
If at First You Don't Succeed

False Hopes of Self-Change

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Despite repeated failure at attempts to change aspects of their behavior, people make frequent attempts at self-change. The generally negative outcome of many such self-change efforts makes it difficult to understand why so many individuals persist at these attempts. The authors have described this cycle of failure and renewed effort as a "false hope syndrome" characterized by unrealistic expectations about the likely speed, amount, ease, and consequences of self-change attempts. In this article, the authors further develop their conceptualization of this syndrome and review its evidential basis. They review the reasons why so many people tend to fail in their self-change attempts and then examine how people interpret these failures in such a way that they are led to keep trying repeatedly despite apparently overwhelming odds. Finally, the authors discuss the psychological consequences of repeated failure and analyze the distinction between confidence and overconfidence.

Most adults make New Year's resolutions each year, mostly concerning health-related behaviors (Norcross, Ratzin, & Payne, 1989). Interestingly, people tend to make the same resolutions year after year, vowing on average 10 times to eradicate a particular vice. Obviously, every renewed vow represents a prior failure; otherwise, there would be no need for yet another attempt. Equally obviously, unsuccessful attempts do not diminish the likelihood of making future plans for self-change¹ (Norcross et al., 1989).

Marlatt and Kaplan (1972) found that 25% of resolutions had been abandoned after 15 weeks, with smoking and other health-related resolutions being the most difficult to maintain. Nearly 20 years later, things were even worse, with close to 25% of resolvers having given up by the end of the first week (although 40% managed to continue for a full 6 months; Norcross et al., 1989). Even those who are ultimately successful at self-change must make the attempt five or six times on average before succeeding. New Year's resolvers typically report making the same pledge for 5 years or more before they manage a 6-month success, and of those who fail this year, 60% will make the same resolution again next year (Prochaska, DiClemente, & Norcross, 1992).

Prochaska et al. (1992) reviewed evidence on self-change attempts, concluding that for addictive behaviors of all types, eventual failure to change is the probable outcome. Failure rates are high for most attempts to give up

unhealthy habits such as smoking and drinking (Gossop, 1989; Mulé, 1981), but even in more benign spheres of behavior, such as studying, resolutions to improve oneself often fall short of the goal (Polivy & Herman, 1999).

An analysis of 10 prospective studies of attempts to quit smoking without formal treatment indicated that despite repeated attempts, only 13–14% of smokers were abstinent from cigarettes 6–12 months after they began their efforts to quit (Cohen et al., 1989). Sutton (1989) concluded that although many therapies help smokers to quit, most smokers will, in the long run, relapse and begin smoking again. Similarly, Prochaska, Velicer, Guadagnoli, Rossi, and DiClemente (1991) noted that "of 30 million Americans who quit smoking in the past decade . . . , an average of 75 to 80% failed to maintain nonsmoking after one year" (p. 84).²

Recovering from alcohol addiction is also subject to high rates of relapse (Brownell, Marlatt, Lichtenstein, & Wilson, 1986; Dimeff & Marlatt, 1998). This situation has not changed appreciably since Hunt, Barnett, and Branch (1971) reported that 50–60% of alcoholics relapsed within three months of treatment. Similarly, 90% of treated alcoholics have had at least one drink within three months of abstinence treatment, and 45–50% have returned to pre-treatment drinking levels within a year (Allsop & Saunders,

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¹ When we discuss self-change in this article, we are referring to people's efforts to change their own (unwanted) behaviors; that is, we are discussing self-change not in the sense of changing the self but rather in the sense of changing one's behavior on one's own (i.e., by oneself).

² These studies suggest that abstinence may possibly be higher one year after quitting than six months after quitting. This difference may seem counterintuitive, inasmuch as one would expect cumulative relapse to recapture an increasing number of ex-smokers over time. An offsetting factor, however, is that smokers tend to make repeated attempts to quit. Each of these attempts has a small probability of succeeding in a permanent way, so that over time, the cumulative likelihood of being abstinent does not necessarily decline and may in fact increase. Success, if it happens at all, usually occurs after several attempts (see, e.g., Schachter, 1982).

1989). The rate of relapse at Gamblers Anonymous is approximately the same as for alcohol problems; only 7% are abstinent after two years (Brown, 1989).

These statistics make it difficult to know whether one should be appalled by how difficult it is to achieve permanent change or astonished by the extent to which people are prepared to try again. It is certainly the case that people show a remarkable willingness to look forward rather than back. Repeated attempts at self-change despite a record of prior failure can be read as a testament either to the resilience of the human spirit or to people's inability to face facts.

One of the most thoroughly accepted notions in psychology is the principle that behavior eventually extinguishes if it is not followed by reward, at least occasionally. The sorry history of so many self-change attempts makes one wonder whether these resolutions represent a threat to the basic laws of learning. To anticipate our conclusion, we believe that the basic laws of learning are safe, at least from this quarter; still, the self-change statistics force us to confront some puzzling psychological issues.

To better understand these issues, we propose to examine first why people tend to fail in their attempts to rid themselves of maladaptive behaviors. Understanding the reasons for these failures—and especially, appreciating how people interpret these failures—can help one in turn to understand how people can summon up the determination to try yet again in the face of what might objectively appear to be overwhelming odds. How failures are interpreted and how people convince themselves to try yet again occupy the second and third sections of this article. The article concludes with an examination of the psychological consequences of repeated failures and an analysis of the distinction between confidence and overconfidence.

The False Hope Syndrome

The cycle of failure, interpretation, and renewed effort constitutes what we have called “the false hope syndrome” (see, e.g., Polivy & Herman, 1999, 2000). First, people undertake a difficult (or impossible) self-change task. In particular, as the statistics cited above indicate, attempts to rid oneself of undesirable but intrinsically rewarding behaviors such as overeating, gambling, smoking, and alcohol or drug use are common yet rarely successful. Although people may achieve some initial progress in this task, ultimately they fail to achieve their goal. Then, having failed, they interpret their failure in such a way that the failure is seen as far from inevitable; people convince themselves that with a few adjustments, success will be within their grasp. Alternatively, people acknowledge that the task is difficult (though not impossible) but believe that the rewards of success make repeated attempts worthwhile. Finally, they embark on yet another attempt, propelled by their memories of their previous, limited success and/or their positive expectations for the future. This cycle is liable to continue indefinitely. We address the elements of failure, interpretation, and renewed attempts in turn and then consider some of the consequences and implications of the false hope syndrome.

Of course, not all of these self-change attempts fail. As many people have quit smoking as currently smoke (de Guia, Levesque, Pickett, Ferrence, & McDonald, 2000). People do manage to lose weight (Schachter, 1982). No doubt other attempts at self-improvement have succeeded; numbers of people have stopped drinking, procrastinating, and being mean. Still, the perennial popularity of self-help books³ on the best-seller lists and the recycling of New Year's resolutions speak to the prevalence of failure.

Because weight loss figures so prominently among resolutions—and indeed, diet books usually outsell books on becoming healthy, wealthy, or wise—we use dieting as our principal example in this article. Not entirely coincidentally, this is the area with which we are most familiar.

Many people believe that they are overweight and diet as a corrective (see, e.g., Brownell, 1991a; Polivy & Herman, 1987; Rosen & Gross, 1987; Striegel-Moore, Silberstein, Frensch, & Rodin, 1989). Obviously, these people intend and expect to lose weight by dieting. Such expectations are generally unrealistic, however; most diets do not achieve more than short-term success (see, e.g., Brownell & Wadden, 1992; Wadden, Steen, Wingate, & Foster, 1996). The typical dieting pattern consists of easier conformity with the diet and greater weight loss initially but then slower weight loss and less dietary compliance (see, e.g., Heller & Edelman, 1991). The restraint that is so noticeable in the early stages of a diet tends to break down, with the result that over the long run, overeating and weight gain are as much a part of dieting as are undereating and weight loss (see, e.g., Heatherton, Polivy, & Herman, 1991; Herman & Polivy, 1988; Polivy & Herman, 1987). As Stunkard (1975) famously observed, “most obese persons will not enter treatment for obesity. Of those who enter treatment, most will not lose much weight and of those who do lose weight, most will regain it” (p. 195). Recent developments have done little to change this dismal assessment; Heatherton, Mahamedi, Striepe, Field, and Keel (1997) observed that “dieting is a notoriously ineffective means of achieving weight loss. Some 95% of those who lose weight will regain the weight within a few years, and many will gain more weight than they originally lost” (p. 118).

Brownell and Wadden (1992) observed that the assumptions on which the dieting enterprise is predicated—such as the notion that one's body can be reshaped on command and the expectation that dieting will yield not only weight loss but increases in attractiveness, health, and popularity⁴—may induce the dieter to set unrealistic goals. Overall, dieting appears unlikely to provide lasting self-improvement. Chronic dieters (or restrained eaters) are therefore an interesting group because they have resolved

³ There is fine irony in the notion that following the prescriptions of others constitutes self-help. Apparently, people like to think that they are engaged in an autonomous effort of self-improvement even while they are relying on the assistance of others.

⁴ Perhaps the reason that diet books dominate the best-seller lists is that diets promise to provide, in addition to weight loss, all the benefits that other self-help programs promise.

to change themselves (by dieting to lose weight) and are very likely to fail.

The fact that diets tend to succeed only in the short term has two important implications for our argument: First and foremost, failure is the typical outcome of diet attempts, but second, before the ultimate failure of the diet, there is often a period during which the diet may be deemed to have succeeded, at least partially. Indeed, almost every diet succeeds before it fails. This initial, temporary success of many self-change efforts and the unrealistic goals based on inflated expectations of reward contribute significantly to the psychology of false hope.

This cycle of commitment to self-change followed by failure and recommitment characterizes spheres other than attempts to lose weight. As discussed above, many smokers, gamblers, and excessive drinkers are likely to evince a similar pattern of resolving to change, failing, and resolving yet again (see, e.g., Gossop, 1989; Mulé, 1981), with failure characterizing as many as 90% of attempts at self-change. Despite the fact that failure lowers the self-esteem of New Year's resolvers, this does not affect their future plans to try again to change (Norcross et al., 1989).

Why Self-Change Attempts Fail

If diets or other alterations of one's behavior succeed initially, why do they eventually fail? Why do the same factors that produce weight loss early on not continue to produce weight loss indefinitely? There are four main sources of failure, each of which is coordinated with an unrealistic expectation about self-change: amount, speed, ease, and effects on other aspects of one's life.

People often believe that they can change more than is feasible (e.g., that they can lose more weight than is realistic; Brownell, 1991b; Heatherton et al., 1991). For instance, Foster, Wadden, Vogt, and Brewer (1997) assessed patients' goals, expectations, and evaluations of various weight loss outcomes before, during, and after 48 weeks of treatment. Before treatment, obese women defined their goal weight and what they saw as their "dream weight," "happy weight," "acceptable weight," and "disappointed weight." Goal weights required an average loss of 32% of body weight. A 17-kg (37-lb) weight loss was generally defined as "disappointed"; a 25-kg (55-lb) loss was "acceptable." After treatment and an average 16-kg (35-lb) weight loss, 47% of patients did not feel that they had achieved even a "disappointed weight." Expectations often exceed what is feasible and lead people to reject more modest, achievable goals. The best is the enemy of the good.

Moreover, people often predict that they will change more quickly and more easily than is possible (e.g., lose weight more quickly and with much less effort than is possible). Buehler, Griffin, and Ross (1994) demonstrated that there is an optimistic bias in people's anticipated speed and success at achieving desired goals. Likewise, people believe that the changes that they desire are more feasible or easier to attain than is often the case. For example, Brownell (1991a) discussed the tendency of overweight dieters to believe that they can modify their weight without

excessive effort, despite the difficulty most individuals encounter in attempting to lose weight. In addition, people overestimate their abilities in many domains and are unaware that they are inaccurate (Kruger & Dunning, 1999). Overconfidence seems to contribute to failure to maintain abstinence from alcohol, as "unrealistically high expectancies for success commonly seen among clients at the time of discharge [from alcohol abuse treatment]" (Goldbeck, Myatt, & Aitchison, 1997, p. 314) have been implicated in relapse. Similarly, despite the prevailing view that smoking is addictive, 60% of adolescent and 48% of adult smokers believe that they "could smoke for a few years and then quit" (Arnett, 2000, p. 625) if they decided to, thus seeing quitting smoking as being easier than it actually is. In addition, smokers who attempt to quit smoking when they are already trying to control another behavior such as eating (Mizes et al., 1998) or alcohol use (Hays et al., 1999) are significantly less likely to succeed (i.e., are unrealistic in expecting to be able to make both changes; see, e.g., Muraven & Baumeister, 2000). Even those who do eventually succeed at altering addictive behaviors usually do so only after repeated attempts and after passing through five or six stages of change again and again before they finally succeed (Prochaska et al., 1992; Prochaska & Velicer, 1997). Self-change is thus generally more difficult and takes longer than many who attempt it realize when they begin.

Finally, people often believe that making a change will improve their lives more than can reasonably be expected. For instance, people believe not only that dieting will result in weight loss but that the weight loss will in turn get them a job promotion or a romantic partner (Polivy & Herman, 1992; Striegel-Moore, McAvay, & Rodin, 1986). At the very least, dieters believe that weight loss will convert their image from that of being "self-indulgent, lazy, or even irresponsible and immoral" to one that symbolizes "self-control, hard work, ambition, and success in life" (Brownell, 1991b, p. 303). These expectations, needless to say, are highly inflated, if not entirely baseless (Brownell, 1991a). Normal dieters and patients with anorexia nervosa or bulimia nervosa all share an expectation that dieting and thinness will produce "overgeneralized self-improvement" (Hohlstein, Smith, & Atlas, 1998, p. 49). Similarly, those who had just resolved to exercise more reported feeling taller than they did before they made the commitment (Trottier, Polivy, & Herman, 2002)!

It is not surprising that dieters have inflated notions of the power of thinness. The covers of women's magazines (and many of the articles inside) convey the impression that losing weight will result in a better life (Malkin, Wornian, & Chrisler, 1999). Malkin et al. (1999) concluded that although men's magazines attempt to provide entertainment and information, women's magazines encourage women to alter their appearance to improve their lives. This problem is often exacerbated by the promises made by self-change programs themselves. Diet programs, for example, not only promise fast, easy, and dramatic weight loss but go further, portraying the weight loss as likely to change one's whole life.

The way that dieters (and smokers and other self-changers) frame their goals may also contribute to their failure to achieve them. Typically, they pursue an *inhibitory goal* (Cochran & Tesser, 1996); success is defined in terms of not giving in to temptation. Each breach of an inhibitory goal is therefore construed as a failure and contributes to the likelihood that the diet (or other effort) will collapse altogether. Cochran and Tesser (1996) argued that self-modifications such as dieting would succeed more often if dieters framed their goals more positively (e.g., eating healthy, low-calorie meals), instead of focusing negatively on instances of disinhibition; if they did, then successes might well outnumber failures. Another strategy might be to set the inhibitory goal more distally; that is, instead of counting each instance of overeating (or smoking or drinking too much) as an instance of failure (or impending doom), failure would be acknowledged only if some longer term (say, monthly) goal were not achieved. Occasional lapses would thus be acceptable, and indeed, they might not even be construed as lapses. Unfortunately, the prevailing emphasis on stringent, negative, short-term goals in American culture makes failure all but inevitable (see, e.g., Elliot & Sheldon, 1998).

Failure is a matter of not achieving one's goals. One way of looking at self-changers' chronic failures is to focus on deficiencies within the individual trying to change; were it not for these shortcomings, the self-change effort would have succeeded. For instance, one might plausibly analyze self-change failure in terms of Wegner's (1997) ironic processing theory, in which the very thoughts that tend to undermine successful self-change—"I really want to smoke that forbidden cigarette"—become more likely to occur as stress or mental load is added to the cognitive system. Wenzlaff and Wegner (2000) noted that those with "unrealistically high expectations concerning their mental control abilities" (p. 69) may become excessively self-critical and may panic following mere cognitive slips, let alone behavioral ones. This distress further depletes cognitive resources, increasing the likelihood of failure. Indeed, those unsuccessful at quitting smoking scored higher on attempted thought suppression than did successful quitters (Toll, Sobell, Wagner, & Sobell, 2001).

Another, related approach (Baumeister, Bratslavsky, Muraven, & Tice, 1998; Muraven, Tice, & Baumeister, 1998) postulates that human beings have a limited amount of energy available for self-regulation; self-change efforts fall short because of energy depletion, and such depletion is exacerbated by the addition of stress or mental load. In principle, appropriate mental hygiene or avoidance of stressors might serve to facilitate successful self-change by preventing ironic processes or self-regulatory energy depletion from undermining one's goal-directed behavior.

We acknowledge the cogency of these analyses; no doubt, weak or faulty cognitions contribute with great frequency to self-control failure. Another way of looking at these failures, however, is to focus less on the shortcomings of the person and more on the difficulty of the goals. If the goals one sets are unrealistic, then failure is inevitable

regardless of how hard one tries or how well one manages one's mental, emotional, and physical resources. The reason that most self-changers fail is that they try to do more than they can realistically do, and even those who do manage to achieve their targets (temporarily or permanently) do not experience the sort of widespread personal and social improvements that they expected or hoped for. Attempting to attain an unreachable goal has been implicated as a cause or maintaining factor in depression (Kuhl & Helle, 1986); depressive mood states are maintained by unrealistic objectives that claim mental capacity needed to enact new, fulfillable intentions. Whereas unattainable goals should theoretically be abandoned after a few attempts, if the intention behind them persists, so do the goals (and attempts to achieve them). One's goals are generally perceived as important, controllable, and desirable (Lecci, Okun, & Karoly, 1994), so individuals persist in efforts to achieve their unrealistic self-change goals.

People are generally overly optimistic in predicting favorable outcomes for themselves (Armor & Taylor, 1998). Even when these overly optimistic expectations are disconfirmed, people are motivated to use a variety of techniques for maintaining their unrealistic beliefs, and by maintaining these unrealistic beliefs, people remain vulnerable to negative outcomes ranging from disappointment to actual endangerment.

Dieters, for example, might succeed more often if their diet goals were adjusted to be more realistic. Unfortunately, more realistic goals rarely coincide with the dieter's personal agenda. Losing less weight, taking longer to lose it, and abandoning one's hopes that weight loss will produce a complete social and personal makeover are not the sort of things that dieters are eager to do. Nor are they encouraged to. The diet industry⁵ thrives for two reasons—big promises and repeat customers. These two reasons are interrelated: The big promises attract the customers in the first place, and the magnitude of the promises virtually guarantees that they cannot be fulfilled, as we have shown.

Thus, self-change efforts are frequently doomed to failure from the outset by the unrealistic expectations brought to the enterprise. Impossible amounts, speed, ease, and rewards of change are anticipated; by definition, these cannot be achieved. The consequent failure, rather than dissuading the individual from the enterprise, somehow sets her up for a renewed attempt. Yet how can this be? Given the unrealizable goals, why does the individual not eventually recognize that the task is impossible and give up trying to change? Can people not grasp that they have not yet succeeded because success is simply not feasible?

⁵ The diet industry is careful to promote the notion that weight loss, although it may require the help of some (expensive) diet aid, program, and/or book, is still basically a matter of self-change. The dieter ultimately is held responsible for the failure (although perhaps not the success) of the diet. This strategy permits those who profit financially from diet attempts—and who profit even more from repeated diet attempts—to deflect blame when the diet fails.

How People (Mis)interpret Their Failures

If people's current failures were seen as prognostic of their likelihood of succeeding in the future, then they might take them at face value and move on to some other, more promising project. They would not make the same New Year's resolution twice. Humans are apparently not designed, however, to accept defeat so easily. Failures are typically followed by explanations—more accurately, exculpations—that cloud or even reverse the message of failure. For example, gamblers continue to believe that they will win next time because they explain away their losses as near wins while accepting their wins as appropriate outcomes (Gilovich, 1991).

How dieters and other self-changers interpret their failures is a topic that has received little concerted research attention and about which we can offer mainly speculations, derived from a few studies but primarily from clinical practice and extended, unsystematic observation. The topic is an important one, however; in our model of the false hope syndrome, it provides a crucial bridge from failure to renewed hope. The following outline is therefore offered tentatively, as a necessary component of our argument and as a stimulus to further research.

Consider someone who has just failed (again) at a self-change attempt. How is that person likely to interpret this failure? In terms of classical attribution theory (Weiner, 1986), attributions for failure could be either internal or external, but in either case, the attribution is likely to help the person to avoid facing facts (see, e.g., Gilovich, 1991, on gamblers). Research on New Year's resolvers indicates that those who engage in wishful thinking (i.e., avoiding the facts instead of recognizing the need to use a practical technique such as stimulus control or even just willpower) are more likely to fail at their resolution (Norcross et al., 1989).

Heatherton and Nichols (1994) examined people's descriptions of successful and unsuccessful life-change experiences and found that in the case of failure, change was described as resulting from external factors and lack of willpower and as being intrinsically more difficult than in the case of success. Successful change was seen to result from greater personal effort. This attributional analysis applies well to dieters; the primary internal attribution used by failed dieters is (lack of) effort. Dieters conclude that they did not try hard enough or try hard for long enough. The "not long enough" attribution is fostered by the dynamic of dieting, which usually involves an initial phase of gratifying weight loss followed by a second (asymptote) phase in which weight loss slows and then stops, and then by a third phase of weight regain. For the self-serving reasons that usually influence attributions, the dieter often is quick enough to take credit for the first phase, ascribing her initial success to the intense effort that she summoned up when her commitment and enthusiasm were fresh. The second and third (asymptote and regain) phases are likely to be attributed to a failure to sustain the effort that was

effective during the first (weight loss) phase. Dieters implicitly accept a variation of the self-regulatory energy model mentioned above, believing that they can exert effort for only so long before giving out, as if effort were a muscle that gets tired. The asymptote and regain phases, then, are seen not as a reflection of a defense of body weight activated once weight drops to a certain level (Brownell, 1991a; Kassirer & Angell, 1998) but rather as an exhaustion of effort. Thus, failures are ascribed to insufficient will rather than to the intransigence of the body.

The notion that lack of sufficient effort is responsible for the diet failure would seem to be fostered by several aspects of the diet experience and culture. First, the difficulty of dieting tends not to become fully apparent until the second and third (asymptote and regain) phases of the diet. Because the defense of body weight is usually not activated until some considerable weight has been lost, the relatively easy first phase gives way to the more difficult second phase; the same effort that produced noticeable weight loss in the first phase may produce no weight loss in the second phase. Yet the delayed onset of resistance to weight loss is easy to misinterpret as a matter of exhaustion of effort.

Dieting becomes more difficult as it progresses, even if a constant effort is maintained, but the dieter may be tempted to assume that the difficulty of dieting remains constant and that therefore the problem must stem from declining effort. Thus, the stage is set for an attribution of insufficient effort; in fact, those who fail at resolutions to change actually claim to have less willpower than do those who succeed (Norcross et al., 1989).

This attribution is enhanced by various circumstances. First and foremost, testimonials provided by others who have allegedly succeeded using the same diet imply that the fault in one's own case must lie in oneself rather than in the diet. People are notoriously prone to accepting testimonial evidence, most of which is of questionable validity (Stanovich, 1998). People do not appreciate the need to demand evidence of follow-up success in these testimonials (assuming that there is any veracity at all in them). Furthermore, people do not appreciate the fact that the ease of losing weight and keeping it off may well depend on how overweight they are to begin with, not to mention a host of other constraining factors that can vary significantly among individuals so that one person may succeed and another fail using the same diet protocol, but not necessarily because the successful dieter exerts more sustained effort. Finally, the promoters of the diet in question have a vested interest in blaming the dieter rather than the diet. If the dieter consults the diet promoter—be it her doctor, her friend, or the clinic where the diet program was obtained—she is likely to be told that she is at fault, in what amounts to a classic instance of blaming the victim (Ryan, 1976). The victim, who has supposedly failed to make the full effort required for success, has before her the opportunity to redeem herself by trying harder next time. Failure is due to an attributionally unstable characteristic (effort) and is therefore correctable.

As an alternative to internal (effort) attributions, the dieter may be tempted to make an external attribution for failure; such an attribution—as long as it focuses on an unstable element of the external situation—may still allow the dieter to put the blame on something that can be changed next time and thus salvage the hope of future success. The main external attribution available is task difficulty. Dieting is perceived as difficult. However, rather than making this attribution about dieting in general, the dieter is often inclined to blame the particular diet that failed during the most recent attempt; the task was so difficult because the particular diet was not up to the task.⁶

This interpretive strategy leaves open the possibility of future success with a new and better diet and is fostered by various circumstances that the dieter frequently encounters.

If the dieter is committed to a particular diet, then she is virtually forced to blame herself for the recent failure (effort attribution); but most dieters are not committed to persevering with the same diet. The range of diets available is enormous and constantly changing (or at least reappearing under new guises, as with the recurrent popularity of high-protein, low-carbohydrate diets). Any dieter inclined to make an external attribution can easily decide that the failed diet was “not for me” and pick another one to try next time. Switching diets, of course, is heartily recommended by the promoters and advocates of the new diet. Blaming the old diet and switching to the new one often has the additional benefit of avoiding the need to try harder next time. One of the main selling points of a new diet, it almost always turns out, is that it is based on a new nutritional principle that makes weight loss virtually automatic, thus requiring little if any effort on the part of the dieter. Switching diets, then, is a preferable tactic psychologically because it relieves the dieter from any blame for the original failure, except possibly that she displayed some naïveté in choosing an obviously inferior diet last time, a mistake that she will not make again. Switching diets also conveniently addresses the task-difficulty problem by reducing or eliminating the difficulty of dieting. In successful self-change efforts, increased attributions of internal control, changing one’s environment, and blaming external events for relapses all seemed to help participants to change their behaviors (Heatherton & Nichols, 1994).

Why People Try Again

If people were to interpret their failures as indicative of their inability to succeed, they might well desist from further efforts. As we have shown, however, the complex dynamics of self-change attempts allow for various interpretations of previous failures (e.g., inadequate effort, the wrong program). Most notably, people may conclude that what caused them to fail is something that can be corrected on the next attempt. If the perceived consequences of success remain attractive, people are unlikely to let prior failures deter them from trying again.

The absence of deterrents from trying again should not be confused with the presence of incentives. What are the incentives to try again? They are the same hoped-for consequences of success that impelled people to try in the first

place. In the case of dieting, there is weight loss, which tends to be seen as an end in itself. Moreover, there are the further consequences of weight loss, those ends (such as attractiveness and health) to which weight loss is simply a means.

Repeated failure, however, threatens to undermine the reinforcing power of these incentives or rewards. After all, they are rarely if ever experienced. Rewards that are expected but never delivered do not provide a particularly compelling basis for reinforcement of dieting attempts. It is possible, however, that the same mechanisms that discount the inevitability of failure also serve to sustain the hope of success. Upon completing a two-week exercise program, participants (who were less successful than they expected they would be) indicated that succeeding at their program led to fewer benefits than they had predicted when they began and also claimed that failing had fewer negative consequences (Trottier et al., 2002). Thus, when they did fail, they decided that it was not so important to succeed after all.

Attractiveness, health, and social and professional success are such powerful goals that people convince themselves that they must be achievable; this positive illusion (Taylor & Brown, 1988) motivates further dieting and self-change efforts. Still, these remote incentives probably cannot fully account for dieters’ proclivity to repeat the unpleasant rigors of dieting. One should look for more proximate rewards and for rewards that are actually delivered during the diet cycle even if the diet is ultimately a failure.

The first and most obvious reward is weight loss itself. Although it remains true that diets tend ultimately to fail and the dieter emerges from the cycle no lighter—and possibly even heavier—than she began, it is equally true that most diet attempts do include an initial successful

⁶ The diet industry may attempt to hold the dieter responsible for failure, but the dieter, by blaming the diet, shifts the blame back. The dieter who uses an external attribution for failure is undermining the very notion of self-change because she is explicitly acknowledging an agency outside the self as crucially involved in the effort. Hochbaum (1965) made this point many years ago, substituting smoking cessation for dieting and a smoking clinic for a formal diet program:

Many a smoker who appears at a clinic probably is basically shifting responsibility to the clinic’s staff. Thus, if he continues, or reverts to smoking, the fault, in a sense, becomes that of the staff. With such an attitude, a smoker is not really committing himself, always leaves a door open to rationalize away his failure to quit and thus lacks the mental attitude of full commitment to cessation which is an indispensable prerequisite to success. (pp. 695–696)

Contemporaneously, Zagona and Zurcher (1965) discovered that people who had managed to quit smoking were less likely than were current smokers to blame others (peers or parents) for their having started to smoke in the first place, suggesting that successful self-change requires taking personal responsibility for one’s behavior. How much more successful would dieters be if they accepted such personal responsibility, dieting on their own without the help of all the publicly available diet programs? Schachter (1982) interpreted his data as indicating that people achieved greater success in self-change (dieting or quitting smoking) when the self-change effort was truly autonomous and not reliant on external or programmatic assistance.

phase in which some—or even substantial—weight is lost. Although this weight loss may be short-term and although it may eventually be reversed, it can serve as a powerful reinforcement for undertaking dieting. Indeed, it can be argued that diets usually succeed; the pernicious aspect of dieting is not that diets eventually fail but that they do not fail before first succeeding. It is this initial success that helps turn what might be a miserable experience, unlikely to be repeated, into an initially euphoric experience, quite likely to be repeated. A simple analogy would be to getting drunk: Even though one may feel terrible the next day, while one is becoming drunk, one feels great. Hangovers do not negate the reinforcing power of that initial inebriation. Rand and Stunkard (1977), while discovering many adverse effects of dieting, also found several positive effects: Of their obese dieters, 82% were hopeful, 49% reported increased energy, and 30% reported an increased feeling of strength. These effects occurred relatively early on, before the diet ran into resistance.

A second source of reinforcement for dieting attempts occurs even earlier in the sequence, before the diet has actually begun. Merely making the commitment to diet produces positive effects in the dieter. Self-change resolutions such as dieting provide the resolver with an initial surge of feelings of control and efficacy, fueling the initial enthusiasm for the endeavor. Resolving to control oneself and go on a diet enhances one's sense of self-control; the very resolution is taken (or mistaken) for an act of self-control. Upon making a resolution to exercise, participants immediately rated themselves as more likely to be successful and more confident in their ability to increase their exercising than they had rated themselves a week earlier (Trottier et al., 2002).

For the most part, people enjoy the feeling of control, whether it be control over the environment or over oneself.⁷ Cancer patients with enhanced perceptions of control over their disease are less depressed, even controlling for related factors such as physical functioning and marital satisfaction (Thompson, Sobolew-Shubin, Galbraith, Schwankovsky, & Cruzen, 1993).⁸ Even minor behavioral efforts at controlling one's problems may be rewarding; merely making a telephone call to schedule an appointment with a psychotherapist produces measurable improvement in distressed individuals (Howard, Kopta, Krause, & Or-linsky, 1986). Resolving to change, then, might well be experienced as rewarding even before any success has been achieved—indeed, even before any effort has been made. (Dieting, quitting smoking, giving up gambling, or other self-change endeavors are effortful, so perhaps one should not be surprised if people feel best before they actually begin exerting themselves!)

To return to our dieting example, the rewards of committing to a diet and the weight loss experienced during the first phase of dieting provide ample reinforcement to the dieter. The veteran dieter is very familiar with the pleasure to be derived from starting a diet. These incentives, plus the confidence that the difficulties of dieting will be avoided this time, are usually sufficient to induce the individual to recommit with enthusiasm to the dieting en-

terprise. Moreover, it is probable that memory for successful dieting is better than that for failed diets.⁹ Several factors suggest this interpretation: First, dieters monitor their weight loss very closely, attending to their weight, to how their clothes feel, and to compliments from others on their achievement, leading to deep processing of the weight loss experience. On the other hand, during weight gain, dieters stop weighing themselves, wear looser, baggy clothes, and do not receive compliments on their appearance, leading to more shallow processing of the experience. Indeed, during the weight gain phase, dieters may try to avoid thinking about what is happening altogether. Second, the time frame for weight loss is distinct (defined by the diet) whereas that for weight gain is more diffuse. Third, weight loss is intentional, but weight gain is not. Thus, memory for weight loss is assisted by attention, a clear and well-defined time frame, and intentionality, whereas memory for weight gain is discouraged by lack of attention, a diffuse time frame, and no desire for it to happen.

Summary of the False Hope Model

A summary of the model that we are proposing may be found in Figure 1. Unrealistic expectations about the speed, ease, amount, and rewards of self-change prompt the individual to make a commitment to change (usually an undesired but intrinsically rewarding behavior). Deciding to change produces reinforcing feelings of being in control, and the self-change effort begins well, generally with success in the early stages. As time goes by and the endeavor continues, change becomes more difficult to sustain, and ultimately, no further progress is made (and backsliding may begin). One or more relapse episodes result in abandonment of the effort, which now is deemed a failure. Although there may be some initial improvement in affect and self-esteem when the self-change effort is succeeding early on, when failure ultimately occurs, the individual feels worse than before the resolution. The individual tries to soften the failure by making attributions to explain it away. These attributions shift the blame away from the unrealistic goals that made the attempt so unlikely to succeed, allowing recommitment to a new resolution.

Consequences

What are the consequences of riding the self-change merry-go-round? Even if a diet fails, the dieter usually ends up no—or not much—heavier than she was to begin with. Where is the harm in that?

The negative consequences of cycling through the false hope syndrome are considerable. Using dieting as our

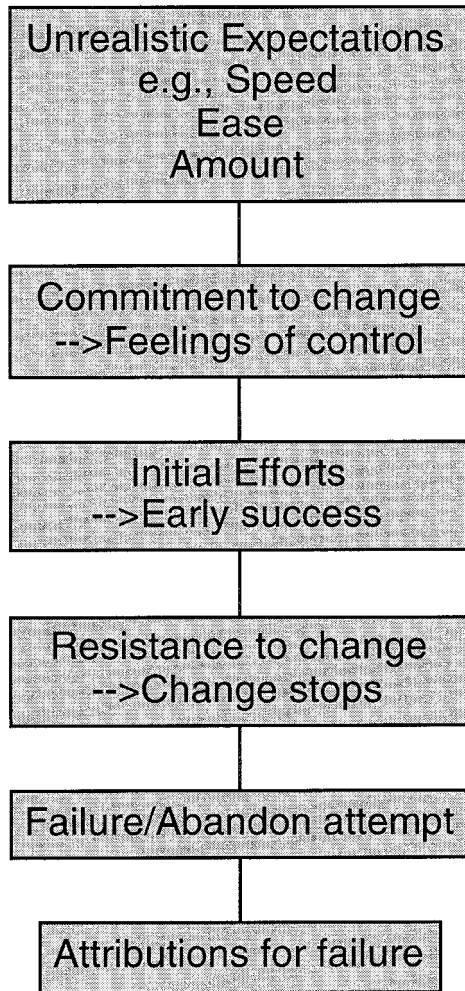
⁷ Why is a sense of control so desirable? Presumably because having control means that various rewards and punishments can be managed in a satisfying way. Conversely, avoidance goals perceived as coerced rather than freely chosen increased reports of physical symptoms (Elliot & Sheldon, 1998).

⁸ On the other hand, Carver et al. (2000) found that perceived control over remaining free of cancer did not inversely predict distress but that expectancy of remaining cancer-free did.

⁹ We are grateful to an anonymous reviewer for suggesting this point.

Figure 1

False Hope Syndrome Model



primary example again, there is a growing literature on the impact of weight cycling on various medical parameters (see, e.g., Lissner et al., 1991; Muls, Kempen, Vansant, & Saris, 1995) and a general agreement that weight cycling is harmful, even if weight does not ratchet its way up with each turn of the cycle (Wing, 1992; but see Jeffery, Wing, & French, 1992).

Psychologically, too, the false hope syndrome takes a toll. Both weight loss and eventual weight gain produce negative psychological consequences (see, e.g., Foreyt et al., 1995). Of course, weight loss often produces positive psychological consequences (see, e.g., Wadden, Mason, Foster, Stunkard, & Prange, 1990), most notably feelings of increased self-worth (see, e.g., Steinhardt, Bezner, & Adams, 1999), but weight loss also brings with it certain cognitive and emotional stresses. For example, 99% of the obese people surveyed by Rand and Stunkard (1977) had tried to lose 10 or more pounds at some point (as had 23%

of controls) and had one or more negative responses to dieting: Forty-eight percent became preoccupied with food or eating; 44% noted increased anxiety; 34% reported increased irritation; 27% had increased depression. "Many will pay an emotional price for trying" (Stunkard, 1975, p. 195). It is important to recognize that even during the phase when the diet is an unqualified success, before any weight has been regained, weight loss may elicit countervailing reactions. Worsened mood, difficulties concentrating, fatigue, and irritability, for instance, are commonly experienced by those who undergo caloric restriction (see, e.g., Laessle, Platte, Schweiger, & Pirke, 1996). There is ample evidence that emotional distress is a threat to the maintenance of dietary restraint; such distress tends to disinhibit eating in those who are trying to eat less (even while, ironically, it suppresses eating in those who are not restraining their intakes; see Herman & Polivy, 1988, for a review). The distress associated with diet-induced weight loss, then, might almost be regarded as a tool for body-weight defense, a natural consequence of weight loss designed by nature to sabotage the diet and restore weight to a higher, more appropriate level.¹⁰

Another consequence of weight loss is an obsession with food (see Herman & Polivy, 1993, or Polivy, 1988, for a review). Like emotional distress, constantly thinking about food seems designed to make reduced consumption and sustained weight loss difficult.

Weight loss itself produces negative psychological effects, but weight regain is just as damaging, if not more so. Foreyt et al. (1995) have commented on the danger of the often-observed cycles of dieting, losing weight, then regaining the weight, pointing out that "weight fluctuation is . . . strongly associated with negative psychological effects in both normal weight and obese individuals" (p. 273). Roncolato and Huon (1998) showed that adolescent dieters became more dysphoric and evidenced less well-being over time the more committed they were to dieting and weight loss goals. Similarly, Sarwer and Wadden (1999) described the feelings of frustration and defeat characterizing obese patients attempting to achieve unrealistic weight loss. Our own research showed that attempting to diet for two weeks made participants feel like failures even when they did manage to lose a pound or two (Polivy & Herman, 1999); once one has committed oneself to a weight loss goal, then achieving anything short of that goal may be counted as a failure. Of course, failed resolutions impair self-esteem (Norcross et al., 1989). Failed dieters tend to feel guilt and self-hatred and see themselves as

¹⁰ Distress is only one of several factors that tend to disinhibit eating in dieters. Intoxication (Polivy & Herman, 1976a, 1976b), prior overeating (Herman & Mack, 1975; Herman, Polivy, & Esses, 1987; Herman, Polivy, & Silver, 1979), the mere belief that one has overeaten or exceeded one's dietary quota (Knight & Boland, 1989; Polivy, 1976; Spencer & Fremouw, 1979), and anticipated overeating (Ruderman, Belzer, & Halperin, 1985) or undereating (Urbszat, Herman, & Polivy, 2002) all may serve to disrupt dietary restraint and lead to overeating. Sometimes it seems that almost everything disrupts dietary restraint and that the fragility of restraint is itself a weapon in the service of restoring lost weight.

lazy, undisciplined, and self-indulgent (Kassirer & Angell, 1998)

Impaired self-esteem from previous failures may have a negative impact on subsequent attempts to change. For example, having fewer previous attempts to quit smoking predicted ultimate success at quitting among adolescents (Milam, Sussman, Ritt-Olson, & Dent, 2000); more numerous previous failures appear to impede successful quitting. Similarly, a history of repeated weight loss was a negative predictor for successful weight loss in a current program (Kiernan, King, Kraemer, Stefanick, & Killen, 1998).

Attempting to attain an unreachable goal has also been implicated as a cause or maintaining factor in depression (Kuhl & Helle, 1986). Kuhl's information-processing model of depression suggests that depressive mood states are maintained by unachievable objectives that claim memory capacity needed to enact new, fulfillable intentions (Kuhl & Helle, 1986). Thus, to the extent that the dieter engages in repeated cycles of diet commitment and failure, she becomes more vulnerable to long-term decrements in self-esteem (Polivy, Heatherton, & Herman, 1988) and more serious psychological debilitation (see Heatherton & Polivy, 1992, for a review).

Confidence and Overconfidence

Consideration of the false hope syndrome forces us to attend to the role of confidence in human endeavors. Much of contemporary psychology has emphasized the importance of confidence as a crucial ingredient in success. This position has been articulated most clearly by Bandura (1977; see also Harvey, 1986), who has argued that self-efficacy, or confidence that one can achieve one's objectives—either broadly or within a narrower domain of ambition—can make all the difference between success and failure. People who believe that they can succeed are more likely to succeed than are people who do not. For one thing, those who believe in themselves are more likely to make the effort in the first place. Second, the confident individual is more likely to persist in the face of obstacles. To the extent that persistence helps the individual to overcome those obstacles, then confidence is critical to success. Indeed, there is substantial evidence that higher self-efficacy scores and confidence are associated with better outcomes in a variety of programs (see, e.g., Coon, Pena, & Illich, 1998; Goldbeck et al., 1997; Noone, Dua, & Markham, 1999; Smith, Kraemer, Miller, DeBusk, & Taylor, 1999; Sobell, Sobell, & Gavin, 1995).

Confidence and hope are not quite the same thing, differing perhaps with respect to locus of control, with confidence implying that one can control one's outcomes and thereby succeed and hope suggesting that some indeterminate combination of internal and external factors will lead to success. Regardless of whatever subtle ways hope may differ from confidence, they both can breed success. The same can be said for optimism or positive expectations, which would seem to combine elements of confidence and hope. Armor and Taylor (1998), in reviewing the effects of optimism, concluded that positive expectations help to produce positive outcomes. Moreover, optimistic

people have greater physical and psychological well-being and coping skills, among other positive attributes. More recent work shows that optimism is associated with feelings of personal control and that both are associated with improved health outcomes (Taylor, Kemeny, Reed, Bower, & Gruenewald, 2000). Measures of trait and state hope collected from college athletes predicted overall school performance success (trait hope) and success in athletic competition on a particular day (state hope; Curry, Snyder, Cook, Ruby, & Rehm, 1997). Moreover, these college athletes had generally higher dispositional hope than did nonathletes, possibly because of their prior athletic successes. The idea that hope is helpful is not new; 30 years ago, Yalom (1970) pointed out the benefits of instilling hope in group therapy patients. The psychotherapy literature indicates that having positive expectations at the beginning of therapy is associated with favorable therapeutic outcomes (Ballinger & Yalom, 1995). In fact, hope, or the belief that it is possible to change, appears to be a powerful curative factor, although the mechanism underlying the effect remains obscure (Ballinger & Yalom, 1995; Peterson, 2000; Siegal, 1986; Taylor et al., 2000).

Confidence would appear to conduce toward success in cases where, without the effort inspired by confidence, failure would be the likely outcome. Confidence, however, is not omnipotent; some obstacles cannot be overcome, despite the prevalent belief that if one tries hard enough, one can achieve anything. This belief is a staple of American culture; encouraging children to believe that they can accomplish anything they want (with enough work) is an axiom of child rearing. One encounters this everywhere: in nursery tales ("The Little Engine That Could"), in popular songs (Jimmy Cliff's [1972] reggae classic: "You can get it if you really want/But you must try, try and try, try and try/You'll succeed at last"), and in commencement speeches (take your pick).

The fact of the matter, however, is that there are some things that one simply cannot do, no matter how much one thinks one can or how hard one tries. A belief that one can succeed at a task that is so difficult that no combination of effort and ability can conquer it is a belief that can only be described as unrealistic. An unrealistic belief in one's ability to succeed is the essence of overconfidence.

Overconfidence is at the heart of the false hope syndrome. If it were possible, realistically, to accomplish the goal, then the hope would not be false. What we have described, however, is a process whereby the indicators that the task may be beyond one's capacity are ignored, rebutted, or distorted, with the result that people convince themselves that they can in fact do it, no matter how solid the evidence to the contrary may be. Thus, whereas optimism is generally associated with positive outcomes, optimistic beliefs that turn out to be wrong can be costly (Peterson, 2000). There is some evidence (Kruger & Dunning, 1999) that, perhaps ironically, incompetent people fail to recognize their own incompetence, making it all the more likely that they will persist in endeavors that are likely to fail. This research does not examine self-change tasks in particular, but there would appear to be no reason

why incompetence at self-change should differ from incompetence at anything else. Overconfidence, then, is likely to appear precisely in those individuals who should be—but are not—concerned about it, including chronic dieters.

One implication of this view is that confidence that is earned (i.e., confidence that is based on a record of success and competence) is more likely to be associated with future success than is confidence that has not been earned and that may, in fact, be totally unwarranted (see, e.g., Peterson, 2000). A closer examination of the literature suggests that such is the case. The high self-efficacy that predicts successful self-change is frequently self-efficacy that is instilled in the course of a program of change, as a consequence of interim successes. For example, Blair and Booth (1992) concluded that building self-efficacy over the course of treatment was associated with reduced emotional eating and increased ability to resist inappropriate social pressure to be thin. Similarly, Sobell et al. (1995) included building self-efficacy as part of their guided self-change program and noted that end-of-treatment (not beginning-of-treatment) self-efficacy scores were associated with improved drinking status in alcoholics. Goldbeck et al. (1997) reported that it was end-of-treatment self-efficacy that predicted abstinence in problem drinkers at three-month follow-up. Coon et al. (1998) found that high self-efficacy at follow-up predicted successful abstinence from cigarette smoking and alcohol consumption. Finally, Noone et al. (1999) found that high self-efficacy at follow-up predicted lower levels of self-reported drinking in former problem drinkers.

The fact that end-of-treatment confidence is a better predictor of ultimate success than is beginning-of-treatment confidence does not mean, however, that all end-of-treatment confidence is necessarily earned and therefore realistic. Goldbeck et al. (1997) noted that “unrealistically high expectancies for success commonly seen among clients at the time of discharge [from alcohol abuse treatment]” (p. 314) have been implicated in relapse; these authors reiterated that success at losing weight (or quitting smoking or drinking) does not guarantee success at keeping the weight off (or avoiding relapse). Arguably, avoiding regain (or relapse) is more difficult than is losing weight (or quitting) in the first place. It is not clear whether more people fail to lose weight (or quit) or succeed at weight loss (or quitting) but cannot sustain the success. People who successfully complete the first phase of self-change tend to think that they have proven that they can do it, but quitting may be easier than staying clean over the long run, so initial success may foster overconfidence.

Is Unrealistic Hope Always False?

Our concern about the dangers of overconfidence sounds a note of pessimism that may be difficult to accept for people who are desperate to change. Is there not always a chance—however remote—of success? We showed earlier that most successful self-change efforts occur only after multiple attempts. Is that statistic alone not grounds for persisting in the face of failure?

Although it is true that eventual success may require multiple attempts, that fact does not imply that multiple attempts guarantee success. If the actuarial chances of success on a given attempt are 5%, then it does not follow that 20 attempts will ensure success or that the probability of succeeding on the 20th attempt (following 19 failures) is greater than 5%. In a strictly actuarial sense, perhaps there is always some hope that on the next attempt, one will succeed. Still, the false hope syndrome is a matter of likelihoods, not certainties. The issue boils down to one of costs and benefits, probabilistically calculated. If after 19 attempts one has not succeeded, the odds against succeeding on the 20th attempt are high. From the dieter's perspective, the tremendous value of success may more than offset the long odds against her succeeding. What the dieter typically neglects to include in the calculation, however, is the cost of another effort. The costs of dieting, even successful dieting, are steep, as we have shown. Successful dieting takes a toll on the dieter's emotions, ability to concentrate, social relationships, and even physical health. There may also be benefits of successful dieting in these domains, but the allure of the benefits should not, as it so often does, lead the dieter to discount or ignore entirely the costs. When these costs are added to the calculations, it is difficult to argue for the merits of launching that 20th attempt. When the costs and benefits of unsuccessful dieting are added, arguing for another attempt is all the more difficult.

The fact that some tasks are (virtually) impossible, however, should not be interpreted as grounds for profound pessimism. After all, some difficult tasks are still possible. The trick is knowing the difference. Unfortunately, knowing the difference requires an honest appraisal of one's (and others') past efforts. Did one fail at prior attempts because the task is simply beyond one's ability, or might one have enjoyed success if only one had tried harder or approached the task differently? The answer to that question determines whether future attempts are worth the effort, but answering that question is rarely a simple matter. Often, after failure, it is supremely ambiguous whether one came close to success and a different angle or energy of attack might have succeeded or whether one was doomed to fail no matter how the task was approached. Whether a particular task is achievable depends on all the particularities of the task and the individual attempting it; one cannot decide in the abstract whether or not it is achievable. If one accumulates a history of failure after failure, though, one might do well to ask whether the chances of success are so remote that one might be better off devoting one's energies to other challenges. Kuhl and Helle's (1986) analysis of goal nonattainment and depression suggests that depression may actually be adaptive in inducing people to abandon unattainable goals (and redirect their efforts more profitably). On balance, it appears to be just as important to know when to abandon goals that cannot be achieved as to know when to redouble one's efforts. In the immortal words of Rogers (Kenny, not Carl), “You got to know when to hold 'em, know when to fold 'em” (Rogers, 1978).

One possibility not acknowledged in Rogers's formulation is in effect a compromise between holding and folding. If one fails at one's first attempt(s), instead of abandoning the effort altogether, perhaps the best strategy is to revise the goal. If, as we have argued, failure tends to arise from attempting to do too much too fast and vainly hoping that self-change will bring in its train a host of additional rewards, then perhaps one should consider scaling back one's ambitions. By definition, reasonable goals are more likely to be achieved than are unreasonable goals. It is not weight loss that is impossible; it is unrealistic weight loss. The data indicating that it often takes several attempts before one reaches one's goal may be read as suggesting that those who eventually succeed are perhaps those who learned from their mistakes. Do those who succeed on their sixth attempt succeed by using, once again, the same strategy that failed on the previous five attempts? Or do those who succeed on the sixth attempt do so because they have adjusted their strategy to make it more realistic and therefore more likely to succeed? If one's goal is to lose 20 pounds (and keep it off), then perhaps one will finally succeed when one abandons the strategy of losing the weight during a 20-day crash diet and resigns oneself to losing the weight over a much longer period of time, changing one's eating habits more or less permanently, and adding regular exercise to the mix. This resignation may represent a disappointment in how easy and quick it will be to achieve the goal, but a realistic approach has the incomparable advantage of promising a reasonable chance of success.

Some Final Questions

This proposal raises the question of whether different types of self-change are more or less feasible and thus more or less likely to produce false hope. Many self-change attempts do succeed; as Schachter (1982) pointed out, everyone knows someone who has succeeded at losing (and keeping off) a large amount of weight or who has quit smoking (e.g., C. Peter Herman, the second author, in 1975). We are trying here to understand the factors contributing to the widespread failure of those who do not succeed, to be better able to implement successful self-change. The value of the preceding argument lies in its attempt to explain people's apparently perverse persistence in self-change efforts despite clear and repeated evidence of failure. It thus applies to any sort of self-modification that lends itself to the unrealistic expectations that we have outlined above, including dieting, smoking, gambling, and drug or alcohol use, but also to any other distorted belief in the power of self-alteration to change not only the behavior involved but additional unrelated aspects of existence not truly dependent on that behavior.

The argument presented here helps make sense of the psychological puzzle presented by repeated attempts to change despite a history of repeated failures. Moreover, elements of the argument are consistent with a great deal of clinical and experimental data. Still, other elements of the argument do not yet have strong research support. For instance, the attributional analysis of how people explain

away their failures is somewhat speculative. We are not aware of any studies that contradict our analysis, but by the same token, studies that support the analysis are not plentiful. (We are confident that such further studies will succeed, but we remain reluctantly cognizant of the possibility that we may be victims of a false hope.) Other aspects of the argument, such as why people fail, have strong empirical support but could use still more attention. The question of why people try again demands much more detailed empirical examination, as do the consequences of becoming immersed in the false hope syndrome. Thinking about self-change from the standpoint of false hope suggests a host of testable questions, mostly concerned with people's beliefs, intentions, and reactions at various stages of the cycle. As the answers to these questions emerge, we expect that some details of our argument may require adjustment. Nevertheless, we hope that articulating the argument at this point will promote more and better research and thereby ultimately allow psychologists to help people (including the psychologists themselves) escape or avoid the demoralizing consequences of false hope.

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