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Hope-The Anchor of the Soul: Cultivating Hope and Positive Expectancy

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Although hope is a valued construct in psychotherapy, it tends to be viewed as adjunct to more focal interventions or as leverage for other valued goals. We contend that hope needs to be a targeted intervention in many cases. We will highlight issues arising in the acquisition of therapeutic hope. We acknowledge hope's dual nature as both a "gift" from God as well as an attribute that can be cultivated. Our main objectives are to define hope, confirm its essential role in well-being, recognize various hope mechanisms, introduce relevant theory, briefly highlight hope attainment issues, promote a variety of hope interventions, and list some helpful assessments and resources that can aid in nurturing the seeds of hope and optimism. Evidence will be reviewed for the role of hope and optimism in relation to physical and mental health, life success and satisfaction, and resilience during adversity. We advocate for the central role of hope in God's plan for his children as well as fundamental to effective psychotherapy.

"Hope is the physician of each misery." ~ Irish Proverb

The absence of hope leads to serious consequences for our clients' souls and their emotional health. Viktor Frankl, in his book *Man's Search for Meaning* (1963) stated, "It is a peculiarity of man that he can only live by looking to the future" (p. 115). He warned that "the sudden loss of hope and courage can have a deadly effect" (p. 120) and observed that "The prisoner who had lost his faith in the future—his future—was doomed" (p. 117). Prisoners who lost hope generally died within a short time. Similarly, the writer of Proverbs instructed, "Hope deferred maketh the heart sick" (Proverbs 13:12). Moroni warned that "if ye have no hope ye must needs be in despair" (Moroni 10:22).

Many consider hope as an element of successful therapy, some considering it one of the four most significant common factors (Hubble, Duncan, & Miller, 1999) in good therapy outcome. Positive expectancy (fundamental to hope) is one component in a four-factor model of "common factors" (extra-therapeutic factors, therapeutic relationship, techniques, and expectancy factors) proposed to contribute to therapy outcomes (Lambert, 1992). Lambert suggested that roughly 15% of therapy outcomes could be attributed to the direct effects of positive expectancy. Positive expectancies also contribute to the development of the other three factors. Therapist effects in therapy outcomes also point to the importance

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of hope. In an early study of therapist effects on therapy outcomes, D. F. Ricks (1974) identified what he labeled a 'supershrink.' This therapist worked with highly troubled adolescents who were later examined for outcomes as adults. Adolescents treated by this therapist exhibited unusually positive outcomes. Some of the important differences between this highly effective therapist and a comparison were a focus on goals, present and future orientation, addressing needs for competence and autonomy, and encouragement; all elements of a hopeful orientation. Hope has direct and indirect positive effects in producing effective therapy outcomes.

The power of hopeful thinking is appreciated and widely acknowledged. Yet, little research has been conducted to systematically study its role in therapy. It is frequently relegated to an adjunct role in support of more focal interventions or as leverage for other valued goals. Nurturing hope is now promoted as a means to prevent or "buffer against mental illness" (Seligman & Csikszenthmihalyi, 2000, p. 5).

A focus on hope may be unnecessary when motivation is high, goals are clear, confidence is strong, skills to regulate behavior are evident, social support is available, faith is present, and circumstances are favorable. Yet a significant portion of our clients struggle with motivation; possess unclear goals and unarticulated values; lack a sense of meaning; struggle spiritually; have little confidence; see no viable options for improvement; experience difficulty with self-regulation; are driven by fears rather than aspirations; recall a history of failed attempts; face chronic, challenging, or unchangeable situations; and possess limited social support. We assert that hope is central to effective therapy and in many cases should be a targeted intervention.

Our main objective is to advocate for the role of hope in psychotherapy and to promote methods for facilitating its acquisition. We will provide a definition of hope, confirm its essential role in well-being, identify hope mechanisms, introduce relevant theory, present a clinical perspective on some hope attainment issues, promote a variety of hope interventions, and list some helpful assessments and resources that can contribute to nurturing the seeds of hope and optimism. Evidence will be summarized for the role of hope and optimism in relation to physical and mental health, life success and satisfaction, and resilience during adversity. We conclude with affirming the role of divine hope centered in Jesus Christ.

DEFINITIONS FOR HOPE

Hope is defined as: (1) "the feeling that what is wanted can be had or that events will turn out for the best", (2) "a person or thing in which expectations are centered", (3) "to look forward to with desire and reasonable confidence", (4) "to believe, desire, or trust", and (5) "to feel that something desired may happen" (Random House Webster's Unabridged Dictionary 2nd ed., 2001). The following definition offers two additional aspects: "Hope is the elevating feeling we experience when we see—in the mind's eye—a path to a better future" (Groopman, 2004, p. xiv). These definitions emphasize the following elements: believing in a future when things turn out well (positive expectancies); experiencing positive and uplifting feelings; focusing expectations on a person, thing, or desired outcome (both generalized and specific hopes); possessing reasonable confidence that either circumstances or our own efforts will bring about a desired future state (personal agency beliefs); and visualizing a path to a better future.

Hope frees us from the negative bonds of past behaviors, thoughts, and feelings, as well as the influence of present fears. Hope includes a positive perspective towards the future and is fueled by affirming the lessons of the past, as well as appreciating the possibilities of the present. Hope is possible because we experience its counterparts: despair, suffering, and pain. Vaclav Havel, poet, playwright, jailed dissident in communist Czechoslovakia, president of the free Czech Republic, and winner of the U.S. Presidential Medal of Freedom stated, "Perhaps hopelessness is the very soil that nourishes human hope" (1997, p. 54). Sir Walter Scott wrote, "Hope is brightest when it dawns from fears" (as cited in Bartlett, 1903, p. 491). The scriptures affirm this principle of "all things… be[ing] a compound in one" in the doctrine of "opposition in all things" (2 Nephi 2: 11). Opposition enables agency. Hope and despair are the heads and tails of the coin of experience. But to hope is no flip of the coin, we choose in the light of our experiences, heads or hope. *To hope is to exercise a choice, an orientation of the spirit.* Hope is the great elixir of life: it heals, soothes, and revitalizes. It develops in the crucible of experience, *if* the right ingredients are added. We will examine these therapeutic ingredients.

ESSENTIAL ROLE OF HOPE

We affirm the essential role of hope in God's plan for humankind. Hope is one of the cardinal virtues in the triumvirate of divine characteristics: faith, hope, and charity (1 Corinthians 13:13). All hope, whether spiritual or psychological, is founded in positive expectancies. Some people are more successful than others in securing and sustaining hope. President Thomas S. Monson (2008) highlighted the condition of life and the role of hope:

> In order to be tested, we must sometimes face challenges and difficulties. At times there appears to be no light at the tunnel's end – no dawn to break the night's darkness. We feel surrounded by the pain of broken hearts, the disappointment of shattered dreams, and the despair of vanished hopes…We are inclined to view our own personal misfortunes through the distorted lens of pessimism. We feel abandoned, heartbroken, alone. If you find yourself in such a situation, I plead with you to turn to our Heavenly Father in faith. He will lift you and guide you. He will not always take your afflictions from you, but He will comfort and lead you with love through whatever storm you face (p. 90).

The scriptures declare, "Wherefore, whoso believeth in God might with surety hope for a better world… which hope cometh of faith, maketh an anchor to the souls of men, which would make them sure and steadfast, always abounding in good works, being led to glorify God" (Ether 12:4). Faith in God leads to hope, which promotes righteous and charitable behavior and increases gratitude towards God. Mormon said, "I would speak unto you of hope" (Moroni 7:40) and then asked, "what is it that ye shall hope for?" (Moroni 7:41). Mormon lived in a time when by all accounts there was little reason for hope. The mighty civilization of the Nephites had been destroyed, the gospel was being distorted and lost, evil and cruelty were prevalent, and his own family was decimated except for his remaining son, Moroni. So why was Mormon writing of hope? Because, *even in the worst of times, hope is possible, hope is necessary, and hope sustains*. Moroni responded to his own question by declaring the object for unfailing hope: "Ye shall have hope through the atonement of Christ and the power of his resurrection, to be raised unto life eternal" (Moroni 7:41). Mormon further explained how that hope is acquired, "[ye] cannot have faith and hope, save [ye] shall be meek, and lowly of heart" (Moroni 7:43).

Hope consists of a yin and yang, a complementary interaction of different processes that create a greater whole. Yin and Yang are concepts rooted in Taoism which suggest that wholeness comes through the interaction of opposites (i.e., male/female, dominance/submission). It is similar to Lehi's pronouncement that there is "opposition in all things," that happiness is not possible without misery, and that "all things must needs be a compound in one" (2 Nephi 2:11). The yin of hope is its gift quality. God can and does bestow hope as a gift through his spirit. Mormon taught, "Because of meekness and lowliness of heart cometh the visitation of the Holy Ghost, which Comforter filleth with hope" (Moroni 8:26). From this perspective hope is conferred upon the meek. The yang of hope depends on our own efforts. We can do much to help build a "house of hope" (*Lopez, Floyd, Ulven, & Snyder,* 2000). Hope is the belief that if we build the "house" (do all that we can on our end), God will fill the house with what is needed. Without the house, there's no place for hope to reside; without hope, the house isn't worth occupying. Hope is strengthened by doing all we can and then assuming what God allows after that is according to His plan. It rests upon our faith that His "ways [are] higher than [our] ways" (Isaiah 55:9) and that we "[do] not comprehend all the things which the Lord can comprehend" (Mosiah 4:9). His grace endows us with peace that reassures and comforts no matter the current conditions.

HOPE WITHIN PSYCHOTHERAPY

Clients arrive at our doors dispirited, depressed, and anxious. Some of our clients' beliefs and behaviors are antagonistic to hope. They may deny or flee from personal threats in attempting to ward off undesired or feared outcomes and experiences. They may possess a generalized view of life as negative and malevolent, believing that hopes and dreams are not to be trusted, concluding they lead only to disappointment and pain. This pessimistic orientation is certainly one of the derivatives of troubles, but these same attitudes also lead to and perpetuate difficulties. We submit that in most cases operating out of fear and negativity is the problem. One of the troubles with fear-driven motivation is its self-confirming bias. We fear, so we don't act. We engage in avoidance and temporarily our anxiety is reduced, but we never collect evidence that can dispute our constructed reality, even

though our reality minimizes hope. Researchers have found that low hope individuals generally cope through avoidance and "do not learn from past experiences…and they become 'passive pawns' in the game of life" (Snyder, Rand, & Sigmund, 2005, p. 266). William James (1907) proclaimed, "Be not afraid of life. Believe that life *is* worth living, and your belief will help create the fact" (p. 62). A hopeful and optimistic orientation cultivates a purposeful approach towards life, allowing us to be pulled forward by our aspirations rather than driven by our fears and failures. Therefore, we maintain that cultivating hope is essential for health, happiness, and wholeness.

Hope has long been considered an essential ingredient for successful psychotherapy (Snyder, Michael, & Cheavens, 1999). Jerome Frank (1968) culled the literature on psychotherapy for a common curative factor and concluded that instilling hope is essential for therapeutic success and is the antidote for demoralization, which he considered the main issue clients bring to therapy. He proposed that hope activates effective work by both the client and the therapist. Irving Yalom (1985) identified "instillation of hope" as the first curative factor in effective group psychotherapy. He claimed,

> The instillation and maintenance of hope is crucial in all of the psychotherapies: not only is hope required to keep the patient in therapy so that other therapeutic factors may take effect, but faith in a treatment mode can in itself be therapeutically effective" (p. 6).

When clients underwent pretreatment hope preparation, especially those who were low in hope, superior treatment outcomes were experienced compared to persons without the hope pretreatment (Irving, Snyder, et al., 1997).

MECHANISMS OF HOPE

Multiple mechanisms influence the ability to cultivate hope. Neurobiological systems that relate to goal-setting, reward and incentive systems, approach behaviors, activation and inhibition mechanisms, self-regulation abilities, attachment and bonding activities, memory retrieval and suppression, anticipatory abilities, attention regulation, and decision making facility may all contribute to experiencing and generating hope. Thus physical well-being and effective self-care influence the ability to hope.

Hope is connected to trust. Erick Erikson stated, "Hope is both the earliest and the most indispensable virtue inherent in the state of being alive…if life is to be sustained hope must remain, even where confidence is wounded, trust impaired" (Erikson, 1964, p. 115). Closely related to the experience of trust is the capacity to form effective attachments to others, including God. Snyder asserted, as "attachment is a key factor in the rise of hope…I would add that attachment often is critical for the fall of hope" (Snyder, 1994, p. 126). He concluded, "Attachment builds an environment where children learn to think of themselves as successful in the pursuit of their goals" (Snyder, 1994, p. 89).

Hope is fostered by attending to and effectively meeting psychological needs. Self-Determination Theory (SDT; Deci & Ryan, 2000; Ryan & Deci, 2000) identifies three basic needs that contribute to well-being and a hopeful perspective: competence, relatedness, and autonomy. There are other basic needs as well, such as a sense of meaning, a feeling of uniqueness, and safety. It is difficult to feel hopeful when we feel incompetent, uncared for, or unable to control our lives. Meeting basic psychological needs creates confidence and facilitates hope.

The essence of hope theory is the belief and capacity to accomplish what we desire (Snyder, 1994). It proposes that hope is created as we successfully set goals, create workable strategies to achieve those goals, and possess positive beliefs about the ability to plan, initiate, and sustain goal oriented behaviors.

Attributions or personal explanations for events contribute to hopeful thinking. Some forms of causal explanations help us feel more hopeful, while others lead to helplessness. An application of this will be shown later using the theory of learned optimism (Seligman, 1991, 2006).

Christian views of hope are rooted in faith and trust in a benevolent and all knowing and powerful God. Thus hope arises out of the belief that God sustains his children, facilitates their development, and eventually delivers them from their difficulties. As Alma stated, "I do know that whosoever shall put their trust in God shall be supported in their trials, and their troubles, and their afflictions, and shall be lifted up at the last day" (Alma 36:3).

Thus hope is generated through many contributing factors. This article will show how each of these can be utilized in building hope intervention strategies.

THEORY TO GUIDE PRACTICE: BUILDING OPTIMISM AND INTILLING HOPE IN CLIENTS

It is necessary for both the therapist and client to possess hopeful perspectives. Inadequate therapist hope weakens problem solving efforts and diminishes the possibility of building a therapeutic alliance. Clients lacking hope are unlikely to invest the energy to bring about positive change. Instilling hope involves creating a renewed sense of purpose, confidence in the future, and belief in abilities to achieve desired aims.

We highlight two theories related to increasing hope: *learned optimism* (Seligman, 1991; 2006) and *hope theory* (Lopez, Floyd, Ulven, & Snyder, 2000; Snyder, 1994).

Learned Optimism

Martin Seligman stated, "Psychology is not just the study of weakness and damage; it is also the study of strength and virtue. Treatment is not just fixing what is broken; it is nurturing what is best within ourselves" (Seligman, 1999). He articulated both theory and application for developing greater optimism in his seminal book, *Learned Optimism* (1991).

Seligman's research began with studying learned helplessness (loss of hope) in animals and humans. He found that when dogs and humans experience an inescapable noxious stimulation they eventually give up escape efforts. He surmised that when efforts to change an adverse situation appear to have no effect on outcome, change efforts fade. This was termed *learned helplessness*. However, Seligman (2006) noted in studies conducted with humans that about one-third avoided getting stuck in this "helplessness." He concluded,

> We all become momentarily helpless when we fail. The psychological wind is knocked out of us. We feel sad, the future looks dismal, and putting out any effort seems overwhelmingly difficult. Some people recover almost at once; all the symptoms of learned helplessness dissipate within hours. Others stay helpless for weeks or, if the failure is important enough, for months or longer" (p.76).

This observation intrigued Seligman and led him to investigate this quick recovery, or "resilience," effect.

According to Seligman (2006), feelings of helplessness are correctable. They are changed by teaching skills of *learned optimism*. Christopher Peterson (2006) provided concise definitions of *optimism* and *pessimism*: "In the face of difficulties, do people nonetheless believe that goals can be achieved? If so, they are optimistic; if not, pessimistic. Optimism leads to continued efforts to attain the goal, whereas pessimism leads to giving up" (p. 120). Pessimists believe bad experiences last indefinitely and negatively impact all aspects of life, they often assume their own flaws played a role in their difficulties, and they believe they cannot exert control over negative experiences. Optimists believe negative events are temporary and limited in scope, they tend to believe bad experiences are caused by external circumstances, and they anticipate being able to improve their situation.

Seligman and colleagues examined why some individuals appear to be inoculated against the effects of helplessness, and they concluded that a person's explanatory style leads to a pessimistic or optimistic perspective (Seligman, 2006). *Explanatory style* is a person's way of making sense of events, and it involves attributing events to various causes. The theory of learned optimism focuses on shifting attribution for negative life events from internal, stable, and global causes to external, variable, and specific attributions. He posited the following three constructs: permanence, pervasiveness, and personalization. Applied examples of these constructs are provided (Table 1).

Seligman (2006) acknowledged that failure and defeat can lead to pessimism, but argued this outcome is not inevitable, "Habits of thinking need not be forever. One of the most significant findings in psychology in the last twenty years is that individuals can choose the way they think" (p. 8). Hope, according to this theory, lies in finding external, temporary and specific causes for misfortune along with internal, permanent and universal causes for good outcomes (Seligman, 2006). Cultivating constructive and optimistic explanatory styles helps people avoid despair.

TABLE 1

Learned Optimism Model: Examples

Construct	Self-Statements	Attribution/Explanations	Possible Actions
Permanence (Pessimism)	"My boss is an insensitive jerk."	"Not much chance of things changing soon."	Angry and unhappy at work.
(Optimism)	"My boss is under a lot of pressure right now."	"Perhaps things will improve when the pressure relents."	Try to understand bosses pressure or may try to relieve the pressure.
Pervasiveness (Pessimism)	"All professors are unfair and uncaring."	"It doesn't matter who I choose."	Resignation and unwillingness to reach out to professor.
(Optimism)	"My present professor is unfair and uncaring."	"Although he is a problem, not all professors are that way."	Accept that some, not all, professors are difficult to work with or see if they can build a better relationship with this professor.
Personalization (Pessimism)	"I can't learn calculus."	"There is something inherently defective about my ability to learn calculus."	Diminished effort, resignation, and avoidance.
(Optimism)	"I haven't had good instruction in calculus."	"I could learn if given proper instruction."	Believe it is possible to learn and actively seek learning experiences.

Seligman developed a method for building optimism through recognizing and disputing pessimistic thoughts. He called it the ABCDE Model (Seligman, 2002, p.93–94):

A = *Adversity*. Recognize that everyone has unpleasant and difficult experiences.
B = *Beliefs*. Examine your beliefs about the situation.
C = *Consequences*. Explore the consequences of those beliefs, noting whether they help you cope with the situation effectively.
D = *Disputation*. Identify dysfunctional and maladaptive beliefs; dispute and refute them.
E = *Energization*. Replace negative beliefs with more adaptive and positive perspectives—feeling energized and revitalized as you do so.

According to Seligman, pessimistic thoughts can be disputed effectively by applying the following principles:

1. *Evidence*: Pessimistic reactions to adversity are often overreactions. Help clients discover how their beliefs are inadequate, inaccurate, and maladaptive.
2. *Alternatives*: Pessimists hold to the most permanent and pervasive cause for events. Assist clients in exploring less negative and potentially positive alternative explanations.
3. *Implications*: If a client's belief about a negative situation is accurate, attempt to "decatastrophize" it. Consider the implications without jumping to the worst-case scenario.
4. *Usefulness*: Examine whether the belief, even if apparently true, is worth dwelling on. If the belief is currently true, can it be changed in future situations? How can it be changed?

HOPE THEORY

Hope theory/therapy (Lopez, Floyd, Ulven, & Snyder, 2000; Snyder, 1994) cultivates hope by focusing on future-oriented goal striving rather than attempting to alter attributions related to negative events. Snyder (1995) described the difference between hope theory and learned optimism: "Hope is conceptualized as a cognitive process involving how people link themselves to positive goals, whereas optimism is basically an excuse-like strategy whereby people distance themselves from negative outcomes" (p. 356). Hope is defined as "the belief that

one can find pathways to desired goals and become motivated to use those pathways" (Snyder, Rand, & Sigmund, 2005, p. 257).

Snyder (2000) proposed that hope is constructed by helping clients turn problems into operationally defined goals. Thus the aim of therapy is to assist clients in developing more effective ways of pursuing their goals. Persons with high levels of hope are those who learn from past events, possess realistic yet confident attitudes regarding their ability to initiate and sustain motivation and effort, and can create viable pathways or strategies that lead to future goal achievement. Thus hope, according to Snyder, consists of three facets:

1. *Goals*: A goal is intentional effort toward accomplishing a task and/or actualizing a value. Goals serve as launching pads for hope.
2. *Pathway thoughts*: As methods or strategies for achieving desired goals, pathway thoughts serve as the steering mechanism for hope.
3. *Agency thoughts*: As the motivational component, these thoughts focus on initiating and continuing effort towards identified goal pathways. Agency thoughts serve as the fuel that thrusts us forward.

Hope Therapy

Snyder and Lopez (Lopez, Floyd, Ulven, & Snyder, 2000) contend that "Being a hopeful helper is very important in conducting hope therapy" (p. 127). They emphasize establishing understanding, trust, empathy, and belief in possibility as fundamentals for building a hopeful therapeutic alliance. They suggest identifying elements of hopefulness that are present or absent.

Hope therapy comprises two stages with two strategies in each stage (Lopez, Floyd, Ulven, & Snyder, 2000):

Stage 1: Instilling hope

Hope finding. Hope finding can also be labeled "hope assessment." This strategy includes the following:

1. Explore client experiences with hope and identify factors that have contributed to hopeful thinking.
2. Attend to the nature and quality of goal formation and pursuit, agency beliefs, and pathway thinking related to goals.
3. Invite clients to tell stories of hope, striving, and coping with adversity.
4. Examine functioning in various life domains.
5. Identify times when hope-damaging thoughts and behaviors have interfered with hope generation and maintenance.
6. Highlight hopeful attitudes currently possessed.

Using formal hope measurement tools may be helpful as a part of this process. The authors of hope theory (Snyder, 2000) believe that "nearly all experiences can be construed with some hope" (p. 129).

Hope bonding. This strategy parallel's Bordin's (1979) model of a working alliance that identifies tasks, goals, and bonds essential in forming a hopeful therapeutic alliance. Specific tactics include the following:

1. Form a hopeful alliance early in therapy and model hopeful thoughts and behaviors.
2. Provide empathy, trust, and understanding.
3. Collaborate with clients to discover components of hope they can act on.
4. Encourage clients to seek out and associate with hopeful people and environments.

This stage of hope therapy acknowledges and utilizes the power of relationships in cultivating hope.

Stage 2: Increasing hope

Hope enhancing. Therapists can enhance hope using the following methods:

1. Identify areas of strength in client hope building abilities and assist in developing skills in areas of weakness.
2. Help clients value goal setting, learn effective goal setting principles and skills, align goals with values, develop the ability to monitor goal performance and attainment, improve self-regulation abilities, and modify goals as necessary.
3. Assess factors that interfere with goal striving, such as perfectionism or poor self-regulation.
4. Explore goals in different life domains (i.e., relationships, achievement, health, etc.).
5. Work on enhancing the capacity for pathway thinking, including the ability to generate alternative goal pursuit strategies.
6. Anticipate and create tactics for overcoming barriers.
7. Strengthen agency thinking and motivational abilities.

Emphasizing and articulating how clients have overcome past obstacles builds confidence in agency beliefs—challenging negative thinking that hinders goal pursuit and diminishes hope. People's beliefs about their abilities do not have to be accurate to be adaptive: "For example, studies reveal relatively greater well-being among people

who show positive illusions, that is, bolstered perceptions of themselves, their futures, and the extent of their control" (Lyubomirsky, 2001, p. 241). Therapists can assist clients in building positive life narratives that focus on successes, resilience, and strengths, helping them generate adaptive, positive self-beliefs that are tied to specific evidence from their lives. Clients too often punctuate their life narratives by emphasizing the negative: Therapists must help clients understand the effects of negative beliefs and teach them to identify, challenge, and refute them. Clients are benefitted by developing the ability to find benefits in adversity (Affleck & Tennen, 1996). Therapists need to emphasize practiced application by the client.

Hope reminding. Therapists can help clients to revisit times when hope was a positive factor in their lives. The following strategies are helpful:

1. Invite clients to review previous hope experiences and times of active engagement with goals.
2. Identify obstacles they encountered and actions they took to overcome those barriers.
3. Help them recognize strategies and attitudes that served them well in the past, and support them in using these in their current situation.

Associating with hopeful individuals facilitates hope reminding, since such mentors are encouraging and positive and will help clients hold on to and remember things that help them in maintaining hope. As they recall successful goal accomplishment, their confidence is renewed and increased. Hope therapy seeks to provide clients with a positive, hopeful, and goal oriented approach to life. The essence of this approach is to assist clients in articulating goals that are consistent with values, to support them in generating strategies for goal attainment, and to foster confidence in their ability to initiate, maintain, and adapt efforts to facilitate goal accomplishment.

CLINICAL PERSPECTIVES AND RECOMMENDATIONS IN CULTIVATING HOPE

Avoid Dichotomous Thinking

Hope is experienced in degrees. Perfectionistic thinking works against positive expectancies. Client's who have difficulty seeing progress and take satisfaction only with complete accomplishment may give up too easily, experience a diminished sense of success, and fortify negative thinking. Deriving satisfaction from effort, experiencing success from incomplete attainment, and savoring the journey helps cultivate a hopeful approach to life.

Paradoxes of Hope

In some situations, it is not optimism, but *defensive pessimism* (Norem, 2001) that helps catalyze action. Concern over potential mishaps may increase motivation to take precautions to prevent fears from being realized. Thus a kind of "hope" may be achieved. A client who anticipates all the things that could go wrong may believe he or she can prevent problems. One could argue that this is not hope at all, but actually the absence of hope. This process may not increase positive feelings, but it likely decreases anxiety. Hope can facilitate both an increase in positivity and a decrease in negativity. But, sometimes hope increases positivity, while doing little to impact negativity. In either situation; hope helps. Therapists have two distinct strategies to consider: diminishing pessimism and/or increasing hope.

False or Empty Hopes

Robert Emmons (2005) declared, "When it comes to contributing to well-being, not all goals are equal" (p. 736). We state that not all hopes are of equal value. Some hopes are actually empty from the outset, and even attaining goals will not satisfy. For example, those who expressed materialistic aspirations (wealth) as freshmen in college were less satisfied with their lives two decades later than those who did not hold these same ambitions (Nickerson, Schwarz, Diener, & Kahneman, 2003). Those with more materialistic values are more likely to suffer from a variety of mental disorders (Cohen & Cohen, 1996). *Affective forecasting* provides a partial explanation for why people strive for things that do not satisfy. This is defined as the ability to accurately predict the pleasure or displeasure derived from a future event (Wilson & Gilbert, 2005; Wilson, Centerbar, Kermer, & Gilbert, 2005). Timothy Wilson and Daniel Gilbert (2005) stated, "People routinely mispredict how much pleasure or displeasure future events will bring and, as a result, sometimes work to bring about events that do not maximize their happiness" (p. 131). They also mispredict the intensity and longevity of negative events. On the other hand, Robert Emmons (2005) found "three types of goal strivings consistently relate to well-being: intimacy, generativity, and spirituality" (p. 736). These strivings

are connected to fundamental human psychological and spiritual needs and thus help nurture hope if successfully met. Therapists should help clients assess the value and utility of their hopes.

Ineffective Goals

Setting and progressing towards goals are significant element of building hope. Therefore, goals that are unclear, unrealistic, not aligned with one's values, too distant, difficult to measure, or perhaps ineffectively monitored hamper hope. Helping clients with appropriate goal setting enhances hope. The SMART model of goal setting (Drucker, 1954) may be useful: Goals should be specific, measureable, attainable, relevant, and time bound. Generally, positive goals are more effective than avoidant or negative goals (Elliot, Sheldon, & Church, 1997).

Flawed and Ineffective Pathways

Hope is difficult to sustain when clients use ineffective methods for achieving desired goals. For example, a client may believe that the best way to overcome a pornography addiction is to keep his attention riveted on any potential temptation. He may be unaware that his own diligence opens the door to enhanced temptation by keeping the focus on the concern. Pursuing ineffective strategies undermines the very hope clients are trying to foster.

Poor Intervention Timing

Stating or implying too soon that our clients should look on the bright side may be interpreted as dismissive, unsupportive, or lacking empathy (Ruvelson, 1990). Although we can model hopeful behaviors and thinking, discussions of hope are most warranted after empathy and understanding have been established. Empathy for current distress can provide the context for discussions of a more desirable future. Hope must be sewn into the fabric of client's lives and connected to their true abilities and potential.

High Risk

Speculative and high risk ventures are more likely when individuals feel optimistic. Occasionally clients may take foolish chances, ignore or diminish risks, and set unreasonable goals that may backfire. This kind of unjustified optimism may prevent sound rational decision making. Therapists are in a position to challenge unwarranted positive thinking and help clients develop more reasonable plans.

Attempts to Control the Uncontrollable

Trying to control uncontrollable events leads to frustration and self-blame. Chris Peterson (2000) warned, "Constant striving for control over events without the resources to achieve it can take a toll on the individual who faces an objective limit to what can be attained regardless of how hard he or she works" (p. 51). But control depends upon perspective. Jenkins and Pargament (1988) found that religious cancer patients coped more effectively when believing in God's control over their own. This perspective led to both submission *and* active coping efforts, including faith and prayer as well as participating in controllable elements of the treatment.

Aspirations Versus Attainment

Goal attainment is important in cultivating hope; but striving for goals, even if attainment is distant or unlikely, still generates positive effects and increases hope (Brunstein, 1993; Watson, 2005). Some goals are lofty and aspirational. For example, many desire to become Christlike. It is hardly conceivable that this goal will be reached in the near future. Yet striving makes us better in the process and leads to increased happiness and hope. The opposite may also occur. Some clients may interpret this negatively, demean themselves because they have "failed" to attain a Christlike nature, lose hope in the process, experience a decrease in happiness, feel a loss of confidence, and give up efforts towards improvement. Therapists should help clients focus on progress and effort. The mediating variables in appreciating progress versus attainment appear to be clients' expectations and the feedback they receive on performance. If clients expect attainment sometime in the distant future, disappointment is less likely if they are not yet there.

Acceptance

Acceptance can pave the way for personal peace. A new portal to hope may appear when a door closes on a disappearing hope. Clients may discover that wayward children are in good hands with God, that life's forest fires crack open the seeds for new growth, or that the diagnosis of a terminal disease sets new priorities in motion and helps to put things in perspective. When appropriate, therapists should encourage clients to alter expectations,

revise goals, adapt strategies, and accept limitations. Clients may need to trust in powers beyond their control, including other people's efforts and divine intervention. Hope is possible even when control is not.

BENEFITS OF HOPE AND OPTIMISM

There are spiritual, physical, and mental health advantages to increased hopeful orientations. Hope aids in coping with adversity and leads to improved life satisfaction. Hopeful individuals make healthier lifestyle choices in areas such as exercise, eating, and drinking (Peterson, 1988). They recover from illness and injury more effectively (Snyder, Rand, & Sigmon, 2005), and have increased life expectancies (Maruta, Colligan, Malinchoc, Offord, 2000). They manifest less depression and anxiety (Cheavens, Feldman, Gum, Michael, & Snyder, 2006) and experience increased positive mental health, personal adjustment, life satisfaction (Gilman, Dooley, & Florell, 2006; Kwon, 2002), and sense of meaning in life (Feldman, & Snyder, 2005). Those with elevated levels of hope improve the most with counseling (Gottschalk, 1995). They persevere when barriers arise (Scheier, & Carver, 1992), are more effective problem solvers (Peterson, & Steen, 2005), and adapt when circumstances warrant it (Snyder, Rand, & Sigmon, 2005). They are successful in finding "benefits" from adversity (Affleck, & Tennen, 1996). They hold positive views of relationships and perceive and receive social support (Snyder, 2002; Snyder, Rand, & Sigmon, 2005). Individuals possessing high hope report less loneliness (Sympson, 2000) and feel socially competent (Snyder, Hoza, et., 1997). Peterson and Steen (2005) suggested that "optimistic individuals may be more likely than pessimists to enter settings in which good things can and do happen" (p. 254). Hopeful students experience enhanced academic success (Snyder, Rand, & Sigmon, 2005). The benefits of possessing a hopeful approach to life are numerous and noteworthy. Those who lack this orientation are at a significant disadvantage.

SUMMARY OF HOPE INTERVENTIONS

We have highlighted many interventions, ideas, and principles as we have explored the construct of hope. Here is a summary of those interventions:

- Be a hopeful helper.
- Build a strong and hopeful therapeutic alliance.
- Activate spiritual beliefs and religious practices.
- Help clients learn how to effectively dispute negative beliefs.
- Foster positive causal explanations that engender hope.
- Encourage clients to engage in and create supportive social networks and seek out positive environments.
- Promote the development of constructive and adaptive self-efficacy/agency beliefs and appropriate confidence.
- Help clients articulate clear and meaningful values to guide decision making and actions.
- Assist in setting clear, effective, and appropriate goals tied to important personal values.
- Teach clients to effectively monitor goal performance, adjust strategy, and alter expectations as needed.
- Collaborate with clients in generating well-planned, flexible, and creative strategies for reaching goals.
- Focus on improving self-regulation by developing the ability to focus, sustain attention, exercise impulse control, and delay gratification.
- Encourage clients to focus on the positive without participating in denial.
- Explore success experiences by prompting clients to remember past accomplishments and helping them envision future success.
- Capitalize on client strengths.
- Assess motivational drives to bring focus to hope intervention strategies (i.e., need for competence, autonomy, relatedness, and sense of meaning).
- Instruct clients in overcoming dichotomous and maladaptive perfectionism.
- Demonstrate empathy for the dilemmas that challenge hope.
- Remember the importance of timing and laying the groundwork for hope.
- Weave hope into the fabric of client lives.
- Challenge unwarranted and potentially dangerous hopeful and optimistic thinking.
- When negative experiences occur, help clients avoid "catastrophizing" these events.
- Teach them to value gradations in success and achievement and value effort as well as outcome.
- Help them enjoy striving as well as attaining.
- Encourage them to adopt healthy lifestyles that will contribute to meeting fundamental spiritual, psychological, social, and physical needs.
- Build resilience, encouraging an attitude of learning from difficulty and failure.

- Promote acceptance when appropriate.

We suggest a few additional hope interventions. We have grouped these under the following categories: cognitive, behavioral, interpersonal, and spiritual as well as mixed modes.

Cognitive Interventions

Facilitate the skills of "benefit finding and reminding." Adversity creates critical junctures for hope. During adversity or disillusionment, hope helps clients cope. Affleck and Tennen (1996) found that "the ability of dispositional hope to predict benefit-finding, controlling for differences in the related constructs of optimism and pessimism, is strong evidence of its unique role in shaping positive appraisals of adversity" (p. 911). In cases of personal loss, 70 to 80 percent of recently bereaved individuals reported positive experiences accompanying the loss (Nolen-Hoeksema & Davis, 2005). This intervention may be more effective later in the process of generating hope, when empathy has occurred and pain is receding, although it also helps put things into perspective and facilitates meaning and healing. A therapist can encourage clients to learn about themselves, life, others, God, and circumstances, helping them recognize the contributions of others to their well-being. Explore how empathy for the plight of others may have increased. Note new priorities and deepening values and commitments. When appropriate, promote the use of humor. Adversity can connect us to humankind in a way that few things can. When exploring lessons from adversity, avoid the implication that your client is necessarily better off for having had the experience, although many clients come to this conclusion on their own.

Attend to "small victories." Hope emerges and is sustained when clients regularly discover evidence for it. Draw attention to the small specific acts of hope that unfold daily (i.e., completing assignments, submitting job applications, or exercising for a few minutes each day). Each of these provides proof that builds self-efficacy, contributes to goal-setting confidence, and sharpens goal pursuit strategies.

Encourage "benefit of the doubt" thinking. Pessimism often arises out of client's overly critical attitudes towards themselves. When appropriate, encourage clients to give themselves the benefit of the doubt. Perhaps they didn't take into account circumstances, degree of difficulty, lack of experience, or partial or temporary success. A variety of factors influence outcomes of which effort is only one aspect. Encourage clients to give the benefit of the doubt to others as well.

Behavioral Interventions

Act "as if." Beliefs are often harder to change than behaviors. Hope is activated when positive change is experienced. The act "as if" (Vaihinger, 1924/1952) principle helps dispute negative beliefs by providing new behavioral evidence that becomes the basis for altered beliefs. In the face of tragic death, a client stuck in despair might express intense feelings: "I can't function anymore. All I want to do is withdraw. I just keep thinking about life without the person. It seems that life has lost its meaning." A therapist needs to acknowledge the pain accompanying the loss, but also encourage clients to "keep going" and "put one foot in front of another," to keep daily routines, to "force" themselves to interact with others, and to engage in life even though they don't feel like it. We might encourage them to "fake it" and "act as if they are functioning adequately." Going through the "motions" often produces real and tangible benefits. Clients need to be reminded that people aren't good mind readers and usually won't know they are struggling. Eventually life will begin to feel rewarding again. This intervention centers on behaviors that lead to positive thoughts, feelings, and outcomes, rather than directly focusing on changing negative thoughts.

Interpersonal Interventions

Encourage clients to confide in trusted others. Sonya Lyubomirsky (2008) asserted, "There may be no better coping mechanism than confiding or sharing a problem with a friend or intimate" (p. 139). Sharing a negative thought with a helpful person often takes the steam out of it. Significant others may help detect and correct distorted perceptions. If this seems overly threatening, the therapist may propose a preliminary step: Ask the client to write about his or her thoughts, making them explicit. Negative thoughts often become ruminative, requiring active intervention to break the negative cycle.

Spiritual Interventions

Clarify the role of religious beliefs. Generally religious beliefs are sources of hope, but sometimes they actually diminish hope. Clients who believe that God will not forgive them for an offense may feel little possibility for

hope. A therapist may want to explore the role of religious values and identify beliefs that appear to negate hope. A different interpretation of religious beliefs and ideas may invite increased hope.

Involve spiritual leaders. When necessary and appropriate, therapists should encourage clients to work with spiritual leaders. These leaders may be able to resolve spiritual concerns, work through repentance issues, and counsel on spiritual strategies for developing faith and hope.

Remember past blessings. When clients face hardship, it is possible to renew hopefulness by recalling past blessings that have accompanied adversity. Clients may be encouraged to retell an experience in vivid detail, including how it was experienced, what it meant for them, and what their role was in receiving the blessings.

Mixed Mode Interventions

Write about your "Best Self." Invite clients to visualize living as their "best self," imagining how they arrived at this desired state and what it feels like. Ask clients to write about this "best self" (Lyubomirsky, 2008). This process heightens awareness of values, priorities, motivations, desired characteristics, and goals, and it can align present actions with a desired future (Emmons, 1986; Pennebaker, 1998). It can increase the sense of control and attainability for the client (Lyubomirsky, Sousa, & Dickerhoof, 2006). Athletes, musicians, and other performers use a version of this strategy as they visualize successful performances. This exercise improves goal clarity, commitment, and performance (Pham & Taylor, 1999), boosts psychological adjustment and acceptance (Rivkin & Taylor, 1999), and leads to more positive affect with its associated benefits (Sheldon, & Lyubomirsky, 2006).

Support vicarious learning. Not all lessons in life need to be learned through direct experience. Much learning comes from vicarious observations. Teach clients to learn from hopeful role models, friends and relatives, ancestors, teachers, mentors, constructive influences, wholesome media, and personal heroes.

ASSESSMENT AND RESOURCES FOR HOPE

Several hope instruments (Lopez, Snyder, & Pedrotti, 2003) have been developed for research and therapy. Snyder and colleagues created the Adult Dispositional Hope Scale (Snyder, Harris, et al., 1991), Children's Hope Scale (CHS; Snyder, Hoza, et al., 1997), and the Adult State Hope Scale (Snyder, Sympson, et al., 1996). The Adult Dispositional Hope Scale consists of 12 items on a 4-point Likert scale (from 1 = *definitely false* to 4 = *definitely true*). It has two subscales that evaluate *agency* and *pathway* dimensions as well as four distracter items. The agency and pathway items are summed to give a total hope score. Various reliability and validity studies indicate good psychometrics. The full scale can be viewed in a chapter titled "Hope: Many definitions, many measures" (Lopez, Snyder, & Pedrotti, 2003). The Children's Hope Scale consists of six items on a 6-point Likert scale, with three items tapping "agency" and three "pathways." This scale has been shown to have acceptable reliability and validity. The Adult State Hope Scale consists of six items on an 8-point Likert scale (ranging from 1 = *definitely true* to 8 = *definitely false*). The authors report adequate psychometrics for this instrument.

For a different approach, the Staats Hope Scale (Staats, 1989) focuses on particular events and outcomes and contains four subscales: self-hope, other-hope, wishful thinking, and expectation. The instrument contains 16 items, which respondents are asked to rate using a 6-point Likert scale (0 = *not at all* to 5 = *very much*), first on the *wish* dimension and then again on the *expect* dimension. This scale also possesses adequate psychometrics. It can be viewed in the same chapter on hope measurement previously referred to (Lopez, Snyder, & Pedrotti, 2003). Seven other hope scales are mentioned and briefly reviewed in this same chapter.

Additional key readings on hope as well as some helpful web resources are available in the appendix.

SUMMARY

This article focused on psychological constructs that help cultivate hope. It emphasized hope's "yang," or the efforts that therapists and clients can exert in cultivating hopeful perspectives. A variety of interventions have been highlighted. We want to conclude by emphasizing the critical nature of divine hope that highlights its "yin" or gift quality.

Hope is an essential ingredient for lives of meaning and happiness. President James E. Faust (1999) declared, "Hope is the anchor of our souls. I know of no one who is not in need of hope—young or old, strong or weak, rich or poor" (p. 59). Hope is possible because God is its

source. Without the atonement of Christ, there would be no lasting hope. His hope is eternal in its duration and infinite in its ability to encompass every experience. This hope never fails. It has been called the "more excellent hope" (Ether 12 32). President Dieter F. Uchtdorf (2008) stated, "No matter how bleak the chapter of our lives may look today, because of the life and sacrifice of Jesus Christ, we may hope and be assured that the ending of the book of our lives will exceed our grandest expectations" (pp. 22-23). Elder M. Russell Ballard (1992) implores us to remember "Regardless of how desperate things may seem or how desperate they may yet become…you can always have hope. Always" (p. 32). God is always ready to dispel despair.

We gain hope, because we believe God has a plan for our lives, even if we don't fully comprehend how it unfolds in our present sphere of possibility. Hope leads us to commend ourselves into His benevolent care. It sustains and strengthens. It calms and quiets. "Hope is an orientation of spirit, an orientation of the heart...It is not the conviction that something will turn out well, but the certainty that something makes sense, regardless of how it turns out" (Havel, 1990, p. 181). Therefore, spiritual hope is sustained not because things turn out as we wish, but because we trust that God has a plan that transcends our understanding and is designed to bless and promote growth.

Hope is increased when we believe we merit God's blessings. Such a belief prompts people who have faith in God to take action to align that faith with their behaviors. As a result of that congruence, a person possesses greater confidence to call upon God for the promised blessings, whether those blessings are designed for now or later. However, the humble seeker of God's grace does not dictate, but implores and pleads, while circumscribing his or her desires within God's will.

Hope is to believe that today's pain is only a way station on the road to deliverance. It is to believe in a day when "God shall **wipe** away all **tears** from their eyes; and there shall be no more death neither sorrow nor crying, neither shall there be any more pain" (Revelations 21:4). Hope is sustained by trusting in God while cultivating patience with current circumstances.

Ultimately, we place hope in a God who metes out mercy as fully as he can, bestows grace in abundance, and reminds us that he has "graven [us] upon the palms of [his] hands" (Isaiah 46:16) as a token that He will "not forget [us]" (Isaiah 46:15). To feel divine hope is to experience God's love in our lives. So when life throws us or our loved ones unexpected challenges, unexplained hardship, or suffering at the hands of others, we can "know that all things work together for good to them that love God" (Romans 8:28) and that "these things shall give [us] experience, and shall be for [our] good" (D&C 122:7). Divine hope is based on obedience, faith, patience, and trust in God. It is predicated on acceptance of divine will, received as a gift, and confirmed by a sense of God's love for us. It is the link between faith and charity. This is the *doctrine of divine hope*.

The *principle of hope* can be applied both spiritually and psychologically. Much can be done to establish habits of hope. These habits are based on positive expectations, approach motivation, goal setting, feelings of efficacy, ability to self-regulate, and the capacity to find, enlist, and create nurturing environments. It is cultivated through righteous living. Hope serves us in the best of times. Yet hope is especially critical when we are struggling, discouraged, or depressed. Hope is the royal road to healing. It keeps us moving forward and leads to action and problem solving. It generates an entire spectrum of helpful outcomes and is essential to a life well lived. Therapists are in a particularly unique role as agents of hope. Let us harness the power of appropriate hope to the benefit of our clients and to our own well-being.

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APPENDIX: HOPE READINGS AND ONLINE RESOURCES

Psychological Readings

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Web Resources

http://www.authentichappiness.sas.upenn.edu/Default.aspx

http://news.bbc.co.uk/1/hi/programmes/happiness_formula/

http://www/ppc.sas.upenn.edu/

http://www.stanford.edu/class/msande271/onlinetools/LearnedOpt.html

Spiritual Readings

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