THE LIVED EXPERIENCE OF HOPE IN THERAPY

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Abstract

The lived experience and meaning of hope in psychotherapy for clients was studied using the hermeneutic phenomenological method outlined by van Manen (1997). Five women in their forties who have completed therapy no less than 6 months earlier were interviewed regarding their experience. Hope in therapy was described as an active experience, with four distinct areas of movement: coming into strength, coming into possibilities and change, coming into connection and coming into universal trust. The themes described the essence of the experience for the five women. A follow up interview was conducted to confirm and clarify the findings generated from the first interview. The results contribute to our understanding of the experience of hope as it pertains to psychotherapy. Recommendations for future research and implications for counselling practice are discussed.
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Chapter One

Introduction

Hope has been the subject of attention in many fields of study, including medicine, nursing, philosophy, theology, sociology and psychology (Farran, Herth & Popovich, 1995; Neuhause, 1996; Sutherland, 1993). Averill, Catlin and Chon (1990) noted that “the idea of hope has been a major thread running through much of the Western history” (p. 2). Hope has also been characterized by a number of authors as being vital to life and imperative for promoting health and healing (Farran, et al., 1995; Sutherland, 1993; Yahne & Miller, 1999).

Nursing research has suggested that hope may have a therapeutic effect on health outcome, and as such is acknowledged as a component of the nursing care process (Hinds, 1984). Obayuwana and Carter (1982) proposed that hope may be “the key to the acquisition of optimum health for humanity, since it functions primarily to reduce anxiety and increase the overall ability to cope with stress” (p. 230). Lee (1999) notes that in the cancer nursing literature hope has been described as a healing power that promotes adjustment and positive health outcomes. Indeed, much of the research on hope and health has been conducted in the nursing context (Neuhaus, 1996).

In the field of psychology, the concept of hopelessness has been studied much more than the concept of hope (Farran et al., 1995). Stotland (1969) and Snyder (1994) proposed theories of the psychology of hope, but most of the research on hope has involved the development and testing of hope assessment tools. Sutherland (1993) suggested that the dearth of literature may be a result of the tendency in the field to focus
on pathology. It is possible that the inherently abstract quality of the concept has also
discouraged further research.

Hope was first acknowledged as a possible psychologically therapeutic element
within the common-factors (also called non-specific factors) body of literature (Frank,
1974, 1991; Garfield, 1973; Snyder, Michael & Cheavens, 1999). Grencavage and
Norcross (1990) explained that the “common-factors approach seeks to determine the
core ingredients shared by the different therapies with the eventual goal of developing
more efficacious treatments based on these components” (p. 372). Jerome Frank (1974,
1991) was an important contributor to the common-factor discussion and suggested that
therapy enhances the client’s hope for healing and by doing so promotes that very
process. In 1999, Snyder, Michael and Cheavens suggested that hope is the foundation of
all the other common factors and as such is crucial for change in therapy.

Hope has also been recognized as important for therapy outside of the common-
factors discussion (Dufrane & Leclair, 1984; Yahne & Miller, 1999). Still, research on
hope has concentrated, for the most part, on its meaning for and role in the lives of people
with chronic or terminal illness (e.g. Callan, 1989; Perakyla, 1991) and on its
measurements and correlates (Farran et al., 1995). Little attention has been paid to the
client’s experience of hope in the psychotherapeutic context.

Reviewing the research literature on the client’s experience of counselling and
psychotherapy, McLeod (1990) noted that “hardly anyone has ever asked clients what
they think about the counselling or psychotherapy they are receiving” (p.1). Similarly,
Elliott and James (1989) argued that the “client’s perspective is the most direct source of
information about client experiences” and that “where information about meaning and
value of therapy are sought, clients may be the only accurate source of information” (p.445). When asked, the research suggests that some clients indeed cite hope as an aspect of their experience in counselling and of therapeutic helpfulness (Elliott & James, 1989; McLeod, 1990; O’Leary & Rathus, 1993). However, there is no research on the client’s experience of hope in therapy.

The Rationale and Purpose of the Study

Research and theory suggest that hope is important for healing and central for therapeutic change, yet the lived experience of hope in therapy remains unexplored. Given this gap in our understanding of the phenomenon, and given its potential importance for the therapeutic aspirations of the profession, the question this study will address is: What is the lived experience and meaning of hope for clients in therapy?

The purpose of this study is to develop and deepen our understanding of the experience of hope in therapy so that we may have richer understanding of our clients and the therapeutic process, as well as a possible means to enhance that process. In addition, this study may open up this area of research for further understanding and exploration.

An exploration into human experience and meaning making warrants the hermeneutic phenomenological method. Phenomenology is a qualitative method of investigation that aims to gain an understanding of our immediate experience in our worlds (Osborne, 1990) and to explore the “way we experience the world pre-reflectively, without taxonomizing, classifying or abstracting it” (van Manen, 1997). It endeavours to describe the essence, meaning and structure of that experience in words (van Manen, 1997).
Definitions

To clarify, definitions of the terms discussed in this study are presented below. Therapy refers to “the entire range of psychological interventions” (Grencavage, Bootzin & Shoham, 1993, p.359) and will be used interchangeably with the terms psychotherapy and counselling throughout the text.

Therapist is a person professionally trained in the theories and techniques of therapy, while client is one who goes through therapy with a therapist. Although the phenomenon of hope may be found in places of healing other than therapy (for example, medicine, nursing, religion), this study will concentrate on the professional, psychotherapeutic setting.

Finally, considering the question this study seeks to explore and the method chosen, defining hope at the outset is neither useful not relevant. As part of this study, each of the participants shared her lived experience of hope and its meaning in the therapeutic process, and an understanding of the phenomenon of hope consequently emerged.

Delimitations of the Study

The delimitations of this study arise from the requirements that participants have been in therapy and have experienced hope in that context. As mentioned above, the phenomenon of hope and its meaning in the and healing process may very well be present in healing contexts other than psychotherapy, however these were not be addressed in this study. In addition, participants were not be selected or rejected based on the theoretical orientation of the therapy they engaged in. In fact, participants with a wide variety of
experiences were sought. Finally, participants must be able to articulate their experience so that the researcher may be able to interpret their experiences.
Chapter Two

Literature Review

Hope has been addressed by theory and research in a variety of fields. Due to the extent of literature on hope in various fields, and considering the research question, the following literature review will focus primarily on writings in the field of psychology, and present only relevant literature from other fields. General theories of hope will be presented first, followed by theories of hope in therapy. Next, research about hope will be discussed, addressing both qualitative and quantitative methods.

General Theories of Hope

Stotland’s theory of hope

Stotland (1969) presented one of the first distinct psychological theories of hope. He defined hope as expectations about goal attainment, and hopefulness as “a construct used to tie together antecedents and consequent events” (p. 3). The theory suggested that hopefulness is a necessary condition for action and as such where there is an increased degree of hope there is an increased likelihood of action toward the goal. Stotland (1969) proposed that motivation is influenced by hope (i.e. expectations about goal attainment). Motivation is also proposed to be influenced by the goal’s importance. For example, if a woman feels that her goal to stop drinking is important, but believes it is unlikely, according to the theory she will not be motivated to take action towards her goal. However, if there is an increase in her level of hope, and therefore her expectations about attaining the goal, she will be more likely to take action towards her goal.
Stotland (1969) argued that “hope of attaining a goal and the importance of that goal also influence the organism’s affective states” (p. 8). The theory put forward that the greater one’s hope (i.e. the higher the organism’s perceived probability of attaining a goal) and the greater the importance of the goal, the greater the positive affect that will be experienced. Conversely, it was suggested that the lower one’s hope and the higher the goal’s importance, the greater the anxiety that will be experienced.

Stotland (1969) also examined the determinants of experienced levels of hope. He discussed these determinants in terms of schemas and concepts, where schemas are “cognitive structures consisting of associations between concepts” (p. 11). The theory suggests that schemas are acquired as a result of a repeated perception of an association between the same concepts, or through communication from other people. Therefore, if hope is a schema, one may become hopeful or acquire a schema of hope by being sufficiently exposed to or having adequate experience with the association between his/her expectations and actual goal achievement, or via communication with another person.

The theory also suggested that schemas may be dormant or in a state of arousal (Stotland, 1969). It is only when schemas are aroused that they have a directive influence on a situation. A schema is invoked when it shifts from a dormant to an aroused state. Schemas may be invoked in the same way that they may be acquired. “The greater the similarity between the event and the constituent concept, or the greater the importance of the person…the more likely is the schema to be aroused” (Stotland, 1969, p. 12).

Finally, Stotland (1969) postulates that the more often a schema has been invoked, and the greater the number of events that have been perceived as consistent with
the schema, and the more important the person from whom the schema was acquired, the more likely a schema is to be invoked and remain aroused.

In sum, Stotland (1969) describes and explains hope in terms of expectations, action, probability, motivation, goals and their relative importance, affective states, dormant and aroused schemas, concepts, communication with others and the relative importance of those involved. This theory was proposed during the cognitive revolution (Corey, 1996) in psychology and its language bears many of the markers of that period. It aims to explain hope in concrete, measurable terms, and in doing so misses to a great extent the richness and depth of what it is actually like to experience hope.

**Snyder’s theory of hope**

Currently, much of the theory and research regarding hope originates from the writings of C.R. Snyder. In *The Psychology of Hope*, Snyder (1994) proposed that “hope is the sum of the mental willpower and waypower that you have for your goals” (p.5). The theory suggested that goals are any “objects, experiences or outcomes that we imagine and desire in our minds” (p.5). Goals may be vague or concrete and short or long term in nature. Like Stotland (1969), Snyder (1994) suggested that hope is only concerned with goals of at least some importance, and adds that hope is relevant only in situations where achieving the goal is neither impossible nor completely certain.

Willpower, according to the theory, is the mental driving force that moves one towards his or her goal. It is made up of thoughts such as ‘I can do this,’ and ‘I’m ready to do this,’ thereby reflecting one’s thoughts about initiating and sustaining movement towards the goal. Snyder (1994) suggested that waypower is composed of the plans that guide thoughts about goal achievement. Waypower is made up of thoughts such as ‘this
is how I can do this.' Both willpower and waypower are more easily kindled with goals that are important, clear and concrete.

Similar to Stotland's (1969) discussion of the acquisition and activation of the hope schema, Snyder (1994) contended that the potential for willpower and waypower ways of thinking depends on one’s past successful experience with them. Snyder’s (1994) theory is also similar to Stotland’s (1969) in its cognitive treatment of hope.

**Farran, Herth and Popovich’s theory of hope**

Based on an extensive review of the research literature, Farran, Herth and Popovich (1995) provided a working definition of hope.

Hope constitutes an essential experience of the human condition. It functions as a way of feeling, a way of thinking, a way of behaving, and a way of relating to oneself and one’s world. Hope has the ability to be fluid in its expectations, and in the event that the desired object or outcome does not occur, hope can still be present (p.6).

The authors suggested hope may be summed up as having four central attributes: (a) an experiential process, (b) a spiritual or transcendent process, (c) a rational thought process, and (d) a relational process. The experiential attribute of hope is described as being intimately related to the experience of hopelessness, and hoping is understood as involving accepting human trials and suffering while expanding the boundaries of the possible. The emphasis is on the dialectic between hope and hopelessness. Hope is understood as having a spiritual attribute where it is inseparable from faith. The rational attributes of hope include components such as goals, resources, activity, control and time.
Finally, Farran et al. (1995) suggested hope has relational attributes, as it is something that occurs between people.

**Theories of hope in therapy**

Frank (1991) proposed that all clients of psychotherapy suffer from a common condition – demoralization. He suggests people become demoralized when they feel they are unable to cope with a pressing problem, are aware of their failure to cope, and feel powerless to change their situation on their own. Psychotherapy in turn, has four common characteristics that attend to and work to alleviate the client’s demoralization: (a) an emotionally charged, therapeutic relationship between client and therapist; (b) a therapeutic setting or sanctioned place of healing; (c) a therapeutic myth or rationale that provides the client with an explanation of his or her situation; and (d) a therapeutic procedure or ritual that prescribes an action to be taken by the client that will bring about change and healing. Frank (1991) argued that although each theoretical orientation provides specific content for the four categories, all therapies function in the same way.

Furthermore, Frank (1991) maintained that the four common features of psychotherapy interact to bring about change by (a) enhancing the client’s hope for relief, (b) providing new opportunities for learning, (c) providing the client with experiences of success and consequently, (d) helping the client overcome the sense of demoralization. Moreover, the importance of hope for effective therapy was emphasized in his discussion of the placebo effect. Frank (1974) suggested that since “assumptions about the future have a powerful effect on one’s present state,” it followed that “favourable expectations generate feelings of optimism, energy, and well-being and may actually promote healing, especially of those illnesses with a large psychological or emotional component” (p. 136).
Snyder, Michael and Cheavens (1999) expanded on Frank’s (1974, 1991) theory of common factors and proposed that hope is not merely one of the factors, but the foundation of all other common factors. Consequently, they claimed hope is in fact crucial for the client’s change process in psychotherapy. The authors presented a theory in which hope was “understood in terms of how people think about goals” (Snyder, et al., 1999, p. 180) and comprised of Agency Thinking and Pathway Thinking. Agency Thinking refers to one’s beliefs about his or her ability to achieve a goal (e.g. “I can do it” p. 183), while Pathway Thinking refers to one’s beliefs about how the goal may be achieved (e.g. “Here’s how I can do it” p. 183). According to this theory, hope is only experienced when both types of thinking are present. Again, this is a predominantly cognitive theory of hope.

Snyder et al. (1999) suggested that Frank’s (1991) four common factors of therapy may be better understood in the context of this model of hope. The first element, the therapeutic relationship, hinges on the therapist having hope that the client can change. The second element, the therapeutic setting, promotes hope by influencing the client’s expectations for healing. Snyder et al. (1999) suggested that the third common element of psychotherapy, the therapeutic rationale, promotes hope by providing the client with an explanation for his or her difficulties as well as a way to resolve them, thereby promoting pathway thinking. Lastly, the therapeutic procedure or ritual portrays to the client the therapist’s ability and conviction in their techniques, thereby providing the therapist with an opportunity to model both agency and pathway thinking.

**Research on Hope**

**Correlates of hope**
Much of the quantitative research of hope in psychology has been conducted using scales and measurements of Hope. Snyder et al.’s (1991) Hope Scale is the most recent and the most commonly used measure (Farran et al. 1995). However, regardless of the instrument utilized, the research concurs – hope is correlated with well being.

Hope has been found to be correlated with self-actualization. Sumerlin (1997) administered the Hope Scale (Snyder et al., 1991), two subjective health and life satisfaction ratings and the Brief Index of Self-Actualization (Sumerlin and Bundrick, 1996) to 149 graduate and undergraduate students. The Brief Index of Self-Actualization (Sumerlin and Bundrick, 1996) is a 40-item measure based on Maslow’s (1954, 1968, 1970, 1971) ideas about a self-actualizing personality, purporting to measure 11 features deduced from Maslow’s writing about the self-actualizing person.

Statistical analysis (Pearson) found Brief Index scores to be significantly correlated with Hope Scale scores ($r=0.72$, $p<0.001$), Pathways scores ($r=0.56$, $p<0.001$), and Agency scores ($r=0.68$, $p<0.001$). All variables were submitted to principle axis factor analysis (oblique). A two factor model was found with Factor 1 designated ‘Striving’ and Factor 2 designated ‘Fulfillment.’ Factor analysis further revealed that Pathway and Agency scores loaded only on the ‘Striving’ factor.

The author concluded that “self-actualization is a broader construct than hope” (Sumerlin, 1997, p. 1105). If self-actualization is the purpose of therapy, than this study suggests that hope may be essential in that context.

Research also suggested that hope is correlated with coping beliefs and hopelessness. Range and Penton (1994) administered the Reasons for Living Inventory (Linehan et al., 1983), a short Suicidal Behaviors Questionnaire, the Hopelessness Scale
(Beck, 1974) and the Hope Scale (Snyder et al., 1991) to 206 undergraduate psychology students. Although exact figures as presented in a table were unclear, Range and Penton (1994) reported that Pearson correlations revealed a significant negative correlation between hope and hopelessness, and between hope and the Fear of Suicide subscale of the Reasons For Living Inventory. As well, hope was positively and significantly correlated with three of the Reasons for Living subscales (Coping Beliefs, Family Responsibility and Child Concerns).

Range and Penton (1994) concluded that facilitating students’ hopefulness may strengthen their coping consequently discouraging suicide. As well, they suggested that “the moderate correlations among scores on hope, hopelessness and coping suggest that all are somewhat unique” (p.457).

In a more specific study of hope and coping styles, Herth (1990) investigated the relationship between hope, coping styles and grief resolution in elderly widows and widowers. Seventy-five bereaved spouses who had been widowed for 12-18 months and had not remarried completed the Herth Hope Scale (Herth, 1985), the Jalowiec Coping Scale (Jalowiec, 1987) and the Grief Resolution Index (Remonder & Hansson, 1987).

Pearson correlation coefficients revealed Hope scores were significantly and positively correlated with grief resolution levels (no statistics provided) and the use of Confrontive (r=. 79, p<. 001), Optimistic (r=. 79, p<. 001), Palliative (r=. 39, p<. 001>, Supportant (r=. 66, p<. 001) and Self-reliant (r=. 51, p<. 001) coping styles. In other words, widows and widowers who had high levels of hope were more likely to use constructive problem solving (Confrontive), have a positive outlook (Optimistic), use stress reducing methods (Palliative), turn to their support systems (Supportant) and
personally initiate activities in order to cope with their loss than those participant who had lower levels of hope. As well, participants with higher levels of hope were more likely to be reconciled to their loss and reinvolved in life than participants with lower levels of hope.

Herth (1990) also found that Hope scores were significantly but negatively correlated with the use of evasive (r = -.62, p < .001), emotive (r = -.70, p < .001) and fatalistic (r = -.67, p < .001) coping styles. Participants with lower levels of hope were more likely to engage in evasive and avoidant activities, have a pessimistic approach and be expressive of emotions. Lastly, a stepwise multiple regression revealed that hope accounted for 79% of the variance in grief resolution, thus suggesting the importance of hope, as measured by the Herth Hope Scale, for Grief Resolution.

Cramer and Dyrkacz (1998) found high levels of hope to be correlated with low levels of maladjustment. The investigators administered Snyder et al.'s (1991) Hope Scale and the MMPI-2 (Butcher, Dahlstrom, Graham, Tellegen & Gaemmer, 1989) to 354 undergraduate psychology students and calculated Pearson Product-Moment correlations between Hope, Agency, Pathways, seven MMPI-2 clinical scales and a composite Maladjustment score based on the seven clinical scales. They found that scores on Agency, Pathways and Hope were significantly (p < .05) and negatively correlated with each of the seven clinical scales, as well as the composite Maladjustment score.

Correlations between the two Hope subscales and the 9 MMPI-2 subscales were subsequently compared. Cramer and Dyrkacz (1998) found that the Agency score was significantly (p < .05) more predictive of Maladjustment than both the Pathways score and
the Hope score. The Hope Scale was significantly (p<.05) more predictive of Maladjustment scores than the Pathways subscale. For the seven clinical subscales, (a) Agency was significantly more predictive (p<.05) than Pathways for five of the clinical subscales, (b) Hope was significantly (p<.05) more predictive than Pathways for six of the MMPI-2 subscales, and (c) Agency was significantly (p<.05) more predictive than Hope for two of the clinical scales. Overall, Agency appeared to be the best predictor of Maladjustment as measured by the MMPI-2. Cramer and Dyrkacz (1998) concluded that “it is more important to consider the extent to which we see ourselves as powerful agents in our lives in order to predict adjustment problems” (p. 1038).

Exploring different aspects of well being, Brackney and Westman (1992) investigated whether a stronger sense of hope is associated with greater psychological maturity and a greater sense of personal control over one’s life. Participants were 108 graduate and undergraduate students who completed four measures: the Miller Hope Scale (Miller and Powers, 1988), the first six stages of Erikson’s Psychosocial Stage Inventory (Rosenthal, Gurney & Moore, 1981), Levenson’s (1972) three-dimensional Locus of Control Scale and Beck’s Hopelessness Scale (Beck and Steer, 1988).

Brackney and Westman (1992) found that hope was significantly and positively correlated with each of the psychosocial development scores. As well, hope was significantly and negatively correlated with two Locus of Control subscales: Powerful Others and Chance.

Brackney and Westman (1992) concluded that “achieving greater psychosocial maturity was associated with greater hopefulness” (p.866), while control by chance or by powerful others was associated with a lessened sense of hope. Consequently, they
suggested that "further research efforts are needed to refine the nature of hope and to understand ways in which it can be encouraged" (p. 866).


Significant and positive correlations were found between Agency scores and Perceived Self-Worth, Perceived Job Competence, Perceived Scholastic Competence, Perceived Social Acceptance and Perceived Creativity scores. Significant and positive correlations were also found between Pathways scores and Perceived Job Competence, Perceived Romantic Relationships and Perceived Creativity scores.

Onwuegbuzie and Daley (1999) concluded that "hope appears to be related to self-perception" (p.539) and suggested that "the extent to which the relationship between hope and self-perception is generalizable may have implications for individuals in the helping profession" (p.540).

High hope has also been found to be correlated with lower levels of dysphoria. In a thorough investigation (Kwon, 2000), undergraduate students completed measures of hope, dysphoria and defence mechanisms in two studies. In the first study 147
participants completed the Defense Mechanisms Inventory (DMI; Gleser & Ihilevich, 1969), the Hope Scale (Snyder et al., 1991) and the Beck Depression Inventory (BDI; Beck, Rush, Shaw, & Emery, 1979). Multiple regression analyses indicated that higher levels of hope were associated with lower level of dysphoria ($\beta=-.45, p<.001$).

Principalization, a defence mechanism measured by the DMI which "involves the reinterpretation of reality through general, abstract, intellectualized principles" (Kwon, 2000, p. 208), was found to moderate the relationship between hope and dysphoria such that use of Principalization reduced dysphoria for individuals low in hope. Nevertheless, individuals high in hope had low levels of dysphoria regardless of their use of Principalization.

Recognizing the limits of the Defense Mechanism Inventory, Kwon (2000) conducted a second study to support his findings with 159 students completing the Defense Style Questionnaire (Bond, Gardner, Christian & Sigal, 1983), Hope Scale (Snyder et al., 1991) and BDI. Indeed, findings showed that lower levels of defence style maturity were associated with higher levels of dysphoria in individuals with low hope. Once again, high hope individuals had low levels of dysphoria, regardless of defence mechanisms. Kwon's (2000) study suggested that although the use of various defence mechanisms sometimes mediates the relationship between hope and dysphoria, high hope is an important predictor of well being.

In sum, research with various measures of hope suggests that hope is correlated with self-actualization, coping beliefs, hopelessness, coping styles, grief resolution, maladjustment, psychological maturity, a sense of personal control over one's life, self-perception, dysphoria and defence mechanisms. Although correlational studies can speak
only to a possible relationship between measures, and causation cannot be inferred, it is clear that hope is an important aspect of well being, one which merits further investigation.

Nevertheless, studies using standardized, pen and paper measures of human experience will inevitably be limited in the depth of information they can provide. Correlations and regressions provide useful information regarding trends in human experiences, but for further detail, depth and meaning, qualitative approaches are much more appropriate. Especially with an abstract concept such as hope, qualitative investigations may provide us with much needed understanding.

**The Experience and meaning of hope**

Studies examining the experience and meaning of hope have often used qualitative methods and were commonly conducted in the context of physical illness. The following is a review of research examining the experience and meaning of hope in the context of psychological health and illness.

Nekolaichuk, Jevne and Maguire (1999) investigated the personal meaning of hope in the context of both health and illness using the semantic differential technique (Osgood, Suci & Tannenbaum, 1957). The sample consisted of 550 people; 146 healthy adults, 159 individuals with chronic and/or life threatening illness experience, 206 nurses and 11 people who were not classified. Participants were presented with 50 bipolar adjective pairs such as meaningful-meaningless, fast-slow and tender-tough. The adjective pairs were selected and created based on three factors suggested by (a) Osgood et al. (1975) as underlying the meaning of most concepts, (b) Dufault and Martocchio’s (1985) model of Hope and (c) adjective pairs related to the domain of Hope but otherwise
Participants rated six hope-related concepts on a 7-point scale of each of the 50 bipolar adjective pairs. The six hope-related concepts were hope, a hopeful person, a person without hope, two brief vignettes and the participant's own personal story of hope.

Nekolaichuk et al. (1999) found three factors that accounted for approximately 40% of the variance. The first factor - Personal Spirit - was interpreted as focusing on the personal dimension of hope, and eight items were selected to represent the essence of this factor: meaningful, bright, valuable, desirable, empowering, strong, caring, and forward. The second factor - Risk - was interpreted as the situational dimension of hope, incorporating components of predictability and boldness. Eight items were selected to represent the second factor: precise, near, certain, stable, expected, fearless, fast, and confident. The third factor - Authentic Caring - was interpreted as focusing on the interpersonal dimensions of hope and included credibility and comfort themes. Eight items represent this factor: honest, trusting, realistic, tender, happy, connected, warm, and accepting.

Nekolaichuk et al. (1999) suggested this model "captures the qualitative experience of hope, within a holistic, multidimensional quantitative framework...as opposed to a point along a single continuum ranging from hopefulness to hopelessness" (p.602). Although this study identifies hope as a complex, multidimensional phenomenon, it is somewhat paradoxical that it does so using participants' thoughts on a collection of predetermined single continuums. Since the meaning of the words used to describe hope by the participants is neither explored nor explained, the reader does not gain further understanding of the experience of hope.
Benzein, Saveman and Norberg (2000) explored the meaning of hope in healthy Swedes who considered themselves not religious. The investigators explained that “none of the participants believed in a personal God and were not regular church attenders” (p.305). Interviews were carried out with 24 participants who were healthy adults, 18 to 80 years of age. Interviews were analyzed using the phenomenological hermeneutic approach. The investigators found hope to have internal and external processes, where the “internal process is related to a person’s being and the external process is related to a person’s doing” (p.308). The findings also suggested that the two processes have a reciprocal relation, where hope related to being is a prerequisite for hope related to doing, while hope related to doing nurtures hope related to being. These findings are reminiscent of Snyder’s (1994) conceptualization of the will and ways of hope, one being cognitive while the other is action oriented.

In this research, hope related to being was understood as having two subthemes: related to the self and related to the world. Participants described hope related to self as an inner process essential for survival and meaning in their life. As one participant shared:

If you have no hope you can’t go on living...what would be the meaning? I think that having hope is really believing in a better future, saying “yes” to a better life... If you have hope and you can make choices in your life then you are a fee person, aren’t you? (Benzein et al., 2000, p.309)

The second subtheme, hope related to the world, expressed the participants’ feeling of belonging to something that is larger than themselves and that is continuous.
Benzein et al. (2000) understood hope related to doing as having two subthemes as well: setting goals and expected positive outcomes and consequences. Setting goals included realistic optimism, and the experience of having meaningful relationships. It is unclear why the researchers interpreted meaningful relationships as an aspect of setting goals. The second subtheme, expected positive outcomes and consequences, expressed the participants' experience of well being and personal competence when hope was associated with positive outcomes.

Lastly, Benzein et al. (2000) suggested that the experience of hope is related to the life process and changes in relation to age. In early childhood the experience of hope involves setting short-term goals for oneself; in adolescence short-term goals are predominant but one also begins to set long term goals; in adulthood, long-term goals are predominant while in late-adulthood participants expressed having short-term goals for themselves and long-term goals for significant others.

In 1984, Hinds, then a doctoral student at the College of Nursing, attempted to induce a definition of hope with the use of grounded theory methodology. Participants were 17 well adolescents from an alternative learning centre for secondary education and 8 adolescents who were in-patients in a treatment unit for substance abuse. Personal interviews were carried out with each of the participants, and included questions such as What is hope to you? What differences does it make if a person has hope or does not? And what do you do to affect your hope level or that of others around you?

Based on these interviews, Hinds (1984) constructed a definition of hope comprised of four categories:
1. Forced effort: the degree to which an adolescent tries to artificially take on a more positive view.

2. Personal possibilities: the extent to which an adolescent believes that second chances for the self may exist.

3. Expectation of a better tomorrow: the degree to which an adolescent has a positive though non-specific future orientation.


Hope was defined as "the degree to which an adolescent believes that a personal tomorrow exists" and this belief extended over the four categories (p.360).

In sum, research about the experience and meaning of hope suggests that hope is a multidimensional experience, involving beliefs, behaviour and interpersonal relations. It is important to note that in literature reviewed, hope was defined and described rather differently depending on the context within which it is studied. This implies either that hope is experienced differently in various settings and by various people, or perhaps that to date, descriptions of hope have not captured its core essence.

Review of the literature did not find any research studies of the lived experience of hope in therapy. Since hope has been put forth as relevant and important for healing and therapy, it is important to investigate its nature in this context. Accordingly, the purpose of this study was to develop and deepen our understanding of the experience of hope in therapy for clients, so that we may gain a richer understanding of our clients' experiences as well as of the therapeutic process. Given the gap in the literature and given
the potential contribution of this research, the question this study addressed was: **What is the lived experience and meaning of hope for clients in therapy?**
Chapter Three

Method

The research design that best addresses the research question is the phenomenological research method. Phenomenology, as described by van Manen (1997), is a method of inquiry and research that asks about the nature and meaning of experience as it is lived. The emphasis is on experience as we live it, rather than as we conceptualize or understand it.

Such emphasis rests on the underlying belief that *lived* experience is the immediate pre-reflective consciousness of life – an awareness that is not aware of itself (van Manen, 1997). The nature of lived experience is such that it cannot be grasped as it is experienced but only in retrospect. The inherent paradox is the attempt to understand and describe an *experience as it is lived* while acknowledging the fundamental difference between experiencing and understanding or describing the experience. Indeed, Osborne (1990) noted that “the profound difficulty in such a task is that there is no complete correspondence between language and experience” (p.82), while van Manen (1997) maintained that our appropriation is always of something that cannot equal the fullness and depth of the lived experience.

This inherent paradox not withstanding, the aim of phenomenology according to van Manen (1997) is:

...to transform lived experience into a textual expression of its essence - in such a way that the effect of the text is at once a reflexive re-living and a reflective appropriation of something meaningful: a notion by which a reader is powerfully animated in his or her own lived experience (p.36).
This textual expression is an attempt to describe the essence of the lived experience and its meaning. It involves a relating of the unique experience to the universal essence – the parts to the whole. More so, its aim is to relate the description and meaning of the phenomenon in a way that genuinely connects with the reader. Ideally, the reader will gain an understanding of the phenomenon that is both reflective and experiential.

Indeed, the task is to evoke the essence of the experience with the reader. Such a formidable task means that the writing of the ‘findings’ is as much a part of the research activity as are interviews and analysis. Van Manen (1997) emphasised that phenomenological research involves the art of writing and re-writing, and “language that authentically speaks the world rather than abstractly speaking of it” (p.13).

Both van Manen (1997) and Osborne (1990) proposed that “there is no such thing as the phenomenological method” (p.83). Nevertheless, van Manen (1997) suggested that the methodical structure of phenomenology may be seen as a dynamic interplay between six research activities. These activities are: (a) fully turning to a phenomenon of interest with depth and commitment; (b) investigating phenomenon as we live it rather than as we think about it; (c) reflecting on the essence of the lived experience – what it is that constitutes its nature; (d) writing and rewriting the description of the phenomenon; (e) maintaining a strong and oriented relation to the phenomenon such that we are fully animated to it, continually seeking depth and substance; and (f) considering parts of the phenomenon against the whole so as to not lose sight of the larger context and essence.

The phenomenological approach was consistent with my aim to achieve an in-depth understanding of the lived experience of hope in therapy and its meaning for the
participants. In addition, it is important to note that I found this research approach particularly suitable to my own ways of understanding and making meaning. I responded enthusiastically to the valuing of human experience that is intrinsic to this method. Thus, a fit existed not only between the research question and the research method, but also between the researcher and the research method. My experience of carrying out this research was of deeply living and discovering both the topic and the method.

I believe it is not possible to objectively, completely and without influence describe someone else’s experience. My use of the phenomenology method was therefore interpretive in approach. With this awareness, I engaged in continued reflection, journaling and discussions with colleagues and supervisors, seeking to explore my own beliefs and experiences and reflect on how they may influence the research. This exposition is presented in the next section and throughout the text for the reader’s consideration. Furthermore, my experience and beliefs are explicated throughout the method section in the various decisions I made regarding the research. This is a form of bracketing that renders my own beliefs and biases as well as my personal process of indwelling with this phenomenon openly to the reader, but that does not attempt to preclude it from the study.

I was committed to respectful, neutral and non-judgemental interaction with participants, and to being just as respectful and non-judgemental with the participants, their experiences and opinions, as I am with my own. Such respect cannot be achieved by bracketing and attempting to disregard my experience, but by recognizing it and remaining aware of its influence throughout the research process. The reader is urged to consider the person of the researcher while reading the results.
Personal Experience and Assumptions

I began working on this project in June of 2000. I knew I wanted to research the experience of therapy and I narrowed the focus down to hope. It sounded intriguing, it sounded like a good simple idea. I was intensely curious about the process and experience of therapy as a whole. At the time, my personal experience in therapy consisted of a total 6 sessions with an EAP counsellor in 1999 that I had described to friends as “better than nothing.” The experience indeed was better than nothing, but not significantly so.

Having arrived at phenomenology as the method of choice for the question, my supervisor asked whether I have ever been in therapy and suggested I may want to do so in order to immerse myself in the experience. It was the last little bit of legitimacy that I needed to seek therapy. The truth is I was deeply depressed for almost a year and felt as though I had barely been keeping my head above water, gasping frantically yet sinking quietly. I jumped on the opportunity. Soon after I began seeing a therapist and at the same time started working on the literature review for this project.

I saw the therapist once every other week for approximately a year. When I started, I had absolutely no speculations about the experience of hope in therapy. I had no notion of what it meant or what it might be like. I just wanted to feel better. I resolved not to forcefully seek hope in therapy, but remain gently open to it in case it arrived. This approach was guided by my understanding of phenomenology and my desire for an experience that was authentic. In truth, I was also so immersed in my sorrows and therapy itself that thinking about hope was a distraction, so I did not.
It was about 10 months later while I was absorbed in the practicum component of the Counselling Psychology program and in the midst of a conversation with a colleague that I arrived at the words for my experience of hope in therapy. I called it Hope for Humanity. The experience had a very distinct meaning and unmistakable feeling for me. It was a regaining of my faith in the world, my trust that people are essentially good and that the world is fundamentally a good and just place.

It was precisely this orientation to the world that I had lost before embarking on therapy. It was by virtue of experiencing a connection with a real, kind human being – the therapist - that I began to once again trust that people are good and the world is basically a good place. It was about regaining hope that things will be ok.

My awareness of the experience had been there for some time before this conversation, but it was at that moment that I was able to articulate it for the first time. The context of the conversation was my own training as a counsellor, and in that context I engaged in many passionate discussions about the nature of therapy. I was living and discovering the therapeutic process as a counsellor, and along with it I was beginning to realize my own beliefs and theories of therapy. What is it that happens in the session? What works? What can I do? How do I do it? What do I believe about people? What do I believe about the world? What is the nature of my relationship with my clients? How does change happen? It was in this context of learning and discovery that I found the words for my experience of hope in therapy.

Indeed, it was during this time that I was moving towards a clearer experience and a knowing of my identity as a counsellor and my corresponding beliefs. Along with a leaning towards Humanistic theories of therapy such as Gestalt and Existential
Psychology, I came to a reverence and a strong belief in what I call a way of being with the client. It was something I experienced as a counsellor – a way of being together in the same room with a person that truly sees and acknowledges their fundamental humanity. It was a deep acceptance and openness to their authentic person. A way of being that inspired our encounters.

Although I was deeply curious about the experience of hope in therapy, I often had doubts about whether it can truly be researched. I feared that it is too abstract and intangible of an experience to get to know directly. On one of these moments of doubt I even approached my supervisor seeking reassurance that the research was indeed feasible.

I began interviewing 6 months after I concluded my own therapy and 8 months after I concluded the practicum. The doubts were still there and it was with these doubts that I began interviewing. Throughout the interview and analysis process, I remained aware of my experience and documented my thoughts. Some of these writings are included in the present text in italic, block format, for the readers' consideration. My intention is to make my experience and my person visible to the reader so that he or she may gain a deeper understanding of the experience of hope in therapy.

Indeed, I believe that the researcher is the research tool. The method is the theory that guides that tool, but to a certain extent it is my way of interacting with the world and my way of making meaning that influence the findings. This does not invalidate the study or this approach to research. Van Manen (1997) noted that the task of the researcher is to construct a possible interpretation of the nature of a certain experience yet "no conceptual formulation or single statement can possibly capture the full mystery of
the experience” (p.92). Revealing what I can of my person will allow the reader a deeper understanding of the research process and the finding.

It is important to note that my analysis and way of making meaning of the interviews and spoken data were also informed by the extensive reading I have engaged in throughout the years of work on this project. Of the readings that I did not use directly in the text and consequently referenced, some were directly relevant to hope, while others were of personal interest in the fields of counselling, psychology, spirituality, philosophy and art.

In light of the emphasis that is placed on the researcher’s experience and biases, it is important to remember that it is a study of the phenomenon, not the researcher, that is at hand. Indeed, Bentz and Shapiro (1998, p.104) comment that:

Although phenomenology may focus on personal experience, one of its primary goals is to understand the real world. It simply recognizes that the real world is given to us in consciousness. Phenomenology is not, as it were, “gazing at your own navel,” but gazing “through your navel” at the world that is given to you, for consciousness is part of the umbilical cord that attaches us to the world.

**Procedure**

**Participants**

Participants were invited to take part in the study in 3 ways: (a) information posters (see Appendix A) were posted at the university and in a community counselling agency, (b) an information email was distributed to various university email mailing lists, and (c) participants were sought through personal contacts and networking. Upon initial
contact, I asked participants whether they have been in therapy, experienced hope in therapy and whether they have concluded their therapy a minimum of 6 months earlier. The purpose of the last criteria was twofold. I sought to ensure that participation in the study would not interfere with ongoing therapy in any way and participants would sidestep any possible harm. Additionally, my aim was to explore an experience that was complete and therefore completed. Surprisingly, none of the participants that came forth intended to discuss an experience that was in progress.

To ensure interview quality, no participants with whom I had more than a cursory acquaintance were included in the study. This decision was based on my assumption that a prior relationship may complicate the dynamic of a personal interview. Such participants may have felt less anonymous and more hesitant to share the depth of their experience. In addition, such participants may have been motivated by a generous wish to support me rather than an authentic response to the research topic.

Osborne (1990) noted that the number of participants needed for phenomenological research is variable, since the “researcher needs as many participants as it takes to illuminate the phenomenon” (p.82). For this study, I anticipated that 4 to 8 participants would be sufficient for a textual description of the experience and meaning of hope in therapy. Following 5 interviews a number of themes began emerging consistently. At this point I felt that I had sufficient information and that any more would detract from my ability to clearly synthesize the data. Indeed, Kvale (1996) noted that in qualitative research “if the number of subjects is too large, then it is not possible to make penetrating interpretations of the interviews” (p.102). Participants were 5 women in their
forties with varying cultural backgrounds. Detailed descriptions of the participants are provided in the results section.

**Screening**

To ensure selection criteria have been met, participants were screened by means of a phone conversation. I was conscious of the importance of the first encounter between each of the participants and myself, and took the opportunity to facilitate building a relationship with the participants. During the screening I introduced the research question and background for the study using an orienting statement (see Appendix B). The purpose of this statement was to encourage the participants to remember and reflect on their experience of hope in therapy so that it will be more easily accessible during the interview. I believed this to be important because the experience of hope in therapy may be more abstract than other aspects of therapy such as the therapeutic alliance. An orientation to the question was therefore meant to allow the participants to move closer to their actual experience of hope in therapy.

The screening interview also gave me the opportunity to anticipate any ethical issues that could arise and prepare an appropriate course of action. Although no ethical issues surfaced, on one occasion I spoke to a potential participant who had heard about the study through a personal contact. During our conversation it became clear that although this woman had a very positive experience in therapy, hope was not a part of her experience. She contacted me with the simple intention of being helpful. Consequently, her experience was not included in the study.

**First interview**
All Interviews took place at a location that was mutually agreeable to both participant and interviewer, and that allowed for privacy and minimal interruptions. The interviews were between an hour to an hour and a half in length, and were audiotaped and transcribed. The transcription process is described in the data analysis section. Upon meeting with each of the participants, an informed consent form (see Appendix C) was presented for review and signing. Participants were encouraged to ask questions and were offered a copy of the form for their records.

Kvale (1996) emphasizes the importance of the interview, claiming that “the interview is a stage upon which knowledge is constructed through the interaction of interviewer and interviewee roles” (p.127) and recommends advance preparation. Although technically the interviews can be described as semi-structured since no fixed set of questions were used, every phase was carefully thought out. Following the signing of the consent form, I introduced myself to the participants, sharing my field of study and my progress in my studies. I then introduced the research topic and spoke about my interest in the experience of hope in therapy. My aim here was not only to provide information to the person I was with, but to give her the opportunity to become familiar with the interview context and continue building rapport. As well, the aim was to allow for a comfort level that would facilitate the in-depth interview, as well as orient the participant towards her personal experience of hope in therapy. Throughout the interviews, I drew on my active listening and empathy skills, as well as my curiosity and reflection.

Following the initial briefing, I asked the participant to introduce herself and talk about the context of her experience in therapy. I inquired about the length of time she was
in therapy as well as when it took place. I also inquired as to the theoretical orientation of the therapist she was seeing. Consequently, I asked the participant to share her experience of hope in therapy.

The research question as presented to the participants was: “please describe your experience of hope in therapy.” Van Manen (1997) emphasized the importance of staying close to the experience as it is lived while interviewing. To do so, he suggests that the researcher remain very concrete while asking what an experience is like, encouraging the participant to recall one specific experience such as an event or a person, then exploring that experience to its fullest. I followed this guideline throughout the interviews. Further questions served to clarify and refine my understanding of the participant’s experience. I was mindful of the way I worded my questions, careful not to use leading questions. I brought the interview to an end once I sensed the participant “ran out of steam”, the focus had shifted or I sensed repetition. I closed the interviews with a summary of what I had heard and encouraged participants to contact me in the event they had anything else to add.

Second interview

The second set of interviews varied from 45 minutes to two hours. The purpose of the second meeting was to verify with participants my understanding of their experience and to share with them my understanding and interpretation of the experience of hope in therapy. The conversation was documented in writing using notes made by both participants and myself during the meeting. I met with four of the five women in person and spoke with the fifth over the phone.
During the second meeting, participants were presented with the following written information: (a) a short description of the participant which I created based on the information she shared, (b) my initial narrative description of my understanding of her experience of hope in therapy and (c) transcribed segments of her interview which I felt were meaningful along with my formulation of the relevant theme. I explained the purpose of our meeting and described the contents of the written information. The women were then asked to correct and/or comment on what they had read. Following that discussion I shared with them my analysis and description of the experience of hope in therapy and invited their comments.

At the conclusion of the second interview, I invited all participants to contribute stories, poems or art that strongly reflected their experience of hope in therapy. The purpose was threefold: (a) to further contribute to my own and the reader’s understanding of each woman’s experience, (b) to enhance the textual description of the experience, and (c) to honour the fundamentally ineffable nature of the experience of hope in therapy. The women’s contributions are presented throughout the text.

Although none of the women felt I had misunderstood their experience, three proceeded to deepen my understanding and continued to reflect on their experience. All resulting changes were subsequently incorporated into the findings.

The second set of meetings was particularly remarkable for me. Although I thought I would be completely open to any comments, I found myself at times feeling somewhat frustrated and wanting to react defensively. My understanding, my analysis, my work was being threatened. At the same time, I had such a strong desire to understand as much as I could the experience that each of the women shared with me and to
demonstrate that understanding and respect to her. I reminded myself of the difference between, on the one hand, empathizing with the person sitting with me and truly hearing their experience and, on the other, the final analysis and synthesis, which were my thoughts and understanding of the ‘data’ as a whole. I was then able to remain open to their experience as it no longer threatened my work. I was also moved by my commitment to the participants and their individual experiences.

It was at this time that the gap between experience and language became especially evident. How can Kate, Elise, Margot, Disa or Lily feel that I really grasped their experience from the few words that I have written? I found myself in an animated conversation with them, attempting to communicate this understanding to them.

**Transcription process**

Recognizing that transcription is not a static procedure but an important part of the data analysis (Lapadat & Lindsay, 1999), I personally completed all interview transcriptions. The transcript took the form of a table (Appendix C), with alternating rows for the participant words and my own. As I transcribed I discovered that I needed to dedicate an area for my thoughts and reflections, and added a column for this purpose.

The transcripts noted verbal and non-verbal information, as well as contextual information and my own field notes. I believe it was important for me to personally transcribe the interviews because I had an understanding of the research question, as well as the interaction and lived experience of the interviews. As such, my transcription has the advantage of being richer than that of an external transcriber. Moreover, the process of transcription facilitated my initial analysis and synthesis of the data.
The transcript included information such as speaking tone. Italicics and bold font were used to denote increasing emphases in speech, and descriptive comments were inserted in brackets for other intonations and pauses.

**Data Analysis**

Following transcription and amalgamation of field notes and my observations and reflections, a thematic analysis was carried out. Van Manen (1997) suggested that "grasping and formulating a thematic understanding is not a rule bound process but a free act of 'seeing' meaning" (p.79). He described themes as experiences of focus and meaning that are simplifications of the lived experience and yet capturing of an aspect of the phenomenon being expressed.

Although I did not have a precise strategy for analysis, the process unfolded naturally. In retrospect it is clear to me that the process was guided by my needs for understanding and seeing meaning. The process of analysis emerged as follows. Each transcript was read through entirely, and initial impressions were noted in the margin. The transcript was then read through again and tentative themes were formulated. A narrative of the participant's experience was then written. This process was repeated in its entirety for each interview transcript. By virtue of repeating this process for each transcript, I began to form ideas about the essential themes and structure of the experience of hope in therapy. Although not yet articulated or even clear, these ideas informed the ongoing analysis.

Next, I returned to each transcript and extracted sentences or paragraphs that I judged to be fundamental to the participant's experience of hope in therapy and created a new document containing these quotes. Going over this document, tentative, freely
worded themes were composed to describe each quote. The process was also carried out for each transcript.

Next, I examined the tentative themes for all interviews and began to compose general themes. I spent time writing and rewriting these themes and went back to each transcript assessing how well each participant's experience fit the reformulated themes. Finally, I began writing my interpretation of the experience of hope in therapy. Much time was spent contemplating and rewriting this description and the wording of the common themes. The process of analysis continued until I completed the writing of this paper.

**Rigour**

Discussing reliability, Osborne (1990) noted that “although there may be several interpretive perspectives on the same phenomenon, sameness (reliability) can arise out of the inconsistency, variability and relativity of human perception” (p.87). Nevertheless, he concluded that with the phenomenological approach, the best the researcher can do is argue their interpretations convincingly and entrust reliability to the reader.

Such inconsistency with regards to reliability is echoed widely in literature about rigour of qualitative research. Mays and Pope (1995) suggested that reliability may be demonstrated when an analysis is repeated by more than one researcher. Accordingly, I presented my analysis for scrutiny by an expert. A person with formal phenomenology research experience reviewed one complete transcript, as well as a document with quotes extracted from the transcript and their corresponding descriptive themes.

The expert was asked to comment on the analysis and themes, and assess whether any interpretations appeared questionable. The expert was further asked to comment on
any themes that she deemed to be missing from the analysis. The expert concurred with the researcher's analysis and themes, and commented that her own analysis placed greater emphasis on one of the presented themes. As such, the expert check lends further weight to claims of reliability as it pertains to phenomenological research.

Osborne (1990) suggests that validity of phenomenological research may be established in four ways. First, bracketing and a careful description of the procedure and data analysis allow the reader to understand how the researcher arrived at the suggested interpretation. I have incorporated this information throughout the text, and specifically in the method section.

Second, interpretations can be checked with participants to verify a fit between the researcher’s interpretations and the participants’ experience. This is a member check procedure. The second meeting with the five women endeavoured to achieve this. Indeed, it was during this time that I discussed with participants my belief that although I cannot know their experience fully, it is my goal to understand and present it as accurately as I could. All five participants agreed with the description of hope and the four emergent themes. Two of the participants reported no hesitation while reading through my understanding of their experience, while three continued discussing their experience to offer a deeper understanding. One of the participants discussed her reaction to the wording of the first theme and the wording was consequently changed. All the women’s comments were incorporated into the data and are noted in the results chapter.

Third, Osborne (1990) suggests that “the most crucial means of validating interpretations of phenomenological data is the juridical process of presenting coherent
and convincing argument” (p.88). This presentation is provided in the fourth chapter of this thesis – the results chapter.

Lastly, validity of the findings may also be established by checking the description of the phenomenon with those who have had the experience but have not participated in the study. If the descriptions fit, one may claim further validity of the results. Such check for validity in this study was carried out by having my research supervisor read the results at various stages of analysis. The supervisor commented on and validated the main themes found in this study.
Chapter Four

Results

In this chapter, the description and meaning of the experience of hope in therapy is presented. A portrayal of the participants is presented first, followed by a representation of the phenomenon as a whole, and finally a detailed description of the four themes.

The Participants

In the following section I will provide a simple description of the five women who participated in the study. This description is based on the information the women provided in the interview in response to the question “Can you tell me a little about who you are?” Their descriptions are presented under a pseudonym of their choice. All descriptions were verified with participants during the second interview. My personal impressions of each of the women are also included. The participants’ individual stories and experiences are developed in greater detail in the description of the four themes.

Margot

Margot is a 49 year old woman who moved to Canada from Europe 10 years ago. She is the 5th child in a family of seven, and shared that her mother started her own business shortly after Margot was born. Margot remembers being a baby, lying in a crib on the floor, gazing up at various pairs of legs walking by her. She is currently working on her Doctorate degree in a social science discipline. My impression of Margot is of an outgoing woman with determination and strength. She speaks with conviction and clarity and has a lively sense of humour.
Margot started therapy in 1993 and saw a number of therapists both in Europe and in Canada. Initially she addressed family of origin issues. However, when speaking about her experience of hope in therapy Margot referred only to her last therapist who she saw for one year in 1995. It was only with this therapist that she had the opportunity to address issues of childhood sexual abuse by a stranger. Margot described the other therapists as either not picking up her clues or being unable or unwilling to address these issues with her. In addition to the individual therapy which involved “process work, neurolinguistic reprogramming and hypnotherapy” Margot also engaged in group therapy.

**Kate**

Kate is a 46 year old woman who is a mother to 3 teenage children. Kate returned to university two years ago and is currently working towards a Masters degree. She has been married for 23 years. I experience Kate as an articulate, passionate woman with a gentle way of expressing herself. Her language is poetic and fluid, and when I am not completely absorbed by it, I find myself wanting her to speak more openly about herself. I experience her as being open and cautiously private at the same time.

Kate divides her experience in therapy into 2 parts. She began seeing a therapist 14 years ago when she was experiencing difficulties in her marriage. Two years later Kate’s husband joined and they saw the same therapist periodically for 12 years. Three years ago Kate began seeing a therapist as a result of suffering from severe physical pain that was not resolved or properly addressed by medical doctors. She found that “western medicine didn’t understand it.” During our meeting Kate spoke only about her second
experience in counselling with a therapist with a Masters degree who she described as doing “work with the body.”

**Lily**

Lily is a woman in her forties who is working towards a Masters degree in Counselling Psychology. She is a mother and is separated from her husband. Lily began our meeting by sharing with me that in 1998 she felt she was unemployable. Though uncomfortable with the connotations, she described herself as a housewife at the time she began therapy, and said she contributed to the family by doing various “really high energy and low money things.” Lily recalled feeling depressed and stuck at the time, and experiencing energy fluctuations. Lily came across to me as a gregarious, energetic, quick witted person. Her voice moved through a wide range of vocal expressions, from strong and animated to barely audible.

Lily began therapy in 1995 with a woman who was a spiritual director and also had a Masters in Counselling Psychology. Her therapy continued for 3.5 years. Toward the end of this course of therapy, Lily also took part in a structured career exploration program that involved some work in a group format. In therapy Lily addressed family of origin issues, relationship issues, her depression and feelings of being unemployable.

**Disa**

Disa is a teacher in her forties who came to Canada from Europe to do her Masters in Counselling Psychology. She has had training in counselling in her home country, and has worked as a counsellor for the past 7 years. Disa comes from a family of 5 children and says her “mother was very unhappy and she didn’t talk about her feelings.” Disa’s voice is soft and even and I experience her as thoughtful and reserved.
During our first meeting I felt I did not manage to connect with Disa to a great extent, as much as I wanted to. Our second meeting felt distinctly more comfortable and spontaneous.

Disa saw a psychiatrist periodically for 7 years, beginning in 1985. She described her therapist as being “Freudian” and “psychodynamic.” Disa sought counselling because she felt she needed help, saying “for me it was almost a question of life or death at that time.” Disa felt since childhood that there was something wrong with her and sought therapy to find out what it was and fix it.

**Elise**

Elise is a 42 year old woman who is working towards a Ph.D. in Clinical Psychology. She is a mother of two teenage girls and married for the second time. Elise moved to Canada from Europe at the age of 19.

I found Elise to be an energetic and engaging woman. She came across as self assured and spoke openly about her life. She seemed to have a joyful curiosity about and compassion for the human experience.

Elise has had many experiences in counselling beginning at the age of 20, “some that had no hope whatsoever and some that did.” Initially she sought counselling due to problems in her marriage but it was only when a therapist addressed Elise’s own pain and experiences of childhood sexual abuse that she experienced hope. During our meeting, Elise spoke about this therapist, who practiced conventional talk therapy as well as rebirthing, and a second therapist who was a Registered Clinical Counsellor and had extensive further training. Elise saw the second therapist in the context of a one year intensive training in her method. This method included techniques such as Focusing
(Gendlin, 1996) and psychodynamic approaches. The training took place in a group therapy format where participants addressed their own issues and practiced the skills they were learning with other participants.

**The Experience of Hope in Therapy**

Out beyond ideas of wrongdoing and rightdoing,

There is a field. I’ll meet you there.

When the soul lies down in that grass

The world is too full to talk about

Ideas, language, even the phrase *each other*

 Doesn’t make any sense

In therapy, the experience of hope is one of opening - an opening *of* the world and an opening *to* the world. Hope is a movement, *active*, that is strongly grounded in the present. More than a future oriented thought, belief, expectation or wish, it is the immediate experience of opening and expansion that leads into a changed future. It is about the here and now much more so than the future. Like the lifting of the clouds to reveal an infinite horizon, hope is the coming into light, the moment of shift.

Hope in therapy is a becoming, a coming into being. Being powerful, being alive in the world in a way that is dynamic, effective and therefore connected. It is a trusting orientation to the world. Still, hope is not merely in the experience of personal power,

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options, connection and trust, but the actual movement towards this way of being. It is the 
opening that makes room for the integration of these into one's present being. There is 
nothing passive about the experience of hope in therapy.

Indeed, movement is the essence of hope. In therapy, this movement is expressed 
in four interconnected realms which will be discussed as four themes. It is a movement 
away from helplessness towards power – a coming into strength. It is the discovery of 
possibilities – a coming into change. It is the shift towards being authentically in relation 
– a coming into connection. It is movement towards trust – a coming into universal trust. 
Each of these movements will be described in detail in the text.

I know hope in therapy is a movement because once immersed in it, in my 
dwelling and rewriting, I become immensely energized.

**Coming into strength**

Coming into strength was experienced by the participants as a movement away 
from feelings of helplessness and powerlessness towards agency and personal power. It 
is a movement in that it is not simply about a feeling one has control in one’s life, but it is 
in the coming into this knowing. The helplessness is a pervading sense of inability to 
effect change in one’s life and particularly the inability to alleviate emotional pain. It is a 
sense that despite all efforts, one is still in the same place and in the same condition, 
stripped of all capacity, where something outside of the person is stronger.

What a struggle to write these words, the experience which I know, the words that 
capture so little. Am I powerless against language? Powerless in the face of the 
gap between language and experience?
But more than powerlessness, hope in therapy is about the coming into personal power. Coming into power is experiencing a real capacity to realize change in one’s life. It is a movement towards a profound understanding that power lies within, that one is not simply a victim of circumstances, not just a ball in the world’s game of tennis, helplessly bouncing back and forth. At the same time, it is an act of surrender. It is the acceptance that one does not have ultimate power over everything in one’s world, and in that recognition is the movement towards regaining one’s strength.

Hope in therapy is the moving experience of empowerment – a reclaiming of one’s own personal power. Margot expressed it clearly when she said “it is possible to change my behaviour, people I associate with, I can select, it’s up to me, I have the power. So that was really...that was amazing!” Similarly, Elise shared that “it was through the process of counselling that I was, that I ... it took a while to, you know, (to) have the hope that I could actually overpower this monster.”

There is such a distinct movement for me at this moment. Being able to begin articulating this, I feel an opening. I am thinking “ok, so I can write what I know, I can do something regardless of gap, with this gap between experience and language.” My despondency seems to lift somewhat.

This coming into strength was experienced differently for the five participants. Although Elise did not have a distinct sense of powerlessness, she began therapy with the goal of fixing her husband. Delving deeper, she later realized that having been sexually abused as a child she felt powerless against the monstrous side of her father. Although on the surface she felt and was strong, she said a part of her felt like a victim. Coming into strength was particularly potent when she realized that it is not her husband that has
control over her well being, it is she who does. Furthermore, she realized that not only is it up to her, but that she can indeed do something about her situation. This coming into power was meaningful not only in her relationship with her husband, but in the rest of her life as well. She describes this moment:

So when I had that first experience of that breathing exercise that I did with this woman, it was devastating to realize how angry I was at my mother because my mom was my life, she was my goddess. And to realize that I hated her! ...and I think that first experience even though it was devastating for the first week I cried, many times because it was like my whole pink world had been shattered!

So that doesn’t sound like an experience of hope however it was because it made me feel, and this is one of the teachings this woman gave me, that I have power over my sorrows, that as long as I focused on him (her husband) and I felt that if he didn’t change I couldn’t be happy — (dismissingly) pfff!

Disa came into therapy hoping to be fixed. Since childhood, Disa felt there was something wrong with her which the adults around her knew about but would not share with her. She kept hoping someone would tell her what is wrong and felt powerless in this situation. Coming into power was experienced distinctly for Disa in the act of seeking and engaging in therapy. She said: “And I think there is always hope just that to phone and to go to (a) therapist means hope. Because you wouldn’t make the connection if you didn’t believe that it would make a difference for you.” For Disa, going to therapy was vital for her experience of hope. She was now doing something to solve the mystery.

In contrast, Disa spoke about feeling powerless in the face of her depression:
This something I was dealing with as long as I could remember, and finally I was doing something about it or finally I was seeking help dealing with it because I couldn’t do it anymore. And hope, I remember thinking that getting older will make my life easier and (pause), finding all kinds of things, believing that they would change my life. Like going abroad, going when I was 18 … to work and that somehow that would make the difference… and it didn’t. Whatever I did I always stayed the same.

The contrast between powerlessness and empowerment is distinctly present in her experience. Although Disa’s hopes for having the problem identified and fixed by the therapist were not realized in that way, she said that with time “it came quite clear to me that this was my work with her help.”

Coming into strength was a significant experience for Margot. During a session with one therapist she voiced her wish to explore her suspicion that she was sexually abused as a child. When the therapist did not respond, Margot felt humiliated, as though the therapist was indicating that she was not even worthy of a response. More so, Margot felt powerless because she did not know how to take care of these issues on her own at the time, and the therapist was withholding the help she needed. It was with a different therapist that Margot felt she was coming into her own power and strength.

[In therapy] I had *entire* control. And that also gave me like the feeling that ok, it’s up to me to run my life, and she’s giving me the tools and I’m not owing her anything other than the whatever she charged, but that was the deal. So she totally shared with me what she had, that she thought would help me. As this other guy wouldn’t even say yes or no.
Margot’s experience was not only of coming into her own power, but of her power within a relationship and of the acknowledgement of her power by another.

Although for Kate coming into strength was not a substantial feature of her experience, it was nonetheless present. Kate began therapy after battling a debilitating physical condition that was not resolved or properly addressed by medical doctors. She said: “I had a tremendous amount of fear; I was having nightmares of landing out in a wheelchair and not being able to speak and never being listened to and never really known for who I am.” She shared that it was a certain helplessness that propelled her to seek therapy:

Probably what took me to therapy was a loss of that (hope), a loss of (pause) not necessarily believing it, but just a loss of not acknowledging it. Feeling helpless and I wonder where helplessness ties in with hopelessness. Because I think that I would have used the word in therapy, feeling of helplessness more so ... than hopelessness.

Coming into therapy, Lily felt completely “unable.” In the beginning, she spent some time telling her therapist how incapable she was. The therapist’s response was a key moment for Lily:

When she said “you’re highly functional” (softly) suddenly I just felt flooded with hope. Because if I were indeed highly functional, there was no reason to think she was lying to me, then...it meant that there was hope that I could learn how to... use that.

Lily began to recognize her own strengths and realized that she was not permanently powerless as she thought. It was in therapy that she realized “well it’s a psychological
condition but it’s also a set of circumstances, so it didn’t have to mean that I was a complete screw up and always would be and this is the proof.”

Coming into strength is gaining the knowledge and experience that one can effectively deal with what seemed insurmountable. It is a movement in the realm of agency towards greater personal power.

**Coming into possibilities and change**

I never saw a purple cow,

I never hope to see one;

-Gelett Burgess

Hope in therapy is an opening to change. It is a movement away from being stuck, unable to see a way out, towards an experience of change and possibilities. It is coming to experience change as truly possible.

It is precisely here that the dynamic and active essence of hope is most noticeable. Movement and change are essential to hope. Hope in therapy is the opening of options and possibilities and an experiential knowing that change can take place, that healing can occur. Moreover, it is the discovery of how change can happen, a finding of the path through the mountains.

The participants described this experience of change and possibilities in a number of ways. Change was meaningful when it was witnessed as the experience of others, such as in group therapy or in the therapists’ sharing of their own healing process. Change was also meaningful when understood in terms of how it may come about and what it may look like. Change was ultimately meaningful when it was personally experienced in or as a result of therapy.
Margot expressed this becoming unstuck enthusiastically, saying “really for me it gave like ok, it is possible, I don’t have to be stuck with this.” The movement was also evident in Lily’s experience. She said “I just thought there’s no way I could hold down a job, so that was adding to my feelings of being stuck” but later “I realized during that (therapy) that I could do that (work) though I might be depressed, though I might have a headache.”

Lily spoke about this realization at length during our second meeting. She explained that as long as she believed she needed to be completely happy before she was able to work, she felt she was standing in front of a towering, insurmountable wall. When she realized depression does not have to stop her from working, it was as though she expanded and was now able to climb over the wall. The obstacle did not disappear, but it was no longer the cause of inaction, the external circumstances that blocked her life. The obstacle no longer obstructed her view. Depression changed into a nuisance, an excuse, no longer an impossible task. Once the initial change took place, Lily described the continuing experience of coming into possibilities:

So there was that huge thing and sort of went from there. I got a job for the summer and it took me away on my own into the interior…and I met people through that and that led to other things it opened up more things in my life and it just went from there. And but see prior to that I was in therapy for three and a half years, so it was this kind of opening and opening and opening that happens, and I think it’s hope. I think that’s essential and I just don’t think anything else works.
Opening to change was also a matter of finding new ways to understand and respond to life. This was Elise's experience - the uncovering of new options. While speaking to her therapist about her marriage she said:

I mentioned that one of my things was this husband of mine and me and our marriage and that...and she drew on her board this thing where she explained to me the...her theory I guess of the path of relationship. And so a lot of us get stuck in the thought that you know, either he wants me too close and I don't want him that close and that's it but she showed me that there's always a third way. She worked that way a lot. What you're living, what you think is the other choice that doesn't work either but there's always a third way. And she drew this thing on the board and I walked out of there thinking oh my god! I'm not with that man anymore but for that moment, you know, she gave...she made me feel like there is...that there is always a third way, that there is always hope.

Witnessing and hearing about others' experiences of change was significant for Lily, Elise and Margot. Change became real and possible because it was seen. For Elise this also functioned as a possible example of how she may experience it herself. She said:

Something else like that was huge for me is their (the therapists') own sharing of themselves, or being vulnerable and saying it can happen, right? Not promising you anything but saying this is how it can happen and explaining to you how that process works.

Margot's words echoed the importance of change. Discovering how she can heal and learning that change is indeed possible were central aspects of her experience.
So all that ... gave me a lot of hope because after every single session whether it was this big group or the sexuality group or the individual, I saw progress...

Whether it was my progress, or whether it was progress that somebody else in the group was telling about. It just gave me the feeling ‘well, it is possible to change!’ it is possible to change my behaviour, umm, people I associate with, I can select, it’s up to me, I have the power. So that was really...that was amazing!

Therapy held the distinct promise of sweeping changes for Disa. Her experience of hope was shaped to a large extent by her experience and expectations of change.

[During therapy] I think my hope went up and down, I think it was very high in the beginning because I trusted this woman immediately, and I thought this is a beginning of a new life for me. And then weeks and months (went by) and I was still myself.

Indeed, without change Disa felt she would have died. But with time she experienced the change she sought: “and it’s true when I say it’s saved my life, but not the sense that... I don’t believe that I would have killed myself. But because she, she changed my life so much.”

After our second meeting Disa shared with me a poem she wrote years ago while she was depressed. She translated it from her native tongue.

The sky cries its tears into the lake
that becomes deeper and bigger and bluer
and the sun’s reflection
is more beautiful than ever
next time she breaks through the clouds.
Driving home from the university, English Bay is covered in clouds, but far off in the distance an orange hue signals the sun is still there behind the clouds, setting and rising as it always does. I come home and write the following: Like the lifting of the clouds to reveal an infinite horizon, hope is the coming into light, the moment of shift.

A movement towards change is also about discovering that choices are available in one’s life. When options are available, then change can be envisioned and brought about. Kate’s experience illustrates the intimate connection between discovering choices and coming into strength:

So that I think that when we, when we get to a place where we realize that we have, we do have choices, and I have spoken to many people who will argue with me, you know, till the cows come home that no we don’t have a choice. I think we do have a choice, and for me when I came to that place of really realizing that yes I did, bottom line, I have a choice as to whether I get out of bed in the morning and feed my kids, I have that choice. So knowing that gives me hope! It gives me the ability to live in the world of countless possibilities...what is hopeful about having that perspective? A belief that anything can actually happen.

The experience of hope in therapy is the experience of possibilities in the face of hardship. None of the women claimed that once they experienced hope their lives had been miraculously transformed and became free of suffering. However, it was with hope, with a knowing of what is possible, that they regained joy in their life. Kate’s vignette illustrates this exquisitely.
It’s something that I’ve seen in children, I’ve seen in infants… I believe they come into this world with the essence of hope. You know…I was watching a video a couple of years ago of one of my kids learning to do somersaults in the back yard, that is a picture of hope! No matter how many times he fell to the side, no matter how many times he was going like this and he just couldn’t get his little bum flipped over, that’s hope, a belief that it can be done, it’s possible, and there’s a joy that goes with that.

**Coming into connection**

It’s not something that we give to another but it’s something that arises in that space of in between, if one of the two people, or one of the two, whether it be the ocean versus the human being, is present to it.

-Kate

Coming into connection was the most clearly articulated theme expressed by the participants. It is a movement away from feeling invisible and disconnected, toward living in relation on any number of levels. Coming into connection was experienced as a safe and trusting relationship with the therapist, becoming aware of one’s own feelings, deepening or re-establishing connections with other people in one’s life, and/or a connection with something greater such as nature and spirituality.

All five participants spontaneously provided examples of therapy where they felt they were not heard. Hearing about where hope was not experienced in therapy illuminated where it actually was. The movement of hope is away from feeling or being invisible. Disa spoke of a therapist she saw once:
She gave me homework. She listened to me for a while and I was talking about school and she sent me home with homework and it was so completely wrong.... And for me she was just saying... she wasn’t listening. She didn’t try to see me, she was just trying to do something I suppose... she missed the point that I wasn’t coming to her to get some good advice about my singing problems. I was coming with my life... She didn’t hear me, yeah. And I didn’t give her a second chance. At least I didn’t go back.

Elise’s early experiences in therapy were similar:

And so we tried a few counsellors, and I always liked them but I can’t say that, you know, the first few ones that I saw I felt that (it gave me) hope. It was always about I would go there and say “well my husband has this this this this” and they would say “ok bring him over”. And the focus was always on fixing him, right? So when I was grown up my father was an alcoholic, I was molested, I mean I had a lot of issues in my life that I thought needed to be addressed but they always went back to let’s fix your husband.

Not being seen was also felt in the context of the community, as well as personal relationships such as marriage and immediate family, as it was in Lily’s experience. She spoke about being a “housewife”:

It’s like the way the community views you – “oh, you must have a lot of leisure, oh your family, your husband must make a lot of money, oh you’re very lucky” you know they don’t see the beater that you drive that breaks down, they don’t see the Value Village, I’m fine with all that but still, the recycling, the barter, the
incredible amount of energy that goes in because you’re not bringing in money.

So there was all that, and I guess that lack of, I wasn’t being seen.

Indeed, being heard, understood, affirmed and supported in therapy are essential to feeling connected. This is captured well by Carl Rogers’ (1951) term unconditional positive regard. It was in the context of connection that Kate experienced hope. She described it:

I found that I really looked forward to seeing (the therapist) because she was not dismissing what I had to say, and she was valuing what I had to say. ... There’s something that happens when you know you are being heard. ... It’s something I can feel in here (pointing to her heart).

The context of a safe and trusting relationship with the therapist was echoed by all the participants. Margot shared an experience that was significant for her. This occurred at the beginning of her individual therapy while the therapist was trying to hypnotize her.

I was just wide awake... and she said “well how do you feel?” and I said “whoa I’m afraid of this. I don’t know where it’s going to take me, it’s scary.” And she said “does it remind you of any other situation earlier?” and I immediately knew that it was the situation where I had been climbing the clotheslines in our basement and I fell right on my nose. And there was a lot of bleeding and then I was taken to the hospital. And at that time, you know, it was long ago so the x-ray was taken I was put to lie on a bed. And then the machine was brought down to my face, and I was all bloody and messy and I had a knife on my belt, I always carried a knife when I was a little kid ... So the doctor was laughing at me about the knife plus nobody explained to me what is going to happen. So I was scared
to death and I was screaming and yelling and the people had to grab me and keep me down there so that they can take the x-ray. So that that’s what was happening to me on that floor. And then she said “oh, oh that must have been very scary” and then she said “I am going to put my hand on your shoulder, if that, if my putting my hand on your shoulder, if it gives you any message, what would it be?” And then she put her hand on my shoulder (reaching and putting her hand on my shoulder) really really gently and I said ‘yeah it’s not going to hurt’, (louder) this is not going to hurt! So that, that was like, OK, this therapist is listening to me. She is taking into account what I need, I just needed that assurance, and she has the skills to do it. So thereafter I didn’t, I was not scared at all, I just went there and I said ‘Lisa, today we do whatever you think works best!’

It was in this context of safety and trust that the women then connected with their own feelings. Once again, all participants spoke extensively about becoming more aware of their own feelings and their own value. It was within a safe connection with a therapist who was intimately attuned to their experience that a sort of mirroring occurred. This mirroring invited the women to experience and accept their own feelings and needs. After Lily’s therapist said that she is high functioning, Lily thought “it went against everything I was believing about myself. But, she didn’t even have to sort of go into it and say I see this and see that...I started seeing it.” Kate said:

I think the honouring of tears, has been, ties into hope as well. Some of the body work that I did with this woman around that experience when I was four, was incredibly, incredibly powerful, very draining, several boxes of Kleenex...and yet, yeah there is a comfort that somehow ties into hope as well.
Lily shared the following poem:

Love after Love

The time will come
when, with elation
you will greet yourself arriving
at your own door, in your own mirror
and each will smile at the other’s welcome,

and say, sit here. Eat.
You will love again the stranger who was yourself.
Give wine. Give bread. Give back your heart
to itself, to the stranger who has loved you

all your life, whom you ignored
for another, who knows you by heart.
Take down the love letters from the bookshelf,

the photographs, the desperate notes,
peel your own image from the mirror.

Sit. Feast on your life.

Connecting with others was another aspect of the movement towards connection. For Kate, coming into connection with her own feelings and her own truth empowered her to live honestly and courageously in her world.

And I believe that that process of therapy gave me the strength to live what it is that I believe regardless of what the cost is going to be. And one of those costs, at several times, could have easily been my marriage. But having somebody that gave me that sense of deep listening that what I felt (pause) it wasn’t so much that it needed to be listened to but that I didn’t have a choice not to listen to it. And that was part of the thinking that went into my back (pain), that I was not listening to what I intuitively knew. And because I wasn’t listening to it I wasn’t living a life that was very honourable. So I wasn’t living in the world with as much truth as what I could be. And so that gave me the courage, being listened to like that, fairly consistently, gave me the courage to say, this is how I choose to live in the world and it’s my choice and, you know, if you can accept that that’s great and if you can’t then that just makes us different it doesn’t make us lesser or greater, it just makes us different.

Similarly, Lily felt that once she connected with her own feelings she was able to bring that honesty into her relationships.
(I was able) to be more honest and say, “You know what? I feel like shit”. It was, it was such a relief, and the people who sort of believed me and were willing to engage with that, like willing...you know, they are still around!

Finally, feeling connected to something beyond oneself such as nature, spirituality or God was also a way that coming into connection has manifested. Elise spoke about a connectedness to God:

I remember going to bed and having this little chat with, I used to call him little God, I’m translating but, and just ask that my mom be ok and whatever, and I always felt this safety connection there but I think what I got through (therapy) was a whole sense that there is a higher self, this is what (the therapist) used to call it, there’s a higher self, your connectedness with...like I said it doesn’t have to be religious or anything but umm...and a real belief that God is there – doesn’t do the work for you but he’s there or she’s there. There to (pause) support you, like the wing under your wings. You’re doing the flying but there’s something there.

Being in connection meant not being alone. Kate shared that “the feeling of never being totally alone helps me live in the world with hope.” For her, this connection with something bigger is essential for life.

And I think that those places of hope that I feel, they do come out of experiencing a depth of relationship with people but that’s only part of it. I can be down in the depths of despair, and standing on a mountain top somewhere and feel the wind in my face or feel the mist from the ocean or something like that, that gives me hope.
Kate later shared the following poem.

It Felt Love

How
Did the rose
Ever open its heart

And give to this world
All its
Beauty?

It felt the encouragement of the light
Against its
Being,

Otherwise,
We all remain

Too

Frightened

3 "It Felt Love" from The Gift: Poems by Hafiz the Great Sufi Master translated by Daniel Ladinsky.

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It is here that the unfolding and opening nature of hope in therapy is especially evident. It is an opening that moves through interpersonal, intrapersonal and transpersonal dimensions, opening up and deeply taking in the world.

**Coming into universal trust**

We shall not cease from exploring,
And the end of our exploring
Will be to arrive where we started
And know the place for the first time.

-T.S. Eliot

Coming into universal trust is the movement towards assimilating a sense of hope as an integral part of one’s attitudes and beliefs about the world. It is a movement towards having that sense of hope as a stable and accessible aspect of one’s life. It is with this new or renewed outlook that one now approaches the world. It is just this approach to life that inspired Elise’s experience:

It’s developing a sense of trust, trusting that life will turn around. Having faith and trust that things can always get better, even when they’re at the worst. And I think that was the gift I got from all those counsellors. That even now when things can get tough and I feel like crap or whatever, I developed through that experience a real strong sense of faith and trust that you always come out the other side.

Once the sense of hope was internalized, it became stable. Margot enthusiastically shared that “It is amazing! And it doesn’t go away! It doesn’t go away!”
I’m still there, six years later!” Indeed, all but one of the women spoke about experiences in therapy that concluded many years ago. They were nevertheless strongly motivated to speak about their experience of hope and met with me despite time restriction and the many demands of student and family life. Indeed, in our second meeting Lily articulated how strongly drawn she was to share her experience.

*Like a movement stirring itself.*

Coming into universal trust was evident in Lily’s sharing of her goal for herself in the world, a goal she is continuously working on.

I think that’s the one sort of goal and aim that I’ve had all through my life that I’ve managed to hang on to, is that I can go into middle age and on, I’m determined to go on to whatever ends, without excess bitterness, callousness, cynicism...because that’s just my highest ideal. It’s that that is a human being, this someone who gets through and isn’t turned off everything, just the sufferings of the world and isn’t completely unable to see innocence and goodness in what’s going on. But it’s a struggle.

Coming into this orientation towards the world was also manifested in the women’s hope for other people – for their children, their spouses, and for humanity. Elise spoke about her children:

But you know that if they have any hurt or harm, I have that hope for them too, you know? That they can seek help or find it within themselves to heal whatever wounds they’ve experienced in their lives. So that my mothering or the way that I raise them is always with hope. And I think I really....I really got that from that experience of seeing that (softer) the biggest pain can turn around.
Similarly, Lily spoke about her children, saying “I began to have hope for my relationship with my children and with my...for their lives.” Speaking about her experience in the group Elise shared that

What was very helpful about that is that you would see other people being processed on stuff and experiencing and you would see them coming out the other side also...and feeling better. And so that was also an experience of, you know, it’s not only me that can change or (the therapist) that can change – lots of people! The hope then became for me with (the therapist) about...humanity almost.

About it’s not only about me and you the counsellor and the client or the, you know, it’s that there is potential for people to get through pain. Pain doesn’t have to have a handle on you for the rest of your life.

For Kate, therapy was a way to reconnect with a fundamental sense of hope that she feels is always there, but that is not always consciously felt. She shared a story that illustrates this experience for her.

For some reason I would be closed off to it, I would shut down. It’s the same thing as love. One of my 19 year olds told me the other day we were talking about moms and whether motherhood is honoured in our society and what does that mean to honour motherhood and this sort of thing. He said to me “you know, I knew”, he said “I’ve always known that you are there for me” but he said “when I was 15 and 16” he said “I was shut off to that.” And I said “well what do you mean?” and he said “I just shut myself off to that.” And he became a rebellious little character and he said “I needed to do that; I needed to push you away to make sure that you’d be there.” And he said “finally I sort of looked around one
day” and he said “I realized that it wasn’t you who wasn’t there, you always have been, I pushed you away.” And so I think that that’s a very, it’s a very powerful story that spoke strongly to me about what has happened in my life of going through points of not feeling hope. It’s not that hope does not exist, but I’ve pushed it away, or I’ve become so hell bent on seeing the world a certain way because that justifies my frustration and my anger, that I’m not fluid enough I’m not receptive enough to see that that hope is actually there.

Kate shared this poem:

A Cushion For Your Head⁴

Just sit there right now
Don’t do a thing
Just rest.

For your separation from God,
From love,

Is the hardest work
In this
World

Let me bring you trays of food
And something
That you like to
Drink.

You can use my soft words
As a cushion
For your
Head

In sum, the experience of hope in therapy was described as an active experience with four areas of movement: coming into strength, coming into possibilities and change, coming into connection and coming into universal trust. This description illustrates that hope in therapy is not a passive thought or emotion; it is the immediate and dynamic movement towards a new or renewed way of being.
Chapter Five

Discussion

This study was a phenomenological inquiry into the lived experience of hope in therapy. The research question the study endeavoured to answer was: What is the lived experience and meaning of hope for clients in therapy? In the following chapter I will discuss the results of the study in light of available current literature, make recommendations for further research, and discuss implications for counselling practice. As well, I will consider the limitations of the study and conclude with a summary.

Comparison to the Literature

Hope has been addressed in numerous fields of study including nursing, psychology, sociology, theology and philosophy. Nursing literature in particular has acknowledged hope as essential for health and healing (Dufault & Martocchio, 1985; Farran, et al., 1995; Hinds, 1984). Literature in the field of psychology reflects a recent increasing interest in hope. The Hope Foundation of Alberta was found in 1998 and is “dedicated to the study and enhancement of hope” (http://www.ualberta.ca/HOPE), while Snyder’s (1994, 2000) theory and measures of hope have provided the basis for numerous research studies.

Surprisingly, despite the extensive recognition of hope as health promoting and therapeutic, little has been written about this phenomenon in the context of psychotherapy. In fact, outside of the nursing and physical illness context, Benzein, Saveman and Norberg (2000) and Sutherland (1993) provided the only research investigations of the experience of hope in physically healthy adults. Snyder, Michael and Cheavens (1999) and Snyder and Taylor (2000) put forth the only theory dedicated to
hope in therapy. Since health and healing are the purpose of psychotherapy, given that hope is valuable for health and healing and considering the need for research in this area, the purpose of this study was to describe hope as experienced by clients in therapy. The results of this study will now be discussed in the context of existing research and theory.

The findings of this study indicated that hope in therapy is an active phenomenon, experienced as a movement towards strength, change, connection and trust. Snyder and Taylor’s (2000) theory of hope in therapy suggests that hope is composed of agency and pathways thinking, both of which are necessary if one is to experience hope. Furthermore, hope is understood to a large extent in terms of goals. This is a cognitive theory of hope that is couched in cognitive terms and focuses on one aspect of the human experience. Naturally, a cognitive approach is quite different from the phenomenological foundation of the current study and consequently the findings are somewhat different.

Nevertheless, a number of fundamental parallels are apparent and warrant discussion. Snyder and Taylor (2000) discussed agency thinking as one of the two elements of hope. According to the theory:

Agency reflects people’s thoughts about their capacity to use the pathways they have selected to reach their goals. As such, agency is crucial for the psychotherapy process because it provides the mental energy so that the client can undertake the various therapy-related activities. (p.92)

In this sense, agency is similar to the movement towards strength as described by the participants in the study. Coming to experience oneself as an agent in one’s life was an essential aspect of their experience of hope in therapy. However, this coming into strength was expressed as more than a thought or belief; it represented a sense of identity
and an action. As well, although implicit goals may have been part of the experience, this experience was not expressed in terms of explicit goals.

The dynamic experience of the participants in this study concurs with Yahne and Miller’s (1999) description of hope as action: “hope is manifest in action. Acting in spite of current circumstances, ‘against all hope,’ is perhaps the deepest expression of hope...Such hope moves from the realm of thought and feeling into expressed action” (p.221). Indeed, Dufault and Martocchio (1985) suggested that the behavioural dimension of hope focuses on an active orientation to hope. They clarified that there is an overlap between the cognitive and behavioural dimensions of hope since thinking is a form of action. More importantly, Dufault and Martocchio (1985) further delineated actions as falling into one or more of four realms: psychological, physical, social and religious.

The active nature of hope as well as the movement towards a sense of strength and agency are reiterated by both theory and research. Discussing agency and action, both Snyder and Taylor (2000) and Dufault and Martocchio (1985) attend to the importance of help seeking behaviour. Snyder and Taylor (2000) review Frank’s (1991) theory of therapy which suggests that clients come into therapy because they are demoralized and feel unable to solve their problems. They suggest that by virtue of seeking help, clients are demonstrating “a sense of agency that therapy will provide assistance or relief” (p.93). Similarly, Dufault and Martocchio (1985) discuss seeking help from others as an example of the behavioural dimension of hope in the social realm. In sum, existing research and theory concurs with the finding that movement or action, as well as a sense of personal strength are elements of hope in therapy.
Movement towards possibilities and change was another element of hope described in this study. This movement bears some similarity to Snyder and Taylor’s (2000) pathways thinking. Pathways is defined as the “individual’s perceptions that they will be able to generate effective routes to desired goals” (p.97), and involves thoughts such as “I can find a way to deal with this.” The experience of coming into change and possibilities is similar to pathways thinking in that it is the experience of becoming unstuck. Being stuck is not being able to see a way out, or not knowing that a way out exist. Moreover, it is the experience of being blocked and therefore ineffective in one’s life. For the participants in this study, coming to experience change as possible indeed involved thoughts such as “it is possible” and “this is how it can happen.”

However, an actual experience of change, along with thoughts about possibilities and ways of change were also an important element of hope for the participants. The women spoke not only their own experiences, but also sharing of others’ experiences of change. Again, Snyder and Taylor’s (2000) cognitive emphases overlooks this experiential aspect of hope.

Coming into connection was echoed in Dufault and Martocchio’s (1985) description of the affiliative dimension of hope. Coming into connection involved a movement from a sense of being alone and invisible towards an authentic connection with the therapist, oneself, other people, nature and finally a spiritual connection. Similarly, the affiliative dimension of hope “focuses upon the hoping person’s sense of relatedness or involvement beyond self” (p.386). Moreover, Dufault and Martocchio (1985) agree that this dimension involves relationships with people, God and other living things.
Similarly, Benzein et al. (2000) described the experience of having meaningful relationships as linked to the experience of hope. Such relationships were described as being in touch with one’s thoughts and feelings, having genuine supportive and trusting relationships with others, and transcendental relationships with a connection to “some higher being” (p.311). This description concurs with the experience of coming into connection described by the participants in this study. Indeed, coming into connection was experienced as a safe and trusting relationship with the therapist, becoming aware of one’s own feelings, deepening or re-establishing connections with other people in one’s life, and a connection with something greater such as nature and spirituality.

Therapeutic process research has long acknowledged the importance of the therapeutic relationship. Frank (1991) suggested that an emotionally charged relationship with the therapist promotes the client’s hope and healing. However the multifaceted nature of coming into connection has not been acknowledged in this context. Nevertheless, this study confirms the importance of the therapeutic relationship and suggests an expansion in our understanding of relationship for the client.

Finally, coming into universal trust was described by participants as movement towards a trusting orientation to the world. This movement was characterized by having hope for other people in one’s life, as well as for humanity as a whole, and the attitude that one can make it through difficult times. It may be speculated that a process of internalizing hope as an aspect of one’s way of being in the world has taken place. It was with such renewed orientation that participants then proceeded to deal with difficulty in their life.
This characteristic of hope has not been discussed in either the literature of hope in therapy, healthy adults or in the nursing literature. However, this orientation to the world is exceptionally similar to Erikson's (1950) first stage of psychosocial development. During this stage, the infant's task is to resolve the crisis of trust vs. mistrust. According to the theory, in the context of consistent, continuous and familiar care, the infant will learn that the world is a safe place and that the people around him are reliable. According to Erikson (1950) this stage occurs during the first year to year and a half of life. If this crisis is resolved, the infant gains hope. This hope is the sense that even when things are not going well, they will work out in the end. It is precisely this orientation to the world that was articulated by participants in the study. It was a regaining of the sense that they will be ok, whatever hardship they must endure. Accordingly, in a quantitative study Brackney and Westman (1992) found a positive correlation between measures of hope and Erikson's first six stages of psychosocial development.

In sum, much of the experience of participants in this study is echoed with some variation in the literature. The exception is the shift in orientation to the world that was described as the fourth theme of the experience of hope in therapy. Although further research is needed to verify the universality of this experience, it represents a possible and intriguing contribution to the field.

Implications for Counselling Practice

Since the experience investigated in this study was set in the context of therapy, a number of possible implications for counselling practice arise. Participants shared that experiencing their own capacity to effect change in their lives was important to their
experience of hope in therapy. Consequently, helping clients arrive at such an experience may prove beneficial for their experience of hope. How can a counsellor facilitate such an experience in therapy? First, it is important for the therapist to discover with the client where their sense of helplessness is located. Clients do not often arrive in therapy feeling completely powerless. Delineating where they feel ineffective in their life is of importance since it is precisely in that realm that a sense of movement and empowerment will be most meaningful for the client.

This study suggests that working in respectful collaboration with a client is fundamental to his or her sense of coming into strength. It is important for counsellors to recognize and acknowledge that there is a power dynamic in their relationship with clients. The nature of the relationship is such that one person comes to another for help, and consequently this relationship is in some ways unequal in power. Many counsellors may be reluctant to acknowledge this however it is precisely in this context that the process of empowerment is relevant.

Consulting with clients regarding their experiences and reactions to the therapy and interventions conveys that they have influence in the relationship with the therapist and over the direction of therapy. For example, communicating to clients that they have control over how far they wish to proceed while dealing with difficult and often frightening feelings invites clients to experience their own power and agency with regards to their life in the session and within the context of a relationship with another.

It is here that clients may begin to rediscover some sense of control in their lives. Implications for the counselling relationship are inherent to this approach. Indeed, the findings of this study reiterate and emphasize the importance of the therapeutic
relationship. This relationship is not only significant for a feeling of coming into strength, but to the client’s feeling of being in connection.

Much has been written about importance of the therapeutic relationship and how it may be established (Egan, 1998; Hackeny & Cormier, 1996). Empathy, unconditional positive regard and genuineness are some of the terms used. The importance of attending to the client’s own unacknowledged feelings has also been written about extensively. However, this study suggests that a safe and trusting relationship with the therapist is only one aspect of the experience of hope in therapy. Authentic relationships with others in one’s life and spiritual relationships that involve a feeling of connection with something bigger than oneself are of importance as well. It may be that the therapeutic relationship is the only aspect the counsellor can actively and directly participate in, but the study suggests that attending to the client’s other relationships, as well as issues of spirituality may be beneficial as well.

The participants’ experience of coming into connection implied an initial sense of feeling closed off to aspects of the world. The experience of hope was that of opening and therefore reconnecting with the world. This suggests that encouraging and working with clients toward re-establishing a sense of connection may be valuable. Where is the client feeling disconnected? What is their way of interacting and living in their world? What is a possible way, considering the person of the client, their current situation and their context, for him or her to experience a sense of connection? Such question may be useful for both therapist and client to consider when contemplating plans for change and action.
This study also suggests that it is important for therapists to have a clear theory of change, as well as a comprehensive and confident understanding of the theories and interventions he or she is using. Moreover, it is important for the therapist to communicate this to the client. The purpose and value of such communication may be seen in three interconnected ways. First, the therapist’s genuine knowledge and confidence may increase the client’s trust in the therapist as a professional and an ally, and therefore enhance the client-therapist relationship. Such development may work to enhance their feeling of connection and safety in the therapeutic relationship.

Second, therapists who share their approach communicate that they have nothing to hide, that they do not possess ‘magical’ power, and that they trust and respect their client. Such communication informs the client and in this sense knowledge may be viewed as power. In general, people often feel more in control when they have a sense they understand their situation. Understanding the therapist’s position and direction offers the client information and therefore power and a sense of control.

Finally, sharing one’s theory of change with the client allows him or her to envision the form that change and healing may take. As such, the client may become more open to possibilities for change and movement in their own situation. This addresses the movement away from being stuck and unable to envision possibilities, and paves the road towards an experience of change. In a sense, coming to appreciate new possibilities is in itself an experience of change.

It was interesting to note that three of the participants described their experience of coming into possibilities and change in the context of a group. Indeed, the participants shared that seeing others find options and experience change stimulated their own sense
that undiscovered possibilities await and change is possible for them. The experience of hope in therapy may be promoted by participation in group therapy. Counsellors may therefore consider encouraging clients to pursue such activities.

The experience of coming into a trusting orientation to the world was described by participants as an attitude that they are capable, and live in a world where they can find a way to overcome any future difficulties. The participants’ description suggests that this was an important aspect of their experience of hope. To facilitate such orientation, it is important that counsellors remain consistent in their interaction and relationship with the client. Such consistent relationship will provide clients with an opportunity to begin acquiring or re-acquiring a sense of stability and trust in the world.

Finally, van Manen (1997) suggests that phenomenological research is valuable because it allows us to become more intimately experienced in the world. Accordingly, this study affords counsellors the opportunity to become more deeply immersed in the experiential world of the client, and move closer to knowing the client’s experience of hope in therapy. Such knowing may enrich and contribute to counselling practice through the person of the counsellor.

**Recommendations for Future Research**

Therapeutic effectiveness is at the core of counselling practice. This study was an investigation of an element of the client’s experience in counselling that has been put forward as essential for successful therapy. The results of this study, though neither broad nor final, raise a number of interesting questions that merit further research.

Qualitative research affords a deeper and more detailed understanding of the human experience than quantitative research. As such, the results of this study
illuminated the possible structure of the phenomenon as it was experienced by the five women who participated. Although 2 men replied to the participant recruitment notice, both were friends with the researcher and were consequently excluded from the study. Further research is needed regarding men’s experience of hope in therapy. Indeed, to expand our understanding of this experience further research is needed with people of various ages and cultural backgrounds.

One aspect of the experience of hope in therapy described in this study – coming into universal trust – emerged as a unique contribution to the field. Further research of such experience has the potential of being especially significant to the counselling field. How do clients arrive at this orientation? Is this orientation gained or re-gained in therapy? How does this attitude to the world affect one’s thoughts, behaviour and emotions? Once gained, how stable is this way of being in the world? These are just a few of the questions that need to be answered.

**Limitations of the Study**

This study was a hermeneutic phenomenological inquiry into the lived experience of hope for 5 women who have been in therapy. Since a qualitative approach guided the inquiry, the familiar limitations of qualitative methods are applicable. Indeed, this study does not allow for generalization of the findings. The study reflects the experience of the five participants and suggests themes that may be essential to the experience of hope. Further research is necessary to confirm the essence, structure and meaning of this experience. Nevertheless, this study contributes to a growing body of knowledge about the experience of hope, and makes a unique contribution in its investigation of hope in the particular context of therapy.
An obvious limitation of the study is that all participants were women, in their 40's and graduate students. Although the participants were students in various disciplines and came from various cultural backgrounds, there is a certain homogeneity to this group of women. It is possible that the essence of the experience of hope in therapy is different for men, and those who are not students. As well, although some cultural variety was represented by the participants, all the women came from a North-American or European culture. Even though the researcher is bi-cultural and a member of both Israeli and Canadian backgrounds, the study is nevertheless limited in its cultural scope. It is unclear whether people of different cultures understand and experience hope, in therapy or outside of therapy, in similar ways.

A further limitation of the study was a result of time constraints present in the context of the research and researcher. It is possible that additional time would have allowed for further analysis and additional depth to the resulting description of the phenomenon. Additional time would have also allowed for numerous meetings with participants and opportunities for clarification and wider inquiry. Nevertheless, it is important to consider that all research is set in the context of time and as such is influenced by this context.

Finally, the data for this study was gathered using personal interviews. The interview format suggests a number of limitations. First, data is limited to what the participant is willing to share with the researcher. Second, investigation of the experience is limited by the participants' awareness of their experience, along with their ability to articulate it. This limitation is particularly relevant for the topic at hand, since hope is
very much an abstract phenomenon. Further research is not only recommended but necessary in order to

**Final Remarks**

As I hope was evident throughout the text, engaging with this research was an exciting and challenging experience for me. My intention was to research something of direct and obvious relevance to counselling practice, as well as something that I was authentically curious about. It was an unexpected joy to discover and employ a method of inquiry that resonated so deeply with me.

Indeed, the experience of conducting this study involved not only engaging with the experience of hope in therapy, but also the lived experience of immersing myself in phenomenological inquiry. Indeed, I learned as much about doing research and about phenomenology as I did about hope in therapy.

Although at times immersing myself in hope and in phenomenology seemed to present the threat of drowning, at other times I was so energized and inspired by the work it was all I could think and talk about.

Carrying out this study has taught me about the privilege and responsibility of conducting research. This experience will undoubtedly inform not only my continued research practice, but my practice of counselling as well.
REFERENCES


Levenson, H. (1972). Distinctions within the concept of internal-external control:


Appendix B: Orienting Statement

My name is Orit Reem, and I am a Counselling Psychology student in the second year of the masters program. For my masters thesis I am studying the experience and meaning of hope in therapy for clients. When we meet, I will be asking you to share with me your own experience of hope in therapy.

I am interested in hearing about what this experience was like for you. To focus our conversation, it may be useful to recall a specific event or moment of hope that you have experienced in therapy. During the interview I will be asking you question that will allow me to further understand your experience and reflect on its essence. Periodically, I will also check my understanding with you.
Appendix D: Transcription Format

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