Letter from the Chair

Because social work is the profession of hope, and the title of this year’s NASW conference was “Restoring Hope: The Power of Social Work” (July 22–25, 2012, in Washington, DC), this issue of the Mental Health Section Connection places a special emphasis on the role of hope in mental health practice. The first article, by Judy Davis, addresses how we define and describe hope, where hope comes from, and what characterizes those who are able to achieve and maintain it in their lives. Judy discusses her use of Jenga blocks as a clinical tool for working and talking about hope with clients: the blocks create a visual representation of building hope and achieving goals, and the act of touching and moving the blocks can itself have a therapeutic effect.

Our second article—“Hearing Voices: A Voice of Hope” by Willa Casstevens—discusses the experience of hearing voices or “voice-hearing.” Although hearing voices can be indicative of a psychotic disorder, a global grassroots movement among voice-hearers argues that the phenomenon is part of the human experience—rather than, necessarily, a symptom of pathology— and administering medication is not always appropriate or obligatory. In her article, Willa explains the voice-hearer movement, how it has served as a source of hope and inspiration for many people who hear voices, what research tells us about non-impairing voice-hearing, and what all of this means for social workers and their clients.

The final article examines “hope theory” and how “hope therapy” can be utilized in concert with other modalities—such as Cognitive Behavioral Therapy (CBT), Motivational Interviewing, Solution-Focused Therapies, etc.—to help clients increase psychosocial well-being.

I believe social work is truly the profession of hope, and bringing it out in those we serve is the keystone to creating a positive therapeutic relationship and opening the door to change. It is hopelessness that burdens so many of our most disadvantaged clients and makes them feel that their problems cannot be solved. Hope supports self-determination and empowerment, and mobilizes clients’ strengths. Hope also helps us, as social workers, to persevere in our work each day and lessen stress and burnout.

We hope you enjoy this latest issue of Mental Health Section Connection.

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Chair, Mental Health Specialty Practice Section
WHAT IS HOPE?
What exactly are we talking about when we say the word, “hope?” How do we put it into operation and what elements are we describing? Is what I mean when I use the word hope the same as what you mean by the word hope? Do we learn to believe in hope from our parents or someone important in our lives? What would our world be like without hope? Can it be lost to some people? How do people lose hope? If hope is lost, how is it recovered? What does it take, exactly, to have hope? Can having hope be taught? If so, what would that look like?

C.R. Snyder, the renowned University of Kansas psychologist describes it this way, “Hope is believing you have both the willagency and the way/pathway to accomplish your goals, whatever they may be. Hope is the sum of perceived capabilities to produce routes to desired goals, along with the perceived motivation to use those routes. So hope is a kind of glue that holds together the rest of the human condition as well as the energy that moves us ahead (Snyder, 2000).”

Dr. Snyder also found evidence to suggest that people who have high levels of hope are able to self-motivate. They feel resourceful and believe they can find solutions to situations and problems and they work well with others. These people also feel able to find more than one way to solve a problem to reach a goal and to change goals if something is really not possible. They also demonstrate the wisdom and good sense to take really large tasks and break them down into smaller pieces to manage. From the framework of emotional intelligence, they are less likely to be stopped by anxiety, defeatist ideas or depression. It doesn’t imply they don’t experience these negative feelings, only that they are not likely to be stopped by them from moving ahead (Snyder, 2000). For them, like Alexander Pope, “Hope springs eternal” (Kluge, 2006).

CLINICAL APPLICATION: THE BUILDING BLOCKS OF HOPE
My clinical work and life experiences have helped me form my working definition of what fosters hope. There seems to be a basic human tendency and need to have hope. It appears in professional and recreational literature and music in many ways. Hope is built into spiritual and cultural ways to engage and understand the world. Hope appears to be grounded in reality and beliefs. Accurate information and knowledge help people think about things and make reasonable plans that can lead to hope and positive change. Previous engagement with other life experiences and situations make it easier for them to find hope and work toward positive change.
illness, and populations with comorbid conditions usually seek help, may not seek the help they need.

can be studied and applied to current life concerns and dreams. Important people stories, stories from our families or our culture can provide reassurance of what we hope can be possible and that we can accomplish the task.

Being able to have control and make choices gives us the learning and experience we need to make other choices and take more control of our lives. There needs to be adequate time to do this and there needs to be practice and feedback over time to get better at managing our lives and how we feel about ourselves in the world.

I wanted to create an interactive strategy to combine intent, giving names to things, movement, change, obstacles and progress towards a goal. So, I settled on Jenga Blocks®. Use of Jenga Blocks® has been a very successful tool for working with and talking about hope. The blocks help create a visual representation of the components of hope and the elements of progress and possibilities. There is also a powerful kinesthetic component in picking up and placing the blocks on the tower. There are many ways to use these blocks. You and the client may elect to start with the tower completed and describe it as the goal the client is after. Then take the tower apart and talk about where the client is now. As you name an element needed to reach the goal, or an obstacle to overcome, add a block to the tower. Or you could build two towers from the pieces. Have one tower represent the obstacles and one the possibilities and strengths. Then compare the two towers. Are the two towers the same size, or is one taller? What does that mean to you and to the client?

Or you can begin the conversation with all the blocks in a pile, not built as a tower. As you and the client talk about what the client wants and how they will get there, use a block to describe each strength, task, ally, possibility or resource they can use. When the tower of obstacles is large, take one block off the pile. Ask the client how they might reduce the obstacle or eliminate it. Once they talk about it and have some kind of idea for reducing its negative impact, it goes on the possibility tower. If the obstacle is really not in their control, remove it from the pile because it has been considered and doesn’t take up any more negative energy. It doesn’t go on the possibility tower but it doesn’t have to weigh the client down. When the client really can’t think of a strength or a way to reduce a barrier, I offer ideas for consideration. If the client likes any of the ideas I offer, it goes on the pile of possibilities. For me this represents a demonstration of reassurance and lets the clients exercise some degree of control and self-determination through recognizing and making choices.

These variations of block exercises can be used with any age client. The concept works well with individuals, couples, family members and issue groups. I have used it with clients, trainees and staff. I sometimes use the blocks in two small piles separated by a foot of space. Then we describe the blocks/tower on one side as where we are. The blocks/tower on the other side are where we hope to go. Then we pick up and describe individual blocks and build a path from one side to the other naming steps, tasks, resources, time or knowledge we will need to accomplish the change we want. What we hope to accomplish and how that would happen is visually represented.

Our social work profession is grounded in hope. We help ourselves; our clients and our world combine motivation and movement toward a goal. The promise and possibility of hope makes the reality of a better world something we can achieve. Hope inspires and motivates us. It provides reinforcement, feedback and reward for continuing to change in positive directions for all of us.

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REFERENCES


Hearing voices, or voice-hearing, is commonly identified as a form of auditory hallucination. Auditory hallucinations are a symptom frequently associated with a diagnosis of schizophrenia, so much so that auditory hallucinations have been called a “hallmark symptom” of schizophrenia (Wible et al., 2009). Over the past thirty years, however, a grass-roots movement has been growing among voice-hearers in Europe, the United Kingdom, and elsewhere around the globe. The movement has now crossed the Atlantic, and identifies hearing voices as part of the human experience, rather than as a symptom of pathology (Klafki, 2007; Romme & Escher, 2007). One of its forums, Intervoice: The International Community for Hearing Voices (Romme & Escher, 2007), has an online presence (www.intervoiceonline.org) that can be a source of hope and inspiration for many people experiencing voice-hearing. Intervoice is not alone – the Hearing Voices Network is an example of another such organization. What sparked this apparent shift in thinking about voice-hearing? Is this merely wishful thinking, or is there a basis for hope in this movement? And finally, what can this mean for us, as social workers?

The hearing voices movement originated in the Netherlands in the late 1980s, with the work of Drs. Marius Romme and Sandra Escher (Romme & Escher, 2007). They announced an invitation on national television for those who had experienced voice-hearing to talk about their experiences with voices. The responses they received could be considered astonishing, as many people reported hearing voices for years, were comfortable with the experience, and living normal lives. That is, Romme and Escher discovered many voice-hearers do not meet criteria for psychiatric diagnosis, and function well on a daily basis without medication or other mental health intervention (Romme & Escher, 2007). These reports are supported by research indicating approximately 10 percent of men and 15 percent of women experience hallucinations at some point in their lives, and “the proportions of hallucinations causing no distress or impairment of function were much higher than those associated with distress or impairment” (Johns & van Os, 2001, p. 1130). Romme and Escher’s work caused a stir in some mental health circles in the late twentieth century, because it implied there could be healthy ways to cope with voice-hearing that were unrelated to medication or
therapy. Romme and Escher encouraged self-identified voice-hearers to consult among themselves to provide information on coping strategies that worked for them and created a supportive community. Thus the hearing voices movement was born.

The hearing voices movement is critical of biological psychiatry’s emphasis on medication, and focuses instead on more holistic approaches to intervention when it is needed. Examples include interventions like therapy (e.g., Morrison, 2001), support groups (e.g., Meddings, et al., n.d.), and self-help materials such as Coleman & Smith’s (2005) Working with Voices workbook. Some individuals are helped by prescribed medication, however, it is recognized that (1) not everyone can tolerate medication side-effects, and (2) some individuals report still experiencing voices while taking antipsychotic medications (Cohen, 2002). This information seems opposed to much of the training I received as a beginning social worker in mental health when I worked with clients, most of whom were taking multiple psychotropic medications.

Let me state clearly that no one on psychotropic medications should suddenly stop taking them without psychiatric supervision and consultation; further, any reduction in these medications should occur under the supervision of a trained psychiatrist. That said, I have worked with clients given schizophrenia diagnoses, who reported feeling best when taking very low, or even no, dosages of antipsychotic medication. Of course, not everyone who experiences voices, or other auditory hallucinations, feels able to cope on low or no doses of medication. The points here are that: (1) medication is not the only available approach to treating distressing voice-hearing experiences; and (2) with psychotropic medications, including antipsychotics, more is not always better.

What this means for us, as social workers in mental health, is we are now able to educate ourselves about the wide variety of developing alternatives becoming available for our clients who hear voices. These alternatives include an array of online resources (e.g., local or regional Hearing Voices networks, Intervoice, Mindfreedom International, etc.); new therapeutic tools (e.g., Kingdon & Turkington, 2005); and other resources (e.g., Romme & Escher, 2000; Coleman & Smith, 2005). Moreover, all these resources can be used in conjunction with medication. The development of additional therapeutic and peer support systems, and other self-help approaches that incorporate recovery, is a beacon of hope for those experiencing the distress and stigma that can be associated with voice-hearing.

REFERENCES


In performing mental health interventions, social workers take pride in our client-centered, empowerment strengths-based approaches that provide hope. In fact, the National Association of Social Workers contends that social work is the profession of hope (National Association of Social Workers, 2012). If true, mental health treatment modalities that are empirically proven to promote hope are central to the realization of the goals of mental health social work.

HOPE THEORY
Snyder (2002) reasoned that hope is not a passive emotion occurring only in life’s worst moments, but a cognitive process through which individuals actively pursue goals. In his articulation of hope, Snyder (2002) defines it as “goal-directed thinking, in which people appraise their capability to produce workable routes to goals (pathways thinking), along with their potential to initiate and sustain movement via a pathway (agency thinking)” (p. 143).

THE PREDICTIVE VALUE OF HOPE
Using the above definition, researchers have developed psychometrically suitable adult dispositional and state measures of hope (Bryant & Cvengros, 2004) and children’s hope scales (Snyder, 2000). In relation to emotional well-being, research using such measures has found that lower hope scores predict depression (Kwon, 2000; Chang & DeSimone, 2001), while higher hope scores reflect better overall psychological and social adjustment (Kwon, 2002).

Research has also shown the efficacy of hope therapy, a treatment modality based on hope’s theoretical principles. A randomized trial of hope therapy in a group setting revealed a decrease in depression and anxiety for those who received hope therapy versus those in the control (Cheavens, Feldman, Gum, & Scott, 2006).

HOPE THERAPY AND SOCIAL WORK
Hope theory and its therapeutic tenets hold the potential to serve as a unifying metatheory for other social work mental health treatment modalities and practices. In fact, hope theory is especially valuable in elucidating the common principles found in all efficacious mental health interventions (Taylor, Feldman, Saunders, Illardi, 2000). A review of literature suggests a client’s hope development may be best achieved through a therapeutic integration of cognitive behavior, solution-focused, and narrative therapies (Lopez, Floyd, Ulven, & Snyder, 2000). Moreover, social work practice techniques related to motivational interviewing, resiliency, strengths-based perspective, and empowerment are all particularly helpful to therapists working to increase a client’s hope. A description of hope therapy and its relationship to existing social work mental health treatment modalities and techniques is discussed below.

Goal building. Given that hope therapy is predicated on the premise that human beings are goal-directed, the first step in a hope-based mental health intervention is working with a client to develop clearly articulated goals. Early in the therapist-client relationship, the hope practitioner helps a client develop a mental health hope profile (Lopez, et al. 2000) answering the question, “What am I hoping for?” By developing a client’s mental health hope profile, the client and therapist are placing the focus on affirmative goal-setting rather than on mental health pathologies, which encourages the client to remain committed to the therapeutic process. For example, positive formulation of the goals of therapy in hope terms, such as “I hope to be happier,” is helpful in motivating the patient.

Pathway building. Once measureable goals are pinpointed, the next step in the hope therapeutic process is building a cognitive pathway toward those goals. The hope therapist helps the client answer the question, “What steps must I take to reach my goal?” Such focus on pathways facilitates application of social work’s person-in-environment...
before?” Such approaches help have my hopes realized?” and, motivated myself in the past to therapy (CBT) is the identification of the presence of obstacles. The role of the hope therapist is to partner with the client to build agency through self-referential activities designed to enhance motivation (Lopez, et al., 2000). The hope-based intervention helps the client answer questions like, “How have I motivated myself in the past to have my hopes realized?” and, “How did I overcome obstacles before?” Such approaches help a client build agency, and thus hope, because of the benefits of reflection on previous goal attainment.

Agency building. Agency is the motivational facet of hope that fuels people along pathways toward goals even in the presence of obstacles. The role of the hope therapist is to partner with the client to build agency through self-referential activities designed to enhance motivation (Lopez, et al., 2000). The hope-based intervention helps the client answer questions like, “How have I motivated myself in the past to have my hopes realized?” and, “How did I overcome obstacles before?” Such approaches help a client build agency, and thus hope, because of the benefits of reflection on previous goal attainment.

Cognitive behavioral therapy: Building pathways. A common element to cognitive behavioral therapy (CBT) is the identification and modification of cognitive distortions that have a negative influence on mental health (Sava, 2009). In hope terms, these cognitive distortions erode agency, limit pathway identification, and thus, erode hope. In hope terms, the emphasis in CBT on hypothesis testing, correcting automatic distortions and self-monitoring serve to elevate agency. Furthermore, cognitive exercises related to homework often employed by CBT help the client begin navigating pathways in vivo between sessions to improve the pathway component of hope.

Solution-focused interventions: linking goals to pathways. Solution-focused therapies utilize several approaches that are useful to building hope. First, as a brief therapy, solution-focused interventions emphasize the importance of affirmative and efficient goal setting (Gingerich & Eisengart, 2000; Lethem, 2002). Hope therapy also centers on the efficient creation of goals as an early step in the therapeutic process. Secondly, solution-focused techniques such as the miracle question (Grant, 2003) involve clients envisioning goal attainment then thinking retroactively to create pathways to the goal, and thus, hope.

Narrative interventions: building rainbows. Although the precise parameters of narrative therapy remain undefined (Wallis, Burns, & Capdevila, 2011), hope theory offers a theoretical means to elucidate the most effective aspects of all therapy approaches that contain narrative aspects. Broadly speaking, the term “narrative” refers to the therapeutic emphasis placed upon the stories of people’s lives and the differences that can be made through retellings of these stories (Wallis et al., 2011). In hope terms, narrative therapists ask a client to tell a personal story of an effort to reach a goal that includes a description of travel down a pathway toward that goal and obstacles overcome. In such a manner, a hope therapist identifies limits on a client’s hope, such as low agentic thinking or a lack of pathways, which is revealed via the narrative.

Motivational interviewing: generating agency. When a hope therapist identifies low agentic thinking toward a goal, the therapist must employ practice skills to help raise agency, and thus hope. One such practice skill is motivational interviewing, defined as a collaborative, client-centered form of guiding to illicit and strengthen motivation to change (Miller & Rollnick, 2009). In hope theory, activities such as motivational interviewing increase motivation, falling squarely under the agency facet of hope.

Empowerment principles and hope. Empowerment theory in social work mental health practice concerns partnership with clients in consciousness-raising, overcoming barriers, developing self-efficacy, and access to personal power (Payne, 2005). Empowerment principles assist clients to view themselves more positively and thus capable of action (Kirst-Ashman, 2008). A concept associated with empowerment is resiliency, which emphasizes the use of strengths to cope with adversity (Gutheil & Congress, 2002).

The heart of empowerment is helping clients see themselves as capable of taking action to continue down a pathway toward a goal despite obstacles. In hope terms, such is the nature of agentic thought. Hope therapists employ empowerment principles to raise agency, which in turn motivates the client to continue down the pathway and thus become more hopeful for a goal.

CONCLUSION
Hope theory and therapy are uniquely suited to mental health social work. The elements of hope therapy, goal-setting, agency, and pathways-thinking, offer a simple and empirically-measurable method to assist a client toward optimal mental health functioning. With hope therapy, social workers have a unique opportunity to embrace a developing evidenced based treatment modality that offers promise as a means to social work’s professed goals of creating hope for improved mental health.

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Did You Know

MAJOR CHANGES IN 2013 FOR CLINICAL SOCIAL WORKERS

Clinical social workers should prepare for three major practice changes which will significantly impact the way in which clinical social workers practice and seek reimbursement for mental health services they perform. Occurring in 2013, the changes are in the areas of coding, diagnosing, and measurement. Visit SocialWorkers.org/practice/clinical/2012/092012.asp for more details.

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