michael et al., 2000). It involves identifying pathways that could be generalized or applied to the client's presenting problem. Although identifying success is done in an effort to identify competence and confidence, focusing on thoughts of agency and exploring past pathways focuses on the various strategies that have been used. This can be accomplished through provocative questioning. For example, a therapist may ask, "This divorce sounds like a pretty difficult experience; how did you get through it last time?"

Creating subgoals is an intervention that assists the client in identifying the small goals that are necessary to achieve before a larger goal may be met (Lopez et al., 2000). It is the process of breaking a goal into smaller subgoals. This is also accomplished through

questioning. For example, a therapist may ask, “What are some of the things you will have to do before you can calmly discipline your child?”

Brainstorming is a process that assists a client to practice designing alternative pathways (Michael et al., 2000). This process stimulates pathways thinking by including creativity, flexibility, and humor. The pathways that the client identifies need not be realistic or even plausible as long as they are related to a goal in some fashion. Asking a client who is shy to create an exhaustive list of how she or he might attract the attention of others would be an example of *brainstorming*.

Data Analysis

Data Collection

Data were collected and analyzed at multiple times. The first data to be collected and analyzed consisted of the personal and family information form and the OQ 45.2, which occurred before the first session of therapy. As described earlier, these data were examined for evidence of hope in the form of data indicating agency thinking, pathways thinking, and goals. Immediately following each session of therapy, data were collected in the form of a DVD recording, case notes, supervisory and teammate notes, the hope scaling question, and a personal reflection journal.

Case Analysis

After each session, data were collected and examined. This examination also resulted in the creation of new data. This was done through the process of reviewing the DVD recording of each session. During this new review of the data, my personal

observations and reflections were recorded, resulting in the creation of yet more data. The intervention checklist provided a starting point for analysis. Each intervention that was utilized was examined along with the other data sources in order to identify my rationale and thought process. The various rationales behind my decision to use each intervention were then compared in order to identify commonalities within each case. Finally, the elements of hope theory (Snyder, 2002) that were present in my rationale were identified and a description or summary of my decision-making process regarding each case was created.

Cross-Case Analysis

Data were pooled into a formal database in order to maintain a chain of evidence (Yin, 2009). This database served to document, organize, and separate evidentiary base data from my reports. The database was then utilized to compare and contrast each case analysis. Themes and patterns that were similar in each case were documented followed by a review and documentation of observations that were unique or different to each case. The similarities and differences between cases were then examined in an effort to identify the therapy process. The underlying decision-making process was then described and reported.

Research Question Analysis

Data collected from the personal and family information form, the OQ 45.2, the hope scaling question, the DVD recording reflection notes, the personal reflection journal, case notes, the intervention checklist, and the teammate and supervisory notes

represent converging bodies of evidence that corroborate and validate one another. This triangulation of data (Yin, 2009) from multiple sources was used to answer the research questions of this study.

Research Question One: Did I demonstrate fidelity to the specific interventions described? This question was answered from analyses of the data obtained from the intervention checklist. After each session of therapy, the intervention checklist was used to code each session and identify how frequently each intervention occurred. These data were tallied and descriptive statistical analyses were used to identify the mean number of hope theory interventions that occurred each session, as well as the interventions that occurred least frequently and most frequently. These data were then used to identify how consistently interventions were utilized across the first, second, and third sessions of therapy.

Research Question Two: How did I make decisions regarding the selection and implementation of hope-engendering interventions (goals, agency, or pathways)? This question was answered by a careful analysis of the personal and family information form, the OQ45.2, the hope scaling question, the DVD recording reflection notes, the personal reflection journal, case notes, and the teammate and supervisory notes. The analytic procedure used was a combination of relying upon theoretical propositions and explanation building (Yin, 2009). This procedure was accomplished by utilizing the basic theoretical formulation of hope proposed by hope theory (Snyder, 2002) as a structure from which an explanation about each case was built. The case explanation was then

validated by referencing data from the database. Case explanations were then compared and contrasted to reveal patterns, themes, and exceptions.

Research Question 3. How did attending to hope theory (Snyder, 2002) benefit or detract from how I performed therapy? This question was answered by an analysis of the teammate and supervisory notes, personal reflection journal, and DVD reflection journal. Client responses and hope scale scores were also considered although personal reflection was used as the primary source of data. These data were read and reviewed for evidence that could suggest that there was a change in my performance as a therapist. As the data were reviewed, common themes were identified and documented. Once a theme was identified, the data sources were reviewed and reread once more in an effort to identify multiple occurrences across multiple sources of data. These themes were then placed or grouped into different categories regarding my performance as a therapist. The various themes that emerged as a result of this examination were then reflected upon, from which a narrative was composed that highlights the advantages and disadvantages of my experience.

Research Question 4. Did clients report an increase in hope? This question was answered by examination of the responses that clients provided to the hope scaling question, “On a scale of one to 10, one indicating I have no hope at all and 10 indicating that I am totally hopeful, how would you rate your current level of hope regarding your belief that you can overcome the difficulties for which you have sought therapy?” Each client response was then documented and these data were graphed. An examination of the graphed data was then used to identify change in each client’s level of hope.

Report

The results of the analyses are reported by thoroughly addressing each research question of the study. A conceptual/thematic description (Sandelowski & Barroso, 2007) is used to integrate concepts and themes from the study, rendering an interpretive transformation of the data. Findings are reported in the results section of this document according to each research question. When appropriate, each case is first considered individually and then cases are considered collectively.

CHAPTER IV

RESULTS

Findings are reported according to the order of the research questions. A brief description of the participants and their presenting problems is given in conjunction with the results of research question two. In order to maintain confidentiality, the participants' names have been replaced with pseudonyms. The results of each research question consider cases individually and collectively.

Research Question One

Did I demonstrate fidelity to the specific interventions described? To ensure fidelity to the hope interventions described, every session of therapy included in the study was recorded and coded by myself utilizing the intervention checklist. After coding for each session was completed, four sessions of therapy were observed and coded by the second observer. After adjustment, scores from each observation checklist were then compared to produce a percentage of agreement score.

Frequency of Interventions

Each session of therapy was recorded and coded by myself in order to identify the frequency of each intervention. The total number of interventions that were identified across the study was 68. These results were tallied and summarized and represent the best estimate of the number of interventions that occurred (see Table 1).

Table 1

Total Frequency of Interventions

| Intervention | Frequency |
|---------------------------------|-----------|
| Identifying goal domains | 6 |
| Specifying goals | 9 |
| Reframing negative goals | 5 |
| Envisioning goals | 1 |
| Positive reframing | 10 |
| Identifying strengths | 11 |
| Establishing positive self-talk | 0 |
| Assigning a small task | 2 |
| Anticipating roadblocks | 0 |
| Providing pathways | 6 |
| Identifying social support | 3 |
| Exploring past success | 12 |
| Creating subgoals | 3 |
| Brainstorming | 0 |
| Total | 68 |

An examination of these results indicates that I utilized an average of 8.5 interventions each session of therapy. The interventions of exploring past success, positive reframing, and identifying strengths were used most often with over 10 occurrences each, while anticipating/preparing for roadblocks, brainstorming, and establishing positive self-talk were use the least often with 0 occurrences each.

Consistency

The number of interventions identified in each session of therapy was also tallied and grouped according to the session number in which they occurred (see Table 2). An examination of these data reveals that the frequency of interventions that occurred during the first session was lower than the frequency of interventions that occurred during the second and third sessions of therapy.

Conclusion

These data reveal that during the course of this study, I frequently utilized hope-engendering interventions that were identifiable to a second observer with an acceptable degree of accuracy. This finding suggests that I maintained fidelity to the interventions identified and outlined in the study.

Research Question Two

How did I make decisions regarding the selection and implementation of hope-engendering interventions (goals, agency, or pathways)? The selection and

Table 2

Observed Frequency of Interventions Across Each Session

| Intervention | Session 1 | Session 2 | Session 3 |
|---------------------------------|-----------|-----------|-----------|
| Identifying goal domains | 5 | 0 | 1 |
| Specifying goals | 3 | 4 | 2 |
| Reframing negative goals | 1 | 4 | 0 |
| Envisioning goals | 1 | 0 | 0 |
| Positive reframing | 3 | 5 | 2 |
| Identifying strengths | 2 | 6 | 3 |
| Establishing positive self-talk | 0 | 0 | 0 |
| Assigning a small task | 0 | 2 | 0 |
| Anticipating roadblocks | 0 | 0 | 0 |
| Providing pathways | 0 | 3 | 3 |
| Identifying social support | 1 | 2 | 0 |
| Exploring past success | 3 | 7 | 2 |
| Creating subgoals | 0 | 2 | 1 |
| Brainstorming | 0 | 0 | 0 |
| Total | 19 | 35 | 14 |

implementation of hope-engendering interventions was tailored to each participant in the study based on the therapist's assessment of hope, client factors/feedback, and the tenets of hope theory (Snyder, 2002). Through detailed documentation and personal reflection, the decision-making process of the practicing therapist was examined relative to each case and a case explanation was created. After the examination and explanation building of each case, explanations were compared and contrasted in order to reveal patterns, themes, similarities, and differences. Each case is reported in terms of its description, my assessment of hope factors, analysis relative to hope theory, client factors and feedback, and a description of my decision-making process. A final cross-case analysis also is presented.

Initial Assessment

Data from the OQ 45.2 and Family Information Intake form were examined prior to each first session of therapy. It was presumed that this information would prove helpful in my assessment of hope. After examination, the data provided by these instruments provided limited information and were not found to be useful. Because the therapeutic interview provided the information necessary to make a more thorough assessment of hope, data from the OQ 45.2 and Family Information Intake form are not referred to in these results.

Case One

Case description. Brittany was a 26-year-old Caucasian divorced female. She no longer had custody of her children, lived at home with her mother, and was employed as a waitress at a local restaurant. She was ordered by the court to attend therapy as a result of a recent drug relapse. Brittany was seeking therapy in conjunction with other mental health treatment in order to sustain recovery regarding drug-seeking behavior and her previous diagnosis of bipolar disorder.

Assessment of goals. Brittany indicated in her intake information that she would like to “have the tools in place to stop relapse and enjoy a life of sobriety.” When asked why she agreed to therapy, she indicated that she believed therapy was helpful because it was structured and gave her an element of weekly accountability. During the assessment process it became clear that Brittany did not have any specific goals. She spoke of “not returning,” “not relapsing,” and “not screwing up again” in reference to avoiding heroin use. It appeared that Brittany was utilizing an avoidance goal of little value to her (not using heroin) and no means of measuring progress or success.

Assessment of agency. Brittany spoke confidently of her ability to overcome drug addiction. She described one situation in which she locked herself in her friend’s house for nearly two weeks, threw away her cell phone, and played video games in order to “detox.” Brittany also spoke of other areas of her life in which she felt successful. She mentioned a romantic relationship and quick advancement at work and reported that these “made her feel good about herself.” The only time Brittany expressed unbelief in herself or her abilities was in relation to managing her bipolar tendencies. Brittany’s timely

completion of homework assignments signified a belief in her abilities to follow directions and try new things. Despite the many times she failed at overcoming her drug addiction and the overwhelming guilt she experienced from losing custody of her children, Brittany made comments and expressed ideas that were indicative of frequent and powerful agency thinking.

Assessment of pathways. Brittany indicated that she believed she already possessed the tools she needed in order to live in recovery. Brittany was able to identify numerous tactics and behaviors from previous therapy experiences that were helpful in overcoming her addiction. Not only was the client able to identify various tools for overcoming addiction, but she was also able to identify new methods on her own. After speaking with her doctor, she said, “I think that quitting smoking is something that could help me because it’s still using a drug to cope with stuff.” Brittany’s responses indicated that she had numerous pathways and was able to identify new pathways with ease.

Hope theory rationale. According to my assessment and conceptualization using hope theory (Snyder, 2002), Brittany demonstrated an adequate amount of both agency thinking and pathways thinking. Brittany’s description of her goals and objectives for therapy, however, were very general, lacked specificity, and were avoidance-based. According to hope theory, Brittany was in need of goals that were clear, specific, rewarding or of significant value, and approach-based.

Client factors and responses to interventions. Brittany described such an extensive history of treatment and experience in therapy that she had reservations about how helpful therapy would be for her. It appeared important to acknowledge her past

success in an effort to preserve her current degree of agency thinking and perhaps strengthen the therapeutic relationship. Because of Brittany's long history of treatment, I reasoned that trying something novel such as designing approach goals would be appealing to her. I further reasoned that allowing Brittany to identify and specify goals with limited guidance from myself could help her feel more control over her own treatment.

Decisions about interventions. Based on my assessment of Brittany's goals, agency thinking, and pathways thinking, I decided to focus on Brittany's goals and agency thinking. After Brittany succeeded at identifying her greatest vulnerabilities, these were transformed into goals that she could pursue. For example, one of Brittany's vulnerabilities was boredom during the winter months. Instead of avoiding "relapse" or "boredom," Brittany identified exciting activities such as snowboarding, intramural sports, going to a sauna, and volunteer work. Engagement in these activities is measurable and could effectively reduce the probability of becoming bored during the winter. Further, relapse prevention is a skill and a client must have the ability to constantly amend or modify a relapse prevention plan as his or her circumstances change. I aimed to assist Brittany in developing a greater sense of agency thinking in this regard by identifying her successes at recognizing and making improvements. For example, Brittany identified the importance of strict environmental control and limited her contact with Salt Lake City and former friends there as much as possible. As she mentioned this, I responded by saying, "Wow, Brittany, the fact that you can identify the importance of

controlling your environment shows me that you're really good at recognizing a danger zone; you are really smart.”

Brittany responded very well to compliments and statements intended to increase her sense of agency thinking in terms of living her relapse prevention plan. Brittany also enjoyed the positive quality of the goals she created. She stated that it was different than any other approach she has had.

Case Two

Case description. Ashley was a 29-year-old married pregnant Caucasian female who was accompanied by her 9-year-old daughter, Jessie. Ashley was employed part-time as a secretary and primarily cared for three children at home. Jessie was generally kind, sociable, and respectful, but Ashley reported that Jessie engaged in frequent uncontrollable outbursts or episodes of rage that lasted for hours. Ashley had tried numerous interventions to no avail before making the decision to come to the clinic.

Assessment of goals. Ashley indicated in her intake information that she would like “help dealing with her 9-year-old.” Upon further investigation, Ashley described Jessie’s problem behavior and indicated that she wanted to eliminate it. When asked why she decided to come to therapy, Ashley indicated that her previous therapy experience at the clinic had been excellent and very helpful. After discussion, it was clear that Ashley was seeking a change in her daughter’s behavior although she did not appear certain whether a change in her own behavior was necessary. Because Ashley had other children, she was able to clearly describe the observable behavior she desired her daughter to demonstrate. Although lacking somewhat in specificity, the participant’s goals of what

she wanted in place of the problem behavior were clear, measurable, and of significant value.

Assessment of agency. Ashley expressed sentiments regarding her belief in being a “good mother.” She cited evidence regarding previous struggles with her children and the current behavior of her other children. She described with great detail her ability to utilize certain parenting techniques. Ashley also expressed belief in her ability to change her own behavior as a parent if needed and to try new things. In describing her previous treatment, she said she learned the importance of maintaining proper boundaries and said, “I’ve thought many times about giving in to my daughter’s demands but I stick with my decision,” a possible indicator of her ability to continue on a selected pathway. Although Ashley expressed a high degree of agency thinking, she also admitted her limits and described the helpful and supportive relationship she had with her spouse. Based upon these data, it appeared that this participant had a high degree of agency thinking or that she believed she was capable of implementing new methods.

Assessment of pathways. Ashley spent several minutes describing in great detail the numerous strategies she had tried, including time-out, taking away possessions, token economics, punishments, and so forth. She described some interventions as more effective than others, but ultimately ineffective. Ashley continually asked, “What else can I do?” She appeared eager to try new things and took notes at the first indication of new information. Ashley completed every homework assignment with exactness and was always willing to try something different. Ashley seemed to be able to identify numerous pathways but definitely expressed a deficit in discovering one that was effective.

Hope theory rationale. According to my assessment and conceptualization of hope theory (Snyder, 2002), Ashley demonstrated adequate goals and agency thinking. Her decision to come to therapy in order to resolve her problem was an example of utilizing a pathway that had been helpful in the past. Because her goals and agency thinking were adequate, I reasoned that Ashley could maintain hopefulness about her situation as long as she was able to continue generating new pathways. According to hope theory, it would be logical to help provide pathways or assist Ashley in generating new pathways. Because an increase in agency thinking leads to an increase in pathways thinking, increasing Ashley's belief in herself and her abilities could help stimulate pathways thinking.

Client factors and responses to interventions. One of the most important factors in this case was remaining sensitive to Jessie's feelings and making therapy an experience that she enjoyed. Ashley had some beliefs or suspicions that her daughter's behavior may have been the result of brain damage sustained as a baby. I did not want her daughter to think of herself as defective or a problem child. Ashley also expressed feelings that indicated she was experiencing guilt because the outbursts only occurred when she was present. As therapy continued, Ashley responded very positively to the introduction of new methods, ideas, and interventions. This feedback solidified my decision to continue focusing on pathways for Ashley in order to maintain her levels of hope.

Decisions about interventions. Based upon my assessment of Ashley's goals, agency thinking, pathways thinking, and other factors, I decided to select interventions that focused primarily on stimulating pathways thinking and maintaining agency

thinking. In this particular case, I decided to provide new pathways to Ashley in the form of introducing an age-appropriate mood log, a cost/benefit analysis activity, and numerous new parenting skills. In order to strengthen Ashley's agency thinking, I positively reframed Ashley's belief that her child's behavior was the result of a bad mother-daughter relationship to the idea that her behavior was the result of a good and healthy mother-daughter relationship where her daughter could openly express the anxiety and troublesome emotions she experienced. The daughter's agency was preserved by externalizing her bad behavior.

Ashley responded very well to the interventions aimed at preserving her agency thinking. Ashley also responded well to the pathways that were provided. Although some pathways were less helpful than others, each one spawned new ideas or generated greater insight that resulted in an increased resolve to find a solution. Ashley always completed her homework assignments even when the assignment was difficult to accomplish in her busy and often hectic circumstances. Jessie appeared to mirror her mother's behavior and exhibited similar characteristics of hope.

Case Three

Case description. Bailey was a 31-year-old Caucasian female who worked in production. She had two children ages 9 and 12. Bailey was separated from her spouse and was in the process of going through a divorce. After experiencing infidelity in her relationship in previous years, she forgave her husband only to discover he was having another affair. She described her current relationship with her husband as very satisfying and yet her husband was seeking a divorce in order to marry his new girlfriend. Bailey

believed she was as sacrificing and kind as any companion could be and expressed feelings of complete rejection.

Assessment of goals. Bailey indicated in her intake information what she would like to see happen as a result of counseling. She stated, “Tell me what would be best for me and my kids, help me get over my husband and what has happened so I can move on.” Bailey wanted to “move on” but had difficulty describing what that meant to her. Bailey then restated her goal as “not be so obsessed.” She did not want to rebound into another relationship but saw her husband’s happiness in his new relationship and felt as though she should be able to move on as he had. Bailey believed “moving on” was what she needed to do, but was honest and indicated it was not what she wanted to do. The goal of “moving on” was a positive approach goal but was general instead of specific. It also was not of significant value to Bailey because it was not what she wanted.

Assessment of agency. Bailey described herself as a very sacrificing individual and as someone who was constantly trying to satisfy the needs of others. It appeared that she chose to define and judge herself almost exclusively by her performance as a mother and spouse. Bailey exhibited signs that she did not trust her own decisions and reported constantly asking coworkers, friends, and family what she should do. She described interactions with her husband in which she felt helpless, incapable of doing certain things, and resisting his will. Bailey also expressed thoughts that she was incapable of doing certain things without her husband, such as having fun. She also shared feelings regarding the challenge of living independently because she had married young and had some uncertainties about being single. Bailey had a strong sense of agency thinking in

relation to earning an income, finding a new partner, and supporting her children. However, in terms of remedying her situation or changing her husband's mind, she felt completely powerless and incapable of utilizing any pathways of persuasion or influence.

Assessment of pathways. Bailey recounted her efforts of trying to go out and have fun but reported feeling blocked because four wheelers and other "toys" were no longer available. She tried dating and reported success at finding numerous individuals that she could be in a relationship with but attributed this to her adaptability and found the relationships to be very unfulfilling. She obtained a job, found a lawyer, and referred herself to therapy, which indicated that her ability to develop pathways was not completely blocked. Bailey also solicited ideas and thoughts from others, which can be considered a pathway itself. It appeared to me that this client was capable of developing pathways in numerous life domains but appeared stifled and blocked in terms of developing pathways to help remedy her current situation.

Hope theory rationale. According to my assessment and conceptualization of hope theory (Snyder, 2002), Bailey was having difficulty formulating goals that were of significant enough value to produce adequate motivation. She had hope based on previous relationship experiences in which infidelity had not necessarily indicated the end of her relationship with her husband. "Moving on" was something she knew she needed to do, yet not what she wanted to do. Her true goal was to influence her husband to change his mind, which resulted in blocked agency thinking and limited pathways thinking. It is possible that when a client loses all hope of resurrecting her relationship, that mourning, grief, loss, and pain will increase the value of a goal to "move on." In

cases of grief and loss, Snyder (1996) suggested building agency thinking and pathways thinking by focusing on and developing other significant goal pursuits. This could include focusing on other meaningful relationships, work, hobbies, and so forth.

Client factors and responses to interventions. Bailey wanted someone very directive to tell her what to do and felt very hopeless about the future. Granting the participant's request may have been ultimately less helpful. I reasoned that being directive in this situation could represent a form of inappropriate helpfulness, leading to greater feelings of dependency and helplessness. Fostering the client's beliefs that she could not rely on her own decisions could further erode her level of agency thinking. As therapy progressed, Bailey responded very well to interventions directed at increasing agency thinking. Interventions that focused on goals were less successful and were met with some resistance.

Decisions about interventions. Based upon my assessment of Bailey's goals, agency thinking, pathways thinking, and other factors, I decided to select interventions that focused primarily on goals and agency thinking. It proved very difficult to utilize interventions intended to establish goals. Bailey had difficulty imagining and articulating what she wanted in terms of her relationship with her spouse. As I moved on to identifying strengths, she responded more positively. After identifying numerous strengths such as being nurturing, sensitive, selfless, sacrificing, adaptable, and easy-going, I attempted to help Bailey identify other meaningful goal pursuits to which these strengths would be of good use. She was able to identify goals relating to work and her children. Although "not being so obsessed" was Bailey's primary objective for seeking

therapy, I reasoned that focusing on other meaningful goal pursuits would be helpful as they would serve as a distractive coping mechanism. Based upon Bailey's feedback, it appeared that she may have seen merit in this intervention but ultimately felt it was unhelpful. Helping Bailey to assess and inventory her own feelings regarding her situation before establishing goals may have proved more effective.

Cross-Case Analysis

In each therapy case, I discovered that the hope assessment process was critical for selecting interventions. Part of this process included looking for evidence that supported and refuted the existence of pathways, agency, and goals. The most helpful tool in assessing these components of hope was the therapeutic interview. When participants did not provide the information I desired, I selected an intervention from each component of hope theory (Snyder, 2002) and observed the ease or difficulty with which the clients gave their responses. After this examination resulted in a rudimentary assessment of hope, I examined my conceptualization of hope theory (Snyder) in order to identify which component needed intervention and what interventions could help. After this self-consultation, I took into account specific client factors including strengths and weaknesses. Based upon all the information gathered, I selected interventions that were tailored to each client's needs and proceeded, taking into account client feedback and making adjustments as needed.

Research Question Three

How did attending to hope theory (Snyder, 2002) affect how I performed therapy?

I evaluated my performance utilizing feedback from client responses, hope scale scores, teammate and supervisory notes, my personal reflection journal, and my DVD reflection journal. These data were considered collectively from which a narrative was constructed, highlighting the advantages and disadvantages experienced by the practicing therapist. Areas that emerged as suggesting how focusing on hope affected how I performed therapy included joining, deviation from my typical approach, organization, and my use of goals.

In order to identify data that could have indicated a change in my performance as a therapist, the reflection journal, case notes, and observation notes were reviewed. These data were then evaluated and subjected to further investigation by finding supporting evidence of their existence across multiple sources of data. Once identified, each item was considered and reflected upon in order to produce these results.

Joining

One of the ways that I join with clients is by taking the first few minutes of therapy to have a friendly conversation with them. I talk about things going on in their lives, their interests, hobbies, sports, news, and anything that comes to mind. I try to find things that I have in common with them or express my own feelings or opinions in hopes that they might find something in common with me. In order to join further with clients, I believe I must demonstrate to them that I understand their situations or that I understand

how they feel about their situations. In the process of identifying strengths in my clients and verbalizing those strengths, I discovered another way to join and strengthen the therapeutic relationship that I had not used before: focusing on hope in early sessions of therapy.

I began identifying strengths and verbalizing them in the form of compliments or verbal praise for the purpose of increasing agency thinking. As I reviewed the video recording of my session with Brittany, I noticed what a powerful impact a compliment had upon her. She appeared to almost stop, as if she was allowing it to fully soak in. As I watched this, I had the thought that I usually connect better with people who see the good in me and that other people may do the same. As I became more comfortable with verbalizing what I believed to be strengths in my clients, I found myself deciding to do it more often, even when I was focusing on formulating goals or increasing pathways thinking.

Deviation from Typical Approach

After reviewing a teammate note, I noticed a comment that asked, “Where was your CBT?” This comment caused me to look closer at what I was doing in order to identify how often I utilized cognitive-behavioral techniques or interventions. As I was reviewing the video recording of other sessions, I also observed that I had used those techniques less frequently than usual. Based upon the data in my personal reflection journal, it appears that my effort to focus on hope during the initial sessions of therapy may have resulted in a failure to focus on other concepts that are important to my typical method of practicing therapy. For example, identifying important relationships and their

impact upon my clients is something I typically assess through constructing a genogram and asking detailed questions about a client's family. Perhaps distracted by my focus on hope for this project, I found myself satisfied to merely identify the current social support structure in place for each client. Evidence to support this finding may also be found by comparing my performance between cases. In Ashley's case, in which hope was already high and my preoccupation with increasing hope was minimal, I found myself utilizing more of the interventions typically associated with my personal style of practicing therapy.

Organization

Analysis of my personal reflection journal revealed that I was less organized than usual in these therapy cases. For the purposes of collecting and recording data, I believe I was more prepared, but I believe my sessions did not flow very well. In my reflections journal, I recorded feelings of being overwhelmed and distracted with so many things to focus on. I remember asking myself as I looked down at my notes during therapy how I should segue into something else and which intervention I should I do first. It may have appeared normal to the participants, but it affected my confidence. I felt as though I had not performed as well as I normally do.

Goals

Assisting the clients to formulate valuable, approachable, and specific goals for therapy influenced my own treatment planning. Generally, I struggle to formulate a concrete treatment plan before the third session. In each of the cases in this study, I felt

prepared to construct a treatment plan much sooner. When working with Bailey, I discovered that the difficulty she demonstrated in creating goals was significant and perhaps a sign that she needed something else. In this particular case, the emphasis on goals helped me better understand the client's needs. In general, as I assisted clients with goals, I noticed that the importance of goals for myself as a therapist increased as well.

Research Question Four

Did clients report an increase in hope? Changes in the participants' levels of hope were assessed through analysis of responses to the hope scaling question which was asked at the conclusion of each session of therapy. These responses were quantified by the participants as they assigned numerical values to their personal assessment of hope. These responses were then graphed (see Figure 1) for case-by-case and collective analyses.

Case One

An examination of Brittany's responses to the hope scaling question indicates that she experienced an increase in hope. After three sessions of therapy, her hope score increased a total of 4.5 points, which represents more than a 100% increase. The most dramatic increase of reported hope occurred at the end of the second session and was followed by a smaller increase at the end of the third session. These results indicate that Brittany did experience an increase in hope.

Case Two

An examination of Ashley's responses to the hope scaling question indicates that she experienced neither an increase nor decrease in hope with each session of therapy. At the end of three sessions of therapy, her hope score remained consistently high. These scores indicate that Ashley did not experience an increase in hope.

Case Three

An examination of Bailey's responses to the hope scaling question indicates that she experienced an increase in hope. After two sessions of therapy, her hope score increased from 1 to 4. Because Bailey did not return for a third session of therapy, there is no score for the third session of therapy. Despite the absence of this final score, these results indicate that she did experience an increase of hope.

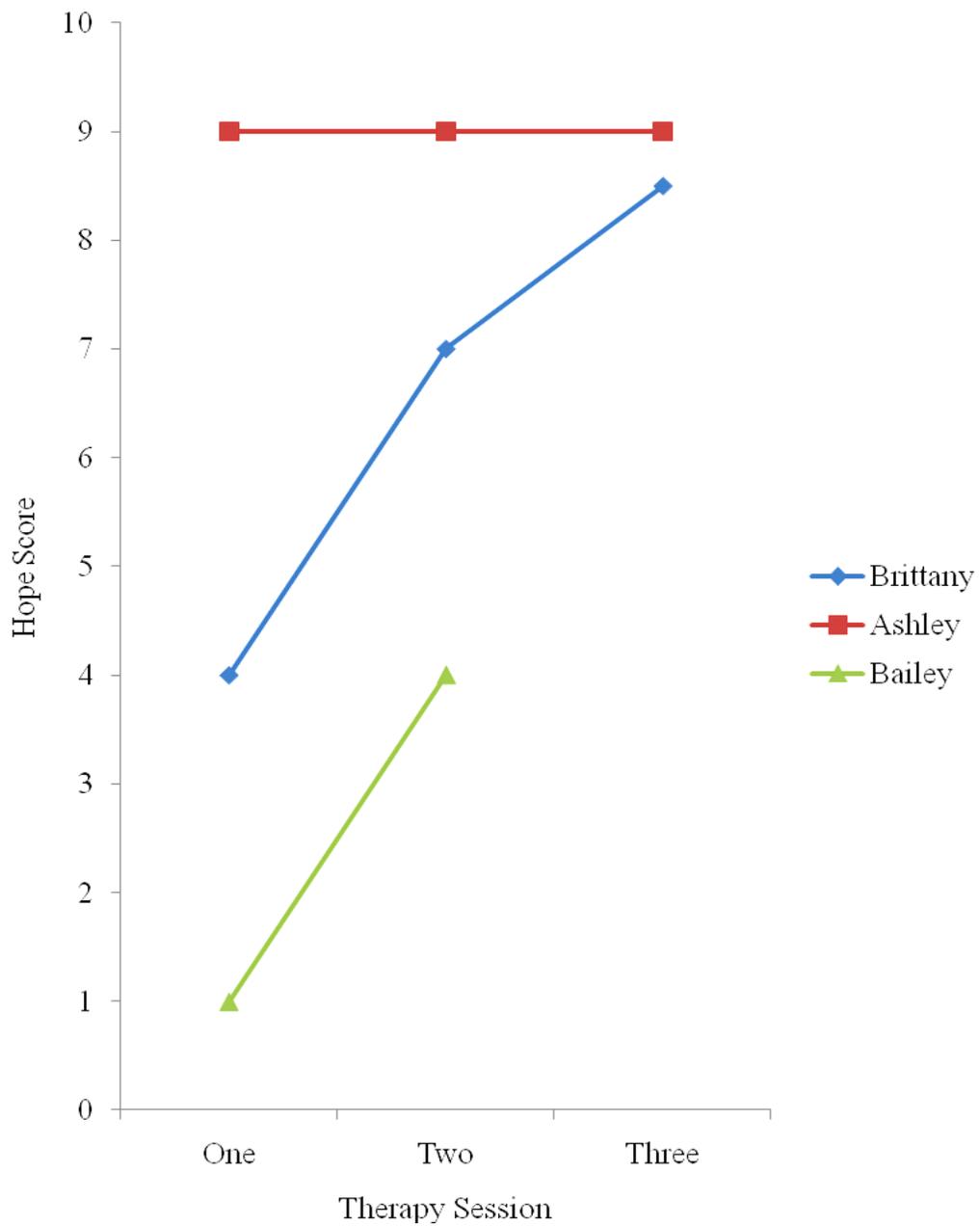


Figure 1. Hope scaling question scores.

CHAPTER V

DISCUSSION

The purpose of this study was to determine how hope theory (Snyder, 2002) could be utilized and applied by one therapist within the first few sessions of therapy in order to engender greater hope for clients. This was accomplished through conceptualizing hope in terms of hope theory (Snyder), assessing the clients' levels of hope at the time of the first and further sessions, examining the decision-making process of the therapist, selecting and implementing hope-engendering interventions, and observing the effects of interventions upon clients. Three individuals who presented for therapeutic services at the USU Marriage and Family Therapy Clinic participated in the study. Eight therapy sessions were conducted across three cases. Each session was videorecorded and coded utilizing a checklist of interventions particular to the study. Intake information, case notes, teammate/supervisory notes, a hope scaling question, and reflection journals were used to assess hope and examine the decision-making process of the therapist. The results of this study suggest that the therapist demonstrated an ability to utilize hope theory (Snyder) to theoretically and rationally assess hope, select interventions, and implement interventions in ways that were beneficial to clients.

The following sections discuss the results of this study as well as unexpected findings, implications, and limitations. Although the primary subject of this study is the practicing therapist, when drawing conclusions from the data, the context of the sample must be considered. All three participants were women, resided in the same city, were relatively young; or between the ages of 26 and 31.

Results

Research Question One

Did I demonstrate fidelity to the specific interventions described? The tallied results obtained from analysis of the intervention checklist data suggest that I demonstrated fidelity to the interventions described in the study as evidenced by frequent use.

Although engendering hope was not my only therapeutic goal during the first few sessions of therapy, it consumed much of my attention. Because I was concerned with the ability of a second observer to recognize the interventions I utilized, I found myself emphasizing them and presenting them so as to be more easily recognizable by others. This seems to have been effective because the majority of the interventions I utilized were recognized by the second observer. Data from teammate/supervisory notes seem to indicate that this practice did not distract the participants or appear mechanical or robotic. This reflection is significant because it suggests that I must pay careful attention to how these interventions are executed in the future. Interventions that are not delivered in a similar manner and perhaps unrecognizable by others may be less effective with clients.

The intervention that was most difficult to identify correctly during observation was reframing negative goals. After the second observer and I discussed our differences it became clear that this intervention was not miscoded but not identified. During one session, the client's goals were both specified and then immediately reframed. The second observer coded only the first intervention for each goal that was discussed with the client. After discussing this and other differences between our observations, the video

was recoded by both myself and the second observer. The results of the second coding indicated that this error was rectified, and data reanalyzed, suggesting that the intervention was applied.

When considered together, these observations indicate to me that I remained true to the hope engendering interventions described in the study. They were described with sufficient accuracy, executed frequently, and observed by someone who was adequately trained.

Research Question Two

How did I make decisions regarding the selection and implementation of hope-engendering interventions (goals, agency, or pathways)? As my cases progressed, it appeared that I began structuring my decision-making process in similar ways. Upon final analysis, it appeared that my decision-making process became more uniform across cases than I had presumed. My final decision-making process placed less emphasis upon my assessment of hope and more emphasis upon client factors and other circumstances. For example, in one case I determined that the most appropriate area of intervention should be formulating goals. Upon assisting the client, she found it very difficult to identify clear goals. Although I believed that goals were still the area most in need of assistance, helping to build the client up and increase her belief in her ability to create goals by focusing on agency thinking proved to be more successful. This was one example in which client factors contributed to and influenced my decision to select interventions.

These results indicate to me that over the course of the study, I developed and formalized a decision-making process that was revealed upon examination. This decision-making process places more emphasis on client responses to interventions and other client factors and less on my initial assessment of hope. In each case, Snyder's (2002) theoretical construct of hope served as the basis of my conceptualization.

Research Question Three

How did attending to hope theory (Snyder, 2002) affect how I performed therapy? Anytime a therapist implements something new or utilizes a new framework in order to conceptualize things differently, it is likely that there will be changes in his or her performance. In utilizing hope theory (Snyder) in order to engender greater hope in clients, I found that it affected many aspects of my performance. The most dramatic changes occurred in my own thinking and affected how I perceived each participant and conceptualized each case. Because engendering hope was only one of my therapeutic goals, many of the other changes that occurred as a result of utilizing hope theory were subtle and required careful reflection. This experience has helped me to understand the great impact that new ideas and theories can have upon a therapist and his or her therapeutic practice.

I believe that some of the positive ways that attending to hope theory (Snyder, 2002) affected how I performed therapy were by increasing my joining practices and helping me to formulate therapeutic goals more quickly. I consider joining to be a vital and important practice that can sometimes be challenging when clients appear withdrawn, uninvolved, and or skeptical. I have found that therapy is often filled with discussions of

problems and complaints that generally result in creating a negative atmosphere. I have rarely found clients resistant to compliments and observations that identify strengths unless they suspect ulterior motives. Although my experience is not the same as the experience of my clients, when I receive a thoughtful compliment from someone, it increases my belief or confidence in their ability to judge me more objectively. My experience during this study has led me to believe that identifying strengths and giving verbal praise can be an effective way of joining.

Formulating therapeutic goals is another component of therapy that is important and one that has been difficult for me to accomplish by the end of the second session of therapy. Because hope theory (Snyder, 2002) places a strong emphasis on the client's ability to formulate goals, I believe it has increased my ability to formulate treatment plans and create goals for each session of therapy. Because my theory of practicing therapy suggests that setting goals should be a collaborative process, helping the client formulate goals has helped me.

I believe that some of the negative ways that attending to hope theory (Snyder, 2002) affected how I performed therapy were by contributing to a disorganization of my thoughts and ideas and leading me to deviate from my typical therapeutic practices. Whether or not it was noticeable to participants, I felt very unfamiliar segueing from one intervention to another. This contributed to feelings reminiscent of my first session of therapy as a new therapist and affected my confidence. I attribute these feelings to my unfamiliarity with weaving these concepts together rather than my unfamiliarity with the concepts themselves. The challenge that this presented distracted me from the delicate

balance of other concepts and details that competed for my attention. My preoccupation with integrating these practices smoothly in therapy ultimately affected what I accomplished in therapy and affected the frequency with which I utilized other interventions that are more typical of my therapeutic practice. According to my own self-evaluation, I believe that my confidence suffered, but it would be reasonable to believe that this could be reconciled with greater experience.

The difficulty I experienced while trying to attend to hope concepts during my typical assessment practices appears to be a more serious observation. Although I believe that one of my strengths as a therapist is my ability to attend to numerous things simultaneously, this observation suggests that I need to recognize my limits. Based on my experience with this study and my own self-evaluation, I have developed the belief that juggling too many concepts or theories during therapy produces mediocre results.

Research Question Four

Did clients report an increase in hope? Results of the analyses of responses to the hope scaling question indicate that clients generally experienced an increase in hope. The increase in hope experienced by most clients may be attributed to numerous factors unrelated to this study or the specific interventions that were utilized during therapy. This assumption does not discredit the study because it has been theorized and recognized that change could occur as a result of numerous variables (Lambert, 1992). Further, the purpose of this study was not to evaluate the efficacy of hope theory (Snyder, 2002) but rather its implementation by the practicing therapist. Although these results do not

necessarily support or discredit the tenets of hope theory they do suggest that the interventions may have been helpful.

Although it was the general trend of clients to report an increase in hope, it is possible that this is the result of a social desirability response bias. Clients may not have experienced a change in hope but desired to be liked by the therapist and, therefore, responded in what they perceived to be a desirable manner. This is an especially important consideration because a client who has developed a good relationship with his or her therapist may be hesitant to damage or jeopardize it (Gaston & Sabourin, 1992). Data from this study, however, would suggest that this was not a significant factor in client responses. Because this study focused on the first few sessions of therapy, it decreases the probability that a very close and therefore more influential relationship existed between the therapist and the clients. Further, one client's reported level of hope remained consistent through the first three sessions of therapy, suggesting that if the client did experience a desire to impress the therapist, it was not acted upon.

Another interpretation of these results was suggested by a client who completed only two sessions of therapy. When asked the hope scaling question, she responded with a number and then said, "My hope about the situation goes up and down; it just depends on the day." Unlike the other clients, this client described a very volatile and unstable level of hope. Interestingly, this client is the one who had difficulty formulating goals for therapy that were of significant enough value to her. One day she was filled with anger and wanted to move on with her life, while on another day, she believed things might

work out for her. Her case suggests that although her level of hope increased, it was unstable because it was not associated with any specific, desirable approach goals.

Other Findings

As the study progressed, I discovered that data from the OQ 45.2 and the Family Information Intake form were not as helpful as I had expected. For example, one client indicated that she failed to answer a question on the Family Information Intake form because she was interrupted by a phone call when filling out the form. These sources of data proved helpful in providing me with an initial starting point but generally resulted in a very rudimentary and inaccurate assessment of hope. When I began utilizing hope-engendering interventions, I discovered that the responses and reactions of clients to these interventions were a much more valuable and reliable source of data. This unexpected finding provided me with the richest form of data from which I could more accurately assess hope.

During the course of this study, I was impressed by the difficulty that many clients demonstrated when goals were discussed. Brittany was working towards preventing or forestalling relapse, something negative from occurring. Ashley was hoping to eliminate her child's negative problem behavior, vaguely describing what she desired instead. Bailey was ultimately unsure of what she wanted and had formulated goals that were also negative in nature and of questionable value to her, resulting in low degrees of motivation. Some of the clients responded well to interventions that specifically targeted their goals, but some found it difficult to specify and transform their goals into positive

approach goals. Positive approach goals, which are of significant value to the client, are an important element of hope according to hope theory (Snyder, 2002). Such goals provide a means by which a client may measure progress and suggest a course of action that may be taken instead of suggesting that there is nothing that can be done and that one is powerless to effect change.

These findings suggest to me that the ability to formulate effective goals is an important skill to both the client and the therapist and that clients and therapists who struggle with formulating effective goals are more likely to experience lower levels of hope. These findings are consistent with the basic premise of hope theory (Snyder, 2002), which suggests that poorly constructed goals lead to a decrease in both pathways thinking and agency thinking.

Another important finding I discovered during the course of this study came from my experience working with Ashley. Ashley had nearly exhausted her resources or pathways in helping to change her daughter's behavior. During the course of treatment, new pathways were explored. Some interventions were more successful than others, but each one contributed to a greater understanding of the situation. Because I was especially sensitive to preserving hope, I encouraged reflection in the presence of failure, and was able to reframe failure into an important part of success. As long as the interventions were carried out successfully, I made it clear to Ashley that failure was still a positive result because it led to another pathway. I believe that this positive reframe is a very important finding about my work as a therapist. In terms of hope theory (Snyder, 2002), such reframing prevents an individual from attributing failure to themselves, preserving

her or his level of agency thinking. If one can be convinced that failure is positive and indeed a step in the right direction, it is my belief that that individual is likely to continue developing new pathways.

Another finding from this study came from my reflection of an experience I had with Ashley and her daughter. After assessing Ashley's hope through the hope scaling question, I asked her daughter the same question. Her daughter looked at her mother and then responded in a similar manner. As the daughter generally answered questions without first looking at her mother, this brief interaction stood out to me and I reflected upon it during the course of the study. Although there are numerous plausible interpretations of this interaction, I believe the mother's level of hope played a significant role in the daughter's level of hope. In terms of hope theory (Snyder, 2002), this may be explained by considering the importance of agency thinking. When agency thinking or an individual's belief in his or her ability to utilize pathways is low, it is possible that this appraisal could be influenced by others. In other words, one's belief in her or himself can be affected by another's belief in her or him.

Scientist-Practitioner Model

According to researchers (Crane et al., 2002), the term *scientist-practitioner* model refers to a perspective of clinical education and practice that includes consuming new research findings, evaluating one's own clinical practice, and contributing to the professional literature through evaluation of one's own clinical work. As a result of accomplishing this research project, I believe I have not only gained scientist-practitioner

skills but also the resolve to remain current regarding the latest research and to frequently evaluate my own practice.

As a student I was made aware of the importance of research from day one. I was continually asked to find it, critique it, and cite it. I believe that by the end of my training, my respect and appreciation for the importance of research was sufficient. In regards to evaluating my own research, I believed I had the abilities but lacked the concrete experience necessary to be successful. Without the help of my major professor and committee I do not believe I would have been successful or obtained results that possessed some degree of validity and reliability.

Because of this research project, I was forced to find research on my own and without the use of my own books or the collected resources and references of others. As a student, I understood that theory was critical for selecting and implementing interventions, but this research project challenged me to see how well I knew that theory. As I added hope theory (Snyder, 2002) to my own personal theory of therapy and change, I began to see what a dramatic effect it had on many other things. This experience has showed me how clinicians must be researchers and how researchers must be clinicians.

Systemic Implications

There are numerous personal reflections and observations that I made during this study that could describe some of the systemic implications of hope theory (Snyder, 2002) on family systems. First, in response to the hope scaling question, I noticed that Jessie responded exactly the same as her mother. Although there could be many interpretations of this event, I believe it suggests that we often look to others to have hope

or believe in us before we will have hope or believe in ourselves. If a mother comes to therapy and does not believe her daughter will or can change, I do not believe it is very likely that change will occur. If I join a family system and do not show hopefulness about a family problem, I do not believe the family is likely to gain hope. It would seem that the hopelessness of significant others may actually stifle or prevent change. Focusing on the individual with the least amount of hope may affect others in the system.

Second, I noticed that Bailey was hoping her husband would change his mind and return to the relationship. I believe that hopelessness grows quickly when we are focused on changing others instead of changing our interactions with others. In terms of hope theory (Snyder, 2002), one may generate numerous pathways to realistic goals but one must have the agency or belief in one's own ability, and not the ability of someone else, to use those pathways.

Cultural Competency

The interventions that were utilized in this study were tailored to the individuals as much as possible. I believe that I was able to do this partly because of my observance and recognition of specific cultural variables. For example, familiarity with drug culture allowed me to recognize that restaurants often attract individuals with impulse control and addiction problems because of the immediate pay. I was able to praise Brittany for her decision to avoid particular environments. Bailey chose to define herself almost exclusively by her roles as a mother and spouse, a belief that she adopted from her family's culture. This allowed me to recognize the significance of helping her to identify other strengths and recent successes such as finding a good job. Although many of the

women in this study had similar cultures, paying attention to the unique circumstances and beliefs of each individual culture allowed me to be more successful in selecting and implementing each intervention.

Implications

In terms of research question one and the fidelity component of this study, it is important to note that these interventions were executed so that they could be easily identified by another observer. The circumstances under which I would execute them without an observer might change how I deliver them. Familiarity with the interventions and a decreased preoccupation with their observation and identification could lead to significant differences in how they are executed in the future.

Further, an analysis of the data indicates that a few of the interventions outlined in the study were not utilized. After consideration of this observation, I have reasoned that these interventions were not utilized because I deemed other interventions more appropriate due to the circumstances and not because I believed the interventions themselves would have been any less effective.

In terms of research question two, I believe that an important part of utilizing a new theory or framework in therapy is identifying the decision-making model that develops as a result. The decision-making model that I developed over the course of the study changed several times and was only fully revealed after structured reflection and an imperative to crystallize my thoughts and report them. Understanding my own thinking process has helped me to reevaluate the importance of specific pieces of information and

feedback from clients. Without understanding one's own thinking and decision-making process, it is almost impossible to evaluate the information one gathers with any degree of objectivity. Just as the decision-making in this study changed over time, the ways that I utilize other theories or concepts is sensitive to time and experience and should be reidentified and reevaluated frequently through the use of scientific means.

In response to research question three, I believe that this study has opened my eyes to the importance of remaining true to one's own theory of therapy and change. Too many thoughts and ideas without structured protocol lead to an amalgam of incomplete assessments and a loss of focus. I believe that utilizing hope theory (Snyder, 2002) in order to engender greater hope can be helpful to clients that are demoralized, destitute, and hopeless, but may be distracting to myself and unhelpful to clients that have adequate levels of hope. I believe that change is never spontaneous and is always the result of doing, thinking, or experiencing something differently. When I believe that low levels of hope are interfering with a client's ability to act, think, or experience things differently, I believe hope theory (Snyder) and these interventions can be useful. Based on my experience during this study I believe that I will selectively borrow from hope theory when I feel it is appropriate.

Based on my other findings, I have gained a greater realization of the importance of effective goal formulation, reframing failure as success, and expressing my hope in and to others. Although I will selectively borrow from hope theory (Snyder, 2002) in the future, I believe that assisting clients to develop helpful goals will remain an important part of my practice. I believe this practice will help clients develop the skill of

formulating goals and assist myself in collaborative treatment planning. Because I have discovered the power of positively reframing failure as success, I believe I will utilize this practice during my first sessions of therapy. I believe that praising clients when they successfully complete assignments, whether effective in bringing about change or not, is an effective way of preserving hope and will help clients understand that therapy is an assisted discovery process that they can be capable of accomplishing on their own.

Finally, I believe that hope can be contagious and that my belief in a client's ability to succeed can affect his or her degree of hope. I believe that inexperienced therapists may do a better job at engendering hope because they maintain the belief that everyone can change. The longer I practice, the more failures I will have. This may lead to the development of more realistic and accurate appraisals of a client's prognosis with me as their therapist. I believe that these beliefs can and will be transferred to my clients. Therefore, I must make a special effort to express my belief in a client's ability to change, and not lose hope myself.

Limitations

There are many limitations to this study. One of the most significant was my involvement as the primary subject of study and the primary observer. Although there were multiple observers and various participants, and although special attention was given to contradictory evidence and alternative explanations, my own subjective reflections and observations represented the primary data sources. This most likely

resulted in a biased interpretation of my own effectiveness and the conceptualization of each case.

Another important limitation of this study is its generalizability. It is not possible to generalize the results of this study to other therapists because, as designed, this study represents an investigation of my own conceptualization, interpretation and utilization of hope theory (Snyder, 2002). Further, because the sample consisted of only three participants, it is difficult to determine whether my findings would remain consistent or could be generalized to other clients such as men or couples.

Conclusion

This study contributed to my understanding of how I might utilize and integrate a new theory or concept into my own personal theory of therapy and change. Further, it contributed to my understanding of how I might conceptualize and assist clients in developing greater hope during challenging circumstances. My experience from this study has resulted in my decision to selectively borrow concepts from this theory when I feel they can be useful, particularly in situations where hope to resolve an issue or concern is particularly low.

Inherent in this study and its design are limitations that reduce its usefulness and generalizability to anyone other than myself. Despite this consideration, this study has represented a very useful and enriching research endeavor because it has informed me of my ability to use theory and provided an enriching experience regarding the use of scientific skills in observing and evaluating my own practice.

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APPENDICES

Appendix A: Informed Consents, Memo



Case # _____

Therapist _____

Marriage & Family Therapy Clinic

INFORMED CONSENT FOR TREATMENT

I understand that treatment with the Utah State University Marriage and Family Therapy Clinic may involve discussing relationship, psychological, and/or emotional issues that may at times be distressing. However, I also understand that this process is intended to help me personally and with my relationships. I am aware that my therapist will discuss alternative treatment facilities available with me, if needed.

My therapist has answered all of my questions about treatment with the Utah State University Marriage and Family Therapy Program satisfactorily. If I have further questions, I understand that my therapist will either answer them or find answers for me; or that I can contact the Director of the Clinic, Dr. Scot Allgood, (435) 797-7433. I understand that I may leave therapy at any time, although I understand that this is best accomplished in consultation with my therapist.

I understand that graduate students in family therapy conduct therapy under the close supervision of family therapy faculty, and that therapy sessions are routinely recorded and/or observed by other Program therapists and supervisors.

I understand that all information disclosed within sessions is kept confidential and is not revealed to anyone outside the Program without my written permission. The only exceptions to this are where disclosure is required by law (where there is a reasonable suspicion of abuse of children or elderly persons, where the client presents a serious danger or violence to others, or where the client is likely to harm him/herself unless protective measures are taken or when there is a court order to release information).

I agree to have my sessions recorded for therapeutic and supervision purposes.

This form is to be signed by all participating clients/children 7-18 must provide signatures as assent.

Signed: _____

Date: _____

Utah State UNIVERSITY

Department of Family, Consumer, and Human Development
USU MFT Program
2700 Old Main Hill
Logan UT 84322-2700
Telephone: (435) 797-7430

Date Created: October 2, 2008; Page 1 of 3
USU IRB Approval 11/10/2008
Approval Terminates: 11/09/2009
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INFORMED CONSENT FOR RESEARCH Utah State University Marriage and Family Therapy Program

Introduction/ Purpose Faculty and students at the USU Marriage and Family Therapy Clinic sometimes use therapy information for research studies. This information includes the forms you fill out, notes used for your therapy sessions, and videorecordings. Research helps us find out more about how therapy works and how effective it is. We are asking to use your information for future research. You are not required to allow your information to be used for research purposes. If we do not have your permission to use your information for research, it will be used for therapy purposes only.

Procedures If you agree to have your information used in research, you will not be asked to do anything different from what you do already. Consenting or not consenting to allow your information to be used in research will not affect your therapy at the MFT clinic in any way.

Risks Because you are not being asked to fill out any new forms or do anything different in therapy, there is no added risk or discomfort. We follow state and federal guidelines for the protection of medical information.

Benefits There may not be any direct benefit to you from using your information for research. The investigators, however, may learn more about how therapy works at the MFT clinic and how effective it is. Therapists who use the information for research may benefit because their therapy skills may improve; in this case, it is possible that allowing us to use your information may improve your therapy.

Explanation & offer to answer questions Someone has explained our request that we use your clinic information for research and answered your questions. If you have other questions or problems related to using your information for research, you may contact Professor Scot Allgood, the director of the MFT Program, at 797-7433.

Extra Cost(s) There are no extra costs or benefits to you for agreeing to allow your information to be used in research.

Voluntary nature of participation and right to withdraw without consequence Giving us your permission to use your information for research is entirely voluntary. You may refuse to participate or withdraw at any time without consequence or loss of benefits. Your information would then be used for therapy purposes only. Your therapy or other services will not be affected in any way.

Confidentiality Just as with therapy, your therapy records will be kept confidential, consistent with federal and state regulations. Only the professors and students in the MFT Program have access to the information, which is kept in a locked file cabinet in a locked room in the Family Life Center. Your therapy information that includes names, addresses, etc. is kept for 10 years, consistent with state law regarding medical information. Any information that is used for research will have this identifying



Department of Family, Consumer, and Human Development
 USU MFT Program
 2700 Old Main Hill
 Logan UT 84322-2700
 Telephone: (435) 797-7430

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INFORMED CONSENT FOR RESEARCH
Utah State University Marriage and Family Therapy Program

information erased or blacked out. If you decide to not give us your permission to use the information for research, your clinic file will be identified with a colored dot so that the information is not used for research. If you do give us permission, no reports about the research will include names or any other identifying information.

Information from videorecordings of your therapy may also be used in research. Videorecordings are typically destroyed when the graduate student therapists finish at the MFT Clinic. Any recordings that are used for research will also be destroyed when the student finishes the research. Transcripts of the recordings or other written records of what happens in the therapy sessions may be kept, but they will include an identifying code only and not your name(s) or any other identifying information. Informed Consents for Research that include your signature(s) will be kept in separate locked filing cabinets.

IRB Approval Statement The Institutional Review Board for the protection of human participants at USU has approved this research study. If you have any questions or concerns about your rights or a research-related injury, you may contact the IRB Administrator at (435) 797-0567 or email irb@usu.edu. If you have a concern or complaint about the research and you would like to contact someone other than the research team, you may contact the IRB Administrator to obtain information or to offer input.

Copy of consent You have been given two copies of this Informed Consent for Research. Please sign both copies and retain one copy for your files.

Investigator Statement "I certify that the research study has been explained to the individual(s) by me or my research staff and that the individual(s) understands the nature and purpose, the possible risks and benefits associated with taking part in this research study. Any questions that have been raised have been answered."

Signature of PI

Scot M. Allgood, Ph.D.
 MFT Program Director
 435-797-7433

Signature of Participants By signing below, I agree to allow my clinical information at the MFT Clinic to be used in research.



Department of Family, Consumer, and Human Development
USU MFT Program
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Logan UT 84322-2700
Telephone: (435) 797-7430

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INFORMED CONSENT FOR RESEARCH
Utah State University Marriage and Family Therapy Program

Participant's signature

Date

Witness

Date

Child/Youth Assent: I understand that my parent(s)/guardian is/are aware that my therapy information may be used in research and that they have given permission. I understand that it is up to me to decide whether I want the information used in research even if my parents say yes. I understand that if I give permission that my name will not be used in the research. If I do not want my information used in research, I do not have to give permission and no one will be upset if I don't want to or if I change my mind later. I can ask any questions that I have about this study now or later. By signing below, I agree to allow my therapy information to be used in research.

Name

Date

Permission granted? ___ Yes ___ No

ID # _____

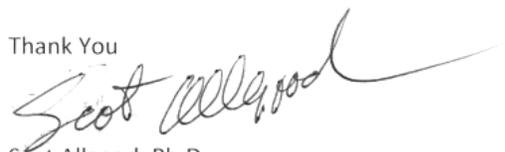
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Marriage and Family Therapy Program
2700 Old Main Hill
Logan UT 84322-2700

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This memo is to certify that Joey Tschudy has permission from the USU Marriage and Family Therapy Program to use our existing data (previously IRB approved) for his thesis.

Thank You



Scot Allgood, Ph.D.

Marriage and Family Therapy Program Director



Appendix B: Instruments

Intervention Checklist

Descriptions of each intervention are found below. Please indicate the occurrence of each intervention with check marks and describe each observation with a brief sentence.

| Client # Date | | |
|--|---------------------------------------|--|
| Goals | Agency Thinking | Pathways Thinking |
| Identifying Goal Domains | Positive Reframing | Providing Pathways |
| Specifying Goals | Identifying Success | Identifying Social Support/Role Models |
| Reframing Negative Goals | Establishing Positive Self-Talk | Exploring Past Success |
| Envisioning goals and recognizing goal achievement | Assigning a Small Task | Creating Subgoals |
| | Anticipating/Preparing for Roadblocks | Brainstorming |

Intervention Descriptions

Interventions That Increase Goal Formulation

Identifying goal domains is the process of assisting clients to examine various life domains, determine their relative value or importance, and assist clients to subjectively rate their personal satisfaction in each domain (Lopez et al., 2000). This process is accomplished by asking the client questions such as, “How important is your work to you?” or “How satisfied are you with your social relationships?”

Specifying goals is the process of transforming a general idea into a concept that can be stated explicitly or in detail (Lopez et al., 2000). For example, a goal such as, “I want to be happy” is unlikely to be accomplished because it is difficult to know what it means. This goal could be *specified* or transformed into “I want to improve my interpersonal relationships” and then into “I want to improve my social skills.”

Reframing avoidance goals is the process of transforming a goal from a negative avoidance context into a positive approach context (Michael et al., 2000). An example of *reframing goals* would be transforming the goal of “arguing less” to “spending more time together and discussing areas of common interest”

Envisioning goals and recognizing goal achievement is the process of assisting clients to visualize and describe their goals (Michael et al., 2000). It also includes assisting clients to establish specific methods of recognizing progress towards their goals and final goal attainment. It may include identifying thoughts, feelings, and behaviors or anything noticeable that would be associated with goal achievement. It is accomplished by directing thought-provoking questions or instructions to the client

regarding their goals, for example, by asking a client, “How would you reward yourself for making progress towards your goal and how would you know when you have made that progress?”

Interventions That Increase Agency Thinking

Positive reframing is the process of altering the meaning of a specific situation or statement in order to reflect positive or desirable characteristics (Lopez et al., 2000). It often allows a client to change the attribution of failure from a personal one (e.g., “I’m a failure”) to an external one such as circumstance, an ineffective pathway or other variables. For example, a client’s belief that he or she is a failure for seeking therapy because of a distressful marriage may be positively reframed to reflect a belief that he or she is wise for seeking therapy, that marriage is an exciting challenge, and that with the proper skills, he or she could achieve success.

Identifying success is the process of identifying competence, power, control, wisdom, capability, or accomplishment (Michael et al., 2000). It may be accomplished by identifying and complimenting the past success of the client, the present success of the client, or the past and present success of others who are similar to or in similar circumstance as the client. This process is most helpful when noticing a personal attribution of the client. For example, a therapist may say, “I think you made a very good decision to come in and speak with me; it tells me that you realize the importance of healthy relationships.” A therapist could also ask, “What is the hardest thing you have overcome in your relationship?”

Establishing positive self talk is the process of assisting clients to develop specific thoughts regarding the appraisal of themselves or their abilities (Taylor et al., 2000). It is accomplished by directing questions to clients that will assist them to identify negative self talk, and replace it with more constructive thoughts. For example, a therapist could ask a client, “What do you tell yourself when you start to doubt your ability to reach your goal?” or “What could you tell yourself instead that would motivate you to continue pursuing your goal?”

Assigning a small task is the process of instructing a client to carry out a specific task that is in his or her perceived ability to perform (Lopez et al., 2000). The first step in this process may involve asking clients to identify something themselves. The second step is to establish accountability for accomplishing the task. Asking the client, “What is one small thing you can do differently this week that you believe will help you in the pursuit of your goal?” is an example of the first step. Asking the client, “Getting an extra hour of sleep each night this week sounds like a great idea; will you be prepared to report back next week and explain what difference that has made for you?”

Anticipating and preparing for roadblocks is the process of assisting a client to identify the most threatening obstacles that are likely to stand in the way of goal attainment (Lopez et al., 2000). It also involves preparing clients by assisting them to feel capable of coping with those situations should they arise. This is also done by asking the client questions such as, “Once you begin to change, where or from whom are you most likely to meet with resistance?”

Interventions That Increase Pathways Thinking

Providing pathways is any process that involves teaching a client new behavioral or perceptual skills (Taylor et al., 2000). This may include education regarding parenting, communication, problem solving, or other skills training. It may also include techniques or skills required to record or alter thoughts and behaviors.

Identifying social support and role models is a process of assisting a client to identify others whose interactions may stimulate pathways thinking (Lopez et al., 2000). This may include friends, family members, coworkers, or anyone who, if made knowledgeable of the client's difficulties, could offer new pathways by way of personal advice or experience. This is done by asking a client questions designed to stimulate his or her thinking regarding social support. For example, a therapist may ask, "Who else knows about this?" or, "I'm sure some of your closest friends have already told you what to do about your situation, but who else in your life might understand what you are going through?"

Exploring past success is a process of assisting clients to identify the specific strategies and pathways that they have previously used in order to achieve their goals (Michael et al., 2000). It also involves identifying pathways that could be generalized or applied to the client's presenting problem. This can be accomplished through provocative questioning. For example, a therapist may ask, "Writing your thesis sounds like a pretty grueling experience, especially since you have the attention span of a fly; how exactly did you get it done?"

Creating subgoals is an intervention that assists the client in identifying the small goals that are necessary to achieve before a larger goal may be met (Lopez et al., 2000). It is the process of breaking a goal into smaller subgoals. This is also accomplished through questioning. For example, a therapist may ask, “What are some of the things you will have to do before you can calmly discipline your child?”

Brainstorming is a process that assists a client to practice designing alternative pathways (Michael et al., 2000). This process stimulates pathways thinking by including creativity, flexibility, and humor. The pathways that the client identifies need not be realistic or even plausible as long as they are related to a goal in some fashion. Asking a client who is shy to create an exhaustive list of how she or he might attract the attention of others would be an example of *brainstorming*.

Reflection Journal Terms

REFLECTION JOURNAL TERMS AND THEIR DEFINITIONS

Specific: referring to one identifiable object or behavior.

General: referring to more than one identifiable object or behavior.

Expectancies: an attitude of expectancy or hope.

Pathways: any means or methods used to obtain goals.

Hope-engendering interventions: Interventions identified and described in the study.

Tailored: adjusted to meet personal characteristics or circumstances.

Reaction: the observable verbal and non-verbal actions of the client.

Sufficient: enough to meet a need or purpose; adequate.

Match: to be like with respect to specified qualities.

Hope Observation Form

During your observation please record any information that could indicate the presence of hope. Hope theory (Snyder, 2002) suggests there are three elements that contribute to the formation of hope, these are explained below.

Goals

The presence of significant, specific, measurable, positive approach goals

Agency Thinking

The presence of thoughts or behaviors that indicate the individuals' belief in their ability to utilize pathways

Pathways Thinking

The presence of thoughts or behaviors that indicate the ability of the client to generate numerous solutions, means, routes, or methods