5 Measuring Hope in Children

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Many times, I have heard people say something akin to the idea that hope is our children's chance for a better future. 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), who described children's *hopelessness* in terms of negative expectancies toward oneself and one's future. Using this hopelessness definition, Kazdin's group 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 from the 1950s through the 1990s, and this approach differs from the more recent positive psychology approach for the study of adults (Snyder & Lopez, 2002) and children (Roberts, Brown, Johnson, & Reinke, 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 measures for children is the focus of this chapter.

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*.

We define hope as a cognitive set involving the self-perceptions that one can produce routes to desired goals (pathways), along with the motivation to pursue those goals (agency). Both components, as well as their respective anchoring in goal formation, must be assessed together to obtain an overall sense of a
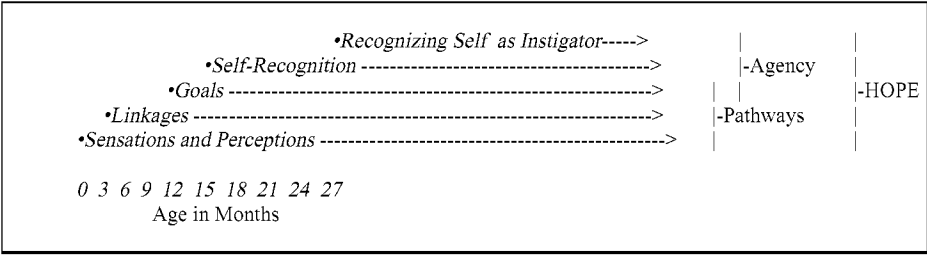
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                            •Recognizing Self as Instigator----->      |           |
                    •Self-Recognition -----------------------------------------> |-Agency    |
                •Goals ------------------------------------------------------->   |  |        |-HOPE
              •Linkages -------------------------------------------------------> |-Pathways  |
           •Sensations and Perceptions --------------------------------------->   |           |

           0  3  6  9  12  15  18  21  24  27
                    Age in Months
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Figure 1. Cognitive Building Blocks of Hope in the Infant-to-Toddler Stage

child's hope. 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 recognition of self, 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.

A brief elaboration of each of the processes in Figure 1 will help clarify the underpinnings of hope (see Snyder, 1994, chapter 3). In regard to sensations and perceptions, the newborn inputs stimulation so as to mentally code it with meaning. Examples include the identification of mother relative to other people through the auditory (Stevenson, Ver Hoeve, Roach, & Leavitt, 1986), olfactory (Schaal, as cited in Berger, 1991, p. 158), 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 3 to 12 months; Stevenson & Newman, 1986). This pointing behavior 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 "what's out there" perceptions and the temporal "this follows that" linkages as the infant focuses on selected goals.

So far, however, the infant does not have a sense that she 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 of life and is clearly in place by 12 to 18 months (Kaplan, 1978). Markers of this "psychological birth" include the toddler's being able to identify 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 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 with the insight that one is the author of actions aimed at reaching desired goals, form agency

thoughts. As seen in Figure 1, goal-directed thinking is shared in both pathways and agency thinking.

To understand this definition more fully, it is necessary to consider 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). According to hope theory, such impediments should elicit negative emotions, and, conversely, the successful pursuit of goals should produce positive emotions (Snyder, 1994). In other words, perceptions about goal pursuits cause certain emotions, and our research supports this contention (Snyder et al., 1996).

The foundation of hope is set by age 2 years, and lacking some profound later childhood stressor, the level of hope would be expected to remain stable as the child navigates the preschool, middle, and adolescent years. Even though toddlers are relatively set in their hopeful thinking, they 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 a self-report hope scale for children ages 7 to 15 years.

Children's Hope Scale

Development of the Children's Hope Scale (CHS) began with discussion of more than 40 items by my research group, which eventually agreed upon 6 items that best reflected pathways thinking and 6 others that best reflected agency thinking. The pathways items tapped content involved with finding ways to reach goals under ordinary and blocked circumstances. The agency items tapped content reflecting an active, "doing" orientation. The 12 items were then read by 25 children (ages 7–15 years) in a pilot study, as well as by 10 of the researchers' children, who were asked to mark their responses on a continuum ranging from 1 (*none of the time*) to 6 (*all of the time*). Using the children's feedback, we developed simplified forms of the items.

This initial 12-item version of the CHS was given to 372 fourth through sixth graders in the public schools of Edmond, Oklahoma (OK pre sample). Factor analysis of the data (using principal components analysis with varimax rotations and a requested two-factor solution) found three agency and three pathway items with weak or equivocal loadings on the two factors, and these items were discarded. The remaining six items formed the final CHS (see Appendix).

To cross-validate the factor structure, the six-item CHS was given to the same Oklahoma sample 1 month later (OK post sample) and then to five other samples:

- 91 children, ages 8–17 years, with sickle-cell anemia, arthritis, or cancer who took the CHS at the beginning (MO pre sample) and end of a 1-week summer camp in Missouri (MO post sample);

- 170 boys, ages 7–13 years, with attention-deficit/hyperactivity disorder diagnoses who attended a summer treatment program in Pennsylvania (PA1 sample);
- 74 nonreferred boys similar in age to the boys in the other Pennsylvania sample (PA2 sample);
- 143 children, ages 8–16 years, previously treated for cancer in Texas;
- 322 children, ages 9–13 years, who attended public schools in Kansas.

Factor analysis showed that the three pathways items typically loaded on one factor more highly, whereas the three agency items loaded more highly on the other. Generally, the pathways items loaded most heavily on the first factor in half of the administrations, and the agency items loaded most heavily on the first factor in the other half of the 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 pathways and agency items are distinguishable in the children's responses. Furthermore, the eigenvalues and variances accounted for supported the robustness of each factor. For example, the median variance accounted for was 36.0% (range: 29.0%–58.1%) for the first factor, 26.4% (range: 11.3%–31.5%) for the second factor, and 63.4% for both (range: 56.4%–69.4%). In addition, the agency and pathways components correlated positively and significantly with each other in the various samples.

Psychometric Properties

The CHS scores from our six samples were negatively skewed, indicating that most children scored toward the high end of the response continuum. Means ranged from a low of 25.41 to a high of 27.03, with a median mean of 25.89 (Table 2). When total mean scores are translated to the average response on each item, a mean of 4.30 results, suggesting that children described their hope level on each item as being between "a lot of the time" and "most of the time." Analyses by subgroups, where possible, showed no significant differences in CHS scores in terms of gender or race/ethnicity. Neither age nor family income correlated with CHS scores.

Overall, the response data showed good variability and reliability. Coefficients of variability for the CHS ranged from .12 to .24, with a median of .19 (Table 2). For all samples, Cronbach's alphas were greater than .70, and item-remainder coefficients ranged from .27 to .68, with a median of .54 ($ps < .01$). In the two instances where the CHS was readministered, test-retest correlations were highly significant ($p < .001$). In the Oklahoma sample, r (359) equaled .71 when retesting after 1 month, and in the Missouri sample, r (89) equaled .73 when retesting after 1 week.

Concurrent Validity

The CHS has performed well in several tests of concurrent validity. In one test, we hypothesized that people, such as parents, who are familiar with

particular children should be able to accurately rate their hope levels. Accordingly, the parents of the schoolchildren in the Oklahoma sample were asked to use a modified CHS to rate how each of the six items described their children's thought processes. Parents' ratings correlated positively with their children's actual CHS (OK pre sample) scores, r (264) = .38, p < .01. Additionally, the parents of children at the summer camps in Missouri also predicted their children's CHS (MO pre sample) scores, r (89) = .50, p < .01, as did the camp counselors, who had interacted with the children for only 5 days, r (89) = .21, p < .05.

In another assessment of concurrent validity, we gave children in four samples (OK pre sample, Kansas sample, and both Pennsylvania samples) the Self-Perception Profile for Children (Harter, 1985), which taps self-perceptions in the areas of scholastics, social acceptance, athletics, physical appearance, behavioral conduct, and global self-worth. CHS scores correlated positively and significantly with these six subscales, with only one exception (physical appearance in the Pennsylvania nonpatient sample) in 24 correlations.

Because of the positive expectations regarding goals in the CHS, positive correlations should result with variables tapping a sense of control. We tested this idea using Nowicki and Strickland's (1973) Locus of Control scale. Scores on this scale were correlated with CHS scores in three samples, yielding the following results: Oklahoma children (OK pre sample), r (337) = −.33, p < .001; Pennsylvania patients, r (35) = −.35, p < .05, and Pennsylvania nonpatients, r (45) = −.29, p < .05.[1] Also in these latter two samples, we used Connell's (1985) Multidimensional Measure of Children's Perceptions of Control, which measures control perceptions in cognitive, social, and physical domains. Correlations of this measure with the CHS showed that higher hope related to personal control (internal factors) for all three domains but did not relate strongly to control attributed to powerful others (external factors).

According to hope theory, children and adults who face repeated goal blockages and unsuccessful attempts to circumvent such impediments 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. To test this notion, the Child Depression Inventory (Kovacs, 1985) was given to the Oklahoma (OK pre) and both Pennsylvania samples. As expected, CHS scores correlated negatively with the depression scores, r (345) = −.48, p < .001; r (109) = −.19, p < .05; and r (71) = −.40, p < .001, respectively.

Effective thinking about goal-related matters often involves other people. Thus, higher-hope children should report less loneliness, as have young adults (Snyder, 1994). To test this concurrent validity with children, we gave the Asher loneliness questionnaire (Asher & Wheeler, 1985) and the Network and Attachment Loneliness Scale (Hoza & Beery, 1993) to the two Pennsylvania samples. CHS scores correlated negatively with overall loneliness indices in the patient sample, r (110) = −.20, p < .04; attachment loneliness, rs (66) = −.28 and −.32, ps < .03, respectively, as well as in the nonpatient sample: overall loneliness, r

[1] Lower Nowicki-Strickland scores reflect more internality.

$(72) = -.38$, $p < .01$; attachment loneliness, rs $(71) = -.26$ and $-.30$, ps $< .03$, respectively.

Other Types of Validity

Children's capacities to form goals and use pathways effectively to pursue those goals should facilitate the learning of school information. As a test of this predictive validity, CHS scores obtained on the Oklahoma (OK pre) sample were correlated with their scores 6 months later on the Iowa Test of Basic Skills (ITBS; Hieronymous & Hoover, 1985), which taps general cognitive skills (word analysis, vocabulary, reading, language, word study, and mathematics; Lane, 1992). CHS scores significantly predicted the ITBS cumulative percentile scores, $r(100) = .50$, $p < .001$.

Discriminant validity demonstrates that there are other indices that bear only very small relationships with a new measure. In regard to the CHS, we believed that it was not tapping the same construct as the Hopelessness Scale (Kazdin et al., 1983). To test this idea, we gave both scales to patients and non-patients in the two Pennsylvania samples. The correlations were negative but not statistically significant, r $(35) = -.18$ and r $(13) = -.24$, respectively. Sharing only 3% to 6% of variance, the positive, hopeful, goal-directed thinking tapped by the CHS is not synonymous with the negative expectancies of the Hopelessness Scale.

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

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? Using ITBS scores as the criterion variable, we entered scores from the global self-worth subscale of the Self-Perception Profile for Children into a hierarchical multiple regression at step 1, yielding an R^2 of .04 ($p < .05$). The addition of CHS scores to the model at step 2 generated an incremental change in R^2 of .22 ($p < .001$). In another regression with ITBS scores as the criterion variable, Nowicki-Strickland Locus of Control scores entered at step 1 resulted in an R^2 of .20 ($p < .001$), and the addition of CHS scores to the model in step 2 produced a positive change in R^2 of .35 ($p < .001$). Both of these analyses demonstrate the incremental validity of the CHS.

Status of the Children's Hope Scale

Across samples of children from differing geographical locations, the pathways and agency CHS subscales have been 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 (Table 1). These two distinguishable components of hopeful thinking emerged within an overall measure that displayed internal consistency via both Cronbach's alphas and item-remainder coefficients (Table 2). 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's alphas and item-remainder coefficients for the CHS are of high magnitudes similar to those for the adult Hope Scale (Snyder 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, sharing variances of 22% to 49% (Table 1). Although other researchers are examining the pathways and agency scores separately, we do not support this practice because of (a) the theoretical foundation suggesting that both thoughts must be added in order to measure the full hope construct, (b) the ample relationships between the components, and (c) 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 1- and 4-week intervals supported this posited stability. These test–retest correlations are of a magnitude comparable 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, the existence of variability among individuals in responding to scale. In fact, the coefficients of variability reveal that the CHS does elicit varying responses *across different children* (Table 2). 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. The .19 coefficient of variability for the CHS is comparable in magnitude to that for the adult Hope Scale (Snyder 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. It is important to note, however, that we cannot make longitudinal inferences from the cross-sectional age cohorts 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,

Table 1. Factor Analyses on Children's Hope Scale (CHS) Items across Six Samples

	OK pre[a]		OK post[b]		MO pre[c]		MO post[d]		PA1[e]		PA2[f]		TX[g]		KS[h]	
Factor #	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2
Agency item																
1	0.85	0.09	0.87	0.14	0.04	0.86	0.06	0.93	0.77	0.02	0.81	−0.03	0.13	0.84	0.26	0.86
3	0.74	0.28	0.79	0.29	0.61	0.42	0.47	0.68	0.71	0.13	0.81	0.09	0.40	0.58	0.34	0.80
5	0.64	0.21	0.57	0.39	0.34	0.69	0.59	0.37	0.18	0.78	0.56	0.37	0.13	0.74	0.67	0.37
Pathways item																
2	0.02	0.85	0.15	0.80	0.76	0.14	0.70	0.10	0.59	0.30	−0.06	0.92	0.77	0.07	0.78	0.21
4	0.32	0.52	0.43	0.65	0.84	0.12	0.71	0.36	0.69	0.40	0.50	0.67	0.68	0.21	0.73	0.34
6	0.41	0.65	0.24	0.76	0.54	0.54	0.83	0.79	0.13	0.82	0.72	0.19	0.69	0.22	0.81	0.25
Eigenvalue	2.65	0.86	3.06	0.78	2.91	0.85	2.98	0.89	2.56	0.87	2.74	1.11	1.74	1.70	3.49	0.70
% Variance accounted for	32.5	25.9	32.6	31.5	34.2	28.5	37.7	26.8	42.7	14.6	45.7	18.5	29	28.2	58.1	11.3
Correlation of agency–pathways*	0.52		0.61		0.61		0.64		0.59		0.47		0.47		0.7	

[a] OK pre = 197 boys and 175 girls, ages 9–14 years, from the 4th through 6th grade in Edmond, OK, public schools.
[b] OK post = 196 boys and 173 girls from the Edmond, OK, schools who retook the CHS after a 1-month interval.
[c] MO pre = 48 boys and 43 girls, ages 9–17 years, who took the CHS at the beginning of 1-week summer camps for children with arthritis, sickle–cell anemia, or cancer, near Kansas City, MO.
[d] MO post = the same 48 boys and 43 girls 1 week after the beginning of the Missouri camps.
[e] PA1 = 170 boys, ages 7–13 years, diagnosed with attention-deficit/hyperactivity disorder who attended a summer program run by the Western Psychiatric Institute and Clinic in Pittsburgh, PA.
[f] PA2 = 74 nonreferred control boys who were similar in age to the PA1 group above.
[g] TX = 70 boys and 73 girls, ages 8–16 years, who were or had been under treatment for cancer at the University of Texas M. D. Anderson Cancer Center.
[h] KS = 154 boys and 168 girls, ages 9–13 years, from the Overland Park and Lawrence, KS, public schools.
* For all agency–pathways correlations, $p < .001$.

Table 2. Psychometric Properties of Children's Hope Scale Total Scores across Six Samples

Measure	Sample[a]							
	OK pre	OK post	MO pre	MO post	PA1	PA2	TX	KS
Mean	25.41	27.03	25.93	26.39	25.49	25.98	25.84	25.71
Standard deviation	4.99	4.51	5.23	5.05	3.63	3.01	5.01	6.11
Coefficient of variability	0.20	0.17	0.20	0.19	0.14	0.12	0.19	0.24
Alpha	0.74	0.81	0.79	0.80	0.73	0.75	0.72	0.86
Item-remainder coefficient[b]	.38/.57	.51/.62	.43/.61	.43/.65	.38/.61	.27/.62	.42/.50	.61/.68

[a] See Table 1 for descriptions of samples.
[b] Value pairs represent ranges.

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 (the Texas 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 affluence 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 more time with them when they were growing up (Snyder, 1994). Although wealthier child-rearing environments have more money 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 the parents are engrossed in career or work activities.

The various CHS results generally support 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 the 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 secure attachments (Shorey, Snyder, Yang, & Lewin, in press) and 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 validational 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 treatments for children. A study reported by McNeal (1998) found that CHS scores increased reliably for a sample of children who underwent residential treatment for acting out inappropriately. 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 et al., 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 1,169 child research participants. Additionally, eight samples

involving 744 children have been gathered by researchers in other laboratories. Thus, the research to date has sampled 1,913 children (roughly equal numbers of girls and boys) in 15 states across the United States. The age ranges of research participants have been from 7 through 16 years. 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 in 1997, this is a modest record—one that represents a start at having more researchers consider the CHS in their work. On this latter point, if hope is indeed our children's chance for a better future, then we adults would be wise to increase our efforts to understand it today.

Author's Note

This article is based, in part, on Snyder, Hoza, et al. (1997). For additional information about hope research, contact C. R. Snyder, 1415 Jayhawk Blvd., Department of Psychology, 340 Fraser Hall, University of Kansas, Lawrence, KS 66045 (crsnyder@ku.edu).

Appendix

Children's Hope Scale

1. I think I am doing pretty well.
2. I can think of many ways to get the things in life that are most important to me.
3. I am doing just as well as other kids my age.
4. When I have a problem, I can come up with lots of ways to solve it.
5. I think the things I have done in the past will help me in the future.
6. Even when others want to quit, I know that I can find ways to solve the problem.

Note: The total score is achieved by adding responses to the six items, where 1 = *none of the time*, 2 = *a little of the time*, 3 = *some of the time*, 4 = *a lot of the time*, 5 = *most of the time*, and 6 = *all of the time*. The three odd-numbered items tap agency, and the three even-numbered items tap pathways.

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