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The Dynamic Gift of Hope in Psychotherapy

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By

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Ad Majorem Dei Gloriam

The Dynamic Gift of Hope in Psychotherapy

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Abstract

Hope has been an articulated aspect of the human experience for thousands of years. In the field of psychology, humanistic theory brought hope out of the shadows while positive psychology's focus on virtues furthered research on hope and brought it into the second millennium.

In borrowing from psychological and theological disciplines the author has sought to provide a comprehensive literature review to explore the role of hope in the lives of clinicians as well as the contagious nature and function of hope in the psychotherapy relationship and process. A review of Snyder's model of hope and the Adult Hope Scale is included and cross-cultural limitations are noted. The related constructs of optimism and imagination are explored.

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Seven psychotherapists and one psychiatrist at an urban community health center in Central Massachusetts were interviewed. Interview questions sought to elicit clinicians' perceptions, stories, and insights regarding the presence, cultivation, and role of hope in the psychotherapy relationship and process. Clinicians also were asked to share personal touchstone experiences of hope.

The clinicians participating in this study commented on several characteristics and functions of hope in the psychotherapy relationship and process: the centrality of the therapy relationship, hope's affective quality, meaning making, God and transcendence, and the mutual/reciprocal nature of inspiring hope in the therapy relationship. Several rich images and metaphors of hope also emerged. Overall, clinicians believed that hope plays a critically important role in the psychotherapy.

The inner congruence of the therapist is explored as an element and dynamic that allows for the holding of hope and the containment of a client's feelings of anguish and hopelessness. Clinicians are encouraged to engage in personal psychotherapy as a means of developing self-awareness and a capacity for holding hope and hopelessness. A continued and intentional dialogue is recommended for psychotherapists, as is a deliberate commitment by leadership in the field to provide practicing clinicians with the time, space and opportunity to reflect upon and cultivate hope individually and collectively.

Preface

Hope¹

'Hope' is the thing with feathers -
That perches in the soul -
And sings the tune without the words -
And never stops - at all -

And sweetest - in the Gale - is heard -
And sore must be the storm -
That could abash the little Bird
That kept so many warm -

I've heard it in the chillest land -
And on the strangest Sea -
Yet - never - in Extremity,
It asked a crumb - of me.

¹ From Emily Dickinson, "Hope' is the Thing with Feathers". *The Poems of Emily Dickinson*, by R. W. Franklin, 1999, Harvard University Press. Retrieved from <http://www.poetryfoundation.org/poem/171619>.

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INTRODUCTION

It is said that, “hope springs eternal in the human heart” (Pope, 1734) and that it is so central to the human spirit, without it we could not endure (1 Cor. 13:13, Holy Bible, 2009). An echo across time, hope has been an articulated aspect of the human experience for thousands of years.

Religious and spiritual traditions hold “hope” as a theological tenet and virtue, and its value has endured in society. In a world marked by a disturbing amount of violence and unrest, religious and spiritually-oriented hope continues to offer meaning and solace to the masses in a way that binds them to their ancestors in faith, and to their God. Christians, Jews, and those faithful to Muslim, Buddhist, Hindu, Native American, and Aboriginal traditions all draw “spiritual light” from hope-oriented belief systems (Scioli, et al., 2007). Then, and now, those faithful to the many faces of God are invited to live in and into a hope that promises freedom, salvation, deliverance, resurrection, and change.

In the field of psychology, the “third force”, humanistic theory, brought hope out of the shadows of psychoanalysis and behaviorism’s fatalism and determinism. Humanistic psychologists (Allport, 1955; Frankl, 1972; Maslow, 1968; Rogers, 1951; Shaffer, 1978) proposed a fundamental belief in people’s goodness and potential, and in their ever-present capacity to act from this place of virtue and opportunity. This third force was a “philosophy of possibilities” (Gould, 1993, p. 125) and a mark of hope in the field.

Hope theory expanded and became an interdisciplinary research focus in the 1990’s as professionals from all aspects of healthcare recognized the link between hope and coping indices (Snyder, Michael & Cheavans, 1999). Snyder, Feldman, Taylor, Schroeder and Adams (2000) highlighted the positive role of hope in human resiliency and posited that

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hope's strength lay both in its capacity to prevent the onset of problems and in its alleviation of existing ones. At the onset of the second millennium hope had become of central importance to the disciplines of both religion and psychology.

Psychology soon sought how best to measure hope, but first it had to define it. Snyder et al., (1991a) conceived a construct of hope that directly focused on an individual's internal process and pursuit. They understood hope as a dynamic relationship between cognitive processes that engage a person's sense of agency and the individual's capacity for planning and execution. Hope was conceptualized as an integrated construct focused on both an individual's "willpower" and "waypower" and as such expanded earlier constructs that solely focused on agency.

In an effort to measure their construct, Snyder et al. (1991a) developed the Adult Dispositional Hope Scale (currently referred to in the field of psychology as The Adult Hope Scale or AHS). Dispositional, or trait hope, as measured by the AHS is an enduring characteristic, a dispositional cognitive set of goal-directed thinking (Snyder et al., 1991a) regardless of situation or circumstance. Dubbed "a measurement of willpower and waypower" (Snyder, et al., 1991a), the AHS is a fast and accessible self-report measure comprised of twelve short questions; test takers respond according to a Likert scale. It takes approximately one-minute to administer and one-minute to score.

Despite its simplicity, the AHS's (Snyder et al., 1991b) psychometric properties prove it to be a powerful instrument for assessing adult trait hope in individuals 15 years of age and older. It taps the dynamic process of agency-pathway interaction while also striving to distinguish these dual elements, and it succeeds. Examined for its factor structure, reliability, convergent and discriminate validity, and the possibility of scale redundancy

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(Steed, 2002), Snyder's (1991b) Adult Hope Scale (AHS) is regarded as the measurement of choice amongst researchers seeking to measure adult dispositional hope. The instrument's efficacy for cross-cultural use merits further research in light of potential problems related to translation equivalence and cultural variance. Snyder, himself, cautions researchers to consider the Adult Hope Scale's limits with regard to cultural sensitivity, stating that "the assumption that hope 'looks and behaves' the same across all groups is a risky one" (Lopez, Snyder, & Pedrotti, 2003, p. 103). This will be further addressed in the literature review.

The constructs of optimism and imagination were examined as related but distinct from the construct of hope as defined by Snyder, et al. (1991a). These "relatives of hope" are likewise related to positive outcomes and a sense of the possible..." (Lynch, 1974) but are distinguished from hope in interesting ways. Most notably hope differs from optimism because of its quality and possession of agency; imagination shares hope's dynamic quality but further invites it into the relational realm of transformation. Bumpus (2010) and Lynch (1974) paint a picture of imagination as a relational space capable of lifting the individual out of isolation and into connection. "Hope not only imagines, it imagines with," Lynch asserts (p. 23). The author's words invite psychotherapists to consider this gift and act of "hoping with" as it relates to their clinical work in the context of psychotherapy.

The works of Rogers (1957), Frank (1971), and Norcross (2011) all speak to the transformative power of the therapeutic alliance in the context of psychotherapy. The positive relationship between this alliance and client treatment outcomes is widely researched and supported (Norcross, 2011, p. 26). Existential philosopher Martin Buber (1878-1965) described an I-Thou relationship as a catalyst and context for personal transformation and Buber's model of relationship was reviewed and upheld as paradigm for a transformative and

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“hope-inspiring” therapeutic relationship. Hope, for Buber (Buber & Smith, 1937), was not a personal possession. It was part of the “we” created in an I-Thou relationship. Hope was not simply a hope for one’s self but a “spreading of one’s hope...” (Gould, 1993, p.115) in the power and context of a relationship.

In light of the importance and focus on the therapeutic alliance as an instrument of hopeful exchange, an exploration of the relational nature of client hope and clinician hope was introduced. Developmental psychologist, Erik Erikson (1902-1994), believed that people hope from birth (Erikson, 1963) and this theory was examined in the context of attachment theory. Most clients experience some modicum of hope by simply reaching out for the services of a psychotherapist. Therapists must also possess hope if they are to ask the same of their clients (Rumsfeld, 1990). Though deeply interior, hope is also a relative term, Lynch (1974) reminds us. Mental health clinicians are in a unique position to cultivate and co-create hope with their clients.

There is a scarcity of research exploring the role of hope in the lives of clinicians, and the potential impact the degree of one’s dispositional hope has on their therapeutic encounters. How do mental health practitioners working with challenging populations find, cultivate, and maintain hope- for themselves, and for their struggling clients- in the midst of suffering? Is there a larger story, icon, or touchstone of hope that they draw upon to maintain hope, and to witness and offer hope to those who seek their help and support?

Hanna (2002) suggests that hope acts as a contagion or positive influence on client change in psychotherapy. Lynch (1974) reminds therapists of their gift and responsibility to be bearers of hope. Buber (1937) speaks to hope in the co-constructing power of an “I-Thou” relationship, imaging the ‘Thou’ as an “eternal butterfly,” ever capable of transformation

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(p.31) and by consequence, hope. Clinicians have the privileged and rare opportunity to be enduring facilitators and agents of hope (Capps, 2001) in their clients' lives. This research study seeks to explore their perceptions, experiences and stories of hope in the context of the clinical relationship and process of psychotherapy.

LITERATURE REVIEW

The Dynamic Gift of Hope in Psychotherapy

Hope in Historical Context

Religion. What qualities and circumstances afford or deprive an individual of hope? What is the nature of this universal concept humans have long referred to as hope? “Can hope be instilled or restored in those suffering from ‘hopelessness?’” (Scioli, Ricci, Nyugen, & Scioli, 2011, p. 78). Across cultures and religious traditions theologians and people of faith have explored these questions for centuries.

“Writers within the Judeo-Christian tradition... have placed hope as one of the triumvirate virtues along with faith and charity. Saint Paul and Martin Luther held hope, along with love, as the essence of what is good in life” (Snyder, 2000, p. 3). Rooted firmly in their relationship with a God who promised them grace and new life from death, Christians believe light *will* overcome darkness (John 1:5, Holy Bible, 2009), even if they can not see or comprehend how in any given moment or situation.

Early and contemporary Christians alike are invited to walk by faith, not by sight (2 Cor. 5:7, Holy Bible, 2009), their hope for more or better grounded in their God’s promise of resurrection in their lives, too. Christians find hope in the Pauline conviction that “nothing can separate us from the love of God in Christ” (Rom. 8:39, Holy Bible, 2009) and in the ultimate Christian Story that promises nothing less than new life in the Spirit (Rom. 8:1-4, Holy Bible, 2009). Christianity proclaims a theology of hope that acknowledges suffering as part a life fully lived (John 10:10, Holy Bible, 2009) but that also “points consistently to a God who is bigger than the diminishment that threaten us (Griffith, *in press*, p. 3). Christianity locates hope in process, and in trusting and faithful partnership with a God who

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has forever promised (new) life beyond and transcendent of any shattered dream or immediate struggle.

Ancient Jews placed their hope in Yahweh, trusting their God would free them from the bondage of Egyptian slavery. Hebrew Scripture offers contemporary Jewish people hope through stories of a God so powerful and allied with them that oceans part on command to offer safe passage in the face of dire and seemingly hopeless circumstances. A reading from the book of Exodus (Ex. 14: 5-18, Holy Bible, 2009) invites those faithful to Yahweh to “Be still... Fear not... Stand your ground, and see the victory the Lord has won for you today.” Then, and now, believers are invited to live in hope.

Christians and Jews are not the only people of faith sustained by hope. “Buddhists, Hindus... as well as the followers of Mohammed, the African Ifa, Native Americans, and the Australian Aborigines draw their “spiritual light” from hope oriented belief systems (Scioli, et al., 2011, p. 78).” Commonly attributed to the Buddha, this passage highlights the undercurrent of hope in Buddhist thought:

“Insight into change teaches us to embrace our experiences without clinging to them - to get the most out of them in the present moment by fully appreciating their intensity, in full knowledge that we will soon have to let them go to embrace whatever comes next. Insight into change teaches us hope. Because change is built into the nature of things, nothing is inherently fixed, not even our own identity. No matter how bad the situation, anything is possible” (Bhikkhu & DeGraff, 2006, retrieved online).

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The “paradox of true hope is that change is definitive, while nothing else is absolutely determined. This reality gives us not only reason to fear but also reason to hope!”

(Groopman, 2004, p. 211).

Transcending time and place, hope is a perception that people have long experienced amidst life’s setbacks and struggles. Mature hope resides in life experiences marked by plenty and by void, amidst accomplishment and disappointment. “Genuine hope understands the limits of hoping and makes a space for them” (McDargh, 2001, p. 7). It is neither Pollyannaish nor untested by life’s adversity. “Hope brings reality into sharp focus” (Groopman, 2004, p. 198) by broadening it in and through the full reality of our lived experience. Groopman (2004), an oncologist, shares wisdom gleaned from his work with patients’ struggling to hope amidst a cancer diagnosis:

“Hope... is rooted in unalloyed reality... giving us the courage to embark and the resilience to endure... It is the elevating feeling we experience when we see – in the mind’s eye – a path to a better future. Hope acknowledges the significant obstacles and deep pitfalls along that path. True hope has no room for delusion”... “True hope takes into account the real threats that exist and seeks to navigate the best path around them” (p. xiv-1... 198).

Theologian Paul Tillich (1886-1965) (as cited in Groopman, 2004, p. 211) said, “true faith does not discount doubt.” The same might be said of hope. True hope respects doubt as a companion and fear as a nemesis, though it concedes the final word to neither. Mature hope acknowledges hard times but believes they are not end times; knows that new life can

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and does emerge from the ashes of personal tragedy; trusts that disappointment and injustice need not have the last word in this world. Mature hope reflects a capacity to believe and live into these places of process and paradox.

Psychology. “When we consider human well being, *hope* should be of interest to everyone” (Lazarus, 1999, p. 1). While an understanding of hope always will occupy the minds and hearts of the religious faithful, hope - its origins, determinants, and deterrents – demands equal attention from mental health practitioners. Lazarus (1999) suggests that depression is “a consequence of despair” (p. 2). The prevalence of clinical depression in modern society suggests a widespread struggle for which hope might offer some remedy. The National Institute for Mental Health (NIMH, 2013) reports that 6.7% of the adult population (age 18-65) in the U.S., and 11.2% of children/adolescent population (ages 13-18), met the criteria for major depression in 2011. Suicide, often characterized by hopelessness and a belief that no relief or alternative choice exists, is the fourth most common cause of death amongst adults in the United States, ages 18-65 (NIMH, 2013). If depression is a consequence of despair, and despair emerges from the abyss of hopelessness, surely hope is a quality worthy of cultivation and possession.

“Snyder regards hope as a human strength and virtue. Virtue, as viewed from a positive psychology perspective, refers to any psychological process that can render a person’s thoughts or actions beneficial to that person and society” (Snyder, 2000, p.1). Positive psychology’s focus on virtues and an individual’s personal freedom to act from this place of goodness and strength found favor and precedence in earlier schools of theory. In reaction to psychoanalysis and behaviorism, humanistic thinkers offered a broader and more

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positive understanding of the human person and human behavior, one that viewed persons far more than a product of their darkest impulses or learned behaviors. “The train of thought of positive psychology had long been operative among humanistic psychologists” (Kwan, 2010, p. 59), whose desire and hope was to “rehumanize psychology... to correct what they [saw] as distortions of the self that began but did not end well with Freud” (Gould, 1993, 124).

Humanistic theory instead focused on each individual's potential and stressed the importance of self-actualization and growth in and through relationship to others. Its fundamental belief (Allport, 1955; Frankl, 1972; Maslow, 1968; Rogers, 1951; Shaffer, 1978) is that people are innately good, and profoundly capable of acting upon that good. This third force of psychological thought paved the way for the emergence of positive psychology and provided its proponents with a solid foundation and anthropology upon which to grow and understand human beings as dynamic, made for meaning, and in process. “Humanism is a philosophy of possibilities” (Gould, 1993, p. 125), a future-oriented posture marked by hopefulness and a belief in human virtue.

During the late 1950's to the 1960's, hope was examined under the guise of more formal, scientific approaches. Anecdotes supporting it as a central component of recovery in medicine, nursing and mental health led to a search for empirical evidence with its predictive powers. While varying definitions of hope were identified, studies investigating hope as a predictive variable for differing outcomes produced inconclusive results (Schrank, Stanghellini, & Slade, 2008). What both psychiatrists and psychologists could agree upon was the premise that hope was based on positive expectations for goal attainment (Frank, 1981; Frankl, 1963; Melges and Bowlby, 1969; Menninger 1959; Schachtel, 1959; Cantril,

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1964; Farber, 1968; Mowrer, 1960; Stotland, 1969, as cited in Snyder, 2000, p. 4), and it further set the stage for the later advent of positive psychology.

The 1970's ushered in an abundance of psychological research focused on stress, coping and illness. Initially, this research focused on the positive correlation between an individual's psychopathology and their compromised physical and psychological well-being. Positive psychology, with its contrary focus on the impact of personal strengths and protective factors still had not emerged as a formidable voice. By decade's end, however, health psychology researchers and practitioners (Cousins, 1976; Frank, 1975; Simonton, et al., 1978, as cited in Snyder, 2000, p.5) "argued that given the involvement of negative thoughts and emotions in poor health, that positive processes such as hope would be worthy of study for possible positive sequelae" (Snyder, 2000, p. 5).

Researchers and scholars (Snyder, Feldman, Taylor, Schroeder, & Adams, 2000) began to broaden their understanding of mental health issues and treatment by focusing on client strengths. What were people doing right to become and stay well? What protective factors did people possess and engage that led them to become happier, whole, and integrated? Snyder, et al. (2000) highlighted the beneficial roles of hope in primary (before the appearance of a problem) and secondary (after a problem has appeared) prevention. The authors' pose that "in secondary prevention, the individual produces thoughts or actions to eliminate, reduce, or contain a problem once it has appeared (p. 256). They argued that hope's strength lay not only in its capacity to prevent the onset of problems but in alleviating existing ones as well.

Hope theory expanded and had become a research focus across disciplines by the 1990's. From psychology to nursing, across disciplines several constructs of hope theory

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were introduced that linked hope to a broad range of positive coping indices (Snyder, et al., 1999). For example, in response to disappointment, it was found that individuals tapped hope to: engage positive reinterpretation and growth, seek emotional and social supports, find comfort in religion, move toward acceptance and alternate planning. Well into the 21st century, decades of productive work on hope theory (Flores & Obasi, 2003; Lazarus, 1999; Lopez, Floyd, Ulven, & Snyder, 2000; Peterson & Seligman, 2004; & Steed, 2002) now offers practitioners ample research and constructs to introduce or utilize in clinical practice.

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If religion offers people agency and solace rooted in and sustained by the belief and promise that “hope will not disappoint” (Rom. 5:5, Holy Bible, 2009), secular society offers an understanding of hope that also looks toward the future with positive anticipation, if not consolation. The *Oxford English Dictionary* (2012) defines hope as an “expectation of something desired.” This echoes the layperson’s understanding of hope as something good and future-oriented, if not salvific in an explicitly religious sense. The benefits of hope appear universal regardless of one’s religious conviction.

“Without hope to fuel our dreams and ambitions, we become captive to whatever is happening in our immediate environment. Without hope’s ability to transcend the limits of the present, we lose our sense of ourselves as independent entities, our feeling of mastery, and our sense of purpose”
(Reading, 2004, p. 3).

Void of hope, individuals look to external forces to define their opportunities and circumstances, to extend the breadth of their life experience and possibilities. They live and

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choose solely at the mercy of chance or positive circumstance. This is not to say we do not need others to support and contribute to our hopes and goals, but that we must claim our active presence and participation in the process.

Without hope, our human experience risks becoming indistinct from the those of all other species that, as far as we can tell, live solely in response to biological needs and to the stimuli of their immediate surroundings. Reading (2004) captures this distinction, and hope's expansive nature:

“Hope is an anticipatory emotion, an expectant savoring in our mind of a desired future occurrence that we believe we can help bring about. It differs from ordinary expectation- that things will continue as they have in the past- because it is based on a belief that we can, through our own actions, make something turn out better than would otherwise be expected... [Humans] are faced with a choice that no other animal ever has- whether to behave in response to our current circumstances or to our imagined hopes and expectations” (p. 4).

It is this ‘savoring’ quality of hope that speaks so distinctly to the human mind and heart.

Snyder’s Model of Hope

Whether or not one bases their hope on a God of new life and promise, with agency as one of its pillars it is clear that hope can only bear fruit in and through human efforts. If it exists at all, hope awaits engagement and furthering by its possessor. That for which we hope is actualized by the work and imagination of human minds, hearts, and hands. Building on Reading’s (2004) concept of hope as an agentic process, Snyder, et al. (1991a) puts forth a

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construct of hope that is directly focused on an individual's internal process and pursuit. The authors conceptualize hope as a dynamic relationship between cognitive processes that engage a person's sense of agency and an individual's capacity for planning and execution.

They offer this two-pronged definition:

“[Hope is] a cognitive set that is based on a reciprocally derived sense of successful agency [goal-directed determination] and pathways [planning of ways to meet goals]... The agency component refers to a sense of successful determination in meeting goals in the past, present, and future... The pathways component refers to a sense of being able to generate successful plans to meet goals” (1991, p. 570).

Snyder, et al.'s (1991a) definition expands earlier constructs of hope focused solely on agency but neglectful of any subsequent planning or pursuit. Snyder (2000) states “routes to the desired goals are absolutely essential for successful hopeful thought (p. 9).” Hope devoid of planning is compromised hope at best. Just as “goals provide the endpoints or anchors of mental action sequences... pathways thinking taps the perceived ability to produce plausible routes to [those] goals” (Snyder, 2000, p. 9). It is a “reciprocal, additive, and positively related” (Snyder, et al., 1991a, p. 571) process during which “the agency and pathways components enhance each other in that they are continually affecting and being affected by each other as the goals pursuit process unfolds” (Snyder, 2000, p. 10). Alone, neither is sufficient to fully engage the process. In tandem, the two generate and sustain hopeful thinking.

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Hopeful thinking, in turn, promotes the agentic motivation and self-perception that further facilitates an individual's planning and movement towards desired goals. It is an empowering intrapersonal dynamic in which "agency and pathways components emphasize cognitive appraisals of goal-related capabilities, underscoring the phenomenological nature of the author's conceptualization" (Snyder, et al., 1991a, p. 571). The authors (1991a) cite that "higher levels of hope involve greater reciprocally derived perceptions of agency and pathways as people consider goals" (p. 581). In this shaping process, our sense of agency in relation to our goals informs our self-perception. It forms and informs our identity and perception of how, or if, we perceive ourselves as agents of change and hope-filled thinking. This posture of hope becomes "an enduring disposition that is [continuously and] subjectively defined as people access their agency and pathways related to goals" (Snyder, et al., 1991a, p. 571) repeatedly throughout the life cycle.

In their seminal work, *Positive psychological assessment: A handbook of models and measures*, Lopez and Snyder (2003) address the emotion-based and cognition-based aspects of hope through differentiation and linkage. "Contrary to what one might intuitively postulate, models that operationalize the construct of hope from an affective point of reference are fewer in number than those that are more cognitive in nature" (p. 91-92). This may be due, in part, to our collective social psyche. "In popular literature and prose, hope often is treated solely as an emotion, a particular feeling that allows one to sustain belief in dire circumstances" (Lopez & Snyder, 2003, p. 92). This portrayal of hope as an emotional escape hatch in difficult times has been internalized by the human psyche over centuries and thus thinned the dimensionality of this vital human virtue.

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Perhaps it is in reaction to this romanticized perspective that the cognitive nature of hope has received so much research attention. Ease of measurement may also be a factor. “Affective conceptualizations do not easily lend themselves to measurement via self-report. This may be attributed to historical difficulties operationalizing hope and a scholarly neglect of models of positive emotions. Cognitive conceptualizations, however, have been operationalized to produce brief, valid self-report measures of hope” (Lopez & Snyder, 2003, p. 97) and have subsequently gained the psychological community’s approval and favor.

While hope research has favored the causative importance of thoughts, “the cognitive emphasis of Snyder et al.’s (1991b) model does not imply that emotions are irrelevant, but rather that emotions are the sequelae of cognitive appraisals of goal-related activities. The quality of emotion for a particular goal-related setting depends on the person’s perceived hope in that setting” (Snyder, et al., 1991a, p. 571) and likely, on the depth of want or need attached to a particular goal. Thoughts drive emotion, with “positive emotions reflecting perceived success in the pursuit of goals, and negative emotions reflecting perceived failures” (Snyder, 2000, p. 11). “Hope... is constructed not just from rational deliberation, from the conscious wielding of information; it arises as an amalgam of thought and feeling.” (Groopman, 2004, p. 120). Snyder (1995) confers:

“Hope theory has both feed-forward and feedback emotion-laden mechanisms that modulate [a] person’s success in attaining a given goal... Hope theory is an interrelated system of goal-directed thinking that responds to emotionally laden feedback throughout goal pursuit. As such, thoughts and emotions work hand-in-hand in hope theory to help the person

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pursue the coveted goals that are crucial in day-to-day living”
(p. 95).

Together, these learning histories and mood predispositions reflect the beginning context for our goal pursuit thinking (Lopez & Snyder, 2003, p. 94-95). Snyder’s (1991a) model of hope (See Illustration 2), inclusive of affect, cognition, and the generative interplay between them, offers a glimpse of the wholeness that is hope: its innate presence within a complex human systems; its dynamism; and its positive impact on subjective well-being.

Measuring hope. Other constructs of hope (Erikson, Post, & Paige, 1975; Gottschalk, 1974; Herth, 1991; Miller & Powers, 1988; Nowotny, 1991; Staats & Stassen, 1985, as cited in Bryant & Cvangros, 2004, p. 279) introduced after Snyder, et al.’s (1991a) construct have led to different views on how best to measure hope. “Some theorists carefully operationalize hope, others rely on vague impressions, further muddying understanding of this concept” (Lopez, Snyder, & Pedrotti, 2003, p. 103). In an effort to focus on conceptualizations that have been scrutinized by social scientists and practitioners, Lopez et al. (2003) located 26 theories or definitions, and a handful of validated measures (p. 91).

Their findings (see Appendix 1) included the: 1975 Hope Scale (Erikson, Post, & Paige, 1975), Gottschalk Hope scale (1974), Herth Hope Scale (1991), Nowotny Hope scale (1991), Miller Hope scale (Miller & Powers, 1988), Expected Balance scale (Staats, 1989) and the Hope Index (Staats & Stassen, 1985). Snyder’s Adult Trait Hope Scale (Snyder, et al., 1991b, see Appendix 3) and Adult State Hope Scale (Snyder et al., 1996) remained prominent amongst those chosen. Diverse definitions and resulting gaps in agreement on how best to measure the construct of hope did not overshadow the universality of Snyder’s integrated model. Proven to possess validity and reliability across studies, the Adult Hope

Illustration 1

Hope Theory Diagram

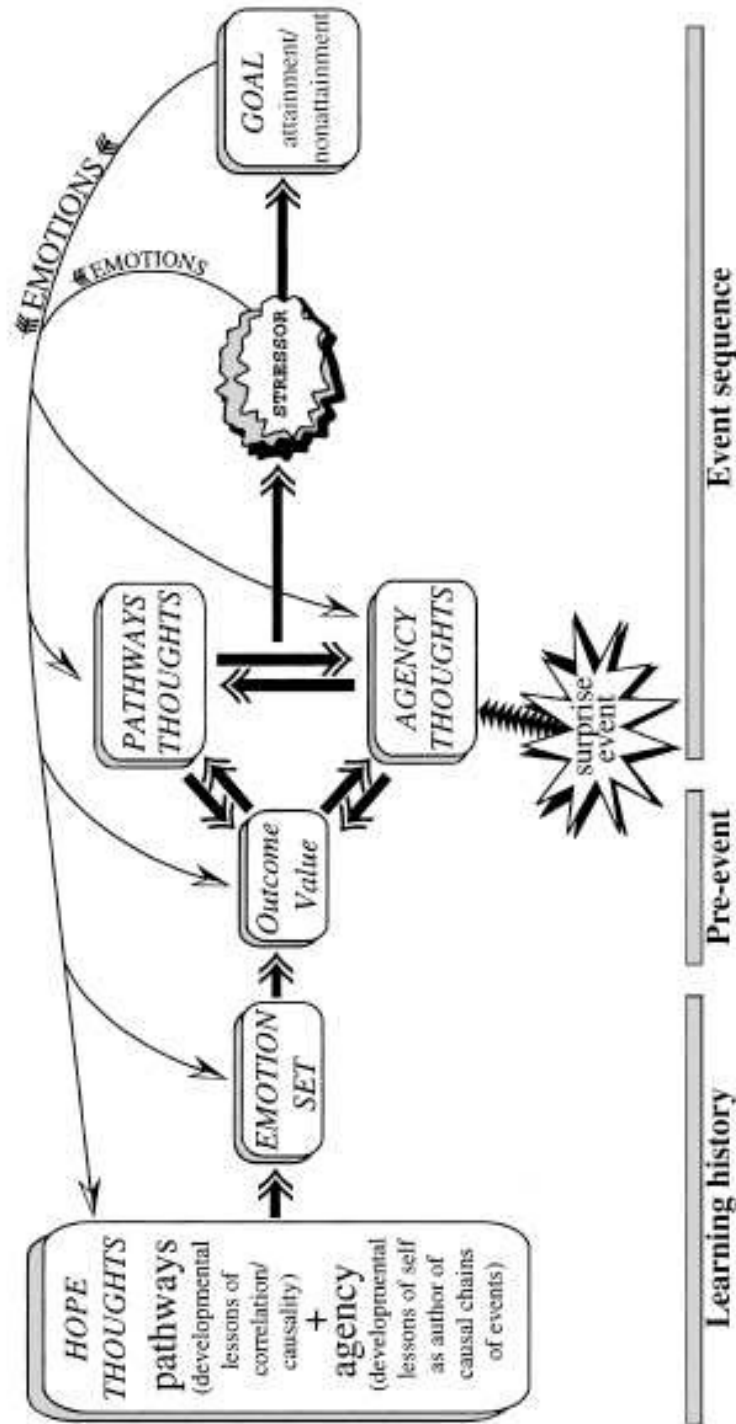


Figure 6.1. Hope theory.

(Snyder et al., 1991a)

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Scale (AHS) emerged as efficacious and as a preferred instrument for measuring adult dispositional hope (See Appendix 3).

Snyder's adult hope scale. The AHS, a measurement of dispositional or trait hope, differs from the Adult State Hope Scale (Snyder et al., 1996), a measurement that may fluctuate with a respondents circumstances depending on current context and moderating variables. The AHS measures an individual's disposition for hope while the latter measures an individual's level of hope in the context of a particular time, place and circumstance. Trait hope as measured by the AHS (Snyder et al., 1991a) is an enduring characteristic, a dispositional cognitive set of goal-directed thinking. According to hope theory, trait hope relates to the intensity of state hope by establishing a range that state hope can vary within (Snyder, 1996). Although specific situations may exert a unique influence on the level of hope, there is nevertheless a resiliency once this cognitive set is established... an underlying sense of agency and pathways" (Snyder, et al., 1991a, p. 571) that informs our overall capacity for hope.

Aptly dubbed "a measurement of willpower and waypower" (Snyder, et al., 1991a), the AHS is a self-report, individual-differences measurement containing twelve items. Individual difference measurements seek to study the ways in which individuals differ in their behavior, and to identify those differences. Since significant variation exists between individuals, but often studies solely seek to identify group similarities, individual differences are essential to explain how individuals differ in their thought or behavior. Implicit in Snyder's conceptualization of individual differences is the assumption that "hope is not a dichotomous motive in which the person either does or does not have hope... rather, there are individual differences involving degrees of hope" (Snyder, et al., 1991a, p. 581). One person

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may possess a robust capacity for agency, another person a strong ability for pathways thinking. Snyder et al. (1991b) built on this premise when devising the Adult Trait Hope Scale, otherwise known as the AHS. The measures tap this process of agency-pathway interaction while also striving to distinguish these dual elements.

It is the differences in pathway thinking and agency that are identified and differentiated by the AHS. The instrument seeks responses to twelve items; four measure pathways thinking, four measure agency thinking, and four are fillers. Participants respond to each item using an 8-point Likert scale ranging from definitely false to definitely true and the scale takes only a few minutes to complete.

Illustration 2

The Adult Hope Scale (AHS)

Response Scale	Items
1. = Definitely False	1. I can think of many ways to get out of a jam.
2. = Mostly False	2. I energetically pursue my goals.
3. = Somewhat False	3. I feel tired most of the time.
4. = Slightly False	4. There are lots of ways around any problem.
5. = Slightly True	5. I am easily downed in an argument.
6. = Somewhat True	6. I can think of many ways to get the things in life that are important to me.
7. = Mostly True	7. I worry about my health.
8. = Definitely True	8. Even when others get discouraged, I know I can find a way to solve the problem.
	9. My past experiences have prepared me well for my future.
	10. I've been pretty successful in life.
	11. I usually find myself worrying about something.
	12. I meet the goals that I set for myself.

Note. Adapted from Snyder, et al. (1991a).

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When administered, the AHS is frequently labeled the Goals Scale or the Future Scale, reflective of its agency and pathway elements. Minimal test administrator's participation is required because of the self-report format and the scale is written at approximately a sixth-grade reading level. Scoring the test requires approximately one minute (Snyder, 2000, p. 59).

Snyder et al.'s (1991b) AHS (also known as Snyder's Dispositional Hope Scale, and most recently, The Hope Scale), is designed to tap the multi-faceted character of hope in adults, ages 15 and older. Originally designed with a 4-point continuum (from 1= definitely false to 4= definitely true), the measure now includes a response option on an 8-point continuum "to encourage diverse responding" (Lopez, et al., 2003, p. 98). Agency and pathways items are summed to yield a total score (8 to 64 with the 8-point version; 8 to 32 with the 4-point version).

A measure of validity and reliability. The AHS was created to collect data intended to measure total score levels of theoretical variables, agency and pathway constructs, that are not easily or directly observable. In order for any assessment to be sound it must be free of bias and distortion and produce stable results over time and across domains.

Reliability and validity define and measure these risks. Reliability measures assess the extent to which research instruments are consistent or stable; tests producing the same stable results with repeated testing possess test-retest reliability. Validity measures assess the extent to which an instrument measures what it intends and was designed to measure. The AHS was assessed for its reliability and validity properties by its author and by adjunct researchers. Steed (2002) compared the psychometric properties of four measures of hope and optimism frequently used in the public domain: the Revised Generalized Expectancy for Success Scale

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(GESS-R, Fibel & Hale, 1978), the Life Orientation Test (LOT; Scheier, Carver, & Bridges, 1994), the Adult Hope Scale (AHS), and the Hunter Opinions and Personal Expectations Scale (HOPES, as cited in Nunn, Lewin, Walton, & Carr, 1996). Steed's research (2002) "verifies the reliability and validity of the AHS, and her findings support an argument for the measure's use as a preferred assessment instrument" (p. 477). Her comprehensive assessment of the scale examined its factor structure, reliability, convergent validity, and the possibility of scale redundancy.

It merits placing in context the collected data that Snyder, himself, utilized to assess the reliability and validity of the AHS before discussing its psychometric properties. Three hundred and forty-seven undergraduate psychology students at the University of Kansas comprised his study: 53% were women and 47% were men. Their mean age was 21.77 and 22.22 years, respectively. In addition to administration of the AHS, three other hope/optimism scales were administered, including the Generalized Expectancy for Success Scale-Revised (GESS-R; Fibel & Hale, 1978), the Life Orientation Test (LOT; Scheier, et al., 1994), and the Hunter Opinions and Personal Expectations Scale (HOPES; Nunn, et al., 1996). Four additional measures were administered: the Positive and Negative Affect Scale to assess for trait negative and positive affect (TNA and TPA; Warr, Barter & Brownbridge, 1983), and the Perceived Stress Reactivity Scale (PSRS; Schlotz, et al., 2011) and the Coping Inventory for Stressful Situations (CISS; Endler & Parker, 1993) to assess for task- and emotion- oriented coping and perceived stress levels. Measurements were administered in large groups during student class time.

Collected data analysis revealed, "all scales had adequate internal consistency, and there was strong evidence of convergent validity" (Steed, 2002, p. 466). The AHS and its

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measurement items accurately operationalized and measured the constructs it sought to identify and measure, and its scores correlated with those on other tests also designed to measure the construct of hope. “Data analysis utilizing LISREL (Joreskog & Sorbom, 1993 as cited in Steed, 2002, p. 475) examined the hypothesized factor structure of each scale. Factor structures and reliabilities, and correlations relevant for convergent validity were reported” (Steed, 2002, p. 475).

Convergent validity is an important characteristic of any new measure as it verifies predictable correlations with other existing measures seeking to gauge the same construct. The AHS appears to have concurrent validity as “it correlates positively with measures of self-esteem, perceived problem-solving capabilities, perceptions of control in life, optimism, positive affectivity, and positive outcome expectancies. Conversely, it correlates negatively with social introversion, depression, negative affectivity, and anxiety” (Snyder, 1995, p. 357). This evidence of convergent and discriminant validity confirms the measures construct validity.

Internal consistency provides additional corroborative information about a new scale, particularly whether it measures what it purports to measure. In relation to the AHS, Snyder’s (1995) research confirmed consistency of results across measurement items.

“High- and low-hope persons report agency and pathways cognitions for their goals that are theoretically predicted. In a situation in which high- and low-hope persons, as measured by the AHS, pursue a goal unfettered by any impediments, the higher hope individuals report more mental energy and pathways for

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their goals. Perhaps even more important, however, it should be noted that higher hope persons especially report more mental energy and pathways for their goals when there are blocks to those goals” (p. 357)

Steed’s (2002) research further supports the measure’s internal reliability. Cronbach’s alpha tests for internal consistency across measurement items on the AHS produced an acceptably high .74 to .84 score for the instrument; the measurements item-remainder coefficients, or the correlation of each test item with the sum of the remaining test items, also proved significant with scores ranging from .23 to .63.

Confirmatory factor analysis (CFA) is the preferred factor analysis in social research, testing whether construct measures are consistent with a researcher’s understanding of the nature of that construct. Its objective is to test whether the data fits a hypothesized measurement model. CFA on Snyder’s two-factor hope model based on agency and pathways items indicated a satisfactory fit of the model to data (CFI= .98, AGFI= .98, RMSEA= .066). A CFI of 90 or higher is considered desirable, and it is generally accepted that adjusted goodness of fit (AGFI) values of 90 or greater indicate well fitting models. A root mean square error of approximation (RMSEA) value of .06 is also indicative of acceptable model fit.

In particular, the four agency items in the AHS measure inter-correlate highly with each other, as do the four pathways items. Factor-analytic procedures used to describe variability among observed, correlated variables confirmed the identifiability of these two components and the appropriateness of their overall summation to yield a total hope score:

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“In several studies, agency subscale scores have correlated in the + .40 range with pathways subscale scores, lending support to the theoretical supposition that these two components of hope are related but not synonymous. In this regard, about 30% of adults, 15 years and older, taking the Hope Scale have both high agency and pathways, and as such exemplify truly high hope. On the other extreme, about 5% of people completing the AHS have relatively low agency and pathways; they are obviously low-hope persons” (Snyder, 1995, p. 357).

Test-retest reliability measures provided ample support for AHS instrument reliability. Given the same assessment twice, separated by days, weeks, or months, test-retest reliability tests for stability of correlation between scores at Time One (1) and Time Two (2). The AHS was “re-administered to people after intervals of 3 to 10 weeks, with the magnitudes of the correlations typically being in the +. 80 range. This lends support to the premise that hope has a dispositional, cross-temporal (and, by inference, cross-situational) underpinning” (Snyder, 1995, p. 357).

Finally, the adequacy of any instrument can be judged only if its stated purpose is known, its item measures articulated and understood, and its trustworthiness consistently proven. Steed’s comprehensive assessment of the AHS, and its yielded results, argue that the LOT and the AHS are the scales of choice when assessing adult hope and optimism (Steed, 2002, p. 466).

The social construction of hope and cultural considerations. “As suggested by historical writing and anthropological accounts, hope is a universal construct- all peoples

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during all times have valued the role hope plays in their lives” (Lopez, Snyder, & Pedrotti, 2003, p. 100). Every one of us is born with distinct personality traits; others we assimilate over time, adopted or imposed on us by the cultures and relationships in which we find or place ourselves. We are all shaped by this confluence of birthright gift and cultural influence. This convergence and engagement of nature and context shapes our expectations and cognitions, and honors and challenges our dispositions toward hope.

“The idea that we can shape our own destiny and make our dreams come true is one of the central tenets of Western society” (Reading, 2004, p. 17). In light of the increasing racial and ethnic diversity of twenty-first century North American society and the impact of globalization across continents, however, such an assumption must no longer be taken for granted in Western contexts. If psychology is to expand its scope of the good life to include what constitutes the good life in different cultures (Arndt, 2004), it is imperative that researchers in positive psychology “consider the cross-cultural applications of positive psychological constructs, evaluate the external validity of their research findings, and develop assessment instruments that are reliable and valid with culturally diverse populations” (Flores & Obasi, 2003, p. 42). A critique of Snyder’s Hope Scale is warranted in light of this imperative for cross-cultural sensitivity. Snyder, himself, warns that “the assumption that hope ‘looks and behaves’ the same across all groups is a risky one” (Lopez, et al., 2004, p. 103) and has encouraged the field of positive psychology to expand its scope “of the good life” across cultures.

Arndt (2004) responded to Snyder’s invitation and found that the scarcity of hope theory across cultures was a reality. “Although the AHS (Snyder et al., 1991), the most widely used scale to measure hope, has been translated into different languages and used

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with culturally diverse groups, a review of the literature revealed no published studies to date with international populations or racial-ethnic groups in the United States” (Arndt, 2004, p. 50). Moreover, while translation allows for administration of the instrument in any number of preferred languages, the potential for translation equivalence bias (Brislin, 1993) remains a threat to the measure’s integrity and utility. Linguist Xiang Yinhua (2011) explains:

“As far as languages are concerned, there are no two absolute synonyms within one language. Quite naturally, no two words in any two languages are completely identical in meaning. As translation involves at least two languages and since each language has its own peculiarities in phonology, grammar, vocabulary, ways of denoting experiences and reflects different cultures, any translation involves a certain degree of loss or distortion of meaning of the source text. [One] can say that equivalence in translation should not be approached as a search for sameness, but only as a kind of similarity or approximation...” (p. 169).

This distinction applies to narrative and psychometric measures, with measures inherently more concise and therefore more vulnerable to the compromise of direct translation. Arndt (2004) warns that when working with culturally diverse populations, “researchers and practitioners must be aware of their personal biases when attempting to make constructive interpretations. Otherwise, the risk of misinterpreting the responses of an individual or groups of people exists” (p. 47).

In an effort to integrate cross-cultural perspectives into hope theory and with the

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hope of broadening positive psychology's reach and understanding beyond that of Western thought, Arndt adapted the AHS for a collectivist/group-centered culture. He began by examining Snyder's (2000) hope theory in relation to individualist (U.S.) and collectivist/group-centered (Mexico) cultures and "determined that collectivist values may impact the experience of hope in non-western cultures and not be adequately represented in [Snyder's] existing Hope scale" (Church & Lonner, 1998; Marin & Van Oss Marin, 1991; Markus & Kitayama, 1991; Singelis, 1994; Yu, 1995, as cited in Arndt, 2004, p. 65).

Because interdependent-collectivist tendencies may well represent a substantive part of hope in Mexican culture, agency and pathway items on the Hope Scale were reworded to enhance culturally relevant content and to maintain Snyder, et al.'s (1991a) cognitive model within a concept of hope that is "not narrowly autonomous but encompasses self-sacrificing, or otherwise group-centered dynamics."

The ten adapted or new agency items that Arndt (2004) used to reflect a new alternative interdependent-collective version of the AHS are:

1. I energetically work on maintaining family relationships.
2. I pursue common goals with friends.
3. My past relationships have prepared me to relate well with others in the future.
4. My personal goals successfully overlap with the goals of my family.
5. I have a pretty successful family life.
6. I take into consideration my parents or older relatives suggestions to be successful in life.
7. I meet the goals that my close acquaintances say are important.
8. I willingly sacrifice my personal goals to also pay attention to the views of my relatives.
9. I share goals in common with classmates.

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10. I have pursued common goals with my co-workers.

The nine pathways items Arndt (2004) adapted or newly created to reflect a new alternative interdependent-collective version of hope were as follows:

1. Even when we disagree, I know my family can find a way to solve our problems.
2. There are many ways to maintain harmony in my group.
3. I can think of many ways to be included in the groups that are important to me.
4. There are many ways to achieve goals that are connected to the expectations of those around me.
5. I can think of many ways to get things in life that my close acquaintances say are important.
6. I can think of many ways to be included in groups that my kin, grandparents, godparents, aunts or uncles say are important.
7. Even when people who are important to me get discouraged, we can find a way to solve the problem.
8. There are many ways to achieve goals that are connected to the expectations of those around me.
9. There are many ways that my own goals tune into the goals of my group.

Two hundred thirty-two native Mexican college students (mean age 21.10; 52% male and 48% female), and 185 European American college students (mean age 21.8; 37% male and 63% female) participated and completed measures in Arndt's cross-cultural study, which included Snyder et al.'s (1991b) Adult Hope Scale (AHS), Arndt's Inter-dependent-Collectivist version of Snyder et al.'s (1991b) Adult Hope Scale (I-C Hope), the Self Construal Scale (SCS) and Satisfaction with Life Scale (SWLS). While the study succeeded in extending the empirical scope of positive psychology into the context of cross-cultural research, the study's findings were mixed.

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“Snyder’s (2000) two-factor model of agency and pathways failed to replicate in Mexico” (Arndt, 2004, p. iv-v). Since the experimental conditions that allow for variability of phenomenon in the U.S. could not be replicated in Mexico without compromising cultural distinction and integrity, the validity and reliability of Arndt’s translated AHS measure could not be confirmed. However, across contexts “two factors that were similar across cultures emerged and were interpreted as family and community hope” (Arndt, 2004, p. iv-v).

Arndt’s efforts to broaden positive psychology’s scope and extend its understanding of hope beyond that of U.S culture and contexts succeeded. The results of the study also highlight the socially constructed nature of hope and invite practitioners to remain cognizant of the unique social and cultural considerations that give shape and meaning to this universal human construct.

Related Constructs

Optimism. The terms hope and optimism are commonly used interchangeably in colloquial exchange. Like hope, optimism is a positive anticipatory state; so it is not surprising that hope and optimism have been portrayed as similar constructs (Gottschalk, 1974; Sethi & Seligman, 1994; Maier, Peterson, & Schwartz, 2000, as cited in Bruininks & Malle, 2005). Despite the generally accepted overlap in terms, however, there are distinctions between the two concepts that are important to note.

Carver and Scheier (1985, as cited in Snyder et al., 1991a) define optimism as “a generalized expectancy that good things will happen” (p. 571). They argue that optimists maintain positive expectations and that “optimism is construed as a stable personality trait that is not limited to a specific setting” (p. 571). Hope is similar to optimism in that it is conceptualized as a stable cognitive set reflecting general rather than specific outcome

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expectancies. Not limited by context or circumstance, individuals possessing hopeful or optimistic personality traits enjoy an enduring posture of confident anticipation. Generally speaking, they look to the future wearing the proverbial rose-colored glasses.

“Hope and optimism differ in the hypothesized relationship between outcome and efficacy expectations and the role this relationship plays in the prediction of goal-directed behavior” (Snyder, et al., 1991a, p. 571). Optimism allows for the possibility that efficacy expectations may impact outcome expectancies, but regards this determinant as optional. Hope, as construed by Snyder et al. (1991a), conceptualizes efficacy expectations as an element of agency and as integral to the goal-directed behavior that drives hope. Hope’s disposition to act distinguishes it. An individual’s sense of optimism may be informed by self-efficacy beliefs, but Snyder et al. (1991a) argues that a causal relationship between self-efficacy and optimism cannot be assumed. While optimism can stand alone in its gaze toward positive expectation, hope’s gaze is always marked by the dynamism of efficacy.

In order to better understand how hope and optimism operate psychologically and distinctly within a situation, Bruinlins and Malle (2005) conducted a study in which participants wrote about a time when they experienced hope and other related psychological states. By examining the contexts in which varied states were experienced, highlights, specific to each, emerged. Study results concluded that “what makes hope distinctive is the combination of the [hoped for] outcome’s valued importance, the difficulty of effecting the outcome through one’s own efforts, and the continuing investment into it through cognitive and emotional energy in spite of the odds against it” (Bruininks & Malle, 2005, p. 348-349). Contexts and attitudes eliciting experiences of optimism were distinctly different and their findings diametrically opposed. Specifically, optimism “was experienced when a positive

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outcome was (89%) likely and when the participants expected a (78%) positive outcome” (Bruininks & Malle, 2005, p. 344). Situations in which participants were optimistic were overwhelmingly situations in which they perceived a high degree of personal control. Optimism emerged when individuals recognized that they faced good odds and clear opportunity. Hope required a different set of variables and emerged only when individuals faced challenges alongside a valued outcome. Hope and optimism are each constructs related to positive outcomes but it is the quality of agency in response to challenge that distinguishes hope.

Rationale for choosing the adult hope scale. Why choose Snyder et al.’s (1991b) Adult Hope Scale (AHS) rather than the Life Orientation Test (LOT and LOT-R; Scheier, et al. 1994), or another respected tool, to measure clinicians’ hope levels? Each of the two instruments possesses strong internal reliability, test-retest reliability, and construct validity. Both are quickly administered and easily scored, and each measures dispositional qualities that lend themselves to positive thinking. The LOT (-R) is a measure of optimism more than it is a measure of hope, however, and optimism as previously noted, is a related but distinctly different personality trait. Steed’s research (2002) confirmed that the “LOT focuses on generalized expectancy as opposed to domain-specific expectancies” (2002, p. 468). The AHS measures domain-specific expectancies and measures hope’s dual qualities of agency and pathways thinking as they relate to goal-specific hopes.

“I see hope as the very heart of healing” (Groopman, 2004, p. 212). Unlike its less discriminate virtue, optimism, hope possesses qualities that offer persons and communities the requisite imagination and agency to be active participants in the healing and co-creation of their own life – their goals, dreams, and fullness of personhood. The very act of reaching

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out to a psychotherapist expresses a desire for help, and perhaps some modicum of hope as well. “Hope is truly on the inside of us, but hope is an interior sense that there is help on the outside of us... this need of help is a permanent, abiding, continuing fact for each human being” (Lynch, 1974, 40). Mental health clinicians have a privileged opportunity to engage their clients in this journey of, and toward, greater hope and to help hope to “rediscover the other half of itself, the outside world and the idea of help” (Lynch, 1974, p. 31-32). Along the way, clinicians may also discover a deepening sense of their own hope as well.

Imagination. “Hope is, in the most general terms, a sense of the possible...” (Lynch, 1974, p. 34) and as such “involves an imaginative projection of the future” (Capps, 2001, p. 54). We move into the future to the degree that we have hope (Lynch, 1974, p. 34). The imagination shares hope’s future-orientation and merits exploration as a related construct.

Bumpus (2010) and Lynch (1974) utilize the language of imagination when examining hope in relation to Christian spirituality. For Christians, a life marked by hope is a life resourced not only by agency and intention, but also by imagination. Bumpus (2010) defines imagination as a cognitive function and facilitator of hope “Imagination is that aspect of [the] mind that ‘bodies forth the forms of things unknown’ and gives to them ‘a local habitation and name’ (p. 24). One hears in this definition consistency with Snyder et al.’s (1991a) understanding of hope as a furthering, goal-oriented, interactive cognitive process.

Bumpus (2010) notes that her work with images often gives clients hope, something they often and direly need (p. 30). God, or another trusted relationship or place, uniquely imaged by the individual, meets them in their struggle or pain. Always a dynamic space, the imagination becomes a relational space as well, capable of lifting the individual out of

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isolation and into connection. This engagement alone may offer relief in the form of relational accompaniment, though experiences of deeper transformation can occur.

Psychologist and philosopher, William James (1999), called such moments religious encounters, transformative experiences of the unseen in the sense of a presence that, unlike intellect, will not deny what is possible despite its lack of current reality. Mental health practitioners have longed combined the eastern spiritual practice of meditation with Western psychology to engage clients in visualizations that empower them to find equilibrium through the creation of safe space, grounding, stress reduction, and deep relaxation (Benson, 1975; Epstein, 1989).

In his classic work, *Images Of Hope: Imagination as Healer of the Hopeless*, psychologist and Jesuit priest, William Lynch (1964), speaks to the relationship between hope and the human imagination. Equating the life of hope with the realistic imagination, he defines imagination as “the gift that envisions what cannot yet be seen, the gift that constantly proposes to itself that the boundaries of the possible are wider than they seem” (Lynch, 1974, p. 35). Such an imagination is at the heart of a hopeful life. Hope imagines, and ‘it refuses to stop imagining’” (Lynch, 1974, p. 30). It ignites our sense of agency and gives shape and form to newly envisioned pathways that invite us to become active participants in realizing our needs and desires. In the context of a relationship, it allows us to share our burdens and become empowered co-creators of our deepest desires, engaging a creative space within us capable of seeing beyond what lies within sight.

The imagination will always be the ally of hope, giving perspective and landscape to hard facts and isolated absolutes (Lynch, 1974, p. 243-244). If hopelessness is “a sense of not being in control or at the mercy of forces outside ourselves” (Groopman, 2004, p. 105),

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the imagination offers a glimpse, if not a doorway, out of the grips of perceived helplessness and towards the freedom and spaciousness born of effort and agency.

Mental health clinicians have the privileged opportunity to support those struggling with self-imposed and socially constructed limitations that diminish their sense of agency and ability to imagine that circumstances can be different. Lynch invites clinicians into “the vocation of the imagination within the great task of helping and healing the mentally ill (Lynch, 1974, 243). “The sense of hopelessness is: there is no way out, no exit... The sense of hope is: there is a way out” (Lynch, 1974, p. 35). As psychotherapists we have the opportunity to awaken our clients’ imaginations and nurture our own “hope-inspiring competence” (Whitley, 2010, p. 239). When we do so we extend previously unknown possibilities to those we companion. We many not see a way out for them, but we honor that its possibility and future existence already lies dormant within them. One might say we are “interrogating hope” (Kwan, 2010, p. 63).

Hope in Psychotherapy

The Therapy Relationship and Alliance. “Hope is not a private, interior act whereby one summons some kind of inner resource and bravely solders on alone and isolate” (McDargh, 2001, p. 6). “Hope not only imagines, it imagines with” (Lynch, 1974, p. 23). “In this space, two imaginations work together and enlarge the possibilities of a situation. This is an act of hope” (Bumpus, 2010, p. 30). The voices of McDargh, Lynch, and Bumpus are those of Christian theologians asserting hope’s adamant relational nature. In these assertions we are convinced that there is nothing of hope that isolates or separates us from one another. Promises McDargh (2001), “Even when we fumble all blind and unseeing, hope embodies the conviction that we are not alone” (p. 6). We experience this “withness”

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not only in our connection to other individuals, but also in our relationship to the social contexts in which we are embedded. Hope's reach is as broad as it is dynamic.

In his classical essay on the metaphysics of hope, *Homo Viator*, Christian philosopher, Gabriel Marcel (1889-1973), spoke of hoping as "a process and psychic activity of persons" (as cited by Pruyser, 1963, p. 90). How might these theological harbingers of hope complement or contribute to the psychological community's understanding of hope and hope's relevance in clinical work?

Within the discipline of psychology it is widely understood that the therapeutic relationship is the primary means by which transformation occurs in the work of psychotherapy (Rogers, 1957; Frank, 1971; Norcross, 2011). If the therapy alliance is not strong, the efficacy of any intervention is compromised. Research evidences this robust and positive relationship between the alliance and treatment outcomes across a broad spectrum of treatments in a variety of client/problem contexts (Norcross, 2011, p. 26). The work of change in psychotherapy requires the committed efforts of both client and therapist. Subtle or profound changes in personality require even deeper processes of transformation rooted in the integrity and commitment of therapist and the therapeutic alliance. There is a quality of mutuality and in the course of effective psychotherapy that is born of an experience of shared personhood and dynamic space.

A therapist's ability to connect, be present, and care consistently for clients is vital. "*Presence*, called the transcendental dimension by Kant and ultimate meaning by Frankl, has three functions for philosopher, Martin Buber (1878-1965): (1) it enables true (I-Thou) relationships, (2) it assures that meaning is present in a situation, and (3) it enables the person to be responsible in the here and now" (Gould, 1993, p. 114). Psychotherapists offer

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something of their presence to clients, in silent connection and in verbal cues, questions, challenges and responses. They work in the facilitating realm of the I-Thou relationship.

Buber speaks of this relational space as the meeting of person with person (Gould, 1993).

Gould (1993) elaborates:

“The difference between I-it and I-Thou is understood in terms of relationships... The world of I-Thou takes place in relationships as they occur... The ‘it’ is transformed into a Thou when it participates in a relationship... The I-it shows us the outer reality of the world; we cannot live without it. The I-Thou shows the inner reality of the spirit and essentially gives us a spiritual perspective that frees us from the dictates of outer circumstances and inner turmoil” (p. 113).

Buber’s I-Thou relationship as the paradigm of the fully human self is the basis of human hope. Hope is not a personal right or possession. It is part of the “we” created in an I-Thou relationship. Hope is not simply a hope for one’s self but a “spreading of one’s hope...” (Gould, 1993, p.115). The therapeutic alliance capable of facilitating hope is an alliance rooted in a relationship marked by this “bond of feeling between one person and another” (Marcel, as cited in Gould, 1993, p. 115). It is marked by an I-Thou relationship.

For Bordin (1975, 1976, 1989, 1994), the working alliance was centrally the achievement of collaborative stance in therapy... and the bond between client and therapist was considered a central tenet (Norcross, 2011, p. 27). Psychiatrist Jerome Frank (1974) spoke to the imperative of the therapeutic alliance to restoring client morale in psychotherapy. Frank’s research suggested that an underlying sense of “demoralization” (Frank & Frank,

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1991) exists with all clients seeking psychotherapy and that typical symptoms of demoralization include hopelessness. Uniquely and powerfully, within an I-Thou relationship, “the therapeutic alliance [becomes] a context in which clients can experience an enhancement of relatedness, agency, and hope, which are orientations that can help them overcome demoralization” (Hammer, 2003, p. 46). In the words of the existentialist philosopher of hope, Gabriel Marcel (1889-1973), “there can be no hope which does not constitute itself through a *we* and for a *we*... all hope is, at bottom, choral” (Jolin, 1973, p. 143).

Hope as a Contagion. “Hanna (2002) raises the notion that hope can be viewed as a ‘contagion’ or positive influence on client change, mirroring the research of Farron, Herth, and Popovich (1995) in suggesting that both hope and hopelessness are contagious” (Coppock, 2006, p. 111). We hear the active, transmitting nature of a contagion in Marcel’s reflection on what constitutes a “we” relationship, that “bond of feeling between one person and another” (Marcel, as cited in Gould, 1993, p. 115). Frank and Frank (1991) argued that the presence of an emotional, confiding relationship with a therapist who is both hopeful and determined to help works to “re-moralize” clients. Therapists must have hope that the client can change (Snyder, 1995). Frank and Frank’s (1991) supposition is consistent with Marcel and Buber’s belief in the transcendent power of a “we” relationship to cultivate hope in both parties.

Indeed, research demonstrates the critical role of helpers' hope in enabling clients to change (Snyder, McDermott, Cook & Rapoff, 1997). Coppock’s (2006) research demonstrated that “levels of therapist hope and client hope do appear to converge over time... consistent with a theoretical model of hope as a contagion” (p. ii-iii... p. 68). The

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great humanistic psychologist, Carl Rogers (1902-1987), would say very simply, “to the degree that each one of us is willing to be himself, then he finds not only himself changing; but he finds that other people to whom he relates are also changing” (Rogers, 1961, p. 22). As individuals and clinicians, we use our uniqueness in relation to others and this, alone, is power for change.

Client Hope. Erikson (1963) argues that hope is one of the most fundamental experiences a person can have as a human being and that it begins to be cultivated deeply in people’s lives at an early age. Placing hope in developmental context, he posits that we hope from birth (Lopez et al., 2003, p. 92). Snyder (2000) elaborates:

“Hope, I would suggest, is established in the infant to toddler stage... infants quickly form perceptions of ‘what is out there,’ and they also learn that certain events co-occur temporally; furthermore, the infant begins to focus on particular goals. By perceiving linkages to goals, the infant has acquired the basic processes necessary for pathways thinking. ” (p. 26-28).

An infant reaches towards her mother in learned and hopeful expectation that the caregiver will respond in turn; a child removes the training wheels from his bicycle and, upon conquering a wobbly start, races down the street to the cheers of encouraging parents. A hopeful posture appears innate in us from the onset of life, its availability subject to nurturing attentiveness or diminishing neglect, each shaping how a child learns to explore and expect, hope and trust.

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One can hypothesize that our earliest capacity to hope is rooted in the secure attachment we develop as infants, that safe base which supports our exploration and curiosity of possibilities outside the realm of those already familiar to us. Child psychologist, David Davies (2004), explains that “attachment has four main functions: providing a sense of security; regulation of affect and arousal; promoting the expression of feelings and communication; and serving as a base for exploration” (p. 8). Each of these finds initial and optimal development in infancy, and all inform and shape the quality of our hope as it extends into adulthood. “It is fashionable to think that such interaction belongs only to childhood...[but] the hopeful relationship between inner and outer worlds has not changed in adulthood. Only the terms have changed” (Lynch, 1974, p. 42).

Clients have some modicum of hope that initially enables them to seek and arrange for psychotherapy. That effort, alone, is an act of hope. Therapists also must possess hope if they are to ask the same of their clients (Rumsfeld, 1990, p. 133), if that emerging “relationship of hope and help is to be one of mutuality” (Lynch, 1974, p. 44). Clinicians enable people to recognize not only what is, but also what could be, by encouraging their vision and agency and by remaining strong in their own steadfast hope.

Clinician Hope. Oncologist, Jerome Groopman (2004), recognized his dearth of hope upon recognizing his failure to convey hope to terminally ill patients. By his own account, he “doubted not only the resilience of my patients but also my own capacity to hope...” (p. 52-53). The intense, I-Thou, dimension of his relationship with some of the very patients he feared he would fail eventually transformed him with hope anew in his personal and work life. These patients claimed profound hope in the face of chronic or terminal cancer and the impact on Groopman (2004) was lasting. There was a dynamic aspect of his

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client's hope that transformed him, and that developed in him a new capacity and eye for hope. "Now when I meet a new patient... I am searching for hope along with x-rays and exam results" (Groopman, 2004, p. 208).

Rumsfeld (1990) explored the function of hope within the therapeutic process through a qualitative study in which therapists were asked to share their thoughts concerning their own sense of hopefulness and hopelessness in their work with clients.

According to all seven therapists interviewed, "it is essential that a therapist have [and convey] hope... the therapist is always needing to find their way back to hope" (p. 132) asserts Rumsfeld (1990). "The more a therapist is a person who experiences hopefulness as part of his or her life, and lives that, then that becomes the central condition of their work" (Rumsfeld, 1990, p. 136). Hanna (2002) elaborates on the dynamic and healing influence of a clinician's hope:

"The apparent convergence of therapist-client hope would appear to be a movement of client hope toward a stable therapist hope. A reasonable conclusion follows that the relative stability of therapist hope provided a positive influence on the client's level of hope. This conclusion not only supports the hypothesis of convergence but adds further support to the notion that hope can be viewed as a 'contagion' (Hanna, 2002, p. 70).

Is hope is a contagion, or is it a co-constructed quality and experience? Each description implies dynamism and movement, though the latter suggests an active involvement of multiple persons rather than the active participation of a giver (Buber's "I")

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to a passive recipient (Buber's "it"). Co-construction requires the "we" of an I-Thou relationship; it requires mutuality and reciprocity, and is more consistent with the relationality that marks an effective therapeutic alliance over time.

Writing to pastors, Donald Capps (2001) claims, "that the basic and fundamental role of the clergy is to be ... agents of hope, and it is terribly difficult, if not impossible, to be an agent of hope if one has oneself lost hope" (p. 3). Rumsfeld's research (1990) confirms that this conviction holds true for psychologists as well. Lynch (1974) captures hopes inherently human and creative nature and reiterates Capps' assertion that therapists must foster the gift and presence of hope in their own identity and work. He writes, "A real human relationship is creative. In it persons depend each on the other, and can therefore hope in the other, freely and without conditions" (p. 159).

While the work of effective psychotherapy is always collaborative, therapists are sometimes in the position of being the initial and sole agent of hope, especially during the early development of the therapeutic relationship and alliance. Frank and Frank (1971) believed that individuals sought psychological help when they became "conscious of having failed to meet their own expectations or those of others, or of being unable to cope with some pressing problem... [and] when they feel powerless to change the situation or themselves" (p. 35). They seek help when they feel hopeless and helpless. Here again, Lynch (1974) reminds therapists of their gift and responsibility to be bearers of hope. "It would be an intolerable burden for the well or the mentally ill if hope turned out to be a rigidly and exclusively interior thing... Though deeply interior, hope is also, fortunately, a relative term" (p. 31-32).

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“Therapists have a particular privilege and responsibility to people who consult with them as both witness and co-create the stories of their lives (White & Epston, 1990). The therapist who has “found their way back to hope” (Rumsfeld, 1990, p. 132) time and again uniquely possesses a facility to convey and “radically listen” (Weingarten, 1995) for hope. Having themselves undertaken a “hero’s journey” (Campbell, 1949) to hope, they know the process and the path, and thus are able to hold and witness authentic hope to those who seek their support.

Clinician Narratives of Hope. “Meaning underlies all the theories of humanistic psychologists” (Gould, 1993, p. 128). Frankl (1972) made meaning the primary philosophical and therapeutic focus of his psychology. Humans are interpreting beings that understand and live life through stories. “The stories we have about our lives are created through linking certain events together in a particular sequence across a time period, and finding a way of explaining or making sense of them. This meaning forms the plot of the story” (Morgan, 2000, p. 5). We give meaning to our experiences constantly even as we live through our existing stories.

Griffith (*in press*) speaks to our individual accounts of hope as the narrative thread our personal hope story as it resides within the larger Christian Story.

“It is difficult to imagine ‘giving an account of our hope’ (1 Pet. 3:15-16, Holy Bible, 2009) without referencing them. Acts of celebration in the practice of hope include both a return to the promises of God, and a catching sight of the vision of the “not yet.” These function to alert us to alternatives in present reality, and they affirm our agency and freedom to participate in the creation of

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something new” (p. 7).

For Griffith (*in press*), our return to the “promises of God” as we simultaneously “[catch] sight of the vision of the ‘not yet’” is our return to our previously lived experiences of hope, those moments that weave and witness for Christians a personal narrative of God’s promise of new life and resurrection in the Spirit. The Christian Story of Jesus’ suffering, death, and resurrection gives meaning and sustenance to the lives and personal stories of Christians around the globe. It provides a dominant narrative that guides their way of behaving, as well their prevailing beliefs, values, and expectations (positive or negative). It is a, if not *the*, meta-story of hope (or despair) that gives shape to their lives.

Narrative therapists seek to understand how persons organize their lives around specific meanings (White & Epston, 1990, p. 3). They listen to recognize the explanatory stories that shape a person’s behavior and experience and constitute how that individual perceives life. Narratives are socially situated and constructed, and regardless our conscious awareness of presence and influence in our lives, we all possess them. They shape the dominant stories that not only affect us in the present but also have implications for our future (Morgan, 2000).

Rumsfeld’s (1990) qualitative study of clinician’s experiences of hope and hopelessness in relation to their clients included the open-ended question, “Please comment on what has contributed to your own sense of hope” (p. 109). Several sources of hope were mentioned several of the therapists interviewed. “An awareness of the vastness of human experience;” “a sense of process;” the creative process as is apparent in the form of the arts and literature;” “knowing and believing that change is possible;” and “a belief in the value, meaning and purpose of one’s existence” were all perceived as resources that provide hope in

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life and clinical practice.

The therapists in Rumsfeld's study (1990) shared anecdotes as a means of providing context to these sources of hope. Surely these were narrative threads that contributed to a larger, more dominant story of hope that ultimately informs and imbues the quality of hope that each of these clinicians brings to the potential "I-Thou" space of every therapeutic encounter.

Summary

There is a scarcity of published research exploring the role of dominant hope narratives in the professional lives of clinicians, and the impact of the presence or absence of these on the level of dispositional hope that clinicians bring to their clinical encounters. This research study seeks to identify the people, places, and stories that clinicians draw upon in psychotherapy in order to find and engage hope. It also seeks to recognize relationships between clinicians' dispositional hope levels and any existing dominant hope narrative, icon, or story in their life. Lastly, it seeks to support the hypothesis that hope "happens" – by contagion, co-creation, or both – only in and through relational connection.

METHOD

Statement of Purpose

The purpose of this study is to understand how mental health clinicians working with challenging populations in community health settings find, cultivate, and maintain hope. The current study will thematically analyze therapists' narratives of clinical hope and relationships between these narratives and the therapist's dispositional/trait hope level. Snyder et al.'s (1991b) Adult Hope Scale has been identified as the measurement of choice for determining dispositional/trait hope.

Several important factors that contribute to the dynamic of hope in the psychotherapy context were reviewed, including the therapeutic alliance, the presence of client and clinician hope, and therapists' personal hope narratives. It also was concluded that hope can function as a contagion, but that it does so only in the context of emotionally charged interpersonal relationships, including the psychotherapy relationship. Martin Buber's "I-Thou" relationship was explored and its dynamic elements upheld as a paradigm for cultivating hope.

The current review of literature revealed a scarcity of research on the relationship between a clinician's dispositional hope level and the hope narratives in their life.

The current descriptive study strives to thematically analyze therapists' clinical narratives of hope, using an appreciative inquiry methodology to extract hope themes, personal resources of hope, and personal hope narratives. Secondly, the study seeks to identify relationships between therapists' dispositional hope levels, and/or their agency and pathways thinking (as measured by the AHS) and the phenomenon of hope as perceived by each clinician through their interview responses.

Research Design

A mixed methods design will be used with both survey and phenomenological methods utilized to gather data. A mixed methods design collects, analyzes, and “mixes” both quantitative and qualitative research and methods in a single study in order to develop a rich and complex picture of a social phenomenon (Greene & Caracelli, 1997, as cited in Creswell, 2008, p. 552).

Data collection will happen in two phases using an explanatory mixed methods design. First, an individual semi-structured interview will be conducted to collect qualitative data. These interviews will explore the ways in which hope exists and functions in the context of psychotherapy relationships and process. Immediately following the interview, Snyder et al.'s (1991b) AHS will be administered to participants to determine the therapist's dispositional hope levels. This survey data may enhance the participant's richer, more narrative interview responses.

The qualitative research portion of the study will utilize an interpretative phenomenological analysis (IPA), an approach to psychological qualitative research that seeks to offer insights into how a given person, in a given context, makes sense of a given phenomenon. Usually these phenomena relate to experiences of some personal significance - such as a major life event, or the development of an important relationship. This research design seeks to understand participant's experiences of hope by exploring the meaning they assign to the experiences of hope as experienced in their significant psychotherapy relationships. Each participant will engage privately with the researcher for a semi-structured interview. This interview, which follows the format of the standardized Appreciative Inquiry protocol (Cooperrider & Srivastva, 1987), will be utilized to shed light

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on these “hope explorations”. The investigator acts as a filter through which the phenomenon of hope is constructed. Each research participant is viewed as the expert of his/her experience, offering a unique perspective on the experiences and issues that influence the phenomenon in question.

The investigator will interview the therapists to elicit reflections on their experiences of hope and the resources upon which they draw to find, cultivate, or maintain hope while serving in an urban community health setting. The investigator will use a digital recorder to record each interview. In the event that the digital recorder fails to operate, a backup digital recorder will be utilized. Interviews will take approximately forty-five minutes.

Upon completion of these individual recorded interviews each will be transcribed into a Microsoft Word document. Consistent with IPA, each interview transcript will be analyzed and coded by the research investigator in order to extract narrative themes of hope, and contributing factors to hope, in the person of the therapist and in the therapy process and relationship.

Snyder et al.’s (1991b) Adult Hope Scale, an instrument already evaluated for reliability and validity, is the survey instrument chosen for the present study. The AHS presents a series of 12 questions with Likert scale response options and requires some form of quantitative analysis. After participant surveys are completed and collected by the investigator, each will be scored and respondents will be assigned a dispositional hope score based on the summation of the instruments agency subscale score (items 2, 9, 10, and 12) and its pathway subscale score (items 1, 4, 6, and 8). Summing the four agency and the four pathway items derives the total AHS score. The research investigator will preserve the completed AHS.

Participants

Licensed mental health clinicians (both master's and doctoral level) will be recruited for this study. To qualify for the study, psychotherapists must be licensed mental health practitioners with a conferred master's or doctoral level degree in counseling or clinical psychology; doctoral level psychology trainees possessing a conferred master's degree in professional or counseling psychology are also eligible to participate. All participants will be recruited from the Behavioral Health Staff at the aforementioned community health center in Central Massachusetts.

Measures

The use of surveys is a typical way to obtain quantitative data about a research sample. Snyder et al.'s (1991b) Adult Hope Scale (Appendix E), a preferred instrument of researchers respected for its psychometric properties (Steed, 2002), will be administered in paper and pencil format to all participants. In addition to this survey, the investigator will utilize an appreciative inquiry approach to conduct a semi-structured individual interview to obtain phenomenological data from the participants about their clinical experience of hope and the resources upon which they draw to find, cultivate or maintain hope. The total time commitment estimated for each participant is 45 minutes; filling out the AHS takes approximately one minute and individual interviews with the investigator are estimated at 45 minutes.

Interview Questions

It has been said that, “*hope springs eternal in the human heart.*”

This research explores the function of hope within the therapeutic process. I am going to ask you to tell me a story about a time when you felt that hope was an important part of your therapy process with clients. It was a time when hope and the feelings that hope generated were crucial for a positive outcome. There was a mutuality of hope in the relationship. You also felt inspired and hopeful because of the work, because of the process. Your experiences are valuable. Thank you for your willingness to share them here. Please tell me about a time when hope was an important aspect of your work with a client? *Really tell me the story.....*

1. What was it about the situation that allowed that story to unfold?
 2. What was about *your client* that contributed to your sense of hope in that experience?
 3. Now step into your client’s shoes for a moment. What do you imagine he or she would say about you? Without being overly humble, what it was *about you* that allowed that experience to unfold?
 - a. What from your particular background- your faith, culture, personal and professional experiences- do you think contributed to the engagement of hope?
 4. Please comment on anything about the culture of the clinic that contributed to your sense of hope in that experience?
 5. It has been written about that hope is *contagious*, that we experience it through our emotional relationships with other people. In what ways was your experience or sense of hope a contagion in this clinical relationship?
 6. We often have touchstones or anchors of hope in our lives. A safe and inspiring person or place, experience or story, we go to when we find ourselves in need of hope.
 - Describe the person or place, story or experience, in your life that you recall when you search for hope.
-

Procedures

Soliciting Participants. An overview of this research study and an invitation to participate will be extended to all behavioral health staff members and doctoral level interns at a Community Health Center in Central Massachusetts during the monthly Behavioral Health Staff Peer Supervision Meeting. The Director of Psychology Training at the health center has given permission for the research investigator to invite all behavioral health staff clinicians to participate. One hour will be allotted the investigator to present an overview of the study to the staff, after which resource packets further outlining the study will be placed in each staff member's mailbox. Currently, there are approximately 15 psychotherapists on staff at the health center; this includes doctoral level psychology interns.

Founded in the early 1970's, the health center has grown from a small practice located in a public housing complex to a multi-site, full service provider of primary care, medical specialties, dental, behavioral health and social services throughout the Central and Metro West areas of Massachusetts. It is located across the street from one of the state's largest public housing complexes. The health center provides services to one of the largest refugee populations in the state. The organization seeks to provide services to everyone, regardless of ability to pay, and therefore primarily serves a financially impoverished population.

The researcher will provide an overview of the research study (Appendix A) to the Behavioral Health Staff during the month of March, 2013. She will assure participant anonymity (through the use of numerically coded instruments, interviews, and collected data), and to provide assurance that participation is strictly voluntary and that a lack of participation will have no negative consequences. Within two weeks of the presentation, all

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psychotherapists will be given a research packet consisting of Appendices A, B, and C, documents that further explain the scope of the study and its expectations as they relate to participants' time, personal information, etc. Upon distributing the research packets, a follow-up email (Appendix B) will be sent to all therapists from the investigator in order to clarify questions and elicit participation.

Enrolling Participants. If therapists agree to participate in the research, they first will be asked to sign a consent form (Appendix C) and to complete a demographic questionnaire (Appendix D). Subsequently, the researcher will contact the participants in person, by email, or phone to set up a time for the individual interview and survey administration.

Instructions to Participants. Each individual enrolled in the study will be informed that their involvement requires participation in one 45-minute interview and a brief (approximately one-minute) survey. Therapists who agree to participate will be instructed to sign the statement of informed consent prior to the interview and survey administration. Participation is strictly voluntary and participants may terminate involvement at any time in the process without judgment or consequence. Anonymity will be maintained through the use of assigned numerical codes on all requisite paperwork, instruments, interviews, and collected data. Excerpts from narrative interviews/data may be anonymously quoted or paraphrased in the final papers and in presentation based on this research.

Data Collection. Surveys will be individually administered and individual interviews conducted non-work hours, at a mutually convenient time for participant and interviewer, and will take place at either the health center, at the participant's home, or at a public library. All interviews will be conducted individually and in private due to the

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personal nature of the questions. The interviews will be digitally recorded and later transcribed.

Coding Data. Dispositional hope levels for each participant will be computed using the Adult Hope Scale's built-in scoring system. Data from transcribed interviews will be analyzed and coded utilizing Interpretative Phenomenological Analysis (IPA) in order to extract narrative themes of hope, and contributing factors to hope, in the person of the therapist and in the therapeutic process and relationship.

Data Storage. All completed copies of the Adult Hope Scale, and all digital recordings and related transcriptions of participant interviews, will be stored in a locked file box or computer folder at the investigator's home. Data will not be accessible to any person other than the researcher and the committee members supervising this doctoral project. The interviewer will assign a numerical code to each participant, and utilize the code on the completed AHS and as identification on all digital interviews. This ensures that participants and their collected data remain anonymous to everyone but the interviewer in compiled data collections, publications, and presentation.

Debriefing. After the interview, participants will be thanked for their time, and be given a brief explanation of the purpose of the research. They will be encouraged to contact the researcher via email post-interview should they have any questions or concerns. If participants feel that they are experiencing emotional distress related to participation in the study, they are asked to bring their concerns to peer supervision and/or to seek a referral from their respective professional organization (e.g. the APA or MPA). A thank you note will be sent to all participants upon completion of the study (See Appendix H).

Protection of Participants / Ethical Considerations.

The researcher will collect an informed consent from all participants. All data collected during this study, including paper, digital recordings, and Microsoft Word files, will be securely stored in a locked file box or computer folder at the researcher's home. If participants feel that they are experiencing emotional distress related to participation in the study, they are asked to bring their concerns to peer supervision and/or to seek a referral from their respective professional organization. While all participants are eligible for a raffle incentive, no other incentives or payment will be issued as a means of soliciting potential participants or thanking consenting participants.

Summary

This chapter has discussed the methodology to be used in this research project. It has outlined the research design, participants, measures and procedures that will be utilized in the present study, and addressed protection of participants and ethical concerns. Subsequent chapters will include the results of the present study (Chapter IV) and a discussion of the collected and analyzed data (Chapter V).

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Appendix A
Explanation of Study

EXPLANATION OF STUDY

A. Overview and Request to Participate:

My name is Christine Kowalcky. I am a doctoral student conducting a study on the function of hope in the psychotherapy process and the resources that mental health clinician's draw upon to inspire hope in their professional lives. I am conducting this study as part of the requirements to complete my doctoral degree in Clinical Psychology at the Massachusetts School of Professional Psychology (MSPP). I would be grateful for your participation.

B. Criteria to Participate:

1) You are a licensed, practicing master's or doctoral-level mental health clinician with a conferred graduate degree in counseling or clinical psychology; or you are a practicing doctoral-level psychology trainee possessing a conferred master's degree in professional or counseling psychology.

C. Procedures:

Participation in this study is strictly voluntary and there is no penalty for not participating. If you agree to participate, you will be asked to take a brief eight-question survey and meet with me for an individual interview. In sum, both the survey and interview will take approximately 45 minutes of your time.

D. Anonymity:

Participation in this study requires that only the interviewer know your identity. Your study results will be kept strictly anonymous, which means that your responses will not be connected to your true identity in any collected or compiled data, published study and presentation of results.

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E. Risks/Discomforts:

Your participation will invite your reflection on personal aspects and experiences of hope in your life and clinical practice. There is minimal risk that you will become emotionally distressed as a result.

F. Benefits:

Your participation may benefit you personally, and the field of psychology, by providing a deeper understanding of the role of hope in the practice of psychotherapy. If you choose to participate, you will receive a complementary copy of the book, *The Anatomy of Hope: How People Prevail in the Face of Illness*, by Jerome Groopman, M.D.

G. Questions/Concerns:

Feel free to contact the primary investigator of this research study, Christine Kowalcky, at anytime by email, at christine_kowalcky@mspp.edu, or by phone, (617) 527-6167.

Appendix B

Follow-up Recruitment Email to Prospective Participants

FOLLOW-UP RECRUITMENT EMAIL TO PROSPECTIVE PARTICIPANTS

Dear (Participant),

You may recall that at this month's Peer Supervision Meeting I introduced my doctoral research project in the hopes of recruiting your voluntary participation. I have since left in your mailbox a resource packet that includes: a request to participate in the study, criteria for participation, study procedures, the potential risks and benefits of participation, and my direct contact information and that of my school so that your questions or concerns may be addressed immediately.

I write today to assess your interest in participating in the research study. As outlined in the resource packet I provided, participation will require no more than 45 minutes of your time. The information you provide if you choose to participate may be of personal interest to you, and be beneficial to the field of counseling and clinical psychology. To ensure your anonymity throughout the study, participants' names will not be used to identify collected data. Rather, I will code all completed surveys, interview responses, as well as subsequent compiled results and publications.

I appreciate your consideration and I hope that you will participate in the study. Please respond to this email if you would like to enroll in this voluntary study.

Thank you again for your consideration.

Sincerely,

Christine Kowalcky
Doctoral Student, The Massachusetts School of Professional Psychology
Email: christine_kowalcky@mspp.edu

Appendix C
Informed Consent

INFORMED CONSENT

Research Protocol # 20130010

Participant's initials: _____

1. I understand that I have the opportunity to participate in a research study conducted by a doctoral student, Christine Kowalcky, in the Department of Clinical Psychology at The Massachusetts School of Professional Psychology (MSPP). I understand that the purpose of this study is to gain a better understanding of how mental health clinicians find, cultivate, and maintain hope in their clinical practice of psychotherapy, that my participation is strictly voluntary, and that I am free to withdraw at any time without judgment or penalty.
2. I understand that if I agree to participate in this study, I will be asked to take a brief (approximate completion time is one-minute) eight-question survey and to participate in an individual interview with the researcher. In sum, both the interview and survey will take approximately 45 minutes of your time. The survey questionnaire used is a highly regarded measurement of adult dispositional hope and the items on the survey will ask you to rate personal aspects of hopeful thinking.
3. I understand that I may skip any interview or survey question I prefer not to answer.
4. I understand that if I can obtain a summary of the results of this study by emailing the researcher on or after September 1, 2013 at: chriskowalcky@gmail.com.
5. I understand that the individual interview portion of this study will be digitally recorded.
6. I understand that if I participate my results will be kept strictly anonymous, which means my true identity will not be connected with any collected or compiled interview data, published study, and presentation of research results. I understand that participation requires that only the researcher know my name and that my survey and interview results will be numerically coded for the purpose of correlating my results and maintaining my anonymity. I understand that all collected data, paper,

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- digital recordings, and Microsoft Word files will be stored in a locked box or computer folder at the researcher's home for five years following the completion of this research or its publication, whichever comes first, and that after that time all data will be shredded and erased.
7. I understand that my participation will invite reflection on personal aspects and experiences of hope in my life and clinical practice, and that by participating in this study there is minimal risk that I may become emotionally distressed. I understand that if I experience distress as a result of my participation, I am encouraged to discuss this matter through peer supervision or to seek a referral for services through the APA or MPA referral networks, or through my preferred professional practice organization. I understand that if I experience a problem or wish to speak to someone other than the researcher about my participation in this study that I may contact the MSPP Institutional Review Board's Human Protection Administrator at 617-327-6777, extension 1279, or the project chairperson, Claire Fialkov, Ph.D., at 617-327-6777, extension 1290.
 8. I understand that I must be a master's or doctoral-level mental health clinician, practicing psychiatrist, or a doctoral level psychology intern with a conferred graduate degree in professional or counseling psychology in order to meet participation criteria for this study, and that my signature on this consent form implies verification of such licensure.

INFORMED CONSENT

Research Protocol # 20130010

Participant's initials: _____

9. I understand that this research study has been reviewed and approved for use by the Massachusetts School of Professional Psychology's Institutional Review Board (MSPP IRB), and that it has been assigned Protocol Number 20130010.

10. I understand that if I have questions or concerns regarding my rights as a participant in this study I may contact the MSPP IRB chairperson, Dr. Edward De Vos, at edward_devos@mspp.edu, or at 617-327-6777, extension 1238. I understand that I may also report my concerns via email to IRB@mspp.edu.

Print your name here

Date

Sign your name here

Date

Researcher's signature

Date

Appendix D

Participant Demographic Questionnaire

PARTICIPANT DEMOGRAPHIC QUESTIONNAIRE

1. What is your gender?

- Female
- Male

2. What is your age?

- Younger than 25 years
- 25-34 years
- 35-44 years
- 45-54 years
- 55-64 years
- 65-74 years
- 75 years or older

3. Since what age have you lived in the United States? _____

4. In which area of the world were you born?

- Canada
- United States
- Central or South America
- Northern Africa
- Central/Southern Africa
- British Isles (England, Scotland, Ireland, Wales)
- Western Europe
- Eastern Europe
- Middle East
- Far East/Asia
- Australia or New Zealand
- Other (please identify) (_____)

5. What is your identified race/ethnicity? Check all that apply.

- American Indian or Alaska native
- Asian
- Black or African American
- Hispanic or Latino/a
- Native Hawaiian or other Pacific Islander
- White
- Other (please identify) (_____)

PARTICIPANT DEMOGRAPHIC QUESTIONNAIRE

6. What is your level of behavioral health licensure? Check all that apply.

- Master's Level
- Doctoral Level

List each of your conferred Behavioral Health Degree(s): (_____)

7. Cumulatively, and including your graduate level internships, residencies, and practicums, how long have you practiced behavioral health in community health settings?

- 1-5 years
- 6-10 years
- 11-15 years
- 16 or more years

8. Do you consider yourself to observe a religious or spiritual tradition?

- Yes
- No

9. Do you practice within a particular faith tradition?

- Yes
- No
- I consider myself spiritual but not religious
- I consider myself religious but not spiritual

10. If you observe and/or practice within a particular faith tradition, what is your chosen faith/religious affiliation(s)? Check all that apply.

- Buddhist
- Catholic Christian
- Christian other (denomination: _____)
- Hindu
- Jewish
- Muslim
- Non-denominational
- Other (please identify) (_____)

11. On a scale of 1-10 (1 lowest, 10 highest), how hopeful do you consider yourself to be?

Rate here: (_____)

Appendix E

The Adult Hope Scale

THE ADULT HOPE SCALE

Directions: Read each item carefully. Using the scale shown below, please select the number that best describes YOU and put that number in the blank provided.

- 1. = Definitely False
- 2. = Mostly False
- 3. = Somewhat False
- 4. = Slightly False
- 5. = Slightly True
- 6. = Somewhat True
- 7. = Mostly True
- 8. = Definitely True

- ___ 1. I can think of many ways to get out of a jam.
- ___ 2. I energetically pursue my goals.
- ___ 3. I feel tired most of the time.
- ___ 4. There are lots of ways around any problem.
- ___ 5. I am easily downed in an argument.
- ___ 6. I can think of many ways to get the things in life that are important to me.
- ___ 7. I worry about my health.
- ___ 8. Even when others get discouraged, I know I can find a way to solve the problem. ___
- ___ 9. My past experiences have prepared me well for my future.
- ___ 10. I've been pretty successful in life.
- ___ 11. I usually find myself worrying about something.
- ___ 12. I meet the goals that I set for myself.

Participant code: _____
(Coding is used to maintain participant anonymity)

Source: <http://www.ppc.sas.upenn.edu/hopescale.pdf>
C. R. Snyder, University of Kansas
(downloaded on January 20, 2013)

Appendix F

Interview Questions

Original Interview Questions

It has been said that, “*hope springs eternal in the human heart.*”

This research explores the function of hope within the therapeutic process. I am going to ask you to tell me a story about a time when you felt that hope was an important part of your therapy process with clients. It was a time when hope and the feelings that hope generated were crucial for a positive outcome. There was a mutuality of hope in the relationship. You also felt inspired and hopeful because of the work, because of the process. Your experiences are valuable. Thank you for your willingness to share them here. Please tell me about a time when hope was an important aspect of your work with a client? *Really tell me the story*

1. What was it about the situation that allowed that story to unfold?
 2. What was about *your client* that contributed to your sense of hope in that experience?
 3. Now step into your client’s shoes for a moment. What do you imagine he or she would say about you? Without being overly humble, what it was *about you* that allowed that experience to unfold?
 - a. What from your particular background- your faith, culture, personal and professional experiences- do you think contributed to the engagement of hope?
 4. Please comment on anything about the culture of the clinic that contributed to your sense of hope in that experience?
 5. It has been written about that hope is *contagious*, that we experience it through our emotional relationships with other people. In what ways was your experience or sense of hope a contagion in this clinical relationship?
 6. We often have touchstones or anchors of hope in our lives. A safe and inspiring person or place, experience or story, we go to when we find ourselves in need of hope.
 - Describe the person or place, story or experience, in your life that you recall when you search for hope.
-

Appendix G

Revised Order Interview Questions

Revised Order Interview Questions

It has been said that, “*hope springs eternal in the human heart.*” This research project explores the function of hope within the therapeutic process.

1. We often have touchstones or anchors of hope in our lives. A safe and inspiring person or place, experience or story, we go to when we find ourselves in need of hope.
 - Describe the person or place, story or experience, in your life that you recall when you search for hope.
 2. It has been written about that hope is *contagious*, that we experience it through our emotional relationships with other people. In what ways was your experience or sense of hope a contagion in this clinical relationship?
 3. Now I am going to ask you to tell me a story about a time when you felt that hope was an important part of your therapy process with clients. It was a time when hope and the feelings that hope generated were crucial for a positive outcome. There was a mutuality of hope in the relationship. You also felt inspired and hopeful because of the work, because of the process. Your experiences are valuable. Thank you for your willingness to share them here. Please tell me about a time when hope was an important aspect of your work with a client? *Really tell me the story....*
 4. What was it about the situation that allowed that story to unfold?
 5. What was about *your client* that contributed to your sense of hope in that experience?
 6. Now step into your client’s shoes for a moment. What do you imagine he or she would say about you? Without being overly humble, what it was *about you* that allowed that experience to unfold?
 7. What from your particular background- your faith, culture, personal and professional experiences- do you think contributed to the engagement of hope?
 8. Please comment on anything about the culture of the clinic that contributed to your sense of hope in that experience?
 9. Is there anything else related to hope that you’d like to say that you haven’t had the opportunity to share?
-

Appendix H

Note of Appreciation to Participants

NOTE OF APPRECIATION TO PARTICIPANTS

Dear (Participant),

Thank you very much for your participation in my research project. The information you provided will be very helpful in understanding the how mental health clinicians find and cultivate hope in their professional and personal lives.

If you would like information about the results of my study, please feel free to contact me directly at the email address listed below, on or after September 1, 2013. I anticipate that the study will be complete and I will be happy to send you a final copy of the results at that time.

Thank you again.

Sincerely,

Christine Kowalcky
Doctoral Student, The Massachusetts School of Professional Psychology
chriskowalcky@gmail.com

RESULTS

Introduction

This chapter begins with a brief review of the methodology upon which the study's initial interview questions were shaped, followed by an explanation of why and how the order of interview questions shifted in response to the feedback of the first interviewees. This is followed by a list of the eight core questions that were asked of every participant during the course of their interview. Each question was designed to invite clinicians to reflect upon and give voice to experiences of hope in the context of their therapy practices. Next, demographic information about the eight participants introduces the results and analysis section of this chapter.

Lastly, participant responses to each core interview question are organized and presented. It is important to note that often, numerous follow-up questions were required of a participant before a coherent comprehensive response could be obtained. Additionally, later core questions and responses sometimes informed or spoke to an earlier core question or follow-up inquiry. In these cases the participant's narratives sometimes integrate multiple, related responses.

The Original Interview Frame

The results of this study provide an account of the phenomenon of hope as experienced by mental health clinicians working in an urban community health center in Central Massachusetts. Study participants reflected upon psychotherapy relationships and encounters that highlighted for them the dynamics and other variables that often contribute to the presence, and absence, of hope in the therapeutic relationship and

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context. Personal, professional, religious, and cultural themes were named as some of the variables that contributed to an engagement of hope in the therapeutic encounter.

These themes, and others, emerged over the course of eight semi-structured interviews averaging 42.7 minutes in length. Several meaningful images of hope also emerged. Interviews followed the format of an Appreciative Inquiry (AI) protocol (Cooperrider & Srivastva, 1987). Appreciative inquiry looks at what gives life to human systems when they are at their best. This appreciative mode of inquiry sought to elucidate the positive factors and personal motivations that contributed to the phenomenon of hope within a therapy dyad. Each study participant was viewed as the expert, offering a unique perspective on the experiences and issues that influenced an occurrence of hope in her or his personal and professional life. The investigator acted as a filter through which this phenomenon of hope was constructed.

AI's methodology is based on the assumption that inquiry into and dialogue about strengths, successes, values, inspirations and dreams is itself transformational. In this spirit, each semi-structured interview began with the examiner articulating this quote: "it has been said that hope springs eternal in the human heart," followed by a very brief reminder of the study's focus: "to explore the function of hope within the therapeutic relationship and process."

Next, the examiner attempted to obtain an overview of each participant's experience as it related to several topics associated with the presence and function of hope in the psychotherapy relationship. Based on the participant's responses to a set of core questions, more specific and directed inquiries were posed. Although the core interview questions were designed ahead of time, numerous queries were simply

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responses by the examiner in an attempt to clarify or obtain greater insight into the participant's experience.

Following Participant Lead

The examiner anticipated posing the interview questions in a predetermined order, beginning with the following:

I am going to ask you to tell me a story about a time when you felt that hope was an important part of your therapy process with a client. It was a time when hope and the feelings that hope generated were crucial for a positive outcome. There was a mutuality of hope in the relationship; you also felt inspired and hopeful because of the work, because of the process. Please tell me about a time when hope was an important aspect of your work with a client...really tell me the story...

Immediately recalling a single experience or client proved challenging for the first two interviewees. Albert, the first interviewee, initially paused in silence. "Well, I think that... I'm thinking of a story about hope. I think I need to try and understand the concept of hope. It is a little bit difficult to think of a specific client." The second interviewee, Audrey, also asked that she first have an opportunity to think about hope from a personal perspective. "Let's start with the personal part, like my story and philosophy of hope. Then we'll go to the patients." With this freedom, Albert and Audrey began to muse about hope in their personal life and work with clients.

Thereafter, the researcher determined that switching the original order of the interview questions would help participants to anchor themselves in their personal experiences of hope, before being asked to share a clinical experience. This change in order proved generative in the third interview and was adopted for all subsequent interviews.

Revised Order Interview Questions

It has been said that, “*hope springs eternal in the human heart.*” This research project explores the function of hope within the therapeutic process.

1. We often have touchstones or anchors of hope in our lives. A safe and inspiring person or place, experience or story, we go to when we find ourselves in need of hope.
 - Describe the person or place, story or experience, in your life that you recall when you search for hope.
2. It has been written about that hope is *contagious*, that we experience it through our emotional relationships with other people. In what ways was your experience or sense of hope a contagion in this clinical relationship?
3. Now I am going to ask you to tell me a story about a time when you felt that hope was an important part of your therapy process with clients. It was a time when hope and the feelings that hope generated were crucial for a positive outcome. There was a mutuality of hope in the relationship. You also felt inspired and hopeful because of the work, because of the process. Your experiences are valuable. Thank you for your willingness to share them here. Please tell me about a time when hope was an important aspect of your work with a client?
Really tell me the story...
4. What was it about the situation that allowed that story to unfold?
5. What was about *your client* that contributed to your sense of hope in that experience?
6. Now step into your client’s shoes for a moment. What do you imagine he or she would say about you? Without being overly humble, what it was *about you* that allowed that experience to unfold?
7. What from your particular background- your faith, culture, personal and professional experiences- do you think contributed to the engagement of hope?
8. Please comment on anything about the culture of the clinic that contributed to your sense of hope in that experience?
9. Is there anything else related to hope that you’d like to say that you haven’t had the opportunity to share?

Overview of Participants

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As detailed in the previous chapter, the participants in this study are mental health clinicians employed at an urban community health center in Central Massachusetts. Participants were selected based on their interest and availability to participate in the study. All interviews took place outside of work hours and at a mutually agreed upon time and place. The sample group was comprised of eight clinicians: five women and three men, ranging in age from 25-54 years old. Four participants identified as White and four identified as Hispanic or Latino/a. Three participants are native to the United States, two to Central/South America, two to the Caribbean, and one to Eastern Europe. All participants currently reside in the U.S. full-time: three have lived in the U.S. since birth, one since age nine, three since age 30, and one since age 40.

Table 1. Participant Demographics¹

Subjects	Age Range	Gender	Identified Race/Ethnicity	Native Country	Living in U.S since age
1- Albert	35-44	Male	Hispanic or Latino/a	Caribbean	30
2- Audrey	44-54	Female	Hispanic or Latino/a	Central/South America	40
3- Joseph	25-34	Male	Hispanic or Latino/a	Caribbean	9
4- Ramona	35-44	Female	Hispanic or Latino/a	Central/South America	32
5- Kristen	45-54	Female	White	United States	Birth
6- Tim	35-44	Male	White	Eastern Europe	30
7- Katrina	45-54	Female	White	United States	Birth
8- Samantha	25-34	Female	White	United States	Birth

¹ All study participant names have been changed to protect confidentiality.

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Three participants are licensed psychologists, one is a licensed psychiatrist, three are licensed mental health counselors, and two are advanced psychology trainees in their fourth year of doctoral studies in clinical psychology. Three participants have doctoral level clinical psychology degrees, three possess terminal master's degrees in counseling psychology (one of whom is in the process of completing a CAGS degree in counseling psychology), two possess en-route master's degrees in professional psychology and will receive doctoral degrees in clinical psychology later this year (2013), and one possesses a medical degree with a specialization in psychiatry. The total years of clinical practice amongst individual participants ranged from 4-15 years.

Table 2. Participant Clinical Training and Education Levels

Subjects	Highest clinical degree/license earned	Total Years of Clinical Practice
1- Albert	Doctoral/PsyD	11-15
2- Audrey	Master's/LMHC	11-15
3- Joseph	Master's/LMHC	6-10
4- Ramona	Master's/LMHC working towards CAGs*	6-10
5- Kristen	Master's working towards doctoral/PsyD	1-5
6- Tim	Doctoral/MD	6-10
7- Katrina	Master's working towards doctoral/PsyD	1-5
8- Samantha	Doctoral/PsyD	1-5

**CAGS- Certificate of Advanced Graduate Studies*

While the examiner intended only to interview psychologists, licensed mental health counselors, and doctoral level clinical psychology students, midway through the participant solicitation process a psychiatric provider expressed an interest in taking part

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in the study although he did not strictly meet the criteria for participation. The examiner deemed that interview data from a participant with a psychiatric medical degree might add something unique to the data and enhance the discussion section of the study. The staff psychiatrist was administered the identical background questionnaire and his interview followed the same format and line of questioning as every other interviewee.

There was a range of responses to inquiries that tried to gauge participants' religious/spiritual beliefs and faith practices. Five participants responded negatively when asked if they were observant of a religious or spiritual tradition whereas three participants responded in the affirmative. When asked if they practiced within a particular faith tradition, two participants responded affirmatively, one responded negatively, and five reported that they are "spiritual but not religious." Three participants chose "N/A" in response to a query asking for their chosen faith/religious affiliation, three more identified as Christian, and one identified as Jewish.

Table 3. Participant Religious Tradition/Affiliation

Subjects	Observant of Religious or Spiritual Tradition	Practice within a Particular Faith Tradition	Chosen Faith/Religious Affiliation
1- Albert	No	Spiritual but not Religious	N/A
2- Audrey	Yes	Spiritual but not Religious	N/A
3- Joseph	No	Spiritual but not Religious	N/A
4- Ramona	Yes	Spiritual but not Religious	Non-denominational
5- Kristen	Yes	Yes	Christian- Catholic
6- Tim	No	Spiritual but not Religious	Christian- Greek Orthodox
7- Katrina	No	No	Christian- United Church of Christ
8- Samantha	No	Yes	Jewish

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As part of the demographic questionnaire participants were asked to provide a self-rated hope score based on a scale of one to ten (1 lowest, 10 highest). At the conclusion of their interviews, each participant completed The Adult Hope Scale and left the completed measure with the investigator. Self-rating scores ranged from seven to ten, while Adult Hope Scale (AHS) scores ranged from 47-61 (out of a maximum possible score of 64). Within the AHS sub-domains, agency scores ranged from 22 to 30 (maximum possible score of 32) and pathways scores ranging from 25-31 (maximum possible score of 32).

Table 4. Participant Hope Scores

Subjects	Hope Self Rating*	AHS Total Score	AHS Agency Sub Score	AHS Pathways Sub Score
1- Albert	8	61	30	31
2- Audrey	10	57	28	29
3- Joseph	8	52	27	25
4- Ramona	8	58	30	28
5- Kristen	7	56	28	28
6- Tim	8	47	22	25
7- Katrina	8	54	28	26
8- Samantha	9	60	30	30
Mean scores	8.25	54.87	27.87	22.20

** Participants were asked the following question: On a scale of 1-10 (1 lowest, 10 highest), how hopeful do you consider yourself to be?*

For the purposes of this section of the study, we will look at each theme that arose on a question-by-question basis, with a summary of important findings to be discussed in

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the following chapter. Interview responses that emerged two or more times were coded and thematically organized by the investigator. Each core interview question is introduced here in the revised list order as outlined in Addendum A.

Core Interview Questions: Responses and Themes

Question 1 – We often have touchstones or anchors of hope in our lives- a safe and inspiring person or place, an experience or story that we go to when we find ourselves in need of hope. Describe the person or place, story or experience, in your life that you recall when you search for hope.

Five central themes appeared in response to this line of questioning. The themes of personal journey, faith of God, meaning and transcendence, the conviction that change is possible, nature’s inspiration, and the importance of role models emerged as salient amongst participants. Several touchstone images of hope also emerged.

Table 5. Core Question One Themes

Subjects	Personal Journey	Faith in God	Meaning Making/ Transcendence	Believes Change is Possible	Role Models	Nature
1- Albert	X		X	X	X	X
2- Audrey	X		X		X	
3- Joseph	X		X			
4- Ramona	X	X		X	X	
5- Kristen	X	X		X		
6- Tim	X					
7- Katrina	X		X	X		X
8- Samantha	X		X			

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The theme of personal journeys as a primary touchstone for hope was shared by each of the eight participants. Albert, a native of Puerto Rico, and the most clinically experienced participant, articulated the theme of personal journey and his experiences of change and moving beyond his difficulties in life:

I think that my own process as an individual, going through experiences and difficult times in my own life, and being able to understand that things can change... this helped me understand that there's hope...there's always change in life, and if there's always change, just believing that things can change makes me believe that any situation can change for the better... My own experience and my own journey... that is how I understand hope.

Kristen, a second career doctoral student, articulated a similar touchstone of personal journey of experience and transformation that cultivated in her a strong belief in the possibility of change and hope:

My personal experiences of being on the far side of suffering and loss... and the process of grieving and reclaiming myself, while at the same time becoming stronger, becoming more me... That touchstone is there, and it's rooted very solidly and prominently in me and in my experience, just waiting for me to touch it and draw from it and remember. I believe deep change is possible.

Katrina, another second career doctoral student, spoke of her personal journey with depression at a younger age, and how that struggle eventually served as a catalyst for a profound change in her perspective on life and ability to hope. She echoed a belief that change is possible from a personal perspective and from the perspective of humanistic theory:

I think hope comes from my own personal experience of being really depressed...when I was younger and trying to figure things out...it comes from a personal journey... having to sit with it and think about it, eventually moving on from it... There's one part of me that believes that things are evolving toward a wholeness and a completeness... Everything, in a humanistic way, we are growing toward wholeness.... I do believe we evolve, we grow unless growth is blocked, and then I feel we can unblock it, however hard it might be... So I'm hopeful for all my clients.

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Ramona, a native of South America who immigrated to the United States ten years ago, spoke of her stressful personal journey of transformation during the years she worked to obtain legal immigration and work status. At one point she became hopeless and literally fell to her knees in desperation. Soon after, an eventual shift in her circumstances led to her dream of living and working in the U.S., and convinced her that change is possible despite life's adversity. To this day that journey continues to serve as a touchstone of hope for her and her clients:

That process took almost two years, which, when you're struggling, seems like forever... I was absolutely desperate, I had tried everything I could think of that was possible for me to do... If I was able to handle and survive that level of stress, I am able to do anything. I think that is the main experience I will never, ever forget... I cannot compare my story to my patients' stories, but if I- as a human being- am capable of overcoming situations and developing resiliency and change- anyone can do it.

Joseph spoke eloquently about the challenging personal journey he experienced as a young boy newly diagnosed with a chronic medical condition. The lessons learned from this early experience transformed him into a young therapist who seeks to actively cultivate and project the possibility of change and hope to his clients:

A turning point in my life was at age 12, when I was diagnosed with type 1 diabetes. I felt like I'd been hit by a curveball... I was forced into treatment, I felt anger, sadness, 'what the hell is this?' It was a lot of ups and downs. I later educated myself and started to accept my diagnosis, and began to use my anger in a productive way... We can draw upon our experiences in the past that instilled hope or brought hope and apply it to the present... We look at things with a new lens, like we're the same person but with different glasses on... We're hopeful that tomorrow will be as good as today.

Audrey shared her extended family's journey of surviving, and perishing, in Auschwitz. As a child she would ask her grandmother to tell her the story again and again. She internalized this family experience as part of her personal story and journey, and

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understands it as a profoundly formative contributor of her inner perseverance, and her belief that her clients can also chose life and hope:

I come from a family where my grandparents ran away from Auschwitz. So I think that experience for them, even though I didn't pass through it...it went to my life through their stories. Part of my family also died there, the sister of my grandfather and his mother. I never met them but that was part of the story of their lives... I've engrained it into my life and become really skillful and perseverant because of it. I use this hope to help my clients make decisions...do I have the transplant or not, do I kill myself or not... to let them see that if they take the chance to do it, they have the option to keep alive for more years rather than die in a couple of months.

Samantha, an early career psychologist in her first year of licensed practice, spoke of hope as a personal journey “that life takes you in all sorts of directions and no matter what the struggle, in the end you're going to get something out of it.” Lastly, Tim, a psychiatrist and native of Eastern Europe, also looks to personal experience and journey. “I get most of my hope from my past experiences...I go to success stories from my own experiences or that of my family.”

Three therapists looked to prominent figures from a religious tradition, and/or to God, as touchstone sources of hope. Albert spoke of St. Francis of Assisi:

I think of Francis of Assisi when I need to continue to feel my hope, sometimes even more than Jesus. When I learned or read the life and the passion that this kind of person has in their life, for me it's very dramatic that somebody can have so much compassion, like complete abandonment of his own self, especially. For me he's a big source of feeling my hope.

Kristen draws from the Catholic faith tradition as well when she articulates an understanding of her personal journey of suffering, new life and a sense of new self possession, as part of the larger Christian story of faith in God:

I look to my own story, which is part of the Christian story, the story of suffering, death, and resurrection, the dying to the self and the suffering, and pain doesn't get the last word. We don't know this when we're in the

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midst of it, but somehow with the help of others, and God working through others, and our own humility and acceptance of support and recognition of being brought to my knees...now I feel self-possessed and I really embrace it all, that painful history but also my strength and my need for other people, and my own power as well.

Ramona echoes a similar experience of being “brought to her knees” before God as she struggled and failed to realize her dreams in the way and timeline she had imagined. She emerged stronger as a result, more humble, and with hope for herself and eventually, for her clients:

I was absolutely desperate, I had tried everything I could think of that was possible for me to do. Then I gave up, got down on my knees by my bed, and I went to the Bible and opened it...this was my last resort...what I read was ‘Give your trust to God and let God figure it out on God’s terms. It was such a level of relief I had at that point, like someone took so much weight off my shoulders- that cool, clear breath... I was more accepting what was happening rather than fighting for me to decide what and how it had to happen...that’s when I believed God existed, and my concept of God changed completely in my head and heart and life... A few days later, things started to happen... I think that was the point, and I always go to that place now. It was proof, of course, of how many strengths I have and how strong I can be.

She also spoke of role models as among her touchstones of hope. In particular she referenced friends from her native country who emigrated to the U.S. several years before she did. “They struggled but had a happy ending...that was encouragement for me. I have all the tools, there has to be a way...there is hope for me, too.”

Four participants spoke of the presence and activity of something transcendent, of “something bigger” and meaningful that they looked when they needed to find or cultivate hope. They did not use the language of faith, God or Christianity that Albert, Kristen and Ramona used, but the language of meaning, or a felt sense of transcendence and grace in the world. Joseph spoke of purpose and meaning as an integral quality of hope that he now possesses:

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You have to find some meaning or purpose for yourself, for your clients... something bigger than yourself to draw upon to move beyond your circumstances, something to look to when you've fallen, when you know you cannot do it yourself. Not just a fleeting feeling or a thought, but something valuable...

Audrey spoke to transcendent meaning making as intrinsic to her capacity to hope and feel that she, and her clients, have choices despite dire circumstances. She experiences deep resonance with the thinking of psychologist and Holocaust survivor, Viktor Frankl, and his philosophy that no matter what happens to us, we always have the freedom to shape our attitude and response:

When I became a psychotherapist I read about Viktor Frankl, and that clicked for me, how you can still survive there, (in Auschwitz)... just thinking about this significant need to keep alive. I think that when you have that kind of information in your life it makes you think that you always have an escape... this hope keeps you going.

Katrina and Albert each spoke of nature as a reference and touchstone for cultivating a lens for transcendence, making meaning, and hope. Says Albert:

The way I can see there is something bigger than all of us or there is something that creates all of this life by itself. I can see the manifestation of that energy in nature. Being able to enjoy the wonderful gift of life is a way for me to understand or convince myself that there's something bigger that created all of this, and that way I feel safer...if I feel a little bit down, I go into the woods or to nature by myself and I will have the reminder, the inspiration, the hope.

Katrina highlighted nature's ever-revolving seasons; the glimmers of transcendent hope that "find her" in ordinary events, and her efforts to cultivate her powers of observance mindfulness, and savoring:

I find hope in the moment, glimmers of hope. I think hope is glimmers of things... And every year I forget what it looks like, the beauty, and how incredible nature is.... The "re-greeting" of New England. And I think the thing about hope, for me, is I don't necessarily look for it; it finds me. And I think that when it catches you, staying with it for a little bit. So that's where I find it on a daily basis to sustain... in terms of flowers,

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watching my young daughters sleep, in my clinical work... it's a sort of transcendent type of hope...

Samantha said simply that she has come to believe "It's about having faith in where you are, where you need to be, and that process...trusting that each experience in life brings its own meaning."

Additional touchstone images of transcendent hope emerged from participant experiences and thoughts. Audrey offered the image of an open window. "I think hope is like the open window that makes you see that there are things to live for..." Katrina referenced an image of the sun with its felt warmth and transcendent presence. "Hope is not something you intellectualize; it's a feeling... Like the sun, like sitting in a sunny window or going outside and you experience that first big ray of sunshine. There's a grace to it." Joseph imaged the planting of seeds that with time and nurturing take root. "I've had 18 years of medical treatment now for my diabetes, so many professionals helping me...those people were planting seeds in me, and some of them grew. Seeds of hope and perseverance..."

Question 2 - It has been written that hope is contagious, that we experience it through our emotional relationships with other people. In what ways is your experience or sense of hope as a contagion present in your clinical relationships?

All eight participants easily connected with the idea and language of hope in psychotherapy as contagious and relational. Six therapists spoke to the emotional quality of hope in relationship. One additional, prominent theme emerged from this line of questioning: the mutual exchange of hope in psychotherapy. Seven of the eight participants easily and quickly recalled experiences during which they felt they not only transmitted hope in the therapy

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relationship but also received it. Finally, multiple images of hope's vibrant quality also emerged.

Table 6. Core Question Two Themes

Subjects	Believes Hope is Contagious	Therapy Relationship as Facilitative	Recognizes Emotional Quality in Hope's Transmission	Experiences Mutuality of Hope's Contagion
1- Albert	X	X	X	X
2- Audrey	X	X		X
3- Joseph	X	X	X	X
4- Ramona	X	X		X
5- Kristen	X	X	X	X
6- Tim	X	X	X	
7- Katrina	X	X	X	X
8- Samantha	X	X	X	X

Albert began by speaking of himself as a person who tries to model and facilitate hope, and as someone who is likewise changed through his relationship with clients:

The healing or cure is the relationship... "You become a role model so there's some learning by serving, by experiencing it, by talking, by change of thoughts. So in different levels of cognitive, emotional, maybe energy-wise... we don't see it but there's some exchange of energy, something that is contagious.... And I'm the person who is supposed to help, but I feel that, I also get from this relationship some change.

Kristen used the language of vibrancy to speak of emotional aspect of hope's dynamism and the contagious quality of a therapist's presence in the therapy relationship. She, too, spoke convincingly about the mutuality and reciprocity of hope in the process of

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psychotherapy, especially as it is transmitted to her as she witnesses the chronic suffering and loss, and the profound strength and resiliency, of particular clients:

I like the word ‘vibrant’ better. In therapy there’s a vibrancy, which I think emerges out of being authentic and good boundaries, and really being human with my clients... being in touch with my own affect and sharing that with them if I am really in solidarity with them... so yeah, I think affect is contagious and hope embodies its own affect.

And I receive- I feel hope from my clients. There’s a mutuality of hope in the relationship... it’s not one-sided. I have clients who have lived through tremendously challenging and chronic trauma, and to see them come out the other side or transcend that, even if they’re not totally there yet... that some of these people get out of bed in the morning is like, how could I not feel hopeful? To see some of them thrive and take steps, and trust God, but also make tremendous efforts despite their pain and loss and trauma, to seek what it is they want, to make their lives better, to give back to their communities or their families...

Samantha recounted an experience with an adolescent client, a female refugee from Iraq, who struggled with severe depression, anxiety, and panic attacks. She, too, has experienced both holding hope for a client, and being engaged by that same client’s perseverance when her own “gas tank” of hope ran low:

You can see change through the relationship, so working closely with that is where I feel the patient can start to feel hope and can feel more engaged in treatment. I definitely feel like sometimes the clinician has to hold the hope for the patient...other times that’s hard, but seeing them persevere and have that for themselves helps me to be more engaged in that way...

She pushes herself, even though her symptoms are really significant and severe. She still comes. She tries to come here on her own...and face her fears slowly...She’s so intelligent, and is really quite insightful about what’s going on. I think that’s part of what gives me hope, too, to see that she has those resources and strengths and it’s a matter of having a consistent caregiver in her life to work through those issues.

Tim spoke to the process of transmitting hope to his clients, many of them refugees who have experienced war, and to his persona and presence as mediators for projecting hope to them:

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People come to you desperate, but also with hope that you have the answer they don't have. And they can see hope for the future through the way you treat them and the way you present the future for them, that they will have choices for their future, therapies. This is a kind of seeding enough hope that they could feel it themselves.... I also think it's my persona and job to help people.

Joseph framed the contagious and emotional nature of hope in the therapy relationship as a positive interaction, one of many opportunities we each have to impact others everyday. He spoke of "leveling the playing field" with clients immediately by naming the mutual exchange he anticipates sharing with them:

Think about any relationship you're in... even a relationship with an inanimate thing or a sport, there is that passion, there is that love, that commitment, dedication. And if you show that to a patient or a family, those are positive. Every interaction is an opportunity, even small ones. You can build off that, just like a small negative interaction can destroy. And all of that happens in the context of a relationship... There are no innocent interactions, we are accountable, we have an impact, and someone is giving us the opportunity to have an impact.... Every interaction is a chance to promote hope, to promote positive expectations. I talk about the relationship from the 'rip.' It's almost like you become a professional friend with sight, with vision, with a mission, with intention. But I tell them, 'I'm going to learn more from you probably than you're going to learn from me.'

Audrey shared her experience of hope as a mutually engaging process and reinforcement while reflecting upon her relationship with Celeste², a client struggling with decades of chronic, early life trauma and suicidal thoughts:

It's definitely reciprocal. I cannot say it's only me, or that I 'put it there' and she finds hope because of me. No. I think giving her hope that she can change things, that she can have a better life, helps her to open a little window. She sees that she can try and she can do it and then she brought it back to me and said, 'you said that I could do it, and I did! Let's try more, let's do more!' I think it's a reciprocal reinforcement.

² All client names have been changed to protect confidentiality.

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Katrina spoke poignantly about the emotional connection she has with a severely depressed client, Tania, and to a deep, unspoken connection that communicates solidarity, containment, and hope in and through a silent gaze:

Just sitting with my client... It's about possibility, and healing in that relationship.... It's wordless with her because it's looking into eyes that were broken, and eyes that were desperate, and holding that gaze, and now how we hold the gaze differently... That experience was beyond any words... it was a connection where words weren't being used...it was sensing something in the gaze between us... and I definitely felt it. It's an exercise in being present...

Ramona offered thoughts and witness to the life-giving relationship with God that several of her female clients possess and rely upon for steadfast companionship and hope:

I think hope has been both ways...I think it's about how much you can grow or be touched in the relationship... When I see these women relate to God... It's this sense of it's not her...someone else is guiding her. They can name it many different ways but once they identify that source of protection or hope, it's not like 'I wait for God to save me,' it's like 'I truly believe that God is here, that this is happening for a reason that I cannot see right now, but I know God- he or she- is with me.' When I see in these women that they feel this connection with God, my relationships with them is wonderful because it's easier for me to guide them. And probably it's my own sense of hope as contagious in that experience, and for them, too.

Finally, images and metaphors of hope's facility and dynamism emerged from participant experiences and thoughts. Tim offered the image and metaphor of a placebo and its effect:

"I use the tool of prescribing to push the benefits of treatment, of medications and therapy, and the hope for better to all my patients. It's very important to help them believe that things might work. I think placebo, which is a kind of hope, it's a powerful tool..."

Kristen imagined an old married couple that simply sit together, without words, yet still communicating something emotional and vibrant:

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I think of the old married couple, who are best friends and who can sit with each other without talking... there's so much connection and vibrancy, and something very alive about that sometimes-quiet space that they share... Therapy has those moments.

Reflecting upon opportunities he has to transmit hope and positive interactions to his clients, Joseph imaged “a dance that you have to manage and balance so you do not become burdened or overworked or overwhelmed, and a flashing a light or flickering match at the end of a tunnel.” He shared the metaphor and universal experience of laughter: “Well, if you're in a room full of people laughing, chances are you're going to at least smile. I'm smiling right now just thinking of it...it's just an organic emotional response.”

Question 3 – (Now) tell me a story about a time when you felt that hope was an important part of your therapy process with a client. It was a time when hope and the feelings that hope generated were crucial for a positive outcome. There was a mutuality of hope in the relationship; you also felt inspired and hopeful because of the work, because of the process. Please tell me about a time when hope was an important aspect of your work with a client...really tell me the story.

While each participant had worked and trained in other clinical settings, all shared a story of a therapeutic relationship from their experience at the community health center where they currently practice. Clinicians' responses to this inquiry varied. Most were able to recall a particular client and briefly name the client's struggle or presenting issue in therapy. Some elaborated and shared a turning point or poignant memory from the therapy. One participant was not able to recall a particular patient and instead spoke of his clients struggle and process of hope in a more general sense throughout the interview. For each of these clinicians, the following narratives capture only the beginning of an interview-long process whereby many more stories and hope-filled moments and memories emerged in response to subsequent questioning.

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Albert spoke of his work with an older man, Tony, who had seen twelve therapists before beginning treatment with Albert. The man was depressed, angry, defensive, and met diagnostic criteria for borderline personality disorder and post-traumatic stress disorder. After three to four years of treatment, the man eventually “shared his deepest secrets... I saw a complete transformation...”

Audrey recalled a client she has treated for more than a decade. The client, Celeste, had a history of chronic trauma, sexual abuse, depersonalization, and she had no hope that she was going to change. “She was going to a hospital probably every six months...because she wanted to die and there was no sense for living... Even her children weren’t enough to connect her with life.” Over time, Audrey felt that she offered Celeste a sense of hope through the realization that healing takes time, and she was not going to become a newborn person, completely different, overnight. Getting better and wanting to choose life would be a process.

Joseph sifted through several stories in his mind before settling on Santos, a young man struggling with stress, anxiety, and depression. The two had been working together consistently for two to three months, and Santos had not missed a session. Joseph spoke of a turning point in the treatment that he felt spoke to the presence of hope:

This guy was stressed the heck out, anxious, depressed, all over the place. He was parched, I could tell he was thirsty and he kept looking at my water...I had just opened the water, too. So I say, ‘you want some water?’ and he says through the interpreter, ‘yeah, can I have some water?’ ... I met his needs, I recognized it and gave him more than just my time, I gave him my energy, humanity... I think you need the human part, the experiential connection, to generate hope.

Ramona spoke of Luz, an immigrant from Brazil. “She had long history of trauma, abused by a partner when she moved here, raped while crossing the border...she

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kept coming, and I asked her amidst depression, “what do you dream about? Asking this future-oriented question seemed to shift something in the young woman’s consciousness. Her only dream was to be a legal citizen because she felt that would change everything—her rights, job and school opportunities. “I didn’t say I’m going to do it for you,” said Ramona. “I said ‘that exists, that what you want exists in reality- it’s not just a dream.’” She followed through and when she got citizenship she was just full of tears, hugging me.

Kristen reflected upon her work with Marie, a middle-aged woman who had moved to the area after a brief period of homelessness on the West Coast. Marie had struggled to maintain close interpersonal relationships for much of her life, felt little sense of her own power or efficacy, and struggled with clinical depression. “But she had three other therapists before me and done well, and so we got down to the work of forming our relationship and alliance, and one step at a time— in work, at home, in her church... Over the course of two years she really made progress, just as she had with her previous therapists.”

No one client came to mind for Tim, the staff psychiatrist. Ted sees an average of forty to fifty people every week, significantly more than the psychotherapist-participants at the same clinic. While he referenced distinct patient encounters later in the interview, like each of the other clinicians, he generally responded to the interview question and to his clinical work with a broad sense of his overall experience.

Katrina referenced her work with a woman named Lucy. Lucy had a severe childhood sexual abuse history and had been sober from alcohol and drug addiction for six years. When Lucy stopped taking her medication, she spiraled into depression and

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started hearing voices. “For me, just her showing up and sitting here as a broken human being... every time she dragged herself in here it was hopeful.”

Lastly, Samantha reflected upon her experience with Ariana, an adolescent with severe depression and chronic panic attacks that interfered with the girl’s life at school and her love of academics.

Question 4 – What was it about the situation that allowed that story to unfold?

Participants named several variables in the situation that they believed allowed the aforementioned stories to unfold. Two themes emerged: utilizing the language of hope with clients in therapy and the importance of a safe therapeutic relationship and environment.

Table 7. Core Question Four Themes

Subjects	Using the Language of Hope	Creating a Safe Relationship-Environment		
1- Albert		X		
2- Audrey	X			
3- Joseph		X		
4- Ramona				
5- Kristen	X			
6- Tim				
7- Katrina		X		
8- Samantha				

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Albert, Joseph and Katrina identified qualities of the therapeutic relationship and environment as situational factors that allowed hope to transpire. Albert posited “the healthy, safe relationship that we have built helps (my client) have hope or some belief that a different kind of reality or meaning in his life.”

Joseph spoke about a hope-generating environment that facilitated a currency exchange of emotion. “We provide the context, the environment and it’s supposed to be a hope-generating one, if anything. That’s our currency: hope, emotions...the smiles, the cries... hope is sprinkled all around it. Maybe sprinkled more in some areas than others, but generally sprinkled throughout the whole.”

Katrina cited feelings of solidarity with her client, and her capacity to contain strong emotions of brokenness, as factors that allowed hope to transpire in her therapy relationship with Lucy. “Being able to connect with her in that gaze, it makes clear that I can hold (her) stuff, that it wasn’t too much and that I could be there.” She also highlighted the importance of their experience of shared vulnerability, Lucy’s brokenness and her openness to holding it with her. “I was looking into eyes that were broken, eyes that were desperate, and holding that gaze. The key to it is vulnerability, I think, and surrendering to it... not to say ‘I’m giving up, but to say ‘here I am.’

Kristen and Audrey each talked about using the language of hope in an effort to instill hope or invite clients to see and make choices that led to a more hopeful life.

Kristen spoke of her intentional use of the word ‘hope’ as a contributing factor that cultivated hope in her scenario. She explains:

Sometimes hope is spoken about very clearly, “what do you hope for,” “my hope for you”, or there’s often a forward sort of thinking or imagining that’s articulated alongside acknowledging the here and now, and maybe especially the pain of now... And hope embodies its own

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affect and qualities, sort of a forward thinking and a far side of difficulty and a capability in the client, ‘you’re capable, and so much is out of your control, but not everything.’

Audrey cited her client’s own recognition of the progress she had made over the course of a decade how that led to a conversation about hope in her life. After the conversation “she could see now that she has made a lot of little changes in the long-term that give her hope to stay alive, to choose life.”

Finally, two images of hope emerged from this line of inquiry, both from Joseph. “I have a tattoo that’s a sun with a tornado in the middle of it...for me it symbolizes there’s always another day to do something or to try something different. The sun is out; it’s another day. Even if it’s raining, the sun comes out.” Lastly, Joseph’s language and image of hope and human emotion as a therapist’s currency speaks to the power and universality of this transcendent and human experience we call ‘hope’.

Question 5 – What was it about your client that contributed to your sense of hope in that experience?

Though this line of questioning focused on their perceptions of other people, participants responded easily and with confidence about their client’s strengths, abilities and triumphs as they related to keeping hope alive in the therapeutic process. Five themes emerged: the client’s inner drive, children as motivation to improve life, intelligence and effort to understand their diagnosis, diligent effort and hard work, a relationship with God. Participants that did not articulate any of these five themes asserted new thoughts or previously reported qualities, including: a belief that change is possible, a recognition of prior accomplishments, vulnerability, a belief in the presence of something transcendent, a belief that there is always choice, even if it is only the choice to think differently about one’s circumstances.

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Three participants articulated an inner drive or energy that existed within their clients that was fighting on their behalf and urging them toward wellness. The same three clinicians spoke of client motivation to hope and work for better in order to keep or obtain custody rights to their children. A second trio of clinicians referenced their client’s intelligence and effort to become educated about their diagnosis and treatment. Two participants highlighted their client’s efforts and hard work to heal and become well again. Lastly, two spoke of their client’s relationship with God as an anchor of hope in the client’s life and therapeutic relationship.

Table 8. Core Question Five Themes

Subjects	Inner Drive or Energy	Desire Better for their Children	Intelligence and Psycho-education	Hard Work and Effort	Relationship with God
1- Albert	X	X	X	X	
2- Audrey					
3- Joseph					
4- Ramona	X	X	X		X
5- Kristen			X	X	X
6- Tim	X	X			
7- Katrina					
8- Samantha					

Albert, Ramona and Tim all spoke of something within each of their clients that was fighting, or fighting on their behalf. Albert noted that while his client “was broken

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somehow emotionally, there was something still there that allowed him to fight back... fight for joint custody of his daughter.”

Tim spoke of this energy to fight as a drive that, when absent, makes it more difficult for clients to get better. “The person has a drive, they want to get better, they want to do better and many have motivations, especially regarding kids, family, duties...when you see them fighting to get better... we have to pick up on that.”

Ramona offered the metaphor of a photographer or chef who recognizes the necessity of a vital ingredient in their creative work. She names this key ingredient that her clients draw upon in their efforts to persist in the face of adversity a “great force” within them:

It’s like when you see something photographic or when you’re a good chef, and you see this is a key point that must be in this dish. With these clients I immediately invest more, support more, confront more, facilitate more...because there is something that has not been damaged even though everything else in their life could be. I have actually seen it; it’s a great force...

Like Albert and Tim, Ramona also articulated the desire and motivation her client possessed to care for her child. “I also used her son (in the therapy work). Everything was related to her son. She was living for him. I think it was that connection that made her feel whole, and she would say about our work and her desire to get better, “I have to do it, I have to do it, for him.”

Albert, Kristen and Ramona named their client’s intelligence and efforts to become educated about their illness and options for treatment as qualities that allowed hope to transpire in the therapy. Albert’s client would purchase texts to learn about the impact of his early life trauma and to grow in self-awareness. “He is very bright and

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bought books and read more about trauma and the impact of trauma, and this helped him understand himself much better and connect with his own emotion.”

Kristen highlighted her client’s diligence and effort to “work with what she’s got, which are a lot of strengths and intelligence,” and Ramona articulated that “information was power” for her client as it related to her understanding of her parental custody rights.

Albert and Kristen each noted a quality and commitment to hard work that their client’s possessed and how it contributed to hope in therapy. Albert spoke of Brian as “a person who was very hardworking... a hardworking guy. There was hope because I can see even with all the trauma he was not so broken that he couldn’t try.”

Kristen highlighted Julia’s capacity and commitment to do the hard work of psychotherapy even during difficult times:

It’s hard work, and with her it’s deep personality work. But she shows up week after week, even when she’s having a really difficult time...She uses the relationship, she uses the space, she does the work. It’s long-term work, but she’s chipping away at it, and there’s no reason not to feel hopeful given that she’s taking steps forward. Maybe baby steps, but sometimes, larger steps.

Lastly, both Kristen and Ramona named their client’s faith and relationship with God as a key factor and quality that allowed hope to transpire in the therapy. Julia, has a bachelor’s degree in Bible, but Kristen sites faith and a relationship with God as her client’s “trump card” in therapy:

A lot of my clients are people of faith, so they sense, not just sense- they believe- they are not alone in their challenges because they believe God is working on their behalf as well...that’s a big trump card for them.... So when I think of this person, she is also a Christian... her God is on her side, so there’s hope implicit in that, a healthy image of God, not a punitive one, but a God that’s on your side, wanting your healing and joy. Even if I didn’t believe in God myself, that’s something I see that gives her hope.

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Ramona offered additional thoughts on her sense of the “great force” within clients that helps them to press on in difficult times. She understands its source to be her client’s connection to God, and she capitalizes on it in the therapy work:

They could feel the worst about themselves, about their family, they may have no connection with anyone or anything they feel is worthwhile, but somehow they have that feeling of some connection with God. It can be used in the process of therapy.

Question 6 – Now step into your client’s shoes for a moment. What do imagine he or she would say about you? Without being overly humble, what it was about you that allowed that experience to unfold?

The personal qualities that therapists offer their clients, and the gift of a relationship, emerged as central themes associated with this core question. Five of the eight participants named the relationship clearly in their response, and all eight articulated the personal qualities they thought their clients appreciated about their companionship. These included: empathic, compassionate, caring, loving, hopeful, honest, direct, humorous, respectful, engaging, cooperative, accommodating, good listener, and non-judgmental. Two additional themes emerged therapist contributions to hope: the creation of a safe therapeutic environment, and seeing clients for whom they really are.

Table 9. Core Question Six Themes

Subjects	Offers Relationship/ Companionship	Therapist’s Personal Qualities	Creates a Safe Therapy Space	Sees Me for Who I Really Am
1- Albert	X	X	X	
2- Audrey		X		
3- Joseph	X	X	X	

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4- Ramona		X		X
5- Kristen	X	X		X
6- Tim	X	X		
7- Katrina	X	X		
8- Samantha		X		

Albert's client told him outright that he provided him with vital companionship. "He used to say to me 'I'm going die from loneliness.' The other day he said that he's not going die anymore from loneliness because of the relationship in our sessions."

Reflecting spiritually on the qualities he offered his client in their relationship:

If I view it from a spiritual perspective... I will say what it is that I enjoy about sitting in this chair listening to these painful memories of clients...it's maybe the love... and the teachings of Jesus, of love, are about staying with a person and listening.

Kristen also spoke of the love that she has for her clients, and to the feedback Marie has given her about their relationship:

I think the word love was mentioned, which is true, I do try to love my clients... it's a different kind of love, and yet I do... I think she would say that I offer her a deeply caring compassionate, non-judgmental support and relationship, and that I facilitate that with different interventions but that it's really the relationship...I think she has said as much.

Katrina thought her client would articulate the quality of care that she shows her. "She would say that I care about her. Because when she misses an appointment I'll call her and say, "Lucy, it's your therapist, why aren't you here?" Tim believed his clients see a relationship as the most valuable thing he offers them, a relationship marked by care and flexibility they may not get elsewhere. "I think that the most hope and reward and everything is my individual relationship with the patients... I try to use our relationship

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for good and I work very hard at it... I'm treating them well, and I'm accommodating them, and I listen to them."

Samantha highlighted the qualities of empathy and patience she brings to her relationship with Ariana as the young woman faces her fears, one at a time. "I think she most appreciates that I try to go into her world... and I'm not pushing her." Ramona spoke powerfully about what she feels her client might say about what she contributes to the process of experiencing hope.

I think she would say that I was able to explore with her and pull from her all that good that there is within her and make it work for her, rather than trying to look somewhere else for it. And she found herself, and when she found herself, the rest is history.

Reflecting upon his own personal style and qualities, Joseph captured his personality in words, and echoed something of Ramona's efforts to facilitate empowerment in the therapy. I think my clients would say:

I'm energetic, charismatic, good sense of humor, make light of things, good direct communication, honest, open, flexible, respects their time, gives them time. Engaging, cooperative... The soil (for that seed of hope in their lives) isn't as rich as we want it to be so we have to help cultivate it and that takes time...and it takes energy. So we have to bring that hope and that rain dance to the relationship, you know?

Initially, Audrey was unsure and shrugged off this question. Soon after, she spoke of love in relationship as it related to helping Celeste cultivate hope. "Hope is a kind of love that you give little by little and people can grow and think in a different way and make little changes."

Albert, Kristen and Joseph each believed that their clients recognized and valued the safe and healing space that they tried to cultivate and offer. In a spirit of creating a hopeful space, Joseph posits: "For 45 minutes you're the only person in the world for that

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person. And my job is to make that world better somehow.” Albert views the space he cultivated as one that projected both hope and safety, and that helped Tony feel accepted and curious:

For him, being able to open and verbally express his deepest secrets helped him heal... I helped create a safe place for him to be himself and not feel rejected. Just being able to be there with him, just listening to him, affected him...I think that was the healing process for him.... Building a safe relationship... that I facilitate a space that helps him to do more exploration... that I projected hope for him in his life.

Kristen and Ramona have been told by their clients that their ability to “see me as I am” has proven valuable. Kristen shared this reflection:

Marie said to me, “You see me for who I am, you don’t judge me, you care,” and this led me to think about that I do care about my clients. I care very deeply. A professor of mine has said, “You gotta find the love, people. You have to find something, even just one thing, that you love about every one of your clients.”

Reflecting upon this ability to “see” one’s client, Ramona said simply and succinctly. “I think she would say that I was able to see her, to recognize how strong she is.”

Lastly, Joseph offered once again an image that captures the liberating work of hope. The image of a door opening to new possibilities was shared in the context of a clinical exercise. To generate hope and possibilities that they do not yet see, Joseph poses a version of the miracle question to his struggling clients and works with them to write the responses:

We’d put giant blank poster paper on the wall and we would draw stem and the leaves and the petals...and I’d say, a year from now, it’s 12/31/13, what three things need to happen for this to be the best year of your life?...and we put those on the petals, I give them a marker to write them down...and then people start talking, and the door starts to open... It’s a visual power and patients remember it. There’s meaning in the vision. And they get it, to think differently about the situation even though it remained the same.

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Question 7 – What from your particular background- your faith, culture, personal and professional experiences- do you think contributed/s to the engagement of hope?

In response to this question, several themes emerged: religious faith/ideals, personal experiences of psychotherapy, influence of professional training, and cultural and ethnic values. Two clinicians spoke of their religious faith and ideals as anchors for their belief about hope. These same two clinicians also referenced their personal psychotherapy as experiences that impacted them and informed their belief in change and hope. Three participants referenced their clinical training as shaping their assumptions about human potential and hope, and two spoke of their ethnicity and ethnic culture as influential factors in the development of hope. Two clinicians had no immediate response to this question.

Table 10. Core Question Seven Themes

Subjects	Religious Faith or Ideals	Personal Experience of Psychotherapy	Influence of Professional Training	Cultural and/or Ethnic Values
1- Albert	X	X		
2- Audrey				X
3- Joseph				
4- Ramona				
5- Kristen	X	X	X	
6- Tim			X	
7- Katrina				
8- Samantha			X	X

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Albert and Kristen spoke of the impact of Catholic Christianity on their understanding of hope. No longer Catholic, Albert spoke of the Christian values that remain with him.

There's a lot of faith and ideals and values that I grew up with... my background, I was raised a Catholic... there's always the idea of helping... And when I think of the idea of helping others, for me it's important to believe that there's hope in order to see a better future for the person who's in front of me.

Kristen, a trained lay minister, spoke more directly to the language of faith that frames her journey and lens for life:

I look to the Christian story, and I have an eye for that, I see that, when I work with clients I believe there is a far side to even being in the most difficult places. As a Christian, we call ourselves a resurrected people, in the same way that seasons come around, you know, winter turns to spring, turns to summer... it always comes, no matter how harsh a winter, and that same rhythm of life that for me is the presence of God, it's woven into the fabric of our being, all of creation, but with people being part of that. And if I believe that, and I do, because I see it, because I've lived it, then when I look out the window, and I see it in client's lives, how can I not feel hopeful?

Albert and Kristen each mentioned their personal experiences of psychotherapy as significant to their sense of what kind of change is possible in the context of a therapeutic relationship and alliance. Albert spoke first:

When you're going to become a psychologist or therapist they always encourage you to do your own therapy, because you have to do your own inner work and learn about yourself and learn about your process... And when you do that it helps you understand others in much better ways... you learn that the relationship is the most important and that what you project when the patient is seeing you is a kind of hope that there could be a better future.

Kristen also learned about hope in relationship through her personal therapy. "My own psychotherapy was a very significant support for me... my therapist was one of my

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biggest cheerleaders. Honestly, it's been one of the most important experiences of my life, a hope cultivating experience, a relational experience."

Samantha, Tim and Kristen all regarded their education and training in mental health as professional formation for instilling and believing in the human potential, the power of relationships, and the hope that emerges at that nexus. Samantha's clinical training was heavily influenced by psychodynamic theory and informs how she believes hope is possible through an experience of relationship. "Honestly, my dynamic background and training...I really believe that it is all about the relationship."

Tim, a psychiatrist who previously named the therapeutic relationship as "the most important thing" in treatment, explained that he was also trained to believe his interventions would help improve people's lives.

We are trained in the medical field to think that things will get better... It's essential that I think I could help you to feel better, otherwise I don't know how I would do this... To assume that our intervention makes things better somehow. It's a professional assumption that we do things so that you will be better...I want to see you have that hope... I'm not sure I could do this work otherwise.

Kristen recognizes that her personal experience has significantly enriched her professional training, yet offered this advice to practitioners and the programs that train them, "This work of therapy is often deep personality work and that takes time... if we as therapists don't believe that's possible, if we are not taught that transformation is possible, then we should be doing another type of work or another type of therapy..."

Finally, the role and contribution of ethnic and family cultures was explored as it relates to the hope clinicians resource and offer in their work of psychotherapy. Two of the eight participants thought that their family and ethnic culture and heritage plays a

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significant role in their belief and capacity to project hope to their clients. Samantha highlighted qualities of her Russian-Israeli background:

Culturally, I think my Russian and Israeli background is very direct and real and so I think I bring that to my work as well. I'm always straight with my patients and I think that's part of the understanding. First you have to understand what you're coming up against, to deal with it... So in a relational aspect, being real, being authentic is very important in creating that hope. To say, "Let's identify what the issue is. Let's identify the obstacle. Now you know what it is, and now let's work together on that.

Audrey once again returned to her family's story of emigration from Nazi Germany.

The way I was raised, there was nothing negative that we could not overcome. There was a belief that 'we can solve this.' My family never said 'this is impossible.' Never. My mother's cancer treatment, we did everything we could until the last moment. It was based on hope that we can change this. My father, even after the family experience in Auschwitz, is a hopeful man. He always has a smile. He always looks for a solution. He would never stop and say, 'Oh my God, I cannot do it.' So now I am a person who always looks for solutions.

Lastly, mothering emerged as an image in Albert's response to this inquiry. A new father, himself, he shared these thoughts of the role of nurturing that is at the center of both the work of parenting and that of psychotherapy:

Here, in therapy, the relationship is the most important and what you project when the patient is seeing you is kind of that hope that there could be a better future. You become like a mother somehow, and you have to believe in what you are doing. If you don't believe in what you are doing, then I think that has an impact on your patient's life.

Question 8 – Please comment on anything about the culture of the clinic that contributed to your sense of hope in that experience.

Four of the eight therapists replied “no” or “not really” in response to this question. The remaining four therapists responded with substantial thought about the overall culture of the clinic, and two themes emerged: the influence of supportive

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colleagues who model hope, and an overall culture of intensity at the clinic based on the pervasive chaos and suffering of the people who utilize its services.

Table 11. Core Question Eight Themes

Subjects	Support of Supervisors/ Team	Intense Nature of Work/Clinic		
1- Albert				
2- Audrey				
3- Joseph				
4- Ramona		X		
5- Kristen	X	X		
6- Tim				
7- Katrina	X			
8- Samantha		X		

Both doctoral trainees spoke of supportive supervisors who both modeled hope and welcomed dialogue around the subject. Katrina spoke to this and to her experience of supervision and training. “People can nurture hope, and Lela is terrific... as someone who is training me, that makes me feel like this is an atmosphere where hope isn’t considered naïve.” Kristen also spoke of the nurturing of hope that she experienced through her relationship with this same supervisor. “There’s a kindred spirit in my supervisor, she’s a solid person and clinician, someone with a similar anthropology who brings a posture of care and respect for clients and models hope in this work.”

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Samantha, Kristen, and Ramona each spoke of the intensity that characterizes the health center, and the work of serving an urban community health population. Samantha spoke extensively about the large refugee community seeking services at the Center:

I think working with the Nepali and Iraqi refugee population has taught me a lot about hope, because of all they've been through...they're so appreciative and grateful for everything that they have and that's very inspiring and hopeful and unique to this clinic... Everything that they've been through and struggled with, to still be able to focus on being appreciative for the little help that they get here or the little things that their family is able to achieve. It's just amazing...to be able to enjoy the little successes, their response is kind of incredible.

I would add that I see resiliency as part of hope. That's part of what I see in the refugee population, that natural resiliency that they don't even realize they have. To me that's very hopeful... It's really recognizing the strengths that each of these patients has, which gives me hope and I think provides hope for them as well.

Kristen shared her experience of working with a client from Africa who struggles with the impact of chronic trauma and loss:

For all her struggles, and they are compounded, she always bounces back. She gives me hope. Nothing's keeping this lady down. For her, that's God, but also her own effort, tireless effort, out of care for herself and care for her children, of wanting to give back, out of wanting a better life...such an extraordinary person. She gives me hope, she fuels the hope in humanity that I claim I have...and that I do have most of the time. But working with the intensity of the population in this clinic can challenge that sometimes. But this client, and others... she gives me hope in humanity and in this work and the human spirit and human resiliency and the human power to transcend and to act on desire or goodness and life.

Finally, Ramona also spoke to the intensity of the health center's client population with respect for how it facilitates hope in relationship, but also expressing the physical and emotional fatigue it can produce. "The intensity of the clinic and population makes you feel like you've been here so many years, even though I haven't. That's both good and it's difficult."

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Question 9– Is there anything else related to hope that you’d like to say that you haven’t had the opportunity to share?

This question provided participants with an opportunity to conclude and contain the interview by offering final or clarifying comments. The question was an add-on and not listed in the original set of questions. Rather, it emerged after the first interviewees took time at the conclusion of their formal interviews to casually articulate lingering thoughts and feelings. Concluding the remaining interviews with this final inquiry proved generative for two reasons: 1) It allowed participants an opportunity to clarify thoughts and contain feelings if needed; and, 2) it provided new themes related to their experiences of hope and psychotherapy.

Two central themes emerged from this last core question: cultivating hope requires hard work, and the risk of experiencing burnout when working in the context of community mental health. Three participants underscored the hard work involved in the cultivation of hope. Three others reflected upon the risk of therapist burnout when working with challenging populations.

Table 12. Core Question Nine Themes

Subjects	Cultivating Hope is Work	Risk of Burnout		
1- Albert		X		
2- Audrey		X		
3- Joseph				
4- Ramona		X		
5- Kristen	X			
6- Tim	X	X		

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7- Katrina				
8- Samantha				

Albert was the first participant to respond to the reality of risk and prevention of burnout in this work:

When we start helping others, it's very easy for you to get burned out because the reality is that you are in front of people that don't have the same resources, they don't have the same opportunities. And sometimes when you understand that, all those dimensions of the patient in front of you, it is very difficult sometimes to see the hope... And when you see that, then it can affect you as an agent of change in this person's life. Then you question, what am I doing here?... So I think that it is very important for me to understand the hope in me, in my own life, and seeing many changes in my life that I never imagined...for me that's proof of hope because I've lived it.

Ramona offered the metaphor of a gas tank on low to describe her feelings of fatigue in the face of her clients' dire circumstances:

Sometimes hope doesn't maintain itself as you hope, you have to work on it. I feel like a car, the gas is going low, and sometimes after years here you feel that you need to take care of that gas, otherwise you're going to run out. You need to replenish, that's part of being a therapist. I took two weeks off but I think it takes more than two weeks.

Audrey spoke of the secondary trauma she experiences in her work with clients: "I'm seeing patients all day long with severe, chronic trauma. I'm getting very traumatized by them, like secondary trauma.... So I need to use my own hope to stay alive, to keep doing what I need to do outside of the clinic."

Kristen cautioned against romanticizing hope. "The seasons, the Christian story, I see hope in it all, but that doesn't mean it doesn't take work... Cultivating hope in the face of life's challenges is quite a process." Finally, Tim shared a recent and painful clinical experience where he was unable to find or cultivate hope in the story of a refugee

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client. His narrative speaks to both the work and challenge of cultivating hope and to the risk of burnout in this work:

We face some difficult situations here at the clinic, and it's not easy. I met with a man whose son was kidnapped, he paid ransom, but they killed his son anyway. This man could not find the hope. The boy was his life and he could not reverse that experience. It was so difficult, and I was even afraid and ashamed to tell him things will get better. I didn't find any words. How do you give hope to that man? What hope are you going to give?

Paradoxically, several new images of hope emerged from participants' responses to this final interview question. Audrey offered the image of water as hope that nurtures.

"Hope is like the water you give plants to grow.... People also need it to grow and mature." Joseph used the metaphor of widening blinders that expand a client's vision and possibility. He explained with a clinical example:

There are always strengths, like working with kids, I ask the parents 'can you tell me something positive about your child, one thing.' And people get refreshed, they think, 'maybe there is a chance, maybe there is some hope. And then they see the change within themselves, within their children, which only reinforces it... Their blinders shift.

Lastly, Samantha imaged hope as a glowing globe in the room as she sits with her refugee clients:

I have an image of a glowing globe, floating in the room. That's how I see it. It's kind of like all of a sudden I see this thing floating and you kind of pay attention. It gets brighter and brighter, that's sort of how I see it when I'm with patients." I think sort of the default is that you're the glowing globe for them, but sometimes if you don't have it then it needs to kind of appear in the room for you to refocus.

Endorsement of Core Question 1 Themes Based on All Interview Responses to All Interview Questions. Themes endorsed with “xxx” reflect those that emerged from a different core question(s).

Question 1- We often have touchstones or anchors of hope in our lives- a safe and inspiring person or place, an experience or story that we go to when we find ourselves in need of hope. Describe the person or place, story or experience, in your life that you recall when you search for hope.

Subjects	Personal Journey	Faith in God	Meaning Making/ Transcendence	Believes Change is Possible	Role Models	Nature
1- Albert	X	xxx	X	X	X	X
2- Adelpia	X		X	xxx	X	
3- Joseph	X		X	xxx		
4- Ramona	X	X	xxx	X	X	
5- Kristen	X	X		X		
6- Tim	X					
7- Katrina	X		X	X		X
8- Samantha	X		X			xxx

Endorsement of Core Question 2 Themes Based on All Interview Responses to All Interview Questions. Themes endorsed with “xxx” reflect those that emerged from a different core question(s).

Question 2 - It has been written that hope is contagious, that we experience it through our emotional relationships with other people. In what ways is your experience or sense of hope as a contagion present in your clinical relationships?

Subjects	Believes Hope is Contagious	Therapy Relationship as Facilitative	Recognizes Emotional Quality in Hope’s Transmission	Experiences Mutuality of Hope’s Contagion
1- Albert	X	X	X	X
2- Adelpia	X	X	xxx	X
3- Joseph	X	X	X	X
4- Ramona	X	X	xxx	X
5- Kristen	X	X	X	X
6- Tim	X	X	X	
7- Katrina	X	X	X	X
8- Samantha	X	X	X	X

Endorsement of Core Question 4 Themes Based on *All* Interview Responses to *All* Interview Questions. Themes endorsed with “xxx” reflect those that emerged from a different core question(s).

Question 4 – What was it about the situation that allowed that story to unfold?

Subjects	Using the Language of Hope	Creating a Safe Relationship-Environment		
1- Albert		X		
2- Adelpia	X			
3- Joseph	xxx	X		
4- Ramona				
5- Kristen	X	xxx		
6- Tim				
7- Katrina		X		
8- Samantha		xxx		

Endorsement of Core Question 5 Themes Based on All Interview Responses to All Interview Questions. Themes endorsed with “xxx” reflect those that emerged from a different core question(s).

Question 5 – What was it about your client that contributed to your sense of hope in that experience?

Subjects	Inner Drive or Energy	Desires Better for their Children	Intelligence and Psycho-education	Hard Work and Effort	Relationship with God
1- Albert	X	X	X	X	
2- Adelpia	xxx				
3- Joseph		xxx			
4- Ramona	X	X	X	xxx	X
5- Kristen		xxx	X	X	X
6- Tim	X	X			
7- Katrina					
8- Samantha		xxx	xxx	xxx	

Endorsement of Core Question 6 Themes Based on All Interview Responses to All Interview Questions. Themes endorsed with “xxx” reflect those that emerged from a different core question(s).

Question 6 – Now step into your client’s shoes for a moment. What do imagine he or she would say about you? Without being overly humble, what it was about you that allowed that experience to unfold?

Subjects	Offers Relationship/ Companionship	Therapist’s Personal Qualities	Creates a Safe Therapy Space	Sees Me for Who I Really Am
1- Albert	X	X	X	
2- Adelpia	xxx	X		
3- Joseph	X	X	X	
4- Ramona	xxx	X		X
5- Kristen	X	X	xxx	X
6- Tim	X	X		
7- Katrina	X	X	xxx	
8- Samantha	xxx	X	xxx	

Endorsement of Core Question 7 Themes Based on All Interview Responses to All Interview Questions. Themes endorsed with “xxx” reflect those that emerged from a different core question(s).

Question 7 – What from your particular background- your faith, culture, personal and professional experiences- do you think contributed/s to the engagement of hope?

Subjects	Religious Faith or Ideals	Personal Experience of Psychotherapy	Influence of Professional Training	Cultural and/or Ethnic Values
1- Albert	X	X		
2- Adelpia				X
3- Joseph				xxx
4- Ramona	xxx			
5- Kristen	X	X	X	
6- Tim			X	
7- Katrina				
8- Samantha			X	X

Endorsement of Core Question 8 Themes Based on All Interview Responses to All Interview Questions. Themes endorsed with “xxx” reflect those that emerged from a different core question(s).

Question 8 – Please comment on anything about the culture of the clinic that contributed to your sense of hope in that experience.

Subjects	Support of Supervisors/Team	Intense Nature of Work/Clinic		
1- Albert				
2- Adelfia				
3- Joseph				
4- Ramona		X		
5- Kristen	X	X		
6- Tim				
7- Katrina	X			
8- Samantha	xxx	X		

Endorsement of Core Question 9 Themes Based on All Interview Responses to All Interview Questions. Themes endorsed with “xxx” reflect those that emerged from a different core question(s).

Question 9— Is there anything else related to hope that you'd like to say that you haven't had the opportunity to share?

Subjects	Cultivating Hope is Work	Risk of Burnout		
1- Albert	xxx	X		
2- Adelpia	xxx	X		
3- Joseph	xxx	xxx		
4- Ramona	xxx	X		
5- Kristen	X	xxx		
6- Tim	X	X		
7- Katrina				
8- Samantha	xxx	xxx		

DISCUSSION

Introduction

This chapter will focus on the following: a) discussing the images, metaphors and salient themes derived from participant interviews, b) assessing the utility of administering The Adult Hope Scale, c) naming unexpected occurrences in the study, d) outlining the strengths and limitations of the research design, e) recommending future research directions, f) recognizing the impact of therapist inner congruence, g) exploring the relationship between hope and hopelessness, h) identifying implications for clinical practice, i) envisioning ways to support and train practitioners in the cultivation of hope.

Images, Metaphors, and Salient Themes

Several rich images and metaphors emerged from the study's "conversations on hope" that merit highlighting and summarizing. These images speak to the power and dynamism of language and the imagination by witnessing how a single word or image can capture a moment or a phenomenon that is otherwise difficult to explain. Hope is a multidimensional construct that possesses qualities of relationship, emotional vibrancy, agency, imagination, planning, and more. It is a human experience and phenomenon embedded in social and cultural contexts. I find that many, if not all, of these qualities and complexities of hope can be *felt* or even *experienced* through the following images and metaphors offered by clinicians:

Subjects	Image(s) and Metaphors of Hope
1- Albert	A Mother's Encouragement; Love
2- Audrey	A Window Opening; Water for Plants; Love

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3- Joseph	Seeds Taking Root; Tornado With Bright Sun at its Center; Emotional Currency; A Door Opening; Widening of Blinders; A Flash of Light at End of Tunnel; The Flickering of a Match; A Rain Dance on Dry Soil; Springtime; Night Turning to Day
4- Ramona	A Great Force From Within; A Full Gas Tank
5- Kristen	The Christian Story of Resurrection; Springtime; People as Works in Progress; Love
6- Tim	The Placebo Effect
7- Katrina	Life's Glimmering Moments; First Rays of Sunshine; Warmth of the Sun; Springtime
8- Samantha	A Glowing Globe

Several salient themes arose in response to the interview questions. The theme of personal journey emerged as a primary touchstone of hope for every therapist. This suggests to me that personal experience, and reflection on those experiences, allows individuals to recognize that despite life's adversities, change and new life are possible. Perhaps, like the study participants, we are each living proof of this reality and source of hope.

Making meaning of life experience, particularly experiences of suffering, also emerged as a common theme among participants. Some looked to faith traditions to find meaning, others looked to ancestors or to nature and the ever-evolving seasons that characterize New England. Still others spoke of something transcendent that they recognized in life's ordinary moments and rhythms.

Participants largely endorsed themes that supported the theory that hope is contagious. Likewise, the therapy relationship was raised up consistently as the primary facilitator of hope in therapy, as was therapists' recognition that the transmission of hope in the therapy context is characterized by strong affect.

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I found it moving to hear most therapists speak so emphatically about the experience of mutually shared hope in their therapy relationships. Their stories and emotions made it clear to me that the transmission of hope is a “two-way street” in the unique relationship shared by clinician and client.

Salient themes emerged that highlighted how important a clinician’s companionship and relationship is to many clients, and how often and accurately clients recognize and draw upon the unique personal qualities of their therapists. It is well known that the relationship serves a central function in psychotherapy (Lambert, as cited in Norcross and Goldfried, 1992, p. 97), regardless of the therapist’s theoretical orientation. When asked to step into their client’s shoes and share something about themselves that their client might highlight as hope inspiring, therapists named qualities such as warmth, care, empathy, honesty, acceptance, respect, compassion, vulnerability, listening, solidarity, humor and love. I believe that the theme and thread that these myriad qualities share are that they are deeply human and relational in nature.

There were no themes I anticipated that did not arise. I was pleased to hear several clinical vignettes or personal journeys that spoke to the emergence of hope in direct relation to spirituality, faith, or a relationship with God. Two clinicians spoke powerfully of personal and transformative spiritual experiences that served as personal touchstones of hope. Another clinician spoke of Jesus of Nazareth and Saint Francis of Assisi as role models that inspired hope. Several clinicians spoke of the steadfast faith in God that many of their clients possessed as a source of hope and protective factor.

Unexpected Occurrences

Several unanticipated occurrences transpired over the course of the study. The first was the unsolicited interest to participate in the study by one of the staff psychiatrists. My original intent was to interview master's and doctoral level clinicians with degrees in counseling psychology or clinical psychology. This was outlined clearly in the guidelines for participation. However, a psychiatrist, Tim, approached me and asked if I would like to interview him. He was not aware of the guidelines but had heard of the study through my department email inviting all behavioral health staff to my "hope presentation" the previous month. I immediately wondered how the stories and insights of someone trained in a medical model of treatment might compare to those trained and taught through a social science lens. This psychiatrist sees many of the same clients for medication management that other clinician-participants see for psychotherapy. I imagined his participation and the data he provided would enrich the study so I welcomed his outreach and participation.

In fact, some of his responses/scores are outliers while others are consistent with those of his psychotherapist colleagues. He shared a powerful clinical vignette, in which he spoke about his feelings of profound helplessness while sitting with a client's experience of profound hopelessness, that proved valuable in that it provided a helpful focus for understanding just what hope is and what it is not. This will be further explored later in this discussion under the header, *Clinical Implications*.

Secondly, I was surprised by how little thought participants had given previously to the presence and phenomenon of hope in their professional work. Many mentioned that this was the first conversation and opportunity they had ever had around the topic. I

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was equally struck by the number of participants who wandered by my office after their interviews - sometimes days later - to continue processing with me the insights that emerged during their interview. I believe this speaks to the depth and universality of hope in the human experience, and to the likelihood that hope as a phenomenon within the clinical practice of mental health awaits recognition, reflection, and cultivation.

Valerie Rumsfeld (1990) explored the presence and function of hope in the work of seven psychodynamic psychotherapists. In her results she spoke of the value of “asking the question,” and of how each therapist she interviewed considered hope as “serving a critical function in the psychotherapeutic process” (p. 198), but simultaneously recognized that they had never given the topic deliberate consideration. While the present study did not formally question participants about the frequency with which they reflect upon the phenomenon of hope in their professional life, my observations of their process, both during and after their interviews, suggests that little has changed since Rumsfeld’s study. Hope continues to remain in the shadows until “asking the question” begins to shed light on its power and presence. This phenomenon reinforces the usefulness and efficacy of an Appreciative Inquiry methodology that is based on the assumption that inquiry into and dialogue about strengths, successes, values, inspirations and dreams is itself transformational. I believe that this process of transformation through inquiry and dialogue was engaged in several participant interviews. Only a formal follow-up with participants could validate this assumption.

Next, I was surprised and moved by the number of images and metaphors that emerged as touchstone reminders of hope for clinicians. The interview questions explicitly sought “persons, places, stories or experiences” that served as touchstones or

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anchors of hope in people's lives, but these questions did not invite consideration of an image, metaphor or symbol. The gift and phenomenon of this occurrence already has been explored in this chapter's introductory section. If I were to embark again on this or a similar study, I would intentionally invite participants to reflect upon or consider an image, symbol or metaphor that speaks to them of hope in their personal and/or professional lives.

I was somewhat surprised that the language of love arose in interviews with four of the eight clinicians. My own clinical relationships over the course of my training suggest to me that it is possible, perhaps even necessary, to love one's clients. In the course of four years of on-site clinical training the topic has never come up, even with supervisors whom I consider excellent and experienced training clinicians. I recall that the topic of [compassionate] love in the context of client-therapist relationships was addressed in two of my doctoral-level psychology classes, once by a professor's initiative ("You gotta find the love, people. You've got to find at least one thing to love about your client."), and once by my own initiative (upon which several classmates appeared free to express feelings of love for some of their clients as well). One might argue that a class on the phenomenon of love in clinical work might be a welcome addition to any number of courses in a clinical psychology curriculum.

Lastly, it became clear that it was important for participants to consider the phenomenon of hope in their personal experience before identifying and drawing upon its presence and function in a particular psychotherapy encounter. The first two interviewees requested that we begin with their personal experience of hope before moving onto their clinical experiences. They needed "prime the pump," and touch the

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dynamic and felt sense of the phenomenon, in order to move beyond it to identify and engage a broader set of “hope experiences.” Revising the order of core interview questions so that they began with each participant’s personal experience and touchstones of hope was consistent with an appreciative inquiry model that follows the lead of the participant responses and questions. In hindsight this is an obvious starting point for a line of inquiry that explores hope; at the time it was surprising discovery, though one that was easily identified and revised.

The Adult Hope Scale

Midway in my research, a lively discussion ensued among my committee members and me regarding the utility of Snyder et al.’s (1991b) Adult Hope Scale (AHS) as an accurate means of measuring a clinician’s hope. The instrument’s validity was not in question. Rather, there were philosophical differences about the very nature of hope. Was hope a cognitive process or a phenomenological one? Could an AHS score shed any light on the relational qualities that characterize and cultivate an individual’s hope or would the tool’s empirical scoring system leave these relational elements unattended? Ultimately, we heeded the counsel of the director of research and agreed that the AHS scores might enhance the themes that would emerge out of the qualitative/interview portion of the study.

It is true that the AHS does not reflect or assess collective/group-centered thinking. Rather, it is reflective of the individualistic thinking that characterizes Western society. This reality is outlined clearly in the literature review. The AHS is an instrument that is useful to assess an individual’s sense of agency and ability to plan, but

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limits access to many other qualities that reflect and nurture hopeful thinking. This said, I found the mean scores of participants clarifying in two ways:

The Adult Hope Scale	Hope Self-Rating*	AHS Total Score	AHS Agency Sub Score	AHS Pathways Sub Score
Mean Score/Maximum Possible Score	8.25/10	54.87/64	27.87/32	22.20/32

* *Participants were asked the following question: On a scale of 1-10 (1 lowest, 10 highest), how hopeful do you consider yourself to be?*

First, I find it encouraging that participants scored a mean of 8.25 out of a maximum of 10 when asked to provide a *Hope Self-Rating*, and that their mean *AHS Total Score* was 54.87 out of a maximum of 64. Snyder's Adult Hope Scale (1991a) was validated on the scores of 347 undergraduate female and male students with a mean age of 21.77 and 22.22, respectively. Years later, Snyder and his colleagues administered the AHS to a several of additional populations, including patients seeking psychological treatment and war veterans suffering from post-traumatic stress disorder (Hansen, retrieved online).

Lopez, Ciarlelli, Coffman, Stone & Wyatt, (2000) report the average hope scale score among these varied populations is 48, though they identify that the average undergraduate score was significantly higher than that of the clinical populations. It is tempting to claim that the current study's AHS mean total score of 54.87 is six to seven points above the reported average of 48, but many variables make this assumption ambiguous if not unlikely. I would need the demographic information of the clinical populations Snyder assessed before similarities and differences to the current study could be identified. Additionally, the multiethnic composition of the present study's

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participants and the small sample size must be taken into consideration before comparisons or generalizations could be made.

Finally, the 5.67-point difference between the mean Agency Sub-score of 27.87 and the mean Pathways Sub-score of 22.20 supports the recommendation that clinicians might benefit from activities that cultivate creative thinking and imagination, personal qualities that likely have influence on an individual's ability to plan for the future, the quality for which Snyder, et al. (1991a) dubbed the term, "way power."

Strengths and Limitations

It can be viewed as both advantageous and disadvantageous that I have worked as an intern for twenty-two months alongside each study participant. I have grown to know some of them fairly well and others very little in our shared professional setting. Some have served as my clinical supervisors, others as occasional office mates. Still others I have only shared time and space with in more formal staff meetings.

I left each interview feeling that I had been given a generous gift, and recognizing keenly the vulnerability and intimate personal experiences that interviewees had shared with me. I do not know if this depth of sharing would have occurred had we never met or engaged one another even casually. Then again, might an even greater depth of sharing occurred if these people were talking to an examiner that they would not see again? I lean towards the belief that our knowing one another, however casually, supported a sense of trust and safety that allowed a personal story and depth of reflection to unfold, but I contend that there may have been advantages to interviewing clinicians that I did not know and had never met.

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I had no problem soliciting clinicians from this health center to participate in this study. In fact, several other staff members offered to interview after I had met my quota of eight. For the sake of time, and because I believed that I had gathered enough rich data and themes, I thanked them but declined their offer. I do not believe that additional themes would have emerged from a larger sample size within this clinic, but I wonder if interviewing clinicians from neighboring or distant community health centers might have elicited additional themes, particularly in response to core question number eight, “Please comment on anything about the culture of the clinic that contributed to your sense of hope in that (clinical) experience?”

In analyzing the data I found that because of the phenomenological nature of the subject matter, common themes emerged in response to different core questions rather than from identical core questions. Still, I chose to analyze the data by question rather than by participant. This did not allow for themes that were shared by participants, but that were shared in response to different core questions, to emerge. I was conflicted over how to honor the integrity of a particular inquiry/question while also honoring the shared themes that eventually emerged over the course of a full interview. I decided to remain true to the responses and themes as they emerged in response to each core question, but to create an additional chart of subject-endorsed themes that emerged across questions and interview (See Appendices).

Recommendations for Future Research

This study sought to explore the phenomenon of hope in the work and therapy relationships of mental health clinicians whose clients suffer with chronic trauma histories and often, material poverty. Through a comprehensive review of literature and

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through interviews with psychotherapists about personal and professional experiences of hope, many insights and additional questions were raised. This study sought to identify themes rather than conclusive answers, and a mixed method approach that integrated an appreciative mode of inquiry, a semi-structured interview, and a simple survey instrument, seemed well suited to this goal and subject matter.

Several ideas for future research arose in the process of completing this study, including:

- One might interview dyads of client and clinician, together or separately. This would offer additional insights into the dynamic and function of hope in the therapy relationship and process, and highlight potentially valuable similarities and differences between client and therapist.
- One might administer the Adult Hope Scale to both clinician and client and explore if and/or how variations in scores impact the psychotherapy process.
- Arndt's (2004) culturally modified/collectivist-focused Adult Hope Scale provides a foundation for further development of a cross-cultural scale that assesses non-Western populations.
- A longitudinal study that follows clinicians, post-interview, to explore the impact of "asking the questions" may provide data that helps clinicians *and* clinics to better understand and appreciate what personal and organizational qualities help clinicians maintain and cultivate hope- and avoid burnout- in a culture of such demanding work.
- Exploring what kinds of organizations sustain hope, while also serving marginalized and/or suffering populations, emerges as a worthwhile endeavor.

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What are the necessary qualities for maintaining and cultivating hope in the midst of dire circumstances? What kind of intentionality and structure do they utilize to create a culture of hope?

- One might conduct a case study in which the presence and function of hope are traced over a course of psychotherapy.

Implications for Clinical Practice

Exploring and assessing a positive trait such as hope stands out as novel and perhaps as a questionable intervention when viewed against the historic backdrop of a field that continues to base diagnostic evaluation on the presence of pathology. Yet it is clear from the data collected in this study that 1) hope plays a significant and positive role in the lives of many people across cultures that suffer and seek mental health services, 2) hope is an equally vital need in the lives of the clinicians who serve them. In light of this shared, human need for hope, I offer the following insights and recommendations to clinical practitioners, and those who train them.

Most of the clinicians interviewed for this study acknowledged that the psychological nature and function of hope was not something that had been drawn into conscious awareness prior to this study. All noted the importance of hope in psychotherapy process, and the mutuality and reciprocal sharing of hope in the therapeutic relationship, yet also noted it was something they rarely, if ever, reflected upon. Simply put, no one had ever engaged them in a dialogue about hope as it relates to their professional practice. One must wonder why something so significant remains overshadowed or neglected?

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One simple response to this unintended disregard of hope is for clinicians to be more intentional about addressing issues and factors of hope in their treatment relationships. We can begin to use the language of hope intentionally in session, mindful that asking the question “What do you hope for?” is itself an intervention. Affirming our clients’ efforts and imaginings can usher in a deeper level of conversation and new perspectives. We can reference images and metaphors of hope and invite clients to articulate their own touchstone images as part of the work. We can create meeting environments where such images and symbols become part of the physical space we share with clients week after week. We might share with clients our own images and metaphors of hope, trusting that “our ability to welcome them into our experiential worlds is often transformative in restoring a sense of emotional dignity” (Jacobs, 2009, p. 106).

Administering the Adult Hope Scale (AHS) to clients and taking the time to process together the questions and results is a quick and simple means of introducing the topic of hope. For those of us working with long-term clients, we could administer the instrument (bi) annually to identify areas growth and those in need of tending.

Several participants shared variations on the miracle question as a means of helping their clients give voice to their hopes and dreams. Questions such as “what needs to happen in the next twelve months to make this the best year of your life?” are meant to spur an individual’s desires and imagination. They cultivate a way of thinking that begins to give birth to “the more, the better, the something different” for which so many clients long but lack vision.

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William Lynch (1965) speaks poignantly about “the firm and constant relationship between hope and wishing” (p.129). “I assume that wishing and wanting reality in any or all its forms is basic to hope, and that it is hard to think of anything more in need of emphasis and analysis among us” (p. 130). I believe that we are all capable of imagining; that this ability to imagine is a birthright gift that requires cultivation like any other gift. Snyder et al. (1991a) dub it “way power” and Lynch (1965) calls it an interior gift. No matter what we call it, this universal human capacity has the power to shift our conscious awareness and paint dreams for a different future.

Clinicians have an opportunity to work with clients to mine and cultivate their hopes and imaginations as sparks or instruments that can help them to meet immediate needs and (re) discover deeper aspirations. “To have no wishes, or to not know what (one’s) real wishes are, is to be separated from oneself” (paraphrased, Lynch, 1965, p. 130).

The present study’s literature review and data results speak convincingly to the contagious nature of hope in therapy and to the role of affect-laden content in its transmission. Surely the emotions that accompany fatigue and burnout are also contagious and transmitted through the therapy relationship. To an extent, this is the reason the threat of clinician burnout exists within this field in the first place. “Hope gives the clinician courage to continue his or her daily labors” (Shechter, 1999, p. 372).

Hope is the most fundamental experience one can have as a human being and it begins to be cultivated deeply in people’s lives at an early age (Erikson & Capps, as cited in Kwan, 2010, p. 52). Clinicians who tend their own hopes and imagination are in a position of strength to invite and teach their clients the skills and habits to do the same.

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More than two decades ago, positive psychology invited mental health professionals to consider the strengths and virtues that their client's possess alongside the struggles that also might characterize their lives. In order to be bearers and agents of hope (Capps, 2001) for our clients we must recognize and tend hope's presence, and absence, in our own lives.

The Clinician's Inner Congruence.

Participants often spoke beautifully about that which is given voice in therapy and that which remains unspoken but nonetheless expressed. Albert recognized that there is power in "what I project when the patient sits with (me) is a kind of hope that there can be a better future." Katrina described a silent but powerful gaze that she shared with a despairing client. "It was a way (for me) to say to her, 'I'm not giving up' ... to say 'Here I am.' It was a connection where words weren't being used...I felt it." Kristen spoke of the shared and dynamic space that characterizes psychotherapy using the language of presence. "We all have a presence, and in therapy what's unspoken... people engage with our presence as much as with our words, our body language and how we sit with them. It's a very powerful facilitator of therapy, of engagement in the relationship..."

Contemporary psychoanalytic theory understands this shared dialogical space- both the spoken and unspoken- as an intersubjective field that is shaped by both client and clinician. Jacobs (2009) explains:

The intersubjective field concept is a doorway to a dialogical sensibility. That is, it is a small step from saying that our emotional lives are utterly interdependent, shaped within intersubjective fields

of reciprocal, mutual, emotional influence, to saying that the quality of entire experiential worlds are contingent on the qualities of relatedness that we inhabit (p. 107).

Each study participant emphasized the mutual transmission of hope in the therapeutic relationship and process. Jacob's offers us a meaningful way to make sense of this interpersonal and intrapsychic dynamic, and intersubjective theory reminds us that as co-participants "in the emotional lives of our patients" (Jacobs, 2009, p. 107), self-awareness and self-reflection are vital and requisite tools of our trade.

Attunement to feelings of transference and counter-transference provide therapists with glimpses and snapshots of the emotional life we share with our clients.

Tim, the psychiatrist in the present study, was the only clinician that spoke of the helplessness he felt in response to his client's experience of hopelessness:

We face some difficult situations and it's not easy. A man whose son was kidnapped, he paid the ransom, but they killed his son anyway. He could not find the hope. The boy was his life and he could not reverse what happened. It was so difficult, and I was afraid and even ashamed to tell him things will get better. I didn't find any words. How do you give hope to that guy? What hope are you going to give?

Shechter (1999) proposed, "in order to be a hopeful clinician one must have an emotional tolerance for the reverse, 'a deep sense for the tragic' in life (Pruyser, as cited in Shechter, 1999, p. 373). Each participant in the present study looked to their personal journey - life's suffering, triumphs, and meaning - as a touchstone of hope. Perhaps hope is most fully savored when we experience it against a backdrop of life's inevitable moments of tragedy of hopelessness. Is this not the "real hope" of which Groopman

(2004) speaks, and which many of us know so well? “A therapist can only attune to the patient from the depths of his or her own experiential world” (Jacobs, 2009, p.109).

Psychology trainees are encouraged to undertake their own psychotherapy so that, among other things, they know what it is like to sit in the chair of the client. “A consistently hopeful state of mind may be unattainable perfection. Nevertheless, an empathic-self that is consistently hopeful is a lifelong goal” (Shechter, 1999, p. 373). If we conceive ourselves to be vital partners in the “I-Thou” (Buber, 1970) relationship and dialogue of psychotherapy, we need an ability to hold “the delicate balance between hope and hopelessness... to stay in touch with both sides of that emotional equation” (Shechter, 1999, p. 373). I believe that the only way we can do this authentically is to undertake the same inner journey and personal work that we invite our clients to engage in each time we meet.

Holding Hope and Hopelessness.

Tim’s willingness to express the feelings of profound helplessness he experienced in response to the anguish of a client/father whose child was kidnapped and murdered invites us to directly consider the phenomenon of hopelessness. What is hopelessness... and what is its relationship to hope in the work of psychotherapy?

Winnicott (1958; as cited in Ruvelson, 1990) speaks of hopelessness as “the unbearable nature of experiencing (despair) without any knowledge of where it will end” (p. 147). Lynch (1965) tells us “it is the worst of human evils and the most painful...” (p. 47). It seems to me that hopelessness is more than the absence of hope; the experience likewise embodies the absence of connection, real or perceived, to that which one deems

most precious in life- a child, meaning and purpose, God, or any other priceless element of life.

“Hopelessness decides that even if there were interior resources and even if help were available- *there is no use*, no good, no sense in action or in life. Here we are up against the lack even or a wish to do or to live” (Lynch, 1965, p. 50). I imagine that sitting with the profundity and passivity of a client’s hopelessness is a challenge of endurance for even the most dedicated clinician, and that feelings of helplessness similar to those that Tim shared may emerge quickly. Yet our willingness to sit with feelings of helplessness and brokenness, our own and our client’s, is its own gift and relational intervention. A “therapists’ capacities for containment are... as germane to the successful treatment of their clients’ hopelessness as is (their) ability to come into contact with but not become overwhelmed by or oblivious to their own potential for experiencing sadness and grief” (Ruvelson, 1990, p. 146). Tim’s failure to find words to respond to his client’s anguish may have been, in fact, the most “successful” thing he could have done. Rather than respond with words that he felt rang hollow, he sat silently and honestly with his own feelings of helplessness. Perhaps that quiet gesture of presence and solidarity acknowledged and contained his client’s pain in a way that words never could.

The present study interviewed clinicians who work daily with refugee clients and others impacted by chronic trauma and material poverty. The need to provide clients with a therapeutic relationship and environment that contains their anguish is a clear but understandably challenging goal. Tim’s experience of sitting with the tragedy in his client’s life was profound, but I imagine it is not unique for psychotherapists within this

setting. The need for these clinicians to possess an inner capacity that allows them to hold the hope, and contain the hopelessness, of their client's life experiences appears central to their work.

“Above all, it is the therapist's willingness to simultaneously believe the client's suffering, and believe in his or her capacity to overcome it that can, perhaps for the first time in the despairing client's life, help to make hope and its maintenance an ambitious and attainable goal” (Ruvelson, 1990, p. 146).

The experiences of hope and hopelessness- however polarized they may appear - coexist on a spectrum of lived humanity. “There is nothing wrong with our hopelessness as long as it does not get into our hope,” Lynch (1965) tells us (p. 47). The goal is not for us to eliminate either, but to allow each their “absolute identities” (Lynch, 1965, p. 47) in the fullness of our human experience.

Future Visions

Earlier I wondered why a variable as significant as hope remains overshadowed or neglected in the therapeutic work. I imagine that in the time pressured environment of managed care that productivity requirements and paperwork often fill the brief moments of rest and reflection that might otherwise nurture thoughts of hope. It is not unique to the urban community health center in which this study took place that clinicians see seven to ten consecutively scheduled clients with only one 45-minute lunch hour giving pause to a full day's work. If clinics require therapists to meet high productivity quotas in a limited time period, then both clinics and clinicians need to

think creatively about how to integrate even small amounts of reflection time into their individual and communal schedules.

For example, I utilized a scheduled monthly peer supervision meeting to introduce my research to my colleagues' and invite participation. The presentation and ensuing conversation lasted less than 90 minutes, but the tenor and content of the questions and dialogue was rich, engaging, and gratifying. Approximately fifty-percent of the behavioral health staff attended; those who did not attend utilized the time to catch up on clinical notes and other required paperwork, something I have done myself when I felt pressured for time. I understand and empathize with the decision of those who did not attend, however, I view their absence, and that of their would-be contributions, as a personal loss for them and a collective loss for the behavioral health team.

Core question number eight asked participants to "please comment on anything about the culture of the clinic that contributed to your sense of hope in that (therapy) experience? Fifty percent of participants had no response, and simply answered "no" or "not really." The tone to their responses suggested that the culture of the clinic was a hindrance more than it was helpful. This is speculation; no formal follow-up questions were posed to further explore or elicit clarification. Later, in response to core question number nine: "Is there anything else related to hope that you'd like to say that you haven't had the opportunity to share?" four out of the eight participants talked about the risk of experiencing burnout when working with challenging populations in the context of a community health center. Perhaps Ramona says it best, "I have been here five years but sometimes it feels like ten."

With whom does the responsibility to support these clinicians rest? I previously asserted my opinion that therapists would benefit from personal therapy and soul searching. But how much responsibility for supporting therapists to do their best work lies with the clinic, the organization's leadership, and the mental health system-at-large?

In her interview, Katrina felt that she benefited tremendously from her clinical supervisor's effort to create a learning environment in which "hope is not considered naïve." Her fellow clinical intern, Kristen, echoed this sentiment and her appreciation of the support provided by the director of training. Supervisors and clinical directors can use peer supervision or corporate retreat time to intentionally cultivate a similar environment and culture at a systemic level. Administering the AHS and reflecting upon the results as a staff or team, with or without an outside facilitator, is one simple way to "invite hope" into the culture of the clinic.

I heard a public radio segment recently that focused on the valuable commodity of time. It highlighted the innovation of one organization for rewarding its employees with sabbaticals or play days rather than with money or material goods. The organization recognized the increasing value of time in today's hectic work culture, and the relationship between time and creativity. Company leadership believed that everyone benefits from unstructured time that allows for personal replenishment and creativity to transpire - employees, employers, and the clients who benefit from an employee's fresh ideas. I imagine that busy clinicians, and perhaps especially those working with marginalized and materially impoverished populations, would be nurtured immensely by this same corporate awareness and compensation. I imagine that time

given for reflection and renewal would positively impact the presence and creativity they bring to their work, and help them to avoid the burnout that lurks in the shadows.

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Appendix 1.1

Characteristics of Often-Used Hope Measures

Table 6.1. Characteristics of Often-Used Hope Measures

Name of Hope Index	Target age	Number of items	Administration time (min.)	Internal consistency	Test-retest reliability	Construct validation
Hope scale Erickson, Post, and Paige (1975)	Adult	20	Brief		.793** (I) .787** (P)	Some support
Gottschalk Hope scale Gottschalk (1974)	Adult	7 categories	5 (per speech sample)		—	Some support
Herth Hope scale Herth (1981)	Adult	32		.75-.94	.89-.91	Some support
Nowotny Hope scale Nowotny (1991)	Adult	47		.90		Some support
Miller Hope scale Miller and Powers (1988)	Adult	40		.93	.82	Some support
Expected Balance scale Staats (1989)	Adult	18	Brief		.66**	Strong support
Hope Index Staats and Stassen (1985)	Adult	18	Brief		.74**	Strong support

* $p < .05$ ** $p < .01$

(Lopez, Snyder & Teramoto-Pedrotti, 2004, p. 101-102)

Appendix 1.2

Characteristics of Snyder Hope Scale

Table 6.2. Characteristics of Snyder Hope Scales

Name of Hope Index	Target age	Number of items	Administration time (min.)	Internal reliability	Construct validation
Hope scale	15-100	12*	2-5	.70-.80	Excellent
Domain Specific Hope scale	15-100	48	7-15	.93	Strong
Children's Hope scale	7-16	6	2-5	.72-.86	Excellent
Young Children's Hope scale	5-7	6	2-5	.86	Some Support
State Hope scale	15-100	6	2-5	.90 _s	Strong
Hope scale-Observer	15-100	8	2-5	—	—
CHS-Observer	7-16	6	2-5	—	Some Support
YCHS-Observer	5-7	6	2-5	—	Some Support

*The Hope scale has 12 items: four reflect pathways, four reflect agency, four are distracters.

Note. — indicates that data regarding psychometric properties are not available because the reliability and validity of these measures have not been examined rigorously.

(Lopez, Snyder & Teramoto-Pedrotti, 2004, p. 101-102)

Appendix 2.

Adult Dispositional Hope Scale Items and Directions for Administering and Scoring the Goals Scale

Directions

Read each item carefully. Using the scale shown below, please select the number that best describes YOU and put that number in the blank provided.

1 = definitely false 2 = mostly false 3 = mostly true 4 = definitely true

1. I can think of many ways to get out of a jam.
2. I energetically pursue my goals.
3. I feel tired most of the time.
4. There are lots of ways around any problem.
5. I am easily downed in an argument.
6. I can think of many ways to get the things in life that are most important to me.
7. I worry about my health.
8. Even when others get discouraged, I know I can find a way to solve the problem.
9. My past experiences have prepared me well for my future.
10. I've been pretty successful in life.
11. I usually find myself worrying about something.
12. I meet the goals that I set for myself.

Notes: When administered, we have called this the “Goals scale” rather than the “Hope scale” because on some initial occasions when giving the scale, people became sufficiently interested in the fact that hope could be measured that they wanted to discuss this rather than taking the scale. No such problems have been encountered with the rather mundane title “Goals scale.” Items 3, 5, 7, and 11 are distracters and are not used for scoring. The pathways subscale score is the sum of items 1, 4, 6, and 8; the agency subscale is the sum of items 2, 9, 10, and 12. Hope is the sum of the four pathways and four agency items. In our original studies, we used a 4-point response continuum, but to encourage more diversity in scores in our more recent studies, we have used the 8-point scale:

1 = definitely false 2 = mostly false 3 = somewhat false 4 = slightly false

5 = slightly true 6 = somewhat true 7 = mostly true 8 = definitely true

Scores using the 4-point continuum can range from a low of 8 to a high of 32.

For the 8-point continuum, scores can range from a low of 8 to a high of 64.

(*Note.* From Snyder, et al. (1991). The scale can be used for research or clinical purposes without contacting the author.)

Appendix 3.

The Adult Hope Scale (AHS)

Directions: Read each item carefully. Using the scale shown below, please select the number that best describes YOU and put that number in the blank provided.

- 1. = Definitely False
- 2. = Mostly False
- 3. = Somewhat False
- 4. = Slightly False
- 5. = Slightly True
- 6. = Somewhat True
- 7. = Mostly True
- 8. = Definitely True

- ___ 1. I can think of many ways to get out of a jam.
- ___ 2. I energetically pursue my goals.
- ___ 3. I feel tired most of the time.
- ___ 4. There are lots of ways around any problem.
- ___ 5. I am easily downed in an argument.
- ___ 6. I can think of many ways to get the things in life that are important to me.
- ___ 7. I worry about my health.
- ___ 8. Even when others get discouraged, I know I can find a way to solve the problem.
- ___ 9. My past experiences have prepared me well for my future.
- ___ 10. I've been pretty successful in life.
- ___ 11. I usually find myself worrying about something.
- ___ 12. I meet the goals that I set for myself.

Note. When administering the scale, it is called The Future Scale. Summing items 2, 9, 10, and 12 derives the agency subscale score; adding items 1, 4, 6, and 8 derives the pathway subscale score. Summing the four agency and the four pathway items derives the total Hope Scale score.

(Note. From C. R. Snyder, University of Kansas

Source: <http://www.ppc.sas.upenn.edu/ppquestionnaires.htm#hopescale>)

*We cannot fall out of this world, so let hope spring eternal!*²

² From Donald Capps. *Agents of Hope: A Pastoral Psychology*, 2001, Eugene, OR: Wipf & Stock Publishers.