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Hope in Cognitive Psychotherapies: On Working With Client Strengths

Jennifer S. Cheavens, PhD
Duke University Medical Center
Durham, NC

David B. Feldman, PhD
Santa Clara University

Julia T. Woodward, PhD
Duke University Medical Center
Durham, NC

C. R. Snyder, PhD
University of Kansas, Lawrence

The field of psychology, which is traditionally rooted in the study and treatment of psychological disorders and pathology, recently has begun to embrace an examination of individual, as well as societal, strengths and virtues. This subspecialty within psychology, known as positive psychology, can be defined as the attempt to understand the characteristics and processes that contribute to optimal functioning, flourishing, and resiliency. The purpose of the present article is to draw a link between traditional psychology and positive psychology using the example of the positive psychological construct of hope. Specifically, we explore the ways in which hope theory can be incorporated into traditional forms of cognitive therapy for symptom reduction and elimination. First, the theory of hope (Snyder, 1994) is introduced and the concept of hopeful thought is defined. Next, we explore the distinction between Snyder's definition of hope and Beck's definition of hopelessness (Beck, Weissman, Lester, & Trexler, 1974). Finally, we present possible strategies for utilizing hope concepts in cognitive therapies. Studying individuals with high levels of hope has resulted in a wealth of information about the ways these individuals overcome obstacles and find multiple ways to the goals that they have set for themselves. Integrating these lessons into empirically based treatments for symptom reduction is likely to result in a synergy that utilizes the most sound aspects of both traditional psychology and positive psychology.

Keywords: hope; positive psychology; treatment; optimal functioning

In the Seligman and Csikszentmihalyi (2000) article on positive psychology, psychologists are described as knowing quite a bit about how people survive and recover from adversity, but knowing very little about what makes people flourish. In this latter regard, positive psychology has arisen with a focus on human strengths and potentials rather than the more

traditional problem-focused or "fixing" framework (Sheldon & King, 2001; Snyder & Lopez, 2003). Thus, because psychotherapy typically focuses on pathology, it has been difficult to draw a link between it and this relatively new emphasis on strengths and assets.

It seems, however, that these links may be intuitive and basic. If psychotherapy cannot help an individual to explore that which makes life worth living, what motivation does the individual have to participate in the arduous work of treatment? Within the context of the medical model, the purposes of therapy are to solve problems and to alleviate unpleasant states. Research suggests, however, that most people maintain high levels of satisfaction despite the fact that they continually encounter obstacles and difficulties throughout their lives (Meyers, 2000). Rather than simply eliminating or changing problem states, therefore, those therapists who seek fulfillment in clients' lives must focus on the treatment goals of identifying and enhancing strengths. Thus, combining positive-psychology concepts with previously empirically based symptom-reduction strategies may allow therapists to offer treatments that not only alleviate immediate symptoms, but also build strengths and increase long-term life satisfaction (Snyder & Lopez, 2003).

Our goal in this article is to highlight the ways in which traditional symptom-focused cognitive treatments can be augmented with techniques derived from a positive-psychology model known as hope theory (Snyder, 2000; Snyder et al., 1991; Snyder, McDermott, Cook, & Rapoff, 2002). The reader will likely note that skilled cognitive therapists already use many of these techniques; they probably do so, however, without paying heed to the positive psychology theoretical framework. Before considering these techniques, it is necessary to describe hope theory, which is the framework within which we present these techniques. We will begin by defining hope and contrasting it with a related construct that already has received considerable attention—hopelessness.

A Definition of Hope

This movement toward a "positive psychology" is not new (see McCullough & Snyder, 2000; Snyder & McCullough, 2000). Since the 1950s, physicians and psychologists have pointed to the role of hope in health and well-being (Frankl, 1963; Menninger, 1959; Schmale, 1972; Siegal, 1986). For example, in his 1959 address to the American Psychiatric Association, Karl Menninger suggested that the power of hope was an untapped source of strength and healing for patients. In this regard, these early writers on this topic defined hope as a positive expectancy of goal attainment (Menninger, 1959; Stotland, 1969).

In 1991, Snyder proposed a cognitive model of hope that similarly focuses on goal attainment. Unlike previous theories, however, Snyder's model focuses not only on expectancies, but also on the motivation and planning that are necessary to attain goals. Specifically, Snyder and his colleagues (1991) define hope as "a positive motivational state that is based on an interactively derived sense of successful (a) agency, and (b) pathways (planning to meet goals)" (p. 287). We will detail each of these components of hope.

Goals as a Component of Hope

One premise of hope theory is that people typically think in terms of goals (Snyder, 1993, 1998, 2002; Snyder, Cheavens, & Michael, 1999). For example, if we asked our clients about what they were thinking about at any given time, the answers probably would involve their goals. On this point, Snyder, Feldman, Taylor, Schroeder, and Adams (2000) have proposed four categories of hopeful goals: approach goals (moving toward a desired outcome); forestalling negative outcome goals (deterring or delaying unwanted occurrences); maintenance goals (sustaining the status quo); and enhancement goals (augmenting an already positive outcome).

In addition to classifying types of goals, it also is useful to determine the environmental circumstances that increase or decrease hopeful thinking (Snyder, Cheavens, & Sympson, 1997). One such environmental factor may be the certainty level of goal attainment. Researchers have found that setting goals of moderate certainty characterizes high hope (Averill, Catlin, & Chon, 1990). Moderate certainty of goal attainment probably enhances hope because it increases motivation; when goals are perceived to be too difficult (i.e., almost impossible) or too easy (i.e., "a sure thing"), people likely do not try as hard to reach them. In the recent incarnation of hope theory, Snyder, Rand, and Sigmon (2002) have provided examples of high-hope individuals injecting uncertainty into extremely high-certainty goals (e.g., getting something done with flair vs. just getting it done) or successfully completing tasks that were previously thought to be exceedingly low in certainty. Thus, it is likely that an outside observer may have difficulty in accurately judging another individual's level of perceived certainty in a goal-pursuit situation. It is likely, however, that hope will be highest when goals are subjectively perceived as being in the intermediate range of attainment certainty.

Pathways Thinking as a Component of Hope

The second component of hope theory involves thinking about one's capacity to find workable routes to reach coveted goals. As such, pathways thinking reflects the perceived ability to produce successful avenues to desired goals (Snyder, Sympson, Michael, & Cheavens, 2000). Pathways thinking is a way to link the present to the future through one's goals. An individual must be able to create an image of him or herself in the present moment, an image of where he or she would like to be, and an image of a route to link the present to the desired future. Research on athletes, for instance, shows that sports performances are increased when individuals envision the sequence of steps necessary to perform well (Mahoney & Avener, 1977; Whelan, Mahoney, & Meyers, 1991). High-hope individuals also should be more skilled at creating a detailed, well-articulated primary route to goal attainment. Additionally, research has shown that high- as compared to low-hope individuals are better able to produce alternative routes to goals, particularly when primary routes are impeded (Irving, Snyder, & Crowson Jr., 1998; Snyder, Sympson, et al., 1996).

Agency Thinking as a Component of Hope

The ability to generate adaptive goals and perceived pathways will not result in actual goal attainment unless the individual also has sufficient motivation to implement those routes. Agency thinking involves thoughts about one's ability to initiate and sustain movement along pathways toward desired goals, even when faced with impediments. As exemplified in the classic children's story *The Little Engine That Could* (Piper, 1978), agency thoughts such as "I think I can" are the fuel that powers goal-pursuits. Related to this point, there is evidence that high- rather than low-hope individuals show a greater preference for agency-affirming statements (e.g., "I can do this" and "I am not going to be stopped"; Snyder, LaPointe, Crowson, & Early, 1998).

The Temporal Relationships of the Components of Hope

Both pathways and agency thinking must be present in some degree for hope to thrive. Snyder (2002) states that these two components are related both additively and iteratively. For example, an individual is classified as high in hope to the extent that he or she is high both in pathways and agency thinking. Although an individual with a high-agency, low-pathways profile may look very different from an individual with a low-agency, high-pathways profile, it is possible that they would have the same overall score as measured by one of our assessment instruments (e.g.,

the Hope Scale [Snyder et al., 1991], the State Hope Scale [Snyder et al., 1996], and the Children's Hope Scale [Snyder et al., 1997]).

In addition to this additive relationship, it has been theorized that the agency and pathways thinking processes are iterative (Snyder, 1995, 1996). Thus, when one is successful in planning routes to a goal, he or she is likely to be energized by the possibility of initiating and maintaining these routes. Conversely, when an individual is excited and energetic about beginning a goal pursuit, he or she also is likely to have more success in generating routes to the goal. Thus, there are ripple effects between pathways and agency thinking (Snyder, 2004; Snyder, Rand, King, Feldman, & Woodward, 2002).

Contrasting Snyder's Hope and Beck's Hopelessness

As previously noted, attention to hope in the process of psychotherapy was widely discussed as early as the 1950s (Frankl, 1963; Menninger, 1959; Schmale, 1972; Siegal, 1986; Stotland, 1969). In reality, however, the focus of traditional, medical-model psychotherapies has been on removing or reducing hopelessness as opposed to actively building hopeful thought. Given the robust link of hopelessness to suicide attempts and completions (Beck, Brown, Berchick, Stewart, & Steer, 1990), the reduction of hopelessness is an important target of treatment. For a variety of reasons, however, targeting hopelessness in treatment is not the same as targeting hope (see Snyder & Rand, 2004).

Beck, among others, has identified hopelessness as one of the fundamental symptoms of a variety of psychopathological conditions, particularly depression, suicidal ideation, and completed suicides (Beck, Weissman, Lester, & Trexler, 1974). These authors based their definition of hopelessness on Stotland's (1969) proposal that hopelessness comprised a system of negative expectancies concerning one's self and future. Thus, Beck and his colleagues designed a 20-item hopelessness scale using statements that were believed to measure pessimistic and negative attitudes toward the future. The resulting scale has proven to be a stronger predictor of both suicidal ideation (Dyer & Kreitman, 1984; Wetzel, Margulies, Davis, & Karam, 1980) and completed suicides (Beck et al., 1990) than has severity of depressive symptoms alone.

Therefore, it would appear that the Hope Scale (Snyder et al., 1991) and the Hopelessness Scale (Beck et al., 1974) might measure the inverse of the same construct. There are, however, two main distinctions that differentiate hope and hopelessness as measured by these two scales. First, Beck's definition of hopelessness is a "system of cognitive schemas whose common denomination is negative expectations about the future" (Beck et al., 1974, p. 864). This type of generalized expectancy about the future is closer to Scheier and Carver's (1985) definition of optimism than Snyder's (1994) model of hope. The title of the article that introduces the Hopelessness Scale, *The Measurement of Pessimism,* is further evidence of this congruence. Thus, Beck's definition of hopelessness emphasizes outcome expectancies and de-emphasizes the role of personal mastery and other bases of outcome expectancies. Snyder's definition of hope (1994), on the other hand, places equal emphasis on outcome expectancies (i.e., agency thinking) and individuals' expectancies about whether or not they will be able to influence these outcomes (i.e., pathways thinking).

Second, the items on the Hopelessness Scale are singularly focused on expectations about one's future (Beck et al., 1974). In contrast, the Hope Scale (Snyder et al., 1991) includes items that assess past and present experiences, along with a de-emphasis on individuals' abilities to forecast the future. In fact, unlike the Hopelessness Scale, none of the items on the Hope Scale explicitly ask participants to imagine or predict their future experiences. Furthermore, Snyder's (2002) most recent conceptualization of hopeful thought suggests that one's learning history and the processes involved in one's present goal pursuit are more salient in determining hope

than are expectations about the future. Thus, the temporal foci of these scales further differentiate the underlying constructs of hope and hopelessness on which they were constructed.

It appears that hope and hopelessness are two distinct, yet related, constructs. As such, it is probably useful to target both constructs in psychotherapy. Therapeutic modalities that target hopelessness have been the focus of several articles (e.g., Beck, Rush, Shaw, & Emery, 1979; Linehan, 1993; Townsend et al., 2001), and they will not be expounded in detail here. The remainder of this article will discuss ways in which hopeful thought can be increased within the context of cognitive therapies.

Introducing Hope Into Cognitive Psychotherapies

In this section, we discuss ways of instilling and strengthening hopeful thinking in clients who are participating in cognitive treatments. Many skills associated with hopeful thought already are present in extant empirically supported treatments. For example, several therapies focus on appropriate goal setting (goals), problem-solving techniques (pathways), and positive self-talk (agency). Therefore, incorporating additional hope techniques into already existing frameworks of therapy often is a relatively straightforward proposition. In fact, hopeful thinking can play a major role in virtually every phase of cognitive treatment.

Next, we divide therapy into three major phases—assessment/orientation, active treatment, and termination—and provide examples of how techniques derived from hope theory are useful in each of these phases.

Hopeful Thinking in the Assessment and Orientation Phase

Hopeful thought can play an important role in cognitive therapy—even in the earliest assessment and orientation sessions. Most therapeutic contracts emphasize the alleviation or amelioration of distress and symptomatology. Accordingly, assessment usually focuses on ways in which the individual is suffering. From our perspective, it is unfortunate that most assessments of psychopathology do not include a thorough investigation of strengths and successes, both past and present (Lopez & Snyder, 2003). There are at least two reasons for approaching a therapeutic contract from a hopeful perspective. First, research shows that positive emotions result from attaining goals (Diener, 1984; Omodei & Wearing, 1990). Enumerating past goal attainments will likely result in some influx of positive emotion even in the initial assessment session. As observed by Frank (1975), many clients enter therapy in a state of demoralization due to inability to overcome obstacles in their lives. Concentrating on past successes may be a first step toward remoralization. These processes are similar to recent speculations about the usefulness of benefit finding and benefit reminding (Tennen & Affleck, 1999, 2002). Second, without a solid understanding of the client's strengths when beginning treatment, it is difficult to know whether to rely on currently existing resources or to commence with additional skill building.

Setting agendas and defining targets also are relatively common features of the early sessions of most cognitive therapies. This is another instance in which hope theory may be useful. In addition to setting goals for removing distress, hope theory would encourage practitioners and clients to set goals that "stretch" the client (Snyder, 2002). In hope theory, goals that are difficult enough to be challenging, but easy enough to be accomplished, are called "stretch goals." Such goals encourage the client not only to "patch up" difficulties, but also to grow as an individual. Stretch goals also are likely to be set in other domains besides symptom reduction. For example, if a depressed college student presented for therapy, one goal might be to alleviate depressive

cognitions, thereby fostering a return to a previous state of health. A further stretch goal, however, might be to increase grades from the previous, nondepressed semester (Snyder, Feldman, Shorey, & Rand, 2002; Snyder & Shorey, 2002). Indeed, having higher hope can be related to better grades (Snyder et al., 2002). Another stretch goal might be to increase social connectedness by becoming involved in an organization that provides service to the community. Continuously setting and meeting stretch goals is a way to move oneself toward a more positive, strengths-based stance (Snyder, Lopez, Shorey, Rand, & Feldman, 2003). Stretch goals also should provide an answer to "What makes this life worth living and this work worth doing?" (Feldman & Snyder, 2005).

Once goals have been set, most cognitive therapies offer some theory of how to most effectively achieve the goal of symptom reduction. Here, the pathways component of hope therapy plays a significant role. For example, for anxiety disorders, it appears that exposure to feared stimuli is an essential pathway to symptom relief (Anthony, Craske, & Barlow, 1995; Heimberg, 1989). Thus, clearly explicating this pathway, as well as how obstacles along this pathway (e.g., discomfort, temporarily increased anxiety, etc.) will be addressed, are important to the viability of therapeutic progress. Cognitive therapies that are designed to treat other classes of disorder also offer equally well-specified and distinct pathways.

Although educating clients about effective pathways for symptom reduction is important, working with clients to design pathways that extend therapeutic work beyond this initial symptom-focused goal is another way to increase hopeful thought. If one imagines a schematic in which a protagonist is attempting to reach a particular endpoint by using a given route, one can imagine how this route actually might extend beyond what originally appeared to be the endpoint. This extension is moving from symptom reduction to actual enhancement of performance and satisfaction—the latter being at the heart of positive psychology. Asking a client to draw pathways (i.e., pathways mapping) can be a powerful tool in therapy. It may be especially powerful when encouraging clients to see past the endpoint of "feeling better" to an alternate endpoint of strengthening skills. Using pathways mapping in conjunction with stretch goals eventually will assist the client in determining that there never will be a true endpoint in developing strengths—the endpoint will keep moving as one approaches it.

Hopeful Thinking in the Active Treatment Phase

Once therapy goals are set and pathways have been constructed, the difficult work of actively pursuing these pathways begins. Although many cognitive therapies have demonstrated efficacious pathways to symptom reduction, it is likely that many of the demoralized clients who present for therapy lack the requisite agency to use these pathways. This observation is substantiated by the fact that many manualized treatments give specific instructions for how to present a treatment "rationale" or use "commitment strategies" to energize and motivate clients to use the pathways of the therapy (Barlow & Cerny, 1988; Beck et al., 1979; Linehan, 1993; Steketee, 1993). These strategies likely increase agency thinking through three mechanisms. First, because the components of hope iteratively influence one another, the client may experience an indirect increase in agency through the increase in pathways thinking. Second, the client may experience increased agency by observing a therapist as a model of hopeful thinking. That is to say, by laying out a well-articulated plan and expressing enthusiasm for that plan, the therapist is providing an *in vivo* example of how to bring these positive psychology concepts to life. Third, by using commitment strategies to challenge a client's dedication to the therapeutic process, the client is encouraged to verbalize his or her commitment, even when obstacles present themselves. Repetition of phrases such as "I want to do this," "I will do this," and "I know I can do this" can engender an increase and maintenance of agency thought.

Thus, balancing a vivid model of hopeful thinking with strong encouragement to express commitment will likely result in increased agency thinking and, ultimately, greater success in traditional treatment strategies.

Among the most important cognitive treatment strategies are monitoring and challenging dysfunctional automatic thoughts or self-talk. All forms of cognitive therapy address self-talk or self-statements. Similarly, hope therapy emphasizes that self-talk is a type of thinking that has a profound impact, despite the fact that it often goes unnoticed by the individual. Hopeless self-talk statements such as "I can't do this" sap agency and stagnate goal pursuits, whereas hopeful self-talk statements such as "I think I can do this" raise agency and reinvigorate goal pursuits. Other strategies such as self-monitoring and hypothesis testing also are likely to increase hopeful self-talk. Thus, much of the cognitive work that often is done in therapy increases agency and energizes goal pursuits.

Another typically used cognitive therapy approach involves setting subgoals. It is unlikely that a skilled therapist would suggest that a client presenting with social anxiety should set the goal of becoming the best public speaker in his entire business operation by the time of the next session. Rather, a cognitive therapist would work with a client to develop an incremental and graded hierarchy of goals (Brown, O'Leary, & Barlow, 1993; Freeman & Simon, 1989; Steketee & Foa, 1985). This process of creating subgoals, or hierarchies of goals, is likely to increase hopeful thinking in the client. On this point, Snyder (1994) has found that high-hope individuals tend to break difficult goals into more manageable subgoals. This probably is related to both effective pathway generation through setting stretch goals, as well as to the continuous boost in agency that occurs with successes along the pathways.

Hopeful Thinking in the Termination Phase

Hopeful thinking is just as important in the termination phase of treatment as it is during the assessment and active treatment phases. There are two major objectives in the termination phase of most cognitive therapies. First, therapists engage clients in a review process, highlighting and reinforcing treatment gains. During this process, therapists seek to remind clients not only of the changes in their lives and symptoms, but also of the skills that they have learned during the course of therapy. Second, therapists apply techniques designed to prevent relapse. Typically, these entail engaging clients in discussions regarding how they will maintain therapy gains in the future.

Each of these two termination objectives relies on one of the components of hopeful thinking. Reviewing gains, for instance, is tantamount to reflecting on successful goal accomplishments. According to hope theory, perceived success at accomplishing goals leads to positive emotions and increased agency. Thus, reviewing gains increases agency. Augmenting agency in this way ensures that the client will remain motivated to maintain gains and continue setting goals in order to make additional gains after therapy has completed.

Relapse prevention techniques, on the other hand, build pathways. In order to prevent relapse, therapists often encourage clients to reflect upon "ways" in which they will continue maintaining gains after therapy has terminated. In addition, therapists ask clients to imagine problems that will likely crop up in the future, along with how to use skills learned in therapy to cope with these problems. As stated previously, high- rather than low-hope individuals are better at producing alternative pathways to goals when their initial pathways have been blocked (Irving et al., 1998; Snyder, Sympson, et al., 1996). Engaging clients in discussions regarding ways around future problems helps to build such alternative pathways even before these difficulties arise. This both provides clients with coping strategies and raises pathways thinking, thereby further decreasing the probability of relapse.

Thus, the termination phase includes powerful techniques for increasing both agency (by reviewing gains) and pathways (by practicing relapse prevention). It is important to note, however, that these hopeful aspects of the termination phase are rarely explicitly acknowledged by therapists or conveyed to clients. Doing so may ensure that clients terminate therapy having received a significant dose of hopeful thought. For more detailed descriptions of how normal activities in psychotherapy represent mechanisms for increasing and maintaining positive change, we refer the reader to Snyder, Ilardi, et al. (2000), Snyder, Ilardi, Michael, and Cheavens (2000), Snyder, Michael, and Cheavens (1999), and Snyder and Taylor (2000).

Closing Comments

To date, there have been at least three experimental trials of hopeful interventions with various populations—older adults (Klausner et al., 1998), mildly depressed and anxious community dwellers (Cheavens, Gum, Feldman, Michael, & Snyder, 2001), and pretreatment community mental health clients (Irving et al., 1997). The results of each of these trials suggest that hopeful thought can be increased and that psychopathological symptoms can be decreased simultaneously. In this article, we have attempted to provide a brief overview of the many strategies used in these studies, specifically highlighting ways in which these strategies can be seamlessly integrated into current cognitive therapies. When we identify, appreciate, nurture, and solidify our clients' strengths and skills, we not only can do a better job of helping to alleviate their psychological pain, but we also can help them increase their productivity and satisfaction in life. These latter strength-related processes exemplify the application of positive psychology to psychotherapy in general, along with the application of hope theory to cognitive therapies in particular.

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Offprints. Requests for offprints should be directed to Jennifer Cheavens, PhD, Department of Medical Psychiatry, Box 3026, Duke University Medical Center, Durham, NC 27710. E-mail: cheav001@mc.duke.edu