Hope and Change – The Intersection

by: Peggy Grall

We are in the change business. Whether we work with children, adults, teams, organizations or corporations, we are first and last, the purveyors of change. People come to us when things aren't how they want them to be or when the status quo just isn't good enough. Sometimes our clients are in emotional or psychological pain, teams and companies are often in financial or competitive pain. Sometimes they want to seize the opportunities that could be theirs - if only they could *change* what they are thinking, feeling or doing. Either way, they hope that we can show them, and their organizations, how to change, and fast!

And, what about us? We are very familiar with the culprits that thwart people's attempts to change, they constitute our Achilles heal and we approach them with Titan resolve. We speak of erroneous belief systems, unconscious mental schemas, life scripts, toxic parents and dysfunctional organizational patterns as we attempt to identify the keepers of the status quo.

In an effort to banish their change resistant demons, we encourage our clients to verbally sketch the new territory, those added benefits the change will make. They respond by describing, in great detail, how much they *want* the change to happen. They produce example after example of how much better life, work or business would be, if only they could change! Often they tell us tales of having *tried* to change this *before*; they offer up vignettes of their past failures in an attempt to warn us of the tenacity of the problem.

We nod, in tell - tale recognition, and in our hearts we feel the pang of doubt for them, and for ourselves. We know how they feel, we've felt it too; that moment when you realize that, despite your best efforts, you - like them, go round again. You find yourself doing the same old thing in the same old way, getting that same old result. And we wonder, will I / will they, ever be able to change *this*?

Yes, the cry comes up from our ranks! Yes, of course we believe people can change. We couldn't ethically continue to do our work if we didn't. But, the status quo is no small adversary.

I've been fascinated for many years now, with this whole idea of how people actually change. I think, in large part it's what drew me to the profession. I consider myself a natural change agent; always looking for what's next, a new idea, adventure or challenge. I've changed many things in my life; careers, offices, partnerships, residences – even navigated divorce and moved countries twice. I've changed my outlook and opinions on religion, politics, sex, aging, success and practically every other subject I've ever ventured to have an opinion on. I change most things with relative ease; I easily and routinely purge closets and storage rooms bidding a fond farewell to possessions that I once held as dear. I sell, donate or simply give away things with a refrain of, "out with the old…in with the new." Gone, I'm done.

And then there are those *other* things in my life. Those seemingly stubborn reactions and responses to situations and people, those unconscious habits that detract and frustrate, those things about me that, despite my Olympian efforts, remain unchanged, fixed in cement. The glaring inconsistency in my ability to change some things about myself, has driven me to investigate this notion of human flexibility, this notion I've clung to that everything, well – almost, can be changed.

As a professional, I have found it particularly curious when I've been working with a client who is attempting to change the very belief, habit or behavioiur that has remained illusive to my own efforts at transformation. I wonder, should I reveal my failure? Do I caution them that *this thing* can't really be changed? What can I give them in the absence of a compelling personal testimony, obvious victories or ribbons won? What can I hold out to them when the question is on my own lips?

Offer hope.

Outcome research reports that Psychotherapy is very effective, with most studies indicating that those brave souls, who engage in therapy with us, are better off than upward of 80% of those who stay home. (Hubble, miller, Duncan, 1977) Impressive. But, what exactly is it that makes the difference? Hope, it turns out, plays a big part.

Research has consistently shown that a substantial portion of the improvement that clients make happens within the first 3 – 4 sessions; before any *treatment* has been applied. In a series of studies, researchers found that 40% to 66% of clients reported positive, treatment-related improvement *before* attending their first session. (Howard et al., 1986: Lawson, 1994; Weiner-Davis, de Shazer, & Gingerich, 1987) It appears that just knowing the cavalry is on its way calms the troupes!

Hope Theory is an interesting framework for making sense of these findings. Basically, in Hope Theory, hope is understood in terms of how people think about their problems and the solutions or goals that they think will help in solving them. Thinking about goals is divided into two streams: 1) Pathways; the ability to think of workable routes to the goal – "I *can* do it" thinking and, 2) Agency; the ability to begin and continue moving towards the goal – "Here's *how* I can do it." thinking. Both pathway and agency thinking are necessary to produce hope.

Researchers, Frank & Frank 1973, assert that people don't seek Psychotherapy because they have problems; they seek help because they have become demoralized in their own ability to think of methods to solve the problem and/or act on those ideas. Frank suggests that there are four factors that will help people combat demoralization and regain hopefulness.

1. An emotionally charged relationship with a helper
2. An inviting therapeutic setting
3. A believable therapeutic myth or rationale
4. A therapeutic ritual

Frank & Frank 1991, suggest that securing an emotional, confiding relationship with a therapist that is both hopeful themselves, and determined to help, is the foundational piece to a successful outcome. Frank speaks of a welcoming relationship that fosters trust, ensures safety, confidentiality and accountability as being a key ingredient in successful therapeutic outcomes.

The therapeutic setting is territory that can be used to combat demoralization in clients. The old adage, "success attracts success" seems to apply here. Creating a setting in which you feel like a strong helper, and in which the client can feel like they have found someone who is really able to be of help to them, contributes to hopefulness. (A.O. Horvath & Greenberg, 1986, 1989; Strupp, Fox & Lessler, 1969)

What are the implications of this factor for you and your practice? Does your receptionist engender hopefulness in how she/he answers the phone? Does your waiting room, literature, lighting, music etc. give your clients the sense that they have arrived at the office of someone who is successful at helping people? How is your own demeanor? Does it radiate humble confidence?

A compelling myth or therapeutic rationale is probably the factor we are most familiar as clinicians. Most of us have spent countless hours and dollars acquiring training in a specific theoretical perspective or model that we believe is a credible way to intervene in most situations. The battle of the belief systems rage – and yet research indicates that one theoretical perspective is just about as good as the next in getting results in therapy. (Duncan, Hubble, & Miller, 1997)

Although one theory doesn't seem to have any more validity than another, clients need to know that you have one; they need to believe that you know the territory, have a map and have walked this way before. They need to believe that you have helped others like them chart a course to the top. Having a compelling theory invites pathway thinking by providing an explanation for how movement toward a particular goal can occur. Having a convincing model also provides agency during the difficult part of the change when continuing on is the greatest challenge. Being able to chart one's progress is comforting to a weary change traveler.

Good MFT therapists know, marriages may be made in heaven - but they are lived out on earth! The "here's *how* I can do it" part of hope creation comes form practical techniques, tools and rituals. I'm continually reminded of the need for common sense, real-world and functional solutions to human dilemmas. We can spend a lot of time trying to convince clients that they *can* change, and forget to give them the tools to make the change happen. In my work with teams and organizations, workshop participants often ask, "so, what *exactly* are we suppose to say or do now." Out beyond the conceptualizing about mental schemas, erroneous belief systems and shifting paradigms lays the territory of *doing* something different. We learn best by test driving alternative behaviours.

How do these common factors for producing hope and ensuring successful outcomes in a therapeutic setting translate into the corporate world? Very nicely, indeed.

Dr. Lynn Johnson of the University of Utah has completed a round of study into the way most companies have traditionally introduced the need for change to their employees. The traditional model has been to: 1) diagnose the problem, 2) analyze how and why things have gone wrong and, 3) focus on the problem and the culprits to determine how to fix it and them. His research agrees with Peter Senge's work on Learning Organizations, in that they suggest turning the process upside down when approaching a business unit in need of significant change. Much like a kissing cousin to a brief therapy model, they suggest a process of:

1. Developing an inspiring question
2. Discovering times of excellence and previous successes
3. Dreaming of what is possible
4. Designing what should be
5. Delivering your design to become your destiny

This approach reminds me a lot of using the Miracle Question where you invite your client, family, leadership group or team to roam around in the anticipated new territory; breathing, tasting, feeling and seeing what *the new and improved* changes would be like. In the experience, they begin to try on their new roles, improvise new solutions and buy-into new approaches. It works in therapy, and in business; seems we respond pretty much the same at home and at work.

Dr. Johnson goes on to suggest that, whether working with individuals or in groups, we must learn to ask powerful questions. He suggests asking:

1. Exception questions – when were you successful in spite of the problem?
2. Transformational questions – what will you be like when this is accomplished?
3. Confidence questions – what parts of this goal feel the most doable?
4. Scaling questions – 1-10, where were we and where are we now?
5. Action questions – what can we start doing *today*?
6. Persistence questions – how can we keep this going?

Of course, we know there are times when we must ask those questions designed to track and reveal a client's emotional state. Most models of therapeutic work would agree that a certain amount of "emotional work" needs to happen; venting and releasing negative emotions often precedes insight. Even in this part of the work we can use key questions to uncover the blockages that are stopping a client from making progress; negative emotions can serve as clues about the underlying goal pursuits that are being thwarted, either by the client's actions or circumstance. Helping the client, family or team to find a new goal is the key. Not a new concept, but in a discussion on creating hope, an important factor to consider. How are you using questions in your work? Are the questions you ask generating hopefulness? Do they invite the client into pathway – "I *can* do it", thinking? Do your questions contribute to your clients being encouraged to start and persist in pursuing their goals?

Just like hope can be encouraged, it can be stopped. So, what kills hope? Here are six factors that appear to have a direct bearing on limiting hopefulness in the therapeutic process.

1. Goals that are more for the helper than the helped. When therapists don't listen well they can end up creating goals that would work for them, but don't foster pathways or agency thinking and responses in the client.
2. When the therapist, rather than the client, is doing all the work. When therapist supply all the energy (agency) and ideas about what should be done (pathways and goals), not surprisingly the client doesn't own the goals. Of course, being overly inactive can create a sense of isolation for the client.
3. When the therapist fails to model hopeful behaviour. Here's the challenge my friend; when we may be tempted to mentally *give up* on a client, we must examine our own biases and pre-judgments (Snyder, 1994b; Snyder, McDermott, et al., 1977)
4. When helpers are wed to a particular paradigm of helping. (Norcross, Karg, & Prochaska, 1977) The most successful therapists appear to be those who refer to themselves as taking an "integrative" approach to working with people.
5. When a therapist allows themselves, as a result of personal burnout or skewed view of humanity, to adopt a "mess" theory of people. Because we work with people who aren't handling their problems well, we can forget that the vast majority of the population is coping quite well.

6. Therapists that focus on a client's weakness and inabilities, rather than their abilities (Higgins, 1994: Rutter, 1994: Werner & Smith, 1982) and routinely disregard or fail to fan the client's strengths.

The circumstances above all serve to thwart the development of hope in the client and concomitantly in the therapist.

We are the change agents. We are the keepers of hope. So how can we maintain our own sense of hopefulness?

Frank & Frank speak of healthy enthusiasm as being a huge factor in maintaining hopefulness, and burnout and disillusionment in the therapist as contributing to lessening the hope of the therapeutic intervention. It has traditionally been the practice of the profession that when the outcome of therapy is good, we vigorously point to our own efforts and methods, and when a client fails to make progress, we often site client factors that have prevented a more successful outcome. Could our own disbelief in the client's ability to get better, or our own ability to help, be playing a bigger part than we once thought? Apparently so!

Have you found yourself doubting for your clients? For yourself? What would increase your hope quotient? What would build your sense of optimism for better outcomes for your clients? As we've seen, therapy works; do you need to get help yourself? My subjective observation tells me that therapists are a bit like the cobbler's children who have no shoes; we spend our time holding hope for others while watching it seep away for ourselves. We have a professional obligation to do whatever we can to strengthen the therapeutic alliance with our client's; could you benefit from being a "client" for a while? Would it renew your faith in the process to be in an "emotionally charged" relationship with a helper? Would it inspire you to spend some time achieving success at your own goals? What do you need to do?

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Peggy Grall is a Certified Executive Coach, key-note speaker and former Psychotherapist with 19 years experience in the areas of Change Management and Conflict Resolution. Organizations experiencing mergers & acquisitions, culture transformations, and other intense change initiatives have utilized Peggy's skills to help them navigate the high-risk, high-reward atmosphere of significant change. Her unique background equips her to work effectively with individuals and teams to assess and address the complex *people issues* affecting *change outcomes*. She is President of the Canadian Association of Professional Speakers Toronto Chapter and in 2004 was nominated for **Business Person of the Year** and nominated again in 2005 for the coveted **Athena Award** recognizing Women in Business.

Peggy can be reached at **1-866-949-6698** p.grall@justchangeit.com www.JustChangeIt.com
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