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Measuring Hope in Children

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Abstract

Hope is defined as goal-directed thinking in which the person has the perceived capacity to find routes to goals (pathways thinking), and the motivation to use those routes (agency thinking).

Using this hope theory, the author and his colleagues have developed and validated a self-report instrument called the Children's Hope Scale for children ages 7 through 15. An overview of the available validation research is given.

Measuring Hope in Children

“Hope is our children’s window for a better tomorrow”

The Evolution of Hope Theory

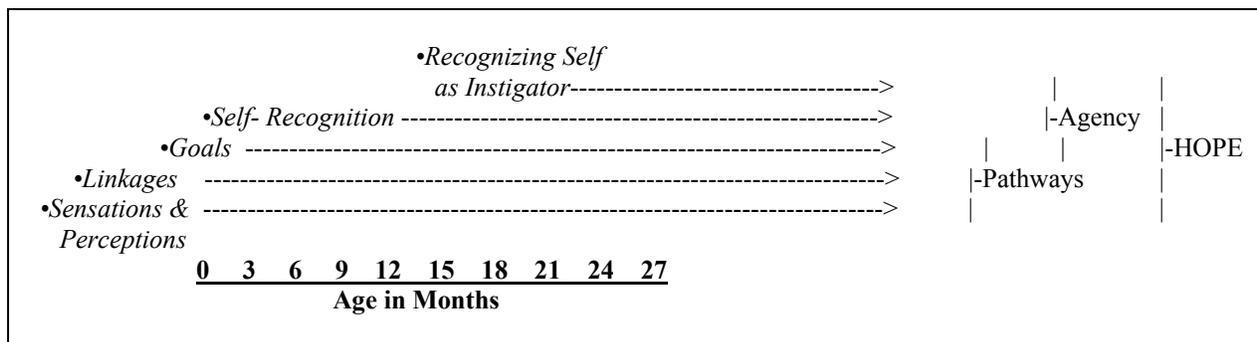
Many times, I have heard people say something akin to the opening quotation—with hope and children always going hand-in-hand. Appealing as this sentiment may be, however, very little psychological theory and research has addressed the topic of children’s hope. The only related research has been that by Kazdin and his colleagues (1983), where children’s *hopelessness* was described in terms of negative expectancies toward oneself and one’s future. Using this hopelessness definition, Kazdin et al. developed the Hopelessness Scale for Children, and this instrument has been used to study the suicidal intentions of children with severe psychological problems (see Snyder, 1994, Chapter 4). As such, the Hopelessness Scale for Children reflects the pathology viewpoint that prevailed during the 1950’s through the 1990’s, and this approach differs from the more recent positive psychology approach for the study of adults (Snyder & Lopez, 2002) and children (Roberts, Brown, Johnson, & Rienke, 2002). Along these latter lines, my colleagues and I have construed hope in general, and children’s hope in particular, in terms of positive expectancies. Our work in developing this theory of hope and its related measure for children is the focus of this paper.

We started by observing that many previous scholars had conceptualized hope as an *overall perception that one’s goals can be met* (e.g., Menninger, 1959; Stotland, 1969). Likewise, we were influenced by the research on adults’ (e.g., Pervin, 1989) and children’s goal-directed thinking (e.g., Dodge, 1986). Springing from these sources of influence, our model and measures of hope were predicated on the assumption that adults and children are goal-directed in their thinking, and that such thinking can be understood according to the associated components of pathways and agency (more on these later).

We define hope as a cognitive set involving the self-perceptions that one can produce routes to desired goals (the pathways component), along with the motivation to use those goals (the agency component). Both components must be assessed together so as to obtain an overall sense of a child's hope. To provide a context for these pathways and agency components as they are related to the shared anchor of goals, I will review their development as part of the normal steps of early childhood (see Snyder, 2000; Snyder, McDermott, Cook, & Rapoff, 2002).

As shown in Figure 1, pathways thinking involves the perceptual recognition of external stimuli, the acquisition of temporal linkages between events, and the formation of goals. Acquired somewhat later temporally, agency thinking reflects the child's recognition of him- or herself, along with the recognition of the self as the source of actions, and the formation of goals. When aggregated, these goal-directed pathways and agency thoughts define hope in this model.

Figure 1. Cognitive Building Blocks of Hope in the Infant to Toddler Stage



A brief elaboration of each of the processes in Figure 1 may help to clarify the underpinnings of hope (see Snyder, 1994, Chapter 3). In regard to sensations and perceptions, the newborn inputs stimulation so as to code it mentally with meaning. Examples include the identification of mother relative to other people through the auditory (Stevenson, Ver Hoeve, Roach, & Leavitt, 1986), olfactory (Schaal, 1986), and visual sensory channels (Barrera & Maurer, 1981). Newborns also quickly learn the temporal connection of events because their

survival depends on such "this follows that" chronologies (Schulman, 1991). From birth onward, newborns refine these abilities to form such linkages as they anticipate and plan for events (Kopp, 1989). The aforementioned perception and linkage learning leads to the infant's pointing to desired objects (from three to 12 months; Stevenson & Newman, 1986). This pointing behavior is called proto-declarative conversation, and it signals the infant's ability to single out one goal and even recruit an adult's help to obtain it (Bates, Camaioni, & Volterra, 1975). Taken together, pathways thinking involves (1) "what's out there" perceptions and (2) the temporal "this follows that" linkages as the infant (3) focuses on selected goals.

So far in this analysis, the infant does not have a sense that s/he is the instigational agent (thus the term agency) of action toward goals. The next processes to be acquired, therefore, involve agency thinking. Learning to identify oneself is necessary for an eventual sense of agency. Such self-recognition increases over the first several months, and it is clearly in place by twelve to 18 months (Kaplan, 1978). Markers of this "psychological birth" include the toddler being able to identify her- or himself in a mirror, the correct usage of the personal pronoun "I," and toddler statements about inner feelings and thoughts (Bretherton & Beeghly, 1982). Along with such unfolding self-awareness, toddlers also realize around 21 months that they are the ones who are making things happen. In this regard, the earliest verbal referents that toddlers make pertain to volitions and capacities (e.g., "I can..."; Corrigan, 1978). These thoughts about selfhood, along the insight that one is the author of actions aimed at reaching desired goals, form agency thoughts. As can be discerned in Figure 1, goal-directed thinking is shared in both pathways and agency thinking.

To help in understanding this definition more fully, it is necessary to discuss children's thoughts about themselves when they run into goal blockages. Early research showed that

children get upset when encountering goal impediments (Barker, Dembo, & Lewin, 1941). Such impediments to goal pursuits, according to the premises of hope theory, should elicit negative emotions; conversely, the successful pursuit of goals should produce positive emotions (Snyder, 1994). In other words, emotions are the causal sequelae of perceptions about goal pursuits, and our research supports this contention (Snyder, Sympson, et al., 1996).

The foundation of hope is set by age two years and, lacking some profound later childhood stressor, the level of hope should remain stable as the child navigates the preschool, middle, and adolescent years. Even though they are relatively set in their hopeful thinking, toddlers still lack the necessary language skills to respond accurately to self-report measures. These requisite language skills for responding to simple questions about themselves should be in place, however, by the second or third grade. Accordingly, we set out to develop and validate a self-report hope scale for children starting at age seven and going to age 15.

The Development of the Children's Hope Scale

The first goal was to construct a scale (the Children's Hope Scale [CHS]) that manifested the proposed two-factor—pathways and agency—model of hope. The second goal was to have the CHS meet the psychometric standards related to internal consistency, temporal stability, and response variability. The third goal was to demonstrate the validity of the CHS.

Item Selection and Factor Structure

The senior author's research group (faculty, postdoctoral and predoctoral clinical psychology students, and undergraduate psychology honors students) discussed a pool of over 40 items, and eventually agreed upon the six best items that reflected pathways thinking and the six best items reflecting agency thought. The content of the pathways items tapped the finding of ways to reach goals under ordinary and blocked circumstances. The agency items tapped content

having to do with an active, "doing" orientation. To get feedback about the clarity of the wording, these twelve items were then read by 25 children (ages 7-15) in a pilot study, as well as by ten children of the research group members. Their feedback, and a second round of discussion by the research group members resulted in a rewriting of items so as to simplify sentence structures. In response to each item, the children were asked to use a six-point response continuum ("None of the time" to "All of the time;" see Appendix for final CHS).

A sample of fourth- though sixth-grade children (197 boys and 175 girls, ages 9 through 14) in the public schools of Edmond, Oklahoma was given this 12-item version of the Children's Hope Scale. A principal components factor analysis with varimax rotations, and a requested two-factor solution was performed. Three agency and three pathway items with weak or equivocal loadings on the two factors were discarded. The remaining six items formed the final CHS.

To cross-validate the factor structure, the six-item CHS was readministered to the same sample one month later. As shown in Table 1, the readministration (OK Post) produced a pattern wherein the three pathway items loaded more strongly on the second factor than the first factor, and the three agency items loaded more strongly on the first factor than the second factor.

 Insert Table 1 Here

Next, we gave the CHS to five other samples for cross-validation of the factor structures. A first sample was comprised of 48 boys and 43 girls (ages 8-17) with sickle cell anemia, arthritis, and cancer; they took the CHS at the beginning and completion of a one-week summer camp held by Children's Mercy Hospital in Kansas City, Missouri (see MO Pre and MO Post in Table 1). A second sample was comprised of 113 boys (ages 7-13) with attention-

deficit/hyperactivity disorder diagnoses who attended the Summer Treatment Programs at Western Psychiatric Institute and Clinic in Pittsburgh (see PA1 in Table 1). The third sample was comprised of 74 nonreferred boys of similar ages to the previous Pittsburgh group (see PA2 in Table 1). In the fourth sample, there were 143 children (70 boys and 73 girls, ages 8-16) who previously had been at the University of Texas M. D. Anderson Cancer Center for cancer treatment (see TX in Table 1). In the fifth sample, there were 154 boys and 168 girls (ages 9-13) from the Lawrence and Overland Park, Kansas public schools (see KS in Table 1).

Results showed that the three pathways items typically loaded on one factor more highly, whereas the three agency items loaded on another factor more highly. Pathways items loaded heavily on the first factor in five administrations, and the agency items loaded heavily on the first factor in three administrations. Occasionally, an individual item loaded incorrectly, but overall the items loaded on the appropriate factor in 42 out of 48 instances (87.5%). Thus, the pathway and agency items are distinguishable in the children's responses. Furthermore, the eigenvalues and variances accounted for supported the robustness of each factor. The median eigenvalue for the first factor was 2.83 (1.74-3.49 range), and the median eigenvalue for the second factor was .88 (.70-1.70 range). Similarly, the median variance accounted for was 36.0% (29.0%-58.1% range) for the first factor, and 26.4% (11.3%-31.5% range) for the second factor. Across the samples, the total variances accounted for was 56.4% to 69.4% (median = 63.4%).

Additionally (see Table 1), the agency and pathways components correlated positively with each other in the various samples (r s of .47 to .70).

CHS Psychometric Properties:

Descriptive Statistics, Internal Consistency, Temporal Stability, and Response Variability

Descriptive Statistics

Means and Standard Deviations. The total scale score means and standards deviations of the CHS for the six samples are shown in Table 2. The means had a low of 25.27 and a high of 27.03 (median mean of 25.89). The scores on the CHS were negatively skewed, with most children scoring toward the high end of the response continuum. On this latter point, if the total mean scores are translated to the average response on each item, a mean of 4.30 results; this suggests that the children described their hope level (on each item) as being somewhat more than "A lot of the time," but not high as "Most of the time."

 Insert Table 2 Here

Gender Differences. Average scores for girls and boys were examined separately for each of the samples in which both genders were represented, and there were no significant differences.

Racial Differences. Only the M. D. Anderson Cancer Center sample had sufficient numbers of children from differing racial groups to allow statistical comparisons. The means for the three racial groups in this sample were: African American (N of 12) = 24.08; Caucasian (N of 70) = 25.34; and Hispanic (N of 59) = 25.49. These means were not statistically different.

Age Differences. Age (7 to 17-year-old range in the various samples) did not correlate significantly with CHS scores in any of the samples.

Family Income. Family income as reported by adult caregivers (in the Kansas sample of school children) did not correlate significantly with CHS scores, $r(296) = .03$.

Internal Consistency

Cronbach alphas for CHS scores in each of the samples ranged from a low of .70 to a high of .86, with a median alpha of .77 (see Table 2). Item-remainder coefficients ranged from .27 to .68, with a median of .54 (all $ps < .01$).

Temporal Stability

The CHS was developed to be a trait-like index. As such, children should produce similar scores when the CHS is readministered at two points in time. Related to this hypothesis, the one-month test-retest correlation for the Edmond, Oklahoma grade-school children was significant, $r(359) = .71, p < .001$. Also, the Missouri sample children who retook the CHS at the beginning and the end of their one-week summer camp produced a significant correlation, $r(89) = .73, p < .001$.

Response Variability

The coefficient of variability is the ratio of the standard deviation to the total scale score (Tabachnik & Fidell, 1996). This coefficient varied from .12 to .24 for the CHS, with a median of .19.

CHS Construct Validation

In this section, I present the discriminant, concurrent, predictive, and incremental validation findings. Because the hope model was developed to reflect the aggregation of the two components, the pathways and agency items will not be examined separately.

Discriminant Validity: Correlations of the CHS with Hopelessness and Social Desirability

Discriminant validity involves the demonstration that there are other indices that bear very small relationships with a new measure. In this regard, I did not believe that the CHS was tapping the same construct as the Hopelessness Scale (Kazdin et al., 1983). To test this relationship, the boys in the Western Psychiatric Institute and Clinic sample completed the two

scales. The correlations were negative, but not statistically significant, $r(35) = -.18$ and $r(13) = -.24$, respectively. Sharing 3% to 6% of variance, the positive hopeful goal-direction as tapped by the CHS is not synonymous with the Hopelessness Scale negative expectancies.

In another test of discriminant validity, it was expected that the responses to a new scale should not be explicable in terms of socially desirable responding. In the sample of Kansas school children, therefore, we administered the Children's Social Desirability Questionnaire (Crandall, Crandall, & Katkovsky, 1965), and the relationship to the CHS was positive, $r(303) = .21, p < .001$.

Concurrent Validity Through Positive Correlations: Observers' Ratings of Hope

Assuming that children manifest behaviors consistent with hopeful thinking, we hypothesized that people who are familiar with those children should be able to accurately rate their hope levels. Accordingly, the parents of the school children in the Oklahoma sample completed a modified CHS wherein the personal pronouns were changed from the first to the third person. The parents used this modified CHS to rate how each of the six items described their child's thought processes (using a six-point continuum of "None of the time" to "All of the time"). Parents' ratings correlated positively with their children's actual CHS scores, $r(264) = .38, p < .01$. Additionally, the parents of the children at the summer camps in Kansas City, Missouri also predicted their children's CHS scores, $r(89) = .50, p < .01$. Furthermore, the Missouri camp counselors rated the children at the end of the camp, with a resultant positive correlation with the children's CHS scores: $r(89) = .21, p < .05$. These latter ratings provide a stringent test because the counselors had interacted with the children for only five days.

Concurrent Validity-Negative Relationships: Correlations of CHS with Depression and Loneliness

Depression. With repeated goal blockages and unsuccessful attempts to circumvent such impediments, according to hope theory, children and adults should be more prone to depression (Snyder, 1994). As such, the perception that one cannot reach desired goals should exacerbate depressive processes. Thus, high CHS scores should relate to lower reported depression. As a test of this notion, the Child Depression Inventory (Kovacs, 1985) was given to the Oklahoma sample and to the two Western Psychiatric Institute samples. CHS scores correlated negatively with Child Depression Inventory scores: Oklahoma sample, $r(345) = -.48, p < .001$; Western Psychiatric patient and nonpatient samples, $r(109) = -.19, p < .05$; $r(71) = -.40, p < .001$.

Loneliness. Effective thinking about goal-related matters often involves other people. Thus, higher-hope children should report less loneliness, as has been the case previously with young adults (Snyder, 1994). In a test of this concurrent validity with children, the Asher loneliness questionnaire (Asher & Wheeler, 1985) and the Network and Attachment Loneliness Scale (Hoza & Beery, 1993) were given to the two Western Psychiatric Institute samples. CHS scores correlate negatively with overall loneliness indices in the patient sample: $r(110) = -.20, p < .04$; attachment loneliness, $r_s(66) = -.28$ and $-.32, p_s < .03$, respectively. Negative correlations also were found with the control sample: overall loneliness, $r(72) = -.38, p < .01$; attachment loneliness, $r_s(71) = -.26$ and $-.30, p_s < .03$, respectively.

Concurrent Validity via Positive Correlations: CHS and Children's Competence-Related Perceptions

Given that hopeful thoughts rest upon a child's self-perceived proficiencies at pursuing various life goals, self-perceived competence should be a suitable variable for assessing concurrent validity. Children from four samples completed the Self-Perception Profile for Children (Harter, 1985), which taps self-perceptions of: (1) scholastics; (2) social acceptance; (3)

athletics; (4) physical appearance; (5) behavioral conduct; and (6) global self-worth. The CHS scores across four samples correlated positively and significantly (only one exception in 24 correlations) with these six subscales (see Table 3).

 Insert Table 3 Here

Concurrent Validity- Positive Relationships: CHS and Control Perceptions

Because of the positive expectations regarding goals in the CHS, positive correlations should result with variables tapping a sense of control.

Perceived Locus of Control. Nowicki and Strickland’s (1973) Locus of Control scale scores were correlated with CHS scores in three samples, yielding the following results: Oklahoma school children, $r(337) = -.33, p < .001$; Western Psychiatric Institute patients, $r(35) = -.35, p < .05$, and controls, $r(45) = -.29, p < .05$ (the negative correlations are explained by the fact that lower Nowicki-Strickland scores reflect more internality).

Perceived Control in Physical, Social, and Cognitive Domains. Connell (1985) developed the Multidimensional Measure of Children's Perceptions of Control so as to measure control perceptions in cognitive, social, and physical domains. Using the two Western Psychiatric Institute samples, the correlations of this measure with the CHS can be seen in Table 4. Results showed that higher-hope (1) related to personal (internal factors) control for all three domains, but (2) did not relate strongly to control attributed to powerful others (external factors).

 Insert Table 4 Here

Predictive Validity: CHS and Cognitive Achievement Scores

Children's capacities to form goals and to use pathways effectively to pursue those goals should facilitate the learning of school information. As a test of this hypothesis, CHS scores obtained at time one on the Oklahoma sample were correlated with their scores six months later on the Iowa Test of Basic Skills (Hieronymous & Hoover, 1985). This latter achievement test taps general cognitive skills (word analysis, vocabulary, reading, language, word-study, and mathematics; Lane, 1992). CHS scores significantly predicted the subsequent Iowa Test of Basic Skills cumulative percentile scores, $r(100) = .50, p < .001$.

Incremental Validity: The Degree to Which the CHS Scores Predicted Later Cognitive Achievement Scores Beyond Variances Related to Other Psychological Measures

Yet another aspect of scale development is incremental validity, which is the degree to which a new scale enhances predictions of a criterion variable beyond scores from previously available measures. For example, do the CHS scores augment the prediction of achievement scores beyond perceived self-worth scores? With the Iowa scores as the criterion variable, and forcing the global self-worth subscale of the Self-Perception Profile for Children into the equation at step 1 of a hierarchical multiple regression, there was a resultant $R^2 = .04, p < .05$. Next, when CHS scores were forced in at step 2, there was an increment in $\Delta R^2 = .22, p < .001$.

In another regression with the Iowa scores as the criterion variable, Nowicki-Strickland Locus of Control scores forced in at step 1 resulted in $R^2 = .20, p < .001$. Moreover, when CHS scores were forced in at step 2, there was an increment in ΔR^2 of .35, $p < .001$. Both of these regression analyses support the incremental validity of the CHS.

Summary and Comments on Status of the Children's Hope Scale

Across samples of children from differing geographical locations, the pathways and agency CHS subscales were found to be factorally identifiable and robust. Extracted total variances of 40% to 50% reflect factor structures with substantial impacts (see Gorsuch, 1983), and the CHS always surpassed this criterion. These two distinguishable components of hopeful thinking emerged within an overall measure that displayed internal consistency (via both Cronbach alphas and the item-remainder coefficients). Self-report scales with internal reliabilities of at least .70 are deemed acceptable for research purposes (Nunnally, 1978), and the CHS repeatedly met this standard. Also, the Cronbach alphas and the item-remainder coefficients for the CHS are of similar high magnitudes to those for the adult Hope Scale (Snyder, Harris, et al., 1991). As such, 7- to 15-year-old children do not appear to be limited by cognitive inconsistencies in responding to the CHS.

Furthermore, despite the fact that the two components were factorally identifiable, they also displayed relationships of .47 to .70 (shared variances of 22% to 49%). Although other researchers are examining the pathways and agency scores separately, we do not do support this practice because of: (1) the theoretical foundation suggesting that both thoughts must be added in order to measure the full hope construct; (2) the ample relationships between the components; and (3) the lack of internal reliability for scales with only three items.

The CHS was developed to tap enduring goal-directed thinking, and the test-retests conducted at one- and four-week intervals supported this posited stability. These test-retest correlations are of a comparable magnitude to those found for the adult Hope Scale (median r of .75; Snyder, Harris, et al., 1991). Additional work is needed, however, to test the stability of the CHS over several months and perhaps even years.

That scores on the CHS appear to be stable over time does not preclude, however, there being variability among individuals in responding to scale. In fact, the coefficients of variability reveal that the CHS does elicit varying responses *across different children*. That is, within each sample, there were children reporting low, medium, and high degrees of hope. Such variability of responses across research participants is important in scale development because it suggests sensitivity to individual differences; moreover, this variability across respondents increases the likelihood that a given scale will manifest relationships with other measures. This .19 for the CHS is comparable in magnitude to the coefficient of variability for the adult Hope Scale (Snyder, Harris, et al., 1991).

No differences in CHS scores appeared in relation to age in the present studies. Recall our earlier assumption that once the level of hope is established in toddlerhood, there should not be any major subsequent changes. Of course, major decrements in hopeful thinking still are possible should the child encounter severe, traumatic events. Importantly, however, we cannot make longitudinal inferences from the cross-sectional age cohorts that were sampled in our various studies. Thus, future research should plot the changes in CHS scores *of the same children* over the course of their middle childhood and adolescent years.

In the present samples of children, as well as in all studies measuring hope in adults, *significant gender differences have never emerged*. Perhaps there truly are no gender differences in hopeful thinking. It may be, however, that the boys and girls in the present studies were thinking about different goals. If a strong gender bias still is operating in the lives of children in the present samples, perhaps the girls relative to the boys may have “settled” for less prestigious or less challenging goals (see Snyder, 1994). In this sense, both girls and boys may be equally high in pathways and agency thoughts *for the goals that they perceive as being “appropriate” for*

their gender. In future research with the CHS, therefore, it will be helpful to ask girls and boys about the actual goals that they are conjuring for themselves.

The lack of racial differences in hope was testable in only one sample (i.e., the M. D. Anderson one), and the means were not statistically different. In the only other reported study of CHS scores and race, Callahan (2000) found that African Americans were highest and Caucasians second highest at the intermediate and middle school years; at the high school level, Caucasians were highest. Moreover, Native American students were third highest, and Hispanic students were lowest in CHS scores throughout the various levels. Obviously, other samples will be necessary before speculating about racial differences, or lack thereof, in CHS scores.

Family income was not related to the scores on the CHS. In this regard, elevated hope should develop in environments where children are given sufficient care and attention, and affluency per se probably does not serve as a proxy for such environments. If the primary caregiver has enough time and energy to foster a child's hopeful thinking, then family income may not have a major impact upon hope. In previous research we have found that high- as compared to low-hope adults reported that their caregiver spent much larger amounts of time with them when they were growing up (Snyder, 1994). Although wealthier child-rearing environments have more money that is available for taking care of children, it may be that this seeming advantage is counterbalanced by the fact that the caregiver parents are personally unavailable to the children because they are engrossed in career or work activities.

The various CHS results generally were supportive regarding concurrent validation. First, it appears that observers can rate a child's hope with some degree of success. Second, the scores on the CHS exhibited predicted negative correlations with depression and loneliness. Elsewhere, we have written that higher hope is learned in a trusting, supportive atmosphere where

interpersonal relationships are a part of many goal-directed activities (Snyder, Cheavens, & Sympson, 1997). On this latter issue, children's higher CHS scores also have correlated significantly with greater parental support (Hodgkins, 2001). Furthermore, we have found empirical support for high hope being related to (1) secure attachments (Shorey, Snyder, Yang, & Lewin, in press), and (2) greater satisfaction with interpersonal relationships (Snyder, 2002).

Children's hopeful thinking is built upon a foundation of perceived proficiency at pursuing goals. The pathways and agency components bear similarities to what Skinner (1992) has called strategy and capacity, respectively. These latter components, according to Skinner, are the bases of children's perceptions of control. On this point, various validation results attest to the fact that higher CHS scores were related to greater self-reported competency ratings. Also, the higher-hope children perceive that they, instead of external sources, were in control in their lives. Overall, the children who score high as compared to low on the CHS are likely to think about themselves as being linked to positive outcomes, thereby validating a central premise of hope theory.

The CHS also manifested discriminant validity in that its scores correlated positively and yet minimally with socially desirable responding. Although the magnitude of this particular relationship is small, it has been suggested that high-hope may at times reflect a slight, positive self bias; moreover, it has been reasoned that such a slight hopeful bias is adaptive (see Snyder, 1989). On this latter point, research with the CHS has shown that the positive biases of higher hope children are slight and are bounded by reality constraints (Hinton-Nelson, Roberts, Snyder, 1996; Kliewer & Lewis, 1995).

Thus, any slight bias that high-hope children may have does not appear to be harmful, and in fact as one data set suggests, higher hope is related to a positive outcome in terms of

performance on the achievement test. Beyond predicting school-related achievement, the CHS scores augmented the perceived competency-based and locus of control predictions. Obviously, however, much additional research is needed to test the longitudinal predictive capabilities of the CHS in a variety of arenas. Such research already has revealed that the adult Hope Scale can be used to make fairly robust predictions in academics, athletics, and health (Snyder, 2002).

One area that has yet to receive much research attention to date involves the role of hope in treatment interventions for children. There was one reported study by McNeal (1998) in which CHS scores increased reliably for a sample of children who underwent residential treatment. It is impossible to make any inferences based on this study, however, because there was no comparison group of children who did not receive treatment. We have suggested that hope may be a common factor in psychotherapy with adults (Snyder, Ilardi, Michael, & Cheavens, 2000), and there is every reason to believe that the same may be true for children undergoing treatment (see McDermott & Snyder, 2000). As such, the CHS may serve as a predictor for successful treatment outcomes for children, and it may be sensitive enough to detect changes in children's hope as a function of treatment.

To date, the CHS has been used in six separate samples in our laboratories, with a total of 1519 child research participants. Additionally, there are eight samples by other researchers in their laboratories, and these have involved 744 children serving as research participants. Taken together, the research to date has sampled 2263 children (roughly equal numbers of girls and boys) from 15 states in the United States. The age ranges of the research participants have been from seven through 16. Moreover, children without any identified problems have participated in the studies, as have children with psychological and physical problems. Furthermore, some initial attempts have been made to compare the Children's Hope Scale scores of children from

differing racial backgrounds. For a scale that was published five years ago, this is a modest record—one that represents a start in having more researchers consider the CHS in their work. On this latter point, if “hope is our children’s window for a better tomorrow,” then we adults would be wise to increase our efforts at understanding it today.

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Appendix: The Children's Hope Scale

Directions: The six sentences below describe how children think about themselves and how they do things in general. Read each sentence carefully. For each sentence, please think about how you are in most situations. Place a check inside the circle that describes YOU the best. For example, place a check (✓) in the circle (O) above "None of the time," if this describes you. Or, if you are this way "All of the time," check this circle. Please answer every question by putting a check in one of the circles. There are no right or wrong answers.

1. *I think I am doing pretty well.*

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
None of the time	A little of the time	Some of the time	A lot of the time	Most of the time	All of the time

2. *I can think of many ways to get the things in life that are most important to me.*

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
None of the time	A little of the time	Some of the time	A lot of the time	Most of the time	All of the time

3. *I am doing just as well as other kids my age.*

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
None of the time	A little of the time	Some of the time	A lot of the time	Most of the time	All of the time

4. *When I have a problem, I can come up with lots of ways to solve it.*

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
None of the time	A little of the time	Some of the time	A lot of the time	Most of the time	All of the time

5. *I think the things I have done in the past will help me in the future.*

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
None of the time	A little of the time	Some of the time	A lot of the time	Most of the time	All of the time

6. *Even when others want to quit, I know that I can find ways to solve the problem.*

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
None of the time	A little of the time	Some of the time	A lot of the time	Most of the time	All of the time

Notes: When administered to children, this scale is not labeled "The Children's Hope Scale," but is called "Questions About Your Goals." The total Children's Hope Scale score is achieved by adding the responses to the six items, with "None of the time" = 1; "A little of the time" = 2; "Some of the time" = 3; "A lot of the time" = 4; "Most of the time" = 5; and, "All of the time" = 6. The three odd-numbered items tap agency, and the three even-numbered items tap pathways.