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Courtney Jones
Therapist's Views of the Role of
Hope in Treatment Goal Setting and
Attainment among Clients with
Posttraumatic Stress Disorder: A
Qualitative Study

ABSTRACT

The purpose of the current study was to determine the way that therapists view the role that hope plays in the treatment of clients with Posttraumatic Stress Disorder, specifically in regard to the treatment planning process and attainment of treatment goals. This exploratory qualitative study aims to contribute to previously existing literature about hope and its influence on treatment processes and focused on the areas of: (a) the role of hope in the therapeutic process, (b) hope and PTSD, (c) the assessment of hope, (d) fostering hope, (e) PTSD and treatment goals, and (f) hope, PTSD, and treatment goals.

Ten therapists from two agencies in Connecticut participated in audio taped interviews in which they answered questions regarding the topics above. A major finding of this research is that clients with PTSD generally have lower hope and often times this hope must be fostered by the therapist. Further, many clients with PTSD have a foreshortened sense of future which can inhibit goal setting abilities. Suggestions for further research included focusing more closely on the role of avoidance in these clients and how the targeting of this symptom might increase hope early in treatment.

**THERAPIST'S VIEWS OF THE ROLE OF HOPE IN TREATMENT GOAL
SETTING AND ATTAINMENT AMONG CLIENTS WITH POSTTRAUMATIC
STRESS DISORDER: A QUALITATIVE STUDY**

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements for the
degree of Master of Social Work.

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2010

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CHAPTER I

INTRODUCTION

Hope is a concept that has become increasingly pertinent to the mental health community in recent years. The relationship between hope and physical and mental well-being has been researched well over the past fifty years (Schrank, Stanghellini & Slade, 2008). These studies have shown that the more hopeful or optimistic a person, the more mentally healthy that person may be in terms of attributes such as high achievement, motivation, and lower depressive symptoms (Gillham, Shatte, Reivich, & Seligman 2001; Gottschalk, Fronczek & Bechtel, 2004; Aikens, Kroenke, Nease, Klinkman & Sen, 2008). More recently, scholars have looked at the influence of hopefulness, and specific clinical training (Brodhagen & Wise, 2008). As a result of the continuing interest in the factor of hopefulness in achieving clinical outcomes, there is a need for ongoing research to progress social work practice and the treatment of a variety of mental illnesses.

This study will examine therapists' views of the relationship between hopefulness and treatment goal setting, especially in clients with a primary diagnosis of Post-Traumatic Stress Disorder (PTSD). Within this purpose, the current study aims to explore if and how therapists assess the level of hopefulness in achieving therapeutic outcomes, and how they go about fostering hope in relation to setting treatment goals in the treatment of clients with PTSD. A set of literature has been reviewed based on these topics. The literature review will look at the most prominent theories of hope as

developed by C.R. Snyder, J.E. Gillham, and C.J. Farran. Examination of these theories can provide the foundation upon which therapists build their understanding of hope in the therapeutic process. Next, the literature review will examine trauma and hope in order to further understand the relationships that might already have been shown to exist between trauma, diagnoses of PTSD, and one's hopefulness. This literature will lend itself to understanding connections between trauma and hope, which exist previous to a therapeutic intervention. Following this, literature focused on client readiness for treatment will be reviewed. The importance of reviewing this literature is to allow for a better understanding of the factors or traits necessary in a client's readiness to engage in therapy. From here the literature review will begin to explore hope and the therapeutic relationship. It will look at the ways that hope has been shown to influence the therapeutic relationship, as well as the way the therapeutic relationship can influence hope. This is an important area of focus as it will begin to focus in on how therapists work with hope, build a therapeutic alliance, and begin to assess hope within this relationship. Finally, the literature review will discuss hope and goal setting and explore the commonalities between trauma and goal setting, and how a diagnosis of PTSD and degree of hope might play a part in the way that goals are developed in treatment.

CHAPTER II

LITERATURE REVIEW

A recent area of clinical focus in relation to hope is in the treatment of individuals diagnosed with PTSD (Brodhagen & Wise, 2008). Hope and optimism have been shown to have a relation to trauma symptoms but little is known about the connection to the area of treatment goal setting (Vincent, Boddana & MacLeod, 2004; Brodhagen & Wise, 2008; Schrank, Stanghellini & Slade, 2008). Existing literature reviewed to date appears to support the basis for the current study; the proposed study will help by exploring philosophies and views held by study participants about the realm of hope and optimism. The review of the literature that follows will consider what research has already been done, and what might need further research in the future.

Theories of Hope

A number of studies have previously explored theories concerning optimism and hope. The following review of this literature explains some of these theories, and also describes studies previously done on these theories. In the realm of hope and optimism, a number of theories have been developed based on the forty-nine definitions that theorists have developed for hope (Schrank, Stanghellini & Slade, 2008). C.R. Snyder offers the following definition of hope: “a positive motivational state that is based on an interactively derived sense of successful agency and pathways.” (Snyder, 2002). More simply put, hope is how people think about goals. Under Snyder’s hope theory, hope

relates to how people think about goals in terms of producing paths to reach their goals (pathway thinking) and the motivating thoughts one has to go down those paths (agency thinking) (Snyder, 2002). These aspects of hope are thought to be reciprocal in that increasing motivation or setting meaningful goals could increase the formation of new pathways and vice versa (Cheavens, Feldman, Gum, Michael, & Snyder, 2006).

Therefore, hopeful thinking is based upon the belief that one can find a pathway to a goal and find the motivation to use the pathway (Snyder, 2002; Cieslak, 2008). Based on this theory, a number of theorists have adopted these goals, pathway thinking, and agency thinking as an expectancy theory at the heart of hope (Snyder, 2002; Snyder, Symptom & Cheavens, 2001; Irving, Telfer & Blake, 1997; Vincent, Boddana & MacLeod, 2004; Schrank, Stanghellini & Slade, 2008). Paired with this theory of hope is the notion that hope is related to finding meaning in life. Feldman and Snyder hypothesized that hope is a central component of life meaning and in their study of 139 college students they determined that hope is a component of life meaning (2005). Other theorists have looked more closely at optimism and define it as hopeful expectations in the form of explanatory styles, or the way in which one explains the happenings of life (Gillham et al., 2001). Explanatory theories link hope and depression through the hopelessness theory of depression (HT) and the tendency of depressed individuals to infer negative characteristics of self and consequences after a negative event occurs (Gillham et al., 2001). Others have viewed hope relationally and believes that it is passed between a giver and receiver and is therefore related to the construct of personal relationships (Farran, et al., 1995) Alessandra Lemma furthers this relational notion in explaining, “Hope can be thought about as the activation of an internalized relationship with a good object” (2004).

In viewing hope through an expectancy lens, one can begin to explore the ways in which hope and creating and completing treatment goals might be linked. Additionally, viewing hope as a relational experience can emphasize the importance of the role of the therapist in treatment (Russonova, 1999). Trauma research has shown that individuals who have experienced trauma often have difficulty planning for the future (Brodhagen & Wise, 2008; Irving, Telfer & Blake, 1997, Vincent, Boddana & MacLeod, 2004). Therefore considering the expectancy, explanatory, and relational theories, and the corresponding definitions of hope, is important in exploring trauma and hope in therapy.

Hope and Trauma

As hope continues to be studied as of recent years, many researchers have begun to look into the way that hope relates to trauma. Just as there are a number of hope theories, trauma has been theorized beginning with Pierre Janet in 1889 as he explored dissociation as it relates to trauma (Stein, 1996). More recently, theorists have determined that trauma can negatively affect one's quality of life (Fierman, Pratt, Hunt, and Warshaw, 1993). In the same light, hope has been linked to depression and many symptoms of depression co-occur in a diagnosis of post-traumatic stress disorder including "markedly diminished interest or participation in significant activities, feeling of detachment or estrangement from others, restricted range of affect, sense of a foreshortened future" (Diagnostic and statistical manual of mental disorders, 2000). Lemma explains that trauma can directly affect hope in that it forces individuals who suffer a trauma to challenge their assumptions about both the goodness of themselves and of others, as well as to mourn lost hopes of outcomes they might have once expected in life. She further explains that hope can more directly relate to trauma if in the traumatic

event, one is given a sense of hope that they might be spared before being victimized (2004). Additionally, researchers have begun to look at the way that coping strategies, social support, and hope relate to PTSD and psychological distress (Benight, 2004). Research has shown that those with high hope often have lower distress and more adaptive coping skills (Horton & Wallander, 2001).

A number of studies examined a relationship between hope and trauma. Glass, Flory, Hankin, Kloos, and Turecki (2009) recently finished their studies on a group of Hurricane Katrina survivors. 228 adult survivors ranging in age from 18-79 were surveyed to see if hope, coping strategies, social supports, and PTSD were at all related. Results showed that those who had avoidant coping strategies and lower levels of hope were significantly related to those who developed PTSD. Further, it was found that hope acts as a moderator between avoidant coping and psychological distress. In another study, Brodhagen and Wise (2008) surveyed 199 college students in Oregon about various childhood and adult traumas in relation to hope. Results indicated that hope and optimism are protective factors for those who experienced trauma. Further, this study suggests that additional research could help emphasize the importance of teaching skills of hope and optimism to clients in psychotherapy (Brodhagen & Wise, 2008). Dougall, Hyman, Hayward, McFeeley, and Baum (2001) looked at optimism, physiological arousal, and symptoms of posttraumatic stress disorder among 159 disaster workers on the site of the US Air Flight 427 crash. This study also examined the relationship of these variables to social supports, coping, and distress. It was shown that those with more social supports had more optimism and coping skills and reported less distress over time (Dougall, et al., 2001).

Irving, Telfer, and Blake conducted a more specific study on hope and combat-related PTSD in 1997. This study compared the hope of veterans with the hope of a control group. In addition, this study examined hope in relation to coping strategies and resilience among 47 veterans at intake and discharge from a brief treatment unit for PTSD (Irving, Telfer & Blake, 1997). Using Snyder's hope scale (Snyder, Simpson & Cheavens, 2001) veterans had lower hope overall than the group of college students acting as the control. One limitation to this is the difference in age between the two groups. While the Vincent, Boddana, and MacLeod (2004) study showed that parasuicidal patients had more agency thinking and less pathways thinking, the Irving, Telfer, and Blake study showed something different for veterans with PTSD. This study showed that veterans reported less agency than pathways goals. Therefore they believe that they can plan steps toward completing goals, but lack the motivation to do so (Irving, Telfer & Blake, 1997).

While these theories have shown a number of variations in the relationship between hope and trauma, Cheavens, Feldman, Gum, Michael, and Snyder took these concepts to the next level in 2006. In their study, 32 participants, who's ages ranged from 32 to 64, participated in 8 two-hour sessions of group therapy that was designed to teach participants how to learn to set meaningful goals, develop pathways to work towards goals, and monitor these pathways and goals. Participants were given a number of measures at the beginning and end of the study that included a hope scale, depression scale, anxiety inventory, self-esteem index, and purpose in life test. It was shown that after participating in the treatment program, participants had increased agency thinking, higher life meaning scores, and higher self esteem. Symptoms of anxiety and depression

were shown to decrease after participation as well (Cheavens, *et al.*, 2006). The importance of this study lies in the support that it gives to the idea that hope can be learned and can aid in the decrease of negative symptoms related to PTSD.

Trauma, Hope, and Treatment

As the relationship between hope and trauma continues to unfold throughout this study, it is important to address the process of trauma treatment as it relates to hope. Two important aspects of this treatment are client readiness for treatment, and the therapeutic relationship. The following literature outlines the relationship that each of these aspects of treatment has with trauma and hope.

Client Readiness for Treatment

When considering therapy as a treatment in general, it is important to consider client readiness. Often times if a therapist intervenes before a client is ready to change, the therapeutic relationship does not often develop to its full potential (Brogan, Prochaska, & Prochaska, 1999). For that reason, matching the client in readiness and exploring this with them is a necessity to treatment. If a therapist fails to meet the client and moves too quickly into treatment interventions, it is possible that the client could feel misunderstood (Reid, 2007). In their study of client readiness for treatment, Prochaska, DiClemente, and Norcross emphasized the importance of working with clients on their motivation to change even prior to the development of a treatment plan (1992). Often times treatment plans are created to target specific behaviors for change and should act as a contract between the client and therapist. However, when a client is ambivalent about whether they want to change this behavior, it is likely that they will not follow through with the treatment plan, thus possibly resulting in termination (Reid, 2007). The concept

of client readiness is one that must be paid close attention to when working with those who have suffered traumatic experiences as it is often difficult to move beyond the ambivalence that their symptoms can change.

Hope and the Therapeutic Relationship

When exploring the nature of the therapeutic relationship it is important to focus on the therapeutic alliance. Therapeutic alliance refers to the bond that occurs between a client and a therapist as they join in collaboration of the work they will do in therapy (Horvath & Luborsky, 1993). Cleary and Dowling explored the importance of this alliance in their study of 153 mental health professionals in 2009. In this qualitative study, participants spoke about the importance of collaboration between clients and professionals. Many of the participants noted that they felt hope played a role in the therapeutic relationship in that when the mental health professionals did not value hope, recovery from certain mental illnesses might not be considered possible (Cleary & Dowling, 2009). Additional research has been conducted on the therapeutic relationship and its' influence on hope in treatment. Russinova (1999) discusses the role of hope in recovery and explores hope as a relational process. She describes a model for the relationship between hope and recovery and the ways that supportive relationships instill hope, including the therapeutic relationship. Specifically, the idea of a therapists' hope-inspiring competence was discussed and the way that therapists can instill and maintain hope for clients through the use of a variety of strategies such as believing in recovery, tolerating uncertainty regarding future outcomes of clients, having motivation to promote better outcomes for clients, and having resources to inspire hope. Russinova further

notes the importance of recognizing how vital hope is in the treatment process and that attending to this can make a difference in treatment (Rusinova, 1999).

Lemma, 2004, explains the complicated role that the therapeutic relationship has on hope and trauma. She writes about the importance of instilling hope in clients by way of a relational concept that involves the therapist becoming an object of hope. This means that the therapist is offering the client the possibility that things can be understood, as well as the possibility that their understanding of experiences can be changed through relating in a way that they haven't been able to since the trauma. She further explains that this "possibility" is the way that hope is instilled in a client (Lemma, 2004).

Hope and Goal Setting

Given the importance of the therapeutic relationship as seen above, it is equally important to spend some time explaining the importance of hope and treatment goal setting. As explained in Snyder's hope theory above, hope is directly related to the formulation of goals, as well as to the ways in which goals are reached (through agency and pathways thinking) (Snyder, 2002). Hope theory goes on to say that those with high hope can move past obstacles that occur when attempting to achieve goals with more success than those with low hope (Yoshinobu, 1989). Further research has shown that those with higher hope have more goals than those with low hope (Langelle, 1989). In more recent years, Mueser and Rosenberg (2009) have looked at how treatment goal setting and trauma are interrelated, particularly in treatment. They propose that therapists need to explore the client's goals for treatment and assess what the client deems as important areas to work on in treatment. They explain that including the client in the

process of creating treatment goals can instill hope as PTSD often interferes with clients' abilities to attain the goals they have set for themselves. Further, there is often an interruption in either agency thinking or pathways thinking that prevents clients with PTSD from believing that they could achieve goals, or from setting goals in the first place (Mueser & Rosenberg, 2009).

Lapierre, Dube, Bouffard, and Alain (2007) explored the relationship between the setting of goals and suicidal ideation. Participants consisted of retirees who were recruited through local papers to join a program called "Managing Your Retirement Goals." The group was designed to help the participants define goals and pursue them effectively. A variety of instruments were given to the members of the group and to a control group who did not participate in the program. Instruments measured emotional well-being, psychological well-being, hope, and the impact of the experimental manipulation on goals (ability to set, plan, and pursue personal goals). After completing the program, it was shown that participants in the program significantly improved their ability and efficacy in reaching goals, as well as improving their psychological well-being. It was determined that the level of hope was also increased in relation to their goal setting abilities. These results remained significant six months after the program and 80% of those in the program reported absence of suicidal ideation (Lapierre et al., 2007). Therefore this study has shown that hope and goals are interrelated in that goal setting and hope can affect one another.

This literature applies to the current study in that hope has been shown to relate to the treatment of PTSD, goal-setting, and the therapeutic alliance. However, it is unclear how therapists perceive the vital importance of hope in therapy as well as its relation to

treatment goal setting. Models such as cognitive behavioral therapy and solution-focused brief therapy have been suggested as ways to encourage the development of hope and optimism in clients to further their ability to work toward treatment goals (Brodhagen & Wise, 2008; Posttraumatic Success, 2008). This review of previous research lends itself to a broader understanding of some of the theory used in hope and optimism that has influenced the purpose of the current study.

CHAPTER III

METHODOLOGY

This qualitative study is an experimental investigation into therapist's views of the relationship between hopefulness and treatment goal setting with a particular focus on clients with a diagnosis of Post-traumatic stress disorder. As discovered in the literature review, there have been studies conducted on the relationship between hope and trauma, however there remains a gap in the study of the connection between hope, trauma, and treatment goal settings. I chose to use a qualitative approach for the flexibility to hear from a sample of experts to expand our understanding of hope, trauma, and treatment goal setting. This study explored the assessment of hope in the therapeutic relationship and the importance of fostering hope in the treatment of individuals with PTSD as it relates to goal setting. This chapter introduces the methods, sample selection, data collection, and data analysis procedures used in this study.

Subjects

Participants for the current study included 10 therapists who speak English, have an advanced clinical degrees including, MSW, Psy D. and clinical Ph.D. Participants had at least three years of experience working with clients who have a diagnosis of PTSD and came from facilities in Connecticut where adults and/or children receive individual treatment for PTSD. The sample comes from the Veteran's Administration in Newington, CT and West Haven, CT as well as Clifford Beers Guidance Clinic in New

Haven, CT. Snowball sampling was used to recruit a small number of participants with a specific expertise in trauma work in order to address the questions. The researcher contacted therapists at these facilities through emails and phone calls explaining the requirements for participants (See appendix A)

Data Collection

Data was gathered through structured interviews conducted at a mutually convenient location. The researcher asked each therapist six questions (see Appendix B) related to hope and treatment of individuals who have PTSD that were previously approved by the Human Subject Review Board (HSRB) at Smith College School for Social Work. Approval of the study proposal (see Appendix C) signifies that the study was in concordance with the NASW *Code of Ethics* and the Federal regulations for the Protection of Human Research Subjects. Participants were given a letter of informed consent to sign previous to interviews outlining the requirements and description of their participation in the study (see Appendix D). Participants also filled out a short demographic questionnaire which was kept separate from any interview materials or informed consent letters (see Appendix E). Interviews lasted between 20 and 40 minutes and were recorded while the researcher took notes. Recordings were transcribed by the researcher and proper actions to safeguard identifiable information were taken including keeping identities confidential, identifying information was deleted from tapes and does not appear in transcription. Materials have been kept secured in a locked drawer and electronic data will be protected for three years as required by federal law at which point it will be destroyed.

Data Analysis

Data collected during recorded interviews were transcribed and analyzed for content for common themes based on words and phrases as the unit of measure. The researcher took notes during interviews and when reviewing transcriptions to note common themes as well as atypical and remarkable responses. Data was then coded and reduced into distinct categories based on themes within the responses to the six questions asked.

CHAPTER IV

FINDINGS

The purpose of this qualitative study is to explore therapist's views of the relationship between hopefulness and treatment goal setting, especially in clients with a primary diagnosis of Post-Traumatic Stress Disorder (PTSD). Further, this study aims to explore if and how therapists assess the level of hopefulness in achieving therapeutic outcomes, and how they go about fostering hope in relation to setting treatment goals with these clients. Although some studies have begun to explore the role of hope in the therapeutic process, little research has been done regarding the way that hope influences the setting and attainment of treatment goals. Further, there is little information about the intricacies involved in fostering hope, and how necessary this is in the treatment of PTSD. This exploratory study will investigate the ways that seasoned clinicians who have worked with clients who have PTSD view hope as it relates to therapeutic outcomes and achievement of treatment goals.

Ten clinicians participated in the study, which included eight women and two men. Participants ranged in age from 28 to 53 and all had at least a master's level degree with experience working with PTSD ranging from 3 to 9 years and are considered experts in their work with clients who have suffered traumas. Of the ten participants, 5 had an MSW, 3 a Psy D and 2 a Ph D. All participants were practicing in Connecticut and worked full-time for one of three agencies where they served children or adults. The

previously mentioned qualifications lead these participants to be experts and speak with knowledge on the topic of hope and trauma.

The findings of this study are organized by the following content areas: the role of hope in the therapeutic process, how hope relates to PTSD, therapist's assessment of hope in clients with PTSD, the fostering of hope in clients with PTSD, PTSD and its relation to treatment goals, and hope as it relates to PTSD and treatment goals.

The Role of Hope in the Therapeutic Process

When asked what they believe the role of hope is in the therapeutic process, the majority of clinicians noted that they felt hope was a very important factor in therapy. Over half of the clinicians went on to explain that they saw hope as a necessary notion in the process of change and that this hope for change is tied to recovery. A few interviewees discussed that they felt coming into therapy is a way that clients show that they have some sense of hope, if they are coming on their own accord and not mandated. One participant explained this specifically:

The act of coming to treatment is one of hope because somebody has hope that someone might be able to help or that there might be able to be some change, so even coming to see us, there might be a little bit there that shows hope.

Additionally, a few therapists spoke about the way that they feel they must carry hope for clients or “foster” hope when clients seem to be lacking hope. A less common but powerful response was that those clients who had seemingly high levels of hope improved faster and had a better therapeutic outcomes. One participant spoke directly about the way hope relates to engagement in treatment, thus facilitating better therapeutic outcomes:

I believe hope is incredibly important in the therapeutic process for a number of reasons. First is just in terms of engagement, I think that the more hope that a client feels the more engaged they're going to be in the therapeutic process, the more motivated they're going to feel that they can actually feel better at the end of this that it's not just for nothing.

While it was less common that participants commented on the effects of hope on the therapeutic alliance, it seemed to be an important factor for those who are beginning to engage in treatment in regards to their ability to make changes in their lives. All participants noted that the role of hope was important as it related to either motivation for change, resilience, or future focus. Additionally, those clinicians who work with children noted a unique piece about parent hope and the way that it influences their children and their engagement in therapy. One participant noted:

I think that hope is a very important factor for the therapeutic process in terms of kids who I think become more resilient if there is some aspect of hope that they have for their future. I also think that in terms of parents, if they view the future as bright, I think they're more capable of working with their kids and following through with their kids because they have this view that things will improve in the future. So in terms of therapeutic process I feel that if you, as a therapist, can connect the work you do with a client and family to assess hopefulness I think it's more effective, I think things can improve faster and I think the outcome overall is better.

A notable part of the previous quote is the way that this participant speaks about the assessment of hope. While this will be discussed in another section, it is important to note that hope as it relates to the therapeutic process must first be acknowledged and assessed by a therapist in order to be a helpful part of the process, as this clinician notes.

Hope and PTSD

While it was clear that the majority of the interviewed therapists found hope to be an important part of the therapeutic process, participants were asked to speak about how they felt this relates to those clients who have PTSD. When asked what they have

noticed about the role hope plays in therapy with clients who have PTSD, the majority of participants spoke about seeing a relationship between high hope and greater resilience to the trauma symptoms. The majority also went on to say that they feel higher hope is linked to better treatment outcomes and often is a driving factor in therapy with these clients. Similarly, others noted that those with less hope seemed to be “more entrenched” in the symptoms of trauma. One participant describes this view in the following quote:

Specifically I think that my experience has been that there is a greater level of resiliency. I think that probably people that I've worked with that experience chronic trauma and people who have not been as hopeful or I guess who don't have kind of a hopeful look at their future; I think they're more entrenched in the symptoms. I think it's harder for them to make gains moving forward and they almost perseverate in a negative cycle that things will not get better. They become their trauma in the way that they identify with some of their symptoms and have a tendency to stay there versus looking into the future and experiencing their traumatic event as an event that then they can kind of overcome.

A number of the responses for this subject area were common to those given about hope and the therapeutic relationship in general, the differing responses related to hope and symptoms of PTSD as spoken about in the quote above. There was a particular focus on the way that a lack of hope might impact clients with PTSD. One particular respondent spoke about a specific lack of hope found in clients with PTSD:

I think one of the identifying markers of my clients with PTSD is that they have no hope. It's very absent and other times they don't even recognize what hope would really look like or what it is. It's a lot of teaching them about hoping again or teaching them what their potential is again. Sometimes helping them paint pictures of what, not literally, but figuratively, kind of paint a picture of what could be or could come out of their circumstances and things like that. I think hope comes a lot more slowly and is much more difficult for clients with PTSD and I think at first I have to just help them recognize that some things they're going through are just natural occurrences from PTSD, you know, night mares, poor eating habits, depression or anxiety, hypervigilance, all those things I can normalize for them so that hope can kind of come into the picture after we've started to build a relationship. I really need to build rapport with them and kind of help them learn that a lot of things they're experiencing are normal before I can

start to interject that hope piece back into the process. I think that's what kind of sticks out to me the most.

This specific mention of clients with PTSD having no hope was a less common response, however many points within this statement were common among other respondents, particularly the notion of “normalizing” and the process of teaching or instilling hope. Over half of the participants noted the importance of educating clients with PTSD about the symptoms and recovery rates which in turn emphasizes the necessity to teach or instill hope through this process. This teaching of hope lends itself to the idea that those clients with PTSD who do not have hope benefit from having hope instilled or held for them throughout the therapeutic process. One participant described this in the following quote:

I think hope is really important and drives my work now because of the kinds of treatment that I do, cognitive processing therapy. By saying that there is hope, that you can recover as research has shown more recently, people can and do actually recovery from PTSD. That is about giving them hope.

This notion of instilling hope was clearly an important aspect to PTSD treatment that was further explored and will be addressed in the “fostering hope” section below.

Assessing for Hope

Given the emphasis past research has put on the notion of hope as a positive factor in not only therapy but in life and survival, an additional focus of this study was on how therapist's, if at all, assess for hope in the clients with PTSD. When asked the ways that they assess for hope, half of the participants noted using a standardized scale which included the Ohio Scale, and the State Hope Scale. Additionally, these therapists mentioned using a standard risk assessment to assess for hope. The Ohio Scale can be used for youth, parents of children, and adults (Ohio Department of Mental Health, 2007). This scale includes problems, functioning, and satisfaction scales. The

component that many therapists use related to hope is the satisfaction scale. This scale asks four questions related to hope: “Overall, how satisfied are you with your life right now? How energetic and healthy do you feel right now? How much stress or pressure is in your life right now? How optimistic are you about the future?” These are examples of the questions as they would be asked of youth directly. A parent version of this scale asks “Overall how satisfied are you with your relationship with your child right now? How capable of dealing with your child’s problems do you feel right now? How much stress or pressure is in your life right now? How optimistic are you about your child’s future right now?” (Ohio Department of Mental Health, 2007). One interviewed therapist describes the way this scale is used in treatment:

On a really kind of concrete level we use the Ohio scales here at the clinic a lot which is really helpful because the top section of the second page is all about how much optimism do you as a parent hold for your child or you as the child hold. I give them to adolescents too see how much hope you have for yourself how much optimism do you feel about your relationship with other family members right now, about who you are as a person. So it really actually concretizes hope and optimism and positive feelings on a very basic level. It’s a very basic scale and when you give that to a client at intake, and again after three months or when they finish treatment and all throughout the process you get this really nice easy tangible data to show them.

In addition to the Ohio Scale, therapists have been using the State Hope scale. This scale is a six question scale developed by C.R. Snyder (1996) which asks people to use a scale to respond to statements related to goal setting and goal achievement. The questions include “If I should find myself in a jam, I could think of many ways to get out of it. At the present time, I am energetically pursuing my goals. There are lots of ways around any problem that I am facing now. Right now, I see myself as being pretty successful. I can

think of many ways to reach my current goals. At this time, I am meeting the goals that I have set for myself” (Snyder, 1996).

While half of the participants spoke about using standardized measures of hope, the other half of the participants mentioned that they ask directly about hope in their work with clients who have PTSD. Additionally, the majority of the participants discussed using the therapeutic relationship as a way to gauge hope. Here is an example of how one participant uses the therapeutic relationship to assess for hope, particularly as it relates to trauma:

I think part of it is working relationally. You get a feel, I think, and it’s about the personal interactions that you make. How a client is presenting or kind of how they seem to be willing or not willing to engage in a relationship with the therapist and be willing to talk about that and process that. I think with PTSD the issue of avoidance is profound and so it’s easy to see a client whose avoidant and, I mean maybe some therapists would see that as a lack of hope and maybe mistake hopelessness and avoidance. I think it’s asking about goals, looking at goals and how realistic they are versus how grandiose or just sort of far reaching they seem. Looking at their ideas of how they can reach their goals. A sense of foreshortened future is an avoidance symptom that sometimes speaks to hopelessness in the sense that I can only kind of do what I can do right now but I can’t worry about a future or look ahead to a future.

This participant noted avoidance, one of the diagnostic criteria of PTSD, as relating to hope or being mistaken for hopelessness, particularly in the sense that a sense of foreshortened future is often seen in clients with PTSD. This piece about future was mentioned by the majority of the participants in terms of future focus, goal setting, and world view. In addition, other participants mentioned using their therapeutic relationship to assess for hope through assessing hope for treatment outcomes, motivation for change, and the clients’ utilization of treatment recommendations. Therapists seem to gauge hope by the way that the clients use treatment and how engaged they are with the therapist and

in their motivation to change or overcome their symptoms in addition to using standardized assessments of hope.

Fostering Hope

As hope has been shown to be important in the therapeutic relationship, the notion of fostering hope has also been shown to be an important part of this relationship in past research. When exploring this with the participants of the study, all ten therapists expressed that fostering hope for clients with PTSD is an important part of the therapeutic process. When asked to elaborate on this, therapists most commonly emphasized psycho-education and normalizing as an important part of fostering and even building hope for their clients. One therapist noted the importance of fostering hope as a part of training in the following quote:

I think it's absolutely essential to the therapeutic process and I don't think we talk about it that much although it's what we're working on. I remember a supervisor when I was an intern saying that we are the embodiment of hope and that we carry that for them but for other people we are trying to foster what little hope they have. It's not just about PTSD but about any suffering.

Similarly, the majority of therapists interviewed noted that working with hope changes depends on the level each client has. For some many feel they must foster hope and for others it is about carrying or even embodying hope. In line with the idea of using psycho-education and normalizing as a way to build hope, others used more explicit techniques such as motivational interviewing or even hope coaching.

Some people question can you really foster hope and optimism or is it just you either have it or you don't? I believe you can foster it. I believe that you can use cognitive interventions to improve people's expectations for the future and to make it realistic and helpful. Not just this 'everything's going to be rosy all the time' but really realistic hope. One of the things I do here is specifically focus with them on goal setting strategies because I use Snyder's theory so he specifically talks about how important goal setting is, and I've come up with this

intervention for parents when they're reporting that they don't feel hopeful or capable at intake. They get this two-session hope coaching intervention with the therapist. We first give them some psycho-education materials about resilience, about the importance of hope, and the importance of goal setting, then we actually have them pick a goal that they want to work on and they can tell us anything, anything that's important to them, and we work with them to break it down into really manageable attainable objectives and do some problem solving if there's any stuck points. Then we meet with them again the next week to check in on how it was and if they have a stuck point we rework the plan and if they were able to attain it we give them lots of praise and we come up with another goal that they can work on and then we pass that information along to the therapist assigned to work with the family so that they can hopefully continue to make progress going forward. So that is something that I've been doing here at the clinic.

While not every therapist interviewed has taken on such an explicit hope coaching process, over half of the clinicians interviewed discussed a unique aspect of fostering hope in those clients who have suffered a trauma and have PTSD. These clinicians discussed the importance of having a balance of just enough empathy, while not joining the client in their hopelessness. It seemed that while fostering hope is extremely important, it is also important to be empathetic. Many explained that empathy is a part of all therapeutic relationships; however with clients who have PTSD, it plays a more significant role. One therapist explains this delicate balance:

I think that there is an inherent attention in our work where we have to acknowledge the very real suffering and pain that people have faced, and tolerate that, while at the same time fostering hope. So you don't want to dwell on the doom and gloom but you don't want to over-cheerlead. So figuring out how to encourage and foster hope while being with the reality of what they've been through or have been suffering. That took a year or two to figure out what my style was about that and how to work with different people who maybe more are pulled to focus on the bad of an experience and how much more I might have to insert where the hope is. Or the other way around, people are sort of glossing over and minimizing, and how I might be able to shift my perspective so that hope is balanced.

It became clear throughout the interviews that this aspect of finding a balance is somewhat unique to work with clients who have PTSD and the balance of empathy and

fostering hope is one that many clinicians say take time to achieve within the therapeutic relationship. One therapist discussed the way that holding the hope is important in the relationship, but also helping clients to see the successes others have made in their treatment which in turn can help to build hope and build the therapeutic alliance simultaneously.

What I like to say to some of the Vets that I work with is that it can be hard to be hopeful for the future and again whether that's related to specific trauma's they've experienced or just the severity of their PTSD but what I've said to Veterans that I've worked with is "right now I can hold the hope for you. I've done this work for a while and you've seen a lot of vets come through the program in a year and from where you're sitting right now it might be hard to see that things can get better but from my vantage point I see things from a bigger perspective and I've seen Veterans come through this program and do well in treatment and go on to live great, fabulous, rich lives that are very meaningful. I can hold the hope right now for you and the hope that you can one day do that too. From right now where you sit and with the severity of symptoms whether it's depression it might be hard for you to grab onto that and I'll hold it for you and we'll negotiate as we work together." Sometimes I think the therapist really holds the hope for the veteran if they are having a hard time holding onto it themselves.

Through the building of the therapeutic alliance, assessing for hope, and fostering hope, it begins to set up the question of how this all leads up to affect the treatment goal setting process.

PTSD and Treatment Goals

Participants were asked to reflect on how a diagnosis of PTSD might impact the treatment goal setting and achievement process, and every clinician mentioned that the diagnosis informs the treatment plan in the sense that it helps to narrow the focus to things such as symptom reduction. While this might seem obvious, that a diagnosis informs a treatment plan, over half of the therapists spoke about the vast differences among each individual client and that the diagnosis can generally shape a treatment plan

but each plan is individually tailored based on things such as a client's motivation to change and use the therapy. Additionally, a common response involved the importance of creating concrete goals related to what the client wants to see change, in order to help these clients work towards meeting their goals. One therapist spoke about the importance of this specifically:

I do think if you tie in the treatment goals with their values, that helps. So instead of making it a goal that is cluttered with psychobabble, if it can really be something important to them like 'I really want to be able to go out to public events like I used to but I'm scared because such and such happens' so working with them on those goals that are important or 'I really wish I could be there for my child but they can't because there's something that triggers them' so you know tying in again to things that are important to them.

In addition to tailoring a treatment plan based on the individual's goals and needs, half of the therapists mentioned avoidance as symptom to target initially in a treatment plan with clients who have PTSD. Because avoidance is a diagnostic symptom of PTSD, it is commonly a barrier to the completion of other treatment goals. Therefore many therapists target this symptom first when working with these clients because it can cater to greater goal achievement later in therapy:

As far as the achievement of goals goes, I think that one of the largest things to talk about in PTSD is things or goals that they might set they don't know how or where to begin, and the avoidance factor of PTSD can really play a huge role in putting up a barrier in different ways for them achieving their goals.

Another therapist explained this role of avoidance in relation to a sense of foreshortened future, another common symptom of PTSD:

The sense of a foreshortened future in people who have survived trauma, particularly combat Veterans, is common. They're just getting through the moment and the day so it can be hard to make that leap to what am I going to do in the future, even a week from now, a month from now, or three months from now when the program ends, or a year after I graduate from the program? So I

think that can interfere with the process and you know the way I view goals and someone coming in with PTSD is someone who is having a hard time imagining goals. The role of avoidance is huge so another part too is that survivors of trauma have a profound sense that life has lost meaning, and seeing horrific things that can make this lack of meaning, so I sometimes ask “how do you know what’s meaningful, how do you find meaning in the things you want to accomplish in your life?” It’s about helping Veterans with PTSD try to imagine what would be meaningful or how they could connect with things that get to that larger picture and have it in mind so it can make the concrete goal setting make more sense.

This quote mentions a number of unique aspects of goal setting in clients with PTSD including things such as the way that a sense of foreshortened future can impact one’s ability to achieve goals or even envision what their goals might be. Additionally, this therapist speaks about the importance of working with someone to imagine life in a way that they want it to be and to hold onto that picture so that they are able to set goals and have something to work toward. In working with clients who have PTSD, it becomes clear that some of the signifying symptoms of the disorder are inherent barriers to creating and achieving treatment goals and goals in general.

A less common noted factor in relation to clients with PTSD was the notion that there are generally other complicating factors in the lives of these clients that takes some of the focus off of symptom reduction and forces attention to improving the quality of life through basic needs. One therapist spoke directly about this:

A diagnosis of PTSD isn’t so cut and dry. Other diagnostic concerns or other issues like housing, substance abuse, relationship issues are impacted all by the diagnosis of PTSD, so I find it’s not just working with PTSD but all of the other goals and issues. Sometimes one or more overshadows the work that you can do with PTSD specifically.

Attending to these other factors when developing a treatment plan with clients who have PTSD can also be a starting place for treatment plans, as it would be difficult to make progress elsewhere when a client’s basic needs are not being met. Therefore it is clear

that not only do the symptoms of PTSD directly impact one's ability to achieve and set treatment goals, but there are often other barriers that are commonly found among those clients with PTSD including issues with housing, substance use, and with maintaining healthy relationships.

Hope, PTSD, and Treatment Goals

We know there are a number of symptoms for PTSD that can impact treatment goal setting, and we have also seen that hope is an influential factor in therapy with clients who have PTSD. Therefore, therapists were asked to speak about the way that hope can influence the treatment plan process and clients' abilities to set, work towards, and achieve treatment goals in therapy. All ten clinicians said that hope continues to be important in this part of therapy as well as the earlier stages of relationship and alliance building. Most commonly, participants mentioned the general lack of hope that some clients with PTSD have as a result of their diagnosis. However, this is not always the case. One therapist explains how a client's perspective on their diagnosis can influence their hope:

In the VA there is a lot that the diagnosis of PTSD can say. It is a prism that people look through that changes depending on who's looking. Sometimes it actually seems like a cloak of honor, sometimes it's a stain or a stigma. So it really depends on the individual and how they see it. Do they think they are sick forever? Some people feel relief, some wonder about service connection and can I get money, so it can be incredibly loaded. I know that I think when someone comes to me with a diagnosis of PTSD it's how are we going to treat them specifically. There is hope that they can recover and that helps to try and get them ready to do that trauma focused work ASAP. That is how I think about hope in the work. "We have treatments that can help you recover, let's get you ready to do that so that it you don't have to keep having this forever and ever but that we can do it in a brief course of treatment."

This therapist mentions the way that a client's view of their diagnosis can influence their hope and thus the way they view their treatment goals. Over half of the therapists interviewed noted a correlation between high hope and higher motivation for change and achievement of treatment goals. In addition, over half of the interviewed therapists spoke about how they feel higher hope helps in mastering trauma, which the therapists above alluded to in the way that hope can help prepare a client to do trauma-specific work within their treatment plan. One expert therapist explained the way that hope has been shown to directly influence the setting and attainment of treatment goals:

I think it is so important. I think it is so important that we know that people who have more hope are more likely to be able to naturally set, work towards and achieve goals naturally because they have some of those skills, and people who are low on hope might need a little bit more coaching, but I think they can then get there. I think that PTSD again, when you get these diagnoses sometimes there's less hope as part of a symptom of the diagnosis and I think that's where you get motivational interviewing and connecting and engaging to really help the client remember what it is that they really want that's really important to them and get there in manageable steps instead of 'all your symptoms are going to go away.' Make it really realistic and attainable so that they can work towards it and to tell them some of the research out there. That hope is something that can be taught and that people that do have hope and optimism tend to have better outcomes later and try to get the buy in there.

One particularly notable part of this statement is not only the therapist's knowledge of what hope can do, but this therapists' own hope which is clearly evident in this statement. It seems that in order for these therapists to hold hope for their clients they must also have their own hope through the understanding of research and knowledge of how helpful it can be for both clients and therapists to be hopeful in their treatments of PTSD.

One less commonly addressed aspect of hope and goal setting in clients with PTSD is the way that these clients can learn through example and by seeing the successes of other people suffering with PTSD. Only a few of the interviewees work in settings

where PTSD groups are a part of treatment, and these therapists all noted the importance of seeing others who are further along in treatment and how this can help build hope and improve goal attainment. One therapist speaks about this:

Sometimes the hope can be a borrowed hope that like “fake it till you make it” but it might be a stretch to apply that to hope but you can borrow it. There’s something special about being in a group based program for PTSD where I think you can see other people who have also survived awfulness and they are living meaningful lives and accomplishing things they want to. So whether it’s through the therapist or role models of recovery and kind of borrowing that hope too, yes. It is important.

Summary

This chapter has presented the findings from six questions asked to expert PTSD therapists. Each question had a few majority responses, with a few responses being less common but powerful. Rarely did responses vary widely, however there were a number of different answers that provided a new outlook on how hope impacts treatment both in general and specifically related to PTSD and treatment goal setting and attainment.

Therapists noted that hope is a very important part of treatment, and that it plays an exceedingly important role when influencing treatment goal setting and attainment with clients who have PTSD. Therapists noted that there are a number of PTSD symptoms that directly influence treatment goal setting, and when hope is inserted into the equation, these symptoms can begin to be reduced thus increasing goal attainment.

CHAPTER V

DISCUSSION/CONCLUSION

This qualitative study explores therapist's views of hope as it influences the treatment goal setting process in clients who have PTSD. A review of the literature showed that current literature focused on hope theory, hope as it relates to trauma, and hope related to the therapeutic relationship. The findings of the current study presented the following themes: the role of hope in the therapeutic process; how hope relates to PTSD; therapist's assessment of hope in clients with PTSD; the fostering of hope in clients with PTSD; PTSD and its relation to treatment goals; and hope as it relates to PTSD and treatment goals.

The Role of Hope in the Therapeutic Process

Many of the findings of this study were consistent with the previous literature. The role of hope in the therapeutic process was consistently seen as an important to each of the respondents, and a number of therapists also noted the importance of fostering hope and the therapeutic alliance. This aspect of the therapeutic alliance is consistent with the literature by Cleary and Dowling (2009) where they explain that hope plays a role in the therapeutic alliance. Further, some respondents noted the effects that hope can have on the therapeutic alliance in regards to influencing change. This is also supported by the research done by Reid (2007) whose findings explain that hope within the therapeutic relationship is connected to client readiness for treatment.

Hope in clients with PTSD

In relation to how this hope applies to those clients with PTSD, the findings of the study showed that the majority of participants believed that hope can relate to greater resilience to trauma symptoms. This finding is consistent with the findings of Horton and Wallander's (2001) study where it was found that higher hope correlated with less distress and higher coping skills in relation to trauma. Further, Glass et al. (2009) studied that those survivors of Hurricane Katrina that had less hope were more like to have a diagnosis of PTSD. Additionally, many participants of the current study noted the comparatively lower hope of those clients with PTSD compared with other clients with varying diagnoses. In terms of assessing this hope, half of the participants noted using a standardized scale, including Snyder's hope scale as a part of the Ohio Scale. The common use of this scale supports the importance of Snyder's hope theory that suggests that hope is related to goal setting and the ways in which we seek out the fulfillment of our goals (Snyder, 2002).

Fostering Hope

Participant's emphasis on the importance of fostering hope was notably consistent with previous literature. Lemma (2004) explained the way that trauma can directly affect hope and therefore must be instilled via the therapist through the use of self as an object. Many of the participants in the current study mentioned the embodying or holding of hope as well as the importance of psychoeducation about the holding of hope. This lends itself to the past research done by Cheavens, et al. in 2006 where they showed that hope is something that can be taught and can improve upon goal setting abilities. This factor

also directly relates to the interplay between hope, PTSD, and treatment goals which is at the heart of this study.

PTSD and Treatment Goals

Findings related to the notion of hope, PTSD and treatment goal setting showed that hope is absolutely a positive force as it relates to therapy in general. Additionally, it was found that many therapists believe that those with more hope were able to have a greater sense of the future and thus have the capacity to set and work towards goals, including treatment goals. Previous research has shown that hope can lead to better treatment outcomes, and that trauma is often a factor that lends itself to the formation of specific treatment goals in line with what the client hopes to gain in treatment (Russinova, 1999; Mueser & Rosenberg, 2009). Quite similarly to this idea, a few participants of the current study spoke about the way that the diagnosis of trauma not only influences the treatment goal setting process because of specific PTSD symptoms, but it also impacts the hope that clients have for change. Many found that less hope often lead to less motivation to change and thus a greater difficulty in setting goals or attainment of goals. However, a number of participants also mentioned that hope was often instilled upon the achievement of one small goal, or through the examples being set by other clients in a milieu setting. Therefore, this suggests that the setting of small attainable goals in line with what the client expects to get out of treatment might in turn increase hope and therefore increase the likelihood that further goals can be set and attained in a course of treatment for PTSD.

Interplay between Hope, Trauma, and Treatment

While there was little previous research about the interplay between hope, trauma, and treatment goal setting, there were a few comments made by participants that might lead to further research in a particular area related to this topic. A few participants discussed the role of avoidance, criterion C of the DSM-IV diagnosis for PTSD (Diagnostic and statistical manual of mental disorders, 2000), as either a notion that can be confused with a lack of hope, or as a contributing factor to less hope in these clients. One participant explained this:

I think that my belief is that hope and treatment planning and goal setting are things that are important for every single client and I think that sometimes with a diagnosis of PTSD you're going to see that avoidance and so sometimes you have to do some preliminary goal setting in terms of targeting that avoidance and giving them some psychoeducation of the philosophy of treatment and why it's going to be beneficial to move forward and revisit the trauma.

A few participants discussed the importance of targeting avoidance at the start of treatment, in order to possibly increase the hope, or to make hope more apparent to clients. While avoidance is not a novel part of PTSD, society might benefit from future research related to the specific influence of avoidance on treatment of PTSD as it relates to hope and treatment goals. One participant spoke about the way that targeting avoidance at the beginning of treatment can then instill hope through the achievement of a particular goal and in turn increasing the possibility to achieve future goals set in treatment. It seems common that clients attempt to avoid some of the direct discussion of trauma despite the knowledge that some of the evidence-based treatments such as cognitive processing therapy and trauma-focused cognitive behavioral therapy where clients are asked to speak or write about trauma can have a positive effect on their lives.

It is in these situations that clients must rely on the therapeutic alliance and psychoeducation from their therapists about the success of these treatments as well as the important role that hope plays in goal setting and future-orientation.

Study Limitations

The limitations of this study include both the make-up of the sample and the sample size. Ideally, one might hope for more diversity within the sample including more men, more people from diverse backgrounds, and a more even distribution of clinicians with varying degrees. Additionally, this study might have benefited from having a larger number of clinicians to interview from a wider variety of settings beyond a VA and a child guidance clinic in Connecticut. While the sample might have limited this study, the measures and questions used for this study appropriately aimed to get at the research question. Additionally, due to the participants' line of work and experience with clients who have PTSD, they were considered experts in their fields.

Implications for Practice

The findings of this study are useful to future practice in that it can inform treatment as well as place an emphasis on the importance of including hope assessment in clinical work with clients who have PTSD. As Snyder's theory suggests that it is through the forming and means by which one achieves goals, it makes sense that hope would influence treatment goals, as was described in this study (Snyder, 2002). Additionally, these findings can influence practice in that it can help therapists decipher between a hierarchy of treatment goals that could be most beneficial in having successful treatments of PTSD. Finally, the findings of this study can be used as further psychoeducational

information to inform the clients with PTSD about the benefits of hope as it relates to PTSD, treatment goals, and goals in general.

Due to the increasing pertinence of hope and its role in therapy, I aimed to study therapist's views of how this hope relates to treatment goal setting and attainment among clients who have PTSD. Further, I explored the way in which the interplay between these three notions can affect treatment, explored the key elements involved in the treatment of PTSD, and looked for ways in which hope is being measured among the therapist's interviewed. Findings revealed that therapists saw hope as an essential part of the therapeutic process, and noted that the use of the therapeutic relationship plays a role both in assessment of hope and in the fostering of hope. The fostering of hope was found to be at the core of PTSD treatment in that many participants noted that they felt clients with PTSD often have less hope. Additionally, it was found that the majority of therapists interviewed believe that this therapeutic relationship lends itself to the formation of treatment goals in line with both the diagnosis of PTSD and with the goals that each individual client has. Hope was shown to play a role in the treatment goal setting and attainment process as it is correlated with a higher motivation for change.

Implications for Future Study

It would be beneficial to continue to look at the role hope plays not only in trauma work but in other types of treatments. Further, it would be beneficial to look more closely at the role of hope as it relates to the avoidance piece of PTSD and the possibility that avoidance might appear to mask hope and thus influence treatment. An additional area of future research might be around the finding that clients suffering from PTSD may be less hopeful. Future research could help to explain both of these ideas further and

could inform the treatment of specific populations such as returning soldiers who might seem difficult to treat given their lack of hope and tendency to avoid.

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APPENDIX A

Recruitment Email

My name is Courtney Jones and I am an MSW student at Smith College School for Social Work. I am doing a research project that focuses on the therapist's perspective on hopefulness, as a factor in improving well-being, and treatment goal setting among clients with Posttraumatic Stress Disorder (PTSD). I am looking to interview therapists about their experience in this topic area for my MSW thesis.

I would love the opportunity to speak with you about my research project and explain more about what the project involves. If you are willing to be a potential participant, please contact me by responding to this email, or calling me at XXX-XXXXXX.

Please forward this email along to any other potential participants who might be interested in my project.

Thank you,

Courtney Jones

APPENDIX B

Interview Questions

1. What do you believe the role of hope is in the therapeutic process?
2. What have you noticed about the role hope plays in therapy with clients who have PTSD?
3. How do you assess for hope in your work with clients with PTSD?
4. Do you find that fostering hope for these clients is an important part of the therapeutic process?
5. How do you find that a diagnosis of PTSD impacts treatment goal setting and the achievement of these goals?
6. How do you believe hope has played a role in clients' abilities to set, work toward, or achieve goals in the treatment of PTSD?

APPENDIX C

Human Subjects Review Approval Letter



Smith College
Northampton, Massachusetts 01063
T (413) 585-7950
F (413) 585-7994

January 20, 2010

Courtney Jones

Dear Courtney,

Your revised materials have been reviewed and they are fine, with the exception of one minor error that resulted from your revision. On page four, first you say that the Informed Consent will be signed and collected at the beginning of the interview and then you say that once the Consent is signed and received, you will set up an interview. Please correct that small error. Send the corrected page to Laurie Wyman.

Assuming that you will send that page, we are happy to now give final approval to your study.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your project.

Sincerely,

A handwritten signature in cursive script that reads 'Ann Hartman I Shw'.

Ann Hartman, D.S.W.
Chair, Human Subjects Review Committee

CC: Elaine Kersten, Research Advisor

APPENDIX D

Letter of Informed Consent

Dear Potential Participant,

My name is Courtney Jones and I am an MSW student at Smith College School for Social Work. I am doing a research project that focuses on the therapist's perspective on hopefulness, as a factor in improving well-being, and treatment goal setting among clients with Posttraumatic Stress Disorder (PTSD). I am looking to interview therapists about their experience in this topic area for my MSW thesis.

As a participant of this study, you will be asked to participate in an interview with me. To be eligible for this study, you must speak English; have an advanced clinical degree, such as an MSW; other master's level clinical education; or a clinical PhD. Participants must also have worked with clients who have a diagnosis of PTSD. I will be gathering some brief demographic information about you. Interviews will take approximately 45 minutes and will be audio recorded and transcribed by me.

The risks of participating in this study are minimal and include revealing personal opinions about clinical approaches. The benefits of participating include having an opportunity to share experience and knowledge about their work with clients. Further, you might gain a new perspective in thinking about the role of hope in the process of treatment goal setting. Participants in the study can also benefit from partaking in the development of knowledge about hope and treatment goal setting that might be helpful to other clinicians.

In order to maintain your confidentiality, your name will be known only to me. Once all identifying information has been removed, my thesis advisor will have access to the data and I will transcribe tapes personally. Any presentations and publications will be prepared in such a way that participants will not be identified. Any vignettes or quoted comments will be disguised. All materials including notes, tapes, and transcripts will be kept secured in a locked drawer and electronic data will be protected for three years, as

required by Federal guidelines, and after that time will be destroyed. If I need access to the materials beyond the three year period, they will continue to be kept in a secure location and will be destroyed when no longer needed.

Participation in this study is voluntary. You may withdraw from the study at any time during the data collection process and you may refuse to answer any question. You will be able to withdraw from the study by sending me a letter to the address below, with your identification code stating that you wish to withdraw. If you wish to withdraw you must do so before March 1, 2010 and all materials pertaining to you will be immediately destroyed. Should you have any concerns about your rights or any aspect of the study, please call me at XXX-XXXXX or the Chair of the Smith College School for Social Work Human Subjects Review Committee at (413) 585-7974.

YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

Participant Signature and Date

Researcher Signature and Date

Please keep a copy of this letter for your records and thank you for your participation!

Courtney Jones
APPENDIX E

Demographic Questionnaire

Demographic Information:

Age:

Gender:

Race/ethnicity:

Years practicing as

therapist: