EUROPEAN JOURNAL OF COUNSELLING THEORY, RESEARCH AND PRACTICE
Vol 1, Article 3, 2017
ISSN 2398-5607
www.nationalwellbeingservice.com/journals

REVIEW PAPER

Teaching clients how to cope

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Abstract
Hopelessness is associated with completed suicides. Hopeless thoughts can be categorised according to their form and function. Different therapeutic strategies such as detached mindfulness may be helpful in combating such thoughts. In addition hopeful thinking can be taught as a skill, and varied according to the type of hopeless thinking being presented by the client. A technique in which the therapist generates imagery of a desired future can be powerful in helping clients who have lost the capacity to project forward, but there are caveats; the degree of positivity in a projected script needs toning down to the level the client can tolerate.

Keywords: *Hopelessness, hope, imagery, hopeful thinking, mindfulness*

Abstrait
Le désespoir est associé à des suicides complétés. Les pensées sans espoir peuvent être catégorisées selon leur forme et leur fonction. Différentes stratégies thérapeutiques telles que la vigilance individuelle peuvent être utiles pour lutter contre ces pensées. En outre, la pensée d'espoir peut être enseignée comme une compétence, et a varié en fonction du type de pensée désespérée présentée par le client. Une technique dans laquelle le thérapeute génère des images d'un avenir souhaité peut être puissante pour aider les clients qui ont perdu la capacité de projeter en avant, mais il y a des mises en garde; Le degré de positivité dans un script projeté nécessite une diminution du niveau auquel le client peut tolérer.

Mots clés: *Désespoir, espoir, imagerie, pensée optimiste, attention physique*

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Funding
None declared

Declaration of conflicting interests
The author(s) declared no potential conflicts of interest in respect to their authorship or the publication of this paper.

Acknowledgments
None declared

Introduction

Hopelessness, or more specifically hopeless thinking has been associated with both depression and completed suicide (Beck, Weissman, Lester & Trexler, 1974,; Kovacs & Garrison 1985; Beck, Steer, Beck & Newman, 1993). Hope is defined in the Oxford English Dictionary as 'expectation of something desired' (OED online 2015). In everyday life expectation fuels motivation, and desirable outcomes elicit pleasure. The loss of hope then, signals the decline of both motivation and pleasure, leaving the client with only the bleakest of futures to contemplate. When faced with a client who appears hopeless it is possible for the therapist to 'catch' the mood and feel his or her own stomach sinking. This is a natural empathic response and may indicate that the counsellor is in tune with the client. On the other hand it is unhelpful for both parties in the therapy room to become hopeless, and so a protocol for assessing and treating hopelessness can be a valuable point of reference.

Assessment of Hopeless Thinking

Not all hopeless thinking is the same, so therapists are encouraged to take a dialectical

approach, assessing what might be reinforcing hopeless thinking at any given moment. The following categories of hopeless thoughts are each treated slightly differently – but the good news is that inviting curiosity about the type of hopelessness being experienced is the first intervention – helping to move the client into a meta-cognitive position, i.e. thinking about their thought processes in a more detached way.

1. "I've lost everything" Although this sounds present-focussed it is often associated with future-focussed thinking. It occurs when a client is attached to a set of proposed events and something happens to thwart that plan. An example is the older couple looking forward to an active retirement when one person suffers a stroke. The anticipated future is lost, and in its place is a natural vacuum. It will take time to formulate new plans and in the adjustment period the client suffers a sense of hopelessness. The client may describe this as 'looking into a void'. This type of hopeless thinking is high when relationships break up, depending not so much on the length of the relationship, but on the amount of emotional investment placed in the anticipated future together.

2. "There's no answer" This occurs when the client is faced with either one big problem to solve, or multiple problems, but literally cannot think of any solutions. It is related to 'writer's block'; an almost physical inability to think creatively. Just as writer's block is probably anxiety related, this type of hopeless thinking is also associated with high emotion. There is evidence that in the grip of strong emotion a client's ability to problem-solve falls off a cliff (Pollock & Williams 1998). Access to logical thought-processes becomes inhibited and problems seem to loom too large to be tackled. This is also a symptom of depression and often eases with anti-depressant medication.

3. "What's the point? It won't work" This type of hopelessness is associated with learned helplessness and often follows a series of disappointments, perhaps over many years. The client is able to conceptualise a future scenario, perhaps even one that would motivate them, but they instantly dismiss the proposal with thoughts such as, 'it will all go wrong'.

4. "I'm too tired" In this case the client can envisage things they might want for the future, but has no energy reserves on which to draw in order to get them. Usually associated with a repeated pattern of striving and defeat. It can also be associated with Prolonged Duress Stress Disorder (PDSD) a lesser-known relative of PTSD (Scott & Stradling, 1994). The presentation in this case is one of physical exhaustion, the client really looks tired. This is one of the hardest forms to treat, because it is not that the client can't see a future, they are just spent. Yet all therapeutic advances will require at least some effort from the client.

5. "It's going to be awful" This is usually related to a specific future event that the person fears. Often cited as the motivation for the high suicide rate amongst newly incarcerated prisoners, or children being bullied at school, it is associated with a sense of certainty in which the person predicts the intensity of their suffering, and usually does not see this coming to an end. People who have an over-controlled coping style can experience high horror-predictions in response to fairly low-level stimuli, such as how they might be perceived at an upcoming reunion.

6. "I'm trapped" It is rare that people are actually trapped in an unbearable situation (although it does happen – see below) but their perception is that the solution that may get them out of their situation – for example leaving an unhappy marriage – would be intolerable. Often at the point of becoming suicidal the person has ruled out the solution so they simply predict unending pain and misery.

7. "This suffering is permanent" Sometimes people have an ongoing and intolerable stressor. For example becoming paralysed from the waist down after an accident, having constant and intractable physical pain from an injury or being sentenced to life imprisonment. This will require adjustment, and is hard to treat in the early phases, however, even then there is usually a dialectical swing when the rejection of their situation is less or more active. To some extent all hopelessness feels like entrapment, as by definition there is absence of hope of finding a way out.

The art of the therapist is firstly trying to engage the client in discernment about their hopeless thinking. Drilling into the experience rather than accepting it at face value. This is rather like the difference between sitting in the driver's seat of a broken-down car lamenting that it is not moving, versus throwing open the bonnet or checking the chassis to find out why. Validation helps to bring the client alongside in this detective work. The counsellor might say, "It is perfectly understandable that you feel really hopeless in this situation, and then that hopelessness adds to your general misery. You become exhausted, battle-weary, and it seems like there is no way out. It just saps your energy and everything becomes too much effort, even trying to engage with our conversation. I am so glad you came here, because I think I can help you with this."

European Journal of Counselling Theory, Research and Practice 2017, 1, Article 3, ISSN 2398-5607

Detached mindfulness

Describing a hopeless thought as just that, and noticing how many times it comes along is called 'detached mindfulness' and is a subset of strategies in the school of Metacognitive Therapy (see Normann, Emmerik & Morina, [2014] for a meta-analysis of studies) so the client might be taught to describe the thought factually, perhaps even counting how many times it occurs in the course of one hour or one day. This prevents the client getting too caught up in the ruminative thought.

Therapist: So it looks like you were ruminating on how much you hate your job?
Client: Yes, but I can't possibly leave, I'm too old to get another job at the same level, and I have a good pension scheme.
Therapist: So it sounds like you have decided to stay, but that 'I can't leave' thought just plagues you all the time.
Client: Yes, it does, and that's when I feel the worst, because I can't leave.
Therapist: OK, try saying to yourself, "there's that 'I can't leave' thought again.
Client: It's not a thought, it's a fact.
Therapist: Either way at the moment it crosses your mind it's a thought, right? The thought "I can't leave" goes through your mind, and you can spot it coming through like a train going through a railway station. You can get on the train if you want, but we all know where that train goes to – a shedload of misery for you.
Client: Hmm... I suppose so.
Therapist: And the more you hang out with that thought the more poignant your situation seems to you. So at the outset we need to just notice it and allow it to go in and out without engaging with it too much. It won't always come in the same format, there might be different words, but you will soon come to recognise them as belonging to that category that we discussed of 'I can't possibly leave'. So next time you think, 'I hate my job, but I'm stuck here' what can you say to yourself?
Client: There goes one of those 'I can't leave' thoughts again.
Therapist: Great, then turn your mind back to whatever you are supposed to be doing at the time, whether it is working at your desk or walking down the corridor.

Generating hope

Whilst the detached mindfulness will help reduce the impact of the hopelessness it is not generating the opposite, which is hopefulness. It is helpful for the therapist to conceptualise hopeless thoughts and hopeful thoughts as two different behaviours.
Having decided which types of hopeless thought are active, the therapist can help the client to solve the problem. It will not work to simply give a positive reframe, or cognitive restructuring. Here are the steps in generating hope:

1. Encourage the client to state the problem accurately, avoiding generalisation Highly specific language is preferable. Rephrase until the sentence captures the factual nature of the problem. For example "I've lost everything" might become, "I have been made redundant and I predict it will be very difficult to get another job." Avoiding phrases like "I'll never get work again" or "That was my last chance". Avoid interpretations like; "my husband has left and is never coming back" It is more factual to say, "my husband has left and has said he will not return" or "my husband has left and I fear that he will not return"
2. Regulate posture, pace and tone Regulation refers to helping the client portray with voice and bodily expression a measured amount of distress. The aim is to reduce vocal tones, posture and gesture that denote too much emotion, or alternatively increase their intensity if the client is under-emoting. So the client hunched over and whispering plaintively, "I've… lost… my… job…" would be encouraged to sit up straight, look forward, speed up her speech slightly and say the phrase in a firmer tone. However, if the same person adopted a dismissive tone, shrugging and saying, "Huh, now I've lost my job. So what? It's just gone the same way as everything else," she might be encouraged to slow down her speech, lower her shoulders, soften her face and say, "I have lost my job, and that is a worry." The counsellor coaches the client to express in a way that is not indicative of hopelessness.
3. Generate some possible solutions to the problem, but predict the obstacles, in the same style as in steps 1 and 2 These predictions will be ego-syntonic, i.e. they are likely to fit how the person sees things and so be more palatable. E.g. NOT "I wonder if you could ask your dad for a loan?" but "I guess if you were to ask your Dad for a loan he would want to know how you got into debt? And he could just say no outright?" Stay upright in posture and reasonable in tone, validate any response that is valid – for example if the client says, "I would hate the look on Dad's face" the therapist would reply, "yeah, it is horrid to be on the receiving end of disapproving looks". The aim is to imply 'co-bearing' (Dunkley 2014) so that the client and therapists are in the situation together.

4. Ask questions about time and duration E.g. Client: "I would be devastated if I can only see the kids at weekends" Therapist: "How long do you think that devastation would go on for?" Hopeless thinking is open-ended, whereas hopeful thinking more accurately follows the ups and downs of daily life. For example, the person who hates their job might be asked; "what point on Monday was the most unpleasant? How long did that go on for? Did you continue to think about it after you got home?" It is a mistake to think of being hopeful as thinking that everything will turn out well (which is positive thinking) but rather that there is a chance things can be better.

5. Paint word pictures of an improved situation This technique uses the metaphor of a crystal ball or a telescope into the future. It relies on fleshing out in as much detail as possible the future scenario on which the client could bank some hope. It needs to be done bearing in mind the principles outlined previously that overly optimistic scenarios are hard to believe. The following section goes into this strategy in more detail.

6. Teach the client to daydream in detail Encourage them to detail things that are 'mundanely possible.' Use the five senses (see more below).

A Telescope into the Future

Access to mental imagery is a resource that can be utilised to bring about a change in emotion (Matthews, Ridgeway and Holmes 201). Counsellors may be unsure about how to use these techniques, and what follows is drawn from the author's clinical experience in using mental imagery to generate more hopeful thinking with clients in both primary and secondary care.

The 'telescope into the future' technique involves the therapist evoking a story of a possible future, recounted as though it has recently happened. From the author's observations the best word-pictures contain 6 key components:

1. They are set in a mundane situation
2. They contain a description of some hardship
3. They include an element of random chance
4. They end up with something that the client would really value.
5. They use the language that the client might use, recognisable phrases.
6. They involve some kind of person-to-person interaction.

Initially, because this is done when the client is really hopeless, the therapist will be the one to generate the word picture. Over time ownership of it transfers to the client. Here is an example of a word-picture painted for a client who is struggling to generate any hope after a painful divorce.

Therapist: I am just looking into the future, Sally, and here is an example of what I can see. I am in the supermarket and I look over the fruit and veg and there you are, picking up some satsumas. You catch my eye and smile, and I come over and say, "OMG Sal, you look well, your cheeks are rosy." You laugh and say, "it's just because I've just rushed across to get some fruit for a picnic tomorrow." I asked how things have been and you say, "to be honest, I didn't think I was going to survive those early days after Clive left, I went from feeling furious to complete despair, and I had to learn how to do lots of things by myself that he used to do. There were some nights I couldn't see a way forward and I just used to think, get through today. Then my car broke down which was a complete disaster! The relay rescue guy turned up and said, 'Cheer up', and I just started crying. He was mortified, and said he knew someone who might be able to fix it cheaply. The next day called round with the name for me. He was just separated from his wife and he said he'd felt like jacking in his job and moving away. After that he made more excuses to come over, but it took me ages to realise he was interested in me, I mean, I was a wreck. But now, well, we have a day off tomorrow and we're going out for a walk."

Often the client will be quiet during this description and then might say something like, "well, I just can't see that happening" but that is unimportant. The way the mind works they just HAVE seen it happening, and this 'virtual reality' effect is very powerful. The therapist can say, "It's not likely to happen like that, it's just an example".

Here is another illustration from a case where the client has lost contact with family due to his alcohol problems.

Therapist: "I'm looking into the future and I bump into you coming out of what looks like a slightly run-down office. You look a bit tired and are chatting with a guy who looks to be in his early 20s. He leaves and you catch sight of me, and you say, "Hmmph, not you again! I did SOME of the things you said, right? So don't get on my case, I got by. It was tough though, on my own, but I went to AA meetings - you know. And it was Geoff from AA who asked me 'Do you want to mentor this lad at

European Journal of Counselling Theory, Research and Practice 2017, 1, Article 3, ISSN 2398-5607

Crossways, you know the teens charity?' and I said, "Get off! Me? What?" But, well… See that lad I was with just then? That's him, the kid I mentored. He's just said to me, "My dad says you're the one that got me off my arse".

I've been listening to all this and say, "Wow…" and you give that sideways look you always do and go, "What?" as if you don't know what I'm talking about, and then we both laugh."

Client: Hmmph. Well your crystal ball's pretty crap. Stuff like that won't happen.

Therapist: You mean in the past it hasn't?

Client: (shrugs) yeah, right.

Therapist: And those hopeless thoughts go round in your mind? You could notice that they are there and then turn your mind back to whatever you are doing in this moment.

Client: what's the point? They won't have me mentoring kids, I'm not even in contact with my own kids.

Therapist: This is true, there would be a very long way to before you would be in a position to do mentoring, what do you think is the major hurdle?

Client: Just staying off the booze. I'm OK for a few months, but…

Therapist: So there are times when your urges to drink are really strong, you will need that extra bit of support when that happens?

Client: I have done AA, it's not that I don't ever go. It's just, well, sticking it out. Yeah, that's tough. These young lads, I see them around the charity circuit. That Crossways is OK. It's not easy though, you know?

Therapist: Yes, very tough. Everyone needs help.

Client: Hmmph. Well.

The extract above shows that even in a short exchange the client has started to demonstrate subtle signs of hopefulness. He first rejects the scenario out of hand, but then shows that his mind has absorbed some details of the scenario. The therapist does not underestimate the value of these tiny changes. Knowing that the client is well-defended the therapist here has incorporated a number of his 'push-backs' into the word-picture (e.g. 'not you again' and 'don't get on my case') thereby modelling as closely as possible the journey he will have to make. The end point in the word-picture is not too ambitious, a chance remark but smuggles to the client that a meaningful 'parental' relationship can happen via non-kin relationships.

With practice therapists can produce a word-picture during the therapy session, but there is no prohibition on preparing ahead of the session. The content is more important than when it was prepared.

Moving to client ownership of future possibilities

A word-picture is undoubtedly most powerful when the client least expects it, it is very different from saying, "Perhaps you could mentor young people?" or "You don't have to be related to people to feel a sense of connection with them". The therapist has done the work of adding in the details to make the scenario believable. Next the client needs to learn how to do this independently.

At this stage the most effective strategy is questioning what it is like seeing themselves in the future in this way, even if they don't fully buy into the image. Asking what kind of details they recognised. For example the client above might say, "Me, in a scruffy looking office looking tired, yeah, that's about right!"

The next stage is to ask the client to practice daydreaming about future scenarios that have a glimmer of something valuable in them. There is no need for it to be wishful thinking, for example, this client does not have to envisage his family welcoming him back. He could imagine putting up a shelf in his flat, and a neighbour coming by and saying, "that looks great." In episodes of hopelessness there is limited capacity to imagine any kind of future other than that one which is endlessly bleak. Breaking this cycle just enough to allow notions of a more realistic future is the essence of developing the skill of hope.

It can also be helpful to gather news stories of random good fortune, which when all else fails is the saviour of the truly hopeless. Just staying alive allows the possibility that fate will effect a rescue.

Once the client has learned to spot hopeless thinking, using mindfulness skills (Dunkley and Stanton 2014, 2016) they can go on to rehearse their new skill of hopeful thinking. Over time they can be encouraged to monitor the consequences of each type of thinking. Of course over-thinking can be problematic if practical actions do not follow by which the hopeful scenario might be brought about.

Considerations for treating different types of hopeless thinking.

1. "I've lost everything" Validate the enormity of the loss. Develop word pictures around low-level achievements. Better to help someone envisage themselves just waking up one morning and for the first time there is no ache in their heart, than trying to see themselves having a great experience. The 'Reasons for Living Inventory' (Linehan et al., 1983) is an excellent resource for anyone working with clients who are suicidal.

2. "There's no answer" often responds better to the question?, "What would you advise a friend in these circumstances?" This helps by-pass some self-defeating cognitions. Start by accepting that there are limitations. Remember the role of random chance in changing things for the better.

3. "What's the point?" Avoid any suggestion that there is a point, as this will encourage the client to rehearse their evidence that nothing will work. Instead, help the client to notice that this is just a thought, and that problem solving is harder when they entertain it.

4. "I'm so tired" Take this very seriously. Explain that the client is in a double-whammy of low energy plus having no positive experiences to regenerate them. The metaphor of riding a bike can be helpful, that it takes the biggest push to get going, but afterwards the momentum makes it easier. Be honest that any progress will involve energy output, and at the same time use phrases like, "I believe I can help you". Postural and tonal changes make a huge difference, for example asking a client to repeat what they just said but to say it slightly quicker and with more upright posture. If asked to justify the request point out that these are important points and deserve to be said in a more forthright manner. In fact the brain will register the new posture to positive effect (Veenstra, Schneider & Koole, 2016)

5. "It's going to be awful" Accept that the predicted scenario would indeed be awful, and enquire whether there are any other possible outcomes. Pain barrier diagrams (Dunkley, 2001) can be a useful way of mapping the client's probable progression through the most difficult times.

6. "I'm trapped" Word pictures in this case are best done in a slightly different format, for example, if the client says, "I couldn't possibly leave my husband, he would be devastated but I just don't feel anything for him, it's hopeless" then the therapist can ask, "let's say you did leave your husband, and I bumped into you in a year's time, what would you say your life was like?" The client may say her life would be miserable. Then the therapist can say, I'm just imagining that we bump into each other again, a year after that first meeting, and I can't believe the difference that second year has made. The reason for this is that the client makes the initial projection, which subconsciously takes them beyond the feared event. Then the therapist only has to show them how to develop hopefulness once the feared event is behind them. Doing the word pictures in this way prevents a tug of war between the therapist and client.

7. "This suffering is permanent" There are some of situations that are inescapable, such as intractable physical, pain and permanent disability. Here the therapist might put less emphasis on a future focus, and more on acceptance-based strategies (e.g. Ramírez-Maestre, Esteve & López-Martínez, 2014; Xia et al., 2014). Even in cases of terminal illness it is possible for people to retain hope that remission may occur without losing their acceptance that their condition is, in this moment, deteriorating. The philosophy of the hospice movement is living right up until the moment of death, and while life is still evident there is the possibility of joy.

Conclusion

Learning to hope is a complex skill, and can be tailored to be more compatible with the type of type of hopeless thoughts that the client is experiencing. It is best for the therapist to get active in the face of hopeless passivity, but without losing the validation that some problems cannot be solved, or are difficult to solve, or cause intense pain in the solving of them. The power for the mind to project both positive and negative futures can be harnessed, but needs to be done in a way that is palatable to the client. ■

Citation

Dunkley, C. (2017). Teaching clients how to cope. *European Journal of Counselling Theory, Research and Practice*, 1, 3, 1-7. Retrieved from http://www.europeancounselling.eu/volumes/volume-1-2017/volume-1-article-3/

Biography

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European Journal of Counselling Theory, Research and Practice 2017, 1, Article 3, ISSN 2398-5607

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