Mobilizing Hope with Brief Psychotherapeutic Interventions that Counter Demoralization—Assessment, Formulation, Intervention in Four Steps

by

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The Hope Modules Seminar from the George Washington University Psychiatry Residency program teaches residents brief psychotherapeutic interventions that residents can use to help patients who have become demoralized by harsh stressors that can be severe, chronic, and uncontrollable (Griffith, 2018). Hope modules are brief therapeutic interventions in which 1) hope is regarded as a practice, i.e., “something you do,” rather than “something you feel”; 2) clinician and patient collaborate in identifying hope practices that constitute the patient’s signature strengths for mobilizing hope 3) these hope practices are then translated into an action plan for responding to adversity.

What is Hope?

For clinical utility, hope requires an operational definition that can activate assertive coping despite expectations that future stressors may be severe, chronic, or uncontrollable. “Hope as a practice” best fits this requirement, among dozens of different definitions of hope in use in the vernacular (Schrank et al, 2008; Weingarten 2000, 2010). Hope is practiced by locating a deep desire, value, or commitment and taking a step towards it (Weingarten, 2000, 2010). “Practice” is used in the sense of a spiritual practice or an ethical practice, as a program of action undertaken, not just for pragmatic purposes, but as an expression of identity as the kind of person one wants to become and how one wishes to act in the world (Weingarten, 2014).

As a coping response, hope as a practice correlates closely with empirically-validated resilience factors that include active coping, grit, hardiness, acceptance, and realistic optimism (Southwick et al, 2008). Practicing hope entails facing, embracing, and engaging adversity, rather than avoiding, submitting, or withdrawing.

Advantages of Hope Mobilization as a Brief Psychotherapeutic Intervention:

- Demoralization represents “normal suffering” as a normal syndrome of distress when patients sense they are failing their own and other’s expectations for coping. Patients feel overwhelmed, “worn down and worn out” by life’s stressors;
- Demoralization is not a mental illness but commonly co-occurs with psychiatric disorders when patients face severe, chronic, uncontrollable stressors;
- Hope is a natural antidote for demoralization. All clinicians can use brief psychotherapeutic interventions to help demoralized patients to mobilize hope;
- Hope mobilization is efficient and sufficiently portable for use for different clinical problems with different patient populations and in different kinds of clinical encounters;
- Hope modules are tailored to help patients access strengths specifically relevant to coping with their unique themes of distress.
Hope modules are designed for use in the midst of crises. They are useful for patients struggling with either symptoms of psychiatric illnesses or symptoms from normal stress responses.

**Introduction.**

Assessment of hope-building competencies during an ongoing crisis enables hope practices to be identified that best fit that particular struggle. Two assessment questions open contrasting conversations (Wade, 1997, 2007):

- “How did this affect you? [i.e., What was its impact? What did this take from your life?]"
- “How did you respond? [i.e. What was the first thing that you did in order to cope?]"

The first question typically evokes feelings of vulnerability, grief, or trauma. However, the second question more often elicits well-rehearsed, over-learned practices that potentially mobilize hope. The clinician then helps the patient to build upon these hope practices by extending their reach, implementing them more effectively, or adding other hope practices of similar kind.

From a cognitive neuroscience perspective, “How did this affect you?” activates bottom-up processing for aversive stimuli. The contrasting question, “How did you respond?” activates top-down cortical regulation over subcortical alarm responses, which can strengthen emotion regulation.

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**Step 1: How did this affect you?**

Listen to the narrative of the patient’s current struggle. Ask about past encounters with adversity.

Suggested Questions:
Tell me what led to you feeling this way?
Tell me how have you came me to where you are now?
Tell me about another time you’ve felt this way?
Can you tell me about another time in your life when you’ve struggled like this?
Tell me about the hardest time you’ve been through?

**Pitfalls:** Beware slipping into the abyss of the patient’s despair. The initial question, *How did this affect you?*, can evoke a sense of vulnerability while telling the story of impact of the crisis. While listening, the clinician should monitor verbal and nonverbal signs of distress, staying mindful of a potential need to interrupt and re-direct should the patient become flooded. Asking about a past encounter with adversity poses less risk of re-traumatization.

**Step 2: How did you respond?**

Suggested questions:
- How did you respond to [situation here]?
- What is the first thing you did to cope?
- Tell me more about what did you do to make it through that difficult time?
- How do you respond when you feel this way?

**Pitfalls:** For many patients, the question, *How did you respond?*, will elicit clear, over-learned practices for how that individual builds hope. For other patients with maladaptive coping behaviors, such as substance use and self-harm behaviors, the clinician may need to persist in questioning how the patient responded:

Follow up questions then can include:
- *It might feel like you [insert maladaptive coping strategy here], but every day you kept going, or we wouldn’t be here talking. Tell me more about how you made it through this period of your life.*
- *So the first thing you did was to get drunk. That gave you a “time out.” So how did you respond after you sobered up? What helped get you through this?*
- *It sounds like you [drink, cut, lash out, etc] when you feel this way. When you could not [insert behavior here], what other strengths did you call on to get through this time?*
Step 3: Assessment: While Listening, Identify Hope-Building Practices Used by the Patient.

Questions to ask yourself:

- Does the patient have a signature strength for mobilizing hope when stressed?
- Which category appears to represent the patient’s strong suit for mobilizing hope?
  1. Organizational thinking and goal setting
  2. Emotional regulation
  3. Activating a core identity
  4. Relational coping
- What hope practices from this category have been available in the past? Are they available now? If not, what are the obstacles?
- Based on these observation, what strategy for mobilizing hope has been the best likelihood for success? What objective should be given first priority?
Step 4a: Intervention. Collaborate with the Patient to See How the Patient Uses that Skill This Time Around.

- Intensify use or expand scope of signature strengths for hope building
- Strategize how to overcome obstacles to accessing hope practices that have been available in the past
- Act as witness to their current and past struggles as you articulate their hope building practices
- Resurrect hope practices that have fallen into disuse due to demoralization
- Add novel-hope practices, preferably from category that is in patient’s strong suit for hope-building

Suggested intervention questions:

- **When you faced a similar challenge you [clearly restate the hope building practices you heard about as patient described their response].**
- **You overcame that crisis by [hope building practice].**
- **When you feel this overwhelming emotion it sounds like [insert practice here] gives you hope that you’ll get through this. How can you use that again?**
- **I’m surprised this isn’t the hardest challenge you’ve faced. Listening to your story I hear these ways that you overcome that struggle [start with most prominent hope building practice].**

Example: *I thought that this cancer would be your biggest trial. Yet when your mother died and you had to take care of your family, it sounds like you tapped into your core identity of being a “fighter.” You call yourself aggressive, but you knew what needed to be done and made a plan to achieve your goals. I wonder if we can apply that here?*

Step 4b: Plan the Intervention. The conversation should end with a plan on how to apply the patient’s hope practices to the current situation, whether a one-time contact or over several meetings during a brief psychotherapy, The final step is helping the patient utilize hope practices to address their current crisis.

The intervention can remain in the planning stages if there is a plan for subsequent psychotherapy. Or the clinician and patient can enact the plan together as the culmination of the therapeutic encounter. For example, the clinician (or other professional or mental health worker) can help the patient contact friends and family for relational coping; encourage the patient to write out the plan of action for organizational
thinking and goal setting in accordance with a core-identity; or to plan use of emotional regulation practices.

References.


