Examining Hope and Resilience among Mississippi Adolescents

Kristie Vail Schultz
University of Mississippi

Follow this and additional works at: https://egrove.olemiss.edu/etd

Part of the Clinical Psychology Commons

Recommended Citation
Schultz, Kristie Vail, "Examining Hope and Resilience among Mississippi Adolescents" (2016). Electronic Theses and Dissertations. 1518.
https://egrove.olemiss.edu/etd/1518

This Dissertation is brought to you for free and open access by the Graduate School at eGrove. It has been accepted for inclusion in Electronic Theses and Dissertations by an authorized administrator of eGrove. For more information, please contact egrove@olemiss.edu.
EXAMINING HOPE AND RESILIENCE AMONG MISSISSIPPI ADOLESCENTS

A Dissertation
presented in partial fulfillment of requirements
for the degree of Doctor of Philosophy
in the Department of Clinical Psychology
The University of Mississippi

by

KRISTIE VAIL SCHULTZ

December 2016
ABSTRACT

Hope theory involves the way in which individuals perceive their abilities in relation to three factors: 1) clearly defined goals, 2) the specific strategies necessary to obtain those goals (called “pathways”), and 3) the sustained motivation necessary to use those specific strategies (called “agency thinking”) (Snyder et al., 1991; Snyder, Lopez, Shorey, Rand, & Feldman, 2003). Hopeful thinking is defined as a belief that an individual can find the pathways to reach a desired goal and the belief that one can use those designated pathways effectively (Snyder, 2002; Rand & Cheavens, 2009). Research shows that hope in adolescents is positively related to areas of psychological adjustment, such as global life satisfaction (Valle, Huebner, & Suldo, 2004) and higher levels of academic achievement (Rand & Cheavens, 2009).

Mississippi adolescents are faced with unique challenges, such as problems with educational achievement (Ladner & Myslinski, 2013) and teen pregnancy (National Campaign to Prevent Teen and Unplanned Pregnancy, 2013). This study examined hope and resilience, a related construct, among adolescents in Mississippi within the following three counties: Coahoma, DeSoto, and Lafayette. When exploring hope in North Mississippi, it was found that males demonstrated higher levels of hope, resilience, and self-esteem than did females in this sample; in regards to ethnicity differences, African-Americans reported higher levels of hope than did Caucasians. No differences were found between counties in regards to hope or resilience in this sample. Implications and directions for future research are discussed.
DEDICATION

My dissertation is dedicated to my mother, Mary Berken Vail. While she is not here to see me complete my dissertation, I know that she is proud. She instilled in me the belief that I could achieve anything I put my mind to and always believed in me. She taught me about hope—and faith, courage, and determination—and for that, I will be forever grateful.
LIST OF ABBREVIATIONS AND SYMBOLS

Δ  Increment of change
∝  Cronbach’s alpha
B  Regression coefficient
F  $F$ distribution
M  Mean
n  Number of cases in subsample
N  Total number of cases
p  Probability
r  Estimate of the Pearson product-moment correlation coefficient
$R^2$  Multiple correlation squared
SD  Standard deviation
t  Student’s $t$ distribution
ANOVA Analysis of Variance
CHS  Children’s Hope Scale
AAAHS-R African-American Adolescent Hope Scale-Revised
BRS  Brief Resilience Scale
RSES  Rosenberg Self-Esteem Scale
ACKNOWLEDGEMENTS

First, I would like to thank Dr. Karen Christoff for believing in me and seeing potential in me when I interviewed for the Clinical Psychology Doctoral Program years ago. I truly appreciate her guidance and support throughout my years in graduate school, and specifically throughout the dissertation process. I would like to thank my committee members for their guidance and support as well. To Dr. Debra Moore, thank you for your research in hope and for constantly encouraging me as I worked on my own dissertation about hope. To Dr. Michael Allen, thank you for your guidance regarding statistics and for always being willing to answer my numerous questions. To Dr. Scott Gustafson, thank you for your support and for your guidance throughout my time in graduate school.

I would like to thank the faculty, staff, and fellow graduate students in the Clinical Psychology Department at The University of Mississippi. Thank you for your encouragement throughout my time in graduate school. I would like to especially thank the Christoff Lab Family—thank you for the encouragement and support and for truly being my grad school family.

Thank you to those in The University of Mississippi family who helped me complete my dissertation, whether through assistance with recommendations of where to collect data, assistance with data collection, or reviewing my documents and presentations; your assistance is greatly appreciated. I would also like to thank the churches and organizations that allowed me into their communities to collect data; I truly appreciate you welcoming me and assisting me with this endeavor.
A big thank you to my family, without whom I could not have achieved my goal. To my parents, for selflessly sacrificing for my education and always encouraging me to chase my dreams, regardless of where that took me. To my siblings and extended family, for always believing that I can accomplish anything I put my mind to. Finally, a heartfelt thank you to my husband, Matthew Patrick Schultz. I cannot thank you enough for your love and support throughout this journey. Thank you for being willing to move to new states and embrace new adventures along this journey with me. This accomplishment is as much yours as it is mine. Thank you for always believing in me and standing by me. I appreciate you and love you more than you know.
TABLE OF CONTENTS

ABSTRACT ...........................................................................................................ii
DEDICATION ...........................................................................................................iii
LIST OF ABBREVIATIONS AND SYMBOLS............................................................iv
ACKNOWLEDGMENTS............................................................................................v
LIST OF TABLES (INCLUDED IN APPENDIX A) .........................................................viii
CHAPTER 1: INTRODUCTION..................................................................................1
CHAPTER 2: METHODS..........................................................................................16
CHAPTER 3: RESULTS............................................................................................22
CHAPTER 4: DISCUSSION......................................................................................28
REFERENCES ........................................................................................................34
APPENDICES ..........................................................................................................46
VITA .......................................................................................................................74
LIST OF TABLES (INCLUDED IN APPENDIX A)

1. Participant Demographics for Total Sample .................................................................48
2. Participant Demographics for Coahoma County ..........................................................49
3. Participant Demographics for DeSoto County ..............................................................50
4. Participant Demographics for Lafayette County ..........................................................51
5. Statistics for Children’s Hope Scale (CHS) .................................................................52
7. Statistics for Brief Resilience Scale (BRS) .................................................................54
8. Statistics for Rosenberg Self-Esteem Scale (RSES) ..................................................55
9. Summary of Correlations for Total Sample .................................................................56
10. Regression Table for Total Sample ...........................................................................57
11. Summary of Correlations for Coahoma County .........................................................58
12. Summary of Correlations for DeSoto County .............................................................59
13. Summary of Correlations for Lafayette County .........................................................60
Defining Hope

Merriam Webster Dictionary (www.Merriam-Webster.com) defines hope as both a verb which means “to want something to happen or be true and think that it could happen or be true” and a noun which means “the feeling of wanting something to happen and thinking that it could happen.” Yet, hope means something different when defined in a psychological setting. Snyder and his colleagues (Snyder et al., 1991) have been credited with originating hope theory. Hope theory involves how individuals perceive their abilities with respect to three factors: 1) clearly defined goals, 2) the specific strategies necessary to obtain those goals, and 3) the sustained motivation necessary to use the specific strategies. The strategies used are known as pathways, and the necessary motivation is known as agency thinking, both of which are necessary for hope to exist (Snyder et al., 1991; Snyder et al., 2003). While the two concepts of pathways and agency thinking are positively related and build upon each other, they are not interchangeable (Snyder et al., 1991; Lopez, Rose, Robinson, Marques, & Pais-Ribeiro, 2009).

Hope can present in various ways. For instance, hope can be seen as a stable trait or a temporary state. It can also vary in terms of targeted goals, which allow for individual differences (i.e., goals can be defined by the individual, and they may vary greatly across individuals). A goal could be comprised of an expansive and life-long process or a short-term,
ordinary task (Snyder et al., 1991; Snyder et al., 2003). Goals can be verbal self-statements or mental images (Rand & Cheavens, 2009). Furthermore, according to Snyder (2002), goals can be one of two types; they can be approach goals, such as working towards a task, or avoidance goals, such as trying to elude an illness.

To be more specific, goals can be found at different levels including general goals, domain-specific goals (or goals focused on a certain area of life), and goal-specific goals (or goals focused on one specific goal) (Snyder et al., 2003; Lopez, Ciarlelli, Coffman, Stone, & Wyatt, 2000). Yet, regardless of the level of the goal, a goal should be important enough to occupy the conscious thought of the individual (Snyder, 2000). Goals should also be attainable as people must be able to engage in pathway thinking, or be able to imagine one or more pathways to reach the goal (Snyder, 1994). Granted, stressors will occur and potentially challenge hope along the way (Snyder, 2002; Edwards, Ong, & Lopez, 2007).

While an individual might believe he or she can achieve a goal, according to hope theory, an individual with high hope would also believe that he or she has a plan to attain the goal and is both motivated and confident in his or her own ability to use the plan to reach the goal (Gallagher & Lopez, 2009). Thus, in hope theory, high emphasis is placed on personal agency, and agency thinking is the motivational aspect of hope theory (Rand & Cheavens, 2009). Moreover, agency is related to initiating and sustaining movement, and thoughts related to agency contain affirming self-statements (Snyder, Lapointe, Crowson, & Early, 1998). Agency also enables individuals to use necessary motivation to move along an alternate pathway if one pathway becomes blocked (Snyder, 1994).

In short, hopeful thinking is defined as the belief that an individual can find the pathways to reach a desired goal coupled with the belief that one can use those designated pathways.
Hope is very much related to the individual and can be enduring, or change over time through sustained effort, such as with counseling (Snyder, 2000). It can also be related to an individual’s emotions, as a goal pursuit that ends successfully lends itself to positive emotions, whereas a goal pursuit that ends in failure results in negative emotions (Valle, Huebner, & Suldo, 2006).

**Hope as a Measurable Construct**

Along with hope theory (Snyder et al., 1991), Snyder developed three scales to measure hope: the Trait Hope Scale (Snyder et al., 1991), the State Hope Scale (Snyder et al., 1996), and the Children’s Hope Scale (CHS; Snyder et al., 1997). Thus, Snyder developed a psychological view of hope that is measurable in different contexts and across many ages.

Hope in adults, as well as older adolescents, is measured with the Hope Scale, also known as the Trait Hope Scale (Snyder et al., 1991). This scale consists of 12 items: four measuring agency, four measuring pathways, and four non-scored distractors. The individual rates the degree to which each question describes them (from definitely false to definitely true, along an 8-point scale), with a total score ranging from 8 to 64, with higher scores indicating higher hope. The creators found that this scale is reliable, has good internal consistency, and has test-retest reliabilities ranging from .85 at three weeks to .82 at ten weeks (Snyder et al., 1991). This scale has been translated into other languages, including Slovak (Halama, 1999) and Dutch (Brouwer, Meijer, Weekers, & Baneke, 2008). In addition, one study (Venning, Eliott, Kettler, & Wilson, 2009) used the Adult Hope Scale to establish normative scores in Australia for adolescents aged 13 to 17. Furthermore, Bailey and Snyder (2007) found that the scores on the Trait Hope Scale differed across age groups and marital status. They found that hope was lower
for individuals aged 54 to 65, compared to other age groups, and also for those who were separated, divorced, or widowed.

The State Hope Scale (Snyder et al., 1996) was created to examine how hope changes over time as an individual pursues different goals. This measure is designed to be used with individuals 16 years old and older, and it consists of only six statements; three statements assess pathways thinking, and three assess agency thinking. The individuals indicate to what degree this statement applies to him or her currently; the responses range from definitely false to definitely true, along an 8-point scale. Scores range from 6 to 48, which higher scores indicating higher levels of hopeful thinking. The authors reported acceptable internal consistency (with alphas ranging from .79 to .95); they also reported varying test-retest correlations ranging from .48 to .93, as would be expected for a measure indicating change (Snyder et al., 1996).

The last of the three hope scales developed by Snyder and his colleagues is the Children’s Hope Scale. The Children’s Hope Scale (CHS; Snyder et al., 1997) is a paper and pencil scale designed to measure hope in children ages 8 to 16. The measure consists of six questions, with three items related to agency and three items measuring pathways. The questions are all answered using a six-point Likert-type scale, with scores ranging from 1 (none of the time) to 6 (all of the time). Total hope scores range from a low of 6 to a high of 36, with an average reported of 25. Agency and Pathways subscales can be determined as well, which each range from 3 to 18; however the scale is intended to measure hope as a whole. This measure has been assessed for its reliability; it demonstrates internal reliability (as shown by Cronbach’s alpha) from .72 to .86 (Snyder et al., 1997). In addition, Valle, Huebner, and Suldo (2004) also showed support for the correlated two-factor model through confirmatory factor analysis procedures. They also found that hope is positively correlated with life satisfaction ($r = 0.49$) and perceived
social support \((r=0.59)\), and it is negatively correlated with externalizing behaviors \((r=-0.33)\) and internalizing behaviors \((r=-0.32)\).

Typically, children who score in the top third of the Children’s Hope Scale distribution and adults who score in the top third of the Hope Scale distribution are known as “high-hope.” Similarly, those who score in the bottom third of the distribution are considered “low-hope” (Lopez et al., 2009).

**Hope, as Related to Other Constructs**

Research has examined hope in relation to other constructs and areas within psychology. In fact, hope is positively correlated with many measures of psychological adjustment. For instance, higher levels of hope are correlated with higher levels of self-esteem, as well as optimism (Snyder et al., 1991) and well-being (Gallagher & Lopez, 2009). Hope is also positively correlated with global life satisfaction in adolescents (Valle et al., 2004).

Agency in hope is related to self-efficacy, as defined by Bandura (1982, 1997). Self-efficacy involves an individual’s evaluation that he or she can both define and use a goal-directed course of action, while agency details the goal-directed behaviors that an individual will apply to achieve goals (Snyder, 2002). Thus, agency is more global than self-efficacy and it involves intent rather than ability (Rand & Cheavens, 2009).

Researchers have suggested that individuals with higher hope are better able to envision and utilize adaptive coping skills when faced with a significant life stressor (Horton & Wallander, 2001; Lewis & Kliwer, 1996), and hope has been shown to have a significant impact on both secondary appraisal and coping (Chang & DeSimone, 2001). Chang and DeSimone (2001) indicate that while primary appraisal is a set of thoughts regarding the personal impact of
a stressful situation, secondary appraisal is a set of thoughts related to having the necessary resources to deal with the situation.

Furthermore, Snyder, Sympson, and their colleagues (1996) found that higher hope was associated with more positive thoughts and fewer negative thoughts after they had college students use a thought record to record their thoughts for 28 days. Research has also shown that when using the Minnesota Multiphasic Personality Inventory (MMPI) to measure psychopathology, as a whole, individuals with higher hope tended to display less psychopathology (Snyder et al., 1991).

Low-hope individuals are more likely to have experienced trauma; for example, they are more likely to have experienced the loss of a parent through separation or death than are high-hope individuals (Westburg, 2001). Research has also found that Vietnam veterans with a diagnosis of Posttraumatic Stress Disorder (PTSD) reported very low hope levels (Irving, Tefler, & Balke, 1997).

Hope appears to exist in contrast to hopelessness, which could be defined as negative thoughts about one’s future (Beck, Kovacs, & Weissman, 1975). Hopelessness seems to be important to both the etiology and maintenance of depression (Beck, Brown, & Steer, 1989), and it has been shown to be linked to a variety of suicidal thoughts and behaviors, ranging from suicidal ideation (Holden, Mendonca, & Mazmanian, 1985) to completed suicides (Beck, Brown, Berchick, Stewart, & Steer, 1990). While hopelessness may initially seem to exist on the same continuum as hope, hopelessness is not a construct explained in great detail in the literature, and hopelessness, as typically regarded, fails to detail what having hope would mean (Glanz, Haas, & Sweeney, 1995). Furthermore, as O’Connor, Connery, and Cheyne (2000) write, hopelessness is a construct that is typically measured by only one scale: the Beck Hopelessness Scale (BHS;
Beck, Weissman, Lester, & Trexler, 1974). Thus, Snyder’s presentation of hope and Beck’s view of hopelessness are actually quite different, as they are unique constructs from independent researchers with different goals and rationales (Henry, 2004). In fact, Grewal and Porter (2007) even propose that hope theory may actually be a better predictor of suicidal ideation and behaviors than is hopelessness.

Hope can be useful in therapy settings, specifically with relapse prevention in cognitive behavioral therapies (Snyder et al., 2000). Once the goals of treatment are complete, a new goal, which specifically focuses on the prevention of relapse, can be added. Since hope theory focuses on attaining one’s goals, making relapse prevention a goal is beneficial to the outcome. Throughout treatment, the client will have likely learned skills, both in session and through homework tasks, that created multiple pathways for them to use their skills, and they will thus be motivated to use these previously effective pathways. Furthermore, when writing reports about the client, Snyder, Ritschel, Rand, and Berg (2006) believe that it is vital to include the client’s strengths, along with their weaknesses. As hope is a cognitive variable that can help lead the client to achieve his or her goal, they assert that it should be considered for inclusion in a comprehensive and well-rounded assessment.

Hope and Resilience

Resilience is another construct that appears to be similar to hope, and the current two-factor model of hope is consistent with definitions of resilience (Snyder et al., 1997). Resilience is defined as a level of adaptability that allows individuals to not only survive, but to thrive, in adverse situations and environments (Dent & Cameron, 2003). In fact, some individuals can become successful and productive adults despite being exposed to negative conditions (Elliott, Kaliski, Burrus, & Roberts, 2013). Thus, children and adolescents who cope successfully with
social and biological challenges would be called resilient (Werner 1982; Werner 1993). Resilience then focuses on overcoming specific challenges rather than on a daily way of thinking (which could be one way to define hope). For example, one study conceptualized hope as a potential resilience factor with their population of mothers of children with Type I Diabetes (Mednick et al., 2007). Thus, while resilience and hope are similar, resilience focuses on reaction to one’s environment while hope would be a more daily way of approaching the world and working towards one’s goals.

**Hope in Children and Adolescents**

According to Snyder (1994), the foundations of hope and goal-directed behavior (such as agency and pathway directed thinking) are established in the first two to three years of life. How one perceives and learns about hopeful thinking continues to grow throughout the preschool years (3 to 6), middle years (7 to 12), and adolescence (13 to 18), with hope emerging as stable as the child grows.

The predominant model of hope in children was defined by Snyder and colleagues (1997) and is based on the assumption that hope in children is similar to that in adults and that persons of all ages are goal-directed. However, it is likely that younger children are not aware of their thoughts of hope, as they likely do not have the language to express this construct (Snyder, 1994). In general, the literature supports the idea that the benefits seen from hope in children are similar to those benefits found in adults, such as higher self-esteem and greater confidence in problem solving (Snyder et al., 1997).

In children, hope scores are positively correlated with their self-perceptions of competence in school and in athletics, as well as their self-perceptions of social acceptance and physical appearance. For high-hope children, hope is related to their beliefs about their own
abilities, which include the ability to achieve goals (Snyder, Symson, Michael, & Cheavens, 2001). In regards to academics, higher levels of hope correspond with higher levels of academic achievement (Rand & Cheavens, 2009). In high school students specifically, higher levels of hope correspond to higher overall grade point averages (Snyder et al., 1991). In college students, high levels of hope during the first semester were related to higher graduation rates, higher grade point averages, and lower dropout rates; these findings were found after controlling for factors such as intelligence, self-esteem, entrance exam scores, and previous academic performance (Snyder et al., 2002; Snyder, Wiklund, & Cheavens, 1999).

Hope is negatively associated with symptoms of depression and anxiety (Snyder et al., 1997). Children with low hope can experience high levels of anxiety, especially test anxiety (Onwuegbuzie & Snyder, 2000; Snyder et al., 1996). Furthermore, middle school adolescents with higher scores on stress scales also displayed lower levels of hope and higher levels of loneliness (Yarcheski, Mahon, & Yarcheski, 2011). Children with low hope are more likely to experience self-doubt and negative ruminations of thought (Snyder, 1999). High-hope students, on the other hand, do not let failures affect their self-worth (Lopez et al., 2009).

Children who have witnessed individuals close to them (such as family members or friends) be victims of interpersonal violence display lower levels of hope than children who have not witnessed such violence (Hinton-Nelson, Roberts, & Snyder, 1996). Research also shows that hopefulness is linked to lower levels of violence among adolescents (Stoddard, McMorris, & Sieving, 2011).

Research shows no statistically significant difference between boys and girls in regards to hope, although it is unclear why such differences are absent (Cheavens, Michael, & Snyder, 2005; Lopez et al., 2009). However, differences do emerge in regards to hope in children and
young adults of different ethnicities (Lopez et al., 2009). Snyder (1995) proposed that ethnic minorities may have lower levels of hope due to their perceptions that goals are not obtainable. Caucasian children are more likely to report fewer obstacles in their paths toward goals than do ethnic minorities (Lopez et al., 2009), but some research shows that members of ethnic minority groups, such as African-Americans, report higher average hope scores than do Caucasians (McDermott et al., 1997). Perhaps having an early experience with goal-related obstacles may actually allow for opportunities to develop more hope (Chang & Banks, 2007).

While variations in hope do exist, the majority of American children describe themselves as having hopeful thinking (Lopez et al., 2009). In addition, hope can be increased. For example, interventions exist for at-risk students on college campuses (Rand & Cheavens, 2009), and studies have shown success when promoting hope in junior high students (Lopez et al., 2000). Lopez et al. (2000) found that nearly all of the individuals participating in a school hope program were able to raise their hope levels.

Individuals with high hope are more likely to have close connections to other people, and be interested not only in their own goals but the goals of others (Snyder, Cheavens, & Sympson, 1997). It follows that high levels of hope are related to more perceived social support (Barnum, Snyder, Rapoff, Mani, & Thompson, 1998) and less loneliness (Sympson, 1999). Furthermore, in many contexts, high hope proves to be a psychological strength for adolescents (Valle et al., 2006). This strength is crucial for adolescents, as adolescence is one of the most challenging periods in an individual’s developmental pathway (Masten, 1994).

Hope, especially in terms of pathways and agency thinking, can be learned more easily during childhood and adolescence than adulthood (Snyder, 2002; Edwards et al., 2007). It is believed that hope and hopeful thinking begins in early childhood, based on a child’s secure
relationship with a caregiver (Shorey, Snyder, Yang, & Lewin, 2003) and also on his or her interactions with his or her parent or caregiver, peers, and teachers (Snyder, Cheavens, & Symson, 1997). For young adolescents, supportive adults and nurturing environments are linked to hopefulness, which suggests that the family and school environments play a crucial role in the development of hope (McGee, 1984; Stoddard et al., 2011).

**Youth in Mississippi**

When looking at the youth who reside in Mississippi, it might seem that they do not have much about which to be hopeful. The comparative state statistics consistently rank Mississippi at the bottom of the list in many important social and economic markers. In 2010, Mississippi was ranked #51 in regards to per capita personal income (National Educational Association, 2012), which placed it below every other state and the DC-area. Recent data shows a 6.9% unemployment rate, which is among the highest unemployment rates in the nation (U.S. Bureau of Labor Statistics, 2010). In 2006, statistics showed that the state has the highest infant mortality rate (U.S. National Center for Health Statistics, 2009), and in 2008, statistics showed that the state has a higher teen pregnancy rate among girls aged 15 to 19 than 48 other states (National Campaign to Prevent Teen and Unplanned Pregnancy, 2013). Furthermore, in regards to education, the state was ranked #48 in 2012 based on the National Association of Educational Procurement standards (Ladner & Myslinski, 2013). While data shows that 80.4% of residents in Mississippi were at least high school level graduates in 2009, which is a drastic increase from 1990 data, that percentage still places Mississippi at #50 when compared to all other states plus the D.C. area (U.S. Census Bureau, 2012b). Time and time again, Mississippi proves to be at the bottom of many lists. However, it seems likely that there may still be variability among Mississippi adolescents, as Mississippi differs even between counties.
When looking at North Mississippi, three counties demonstrate the differences that emerge in the state. The first area is Coahoma County, Mississippi; the county seat is Clarksdale. Coahoma County is located in the Mississippi Delta, an area known to be a financially poor, rural area. In this county, the median household income for the county in 2011 was $27,349, which was below the median income for Mississippi ($36,963) and for the United States ($50,502). In fact, 51.7% of individuals under the age of 18 in Coahoma County are considered to be in poverty (U.S. Census Bureau, 2012a). The second area is Lafayette County, Mississippi; Lafayette County includes Oxford, which is a college town (home to the University of Mississippi) in a rural area. Lafayette County had a median income of $39,853 in 2011, which was above the median income for Mississippi but below the median income for the United States; within this county, 23.4% of children under the age of 18 are in poverty (U.S. Census Bureau, 2012a). The third area is DeSoto County, Mississippi, the most urban of the three areas; Southaven and other cities in this county are considered to be suburbs of Memphis, Tennessee. The median household income in 2011 for DeSoto County was $54,495, which was above both the medians for Mississippi and the United States. In this area, only 15.7% of the children under the age of 18 are considered to be in poverty (U.S. Census Bureau, 2012a). These three areas, while all in the northern half of Mississippi, differ widely.

**Hypotheses Tested**

Hope is the main focus of this study, which was measured by two hope scales: Children’s Hope Scale (CHS; Snyder et al., 1997) and African-American Adolescent Hope Scale—Revised (AAAHS-R; Moore, 2006). Two other variables of interest were also measured; resilience was measured by the Brief Resilience Scale (BRS; Smith et al., 2008), and self-esteem was measured by the Rosenberg Self-Esteem Scale (RSES; Rosenberg, 1965). The two hope scales were
expected to be positively correlated with each other, and with the scales for resilience and self-esteem as well.

It was expected that adolescents in North Mississippi would as a whole demonstrate hopeful thinking, as the majority of American children do (Lopez et al., 2009), even despite the statistics regarding the state’s rankings in national standings. However, some differences were expected to emerge. As hope has shown to be negatively related to exposures of trauma (Hinton-Nelson, Roberts, & Snyder, 1996; Westburg, 2001) and positively related to supportive environments (McGee, 1984; Snyder, 1994), the relationship between hope and trauma, as well as hope and support, were examined, with the expectation that higher hope would be related to lower levels of trauma and higher levels of support. Furthermore, research has shown that hope varies by ethnicity, such that Caucasians exhibit higher levels of hope than do African-Americans (Lopez et al., 2009; Snyder, 1995). While some literature has demonstrated different relationships between hope and ethnicity (McDermott et al., 1997), it was expected that in this sample, differences in hope as related to ethnicity would exist, with Caucasians demonstrating higher hope than African-Americans.

Gender and ethnicity were examined, to see if there were main effects or interactions when looking individually at hope, resilience, and self-esteem. Expectations continued that there would be differences among the variables in regards to ethnicity, such that Caucasians would exhibit higher hope, resilience, and self-esteem than African-Americans. No gender differences or interactions were expected, as the literature has shown no differences between genders in hope (Cheavens et al., 2005; Lopez et al., 2009). Further, it was expected that ethnicity and exposure to trauma would contribute the most variance to hope.
In addition to the hypotheses listed above examining hope in North Mississippi, further hypotheses existed related to how hope presents based on county. This study hypothesized that the adolescents in Coahoma County would display lower levels of hope than would the adolescents in Lafayette or DeSoto Counties. Possible differences in hope were expected due to differences in the environment in which the youth grows up. The development of hope depends on personal agency, but also to some degree on the environment in which he or she was raised. Research has long found that childhood and adolescence is a crucial period in development, as that is when a youth learns hopeful thinking (Snyder, 2002; Edwards et al., 2007). This type of thinking depends on the youth’s interactions with his or her parents, peers, and teachers (Snyder, Cheavens, & Sympson, 1997), as well as exposure to supportive adults and nurturing environments (McGee, 1984; Stoddard et al.2011). Thus, if the parents are able to provide for their children and provide a stable home environment, as is more likely in Lafayette and DeSoto, they would also likely be able to instill more hope in their children. However, if parents are struggling to care for themselves, as was expected to be more likely in Coahoma, they may not be as able to create an environment conducive to learning hopeful thinking.

In addition to the expectation of lower hope, it was also expected that resilience and self-esteem would be lower among the adolescents in Coahoma County. It was expected that the positive correlations between the four scales used (CHS; AAAHS-R; BRS; RSES) would be present in each of the three counties. Additional demographic variables were assessed, with expectations of higher reported exposure to trauma and lower levels of support in Coahoma County.
Importance of This Research

If adolescents in a particular area exhibit low hope, it can have many implications for that area, suggesting the need to implement interventions to increase hope. If the adolescents do have low hope, psychologists and educators can help to enhance children’s level of hope, which can be done in individual or group settings in schools, churches, and homes (Lopez et al., 2009). Lopez et al. (2009) found that effective methods for increasing hope are structured around creating attainable goals, which can be achieved along multiple pathways, and enhancing agency. The adolescents continue to check in with a psychologist, or other professional, in order to monitor their progress. McDermott, Pedrotti, Edwards, and Houske (2002) found that positive feedback from adults, like teachers and parents, is crucial to the increase of hope for the individual. The increase in hope can be seen in multiple settings in the life of the adolescent, but one main area is that of education.

Hope helps adolescents to eliminate barriers in their pathways to educational attainment, and students can work together to achieve their own goals (Lopez et al., 2009). Because research has shown that higher levels of hope correspond with higher levels of academic achievement (Rand & Cheavens, 2009), adolescents in Mississippi with low hope could be taught to increase their hope, which could increase their academic achievement. If only 80.4% of Mississippians are graduating from high school (U.S. Census Bureau, 2012b), perhaps hope could help more adolescents attain a high school diploma and continue with their education. As Mississippi struggles with educational attainment compared to other states (U.S. Census Bureau, 2012b), increasing hope may ultimately help adolescents in this state help to close the current gap in achievement in this area.
CHAPTER 2

METHODS

Participants

For this study, 141 adolescents between the ages of 13 and 18 across North Mississippi participated, following parental consent. The mean age of the participants is 15.29, with a standard deviation of 1.65. These teenagers were recruited from three different areas within North Mississippi: Coahoma County (located within the Mississippi Delta), Lafayette County (home to a major university), and DeSoto County (a suburb of Memphis, Tennessee). These three areas are diverse, but attempt to represent the diversity of Northern Mississippi.

One hundred seventy three individuals originally completed the anonymous questionnaire. Of the 173 total, 32 participants were excluded from the analysis: 2 due to not listing an age, 12 due to ages outside of the designated age range, 3 for being from another county than the ones listed, 1 for missing data for all scales following demographic information, 11 for not answering a qualifier question correctly (e.g. “Select TRUE for this answer”), and 3 for reporting data considered to be extreme outliers (i.e., at least four standard deviations below the mean). The remaining 141 participants were used for the analysis.

Refer to Appendix A Table 1 for the participant demographics, including gender, ethnicity, age, and county. Appendix A Table 2 details the participant demographics for
Coahoma County, Appendix A Table 3 details the participant demographics for DeSoto County, and Appendix A Table 4 details the participant demographics for Lafayette County.

**Measures**

Demographics were collected for each participant. Each participant provided his or her age, grade, ethnicity, and gender. The other demographic questions (such as “I live with both of my parents”) were presented in a True-False format, and assessed topics such as support system and trauma history. These questions, as well as the format, were based on the Demographic Report Form (Moore, 2006), although other questions were added. From the demographics questions, other subscales were formed in order to determine certain experiences of the adolescents, such as Trauma (with up to five experiences, including whether the individual has been bullied, experienced a natural disaster, been the victim of abuse or assault, witnessed something traumatic, or had a close friend or family member murdered) and Support System (with up to four responses, such as having people in his/her life who help him/her to do what is right and having an adult in three different settings that he/she can talk to if needed).

The Children’s Hope Scale (CHS; Snyder et al., 1997) is a scale designed to measure hope in children aged 8 to 16. The measure has six questions, all of which are answered using a six-point response. Options range from “none of the time” to “all of the time,” and the answers provide a total range of scores from 6 to 36, with higher scores indicating higher hope. This measure has been shown to be both reliable and valid (Snyder et al., 1997; Valle et al., 2006). When assessing for this scale’s reliability, the internal reliability shows Cronbach alphas from .72 to .86; in addition, test-retest correlations of a 1-month interval show correlations for .71 and .73 (Snyder et al., 1997). Test-retest reliability for this measure for one year was .47 (Valle et al., 2006). Valle, Huebner, and Suldo (2004) also showed support for the correlated two-factor
model through confirmatory factor analysis procedures. This scale was initially administered to a sample of children in Oklahoma (aged 9 to 14) and then to five additional samples in five other states. The scale has been used with diverse populations, which include healthy children in public schools, children with medical problems, child burn victims, and adolescents exposed to violence (Snyder et al., 1997). The scale was also used in a study of 460 students in a public school system in a southeastern state; students in this sample were aged 15 to 19 (Valle et al., 2004). This sample provided support for the use of the Children’s Hope Scale with adolescents in this age range. The older adolescent sample also showed adequate internal consistency reliability, and a confirmatory factor analysis upheld the correlated two-factor model.

The African-American Adolescent Hope Scale – Revised (AAAHS-R) was created by Debra Moore, Ph.D. (2006). The scale is a shortened version of the African-American Adolescent Hope Scale (AAAHS), which was normed on Mississippi adolescents. The AAAHS-R is able to be used with adolescents of any ethnicity. The AAAHS-R consists of seven items on a five-point Likert-type scale, and total scores range from 7 to 35, with higher scores indicating higher hope. In regards to reliability, this scale demonstrates a Cronbach’s alpha of .83, and test-retest reliability of $r = .78$. This scale correlates with the CHS at $r = .47$.

The Brief Resilience Scale (BRS; Smith et al., 2008) was designed to assess “the ability to bounce back” from stress (p.194). The scale consists of six questions on a five-point Likert-type scale. To obtain the final score, three items are reverse coded, and then the sum of the scores is divided by six to obtain the mean score. Final scores range from 1 to 5, with higher scores representing higher resilience. The scale was originally tested on undergraduates and adults with health problems. The authors (Smith et al., 2008) report that the measure presents one unified factor, with good internal consistency (.80 to .91); the measure is also positively
correlated with other resilience measures. However, while this measure is typically used for adults, one of the four samples on which it was originally tested was a sample of college students with a mean age of 19.8 years. It was chosen for this study because of its brevity and ease of understanding. While the main variable of interest in this study is hope, a resilience scale is also included in order to explore how Mississippi adolescents have responded to environmental stressors, as well as to further examine the relationship between hope and resilience.

The Rosenberg Self-Esteem Scale is a 10 item measure of self-esteem (Rosenberg, 1965) with four answers per question, ranging from “Strongly Agree” to “Strongly Disagree.” Total possible scores on this score can range from 10 to 40, with higher scores indicating higher self-esteem. This scale was normed on a sample of high school juniors and seniors; it was chosen for use in this study due to its previous use with high school students and its ease of understanding. The Rosenberg Self-Esteem Scale is widely-used and is considered a valid measure of global self-esteem (Byrne, 1983). It has high reliability (Blascovich & Tomaka, 1993; Rosenberg, 1986) and excellent convergent validity with other self-esteem scales that use it as their standard (Robins, Hendin, & Trzesniewski, 2001).

In this study, there were missing cell values in the Rosenberg Self-Esteem Scale (where 9 participants each omitted one question each). Due to the low occurrence of missing data (9 of the 1410 total cells for this scale, or 0.64%), the missing data were filled in by imputing the mean within cells.

Appendix A Tables 5-8 report the ranges, means, standard deviations, and reliabilities found for each measure in this study. Table 5 reports on the Children’s Hope Scale, Table 6 reports on the African-American Adolescent Hope Scale—Revised, Table 7 reports on the Brief Resilience Scale, and Table 8 reports on the Rosenberg Self-Esteem Scale.
Procedures

Permission for this study was obtained through the Institutional Review Board (IRB) at the University of Mississippi. The IRB required parental consent for the participants of this study. As such, every parent was required to sign a parental consent form before their child could participate.

The adolescents for this study were recruited from various churches and community settings across North Mississippi, within Coahoma, DeSoto, and Lafayette Counties. The church settings and youth groups included a variety of religions from across the counties, and the community settings included locations such as after-school programs and a community meal. Youth leaders associated with these organizations helped to gather parental consent forms. It is important to note that the number of participants at each location was typically quite small, with a mean of 9.61 participants per site where adolescents brought their consent forms.

Once the participant turned in the consent form, they were given a pencil-and-paper questionnaire to complete. The survey was anonymous and included 79 questions in a multiple-choice format. While the demographic information was asked first, the other measures were counter-balanced to reduce order effects. The questionnaires took no longer than thirty minutes to complete. After the participant turned in the survey, he/she could sign up to be entered into a drawing for gift cards, where the chance of winning was approximately 1 in 50. The names for the drawing were kept separate from the completed surveys.

Instead of providing each student with a resource list for obtaining help or further information about the questions in the study, at least one adult per site was given a resource list that they can provide for the adolescents, if the need for it should arise. The contact information
or the researcher was given to the adult at the site, should the adolescents want to learn more about hope or the current research being conducted.
CHAPTER 3

RESULTS

Demographic Information about Sample

In examining demographics in this sample, it was found that these adolescents are involved in their community, as was expected. Ninety-three percent of this sample said that they participate in sports, scouting, church activities, school activities, or clubs, with 84% of the total sample reporting that they attend church at least twice a month. In this sample, the majority of teenagers know someone who went to college (99%) and want to go to college themselves (97%).

In regards to environment, 30% reported that their parents sometimes worry about having enough money to pay the bills. In regards to support, 72% of the sample reported that they have people in their lives who help them to do what is right, and they have at least three adults that they can talk to if they need help (i.e., an adult family member, someone at church, and a teacher). However, 24% of the sample reported that they are not comfortable asking for help if they need it.

Trauma experience was also examined. Thirty-eight percent of the sample reported that they have been bullied before. Seventy-five percent of the sample indicated that they had experienced at least one trauma (where bullying is included as a trauma), and 23% of the total sample reported that they have experienced three or more traumas during their lifetime.
Examining Hope in Total Sample

For hope, two independent measures were used. The Children’s Hope Scale (CHS) demonstrated a Cronbach’s alpha of .84; the African-American Adolescent Hope Scale-Revised demonstrated a Cronbach’s alpha of .67. The two scales are correlated at \( r = .58, p < .001 \). In the following analyses, the Children’s Hope Scale will be used to represent hope when only one measure is used.

Appendix A Table 9 shows the correlations for the total sample. The results show that the hope scales are significantly correlated with each other, and that, as predicted, the self-esteem scale is significantly correlated with both hope scales. Furthermore, the resilience scale is significantly correlated with hope as measured by the Children’s Hope Scale and the African-American Adolescent Hope Scale-Revised.

When examining hope by CHS, the average score for adolescents in North Mississippi is 27.09, which falls in the top third distribution of the scale. Total hope scores on the CHS were then analyzed, such that the bottom third of the scale distribution would be considered low hope and the top third would be considered high hope (Lopez et al., 2009). In this sample, only two individuals would be considered to have low hope (1.4%) and 84 individuals would be considered to have high hope (59.6%). Thus, the adolescents demonstrate hopeful thinking, as predicted.

Additional analyses were used to examine hope, as measured by CHS, and demographic variables. A one-way ANOVA found no significant differences in hope when looking at the ages included for analysis, such that \( F(5, 135) = 1.30, p = .27 \). Correlations then examined the relationship between hope and other demographic variables, such as trauma and support systems. Hope and trauma are negatively correlated, as suspected, but this correlation is nonsignificant.
Hope and level of support are positively correlated \((r = .14, p = .10)\), as expected, but again this correlation is nonsignificant.

**Examining Variables as Related to Ethnicity and Gender**

In order to determine whether hope as measured by CHS, hope as measured by AAAHS-R, resilience, and self-esteem varied by ethnicity (Caucasian or African-American) and gender (male or female), two-way analysis of variances (ANOVA) were conducted. For these analyses, 133 participants were included: 19 African-American males, 20 African-American females, 39 Caucasian males, and 55 Caucasian females.

When examining hope as measured by CHS, there was a significant main effect of gender on hope \((F(1, 129) = 5.01, p < .05)\), such that males reported higher hope scores than did females. The main effect of gender on hope is inconsistent with the original hypothesis. There was also a significant main effect of ethnicity on hope \((F(1, 129) = 3.91, p = .05)\), such that African-Americans displayed higher levels of hope than did Caucasians. While a difference in ethnicity was expected, it was not originally expected in this direction. There was a nonsignificant interaction of gender by ethnicity on hope \((F(1, 129) = .16, p = .69)\).

Analyses were also run to examine hope as measured by AAAHS-R. In these analyses, there was a nonsignificant main effect of gender on hope \((F(1, 129) = .14, p = .71)\), nonsignificant main effect of ethnicity on hope \((F(1, 129) = 2.89, p = .09)\), and nonsignificant interaction of gender by ethnicity on hope \((F(1, 129) = 1.91, p = .17)\).

Analyses related to resilience were examined next. An ANOVA revealed that while there was a nonsignificant interaction of gender by ethnicity \((F(1, 129) = .37, p = .54)\) and a nonsignificant main effect of ethnicity on resilience \((F(1, 129) = 3.36, p = .07)\), there was a significant main effect of gender on resilience \((F(1, 129) = 18.13, p < .001)\), such that males
reported higher resilience scores than did females. Thus, while there is no significant difference as related to ethnicity, gender differences are again present.

Furthermore, an ANOVA showed that while there was a nonsignificant interaction of gender by ethnicity on self-esteem ($F(1, 129) = .14, p = .71$) and nonsignificant main effect of ethnicity on self-esteem ($F(1, 129) = .72, p = .40$), there was a significant main effect of gender on self-esteem ($F(1, 129) = 7.61, p < .01$), such that males reported higher self-esteem scores than did females. Therefore, when looking at the analysis of all four scales, males reported higher levels of hope, resilience and self-esteem, which was contrary to initial predictions.

**Regression Analysis of Hope**

A hierarchical multiple regression analysis was also conducted. Hope (as measured by the Children’s Hope Scale) served as the criterion variable with five independent variable predictors. Ethnicity was entered at stage one, exposure to trauma at stage two, and support system, gender, and age at stage three. Appendix A Table 10 details the results of this regression analysis (with $n = 126$). Significant predictors for the final model, in order of the amount of variance that each contributes, are gender (6.20%) and ethnicity (5.66%). Thus, with this model, gender contributes the most variance. While it was expected that trauma and ethnicity would be the strongest predictors, gender emerged as the strongest predictor.

**Information about Each County**

Since the data was collected in three different counties, information about each area is explored in this section. First, it is important to note that that these groups (i.e., Coahoma, DeSoto, and Lafayette) differ significantly by age, even though the range of ages in each county is 13 to 18 years old. A one-way ANOVA indicated that age varies by county, $F(2, 138) = 8.64$, $p < .001$. Games-Howell post-hoc tests were conducted on all pairwise contrasts. The results
showed that the age of adolescents in Coahoma ($M = 16.13, SD = 1.32$) is significantly different than the age of adolescents in DeSoto ($M = 14.79, SD = 1.74$) at $p < .001$ and the age of adolescents in Lafayette ($M = 15.26, SD = 1.50$) at $p < .05$. However, the ages of adolescents in this sample in Lafayette and DeSoto Counties do not differ significantly ($p = .31$).

Appendix A Tables 11-13 detail the summary of correlations of scales for the sample, as divided by counties. Table 11 details the correlations for Coahoma, Table 12 details the correlations for DeSoto, and Table 13 details the correlations for Lafayette.

**Comparisons of Hope, Resilience, and Self-Esteem between Counties**

Next, one-way ANOVAs detailed that hope as measured by CHS does not differ significantly by county, $F(2, 138) = 1.08$, $p = .34$, nor does hope as measured by AAAHS-R, $F(2, 138) = .13$, $p = .88$; this finding is not consistent with the initial hypothesis. No significant differences were found among resilience, $F(2, 138) = .47$, $p = .63$, or self-esteem, $F(2, 138) = 2.85$, $p = .06$.

**Comparisons of Demographic Variables between Counties**

In addition to these analyses, demographics of interest were examined to see if certain factors differed by county in North Mississippi, which were analyzed by using one-way ANOVAs. Results showed a nonsignificant difference when it comes to levels of support provided by trusted adults, $(F(2, 134) = 1.48$, $p = .23$).

However, significant differences between counties emerged in regards to trauma exposure $(F(2, 133) = 10.09$, $p < .001$), such that Games-Howell tests showed that individuals in Coahoma ($M = 2.18, SD = 1.43$) reported significantly higher rates of trauma than did individuals in DeSoto ($M = 1.31, SD = 1.13$) at $p < .01$, $r = .32$, and individuals in Lafayette ($M = 1.05, SD = .96$) at $p < .001$, $r = .42$. Reported rates of trauma in DeSoto and Lafayette were not
significantly different, $p = .44$. Thus, levels of experienced trauma do differ between county, with Coahoma experiencing the highest levels of trauma, as predicted.
CHAPTER 4

DISCUSSION

Implications

When looking at hope across the sample for this study in North Mississippi, significant differences were found in the scores in the Children’s Hope Scale when examining ethnicity, such that African-Americans reported higher levels of hope than did Caucasians. While this finding was contrary to the initial hypothesis and some literature (Lopez et al., 2009; Snyder, 1995), it is actually consistent with other literature (McDermott et al., 1997; Chang & Banks, 2007) which suggests that ethnic minorities may report higher levels of hope due to earlier opportunities to develop hope. For example, if individuals encounter obstacles, they are given the chance to learn alternate approaches to their pathways, thus generating higher hope. Exploring levels of hope among different ethnicities should continue to be a focus of future research.

In addition to this difference in hope, males report significantly higher levels of hope than do females in this sample, which is contrary to previous research as well, given that research has shown that hope does not vary by gender (Cheavens et al., 2005; Lopez et al., 2009). In this sample, such differences may possibly emerge due to upbringing in a rural Southern state and the gender expectations assigned to youth. Perhaps males report higher levels of hope because they identify fewer barriers in their pathways to achieving their identified goals.
While hope is measured in this sample, it is unclear what the hopes of the individual might be, as the individuals may have different goals (Snyder et al., 1997). Some individuals may have set higher goals than others, and the specific goals are not assessed in this study. Future research should examine not only gender and hope in populations where such differences might exist, such as the South, but also how goals differ in gendered populations as well.

Findings of this study also show higher levels of self-esteem and higher levels of resilience among males than females. Such variables are present-focused, rather than future-focused, showing that perhaps males feel more confident not only about the future but also about their abilities in the present than do females. With gender differences emerging in multiple domains, further research is needed in these areas, especially in states located in the Southern United States. These findings also suggest that more programs should focus on increasing these variables in females.

Regression analyses for the sample of adolescents in North Mississippi found that gender and ethnicity account for the most variance in hope. Unexpectedly, exposure to trauma was not found to be a significant factor in accounting for variance in this model. This sample is unique in that 75% of individuals have experienced at least one trauma, and while exposure to trauma is typically associated with lower levels of reported hope (Hinton-Nelson et al., 1996; Westburg, 2001), only two individuals in this sample demonstrate low hope. Adolescents in this sample may have high levels of hope, regardless of exposure to trauma or the state in which they live. However, the high report of trauma in this state does call for necessary supports to be in place to care for such children in case negative effects of trauma emerge.

In addition, more research needs to be dedicated to the effects of trauma on both negative and positive life factors. For example, extensive research has been conducted through the studies
examining Adverse Childhood Events, with results showing connections between such negative events and negative mental health outcomes (Chapman, Dube, & Anda, 2007). However, Ungar (2015) calls for providers to learn to diagnose resilience when a child has been faced with social and psychical challenges. While studying the negative outcomes of such traumas are vital to understanding long-term effects, it is important to give attention to the protective factors that individuals demonstrate as well.

When examining hope and resilience by county, results showed that no significant difference existed between the three counties of interest: Coahoma, DeSoto, and Lafayette. This finding was contrary to hypothesis, as differences were expected in those domains. It appears as though overall, adolescents in this sample in North Mississippi are quite hopeful about their futures.

While differences do emerge in demographic factors (such that individuals in Coahoma County have experienced significantly higher levels of trauma than individuals in the other two counties), it is possible that the adolescents in this sample are more alike than different when looking to their futures. Adolescents in Mississippi are faced with unique challenges, and that is true regardless of which county the individual lives in. It is what the adolescent does next that will help to determine his or her future. More research is needed on adolescents in Mississippi, but that research should focus not just on negative aspects of these youth, but on positive aspects such as hope and resilience as well.

**Limitations**

It is important to note that the participants in this study were recruited through church youth groups and community events, which resulted in a biased sample. Furthermore, the participants were recruited through locations where permission was granted to the researcher. As
many potential sites did not give permission, those locations were not used to gather participants. The participants used in this study were not gathered through random selection, and at this time, it cannot be said that this population is representative of the population of North Mississippi. In addition, due to the small sample size, it is difficult to make generalizations from this sample.

When this study was proposed, it was proposed that this anonymous questionnaire would be best conducted with the use of passive parental consent. However, based on the requirements of the University of Mississippi Institutional Review Board (IRB) and current state laws, active parental consent was required, and obtained, from adolescents. Due to the use of active parental consent, however, this sample is biased. While it is unclear the return rate of consent forms in this sample, the return rate for active parental consent (30% to 60%) is much lower than the rate of participants who are included when passive consent is used (93% to 100%) (Tigges, 2003). In this sample, there were some sites where no one returned consent forms by the day in which data was to be collected, with up to 20 students having been given consent forms. In some cases, parents were emailed the consent form to sign directly by the youth group leader who was in frequent contact with the parents, but consents were still not returned.

In samples of adolescents where parental consent is required, the participants may have parents who are more involved, which may mean higher levels of parental and familial support and investment. Active parental consent typically leads to exclusion of minority students and students who are having academic or behavioral problems (Tigges, 2003). These students typically display lower levels of self-esteem and higher levels of risk-taking behaviors, and they are less likely to live with both parents (Dent, Galaif, Sussman, & Stacy, 1993). Thus, with many children excluded from participating due to not returning the parental consent form, the
sample of participants for this study does not represent the full range of adolescents in North Mississippi.

Finally, this study purposely set out to examine hope and resilience among adolescents in Mississippi, a very unique population. These findings about hope are likely not generalizable due to this limited sample and area included. However, more research is needed not only on hope within this state, but on positive variables with adolescents as a whole.

**Future Research**

Future research should continue to examine hope and resilience among adolescents, especially in states such as Mississippi. Exploring hope and resilience in a population with passive parental consent may provide a more comprehensive look at such variables in this population.

Further importance should also be placed on how to further increase hope in this population. While the group as a whole had high ratings of hope, their levels of hope could still be further increased, especially among females and Caucasians. Given that adolescents as a whole in Mississippi exhibit lower levels of academic achievement than do adolescents in other states (U.S. Census Bureau, 2012b), and research shows that higher levels of hope correspond to higher levels of academic achievement (Rand & Cheavens, 2009), emphasis should be placed on further increasing hope among adolescents in Mississippi in high school. Increasing levels of hope could potentially increase academic achievement in Mississippi.

Increasing hope is something that can be done in a variety of settings—individual or group settings, in homes, schools, or churches. To increase hope, adolescents must learn to create attainable goals, generate multiple pathways, and increase agency (Lopez et al., 2009). Having an adult to help monitor progress is key, as is receiving positive feedback from adults (Lopez et
al., 2009; McDermott et al., 2002). Teaching adults how to effectively mentor adolescents in a variety of settings can have a positive impact on hope, which can impact not only the academic success of individuals, but also have lasting impacts in multiple settings in the life of the adolescent.


measures, and interventions (pp. 57–85). San Diego: Academic Press. doi:
10.1016/b978-012654050-5/50006-3

10.4324/9780203106525.ch3

10.4324/9780203052723


10.1080/02739610701601403


www.nea.org/assets/img/content/NEA_Rankings_And_Estimates-2013_(2).pdf.


doi:10.1177/0146167201272002


APPENDIX A: TABLES
Table 1

*Participant Demographics for Total Sample*

<table>
<thead>
<tr>
<th>Variable</th>
<th>N</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>61</td>
<td>43.3%</td>
</tr>
<tr>
<td>Female</td>
<td>80</td>
<td>56.7%</td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caucasian</td>
<td>94</td>
<td>66.7%</td>
</tr>
<tr>
<td>African-American</td>
<td>39</td>
<td>27.7%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>4</td>
<td>2.8%</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
<td>2.8%</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>30</td>
<td>21.3%</td>
</tr>
<tr>
<td>14</td>
<td>20</td>
<td>14.2%</td>
</tr>
<tr>
<td>15</td>
<td>25</td>
<td>17.7%</td>
</tr>
<tr>
<td>16</td>
<td>22</td>
<td>15.6%</td>
</tr>
<tr>
<td>17</td>
<td>33</td>
<td>23.4%</td>
</tr>
<tr>
<td>18</td>
<td>11</td>
<td>7.8%</td>
</tr>
<tr>
<td>County</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coahoma</td>
<td>38</td>
<td>27.0%</td>
</tr>
<tr>
<td>DeSoto</td>
<td>61</td>
<td>43.3%</td>
</tr>
<tr>
<td>Lafayette</td>
<td>42</td>
<td>29.8%</td>
</tr>
</tbody>
</table>
Table 2

*Participant Demographics for Coahoma County*

<table>
<thead>
<tr>
<th>Variable</th>
<th>N</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>12</td>
<td>31.6%</td>
</tr>
<tr>
<td>Female</td>
<td>26</td>
<td>68.4%</td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caucasian</td>
<td>29</td>
<td>76.3%</td>
</tr>
<tr>
<td>African-American</td>
<td>8</td>
<td>21.1%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>1</td>
<td>2.6%</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>3</td>
<td>7.9%</td>
</tr>
<tr>
<td>14</td>
<td>1</td>
<td>2.6%</td>
</tr>
<tr>
<td>15</td>
<td>7</td>
<td>18.4%</td>
</tr>
<tr>
<td>16</td>
<td>6</td>
<td>15.8%</td>
</tr>
<tr>
<td>17</td>
<td>19</td>
<td>50.0%</td>
</tr>
<tr>
<td>18</td>
<td>2</td>
<td>5.3%</td>
</tr>
<tr>
<td>Variable</td>
<td>N</td>
<td>Percentage</td>
</tr>
<tr>
<td>-------------------</td>
<td>-----</td>
<td>------------</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>29</td>
<td>47.5%</td>
</tr>
<tr>
<td>Female</td>
<td>32</td>
<td>52.5%</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caucasian</td>
<td>41</td>
<td>67.2%</td>
</tr>
<tr>
<td>African-American</td>
<td>13</td>
<td>21.3%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>3</td>
<td>4.9%</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
<td>6.6%</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>21</td>
<td>34.4%</td>
</tr>
<tr>
<td>14</td>
<td>10</td>
<td>16.4%</td>
</tr>
<tr>
<td>15</td>
<td>11</td>
<td>18.0%</td>
</tr>
<tr>
<td>16</td>
<td>5</td>
<td>8.2%</td>
</tr>
<tr>
<td>17</td>
<td>8</td>
<td>13.1%</td>
</tr>
<tr>
<td>18</td>
<td>6</td>
<td>9.8%</td>
</tr>
</tbody>
</table>
Table 4

*Participant Demographics for Lafayette County*

<table>
<thead>
<tr>
<th>Variable</th>
<th>N</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>20</td>
<td>47.6%</td>
</tr>
<tr>
<td>Female</td>
<td>22</td>
<td>52.4%</td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caucasian</td>
<td>24</td>
<td>57.1%</td>
</tr>
<tr>
<td>African-American</td>
<td>18</td>
<td>42.9%</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>6</td>
<td>14.3%</td>
</tr>
<tr>
<td>14</td>
<td>9</td>
<td>21.4%</td>
</tr>
<tr>
<td>15</td>
<td>7</td>
<td>16.7%</td>
</tr>
<tr>
<td>16</td>
<td>11</td>
<td>26.2%</td>
</tr>
<tr>
<td>17</td>
<td>6</td>
<td>14.3%</td>
</tr>
<tr>
<td>18</td>
<td>3</td>
<td>7.1%</td>
</tr>
</tbody>
</table>
Table 5

*Statistics for Children’s Hope Scale (CHS)*

<table>
<thead>
<tr>
<th>Population</th>
<th>N</th>
<th>M</th>
<th>SD</th>
<th>(\alpha)</th>
<th>Actual Range (Potential: 6-36)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Sample</td>
<td>141</td>
<td>27.09</td>
<td>5.29</td>
<td>.84</td>
<td>15</td>
</tr>
<tr>
<td>By County</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coahoma</td>
<td>38</td>
<td>27.26</td>
<td>5.45</td>
<td>.87</td>
<td>16</td>
</tr>
<tr>
<td>DeSoto</td>
<td>61</td>
<td>26.39</td>
<td>5.24</td>
<td>.82</td>
<td>15</td>
</tr>
<tr>
<td>Lafayette</td>
<td>42</td>
<td>27.93</td>
<td>5.21</td>
<td>.83</td>
<td>15</td>
</tr>
<tr>
<td>By Ethnicity</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caucasian</td>
<td>94</td>
<td>26.56</td>
<td>5.16</td>
<td>.85</td>
<td>15</td>
</tr>
<tr>
<td>African-American</td>
<td>39</td>
<td>28.67</td>
<td>5.09</td>
<td>.78</td>
<td>15</td>
</tr>
<tr>
<td>By Gender</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>61</td>
<td>28.56</td>
<td>4.85</td>
<td>.85</td>
<td>16</td>
</tr>
<tr>
<td>Female</td>
<td>80</td>
<td>25.96</td>
<td>5.37</td>
<td>.81</td>
<td>15</td>
</tr>
</tbody>
</table>
Table 6

*Statistics for African-American Adolescent Hope Scale—Revised (AAAHS-R)*

<table>
<thead>
<tr>
<th>Population</th>
<th>N</th>
<th>M</th>
<th>SD</th>
<th>( \alpha )</th>
<th>Actual Range (Potential: 7-35)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Sample</td>
<td>141</td>
<td>31.45</td>
<td>2.92</td>
<td>.67</td>
<td>Low 23 High 35</td>
</tr>
<tr>
<td>By County</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coahoma</td>
<td>38</td>
<td>31.61</td>
<td>2.71</td>
<td>.73</td>
<td>Low 25 High 35</td>
</tr>
<tr>
<td>DeSoto</td>
<td>61</td>
<td>31.31</td>
<td>2.94</td>
<td>.66</td>
<td>Low 23 High 35</td>
</tr>
<tr>
<td>Lafayette</td>
<td>42</td>
<td>31.52</td>
<td>3.14</td>
<td>.66</td>
<td>Low 23 High 35</td>
</tr>
<tr>
<td>By Ethnicity</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caucasian</td>
<td>94</td>
<td>31.15</td>
<td>2.89</td>
<td>.66</td>
<td>Low 23 High 35</td>
</tr>
<tr>
<td>African-American</td>
<td>39</td>
<td>32.18</td>
<td>2.95</td>
<td>.68</td>
<td>Low 23 High 35</td>
</tr>
<tr>
<td>By Gender</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>61</td>
<td>31.79</td>
<td>2.69</td>
<td>.62</td>
<td>Low 25 High 35</td>
</tr>
<tr>
<td>Female</td>
<td>80</td>
<td>31.20</td>
<td>3.08</td>
<td>.72</td>
<td>Low 23 High 35</td>
</tr>
</tbody>
</table>
Table 7

*Statistics for Brief Resilience Scale (BRS)*

<table>
<thead>
<tr>
<th>Population</th>
<th>N</th>
<th>M</th>
<th>SD</th>
<th>α</th>
<th>Actual Range</th>
<th>Low</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(Potential: 1.00 – 5.00)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Sample</td>
<td>141</td>
<td>3.18</td>
<td>.74</td>
<td>.72</td>
<td>1.00</td>
<td>5.00</td>
<td></td>
</tr>
<tr>
<td>By County</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coahoma</td>
<td>38</td>
<td>3.10</td>
<td>.62</td>
<td>.62</td>
<td>1.83</td>
<td>4.83</td>
<td></td>
</tr>
<tr>
<td>DeSoto</td>
<td>61</td>
<td>3.17</td>
<td>.76</td>
<td>.75</td>
<td>1.00</td>
<td>5.00</td>
<td></td>
</tr>
<tr>
<td>Lafayette</td>
<td>42</td>
<td>3.26</td>
<td>.82</td>
<td>.74</td>
<td>1.33</td>
<td>5.00</td>
<td></td>
</tr>
<tr>
<td>By Ethnicity</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caucasian</td>
<td>94</td>
<td>3.24</td>
<td>.75</td>
<td>.80</td>
<td>1.00</td>
<td>5.00</td>
<td></td>
</tr>
<tr>
<td>African-American</td>
<td>39</td>
<td>3.03</td>
<td>.69</td>
<td>.54</td>
<td>1.67</td>
<td>4.83</td>
<td></td>
</tr>
<tr>
<td>By Gender</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>61</td>
<td>3.49</td>
<td>.71</td>
<td>.65</td>
<td>1.83</td>
<td>5.00</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>80</td>
<td>2.94</td>
<td>.68</td>
<td>.69</td>
<td>1.00</td>
<td>4.67</td>
<td></td>
</tr>
</tbody>
</table>
Table 8

Statistics for Rosenberg Self-Esteem Scale (RSES)

<table>
<thead>
<tr>
<th>Population</th>
<th>N</th>
<th>M</th>
<th>SD</th>
<th>α</th>
<th>Low</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Sample</td>
<td>141</td>
<td>31.27</td>
<td>6.21</td>
<td>.87</td>
<td>15</td>
<td>40</td>
</tr>
<tr>
<td>By County</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coahoma</td>
<td>38</td>
<td>29.35</td>
<td>5.54</td>
<td>.82</td>
<td>17</td>
<td>40</td>
</tr>
<tr>
<td>DeSoto</td>
<td>61</td>
<td>31.59</td>
<td>5.59</td>
<td>.84</td>
<td>16</td>
<td>40</td>
</tr>
<tr>
<td>Lafayette</td>
<td>42</td>
<td>32.53</td>
<td>7.27</td>
<td>.92</td>
<td>15</td>
<td>40</td>
</tr>
<tr>
<td>By Ethnicity</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caucasian</td>
<td>94</td>
<td>31.57</td>
<td>5.94</td>
<td>.89</td>
<td>15</td>
<td>40</td>
</tr>
<tr>
<td>African-American</td>
<td>39</td>
<td>30.87</td>
<td>6.78</td>
<td>.85</td>
<td>16</td>
<td>40</td>
</tr>
<tr>
<td>By Gender</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>61</td>
<td>33.32</td>
<td>5.71</td>
<td>.85</td>
<td>16</td>
<td>40</td>
</tr>
<tr>
<td>Female</td>
<td>80</td>
<td>29.70</td>
<td>6.15</td>
<td>.87</td>
<td>15</td>
<td>40</td>
</tr>
</tbody>
</table>
Table 9

*Summary of Correlations for Total Sample*

<table>
<thead>
<tr>
<th></th>
<th>CHS</th>
<th>AAAHS-R</th>
<th>BRS</th>
<th>RSES</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHS</td>
<td>---</td>
<td>.58**</td>
<td>.43**</td>
<td>.49**</td>
</tr>
<tr>
<td>AAAHS-R</td>
<td>.58**</td>
<td>---</td>
<td>.22**</td>
<td>.43**</td>
</tr>
<tr>
<td>BRS</td>
<td>.43**</td>
<td>.22**</td>
<td>---</td>
<td>.49**</td>
</tr>
<tr>
<td>RSES</td>
<td>.49**</td>
<td>.43**</td>
<td>.49**</td>
<td>---</td>
</tr>
</tbody>
</table>

**Correlation is significant at the 0.01 level (2-tailed).
Table 10

*Regression Table for Total Sample*

<table>
<thead>
<tr>
<th>Variable</th>
<th>Model 1 B</th>
<th>Model 2 B</th>
<th>Model 3 B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constant</td>
<td>26.53**</td>
<td>27.03**</td>
<td>17.48**</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>2.79**</td>
<td>3.02**</td>
<td>2.96**</td>
</tr>
<tr>
<td>Trauma</td>
<td>- .37</td>
<td>- .13</td>
<td></td>
</tr>
<tr>
<td>Support</td>
<td></td>
<td></td>
<td>.99</td>
</tr>
<tr>
<td>Gender</td>
<td>- 2.68**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>.46</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$R^2$</td>
<td>.05</td>
<td>.05</td>
<td>.12</td>
</tr>
<tr>
<td>$F$</td>
<td>7.25**</td>
<td>4.12*</td>
<td>4.34**</td>
</tr>
<tr>
<td>$\Delta R^2$</td>
<td>.01</td>
<td>.09</td>
<td></td>
</tr>
<tr>
<td>$\Delta F$</td>
<td>.99</td>
<td>4.27**</td>
<td></td>
</tr>
</tbody>
</table>

** Correlation is significant at the 0.01 level (2-tailed).
* Correlation is significant at the 0.05 level (2-tailed).
Table 11

*Summary of Correlations for Coahoma County*

<table>
<thead>
<tr>
<th></th>
<th>CHS</th>
<th>AAAHS-R</th>
<th>BRS</th>
<th>RSES</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHS</td>
<td>---</td>
<td>.43**</td>
<td>.27</td>
<td>.34*</td>
</tr>
<tr>
<td>AAAHS-R</td>
<td>.43**</td>
<td>---</td>
<td>.24</td>
<td>.26</td>
</tr>
<tr>
<td>BRS</td>
<td>.27</td>
<td>.24</td>
<td>---</td>
<td>.43**</td>
</tr>
<tr>
<td>RSES</td>
<td>.34*</td>
<td>.26</td>
<td>.43**</td>
<td>---</td>
</tr>
</tbody>
</table>

** Correlation is significant at the 0.01 level (2-tailed).
* Correlation is significant at the 0.05 level (2-tailed).
Table 12

**Summary of Correlations for DeSoto County**

<table>
<thead>
<tr>
<th></th>
<th>CHS</th>
<th>AAAHS-R</th>
<th>BRS</th>
<th>RSES</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHS</td>
<td>---</td>
<td>.59**</td>
<td>.56**</td>
<td>.63**</td>
</tr>
<tr>
<td>AAAHS-R</td>
<td>.59**</td>
<td>---</td>
<td>.17</td>
<td>.49**</td>
</tr>
<tr>
<td>BRS</td>
<td>.56**</td>
<td>.17</td>
<td>---</td>
<td>.46**</td>
</tr>
<tr>
<td>RSES</td>
<td>.63**</td>
<td>.49**</td>
<td>.46**</td>
<td>---</td>
</tr>
</tbody>
</table>

** Correlation is significant at the 0.01 level (2-tailed).
Table 13

Summary of Correlations for Lafayette County

<table>
<thead>
<tr>
<th></th>
<th>CHS</th>
<th>AAAHS-R</th>
<th>BRS</th>
<th>RSES</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHS</td>
<td>---</td>
<td>.70**</td>
<td>.38*</td>
<td>.49**</td>
</tr>
<tr>
<td>AAAHS-R</td>
<td>.70**</td>
<td>---</td>
<td>.28</td>
<td>.51**</td>
</tr>
<tr>
<td>BRS</td>
<td>.38*</td>
<td>.28</td>
<td>---</td>
<td>.54**</td>
</tr>
<tr>
<td>RSES</td>
<td>.49**</td>
<td>.51**</td>
<td>.54**</td>
<td>---</td>
</tr>
</tbody>
</table>

** Correlation is significant at the 0.01 level (2-tailed).
* Correlation is significant at the 0.05 level (2-tailed).
APPENDIX B: DEMOGRAPHIC QUESTIONNAIRE
Please circle (or fill in) the response that fits you best.

1. What is your gender?
   Male       Female

2. Are you currently enrolled in school?
   Yes       No

3. If yes, what grade are you currently in?    

4. What is your ethnicity?
   Caucasian   African-American   Asian   Hispanic   Other:    

5. How old are you?    

6. What county do you live in?    Coahoma   DeSoto   Lafayette   Other:    

7. I participate in sports, scouting, church activities, school activities, or clubs.
   True       False

8. There are people in my life who help me do what’s right.
   True       False

9. I worry about my health.
   True       False

10. I am close to my family.
    True       False

11. I often get into fights or arguments with my peers.
    True       False

12. I live with both of my parents.
    True       False

13. Sometimes, my parents worry about having enough money to pay the bills.
    True       False

14. At least one of my parents works.
    True       False

15. At least one of my parents completed high school.
    True       False

16. I am a parent.
    True       False
17. My parents are very strict, and what they say goes.
   True          False

18. My parents are very permissive, and they let me do whatever I want to do.
   True          False

19. I don’t live with my parents; I live with a family member, a friend, or a foster family.
   True          False

20. I attend church twice a month or more.
    True          False

21. I often skip school.
    True          False

22. I have missed so many days of school that I have been considered truant before.
    True          False

23. If I did something really bad, I would get a whipping.
    True          False

24. I have a job right now.
    True          False

25. In the past, I have repeated or failed a grade in school.
    True          False

26. I do well in school and make good grades.
    True          False

27. Some people would say that I have a bad attitude.
    True          False

28. I feel good about myself, or I like myself.
    True          False

29. I do not drink alcohol.
    True          False

30. At least one of my parents went to college after high school.
    True          False

31. I know someone who went to college.
    True          False
32. I have never been to youth court, had to talk to a juvenile officer, or been arrested.
   True  False
33. I have never been expelled or suspended from school.
   True  False
34. I really like attending school.
   True  False
35. I have a chronic illness, like diabetes or epilepsy.
   True  False
36. I have disobeyed my parents’ rules many times.
   True  False
37. I have been bullied before.
   True  False
38. I have been diagnosed with a learning disability.
   True  False
39. I want to go to college.
   True  False
40. I really enjoy attending church.
   True  False
41. I have experienced a natural disaster, like a tornado or a flood.
   True  False
42. I have been the victim of abuse or assault.
   True  False
43. I have witnessed something traumatic.
   True  False
44. I have had a close friend or family member murdered.
   True  False
45. I have an adult family member that I can talk to if I need help.
   True  False
46. I have someone at my church that I can talk to if I need help.
   True  False
47. I have a teacher that I can talk to if I need help.
   True          False

48. I am comfortable asking for help if I need it.
   True          False
APPENDIX C: CHILDREN’S HOPE SCALE (CHS)
Directions: The sentences below describe how children think about themselves and how they do things in general. Read each sentence carefully. For each sentence, please think about how you are in most situations. Place a check inside the circle that describes YOU the best. For example, place a check (✓) in the circle (O) above "None of the time," if this describes you. Or, if you are this way "All of the time," check this circle. Please answer every question by putting a check in one of the circles. There are no right or wrong answers.

1. I think I am doing pretty well.

<table>
<thead>
<tr>
<th>None of the time</th>
<th>A little of the time</th>
<th>Some of the time</th>
<th>A lot of the time</th>
<th>Most of the time</th>
<th>All of the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>None of the time</th>
<th>A little of the time</th>
<th>Some of the time</th>
<th>A lot of the time</th>
<th>Most of the time</th>
<th>All of the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>None of the time</th>
<th>A little of the time</th>
<th>Some of the time</th>
<th>A lot of the time</th>
<th>Most of the time</th>
<th>All of the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>None of the time</th>
<th>A little of the time</th>
<th>Some of the time</th>
<th>A lot of the time</th>
<th>Most of the time</th>
<th>All of the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>None of the time</th>
<th>A little of the time</th>
<th>Some of the time</th>
<th>A lot of the time</th>
<th>Most of the time</th>
<th>All of the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>None of the time</th>
<th>A little of the time</th>
<th>Some of the time</th>
<th>A lot of the time</th>
<th>Most of the time</th>
<th>All of the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
</tbody>
</table>
APPENDIX D: AFRICAN-AMERICAN ADOLESCENT HOPE SCALE-REVISED

(AAAAHS-R)
Directions: Read each item and select the number from the scale below that best describes your opinion.

<table>
<thead>
<tr>
<th>Scale</th>
<th>Definitely</th>
<th>Mostly</th>
<th>Neither</th>
<th>Mostly</th>
<th>Definitely</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Disagree</td>
<td>Disagree/agree</td>
<td>Agree</td>
<td>Agree</td>
<td></td>
</tr>
</tbody>
</table>

1. Like Martin Luther King, Jr., I have a dream about a better future.
   1=Definitely  2=Mostly  3=Neither  4=Mostly  5=Definitely
   Disagree  Disagree/disagree/agree  Agree  Agree

2. I am working to achieve my goal of completing my high school education.
   1=Definitely  2=Mostly  3=Neither  4=Mostly  5=Definitely
   Disagree  Disagree/disagree/agree  Agree  Agree

3. I have made plans about what I want to achieve or become when I graduate from high school.
   1=Definitely  2=Mostly  3=Neither  4=Mostly  5=Definitely
   Disagree  Disagree/disagree/agree  Agree  Agree

4. I am trying to do well in school, because I believe that if I get an education, I will have better opportunities.
   1=Definitely  2=Mostly  3=Neither  4=Mostly  5=Definitely
   Disagree  Disagree/disagree/agree  Agree  Agree

5. I believe that I will be successful as an adult.
   1=Definitely  2=Mostly  3=Neither  4=Mostly  5=Definitely
   Disagree  Disagree/disagree/agree  Agree  Agree

6. I don’t worry about failure because I am not going to allow anything to hold me back or keep me down.
   1=Definitely  2=Mostly  3=Neither  4=Mostly  5=Definitely
   Disagree  Disagree/disagree/agree  Agree  Agree

7. I still believe that one day I will be a success.
   1=Definitely  2=Mostly  3=Neither  4=Mostly  5=Definitely
   Disagree  Disagree/disagree/agree  Agree  Agree
APPENDIX E: BRIEF RESILIENCE SCALE (BRS)
Instructions: Use the following scale and circle one number for each statement to indicate how much you disagree or agree with each of the statements.

1 = Strongly Disagree    2 = Disagree    3 = Neutral    4 = Agree    5 = Strongly Agree

1. I tend to bounce back quickly after hard times…….. 1 2 3 4 5
2. I have a hard time making it through stressful events……. 1 2 3 4 5
3. It does not take me long to recover from a stressful event….. 1 2 3 4 5
4. It is hard for me to snap back when something bad happens…. 1 2 3 4 5
5. I usually come through difficult times with little trouble……. 1 2 3 4 5
6. I tend to take a long time to get over set-backs in my life……. 1 2 3 4 5
APPENDIX F: ROSENBERG SELF-ESTEEM SCALE (RSES)
Instructions: Below is a list of statements dealing with your general feelings about yourself. Please indicate how strongly you agree or disagree with each statement.

1=Strongly Agree  2=Agree  3=Disagree  4=Strongly Disagree

1. On the whole, I am satisfied with myself.
   Strongly agree  1  2  3  Strongly disagree  4

2. At times I think I am no good at all.
   Strongly agree  1  2  3  Strongly disagree  4

3. I feel that I have a number of good qualities.
   Strongly agree  1  2  3  Strongly disagree  4

4. I am able to do things as well as most other people.
   Strongly agree  1  2  3  Strongly disagree  4

5. I feel I do not have much to be proud of.
   Strongly agree  1  2  3  Strongly disagree  4

6. I certainly feel useless at times.
   Strongly agree  1  2  3  Strongly disagree  4

7. I feel that I’m a person of worth, at least on an equal plane with others.
   Strongly agree  1  2  3  Strongly disagree  4

8. I wish I could have more respect for myself.
   Strongly agree  1  2  3  Strongly disagree  4

9. All in all, I am inclined to feel that I am a failure.
   Strongly agree  1  2  3  Strongly disagree  4

10. I take a positive attitude toward myself.
    Strongly agree  1  2  3  Strongly disagree  4
VITA

KRISTIE VAIL SCHULTZ, M.A.

EDUCATION

**Doctoral Candidate in Clinical Psychology**

The University of Mississippi, Oxford, MS

Currently Enrolled

**Doctoral Dissertation:** Examining Hope and Resilience among Mississippi Adolescents

**Committee Members:** Karen A. Christoff, Ph.D. (Chair), Michael T. Allen, Ph.D., Scott A. Gustafson, Ph.D., and Debra J. Moore, Ph.D.

**Master of Arts, Clinical Psychology**

The University of Mississippi, Oxford, MS

May 2012

**Master’s Thesis:** Impacts of Race/Ethnicity and Self-Esteem on Body Dissatisfaction in Women

**Committee Members:** Karen A. Christoff, Ph.D. (Chair), Stefan E. Schulenburg, Ph.D., and V. Carrie Smith, Ph.D.

**Bachelor of Science, Psychology**

Magna Cum Laude, with a minor in Business

Tulane University, New Orleans, LA

May 2009

**Honors Thesis:** Effect of Self-Esteem and Ego Threat on Perspective Taking

**Committee Members:** Carrie Wyland, Ph.D. (Chair), Julie Alvarez, Ph.D., and Michele Adams, Ph.D.

**Bachelor of Arts, English**

Cum Laude, with a minor in Sociology

Tulane University, New Orleans, LA

May 2009
CLINICAL INTERNSHIP

University of Louisville School of Medicine, Department of Pediatrics
Clinical Child and Pediatric Psychology Doctoral Internship Program
July 1, 2015 – June 30, 2016

- Duties as a therapist included conducting intake assessments, individual therapy, and family therapy with children and adolescents with a variety of presentations, including youth with chronic pain and chronic illness
- Duties as an assessment technician included preparing for and administering assessment batteries for a variety of presenting problems, scoring the assessments, preparing the integrated report, and providing feedback
- Duties as an Emergency Room Evaluator included conducting psychological assessments in the Kosair Children’s Hospital Emergency Room to a variety of patients who presented due to concerns of safety, generating a disposition, and recommending appropriate follow-up care
- Duties on the Medical Specialties rotation included seeing patients on a multidisciplinary team in both Neurology and Endocrinology, with an emphasis on using psychological treatments to aid in management of illness, such as using biofeedback or behavioral plans
- Duties on the Consult/Liaison rotation in Kosair Children’s Hospital included assessing reason for referral, teaching appropriate coping skills (e.g., diaphragmatic breathing), writing notes to be read by a multidisciplinary team, and recommending appropriate follow-up care
- Duties on the Ackerly Psychiatric Unit included attending multidisciplinary rounds, seeing youth on the psychiatric unit for individual therapy, and attending family sessions led by social workers
- Supervisors included Bryan D. Carter, Ph.D., Sarah E. Spurling, Ph.D., and Brooke Threlkeld, Ph.D.

CLINICAL EXPERIENCE

Communicare
Community Mental Health, Calhoun County, Mississippi
Therapist Intern
2014-2015

- Duties as a therapist include conducting intake assessments, individual therapy, and family therapy with adults with serious mental illness and adolescents with severe emotional disturbance, as well as completing all necessary paperwork
- Supervised by Dixie J. Church, M.A., LMFT, LSW, Clinical Director of Adult Services

Psychological Services Center
The University of Mississippi
Graduate Student Therapist
2012-2015

- Duties included conducting intakes, seeing clients (from the community and the university, both adults and children), and completing all necessary paperwork
- Supervisors include Karen A. Christoff, Ph.D., Tom Lombardo, Ph.D., Laura R. Johnson, Ph.D., and Scott A. Gustafson, Ph.D.
Psychological Assessment Center  
The University of Mississippi  
Graduate Student Assessment Administrator  
2011-2015  
- Duties included administering comprehensive batteries of assessments (tests of intelligence, achievement, and personality) to clients (both adults and children), scoring the assessments, preparing the integrated report, and providing feedback  
- Supervisors include Stefan E. Schuenburg, Ph.D. and Scott A. Gustafson, Ph.D.

Region IV Mental Health Services, Youth Services Office  
Community Mental Health, DeSoto County, Mississippi  
Graduate Intern  
2012-2014  
- Duties as a therapist included seeing school-aged children with severe emotional disturbance for therapy either in a school setting or in an office setting, conducting intakes, meeting and keeping in contact with parents, consulting with the school as needed, and completing all necessary paperwork  
- Additional duties as a therapist included leading Anger Management Groups for court-ordered adolescents in an office setting  
- Duties as an assessment administrator included meeting with the child’s parent, conducting a comprehensive assessment (which typically included tests of intelligence, achievement, and personality), scoring the assessments, contributing to the final report, and assisting with feedback sessions  
- Supervised by Priscilla Roth-Wall, Ph.D., licensed clinical psychologist

Office of Student Disability Services  
The University of Mississippi  
Verification Specialist  
2011-2012  
- Duties included conducting an initial interview with the university student seeking accommodations for disabilities due to psychological, attention, or learning difficulties, reviewing all necessary paperwork provided by the licensed professionals, and verifying the student for additional services  
- Supervised by Stefan Schulenberg, Ph.D.

RESEARCH EXPERIENCE

The University of Mississippi—Clinical Disaster Research  
Research Assistant  
2011-2012  
- In response to the Deep Horizon Oil Spill, studied the effects of the oil spill on the mental health of affected individuals on the Mississippi Gulf Coast in a grant-funded effort, supervised by Stefan E. Schuenburg, Ph.D. (The University of Mississippi), in conjunction with the Mississippi Department of Mental Health  
- Duties included weekly contact with three mental health sites, quarterly visits to the sites, data entry, and assisting in preparing the quarterly reports
Mississippi Youth Programs Around the Clock (MYPAC)
Research Assistant
2010-2011
 Assisted in a research project focused on Mississippi Youth Programs Around the Clock (MYPAC), which provided an array of services for Mississippi youth with severe emotional disturbance as an alternative to traditional psychiatric residential treatment facilities, as supervised by John Young, Ph.D. (The University of Mississippi)
 Duties included traveling to MYPAC sites around the state of Mississippi and administering psychometric batteries to parents and children receiving services, as well as data entry for such batteries

Diabetes Research
Research Assistant
2006-2008
 Assisted in a study which examined if an internet tool would lead to better blood sugar control with children with Type I and Type II diabetes, which was supervised by Enrique Varela, Ph.D. (Tulane University) and Jodie Kamps, Ph.D. (New Orleans Children’s Hospital)
 Duties included recruiting families for the study, administering surveys, uploading data from glucose meters, and entering data into SPSS

PRESENTATIONS


*Note: Name was legally changed in January 2012 from Kristie Vail to Kristie Vail Schultz.

**AD-HOC REVIEWING**

In J. M. Sattler (Ed.), *Foundations of Behavioral, Social, and Clinical Assessment of Children.* La Mesa, CA: Jerome M. Sattler, Publisher, Inc.
- Reviewed four chapters in the 6th edition of this textbook.
- Listed in the acknowledgements section of the text
TEACHING EXPERIENCE

Graduate Instructor of Record
The University of Mississippi
- Psychology 301: Developmental Psychology (DeSoto Campus: Summer 2013)
- Psychology 201: General Psychology (Oxford Campus: Fall 2013, Spring 2014)
- Psychology 311: Abnormal Psychology (DeSoto Campus: Fall 2014; Spring 2015)

Graduate Teaching Assistant
The University of Mississippi, Oxford Campus
- Psychology 201: General Psychology (Fall 2010, Spring 2011)
- Psychology 311: Abnormal Psychology (Spring 2011)
- Psychology 610: Graduate Cognitive Assessment (Fall 2011)
- Psychology 611: Graduate Personality Assessment (Spring 2012)

OTHER WORK EXPERIENCE

Big Brothers Big Sisters of Southeast Louisiana
New Orleans, Louisiana
Match Support Specialist
July 2009 – July 2010
- Served as a contact for families of children and volunteers who wish to be paired in a one-to-one mentor relationship
- Collected data on the progress of the matches from parents, children, and mentors
- Oversaw the progress of ninety community-based matches
- Oversaw the school-based mentor programs in three New Orleans schools

VOLUNTEER EXPERIENCE

American Foundation for Suicide Prevention
Walk to Prevent Suicide, The University of Mississippi
2011-2013
Planning Committee and Volunteer
- Assisted in planning the annual walk, fundraising, and preparing the memorial

SEMINAR COURSES

While attending The University of Mississippi in the Clinical Psychology Doctoral Program, the following seminars were included in my coursework (and are each listed as PSY 621 on my transcript):
- Multicultural (in Spring 2012 with Dr. Laura R. Johnson, Ph.D.)
- Anxiety Disorders: Assessment and Cognitive-Behavioral Treatments (in Fall 2012 with Todd A. Smitherman, Ph.D.)
- Acceptance and Commitment Therapy (in Spring 2013 with Kelly G. Wilson, Ph.D.)
HONORS

Child Clinical and Pediatric Psychology Internship Award for Excellence
June 2016
Awarded this honor in recognition of outstanding performance in training as an aspiring child or pediatric psychologist by the Department of Pediatrics at University of Louisville School of Medicine

Mississippi Psychological Association Poster Award
September 2013
Awarded this honor in regards to “The evolution of bullying among adolescents: A call for research”

Mississippi Psychological Association Poster Award
September 2011
Awarded this honor in regards to “Application of Beck youth inventories-second edition to patients with chronic illnesses”

Newcomb Scholar
May 2009
Awarded this honor for excellence in research by Tulane University in regards to “The effect of self-esteem and ego threat on perspective taking”

MEMBERSHIP

American Psychological Association (Student Affiliate)
Association for Behavioral and Cognitive Therapies (Student Affiliate)