In hope therapy, goals are viewed as the mental endpoint of hopeful thought. Snyder et al. perceived emotions to be the outcome of goal pursuit. The successful pursuit of goals leads to positive emotion, while the unsuccessful pursuit of goals leads to negative emotion. One's level of trait hope can develop overtime as one develops a history of successful or unsuccessful experiences [24].

Techniques of Hope Therapy

Hope therapy was designed to increase one's hopeful thought regardless of the presenting problem. Snyder believed hope was a common factor of all psychotherapies and proposed that therapy works specifically because it enables people to identify goals that represent solutions to their problems. Interventions designed on Snyder's hope theory have several components in common.

1. **Psychoeducation about hope.** The basic principles of hope theory are presented to the client, including a description of hope as a cognitive construct related to goal pursuit, an illustration of agency and pathways thinking, and a discussion of barriers and the negative emotions they can elicit.
2. **Goal-setting.** The client identifies meaningful goals. Goal identification can be accomplished by encouraging the client to explore his or her satisfaction in various areas of life such as school, work, and relationships. After a personally relevant goal has been identified, the next step would be for the client to generate multiple pathways toward its accomplishment. Pathways cognitions can be increased by breaking goals into smaller steps, anticipating obstacles, and planning alternative routes in case of setbacks.
3. **Agentic cognitions.** Next, the client would identify thoughts about perceived agency related to the desired goal. Ways to identify and modify thoughts may include use of personal narratives and storytelling. For example, clients might be encouraged to relate and transcribe stories about events in their childhood that illustrate their capacity to face specific challenges. Clients may identify low-hope elements of these narratives and replace them with positive, hopeful thoughts.

Research

A meta-analysis of 27 studies utilizing hope interventions and involving 2154 participants showed significant but small effect sizes for hopefulness and life satisfaction, and no overall relationship between hope-enhancement strategies and decreased psychological distress. It also appears that briefer interventions in structured settings are better at improving hope [25]. Hope therapy is likely to be most useful when integrated with other empirical forms of psychotherapy and treatment.

Future-Directed Therapy

Future-directed therapy (FDT) was developed as an evolved form of cognitive therapy, to map onto the cognitive and biological knowledge that has emerged regarding future thinking. The "future" in FDT is not necessarily far off in time; it can refer to any point in time beyond the present moment, near or far. Rather, FDT is about understanding that because we can only move forward, most of our thinking and behavior is anticipatory or future-oriented. We constantly speculate about what will happen,

whether it is in the very next moment, tomorrow, or five years from now, and that speculation has a huge impact on how we process information, how we feel about different situations and, ultimately, how we create our lives.

Future-directed therapy was originally designed as a full clinical intervention intended to reduce symptoms of depression and improve well-being by promoting a paradigm shift from dwelling on the past, or highlighting one's limitations in the present, toward creating more positive expectancies about the future, by developing and employing a comprehensive and well-defined set of skills. It is based on a positive psychology model, and the skills in FDT are applicable to any individual interested in developing skills for creating positive future experiences.

The theoretical premise behind FDT is based on humanistic models of behavior and posits that human beings live in a continuous state of wanting to close the gap between where they are in the present and where they want to be in the future. Each time a desired want is attained, a new want is born. When individuals perceive they can move toward a desired state, they feel they are able to thrive and grow, which is experienced as positive emotion. However, when movement toward desired states is inhibited, it generates negative emotions. The more unable to thrive one feels, the more emotional distress he or she will experience. Improved thriving is achieved by actions taken to close the gap between present states and future desired states [26].

Techniques of Future-Directed Therapy

Unlike traditional cognitive therapy, in FDT the focus is on the anticipatory part of the human experience, both in understanding the patient's problem as well as where primary interventions occur. The interventions in FDT center around the FDT anticipatory cognitive model of human experience (Figure 41.1), in which a distinction is made between anticipatory beliefs and the present or past beliefs on which anticipatory assessments are based. It highlights the anticipatory response process of choice calculation, in which people decide what actions they will take based on what they anticipate will happen in any given situation. If a patient is aware of what his/her faulty thoughts are about a future situation

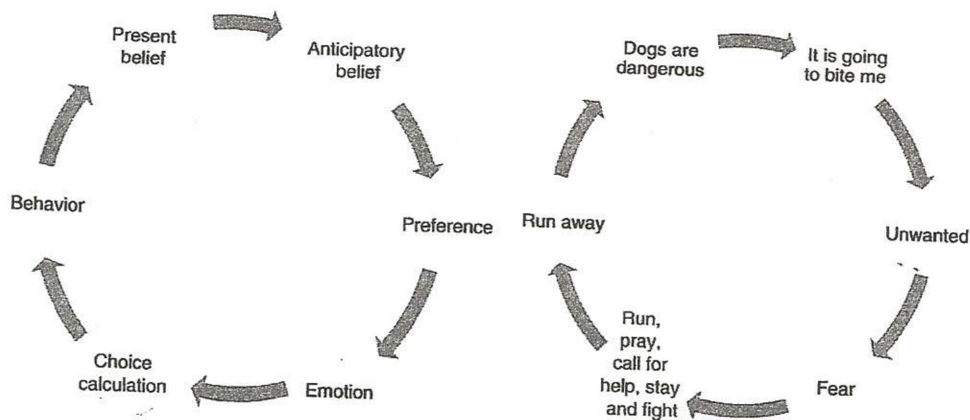

Figure 41.1 FDT anticipatory cognitive model of human experience.

then they can be changed before the situation occurs and, potentially, a different outcome can be created.

The interventions in FDT also integrate knowledge about attentional and cognitive biases in reward processing and are incorporated into what is referred to as the 4-A (anticipate, activate, assess, act) achievement model, which represents the sequential set of skills the individual is taught to use to improve their ability to create more positive future experiences.

1. **Anticipate.** In the *anticipation* phase, the individual identifies what they want, what steps are necessary to achieve it, what the obstacles are, and what their current beliefs are about their ability to achieve their goal. During this initial phase, there is a significant education process around the anticipatory model and about the relationship between anticipatory thought and action that creates lived experiences.
2. **Activate.** This is the phase where there is a significant effort to shift biased thinking away from the unwanted to the more wanted aspects of a situation. In this phase, individuals *activate* attention to benefits of a desired goal (e.g., journal exercises, worksheets) to increase a goal's value, which increases motivation to act. They also decrease attention to costs by giving more attention to implementation plans to overcome perceived obstacles. This shifts belief in one's ability to achieve the desired goal by increasing the focus on why and how it can be done. This phase highlights another unique component of FDT in that it uses affect-biased attention as a direct emotion regulation strategy, by training patients to self-monitor attentional process and to redirect attention to rewards.
3. **Assess.** Cost–benefit ratios of action to outcome are the basis of all decisions to engage in behavior that will lead to any desired goal. In this phase the individual *assesses* the planned steps toward their goal, along with their plans to overcome any obstacles, and makes a determination as to whether they are likely to achieve an outcome that is worth the cost of their actions.
4. **Act.** In this phase the mental process and planning to engage in the desired goal has been achieved, and mental barriers have been removed so the focus is on implementing the action plans developed at earlier stages.

Research

Two non-randomized clinical studies have been completed using FDT. The first study involved comparing 16 patients in an FDT group with 17 patients treated simultaneously in traditional CBT groups. All patients had a confirmed diagnosis of DSM-IV major depressive disorder. Patients treated with FDT demonstrated significant improvements from baseline to posttreatment, with a reduction of symptoms of depression ($p = 0.001$) and anxiety ($p = 0.021$) and reported improvement in quality of life ($p = 0.035$). Additionally, they reported high satisfaction with the therapy [27].

In a follow-up study that again compared FDT to group-based CBT, the Beck Hopelessness Scale (BHS) was added to assess positive and negative anticipation. In one year, 42 patients completed a 10-week, 20-session group therapy program (FDT [$n = 22$] and CBT [$n = 20$]). Key findings from baseline to posttreatment showed that FDT improved depression ($p = 0.001$), positive anticipation (BHS-subfactor) ($p = 0.001$), and quality of life ($p = 0.001$); FDT was significantly better than CBT at reducing anhedonia. Regression analysis indicated that change in positive anticipation (BHS) predicted change in anhedonia ($p = 0.038$) and overall depression ($p = 0.008$) in the FDT group, but not the CBT

control group. Even with small sample sizes and non-randomized assignment to conditions, these findings suggest that FDT is uniquely changing depressive symptoms via alteration of cognitions regarding positive expectations [28].

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