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JENNIFER S. CHEAVENS, DAVID B. FELDMAN, AMBER GUM, SCOTT T. MICHAEL and C. R. SNYDER

HOPE THERAPY IN A COMMUNITY SAMPLE: A PILOT INVESTIGATION

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ABSTRACT. We report findings from an initial empirical test of a hope-based, group therapy protocol. In this context, hope is defined as a cognitive process through which individuals pursue their goals [Snyder, C. R.: 1994, Free Press, New York]. As such, the eight-session group treatment emphasized building goal-pursuit skills. Findings from a randomized, wait-list control trial using a community sample ($n = 32$ completers) are reported. Participants underwent structured diagnostic interviews (SCID-I) and completed assessment packets. Post-participation assessment results indicate the intervention was associated with statistically significant ($p < 0.05$) improvements in the agency component of hope, life meaning, and self-esteem as well as reductions in symptoms of depression and anxiety. These results suggest that a brief hope intervention can increase some psychological strengths and reduce some symptoms of psychopathology.

1. INTRODUCTION

In this article, we describe the development of a hope-based group therapy protocol and report an initial test of its efficacy. Admittedly, we are not the first to discuss the role of hope in psychotherapy. For decades, an accepted perspective among psychologists has been that hope counteracts mental illness (Frank, 1978). This traditional perspective is rooted in the pathology model of psychotherapy in which the major purpose of treatment is to alleviate mental illness and "fix" the person. In contrast, we propose an approach that is based in the positive-psychology focus on human strengths rather than weaknesses (Seligman, 2002).

Although treating mental illness is an important therapeutic objective, we see two difficulties with an approach that is solely pathology-focused. First, many individuals who seek psychotherapy are not mentally ill (Regier et al., 1993). Although they may feel that their lives are uninteresting, dissatisfying, or not worth living, they nevertheless do not meet diagnostic criteria for any mental illness. In order to receive third-party payment, mental health

practitioners often assign these clients with a diagnosis of Adjustment Disorder (Kielbasa et al., 2004). For example, Keyes (2005) found that languishers, individuals with low mental health but no diagnosable mental disorder, functioned more poorly than individuals with major depression, general anxiety disorder, panic disorder, or alcohol dependence in terms of helplessness, goal orientation, intimacy, and resilience. Such clients seek treatment to improve their lives rather than to alleviate a diagnosable mental disorder. Second, even if clients do present with psychopathology, focusing treatment on past deficits rather than current strengths and future aspirations may not represent the optimal therapeutic strategy (Seligman and Peterson, 2003). According to Seligman and Peterson (2003), focusing solely on specific "damage-healing techniques" removes focus from equally, if not more, powerful strategies focused on identifying and building client strengths. Moving to a model that includes strategies to both eradicate symptoms and reinforce/instill strengths will treat the current symptom presentation and buffer the client against future stressors and difficulties.

There presently are very few therapy protocols that focus on enhancing strengths and resiliency without a focus on diagnosis and pathology. In this article, we offer one such protocol. Specifically, we offer a group treatment protocol that is based on Snyder and colleagues' cognitive conceptualization of hope (1991). This hope intervention is in many ways typical of cognitive–behavioral group therapies (see Snyder et al., 2000). This treatment offers psychoeducation, skills training, and group process components. In two important ways, however, it is novel. First, it was not specifically designed to alleviate psychopathology. Although many of the participants in the study qualified for DSM-IV-TR (2002) diagnoses, the focus of the treatment was to increase clients' levels of hope, not to alleviate specific symptoms. Second, because the protocol is not pathology-focused, it is widely applicable. We will now discuss hope theory.

2. HOPE THEORY

There are several ways to define hope based on both cultural and scientific perspectives. Throughout this paper, we will be using the definition of hope operationalized by Snyder and colleagues (1991). In this theory of hope, Snyder reasons that hope is not a passive emotion occurring only in life's darkest moments, but rather it is a cognitive process through which individuals actively pursue their goals (Snyder, 1994). Research has shown that hopeful individuals report fewer symptoms of depression and anxiety (Snyder et al., 1991) and more life meaning (Feldman and Snyder, in press) than less hopeful

individuals. Hopeful individuals also do well in academic and sports performance (Curry et al., 1997), and they generally report accomplishing their goals more frequently than their low-hope counterparts (Feldman, Rand, Kahle, Shorey and Snyder, unpublished manuscript). In these ways, high hope individuals are similar to "flourishers", as defined by Keyes (2005). Keyes found that flourishers had clear goals in life (both short and longer term), demonstrated high resiliency (similar to meaning making), and low helplessness. As flourishing is indicative of a state of mental health, it may be that hope is a central construct to achieving and maintaining this state.

Snyder (1994, 1995) has operationalized hope as a process through which individuals (1) set goals; (2) develop specific strategies by which to achieve those goals, and; (3) build and sustain the motivation to execute those strategies. These three components of the hope model are referred to as goals, pathways thinking, and agency thinking. Now, we will discuss each of these components briefly.

2.1. Goals

Goals are the endpoints associated with planful behavior (Snyder, 1994; Snyder et al., 1999). In other words, much of what one does is directed toward achieving some goal. Goals consist of anything that an individual desires to get, do, be, experience, or create (Snyder et al., 2002). As such, goals vary widely and encompass virtually every life domain (Snyder and Shorey, unpublished manuscript).

Furthermore, in hope theory, goals are conceptualized as the major source of emotion. Positive emotions result upon perceived achievement of or movement toward one's goals, whereas negative emotions result from perceived goal failure or movement away from one's goals (Snyder, 2002). Given this connection between goal achievement and positive affect, it might seem that the best strategy would be to set easy, high probability of achievement goals. On this point, however, high-hope people appear to inject a certain amount of uncertainty into their goal-pursuits and do not simply choose "sure-thing" goals (Snyder, 1994); instead, they set goals with moderate levels of difficulty (called "stretch goals") that appear to maximize the pathways and agency components of hope more readily than easier goals.

2.2. Pathways Thinking

Pathways thoughts reflect a person's perceived ability to identify and develop routes to goals (Snyder, 1994). People engage in pathways thinking

when they plan out ways to reach their goals. Because some plans may not succeed, high-hope individuals also produce many pathways in order to circumvent possible obstacles. With more important goals and higher likelihoods of being confronted with obstacles, high-hope individuals are likely to develop more alternatives (Snyder et al., 1991, 1996; Irving et al., 1998). It is important to note, however, that the beneficial effects of hope do not result from being able to plot pathways, but from the *perception* that such pathways could be plotted if desired (Snyder et al., 1991).

2.3. *Agency Thinking*

The third component of hope, agency thinking, is defined as "the thoughts that people have regarding their ability to begin and continue movement on selected pathways toward those goals" (Snyder et al., 1999, p. 180). As in Piper's (1978) *The Little Engine That Could*, agency thoughts such as "I think I can" are the fuel that powers the goal-pursuit engine (Snyder et al., 1998). Such thoughts are reflected in the positive self-talk such as "I'm capable of this" or "I am not going to be stopped" that is frequently exhibited by high-hope individuals (Snyder et al., 1998). Agency thoughts motivate individuals to initiate and sustain movement along pathways toward their goals.

2.4. *The Reciprocal Nature of Hope*

A last aspect of the hope model is the notion that goals, pathways thinking, and agency thinking reciprocally influence one another. For example, setting important or particularly meaningful goals may lead to increases in motivation (i.e., agency). In turn, the elevated motivation may inspire the plotting of new pathways. In support of such postulations, research has shown reliable correlations of 0.45 to 0.70 between agency and pathways scores on a paper-and-pencil measure of hope (Feldman and Snyder, in press; Snyder et al., 1991). Having discussed hope theory, we now turn to a discussion of how we translated it into the present group therapy protocol.

3. THE HOPE THERAPY PROTOCOL

The treatment protocol was designed to increase hopeful thinking and enhance goal-pursuit activities as described in hope theory (e.g., Snyder, 1994). Group participants first are introduced to the principles of hope theory and thereafter are given suggestions about how to apply these principles to their

own lives. In doing so, participants learn how to (1) set meaningful, achievable, and measurable goals; (2) develop multiple pathways to work toward goals; (3) identify sources of motivation and counteract any drains on motivation; (4) monitor progress toward goals, and; (5) modify goals and pathways as needed. Additionally, this intervention is conducted in a group setting because it has been theorized that hopeful thinking reflects a transactional process (Snyder et al., 1997). As opposed to more problem-oriented therapies, hope therapy frames goals as positive outcomes that are to be actively pursued rather than focusing on ways to avoid problems or remove symptoms.

This pilot study was designed as a first evaluation of this protocol, and participants were randomly assigned to the treatment group or a wait-list control group. We hypothesized that, compared to the control group, the treatment group would have higher increases in hopeful thinking, meaning in life, and self-esteem, as well as greater reductions in symptoms of depression and anxiety.

4. METHOD

4.1. Participants

A total of 39 participants completed the intake phase of the study, with 32 finishing the entire treatment. There were no significant differences between completers and non-completers on various demographic factors (e.g., education, age, marital status) and other pre-treatment variables of interest (e.g., agency, pathways, hope, depressive symptoms). Five of the non-completers had been assigned to the treatment group and two of the non-completers had been assigned to the wait-list control group. Thus, the rate of completion for the hope treatment group was 78% and the rate of completion for the wait-list control was 88%. The remainder of the data are presented for protocol completers.

In this predominantly Caucasian (94%) female (74%) sample, the average participant was 49 years old (SD = 7.67; range = 32–64), had completed 16 years of education (SD = 1.97, range 12–19 years), and was married (60%). Approximately 81% of the participants previously had completed some form of psychological treatment, and 37.5% currently were involved in some form of psychological treatment. Three of the participants reported a previous psychiatric hospitalization, but none of the participants indicated current suicidal ideation. Based on SCID-I (First et al., 1995) data, diagnostic criteria was met for current episodes of recurrent major depressive

disorder (MDD; $n = 6$), social phobia ($n = 4$), specific phobia ($n = 3$), recurrent MDD in partial remission ($n = 1$), MDD single episode ($n = 1$), dysthymic disorder ($n = 1$), panic disorder ($n = 1$), and generalized anxiety disorder ($n = 1$). Although some participants met criteria for multiple DSM-IV disorders, here we only list current disorders that were described by the participants as the primary diagnosis. Thus, the preceding categories are mutually exclusive, with 18 participants meeting criteria for at least one Axis-I disorder and 14 participants not meeting criteria for any Axis-I disorder.

4.2. Measures

4.2.1. The State Hope Scale. The State Hope Scale (Snyder et al., 1996) was used to track levels of hopeful thinking. This measure consists of six statements that represent pathways and agency thinking at a given moment of time. Respondents indicate the degree to which each statement applies to them at the present moment on a 1 (*definitely false*) to 8 (*definitely true*) scale. Therefore, scores can range from 6 to 48, with higher scores indicating higher levels of hopeful thinking. Subscale scores are computed by adding the three even numbered items for Agency and the three odd numbered items for Pathways. Snyder et al. (1996) reported acceptable internal consistency for the State Hope Scale with alphas ranging from 0.79 to 0.95. A state measure of hope was chosen in order to tap changes in hopeful thinking at different times in the treatment process.

4.2.2. Center for Epidemiologic Studies – Depression Scale (CES-D). The CES-D (Radloff, 1977) is a 20-item measure that was used to assess depressive symptoms over the past week. On this scale, respondents indicate the frequency of each feeling or behavior [0 (rarely or none of the time) to 3 (most or all of the time)], with higher scores indicating higher levels of depressive symptomology. The CES-D has evidenced high internal reliability in both patient (alpha = 0.90) and adult (alpha = 0.85) samples (Radloff, 1977). In addition to internal consistency, the CES-D has demonstrated acceptable test-retest reliability, with correlations ranging from 0.45 to 0.70 for 2–8-week intervals, respectively.

4.2.3. State-Trait Anxiety Inventory (STAI) Form Y. The state form of the STAI (Spielberger et al., 1983) was used in order to assess change in anxiety levels at different times over the course of the treatment. This instrument consists of 20 items that tap the intensity of anxious

symptomatology at a given moment. Form Y was designed specifically to differentiate between depression and anxiety, as well as to tap both anxiety-present and anxiety-absent symptoms. Respondents indicate the intensity of each feeling on a four-point scale [1 (not at all) to 4 (very much so)], with higher scores indicating higher levels of anxious symptoms. Spielberger et al. (1983) reported that the mean in a sample of working adults was 35.72 (SD = 10.40). The inventory demonstrates adequate internal reliability with alphas ranging from 0.86 to 0.95 in samples of high school students, college students, working adults, and military recruits.

4.2.4. Index of Self-Esteem (ISE). The ISE (Hudson and Proctor, unpublished manuscript) is a 25-item measure that assesses difficulties with general self-esteem and self-admiration. Respondents indicate the frequency with which they experience the thoughts and feelings representative of difficulties with self-esteem [1 (none of the time) to 7 (all of the time)]. The constant of 25 is subtracted from all scores so participant scores can range from 0 to 150, with higher scores indicating more severe problems with self-esteem. Hudson and Proctor suggested that scores above 30 indicate a clinically significant problem, whereas scores of 70 or higher indicate severe stress. Abell et al. (1984) found acceptable internal consistency for the ISE, with a mean alpha of 0.93. Furthermore, Hudson and Proctor (1976) reported a test–retest correlation of 0.92 for a 2-h time interval.

4.2.5. Purpose In Life Test (PIL). The PIL (Crumbaugh and Maholick, 1964) is a 20-item scale used to measure changes in purpose in life and meaning during the treatment period. Respondents indicate the degree to which they agree with the items on a scale ranging from 1 to 7; each item on the PIL includes unique anchor statements corresponding with the "1" and "7" answer choices. The authors reported acceptable internal reliability for the PIL ($r = 0.81$) and suggested cut-off scores to discriminate between patient and non-patient populations. According to the authors, scores lower than 111.5 for females and 107.5 for males are indicative of patient status. In other words, scores below these cut-off points suggest that a respondent is experiencing "pathologically" diminished purpose in life.

4.3. Procedure

Participants were recruited through advertisements in the local newspaper and flyers distributed throughout the community. These materials stated that we sought participants who were willing to attend weekly group

meetings that were designed to increase participants' abilities to reach goals. Potential participants called an intake number and were scheduled to complete an assessment. After informed consent was obtained, participants completed a pre-test assessment consisting of the SCID-I interview (First et al., 1995) and the aforementioned paper-and-pencil assessment measures. Advanced clinical graduate students who had undergone extensive training by experienced clinical faculty members conducted all SCID-I interviews. SCID-I interviews were completed over the phone in order to reduce the burdens on participants. Participants then were assigned randomly to either the treatment condition or the wait-list control condition. Participants assigned to the wait-list control condition were offered the intervention after completion of the study.

4.3.1. The Treatment. The treatment manual was designed for a group format over eight 2-h sessions, each having four segments. In the first segment, approximately 30 min were dedicated to discussing the participants' previous week. During this time, homework was reviewed and participants were encouraged to help one another with homework difficulties. The second segment, approximately 20 min in length, was dedicated to psychoeducation. In this segment, participants were taught a new hope-related skill each week. These skills fell into three categories – goals, pathways, and agency. In the third segment, approximately 50 min were spent discussing ways of applying these skills to participants' lives. Participants were encouraged to raise problems and help one another to use the hope skills to solve them. During this segment, the therapists encouraged group process and simultaneously focused the conversation on topics that were relevant to the hope skills. Finally, the last 10 min of each session were dedicated to the next week's homework assignment. Each week, participants were asked to complete an assignment designed to aid them in applying the hope skills in their daily lives. At the outset of the group, each participant was asked to select a specific goal to "workshop" over the course of the protocol, as well as to learn to apply each session's specific skill to that goal. Examples of goals that participants selected were increased exercise, improving interpersonal relationships, and changing occupations.

Treatment protocols and homework assignments were designed for each of the eight weekly sessions. The protocols are based heavily on the theoretical work of C. R. Snyder (1994) and the applied work of McDermott and Snyder (1999). Additionally, some of the techniques were based on goal-setting and therapeutic-motivation research (Lecci et al., 1994; Thayer et al., 1994; Coats et al., 1996; Kasser and Ryan, 1996). The protocols were

modified based on participant and clinician feedback from a feasibility and treatment manual development study with seven participants.

Participants in the treatment condition attended therapy groups lasting 2 h each session, for a total of eight sessions. Groups had between four and eight participants and were lead by two leaders. All of the group leaders were advanced doctoral students in clinical psychology. The group meetings were audio-recorded and reviewed by the first author in order to ensure consistency across groups and therapists. At the final group meeting, treatment condition participants were administered the paper-and-pencil post-assessment measures. Wait-list control participants were mailed the post-assessment measures with self-addressed, stamped envelopes. Wait-list control participants received a reminder call to maximize completion of the measures.

5. RESULTS

The initial step in the data analytic plan was to examine the distribution of the variables in order to evaluate the influence of potential outliers, skewness, and kurtosis. Because the data were normally distributed and were without significant outliers, no transformations were made for the remaining analyses. Additionally, there were no significant differences between groups on any of the variables of interest at intake, suggesting that randomization was effective. The means, standard deviations, and correlations among of variables at pre-test and post-test are presented in Tables I and II, respectively. Treatment effects were examined using mixed, two-way analysis of variance (treatment condition as the between-subject variable and assessment point as the repeated-measures variable). Table III contains the test and descriptive statistics from the interaction of treatment condition by time for each outcome variable.

5.1. State Hope Results

Our primary hypothesis was that the group intervention would increase State Hope Scale scores, resulting in a significant treatment condition by assessment point interaction effect. As detailed in Table III, this interaction approached significance ($p = 0.07$). Thus, although not significant, individuals in the treatment group tended to change more from pre-test than participants in the wait-list control group. If we had used a one-tailed alpha, this result would have been significant and in the predicted direction. In all of the analyses, however, we chose to use the more conservative two-tailed test.

TABLE I

Means, standard deviations, and Pearson correlation coefficients at pre-treatment

Measure	1	2	3	4	5	6	7
1. Hope		0.93	0.90	−0.73	−0.64	−0.67	0.70
2. Agency			0.67	−0.72	−0.61	−0.63	0.67
3. Pathways				−0.61	−0.55	−0.59	0.60
4. CESD					0.75	0.68	−0.78
5. STAI						0.73	−0.62
6. ISE							−0.74
7. PIL							
Mean	25.08	10.82	14.26	26.99	53.85	70.04	82.49
SD	10.36	6.14	5.18	12.59	12.46	28.04	23.23

*For all correlations, $p < 0.001$.*Note*: Hope = State Hope Scale; Agency = Agency Subscale of State Hope Scale; Pathways = Pathways Subscale of State Hope Scale; CESD = Center for Epidemiologic Studies – Depression Scale; STAI = State-Trait Anxiety Inventory; ISE = Index of Self-Esteem; PIL = Purpose in Life Test.

This analysis was followed by two additional mixed, two-way analyses of variance to determine whether there were significant changes in agency and pathways scores of the State Hope Scale over time for each condition, presented in Table III. Using the Agency subscale as the dependent measure, the predicted treatment condition by assessment point interaction was

TABLE II

Means, standard deviations, and Pearson correlation coefficients at post-treatment

Measure	1	2	3	4	5	6	7
1. Hope		0.95	0.93	−0.88	−0.77	−0.71	0.80
2. Agency			0.78	−0.82	−0.70	−0.63	0.78
3. Pathways				−0.83	−0.76	−0.71	0.73
4. CESD					0.91	0.85	−0.88
5. STAI						0.82	−0.85
6. ISE							−0.77
7. PIL							
Mean	32.34	15.06	17.28	20.70	48.00	60.07	90.16
SD	9.60	5.50	4.72	13.96	14.00	30.24	23.44

*For all correlations, $p < 0.001$.*Note*: Hope = State Hope Scale; Agency = Agency Subscale of State Hope Scale; Pathways = Pathways Subscale of State Hope Scale; CESD = Center for Epidemiologic Studies – Depression Scale; STAI = State-Trait Anxiety Inventory; ISE = Index of Self-Esteem; PIL = Purpose in Life Test.

TABLE III

ANOVA results: treatment condition×time

Statistic	*F*	*p*	Treatment M (SD)		Control M (SD)	
			Pre	Post	Pre	Post
1. Hope	3.56	0.07	24.56 (8.07)	33.78 (9.61)	26.79 (11.03)	30.50 (9.61)
2. Agency	4.84	0.04	9.89 (4.69)	15.78 (5.16)	12.07 (6.80)	14.14 (5.88)
3. Pathways	1.15	NS	14.67 (4.83)	18.00 (4.97)	14.71 (4.97)	16.36 (4.38)
4. CESD	3.67	0.07	26.06 (11.31)	17.63 (12.87)	26.04 (15.31)	24.21 (14.80)
5. STAI	10.73	0.003	56.44 (12.00)	45.61 (14.43)	50.93 (13.62)	51.07 (13.27)
6. ISE	5.16	0.02	79.11 (22.48)	90.50 (24.59)	88.14 (22.03)	89.71 (22.78)
7. PIL	6.12	0.02	74.86 (28.35)	60.23 (31.23)	62.14 (26.90)	59.86 (30.08)

Note: Hope = State Hope Scale; Agency = Agency Subscale of State Hope Scale; Pathways = Pathways Subscale of State Hope Scale; CESD = Center for Epidemiologic Studies – Depression Scale; STAI = State-Trait Anxiety Inventory; ISE = Index of Self-Esteem; PIL = Purpose in Life Test. df = 1,30 for all measures except CES-D, for which df = 1,28.

significant ($p = 0.04$). This interaction showed that participants in the treatment group increased agency significantly more from pre-test to post-test than participants in the wait-list condition. Using the Pathways subscale as the dependent measure, however, the predicted treatment condition by assessment point interaction was not significant. As such, participants in the treatment group did not increase pathways scores from pre-test to post-test more so than participants in the wait-list group; although, as can be discerned in Table III, the results were in the predicted direction.

5.2. *Depressive Symptoms Outcomes*

Although the treatment did not specifically target depressive symptoms, a second hypothesis was that participants in the treatment condition would have a greater decrease in depressive symptoms from pre- to- post-test than participants in the wait-list condition. The results of the mixed, two-way analysis of variance for depressive symptoms were similar to the results for the State Hope scores. The predicted treatment condition by assessment point interaction effect approached significance ($p = 0.07$, Table III). This suggests that, although not significant using a two-tailed alpha, the participants in the treatment condition had a greater decrease in depressive symptoms from pre-test to post-test than participants in the wait-list condition.

5.3. *Anxiety Symptoms Outcomes*

As with depressive symptoms, although anxiety was not specifically targeted in the intervention, it was hypothesized that participants in the treatment condition would have a greater decrease in anxiety symptoms from pre- to post-test than participants in the wait-list condition. As predicted, there was a significant treatment condition by assessment point interaction effect ($p = 0.003$, Table III). Again, this suggests that participants in the treatment condition evidenced significantly greater reductions in anxiety symptoms from pre-test to post-test than those participants in the wait-list control group.

5.4. *Life Meaning Outcomes*

As expected, the treatment condition by assessment time point interaction effect also was significant for Purpose in Life scores ($p = 0.02$, Table III). Participants in the treatment condition evidenced greater increases in self-reported life meaning from pre-test to post-test than participants in the wait-list control condition.

5.5. *Self-Esteem Outcomes*

The predicted interaction effect also was significant for the measure of self-esteem ($p = 0.02$, Table III). Again, individuals in the treatment condition showed greater reductions in self-esteem difficulties from pre-test to post-test than participants in the wait-list control condition.

5.6. *Relationships Among Hope and Psychopathology Symptoms*

Although this study was not designed to test the longitudinal relationships among hope and psychopathology symptoms, we conducted post hoc analyses to examine the contributions of both hope and symptoms of psychopathology to post-treatment symptom levels for all participants. Only analyses conducted with the entire sample are presented here, although results were very similar when only participants in the hope treatment condition were considered.

In the first analysis, a hierarchical regression model was conducted with post-treatment depressive symptoms as the criterion variable. In the first step, pre-treatment depressive symptoms were entered into the equation and, as expected, proved to be a significant predictor, Adj. $R^2 = 0.54$,

$F(1, 28) = 32.38$, $p < 0.001$. In the second step, pre-treatment hope scores and hope change scores from pre- to post-treatment were entered into the model. This step resulted in a statistically significant increment in the prediction of post-treatment depressive symptoms, Adj. $R^2 = 0.84$, $R^2\Delta = 0.32$, $F(2, 26) = 29.09$, $p < 0.001$. Importantly, both pre-treatment hope score (standardized Beta $= -0.52$, $p = 0.001$) and hope change (standardized Beta $= -0.69$, $p < 0.001$) remained significant predictors of post-treatment depressive symptoms after accounting for the variance associated with pre-treatment depressive symptoms.

A similar pattern emerged when a hierarchical regression analysis was conducted with post-treatment anxiety symptoms as the criterion variable. Again, as expected, pre-treatment symptoms of anxiety significantly predicted post-treatment symptoms of anxiety, Adj. $R^2 = 0.45$, $F(1, 30) = 25.82$, $p < 0001$. When pre-treatment hope and hope change from pre- to post-treatment were entered into the second step of the model, the addition resulted in a significant increment in the prediction of post-treatment anxiety symptoms, Adj. $R^2 = 0.73$, $R^2\Delta = 0.29$, $F(2, 28) = 16.43$, $p < 0.001$. Again, both pre-treatment hope scores (standardized Beta $= -0.41$, $p = 0.005$) and hope change scores (standardized Beta $= -0.59$, $p < 0.001$) remained significant predictors of post-treatment anxiety symptoms after accounting for the variance associated with pre-treatment anxiety symptoms.

6. DISCUSSION

When distressed individuals seek therapy, it is natural to hone in on what is going wrong in their lives. The shared expectation of both client and therapist, therefore, is that therapy is a place to talk about problems. This focus on problems is pervasive in psychotherapy and often taken for granted as the only viable approach. Unfortunately, many of the client's strengths can be "swept under the rug" and forgotten when such an approach is used. An equally valid approach can be to focus on or to incorporate what the client is doing well, what he wants more of in his life, what he aspires to do, and to use the therapy to enhance these aspects of the client's life. In this light, a hope-based approach may address targets not ordinarily addressed in traditional treatments.

The present study was designed as an initial test of a group therapy protocol to increase hopeful thought in community dwelling adults. Findings indicate that participation in the 8-week treatment program resulted in increased agency thinking (a component of hopeful thinking), life meaning, and self-esteem as well as decreases in anxiety and depressive symptoms

when compared to a wait-list control. Additionally, results indicated that changes in Hope Scale scores were associated with reductions in post-treatment anxiety and depression scores, even after accounting for the variance associated with the respective pre-treatment scores. These findings are very promising; hinting at the potential value of therapies designed around hope and other strength-based constructs.

Of importance, the therapy protocol was not designed to treat any particular psychopathology or diagnostic category. This represents a radical departure from the exclusively pathology-focused approach of most therapy protocols. The level of distress reported by participants was somewhat higher than expected at the initiation of the study, as distress was not an inclusion criterion. The pre-treatment mean scores were in the range indicating clinically significant distress for all measures with such cut-offs. This level of distress presented both opportunities and challenges given the purpose of the study. Due to the high level of distress, we were able to test the relationships among hope and markers of psychopathology. This was an unexpected benefit. It is possible, however, that due to the level of distress, we were unable to evaluate the targeted outcomes in the manner that was initially planned. In other words, it is difficult to draw firm conclusions about the ability to impact hope levels in non-patient populations.

Nonetheless, the change in State Hope Scale scores from pre- to post-test in the treatment group, although promising, were not as strong as predicted. Recall that only agency scores were significantly increased by the therapy. The increase in total hope scores was approaching significance, whereas the therapy did not appear to affect pathways scores at all. This may be due to the high level of psychological distress at intake, as discussed. Another explanation for this finding may be that the participants in the wait-list control group experienced an increase in hopeful thought due to expectancies about treatment initiation. For this control condition, all participants were eligible to receive the hope intervention at some point and as such, may have demonstrated some benefit from this knowledge. It also is possible, however, that this finding was not stronger due to something inherent in the treatment design. Clinical observation suggests that the length of treatment may not have been sufficient for changes in goal setting and goal pursuit to take full effect. Future studies may wish to include a longer treatment period and follow-up assessments. Inclusion of follow-up assessments would allow for researchers to determine if significant effects are maintained and also would allow for the detection of sleeper effects that may emerge over time.

The significant changes in agency scores, meaning, and self-esteem suggest that interventions designed to increase client strengths (in this case, hope), influence other psychological constructs. This fits with the premise that in addition to targeting symptom reduction, effective treatments also should bolster and augment other areas of strength and resiliency. This is likely to be particularly important in cases when clients are not presenting with psychological distress. For example, future studies may wish to use this or a similar intervention with non-distressed adults or individuals who have remitted psychological disorders. If increases in hope, life meaning, and self-esteem are maintained in such a sample, this would provide further evidence that even without symptom reduction per se, increases in mental health and optimal functioning are possible with a relatively short-term, group treatment. Furthermore, a brief group-based hope intervention may be effective as a ''relapse prevention'' component used in the latter stage of treatment for specific disorders.

The results from the present study are congruent with at least one other similar study. Klausner and colleagues (Klausner et al., 1998, 2000) conducted a hope-based intervention for older adults diagnosed with depression and maintaining residual depressive symptoms after at least 10-weeks of therapy. Using stratified randomization, participants were assigned to either a hope-based group intervention or a reminiscence therapy group intervention (Klausner et al., 1998). Although all participants demonstrated statistically significant improvement in depressive symptoms, on average, participants in the hope-based group demonstrated a greater change in Hamilton Rating Scale for Depression (HAM-D; Hamilton, 1960) scores (pre = 22.7, post = 7.6) than individuals in the reminiscence group (pre = 24.8, post = 20.2). The hope-based group resulted in significant improvements on all measured outcomes (e.g., hope, anxiety, family interactions) and resulted in stronger effect sizes than reminiscence therapy (i.e., HAM-D change $d = 2.51$, $d = 0.57$, respectively).

There are limitations to the present study in addition to those we have already raised. First, the sample size is relatively small, rendering it difficult to draw definitive conclusions. As a pilot trial, this study was conducted to provide initial evidence of possible efficacy. Thus, larger trials should be conducted to replicate and determine the stability of the effects. It is encouraging, though, that a number of the analyses were significant given the small sample size and associated limitations on power. On this point, using one-tailed analyses in the predicted direction would have yielded significant interaction effects with the agency and depressive symptom dependent variables. However, we chose to present the more conservative

estimates due to the preliminary nature of the study. Second, although this trial utilizes a randomized, control methodology, the comparison condition consisted of a wait-list rather than an active treatment. Later trials that include an active treatment component/attentional control group would increase the rigorousness of the design. As previously stated, in order to further test the strength enhancement model, we also would like to see these trials conducted with individuals who either are non-distressed or have completed traditional psychotherapy.

In conclusion, this trial provides promising information about the initial efficacy of a group intervention to increase hope and enhance strengths. Although many of the participants in this study had some form of psychopathology, many did not. Nonetheless, if any of these individuals sought mental-health services, they would likely find themselves submersed in a therapeutic culture emphasizing pathology. Because of the pervasiveness of pathology-focused models of psychotherapy, strengths-based approaches have been slow to develop. We hope that the present study stimulates further research on interventions that emphasize the development of client strengths. We believe that it is essential to promote mental health in clients, children, individuals who are languishing, and others who are not at their full mental health potential. By turning our attention to hope and other constructs associated with mental health (e.g., self-esteem, social connectedness, resiliency), there is likely to be movement toward increasing human potential individually and collectively. There is likely a place for such strength-based interventions in treatment and prevention of mental illness and promotion of mental health. Future studies will provide additional information about optimal treatment design, most appropriate participants, and longevity of results.

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Duke University Medical Center J. S. Cheavens
E-mail: cheav001@mc.duke.edu

Santa Clara University D. B. Feldman

University of South Florida A. Gum

VA Puget Sound Health Care System, Seattle Division S. T. Michael

University of Kansas C. R. Snyder