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Hope and the Child Care Counsellor

by

Christopher W. Armstrong 

A thesis submitted to the Faculty of Graduate Studies and Research in partial fulfillment of the requirements for the degree of Master of Education

in

Counselling Psychology

Department of Educational Psychology

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The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research for the acceptance, a thesis entitled **Hope and the Child Care Counsellor** submitted by **Christopher W. Armstrong** in partial fulfillment of the requirements for the degree of Master of Education in Counselling Psychology.

Dr. Ronna F. Jevne

Dr. Robin D. Everall

Dr. Ingrid Johnston

Date: September 24, 2001

'It's a nice day to start again.'
- Billy Idol

In memory of my fiery and charismatic little sister who could start up a conversation with just about anyone,
Shauna Lee Armstrong,
who showed many the face of hope as she stood against Leukemia, and who continues to hold me fast to our clan maxim: Invictus Maneo.
We remain unvanquished.

'There's nowhere you can be that isn't where you're supposed to be.'
- The Beatles

In honor of my parents,
Wayne and Shirley Armstrong,
who made it possible to approach life as a grand adventure and who have supported me absolutely – even when they firmly believed that I should have thought things through a little bit better. There are no words to express how grateful I am for their allowing my youth to be golden and brimming with curiosity - and for their unconditional love, faith and sacrifice.

Abstract

Research links hope with health within the contexts of crisis, trauma, and distress, and also suggests that the helper's hope positively influences the hope of those around them. Despite this, little is known about the hope of the child care counsellor. The purpose of this exploratory study was to investigate the hope of this population in relation to gender, tenure, type of employment setting, employment status, and duration of client residency. Using a cross-sectional survey research design, data was collected through 3 questionnaires, including the Miller Hope Scale, that were completed by a convenience sample of child care counsellors (n=57) from 11 residential treatment settings for at-risk youths. No statistically significant differences in the hope of the participants across the above variables were found. This suggests that these variables may not influence the hope of the child care counsellors, or that there are other variables at play in this relationship.

Preface

I would like use the next several pages to address a deceptively simple question: "How did you come to study the topic of hope?" That question was the first question presented to me at my defense for the thesis at hand. At the time, the kind chair of the proceedings thought that such an opening question would provide a good chance for me to "warm-up" before the tougher questions were fired my way. In reflection, I believe that my answer to that question may provide for those of you who are unacquainted with hope research something that I was lucky enough to chance into in a classroom in 1999: a curiosity about hope.

My curiosity about hope, and the genesis for this research, began unexpectedly in the classroom of Dr. Ronna Jevne, and more specifically, during a lecture that she had dedicated to the topic of hope. To those of you who are unacquainted with Ronna, a short list of her accolades would have to include that she is one of the foremost experts in the world on the subject of hope, a seasoned researcher, lecturer and psychologist, and a founder of the Department of Psychology at the Cross Cancer Institute. She is also an avid dogsledder, fascinated by photography, unabashed about cherishing her marriage to Allen, has toured England on a bicycle, and recently, has acquired the power to officially marry people – which she enjoys immensely for, among other reasons, her ability to get masses of people to sit up and down with simple hand movements. In all, when Ronna speaks about something, most people find that they do not have a problem with their attention. I have to admit though, that for Ronna's lecture on hope my attention was extra keen, but not because I thought of hope as being something worthy of extra consideration. As with many people, I thought of the subject of hope as a "soft" subject

that was best delegated to the philosophers that hung out at the coffee shops around Edmonton. Fancying myself at the time as somewhat of a disciple of cognitive behaviourism, the field of hope seemed to be a far ways off from something worthy of much discussion.

As fate would have it, I walked out of that classroom with part of my brain forever viewing life through the lens of hope. Ronna began the lecture by painting a very intricate picture of the merit of hope in our recovery from life-threatening illness. I remember several "ah-hah" moments, and then the eye opener: "hope is an expectation that there will be a future in which you want to participate, a future that you can take active steps towards creating." That definition of hope, which she has tossed out with several others, clamped onto the front of my brain. It was months before I accepted that I would never see things the same way again. Countless car rides to school were spent thinking about hope in relation to my two primary interests in counselling: our recovery from cancer and counselling at-risk youths. I began to develop big questions: "Can we recover from acute stress or trauma without hope?"; "Will any intervention that a counsellor can muster be effective if his/her client does not possess hope"; "How many of the negative behaviours that we see in children and adolescence can be explained from a hope perspective"; and (list not inclusive), "What happens if the helper does not have hope?"

Three thousand cognitive miles later, I decided that I was going to study hope in relation to youths suffering from cancer. As I dug through the literature, I found a strong argument that our hope is linked to both our psychological and physical health. More specifically, I found compelling evidence that hope, within the context of acute stress and

crisis, is linked to our coping, healing, and our quality of life. I also found that our hope can impact the hope of those around us, and thereby affect their health. With each reading of prior hope research in this area, what was once a subject that I had delegated to the posterior of my education, the phenomenon of hope grew to hold an indelible importance.

As fate would have it, though, the acquisition of enough participants for study that I had planned with youths recovering from cancer presented a major difficulty. It became clear at that point what direction my hope research would have to take. As a child care counsellor with six years of experience, I set eagerly into the literature to see what hope research had been undertaken in the area of child care counselling and residential treatment. With some surprise, I found next to nothing.

Now I sat with a research problem, the same that serves as the foundation for the present investigation: "If our hope has been linked to our health, the health of those around us, and to our coping, quality of life, and healing with regards to acute stress, trauma and crisis – how come we know so little about the hope of the child care counsellor?" The thesis in your hands represents my small attempt to remedy that situation, and to relieve a curiosity about hope that lingers still – two years away from the classroom where this all started.

Acknowledgements

I would like to express my sincere thanks to the following people who have given me an unbelievable amount of support throughout my long and winding academic pursuits:

Again, I would like to thank my parents for being my generous sponsors. I would officially like to thank you for the following (list not inclusive):

1. "persuading" me to visit Susan Mandrusiak so that I could learn how to write.
2. enrolling me in university without my knowledge in 1989.
3. kicking me out of the house when I took a "sabbatical" from university after my first year – which gave me very much inspiration continuing my education.
4. creating a unified front on very controversial issues such as the aforementioned sabbatical.
5. for keeping me warm (paying rent, utilities, etc.), mobile (car, maintenance, insurance, etc.), somewhat stylish (clothes, dental, etc.), up to speed (television, cable, money to go out, etc.), competitive in school (pens, paper, computers, printers, etc.), and a little cultured (trips to California, Mexico, Hawaii, Cuba, England, etc.). I am about to cry!
6. for persistently not accepting that I can quit school at any time.
7. for teaching me that the right thing to do is not always the easiest thing to do.

I would like to thank the both of you for always making the whole process easier, for helping me to think about a big world, and for encouraging me to learn.

I would like to thank Susan Mandrusiak for teaching me how to write at the age of 21 years, for countless hours (days) of editing that I still owe her for, and especially, for her guidance in my "keeping it tight."

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Last but certainly not least, I would like to express my thanks and admiration to all of the child care counsellors who have chosen to devote themselves to helping youths who suffer.

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Chapter One: Introduction

Statement of the Problem

The therapeutic value of hope has not gone unnoticed by the child care counsellors in their treatment of children and adolescents who suffer from the distressing effects of a severe behaviour disorder and/or of profound abuse, neglect, and abandonment. Based on their experiences in the field, most child care counsellors will inherently agree that hope is essential to the residential treatment of youths who intensely suffer. As testament to this, an abundance of case studies that detail the perplexity of how some moderately wounded youths do not respond to proven therapies, and of how gravely wounded youths "burn so bright whilst we can only wonder why" (Cocker, 1997), acknowledge the therapeutic value of hope. Despite this widespread recognition of the "reviving effect" and the "survival function" (Menninger, 1959, p.486) of hope in the day-to-day life of the residential treatment of distressed youths, little hope research has occurred in the field of child care.

At his landmark presidential address of the American Psychiatric Association, Menninger (1959) focused his attention on a similar lack of hope research within the literature of the field of psychiatry. Despite the common observation within the field of medicine of patients who grossly defied the expected odds of recovery, he noted that "the shelves on hope are bare" (Menninger, 1959, p. 481). Menninger went on to challenge the medical community to consider hope as an essential element to their practice:

> I speak...to the point of focusing attention upon a basic but elusive ingredient in our daily work – our teaching, our healing, our diagnosing. I speak of hope....Are we not

> duty bound to speak up as scientists, not about a new rocket or a new fuel or a new bomb or a new gas, but about this ancient but rediscovered truth, the validity of hope in human development. (Menninger, 1959, p. 481).

In response to Menninger's call for the investigation of hope, an overdue burgeoning of its empirical study has emerged within the fields of psychology and medicine.

Reflecting the diversity of the areas involved in the concerted effort to bring the therapeutic value of hope to light, the phenomenon of hope has been explored across a wide variety of contexts, ranging from the homelessness (Herth, 1996) to the terminally ill (Danielsen, 1995). Much of this research is of direct relevance to the child care counsellor in that the link between hope and health was addressed in relation to the experience of stress, anxiety, and depression resulting from the experience of trauma, distress, and crisis; these experiences are well observed within the residential treatment settings for distressed youths (Newell, 2000).

With respect to the child care counsellor, it has been established from the findings of this research that our hope is inextricably entwined in the processes of coping (Herth, 1996; Chang, 1998; Jevne, 1991), of healing (Gottschalk, 1985; Gottschalk & Fronczek, 1993; Heszen-Niejodek, Gottschalk & Januszek, 1999; Udelman & Udelman, 1986), and of attaining quality of life (Stoner & Kaempfer, 1985; Stotland, 1969) when we are faced with adversity. It is these very fundamental processes that underlie the recovery and the maintenance of the health for individuals suffering from the mental disorders that are common to those who experience trauma, whether directly or vicariously, such as mood and anxiety-based disorders (Bernard, 2000; Kadambi, 1998; Newell, 2000; Gottschalk & Fronczek, 1993).

More remarkable yet are the findings of a growing body of hope research that reveal that (a) the hope of the provider is important to a hopeful outcome of treatment (Jevne & Nekolaichuk, 2000) and (b) that a positive reciprocal relationship exists between the level of the hope of the helper and the level of the hope of the individual under her or his care (Farran, Herth & Popovich, 1995). In other words, the hope of the child care counsellor is conducive to the hope of those colleagues or distressed youths that they are in contact with. Coupled with recent findings that indicate that the hope of a youth is linked to their coping, healing, and quality of life within the context of acute crisis (Danielsen, 1995), it is the assumption of this study that the hope of the child care counsellor has therapeutic value for the at-risk youths with whom he/she works.

Despite these findings, though, we know little about what factors influence the hope of the child care counsellor. Child care counsellors have somehow largely escaped the list of professionals who have had their hope investigated - a list that includes psychologists, occupational therapists, nurses, social workers, psychiatrists, and vocational rehabilitation counsellors, among many others (Woodside, Landeen, Kirkpatrick, Byrne, Bernardo, and Pawlick, 1994). With regard to empirical literature investigating the hope of the child care counsellor, the literature review conducted for this study reveals that the shelves are still bare.

Purpose of the Study

As a step towards establishing what factors influence the hope of the child care counsellor, the purpose of this very basic and exploratory research is to investigate the hope of the child care counsellor across five variables: (a) age, (b) gender, (c) tenure, (d) employment status, and (e) typical duration of residency of the at-risk youths within their residential treatment setting of employment. The purpose is based on the assumption that such an investigation is necessary before more experimental studies can be efficiently used to establish what factors influence the hope of the child care counsellor (Fraenkel & Wallen, 2000). It needs to be determined if relationships between the hope of the child care counsellors and these variables exist before the nature of such relationships can be investigated.

A second purpose of this research is to generate questions for future studies of hope concerning the populations of child care counsellors and at-risk youths. This second purpose is based on the assumption that it will become more clear from this exploratory study which aspects of the child care counsellors' hope are in need of further investigation. In light of the growing body of research that demonstrates that hope is linked to health, the well-planned focus of empirical attention on the hope of the child care counsellor is overdue.

This investigation was guided by five research questions. These questions were based on those chosen by Woodside et al. (1994) for their pilot investigation of the hope of health care professionals who worked with people who suffered from schizophrenia. Their questions were adapted for this investigation because they were compatible with both the purposes of this investigation as well as with its exploratory nature. The

following five research questions involved universal demographic and work-related variables:

1. Among child care counsellors, is there a relationship between the length of their tenure as a child care counsellor and their level of hope?
2. Among child care counsellors, is there a relationship between their clients' typical duration of stay at their employment setting and their level of hope?
3. Among child care counsellors, is there a difference between the hope levels of those who work in secure residential treatment settings and the hope levels of those who work in open residential treatment settings?
4. Among child care counsellors, is there a difference in the levels of hope between those who are employed on a part-time or "relief" basis and those who are employed on a full-time basis?
5. Is there a difference between the hope levels of male child care counsellors and of female child care counsellors?

Significance of the Study

This study will advance our understanding of what factors influence the hope of the child care counsellor working with at-risk youths in residential treatment settings, in that the relationship between their hope and the factors under investigation will be better understood. A better understanding of the relationship between the hope of the child care counsellors and the variables focused on in this study will set the stage for further hope research that will help us to explore how best to promote their hope in a residential treatment setting that houses at-risk youths. The significance of promoting the hope of the child care counsellors lies in the growing body of research that indicates that their

hope is (a) linked to their mental health, and (b) that it is also conducive to the hope of their colleagues and of the at-risk youths with whom they work. For the child care counsellor, these findings suggest that the facilitation of their hope may prevent, offset, or foster recovery from the experience of the psychological discord, such as anxiety and depression. Such discord can negatively impact both the mental and the physical health of both the counsellor and distressed youth alike in residential treatment settings (Bernard, 2000; Gottschalk, 1993; Kadambi, 1998; Danielson, 1995).

The significance of this study extends to the counselling psychologist as the child care counsellors are an integral component of any treatment plan devised by a psychologist to help distressed youths in a residential treatment facility. Often under the direction of the counselling psychologist, the child care counsellors carefully monitor and document the behaviour of the youths in their residential treatment settings on a 24-hour basis. They also play a large role in the assessment of the youths' treatment progress and in the development of efficient and successful treatment strategies. Working in tandem with the psychologist, it is the child care counsellor who directly manages the difficult behaviours of the distressed youths throughout their treatments and their recovery. It is the child care counsellor who applies the treatments devised by psychologists. It is also the child care counsellor, as a role model, who provides so many elements that are essential to the treatment of youths with backgrounds of disorder, abuse, neglect, and abandonment: safety, respect, humor, structure, opinion, and unconditional care. In light of all of this, which is not an inclusive list of the child care counsellor's duties by any means, it becomes apparent that the health of the child care counsellor is crucial to the effectiveness of many of the counselling treatment plans developed by psychologists for

distressed youths. The more psychologists understand the factors that influence the hope of the child care counsellors, the more they will be able to effectively work with them. In addition, in that the child care counsellors are an integral component of the treatment of many distressed youths, any research that advances the promotion of the health of the child care counsellor can be considered as being of importance within the field of counselling psychology.

Definition of Concepts

Child / Adolescent / Youth

For the purposes of this investigation, a child is defined as a person who is between the ages of 6 and 12 years (Wolman, 1973). An adolescent is defined as a person who is between the ages of 12 to 17 years. The word youth refers to both children and adolescents in this investigation.

At-Risk

At-risk is a term designated to individuals afflicted with severe emotional disturbance or psychological disorder/pathology who are prone to engage in behaviours that endanger the well-being of themselves, others, and/or public property (K. Nelson, personal communication, June 25, 2001). Frequently, at-risk youths suffer from severe forms of mental disorders (e.g., mood disorders, anxiety disorder, disruptive behaviour disorders, and adjustment disorders; list not inclusive) and/or issues that arise from the experience of profound abuse, neglect, and abandonment (Newell, 2000). At-risk children or adolescents often enter into residential treatment with presenting issues that are beyond the capable management of their current caregivers and/or with frequent involvement in the following acts: aggressive behaviour, antisocial behaviour, prostitution, drug abuse,

attempted suicide, self-destructive behaviour (e.g., slashing), juvenile delinquency, theft, absence without leave (AWOL), truancy, and/or living underage on the streets (N.B., list not inclusive).

Residential Treatment Facility

The term residential treatment facility refers to those facilities licensed by the provincial government through the Ma'Mowe Capitol Region Child and Family Services to provide care to four or more adolescents on a 24 hour basis (Ma'Mowe Capitol Region Child and Family Services, personal communication, June 10, 2001). Adolescent boarders of residential treatment facilities or settings usually have been given status for care by the division of Child Welfare (e.g., various types of status include, Custody by Agreement, Apprehension, Permanent Guardianship Order, Temporary Guardianship Order, Secure Treatment Order, and various types of support agreements). The status of the youth indicates the nature of Child Welfare's involvement in their case.

Residential treatment facilities, which are also referred to as group homes, generally board from eight to twelve unrelated people, who reside with the constant bearing of supervisory personnel or child care counsellors. Youths in open residential treatment facilities are able to venture unsupervised into the community; conversely, with regards to youths in secure treatment settings, the judicial system has restricted their freedom of movement. Youths in secure treatment settings must stay within the facility's premises unless special circumstances warrant otherwise (e.g., court appointments), and they must remain under constant supervision by child care counsellors.

Hope

As the fields of psychiatry, psychology, and medicine have intertwined and matured, clinical interpretations of hope have emerged. As a reality-based motivational force, hope has been defined as "an expectation greater than zero of achieving a goal" (Stotland, 1969, p. 2) and as "the expectation that there will be a future in which you want to participate, and that you can take active steps towards creating that future" (R. F. Jevne, personal communication, July 4, 2000). Another commonly quoted definition of hope comes from Snyder (1994), who defines hope as "the sum of the mental willpower and waypower that you have for your goals" (Snyder, 1994, p. 5).

However, numerous models of hope that are less oriented to goals have also emerged. Of them, the description of hope put forth by Farran, Herth, and Popovich (1995) is gathering widespread acclaim within the field of psychology. Farran et al. (1995) contend that hope, as a multidimensional construct that is generalizable across the life span, has four central attributes that can be clinically assessed: (a) an experiential process, (b) a spiritual or transcendent process, (c) a rational thought process, and (d) a relational process. As an experiential process, hope is something that can only be understood through the experience of hopelessness, such as that caused by suffering (Farran & Popovich, 1990). As a spiritual or transcendent process, hope is often characterized as being inseparable from faith, or is "a faith in oneself or others...a conviction about something that has not yet been proven...or a sense of certainty about that which is uncertain" (Farran et al., 1995, p.8). As a rational thought process, these authors further contend that hope has a reality base and is generated through a combination of the following attributes: (a) realistic goals; (b) resources (physical,

emotional, and/or social); (c) action; (d) a sense of control over one's destiny; (e) time (experience and learning). Lastly, as a relational process, hope is something that occurs between persons and that is directly influenced by others. In summary, Farran et al. (1995) hold that hope "constitutes a delicate balance of experiencing the pain of difficult life experiences, drawing upon one's soul, spiritual, or transcendent nature, and at the same time, maintaining a rational or mindful approach for responding to these life experiences" (p. 9).

Whether it is a definition of hope or a description of hope, work needs to be done with regard to establishing a working conceptualization of hope that can be used within the context of child care. For this investigation of the hope of the child care counsellor, hope is defined as follows: "hope is an anticipation of a future which is good, based on mutuality (relationships with others), a sense of personal competence, coping ability, psychological well-being, purpose and meaning in life, and a sense of the possible" (Miller & Powers, 1988, p. 6). This definition is extended with Farran, Herth and Popovich's (1995) conceptualization of hope, which has gained wide support from both clinical and academic circles within psychology: "Hope...functions as a way of feeling, a way of thinking, a way of behaving, and a way of relating to oneself and one's world. Hope has the ability to be fluid in its expectations, and in the event that the desired object or outcome does not occur, hope can still be present" (p. 6).

Chapter Two: Literature Review

The Therapeutic Value of Hope

Well over a half of a century has past since Freud "spoke of the intricate link between expectations, illness, and effective needs of treatment and appeared to recognize the importance of hope in all of therapy" (Jevne & Nekolaichuk, 2000, p. 91). Freud stated the following:

> Our interest is most particularly engaged by the mental forces that have the greatest influence on the onset and cure of physical disease, fearful expectation is certainly not without its effect on the results....the contrary state of mind, in which expectation is colored by hope and faith, is an effective tone with which we have to reckon....in all our attempts at treatment and care. (p. 91)

Freud's insights heralded the arrival of international attention to the study of hope. With a dramatic increase of interest expressed by clinicians and scientists after repeated findings indicating that hope has a considerable impact on our health, the therapeutic value of hope has come to be well established in both clinical and academic settings (Jevne & Nekolaichuk, 2000; Miller & Powers, 1988; Farran, Herth, & Popovich, 1995; Morsi, 1999; Hanna, 1991; Cope & Wolfson, 1994; Dufault, 1990; Danielsen, 1995). In reviewing the following research, it becomes obvious that therapeutically, hope is inextricably linked to the mental wellness of both counsellor and client alike.

With regards to coping, hope has been described as "a healing force, and as a powerful coping mechanism that enables the individual to ward off despair and transcend current difficulties" (Herth, 1996, p. 744). The phenomenon of coping, though, is only one of three threads that tie most hope research. In addition to facilitating the coping

process, findings have also repeatedly suggested that it may promote healing (Gottschalk, 1985, 1993; Udelman & Udelman, 1986) and enhance quality of life (Stoner & Kaempfer, 1985; Stotland, 1969) when we are faced with extreme adversity. Overall, hope has consistently been found to be "positively linked to health" (Nekolaichuk et al., 1999, p. 591), and is increasingly regarded as being indispensable in our recovery from the effects of both mental and physical illness and discord (Bruhn, 1984; Jevne & Nekolaichuk, 2000; Gottschalk, 1985; Snyder, 1998a, 2000; Snyder, Cheavens & Michael, 1999).

Current research indicates not only that hope moderates our adverse emotional reactions to stress, such as anxiety, but also that it may increase both our ability to cope and our ability to function when we are faced with stressful life events (McGee, 1984; Chang 1998; Cope & Wolfson, 1994; Gottschalk & Fronczek, 1993; Heszen-Niejodek, Gottschalk, & Januszek, 1999; Irving et al., 1997). More specifically, research has indicated that hope acts as an antecedent to coping: "Hope determines whether the individual will indeed have the capacity to be hopeful and to cope with potentially threatening circumstances" (Farran et al., 1995, p. 18). In other words, we do not begin the process of coping unless (a) we believe that there is a positive future to be had, and (b) we further believe that we have the ability to create that future. Other studies have indicated that hope is a coping strategy in itself and that it can "function both as an emotion-focused and problem-solving coping strategy and as a method of cognitive appraisal" (Farran et al., 1995, p.18). Overall, hope has been found to assist individuals in decreasing emotional distress, facilitate their reality-based attack of the problem, and function as a process of rethinking the feelings, attitudes, or approaches that one takes

towards a given stressful situation or event (Cope & Wolfson, 1994; Chang, 1998; Gottschalk, Snyder, Ilardi, Michael & Cheavens, 2000).

In his research of the relationship between hope and coping with crisis, Chang (1998) studied college students undergoing the pressures of examination. He found that their level of hope was positively related to both their engagement in the process of achieving a goal, and a reduction in their experience of stress and anxiety within a stressful, anxiety-provoking context (Chang, 1998, p. 953). When faced with stressful academic situations, students with high levels of hope were found to have greater problem-solving abilities than students with low levels of hope. In addition, students with high levels of hope employed a lower amount of disengagement strategies, such as social withdrawal and self-criticism, than students with low levels of hope.

Through its physical impact on our bodies, our emotional reactions to crisis or acute stress have also been found to affect the course of an illness, the outcome of a treatment, and our vulnerability to illness (Gottschalk & Fronczek, 1993; Heszen-Niejodek et al., 1999). A growing body of research has found that hope may also offset the physical toll of the anxiety produced by our stressful experience of crisis. With regards to the phenomenon of intense stress, hope has been studied in a variety of populations, including the chronically ill (Nekolaichuk et al., 1999); the acutely ill (Heszen-Niejodek et al., 1999); individuals with life-threatening illness, such as cancer (Danielson, 1995; Ersek, 1992; Herth, 1991; Heszen-Niejodek et al., 1999; Hinds & Martin, 1988; Morse & Doberneck, 1995; Nekolaichuk et al., 1999) and HIV/AIDS (Wong-Wylie & Jevne, 1997); and individuals with posttraumatic stress disorder as a result of torture and

catastrophic trauma (Crandall & Keen, 1998). Acknowledged within the findings of these studies is the therapeutic value of hope with regards to treatment outcomes.

In the research of hope as a protective factor in physical and mental disorders, a variety of populations have been studied, including normal adults (Gottschalk & Fronczek, 1993), adult patients with cancer (Gottschalk, 1985; Hezen-Niejodek et al., 1999), adult patients with psychoneuroses (Gottschalk & Fronczek, 1993), and patients with acute schizophrenia (Gottschalk & Fronczek, 1993). In an early study, Gottschalk found that hope scores derived from verbal samples "predicted the duration of survival of patients with terminal cancer receiving irradiation treatment" (Gottschalk & Fronczek, 1993, p. 339). In another study of cancer patients, Gottschalk further found that the hope levels of the patients were negatively related to the severity of their anxiety and to their prognosis. With populations of patients suffering from schizophrenia, he went on to find that hope scores were significantly positively related to their sedative medication (thioridazine) and negatively related to their levels of hostility outward and depression (Gottschalk & Fronczek, 1993, p. 341).

The most intriguing support, though, for the positive relationship between hope and physical health comes from research by Udelman & Udelman (1986). These researchers reported a significant correlation between hope scores and indicators of immune competence, namely mitogenic stimulation by concanavalin A and percentage of B cells (Udelman & Udelman, 1986, p. 249). In all, these findings support Gottschalk's contention that hope may be capable of influencing the onset or course of an illness, and that hope "functions to strengthen tolerance to life stress" (Gottschalk & Fronczek, 1993, p. 340).

With further regards to the role that hope plays in our ability to cope, to heal, and to achieve a good quality of life, other research has been executed using populations of youths who are experiencing acute crisis. In her work with youths experiencing the crisis of a life-threatening illness, Danielson (1995) argues that the hope a youth is conducive to their coping with the emotional turmoil that can arise from the stresses of their illness. In agreement with Danielson (1995), Hinds and Martin (1988), in their study of adolescents receiving treatment for cancer, declare that hope "is vital for resolving illness-related threats such as cancer...[including] protecting the adolescent from incapacitating despair" (p. 336). In another population of adolescents, Yarcheski, Scoloveno and Mahon (1994) found that hope was a mediator in the relationship between perceived social support and general well-being (p. 291). As the degree of their perceived social support increased, the hope of the adolescents "[took] on greater psychological significance, and this...contributes in turn, to their general well-being" (p. 292). In light of findings, which indicate that the hope of the helper is conducive to the hope of their client (Farran et al., 1995), it is again emphasized that it can be suggested from these findings that the child care counsellor is linked to the at-risk youth's recovery from crisis, trauma, and acute stress.

Hope has been also been found to have a beneficial effect on coping, healing, and quality of life of individuals suffering from issues directly related to those common in the residential treatment setting. In their study of posttraumatic stress disorder treatments for Vietnam combat veterans being treated in an inpatient hospital setting, Irving, Telfer and Blake (1997) found hope to be useful in shifting perceptions and for minimizing or preventing denial (p. 465). In studying a homeless veteran population, Tollett and

Thomas (1995) found depression to be negatively correlated with hope, self-efficacy, and self-esteem (p. 76). Increased levels of hope and self-esteem were seen with decreased levels of depression after a hope-focused nursing intervention was applied to these individuals.

In another study, investigating the relationship between adolescents' exposure to violent and non-violent traumatic life events, Morsi (1999) discovered that hope (as a "prosocial resiliency factor") moderated the effects of exposure (p. 5312). She also found that increased levels of hope among these adolescents "were protective and ameliorated the detrimental effects of exposure to violent traumatic life events" (p. 5312). From her findings, Morsi further contends that hope can be used to decrease the deleterious effects of such trauma and is a potential "avenue" for prevention strategies (p. 5312).

With regards to loss, hope has been found to facilitate the process of adjustment (Dufault, 1990; Farran & McCann, 1989; Farran, Salloway, & Clark, 1990; Snyder, 1998b). In her study of the elderly, Dufault (1990) describes hope as being a resource in coping with the significant losses associated with aging (e.g., loss of loved and traditional lifestyle). She further contends that hope is also a resource for coping with the anguish and despair that accompany significant loss. Hope has also been described as representing a "major step" for an individual in finding meaning in and growing from experiences of sexual assault, bereavement, abuse, or relationship dissolution – all realities that at-risk youths must often face (Harvey, Orbuch, Weber, & Merbach, 1992). Cope and Wolfson (1994) found hope to be "a key" in crisis intervention with patients suffering traumatic brain injury and their families in a Shock Trauma Centre, and for

facilitating their emotional adjustment to loss coupled with dramatic changes in lifestyle (p. 80).

With regards to depressive behaviours, hope is increasingly being acknowledged as a factor in the prevention and offsetting of vicarious traumatization (Kadambi, 1998; Pearlman, 2001) and burnout in practitioners in the helping profession (Landeen, Kirkpatrick, Woodside, Byrne, Bernardo & Pawlick, 1996). Concerning suicidal ideation, Range and Penton (1994) found that in a college students, hope was not only negatively correlated with hopelessness, but that it was also a better predictor of suicidal ideation (p. 458). Hope was found to be negatively correlated with student reports of suicidal ideation and past attempts. In light of their findings, Range and Penton (1994) contend that "facilitating [the] hopefulness [of suicidal individuals] may bolster their coping, thereby discouraging suicidality" (p. 458). In related studies, the creation of hope reduced the anxiety of suicidal students, and its rational aspect was found to facilitate the coping of the suicidal individual as well as the effectiveness of therapeutic interventions (Hanna, 1991; Peach & Reddick, 1991; Lesse, 1988).

In conclusion, the therapeutic value of hope has been well established in both clinical and academic settings. More specifically, hope has been linked to the processes of our coping and healing from the psychopathology and deterioration of physical health that can arise from our experience of intense stress, trauma, crisis, and emotional turmoil. Of further pertinence to the child care counsellor, it is suggested in an increasing amount of literature that the hope of the helper promotes the hope, and thereby, the health of both their colleagues and the injured individuals in their care. Despite the widespread recognition of hope as being "positively linked to health" (Nekolaichuk, 1999, p. 591)

and necessary for healing (Jevne, 1991), combined with a growing acknowledgment of the importance of the hope of the helper in treatment delivery and outcome (Jevne & Nekolaichuk, 2000), little attention has been directed towards investigating which factors influence the hope of the helper. This exploratory investigation of the hope of the child care counsellor across universal workplace and demographic variables has the potential to set the foundation for further hope research that can benefit the field of child care through improving the physical and mental wellness of both the child care counsellors and the at-risk youths alike. It is clear from a review of the literature that hope research can be applied in and undoubtedly benefit the child care profession.

Chapter Three: Research Method

Research Design

This study was designed to investigate the hope of the child care counsellor population using quantitative research methodology. More specifically, the purpose of the present quantitative investigation was to investigate the hope in the child care counsellor population in relation to the following variables: (a) their gender; (b) their tenure; (c) the type of residential treatment setting they worked in; (d) the average amount of time they spent working with an at-risk youth; and (e) whether they worked on a part-time or a full-time basis. To attain that end, a cross-sectional survey research design was chosen as an appropriate method for this investigation. Using this method, 130 surveys were distributed to a voluntary adult sample of child care counsellors (N=130) in the form of three questionnaires.

Sample

Selection Criteria

For those individuals in the accessible population, the general criteria for selection included those individuals who were child care counsellors of level-I or level-II status. This criteria of status was decided upon with the intent of keeping the sample population homogenous; level-I and level-II child care counsellors, as opposed to level-III child care counsellors, have a greater amount of client contact time and less administrative work. For the child care counsellors meeting this criteria, it was also necessary that they were employed in an accredited residential treatment facility. Child care counsellors of either gender were eligible for selection, so far as they were able to read English and give

informed consent. These criteria were established to increase the heterogeneity within the sample, in hopes that this would facilitate the study's generalizability.

Sampling Issues

With the cross-sectional survey, the researcher can collect information drawn from a sample at just one point in time (Fraenkel & Wallen, 2000). Traditionally, the best sampling procedures of the quantitative methods aim primarily on maximizing the generalizability of a study's findings to a population of interest (Fraenkel & Wallen, 2000). This is done through the selection of a sample that is highly representative of the target population.

The target population for this study was the child care counsellors of Edmonton, Alberta, who were of level-I or level-II status and who were working with at-risk children and adolescents within an accredited residential treatment setting. The selection of a sample from this population that could be both representative and generalizable presented a major challenge. Two factors influenced the sample selection process: (a) the feasibility of ascertaining the number child care counsellors employed in the city of Edmonton, Alberta, and (b) the number of respondents necessary for the statistical analysis to be meaningful.

As it is, the title of child care counsellor, level-I, is automatic upon employment in a group home sheltering at-risk youths. Consequently, it is extremely difficult to estimate how many level-I child care counsellors are currently employed in Edmonton. For an estimate of the number of child care counsellors in Edmonton to be possible, the researcher must have access to the majority of residential treatment facilities that are in operation in Edmonton. Such a task would not be feasible for this study. Ma'Mowe

Capitol Region Child and Family Services, formerly Social Services of Alberta, estimates that it currently has licensed approximately 200 residential treatment facilities within the city of Edmonton. They have no estimate of how many level-I child care counsellors are employed in these facilities.

Other sampling procedures were considered and ruled out after consideration was given to the number of respondents necessary for the meaningful statistical analysis of the data collected through the survey package used for this investigation. With these limitations recognized, potential sample sources were identified at the outset of the study and they were approached for their participation.

Sampling Method

Keeping in mind the sampling issues, a convenience sampling procedure was selected as being an appropriate method of sampling. A convenience sample of child care counsellors who met the aforementioned criteria was culled from an accessible population of child care counsellors who were employed in 11 accredited residential treatment facilities for at-risk adolescents. These group homes were operated by two large, established Ma'Mowe Capitol Region Child and Family Services Agencies in Edmonton, Alberta.

To preserve their confidentiality, these agencies will be referred to as Agency I and as Agency II. Agency I was established in 1975 and Agency II was established in 1967. Both agencies are non-profit, government funded organizations that assist at-risk adolescents in developing the skills and supports necessary to function effectively as members of their communities. Once these accessible populations were identified, the process for accessing individual participants varied from agency to agency. The specific

methods for accessing participants between agencies will be discussed in more detail under the heading of Data Collection.

Sample Size

For this investigation, descriptive and inferential statistical techniques were used in analyzing the data. In studies that use correlational statistics, large sample sizes are typically preferred because correlation coefficients tend to be less reliable from small samples. According to Fraenkel and Wallen (2000), a sample size of no less than fifty individuals is sufficient for correlational studies. Fraenkel and Wallen argue that with this size of sample, the existence of a relationship can be established. Therefore, based on Fraenkel and Wallen's guidelines, a sample size of 57, used for this investigation, was adequate to employ correlational statistics for this study.

The univariate analysis of variance (ANOVA) is an inferential statistical technique that was also employed in this study. Used to find out if there are significant differences between the means or averages of two groups, the ANOVA requires that the sizes of the two groups be not only large, but also similar (Fraenkel & Wallen, 2000). With respect to this study, the groups (males versus females) to be compared in relation to hope were both sufficiently large and similar in size for each gender (approximately 30). This allowed for the ANOVA statistical technique to be an appropriate method of statistical analysis for this investigation.

Instrumentation

The variables of this study were assessed through a survey package that was comprised of three questionnaires (Appendix B, C, and D, respectively): the Miller Hope

Scale questionnaire (J. F. Miller, 1988), the 3 Child Care Hope Statements questionnaire, and the Demographic Questionnaire.

The Miller Hope Scale

Developed in 1988 by J. F. Miller, the Miller Hope Scale (MHS) is a widely used instrument for the measurement of the multidimensional attributes of hope in adults. The MHS is a 40-item scale using a 5-point Likert format from 6 (strongly agree) to 1 (strongly disagree). The range of scores on the MHS is 40 to 240, with high scores indicating high levels of hope. The MHS was developed using both well and acute/chronically ill adult populations (Miller & Powers, 1988). Before using the MHS on ill subjects, Miller established norms for the instrument using 522 healthy university students, with an age range from 18 to 52 years (M age = 21 years). Of this healthy sample, 336 (64%) were female and 145 (27%) were male. Their average overall MHS score was 164.46 (SD = 16.31). Repeated evaluations of the MHS have well established its internal consistency, test-retest reliability, content validity, criterion validity, divergent validity, and construct validity (Miller & Powers, 1988; Farran et al., 1995).

The 3 Child Care Hope Statements Scale

The 3 Child Care Hope Statements Scale was a rating scale that was used to assess the hope of the child care counsellors specific to the at-risk children and adolescents with whom they worked. The development of this scale was necessary in that the Miller Hope Scale contained no items for ascertaining this specific type of hope. This questionnaire was composed of three items that were based on those originally developed by Woodside et al. (1994) for their study of the hope of nurses with regards to their patients who suffered from schizophrenia. The items of the 3 Child Care Hope Statements Scale are as

follows: (a) "I believe that at-risk youths can eventually attain a satisfying quality of life"; (b) "I believe that the prognosis for at-risk children is good"; and (c) "I believe that I can make a positive difference in the lives of the at-risk children and adolescents with whom I work." As with the Miller Hope Scale, this three item scale used a 6-point Likert format, from 6 (strongly agree) to 1 (strongly disagree). The possible range of scores is from 3 to 18, with a high score indicating high hope. As found with the items developed by Woodside et al. (1994), a correlational analysis revealed that the items of the MHS and those of the 3 Child Care Hope Statements were moderately related ($r = .43$; $p < .01$).

The Demographic Questionnaire

Included in the survey package was a short, one-page questionnaire (Appendix D) that was used to collect demographic information concerning the respondents. Through this questionnaire, each participants was requested to provide personal information concerning the following: (a) age; (b) gender; (c) level of education; employment status (full-time versus relief); (e) type of occupational setting employed in (open versus secure); (f) tenure as a child care counsellor; and (g), typical length of client residency in their employment setting. As with the other questionnaires, no information that could directly identify the person or the organization for which they worked was requested.

Data Collection

A three-step process was used for data collection. The first step involved obtaining approval to conduct the present study from the Department of Educational Psychology Research and Ethics Committee. Once this approval was granted, the second step of the data collection commenced: the identification of potential sample sources. For this study,

the primary sources for the sample were intact groups, which were the 11 residential treatment facilities of Agency I and Agency II.

Once the sample sources were identified, the third step of data collection focused on accessing the individual participants. This step consisted of obtaining appropriate approval from the Director of each agency, clarifying the nature of informed consent from them, and distributing the survey packages to the group homes under their supervision. The data for this investigation was collected concurrently from multiple sources. All of the questionnaires were distributed by a contact person. Participants returned the completed questionnaires to the investigator through the same contact person. An addressed return envelope that contained the questionnaires helped to facilitate the collection of the surveys by the investigator.

Sample Sources

Agency I and Agency II were identified as potential sample sources in that they employed a large number of child care counsellors who met the selection criterion for participation in the present investigation. Together, both agencies employed 194 child care counsellors and operated 11 accredited residential treatment facilities. With a mean age of 34 years, the male child care counsellors of the two agencies numbered 77 (39.69%) and the females numbered 117 (60.30%). Together, these agencies employed 89 (45.87%) child care counsellors on a full-time basis and 105 (54.12%) child care counsellors on a part-time basis.

Agency I operated five of the accredited open residential treatment facilities involved in this study and employed a total of 76 child care counsellors. With regards to the demographics of this child care counsellor population, 25 (32.89%) of them were men

and 51 (67.10%) of them were women, with an average age of 32 years. Of these potential respondents, 32 (42.10%) were employed on a full-time basis and 44 (57.89%) were employed on a part-time or relief basis.

The slightly older Agency II employed a total of 118 child care counsellors and operated 6 residential treatment facilities involved in this study. Three of these facilities were open settings and the remaining three were secure settings. With regards to the demographics of this child care counsellor population, 52 (44.06%) were male and 66 (55.93%) were female, with the average age of 37 years. Concerning employment, 57 (48.30%) of these child care counsellors were employed on a full-time basis and 61 (51.69%) were employed on a part-time basis.

Increasing their appeal as potential sample sources for this investigation was the homogeneity of both agencies' child care counsellors on several different levels. For the child care counsellors of both agencies, the duties and the experiences entailed by their position were alike. For both agencies, the workers were employed in homes that housed 8 to 12 at-risk adolescents who were dealing with similar issues arising from much the same negative environmental backgrounds and physiological disorders. Clinically, both agencies have the same referral base. Further, the youths whom the child care counsellors worked with were exhibiting aversive behaviours of relatively equal type, duration, and intensity. This assumption of the researcher is based on his employment in all 11 of the group homes accessed for this investigation at some point in time throughout his six-year tenure as a child care counsellor.

With regards to their duties, the child care counsellors for both agencies were required to attend to the physical, emotional, and administrative needs of the adolescents,

and to manage their behaviours, within similarly strict regimens. These regimens, which were essential to the elaborate behaviour modification programs around which the houses were hinged, were alike in structure and routine. The behaviour modification techniques used by the child care counsellors of both agencies were identical, and placed them under similar amounts of pressure and duress when applied.

Essentially, the primary difference between the residential treatment facilities involved in the study involved the freedom of the youths to come and go from their home premises. It is unclear how the youths in these setting differ with respect to their aversive behaviors in terms of frequency and intensity. What is certain is that the child care counsellors employed in open settings may have had less client contact time than those employed in secure treatment settings.

Accessing the Sample

After ethics approval was obtained from the Department of Educational Psychology Research and Ethics Committee and the potential sample sources were identified, different approaches were implemented to access the sample. This third step of the data collection focused on obtaining appropriate approval, clarifying the requirements of informed consent, and distributing the questionnaires.

Agency I.

For Agency I, verbal approval was required for this study from the agency's Director. To obtain verbal approval, the investigator contacted a supervisor for one of their residential treatment facilities. This group home supervisor presented a copy of the research proposal to a Director of the agency for approval. Approval for the study was granted by the Director. Written, informed consent was not required.

The supervisor initially contacted about the study volunteered to distribute 30 of the survey packages to the child care counsellors of their 5 group homes. Upon their completion, the same supervisor collected the survey packages and returned them to the researcher. Before the supervisor distributed the questionnaires, she was debriefed by the researcher about the nature of the study and the completion of the survey package. The anonymity of the participants' identities, the identities of the residential treatment facilities, and the limits of confidentiality were emphasized.

To assist with informing the participants of the nature of the research and of their rights therein, a cover letter (Appendix A) was included in each survey package that was titled: "An Invitation to Participate in Hope Research." This cover letter, which invited the child care counsellor's participation in the study, clearly explained to the potential respondent the purpose and the nature of the study, as well as the possible uses of the results. Also delineated were the limits of the confidentiality surrounding their participation. Participants were assured that their identities would remain anonymous. It was also stressed that participation was entirely voluntary, that participants could withdraw at any time, and that the results would be made available to them. Finally, the participants were informed through the letter that the time necessary to complete the three questionnaires in the survey package would be approximately 30 minutes.

The cover letter was placed with the three questionnaires (Appendices B, C, D) in a open, brown envelope. Upon completion of the questionnaires, participants could seal the documents in the envelope before returning it to the designated contact person. This further assured the confidentiality surrounding their participation in the study. To further this end, written consent was not obtained from the respondents. The participants

completion of the survey package was taken as their informed consent to participate in the present study. All questions and comments from the directors, supervisors, and participants were accommodated by the researcher.

Agency II.

For Agency II, the process to obtain participants differed slightly from the first group. A copy of the research proposal, as well as a letter (Appendix A) outlining the nature of the research was forwarded to the Director of the agency. Subsequent to this, an oral presentation explaining the study was made to the Director and the Assistant Director. These two individuals reviewed the research proposal and granted approval for the study.

Once approval to conduct the present study within Agency II was obtained, the primary distributor of the surveys, the Assistant Director, was informed about the nature of the study and the requirements of the survey. The Assistant Director then distributed 100 survey packages to the supervisors of their 6 group homes. These supervisors then further distributed the packages to the child care counsellors under their charge. The child care counsellors were responsible for returning the completed surveys to the Assistant Director. An emphasis was placed on retaining anonymity for all levels of participation in the study, including the participant, the residential treatment facility, and the organization.

As with Agency I, a cover letter (Appendix A) was included in the survey package to ensure that the participants were informed of the nature of the study, the limits of confidentiality, and the necessary anonymity of their participation. Further, as with Agency I, the survey package contained three questionnaires (Appendices B, C, D) in an open, brown envelope. Individuals who required more information about the study were directed through the cover letter to contact the investigator directly. As with Agency I,

consent to participate was inferred from those participants who returned completed questionnaires to the investigator.

Of note is that the residential treatment facilities for both organizations were surveyed at different times. Those group homes of Agency II were surveyed approximately 14 days after those group homes of Agency I. Some minor revisions of the questionnaires were made after the first survey (see Appendix D), but all of the questions reported in this study were identical in the two samples.

Response Rates

To increase the response rate of the sample, a number of methods were utilized. A detailed explanation of these methods follows:

1. Cover letter: A cover letter (Appendix A) was included in each survey package. In addition to explaining the purpose and nature of the research, the cover letter provided potential respondents with an estimate of how long it should take to complete the questionnaire. Furthermore, the cover letter was used to explain how the participants' involvement in the study could benefit both the child care counsellor population at large and the at-risk youths with whom they work.

2. Questionnaire format: The use of questionnaires reduced the disruptiveness of this study to the work routines of the child care counsellors. A benefit of using the questionnaire as a data collection method is that it could be incorporated into the child care counsellors busy and unpredictable work day.

3. Credibility of the research: The participants of this study were informed of the affiliation of the research with the University of Alberta, either verbally or in writing.

4. Involvement of the investigator: Whenever possible, the investigator provided an overview of the study to the participants in person. When this was not possible, the main distributors of the questionnaires were familiarized with the research at hand.

5. Collection of completed questionnaires: Upon deciding the best distribution process for the questionnaires at each agency, a deadline was set for their completion. After this deadline, the researcher returned to the agency headquarters to collect the completed questionnaires from a prearranged pick-up point.

6. Ethical considerations: All responses to the questionnaires were held as being strictly anonymous. No information that would directly identify the participants, the residential treatment settings, or the agency was requested.

Data Analysis

In order to answer the research questions of this study, a statistical analysis of the data was performed using the Statistical Package for the Social Sciences for Windows, version 10.0 (SPSS 10.0 for Windows, 2000). Using the SPSS 10.0 package, the data collected from the participants could be analyzed statistically for inferential and descriptive information. In addition, this package allowed for the relationships between variables to be analyzed for significance using bivariate correlational and ANOVA statistical analyses.

Measures

Level of Hope

Each participant's level of hope was derived from his/her responses to items 1 through 40 on the Miller Hope Scale (MHS; Appendix B). In accord with how the participant felt concerning the given question, the participant rated each item on the scale

ranging from 1 (strongly disagree) to 6 (strongly agree). By combining the participant's responses to the 40 items, an overall hope score, or their level of hope, was determined. This overall hope score was obtained, which ranged from 40 (low level of hope) to 240 (high level of hope), with numerically higher scores indicating high levels of hope (range = 147 to 240; M = 199.14; SD = 23.81). The coefficient alpha for this scale was .97.

Of note regarding the use of the MHS in the present investigation is that items numbered 41, 42, and 43 were not included in the composite score for each participant. This was so because they (a) they "are not considered part of the Hope Scale" (Miller, 1988), and because they were ill matched with the sample of this study. This procedure was used by Woodside et al. (1994) in their study of the hope levels of nurses when they found that the same questions were poorly fitted to their sample. Of note is that the above coefficient alpha of the MHS was calculated without items numbered 41, 42, and 43. Of further note is that a number of items of the MHS are reversed scored: items numbered 10, 12, 15, 17, 24, 26, 27, 30, 32, 33, 37, and 38. For reverse scored items, 6 is endorsed if the participant "strongly disagrees" with an item, and 1 is endorsed if they "strongly agree" with an item.

The child care counsellor's level of hope was also measured from his/her responses to items one through three of the 3 Child Care Hope Statements Scale (Appendix C). As with the Miller Hope Scale, in accord with how the participant felt concerning the given question, the participant rated each item on the scale ranging from 1 (strongly disagree) to 6 (strongly agree). The three items of the 3 Child Care Hope Statements Scale were as follows: (a) "I believe that at-risk youths can eventually attain a satisfying quality of life" (range = 2 to 6; M = 4.60; SD = .90); (b) I believe that the prognosis for at-risk children

is good" (range = 2 to 6; M = 4.00; SD = .91); and (c), "I believe that I can make a positive difference in the lives of the at-risk children and adolescents with whom I work" (range = 2 to 6; M = 4.8; SD = .93). By combining the participant's responses to the three items, an overall hope score was obtained, which ranged from a possible 3 (low level of hope) to 18 (high level of hope), with numerically higher scores indicating high levels of hope (range = 6 to 18; M = 13.40; SD = 2.40). For the 3 Child Care Hope Statements Scale, none of the items were reverse scored. The coefficient alpha for this scale was .85.

Average Duration of Client Residency

The average duration of the residency of an at-risk adolescent at the participant's residential treatment facility of employment was obtained from the demographic questionnaire (see Appendix D). For item number 6 of the demographic questionnaire, the participant was asked to respond to a question regarding "the amount of time typically spent working with a specific client." The participant responded by selection one of six response options: (a) less than or equal to one month; (b) less than or equal to three months; (c) less than or equal to six months; (d) usually about one year; and (e), usually about 2 to 5 years.

Length of Tenure as Child Care Counsellor

The length of the participant's tenure of employment as a child care counsellor was assessed with the following question on the demographic questionnaire (see Appendix D): "Considering your employment history, what is the duration of your employment as a child care counsellor within the field of Child Care and residential treatment." This question was clarified with an example: "e.g., estimated total time worked as a child care

counsellor in all is 1 month, 1 year, 5 years, 10+ years." The subject's response to this question was taken as their length of tenure as a child care counsellor.

Type of Residential Treatment Setting Employed

Information about the type of residential treatment setting within which the participant was employed was obtained by their endorsement of one of two optional responses on the demographic questionnaire (see Appendix D): (a) "secure" and (b) "open."

Gender

The participant's gender was determined by their endorsement of one of two optional responses on the demographic questionnaire (see Appendix D): (a) male or (b) female.

Occupational Status

The participant's occupational status was obtained from their endorsement of one of two optional responses on the demographic questionnaire (see Appendix D): (a) "full-time" or (b) "relief."

Ethical Considerations

A number of ethical issues were considered throughout the design of this study. These issues included informed consent, voluntary participation, confidentiality, and anonymity. A variety of methods were used to obtain a high standard of ethics for this study. These methods were both informal, such as obtaining verbal approval from individuals skilled in the area of research, and formal. Formal approval was obtained from the internal ethics committee in the Department of Educational Psychology, The University of Alberta, prior to data collection. In addition, informal ethics approval was

obtained from the Directors of both Agency I and Agency II before the surveys were distributed to their employees.

The issue of informed consent was given a high priority throughout this study, and consequently, it was addressed in a number of ways. Every effort was made to obtain the informed consent of both the agency and the child care counsellor with regards to their participation in the study. A cover letter was attached to both the proposal handed to the Directors and to the survey package issued to the child care counsellor (see Appendix A). This letter informed the potential participants of the nature of the research and of their rights therein. Consent to participate was inferred for those child care counsellors who completed questionnaires.

The issue of voluntary participation was addressed in a number of ways. The most direct way of ensuring this right of the participant was to inform them by way of the cover letter that their participation was voluntary and that they were free to withdraw at any time without penalty (see Appendix A). The voluntary participation of the participants, though, was also addressed through maintaining the anonymity of their identities and the confidentiality of their participation throughout the study. By doing so, it was hoped that their participation would be free from coercion; it was anticipated that without their anonymity, participants may experience either direct coercion, such as perceived pressure from their employers, or indirect coercion, such as the experience of guilt for not completing the questionnaires.

The issues of confidentiality and anonymity presented an unusual challenge with regards to their incorporation into the present investigation. It was very important to ensure the anonymity and the confidentiality surrounding the participants, their work

setting, and their employers. All of the child care counsellors, the residential treatment facilities, and the agencies involved in the study had hard-earned, respectable reputations and identities within their community. Therefore, the results of the investigation were not directly linked to any of the residential treatment facilities involved in the study. The Directors of each agency were verbally informed of their agency's right to confidentiality and anonymity with regards to their participation in the study. The child care counsellors were informed of their right to confidentiality and anonymity through both verbal and written means.

Chapter Four: Results

Response Rates

Of the130 surveys that were distributed, 57 were completed and returned, for an overall response rate of 43.84%. This response rate is consistent with similar research which has found response rates from health care professionals between 34% (Nekolaichuk, 1995) to 60% (Woodside et al., 1994). All of the returned questionnaires were considered valid and were subsequently used for data analysis. Within Agency I, a total of 17 child care counsellors responded to the questionnaire. Within Agency II, a total of 40 child care counsellors responded to the questionnaires. A summary of the response rates for the total sample, based on general group categories, appears in Table 1. To protect the anonymity of the residential treatment settings involved in this study, respondents were not required to identify the setting within which they worked. Consequently, the response rate for each residential treatment facility cannot be calculated. No attrition occurred through the child care counsellors deciding to opt out of the study once they completed the questionnaire.

Respondents

The sample of 57 participants represented a diverse group of child care counsellors with varying levels of experience. The age of the participants ranged from 19 to 53 years, with a mean age of 34 years (SD = 9.11). This age distribution of the sample is comparable to that of the accessible child care counsellor population, and it is noted that both groups share the same mean age. This sample population is dissimilar to the accessible population (the employees of both Agency I and Agency II, combined), though, in that the men were slightly over-represented. The sample population was also

Table 1

Response Rates to the Total Sample (N=57) Based on General Group Categories

Sources	Frequency (Distrib)[a]	Frequency (Returns)[b]	Response Rate (%)	Sample Percent[c]
Agency I	30	17	56.67	29.82
Agency II	100	40	40.00	70.17
TOTAL	130	57	43.84	100.00

[a]The number of questionnaires distributed to the agency.

[b]Frequency of returns represents the number of valid questionnaires returned.

[c]The percent of the sample that the agency's child care counsellor participants compose.

dissimilar from the accessible population with regards to occupational status, in respondents of full-time status (n = 47) greatly outnumbered the respondents of part-time status (n = 9). For the accessible population, 82 child care counsellors were employed on a full-time basis and 105 child care counsellors were employed on a part-time basis. In addition, with respect to gender, the female to male ratio for the accessible population was roughly 2 to 1. For the sample of this study, both women and men were equally represented: 29 (50.87%) of the participants were men and 27 (47.36%) of the participants were women. One person (1.75%) did not identify themselves by gender.

Participants varied remarkably in terms of the length of time they had been working in the capacity of a child care counsellor with at-risk adolescents. The tenure of the respondents ranged from 1 month to 336 months (M = 102.13; SD = 82.09). Further to the tenure of the participants, it was noted that there were three modes: 10.52% of the respondents reported having a tenure of 36 months, 14.00% reported having a tenure of 60 months, and 17.54% reported having a tenure of 120 months. There was little variance, though, with regards to the amount of time participants typically spent working with a specific at-risk youth (Table 2).

Of note is that the majority of respondents (89.47%) who participated in this investigation worked in settings where the clients or residents tended to reside for 12 months or less. This distribution represents what would be expected of the 11 residential treatment facilities involved in this study and of their child care counsellor population. A majority of the participants (n = 47; 82.45%) expressed that they had attained a university or a college degree. With respect to employment, both secure and open residential treatment facilities for at-risk youths were equally represented by the participants of this

Table 2

Distribution of Respondents by Typical Duration of Client Residence

Average Client Residence Category	Frequency	Percent
Less than or equal to 1 month	17	29.82
Less than or equal to 3 months	12	21.05
Less than or equal to 6 months	11	19.29
Approximately 12 months	11	19.29
Approximately 24 to 60 months	1	1.75
Greater than 60 months	2	3.50
No response*	3	5.26
TOTAL	57	100.00

*Amount of time typically spent working with a particular at-risk youth not specified.

study. Of the 57 respondents, 27 (47.36%) were employed in a secure residential treatment facility, and 29 (50.87%) were employed in an open residential treatment facility. One respondent (1.80%) did not identify the residential treatment setting that they worked in.

Hope and Tenure as a Child Care Counsellor

With regards to the first research question, concerning the relationship between the child care counsellor's level of hope and the length of their tenure as a child care counsellor, hope was measured in two ways. The relationship between the child care counsellor's level of hope and the length of their tenure as a child care counsellor was analyzed with two bivariate correlational analysis: For one correlational analysis, the Miller Hope Scale was used, and for the other, the 3 Child Care Statements Scale was used. When using the Miller Hope Scale in the analysis, as a measure of a general hope level, the correlation between the participant's tenure (M = 102 months; SD = 82.09) and their level of hope (M = 199.14; SD = 23.81) was found to be insignificant (r = .09; ns). When using the 3 Child Care Hope Statements Scale in the analysis, as a measure of the child care counsellor's hope that is more specific to their work with youths than the Miller Hope Scale, the correlation between the participant's tenure and their level of hope (M = 13.42; SD = 2.40) was also insignificant (r=-.02; ns). The result of these correlational analyses indicate that the child care counsellor's level of hope is not related to the amount of time that they have been employed as a child care counsellor.

Hope and Typical Duration of Client Residency

For the same reasons as with the analysis of the first research question, the relationship between the child care counsellor's level of hope and the typical duration of

their clients' residency was analyzed with two bivariate correlational analyses: For the first correlational analysis, the Miller Hope Scale was used, and for second correlational analysis, the 3 Child Care Statements Scale was used. When using the Miller Hope Scale in the analysis, the correlation between the participant's hope level and the typical stay of residency for their clients was found to be insignificant ($r = .14$; ns). When using the 3 Child Care Hope Statements Scale, the correlations between the child care counsellor's level of hope and their clients' typical stay in residence was also insignificant ($r = .15$; ns). These results indicate that the hope of the child care counsellor is not related to the typical stay of residency of the at-risk adolescents at their place of employment.

Hope and Employment Setting

To investigate the third research question, whether there was a difference between the hope levels of child care counsellors who worked in secure residential treatment settings and those who worked in open residential treatment settings, two univariate analysis of variance (ANOVA) were performed. The child care counsellor's hope level, as measured by the MHS, was used in the first ANOVA. For the second ANOVA, the child care counsellor's hope level, as measured by the 3 Child Care Hope Statements Scale, was used. Using the MHS, the ANOVA revealed no statistically significant main effect for employment setting [$F(1, 54) = .05$; ns]. Participants employed in secure settings did not score significantly higher on Miller Hope Scale than participants employed in open settings (M secure settings = 200.00; $SD = 25.16$; M open settings = 198.55; $SD = 23.33$). Using the 3 Child Care Hope Statements Scale, the ANOVA also revealed no significant main effect for employment setting [$F(1, 54) = .61$; ns]. Participants employed in secure settings did not score significantly higher on the 3 Child Care Hope

Statements Scale than participants employed in open settings (M secure settings = 13.15; SD = 2.51; M open settings = 13.66; SD = 2.35). For both the MHS and the 3 Child Care Hope Statements, the average scores obtained by these two groups were approximately the same. This suggests that the child care counsellor's level of hope is not impacted by the residential treatment setting in which they are employed.

Hope and Occupational Status

It was not possible to investigate whether there were differences between the hope levels of child care counsellors employed on a full-time basis and those child care counsellors employed on a part-time basis. Only 9 child care counsellors in the sample identified themselves as being employed on a part-time basis. This was not a sufficient sample size to allow meaningful statistical investigation.

Hope and Gender

To investigate the fifth research question, whether there was a difference in the level of hope between male child care counsellors and female child care counsellors, two ANOVAs were performed. The child care counsellor's hope level, as measured by the MHS, was used in the first ANOVA. For the second ANOVA, the child care counsellor's hope level, as measured by the 3 Child Care Hope Statements Scale, was used. Using the MHS, the ANOVA revealed that there were no statistically significant difference between the average MHS scores of the male participants and the average MHS scores of the female participants [$F(1, 54) = 1.10$; ns]. The average score on the MHS for the male participants (M males = 196.00; SD = 26.80) was roughly equal to that of the average score on the MHS for the female participants (M females = 202.74; SD = 20.54). Using the 3 Child Care Hope Statements Scale, the ANOVA also revealed no

significant main effect for gender [F(1, 54) = .58; ns]. The average score on the 3 Child Care Hope Statements Scale for the male participants (M males = 13.17; SD = 2.28) was roughly equal to that of the average score on the 3 Child Care Hope Statements Scale for the female participants (M females = 13.67; SD = 2.57). This suggests that both male and female child care counsellors possessed relatively the same level of hope.

Chapter Five: Discussion

Discussion of the Findings

This study represents an initial investigation of the hope of the child care counsellor across the variables of age, gender, tenure, employment status, and typical residency of their at-risk clients in their employment setting. A number of things can be gleaned from the findings of this investigation. Most notably, from these findings, it can be said that child care counsellors are a relatively hopeful lot. The child care counsellors of this investigation attained significantly higher scores on the Miller Hope Scale than those attained in previous studies by university students (Miller & Powers, 1988) and a variety of health care professionals (Woodside et al., 1994) such as nurses, social workers, psychiatrists, occupational therapists, vocational rehabilitation counsellors, and psychologists.

These findings, though, must be interpreted with caution in that one of the limitations of this investigation is that approximately 56% of the sample did not respond to the survey, and therefore, did not complete the MHS. Consequently, it is possible that hopeful child care counsellors were more inclined to complete the MHS than less hopeful child care counsellors, thereby biasing the findings. More comparison studies are needed that measure the hope of the child care counsellor population using instruments such as the MHS as a measure of hope before it can be said with certainty that child care counsellors are reliably more hopeful than other health care professional populations. Further, it would be beneficial if such studies used larger samples and randomly selected participants. This would increase the certainty of their findings and reduce the level of bias that may be a factor in the findings of this study.

Regardless, these findings do indicate that child care counsellors possess higher levels of hope than do other professionals working in different areas of the health care field, and this begs several questions. Are people who choose to work with at-risk youths in the capacity of child care counsellor generally more hopeful individuals than other areas of the helping profession? Again, research is lacking that can answer this question through the comparison of a variety of populations' measures of hope on the MHS. If child care counsellors are such a hopeful lot, what factors are making them so? What factors influence the hope of the child care counsellor? Further, if child care counsellors are a characteristically hopeful population, why are their turn-over rates so high?

With the research questions put forth at the outset of this study, the attempt to answer the latter questions has begun. In the current study, an effort was made to discern if there were differences in the hope levels of child care counsellors between the variables of gender, age, tenure, and typical duration of client residency. With the findings at hand, there is indication that the hope levels of the child care counsellors remains constant across these variables. This suggests that it is not just the demographic and workplace variables that were focused on in this investigation that influence the hope of the child care counsellors. It also suggests that there may be mediating or moderating variables at play that influence the relationship between the workplace and the demographic variables measured and the hope of the child care counsellors.

Though intriguing, this finding does not make the child care counsellor population unique. With regards to gender, the little research to date that has addressed possible gender differences in hope has produced findings that are similar to those of this investigation. As with this present study, Snyder et al.(1998a) reported "no differences

between male and female adults as measured by dispositional and state indices of hope" (p. 425). He further stated that no gender differences have appeared with the Children's Hope Scale, with the results reflecting the scale responses of more than 10,000 adults and 1000 children (1998a). In addition, Woodside et al. (1994) have also found that there were no significant differences in the respondents overall scores on the MHS with regards to males versus females.

With regards to the other variables analyzed in this study, these findings indicate that the child care counsellors retained a high level of hope regardless of their age, their tenure, or their client's typical stay within their employment setting. Other studies of the hope levels of child care counsellors are not available to discern whether or not these current findings are typical. Of the few existing hope studies using populations of other health care professionals, Woodside et al. (1994) found that the hope levels of their sample of health care professionals also remained constant between gender. Further, like this study, they found no statistically significant relationship between the hope levels of their participants and the ages of the participants.

With this study, many directions for hope research concerned with child care counsellors have become clear. Dufault and Martocchio (1985) contend that hope can be considered as being composed of two spheres: generalized hope and particularized hope. The findings of this study support their contention: A discrepancy was found between the child care counsellors' generalized hope (as measured by the Miller Hope Scale) and their particularized hope (as measured by the 3 Child Care Hope Statements). This gives weight to another contention by Dufault and Martocchio (1985): "understanding the spheres and dimensions of hope....needs to be considered in assessing and maximizing

hope." Future hope research might be concerned with understanding the spheres and dimensions of the hope of the child care counsellor.

Once again, it would be beneficial if more hope research was concerned with child care counsellors before the present findings can be validated. More specifically, further research is necessary using a wider variety of child care counsellors that are employed in residential treatment settings at various stages of establishment. In the present study, both Agencies that composed the accessible population were very established, and by this it is meant that the child care counsellors were very highly trained and experienced, and usually of long tenure at their current employer. Consequently, group homes used for this study's sample may not be representative or generalizable in that many group homes are characterized by a high staff turnover and much more disorder. Future hope research could focus on comparing the hope of child care counsellors from a variety of settings with varying degrees of organization and stability, or in other words, from a wider variety of accessible populations.

Along these lines, our understanding of the hope of the child care counsellor might be deepened if there were a comparison of the hope of healthy child care counsellors with the hope of child care counsellors who are on leave of absence for disability and illness, such as burnout and vicarious traumatization. This investigation of the hope of the child care counsellor represents, essentially, a baseline reading of their hope levels when they are healthy enough for employment. More investigations need to be undertaken to establish an overall hope profile of child care counsellors. Further, it might also be worthwhile to develop a working definition of hope for child care counsellors. Qualitative studies would suit this purpose. In all, the advancement of the

conceptualization of the hope of the child care counsellor will further our progress towards incorporating hope into the residential treatment setting context for the improvement of their health and the health of the distressed youths with whom they work.

Several other directions for future hope research with child care counsellors became apparent during the course of the present investigation. First of all, hope research is needed involving child care counsellors that uses a variety of instruments to measure hope. The assessment of the child care counsellors' hope will not only verify existing findings, it will also add to the conceptualization of a structure of the hope of the child care counsellors that can be compared to the structure of existing theoretical frameworks of hope. Second, it may be beneficial to investigate the structure of the child care counsellors' hope based on personal experience and meaning, and to compare this structure with those of existing theoretical frameworks.

Limitations

The investigator recognizes several limitations that require viewing the findings with some caution. A major limitation of this investigation concerns its small sample size. The small size of the sample population used in this study precluded the possibility of testing the fourth research question, "Among child care counsellors, is there a difference in the levels of hope between those who are employed on a part-time or relief basis and those who are employed on a full-time basis?" In addition, the small sample size of this study reduced the power of the statistics used and increased the likelihood of bias undermining the findings. In consideration of this limitation, the response rate of the

accessible population could possibly have been increased if written consent was requested of the participants that would allow for potential follow-up.

The use of a convenience sample was another limitation of this investigation. Since a convenience sample was used, these findings can only be generalized to persons who participated in the study. Consequently, the findings of this study cannot be considered representative of the population of child care counsellors. In consideration of this limitation, a random sampling procedure would have increased the representativeness of the findings of this investigation.

Another limitation of this investigation lies in the fact that characteristics of the population that did not respond to the survey, and who did not fill out the questionnaires, remains unknown. This limitation could have been possibly bypassed if the accessible population used for this investigation was directed to complete the demographic questionnaire of the survey package even if they had decided not to complete the attached measures of hope.

Delimitations

The findings of this study are also subject to several delimitations. First, the findings were fixed in that three sources of data were collected: (a) demographic data; (b) hope data as gathered by way of the Miller Hope Scale; and (c) hope data as gathered by way of the 3 Child Care Hope Statements Scale. Second, no information was acquired regarding the sample portion that did not complete the questionnaires. Third, only child care counsellors of level-I or level-II status were invited to participate in this investigation. Further, those child care counsellors who were invited to participate in this study were all employed in one or more of 11 residential treatment facilities that are

operated by two large, established Ma'Mowe Capitol Region Child and Family Services Agencies in Edmonton, Alberta. Child care counsellors who did not meet this criteria were not involved in this investigation, such as child care counsellors employed at other agencies or who were of level-III status. A fourth delimitation of this investigation is that the survey packages were delivered by a representative of the investigator instead of other means of delivery, such as in person by the investigator. Finally, the findings of this study were fixed in that a convenience sampling procedure was used to acquire participants for this study from the accessible population instead of a random sampling procedure.

Summary

This study represents a very basic and exploratory investigation of the hope of the child care counsellor across the variables of age, gender, tenure, occupational status, and the typical duration of the residency of the at-risk youths housed in their employment settings. Overall, the findings indicate that the hope levels of the child care counsellors remain constant across these variables. This is with the exception of the variable of occupational status, which could not be examined because the small sample size of this study. These findings suggest that (a) mediating and moderating variables are at play in the relationship between their hope and these variables, or that (b) other factors may influence the hope of the child care counsellor. Interestingly, these findings also indicate that child care counsellors have higher levels of hope than other populations, including students, nurses, occupational therapists, and psychologists. In that a growing body of research has established that hope is inextricably linked to health, and that the hope of the helper can positively influence the hope of those around them, be they client or colleague,

more research is needed investigating what factors influence the hope of the child care counsellor.

This study has sparked new thought and opened new doorways into the exploration of the hope of the child care counsellor. As a result of the present findings, a better understanding has been attained of the relationship between the hope of the child care counsellor and several demographic and workplace factors that may influence their hope. While we are still far away from testing an intervention model of hope, blending these findings with our existing clinical knowledge sets the stage for research that can investigate how to promote hopefulness in child care counsellors within the context of the residential treatment facility. In that the counselling psychologist and the child care counsellor are seamlessly joined in the purpose of treating distressed youths, any advancement of our knowledge of the hope of the child care counsellor is a benefit to the effectiveness of the psychologist's practice.

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APPENDIX A

Cover Letter

An Invitation for Child Care Counsellors to Participate in Hope Research

PRINCIPAL RESEARCHER: Christopher Armstrong
Department of Educational Psychology
University of Alberta
Supervisor: Dr. Ronna Jevne

WHO IS CHRIS ARMSTRONG ?

I'm both a "professional student" and a long-time child care counsellor. I have worked as a child care counsellor (level-I) for approximately seven years in various agencies and residential treatment facilities throughout Edmonton. Currently, I am a graduate student at the University of Alberta, working on my Masters degree in Counselling Psychology. What am I interested in? My interest is in finding new ways to help you to do what you love to do, while maintaining your good mental health: Have a positive impact on a troubled kid's life.

THE RESEARCH QUESTION

For my Masters thesis project, I am investigating ***the levels of hope of child care counsellors working with at-risk children and adolescents in residential treatment settings***. The therapeutic value of hope has been well documented. Hope is widely considered to be a necessary ingredient for our adaptation or adjustment to trauma, crisis, and turmoil. It has been found to be a factor in the effective psychotherapy of children coping with cancer, of clinical patients suffering schizophrenia, and of the family adjusting to crisis. Other researchers have shown that hope has a positive impact on the mental wellness of helpers, and that it can offset burnout and vicarious traumatization. The best part...hope is contagious. We can affect each other's hope with very little effort. Despite the widespread recognition of hope as being essential for counselling and necessary for healing, nobody has studied hope and the child care counsellor on the front lines in residential treatment settings.

YOU CAN MAKE A DIFFERENCE

I'm writing to request your participation in this study of hope. By participating in this research project you contribute to an exceptionally important area of investigation. With the findings of this research, work can get underway towards understanding hope in relation to child care counsellors and at-risk youths.

IF YOU'RE REALLY INTERESTED

Enclosed with this letter are three questionnaires that will measure your levels of hope: one asks for background information and the other two assess one's level of hope (the Miller Hope Scale. It should take you approximately 30 minutes to complete all three.

WILL ANYONE KNOW ABOUT WHAT I SAY?

In efforts to assist in the development of the Miller Hope Scale, and establish normative data, I am sending the ***anonymous*** participant scores on the measure and general demographic information (age, gender, education) to Dr. J. F. Miller, developer of the scale.

Your participation in this study is on a ***voluntary*** and ***confidential*** basis. Your name nor identity will not be given out to anyone. I will only give overall group findings to agencies, institutions or the individuals involved in the study. No information that is specific to you as an individual or data that will identify a single institution/agency will be included in the data or research findings. Anonymous excerpts from this research may be used during verbal presentations and/or written reports about the study and may be published.

WHAT IF I CHANGE MY MIND?

You may participate or withdraw at any time, by verbally saying so or in writing, without penalty.

WHAT HAPPENS TO THE QUESTIONNAIRES?

These documents, which will not have your name on them, will be kept in a locked office. The information gathered may be used for future research studies and/or for the education of other professionals and students at professional conferences and/or workshops. This study will be kept at the HOPE Foundation of Alberta, Edmonton, Canada.

CAN I SEE THE FINAL PRODUCT?

Absolutely! At your request, I'll send you a summary of the results, and a final copy of the study upon completion.

YOUR PARTICIPATION IN THE STUDY WOULD BE GREATLY APPRECIATED

Please feel free to ask questions about the project. Should you decide to consent to participate in this study, please complete all three enclosed questionnaires and return them in the envelope provided. This form may be kept for your own records.

If you have any questions, please do not hesitate to contact me: **780-XXX-XXXX (home); 780-XXX-XXXX (University of Alberta); or, at X@X.com.**

Sincerely,

Christopher W. Armstrong, B.A.
University of Alberta

Thank you for your participation.

APPENDIX B

The Miller Hope Scale

MILLER HOPE SCALE©

Circle one number for each statement which best describes how much you agree with that statement right now. The numbers refer to:

Very Strongly Disagree	Strongly Disagree	Disagree	Agree	Strongly Agree	Very Strongly Agree
1	2	3	4	5	6

There are no right or wrong answers.

1.	When I ask for help I usually receive it.	1	2	3	4	5	6
2.	I am positive about most aspects of my life.	1	2	3	4	5	6
3.	I look forward to an enjoyable future.	1	2	3	4	5	6
4.	I am flexible in facing life's challenges.	1	2	3	4	5	6
5.	There are things I want to do in life.	1	2	3	4	5	6
6.	I am able to set goals I want to achieve.	1	2	3	4	5	6
7.	My life has meaning.	1	2	3	4	5	6
8.	I make plans for my own future.						
9.	I am able to imagine a positive outcome to most challenges.	1	2	3	4	5	6
*10.	Time seems to be closing in on me.	1	2	3	4	5	6
11.	I have energy to do what is important to me.	1	2	3	4	5	6

*12.	I find myself becoming uninvolved with most things in life.	1	2	3	4	5	6
13.	I intend to make the most of life.	1	2	3	4	5	6
14.	I am positive about the future.	1	2	3	4	5	6
*15.	I am not interested in life.	1	2	3	4	5	6
16.	I have ability to handle problems.	1	2	3	4	5	6
*17.	I feel trapped, pinned down.	1	2	3	4	5	6
18.	My personal beliefs help me feel hopeful.	1	2	3	4	5	6
19.	I value my freedom.	1	2	3	4	5	6
20.	I spend time planning for the future.	1	2	3	4	5	6
21.	I am able to accomplish my goals in life.	1	2	3	4	5	6
22.	I am valued for what I am.	1	2	3	4	5	6
23.	I have someone who shares my concerns.	1	2	3	4	5	6
*24.	I am hopeless about some parts of my life.	1	2	3	4	5	6
25.	I look forward to doing things I enjoy.	1	2	3	4	5	6
*26.	It is hard for me to keep up my interest in activities I used to enjoy.	1	2	3	4	5	6
*27.	It seems as though all my support has been withdrawn.	1	2	3	4	5	6
28.	I am satisfied with my life.	1	2	3	4	5	6
29.	I am needed by others.	1	2	3	4	5	6
*30.	I do not have any inner strengths.	1	2	3	4	5	6
31.	I know I can get through difficulties.	1	2	3	4	5	6
*32.	I will not have good luck in life.	1	2	3	4	5	6

*33. I am so overwhelmed, nothing I do will help.	1	2	3	4	5	6
34. I try hard to do things that are important to me.	1	2	3	4	5	6
35. I feel loved.	1	2	3	4	5	6
36. I try to find meaning in life events.	1	2	3	4	5	6
*37. I am bothered by troubles that prevent my planning for the future.	1	2	3	4	5	6
*38. I feel uninvolved with life.	1	2	3	4	5	6
39. I trust that things will work out.	1	2	3	4	5	6
40. I can find reasons to keep positive about my health.	1	2	3	4	5	6
+41. Despite any physical changes due to illness, I'll still be the same me.	1	2	3	4	5	6
+*42. There is nothing I can do to help myself.	1	2	3	4	5	6
+*43. I no longer care about the things I used to care about.	1	2	3	4	5	6

JFM:bja 4/91
revised 5/92

Note. The layout of the Miller Hope Scale for this Appendix has been reduced in size for fit. * = items reverse scored; + = illness subscale items (not part of Hope Scale) not included in the survey package used for this study.

APPENDIX C

The 3 Child Care Hope Statements Scale

3 CHILDCARE HOPE STATEMENTS

Circle one number for each statement which best describes how much you agree with that statement right now. The numbers refer to:

Very Strongly Disagree	Strongly Disagree	Disagree	Agree	Strongly Agree	Very Strongly Agree
1	2	3	4	5	6

There are no right or wrong answers.

1.	I believe that at-risk youths can eventually attain a satisfying quality of life.	1	2	3	4	5	6
2.	I believe that the prognosis for at-risk children is good.	1	2	3	4	5	6
3.	I believe that I can make a positive difference in the lives of at-risk children and adolescents with whom I work.	1	2	3	4	5	6

APPENDIX D

The Demographic Questionnaire

Demographic Questionnaire

1. **Age:** _____.
2. **Gender**

   Male
   Female

3. **Current occupational status:**

   Full-time
   Relief

4. **Current residential setting (if full-time) or residential setting most frequently worked in (if relief):**

   Secure
   Open

5. **Considering your employment history, what is the duration of your employment as a child care counsellor within the field of Child Care and residential treatment:**_____ (e.g., estimated total time worked as a child care counsellor in all is 1 month, 1 year, 5 years, 10+ years).

6. **Amount of time typically spent working with a specific client:**

   less than or equal to 1 month
   less than or equal to 3 months
   less than or equal to 6 months
   usually about 1 year
   usually 2 to 5 years
   greater than 5 years

7. **Education:**

   High School Graduate
   Some University or College
   University or College Graduate
   Some Graduate Coursework
   Graduate Degree