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Hope Therapy in Depression: A Clinical Case Work

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***Abstract*:** The term hope has been used in literature, philosophy and other disciplines of social sciences as a desirable human trait which has thought to have significant positive implications in all spheres of human life. Almost all religious scriptures aim to make human beings as being hopeful and hope has been considered as an important component of faith. The scientific work on the variable of "hope" started in the 1950s. In the clinical area, Jerome Frank (1968, 1973), Karl Menninger (1959), Victor Frankl (1966, 1992) highlighted the importance of hope in alleviating suffering through psychological interventions. Frank posits that psychotherapy is a sort of persuasion and healing process which inculcate hope in people who are suffering from emotional problems. Synder, Higgins and Stucky (1983) started formulating the basic tenets of hope theory by asking people's explanations of their possible reasons of their failures or when they perform poorly on a given set of tasks. The most comprehensive and elaborative recent work on hope has been done by Synder et al (1991).The objectives of the present paper will be to focus on the theory of hope and clinical case illustration of hope therapy. The new emerging model of hope intervention has been research on mental health issues like depression. It needs to be incorporated with other contemporary models of psychotherapy. It has implications not just for alleviating mental health issues but also for improving emotional well-being. The current case illustration of hope therapy in a case with depression highlights the significance and emerging importance of strengths based interventions like hope therapy.

Key words: *Hope, hope theory, hope therapy*

Introduction

The term hope has been used in literature, philosophy and other disciplines of social sciences as a desirable human trait which has thought to have significant positive implications in all spheres of human life. Almost all religious scriptures aim to make human beings as being hopeful and hope has been considered as an important component of faith. The scientific work on the variable of "hope" started in the 1950s. In the clinical area, Jerome Frank [1,2], Karl Menninger [3], Victor Frankl [4,5] highlighted the importance of hope in alleviating suffering through psychological interventions. Frank posits that psychotherapy is a sort of persuasion and healing process which inculcate hope in people who are suffering from emotional problems. Synder, Higgins and Stucky [7] started formulating the basic tenets of hope theory by asking people's explanations of their possible reasons of their failures or when they perform poorly on a given set of tasks. The most comprehensive and elaborative recent work on hope has been done by Synder et al [7].

Basic Concepts of Hope Theory

Snyder [7] assumed that human actions are goal directed and accordingly goals are the targets of mental action sequences and they provide the cognitive component that anchors hope theory. They argue that goals may be long or short term in nature. It is important, however, that the goals should have sufficient values for the people. They also assert that planned goals should be attainable but must have some degree of uncertainty. They defined hope as "a positive motivational state that is based on an interactively derived sense of successful (a) agency- goal directed energy and (b) pathways-planning to meet goals". Another definition of hope is "a cognitive set that is based on a reciprocally-derived sense of successful agency (goal-directed determination) and pathways (planning to meet goals)". In general sense hope is the sum of perceived capabilities to produce routes to desired goals, along with the perceived motivation to use those routes. There are three important components in hope theory. In other words, hopeful thinking always includes three components which are as follows:

Goals: As per hope theory framework, a goal is anything that an individual desires to get, do and experience or create. There may be long term goals which may take weeks, months or years to achieve for example to open a center of psychology for orphans or short term goals which may require days, even minutes to achieve the goals for example reaching one's clinic, or eating lunch. In hope theory, goals vary in attainability. It is important that goals set should have some uncertainty. It is assumed in hope theory that human behaviour is goal directed and when an individual initiates a volitional behaviour sequence, it must be directed toward achieving some specific outcomes. Before initiating in the volitional behaviour sequence, an individual must engage in two other types of cognitive/mental activities. These two other cognitive/mental activities are remaining components of hope theory.

Pathways: It is also known as pathways thinking. It refers to the ability of people of generating workable routes to achieve their desired goals. It reflects a person's perceived capacity to produce cognitive routes to the desired goals. A person involving in pathway thinking will say "I will find a way to get my work done". Pathways thinking in any given instantiation involve thought of being able to generate at least one and even more usable routes to get the desired goals. The production of several pathways is important when encountering blockages in goal attainment. People with high hope, are able to produce multiple ways to attain their goals.

Agency: It is also known as agency thinking. Generating pathways is not sufficient to attain their goals. Agency reflects the person's perception that he or she can begin movement along the imagined pathways to goals. It is the thoughts that people have regarding their ability to begin and continue movement on selected pathways toward those goals. It is through mobilizing agency thoughts that a person is sufficiently motivated to initiate and sustain movement toward goal attainment. So, agency is a motivational component of hope theory. Agentic thinking reflects the self-referential thoughts about both starting to move along a pathway and continue to progress along that pathway. Agentic thinking is important when the initial routes of goal attainment are blocked and provides the required motivation that must be channelled to the alternative pathways.

Synder [7], thus, conceptualized hope as reflecting both the will (confidence) and the ways (pathways).

Emerging Clinical Application of Hope: Hope Therapy

From the 1960s through the 1980s, Jerome Frank [1,2] pioneered a view that hope was a common process across differing psychotherapy approaches. Whatever a system of psychotherapy was being administered, the beneficial changes occur because patients have been learning more effective agentic and pathways goal directed thinking. Hope therapy is designed to capitalize upon hope in the process of therapy as hope seems to be a malleable strength that can serve as an important therapeutic change agent. Therapists who practice hope therapy or components of hope therapy help clients to conceptualize clearer goals, to learn how to produce multiple pathways to reach goals and to generate the mental energy needed to sustain goal pursuits in order to positively change client self-perceptions regarding their abilities to engage in goal directed and agentic thinking. In order to understand the hope therapy, it is important to understand the assumptions about hope.

Assumptions about Hope

The assumptions therapists hold about hope and the change process in therapy are as follows

Hope theory is a cognitive model of human motivation.

All people have the capacity for hopeful thinking.

Level of hopeful thoughts can be increased.

People are time oriented with evaluations of the past and the future influencing the present.

Nearly all situations can be construed hopefully.

Experiences and social expectations affect the development of hope.

Supportive therapist-client interactions enhance hope.

Hope enhancement in therapy generalizes to situations outside of the therapy context.

Many people face automatic negative thoughts that may impede successful goal pursuits and

Focusing on the positive is as legitimate on the negative aspects of functioning.

Basic Principles of Hope Therapy

Some of the important basic principles of hope therapy are as follows

1. Hope therapy is based on the theoretical tenets of Synder's conceptualization of hope, including its dispositional, state like and situational aspects.

2. Hope therapy is a semi structured, brief form of therapy in which the focus is on present goal clarifications and attainments. The therapist attends to historical patterns of hopeful thoughts and desired cognitive, behavioural and emotional changes.

3. Clients' self-referential beliefs are enhanced by focusing on goals, possibilities and past successes rather than problems or failures.

4. A sound positive, trusting and positive therapeutic alliance is formed so as to facilitate the client's active participation.

5. The therapist is active and directive in helping the client to develop a new framework for change, while respecting that the client is the expert of his or her situation.

6. Hope therapy is an educative process in which the aim is to teach the clients to handle the difficulties of goal pursuits on their own.

7. Hope therapy mirrors the hope development process. The therapist and the client clearly conceptualize feasible client goals, as well as how to help the client to summon mental energy necessary for initiating and maintaining the pursuit of therapy goals. Besides, the client is aided in developing multiple pathways to positive and desired therapy goals and in eliminating any barriers that may emerge.
8. In hope therapy, change is initiated at the cognitive level with a focus on enabling clients' self-referential agentic and pathway goal directed thinking.
9. By incorporating common therapeutic factors and narrative, solution focused and cognitive-behavioural techniques, hope therapy has evolved into a new therapeutic system in its own right.

The Process and Components of Hope Therapy

Before starting hope therapy, it is always important to have assessment of hope among the clients using different measures of hope depending on the client's demographic variables.The therapeutic hope process is comprised of two major stages each involving two steps. The first stage is *instilling hope* which is achieved through hope finding and hope bonding. The second stage is *increasing hope* which is attained as therapists facilitate hope enhancing and hope reminding.

Instilling hope: As discussed above, it is achieved through hope finding and hope bonding. Lets understand each of these one by one.

Hope finding: An important part of hope finding process is to recognize the strands of hope that run through people's lives. Therapists can help their clients to identify these hopeful strands through narratives. When implementing narrative strategies for hope finding, therapists educate clients about goals, agency, and pathways thinking through sharing stories of hopeful characters. Eventually, clients are asked to tell stories from their own lives in which the components of hope can be identified and made explicit. Many times, clients tell stories of hope without even realizing it; hence, astute therapists will be able to point out the components of hope in a client's life even if the client was not specifically asked to share a hopeful life experience story. The clients' stories provide real-life circumstances in which personal diminishes or flourishes. An additional advantage is that the therapist can observe the client's usual explanatory approach for personal accomplishments. Therapists can increase client's willingness to engage in the use of narratives in Hope Therapy by providing clients with a rationale for doing so. More specifically, explaining to clients that the goal of this therapeutic technique is to help uncover times when clients have been hopeful so that they realize that they have this ability is the key. In order to avoid demoralization, therapists should also be clear that hope finding is often difficult at first and something that may take time. The clients may need to be reminded that they are in charge of their life stories. In addition, clients should be encouraged to practice hope finding between the therapy sessions.

Hope profiling is another narrative technique for identifying hope that clients can be assigned to complete outside of therapy sessions. Clients are asked to write approximately five short stories about their previous or current goal pursuits. They can also be encouraged to write stories about a variety of life domains (i.e., work-related, family-related, sport-related, etc.). These stories are then reviewed within the therapeutic context and utilized to help clients see that they have the resources needed to make life changes.

Hope bonding: The goal of Hope Bonding is to foster a strong, hopeful working alliance with clients. Indeed, there appears to be much overlap between the three components of hope and the three components of the working alliance as defined by Bordin [16]. More specifically, working alliance goals seem to overlap with the goal component of hope, the tasks component of the working alliance relates to pathways thinking, and the bond component of the working alliance corresponds to agency thinking. Given the extensive research that supports the relationships between the working alliance, hope, and positive therapeutic outcomes, working to build hopeful alliances is the key in Hope Therapy. Hopeful alliances become more likely when therapists engage clients in their own treatment planning and therapeutic outcome goal-setting. Many clients feel more comfortable in therapy and with their therapists if they have a sense of why they are being asked to engage in various discussions, activities, and homework assignments. Once therapeutic goals have been established through collaborations between therapists and clients, generating a variety of pathways to goal attainment, again in conjunction with clients, also serves to strengthen the therapeutic bond while simultaneously building hope. More generally, hopeful alliances are also more likely to be fostered when therapists are able to establish trust, be empathic, and understand clients in their totality and within their cultural contexts while also modelling hopeful behaviors and using hopeful language.

Increasing Hope: People who are seeking hope therapy have been experiencing difficulties in goal setting, pathways and agentic thinking. Hope therapy is designed to aid therapists in identifying the strengths and increasing their proficiencies in the areas needing improvement. One of the aims of hope therapy is to alter client's habitual and unproductive ways of approaching previously problematic goals. For this, practice is must. Similarly, altering hope is a learned process.

Hope enhancing: The goal of Hope Enhancing is to increase hopeful thinking in clients who may be lacking hope in general or in a specific life domain. This can be measured by

Synder's adult hope scale. Therapists should provide feedback to clients on this assessment and educate them about hope theory and the role of hope in the therapy process. In particular, pointing out the components of hope that are strengths for clients as well as those that leave room for improvement should occur. Hope Therapy provides several techniques that can be followed for enhancing those component(s) of hope that clients are lacking. There are two tope therapy techniques that can be utilized for helping clients who struggle with the process of goal development. Indeed, for some, developing goals is not easy because they are uncertain about where to begin. Hence, therapists can help provide structure for goal development by asking clients to create lists of their various life domains, prioritizing which are most important and rating their current levels of satisfaction within each domain. Next, positive, specific, and workable goals are developed for each life domain. This is done collaboratively between clients and therapists. The goal is to help clients state their goals as precisely as possible. Clients should also be guided in stating their goals positively, as this often facilitates pathways planning and helps to shift the focus from reducing negative to increasing positive behaviours. These positively framed goals could then be made even more explicit by defining exactly how often the client will work out and what healthier eating entails. Likewise, helping a client set a goal to be more spontaneous and try new things rather than to avoid being so regimented and structured provides more options for determining the pathways to take en route to this goal.tes pathways planning and helps to shift the focus from reducing negative to increasing positive behaviours. Several strategies for helping clients who struggle with the pathways component of hope include teaching clients how to break pathways planning down into a series of smaller steps and to be creative and flexible in their thinking about how goals can be attained. More specifically, clients are asked to mentally picture the steps needed to approach a goal as if they were watching themselves in a movie. Through this process, they can identify on their own (or if shared out loud with their therapist, can be assisted in identifying) whether or not the pathways chosen are likely to lead to success and if not, they can mentally rewind and choose an alternative pathway. In addition, they can envision obstacles that may arise and devise pathways for navigating these barriers in their goal pursuits. Another technique for building pathways thinking is for therapists to challenge clients to come up with as many possible routes to a goal as possible. This could be accomplished via a written homework exercise, through discussion between clients and therapists, or through client discussions or consultations with trusted others outside of the therapeutic context. Clients who struggle with the agency component of hope can be assisted to increase their motivation to work toward goals by coming to understand what, in general, serves to motivate them. Asking questions about what has motivated clients in the past and how they have overcome barriers before can prove useful. In addition, teaching clients to engage in positive rather than negative self-talk about their abilities to successfully pursue goals while also learning to enjoy the process of working toward goals rather than focusing only on the outcomes is advised. Once goal, pathway, and agency planning are complete, clients are encouraged to visualize and mentally rehearse their goal pursuits and then to actually put these plans into action. Therapists continuously check in with clients on their goal progress and help clients adjust or modify any problems related to goal attainment that may be identified along the way.

Hope Reminding: It consists of teaching clients how to self-monitor their own hopeful thinking and use of hope enhancing techniques so that they can sustain high hope levels independent of their therapists. Hope Reminding can be carried out by providing clients with mini-assignments or interventions such as: (a) having them review their personal hope stories as generated during the Hope Finding phase of therapy; (b) finding a "hope buddy" in their personal life that they can turn to for assistance in goal planning or for reinforcement when goal pursuits become difficult; (c) reflecting upon successful goal pursuits and what they did that lead to the success and (d) completing automatic thought records in order to understand and confront barrier thoughts.

Clinical Case of Hope Therapy

Mr. A, a 27 year unmarried Muslim male educated till graduation (B.Com) hailing from Bangalore City currently working as an office assistant in a private college with nil significant past and family history of any psychiatric illness directly contacted a clinical psychologist with the complaints of sad mood, irritability, loss of pleasure in usual pleasurable activities, hopelessness in every activity for better outcomes, low work productivity at work, and poor sleep for the last three months. The patient's symptoms were fluctuating and he could manage day to day and occupational functioning but with difficulty. The reason for contacting at that point of time was decreasing interest in work and poor sleep. Beck Depression Inventory (BDI) was administered and the patient obtained a score of 17 and the clinical interview was done. It revealed mild depression. The psychiatrist evaluated the patient and preferred non-pharmacological intervention for the patient. The clinical evaluation of the case by the clinical psychologist revealed cognitions of hopelessness " I can't improve my work" "the world is bad place" and poor planning of the patient. Based on these, goal setting was initiated and working alliance was developed between the

patient and the therapist. Hope based psychotherapy was planned considering the clinical symptoms. The total of 17 sessions was held. The goals set for therapeutic gains were
Instilling hope
Improving mood
Improving planning skills
Enhancing sleep
The psychotherapeutic strategies planned to work on the above mentioned goals were
Activity scheduling to instil pleasure and mastery
Problem solving skills to enhance planning skills
Cognitive restructuring to work on negative cognitions
The therapy sessions were planned weekly with approximately one hour duration. The therapy took place between April 15 and August 10, 2010. The details of the sessions are as follows

Session 1: Detail clinical interview and exploring the details of symptoms and brief orientation about assessment and therapy process.

Session 2: Psycho diagnostic assessment using BDI was done for exploring symptoms in details and planning therapy.

Session 3: Feedback about the psycho diagnostic assessment and development of working alliance based on therapeutic bond, goals and task setting process.

Session 4: Activity scheduling intervention and its rational was explained to the patient.

Sessions 5-7: Activity scheduling intervention continued and the patient was also trained to work out the possible reasons whenever he was not able to follow any of his activity that was planned for that day and to find out the solution himself for not doing the activity.

Session 8: Hope therapy component like instilling hope using the narratives of the patient's own personal lives and successful accomplishment of some of the goals were highlighted for example successfully passing Graduation despite difficult life situations of the patient. It was also meant to sensitizing him about his strengths and ability to successfully achieving the goals set by him (Passing graduation and getting a job).

Sessions 9-10: Narratives of patient's life and hope instilling strategies continued. In these sessions, the patient narrated some more of his life challenges during his job (At the verge of losing job because of poor productivity) and how these were successfully handled by him. The patient started realizing about his strengths and expressing more hopeful cognitions ("I can handle situations and work out if any such or similar life difficulty arises").

Session 11: The patient was encouraged to continue activity scheduling and successive narratives based on daily life activities. These were done to build his strengths repertoire, mastery and pleasurable activities to lift his mood.

Session 12: The session was focused on strengthening working alliance between the patient and the therapist by highlighting the significance of following activity scheduling and narratives of patient's own successful life experiences and how the patient's own strengths have helped him successfully facing his difficult life circumstances.

Session 13: Problem solving skills training was started in this session. Based on patient's own strengths as revealed in earlier therapy sessions, he was asked to set daily goals/short term goals which are achievable and stated them in positive terms. For example," I will type 5 papers today and I know I can do it". The therapy session was also focussed on helping the patient to learn the skills of developing multiple plans if a set plan does not work to achieve a particular goal. It was aimed to teach planning skills and increase his pathway skills in terms of hope model.

Session 14: Problem solving session continued to enhance patient's planning skills.

Session 15: In this session, the therapeutic outcome was discussed and the patient's feedback was taken about his symptoms. BDI was administered to evaluate the scores on it subsequent to therapy. The patient reported 80-85% improvement in his mood and reported feeling euthymic, increased interest in his usual pleasurable activities (Watching T.V., going to gym and interacting with friends) and more positive outlook and thoughts toward achieving goals of life ("I have the ability to achieve my goals, life can be made better by efforts and trying"). He also reported increased work productivity at work place. On BDI, the score dipped from 17 to 10. The patient was encouraged to continue following the skills and activities learned in therapy sessions.

Session 16-17: In these sessions, therapy terminations, importance of follow up and behavioral relapse indicators and how to work on the possibility of relapse were discussed in detail. The patient was reminded to work on his strengths and keep working on hope building and hope instilling techniques discussed in the therapy process.

Clinical Observations and therapist's reflections

The therapist observed that using components of hope therapy like narratives and hope instilling and hope enhancing were highly motivating for the patient and he enjoyed following these techniques based on his daily life experiences. It was clinically observed that following strength based interventions are more appealing to the patient as it helped him knowing his positive aspects. Strength based therapies need to be incorporated in all traditional approaches to therapy. Humans are probably hard wired to listen their strengths and feel good rather than listening their black spots and limitations. This needs to be utilized in psychotherapeutic endeavours.

Implications and Research Evidence of Hope Therapy

Psychological interventions using hope as an important therapeutic components have significant implications not only in clinical areas but also in areas of education, organizational psychology, military psychology, sports psychology and in almost all areas of psychological sciences. Snyder et al [17] assert that higher hope is related to benefits across a wide range of therapy outcome indicators. More specifically, research shows that high-hope individuals have more positive and less negative thoughts and see themselves in a more favourable light than those with low-hope. In addition, high-hope people have higher self-esteem, and report having more energy and confidence, and being more challenged by their goals than those with lower hope.

During the first four weeks of psychological treatment, many clients improve considerably Howard et al [18] Indeed, even without actual treatment, the mere promise of therapy can set a positive change process into motion, for example, 40% to 66% of clients have reported feeling better before their initial counseling sessions. In addition, 56% to 71% of the overall change variance in psychotherapy has been found in the early stages of treatment Fennell and Teasdale [19].

CONCLUSION

During this case and working on hope therapy has gained a greater realization of the importance of effective goal formulation, reframing failure as success, and expressing hope in and to others. Assisting clients to develop helpful goals will and can be an important part of clinical practice. This practice will help patients develop the skill of formulating goals and assist therapists in collaborative treatment planning. The clinical hunch says that praising patients when they successfully complete assignments, whether effective in bringing about change or not, is an effective way of preserving hope and help them understand that therapy is an assisted discovery process that they can be capable of accomplishing on their own.

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