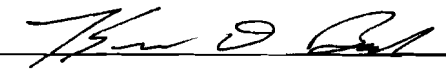


AN ABSTRACT OF THE THESIS OF

Julie Ann Moreland for the Master of Science  
in Psychology presented on February 22, 1999  
Title: The Relationship Between Hope and Social Support  
Among College Students and Individuals with Substance Abuse  
Abstract approved: 

The purpose of this study was threefold. First, it sought to determine what relationship existed between hope and social support. Second, it investigated the relationship between substance abuse and/or dependency and its effect on hope and social support. To assess these variables, the Hope Scale and the Social Support Questionnaire (Short Form) were administered to 26 individuals identified as substance dependent and 25 participants not identified as substance dependent. It was hypothesized that a positive relationship existed between hope and social support. In addition, it was hypothesized that individuals identified as substance abusing/dependent would have low hope and inadequate social support compared to individuals not identified as substance dependent. Results supported each hypothesis indicating that substance dependent participants had lower levels of hope and perceived having fewer social supports than those not identified as chemically dependent. There are several suggestions for future research.



THE RELATIONSHIP BETWEEN HOPE AND SOCIAL SUPPORT  
AMONG COLLEGE STUDENTS AND INDIVIDUALS WITH SUBSTANCE ABUSE

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A Thesis Presented to  
the Division of Psychology and Special Education  
EMPORIA STATE UNIVERSITY

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In Partial Fulfillment  
of the Requirement for the Degree  
Master of Science

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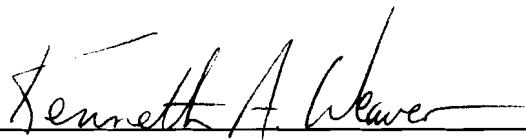
by

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## CHAPTER 1

## INTRODUCTION

People who have strong social support networks reportedly have heightened levels of hope. Snyder (1994), an expert on hope theory, stated that "in interviews I have held with high-hope people, they appear to have a social support network they can call on in the good and the bad times" (p. 60). When we are surrounded by supportive friends, family, and peers, our lives seem more meaningful, and obstacles seem less of a threat. Melges and Bowbly (1969) concluded that "feeling able to rely on others also plays a large part in determining feelings of hope" (p. 691).

Much research has been conducted on special populations where social support is very important. Social support benefits substance abusers (Tucker, 1982; Westermeyer, 1989; Westermeyer & Neider, 1988), those dealing with chronic illnesses (Strudler Wallston, Whitcher Alagna, McEvoy DeVellis, & DeVellis, 1983), and mental health (Greenblatt, Becerra, & Serafetinides, 1982). To date, the two concepts of hope and social support have not been combined to assess their interrelationship. This study seeks to gather information regarding the relationship of these two variables in substance abusers.



### Purpose of Study

The purpose of this study was threefold. First, it was to determine the relationship between hope and social support. Past research suggests that the two concepts separately produce some of the same positive affective states. Therefore, there may be a direct relationship between the two. Second, it was to determine if levels of hope in individuals abusing and/or dependent on substances were different than those not identified as substance dependent. The expectation is that abusing substances negatively affect an individual's level of hope. Third, it was to investigate the social support networks of those two identified populations. Due to the body of research which supports the importance of social support networks in recovery from physical ailments and mental illnesses, social support networks become an important issue when recovering from substance abuse.

### Hope

The Greek myth of Pandora's box is not clear about whether hope was to be the antidote for evil or an illusion to prolong the suffering of humankind. Ezra Stotland, a hope theorist, contends that "with hope, man acts, moves, achieves. Without hope, he is often dull, listless, moribund" (1969, p. 1).



Contrary to Stotland's theory, William Shakespeare once wrote, "and so, by hoping more, they have but less" (1935, p. 79). From this notion, hope is most like a curse, portrayed as an illusion, lacking a basis in reality. Snyder combines these two viewpoints by stating "we have been bestowed a very favorable gift, as long as it is goal-directed hope" (1994, p. 3).

### Theories of Hope

Several theories of hope have been developed over the past three decades. Averill, Catlin, and Chon (1990) perceived hope as an emotion governed by cognitive rules. These authors conducted survey research aimed at discovering how people define hope. Participants in their research revealed that the emotion of hope is normal when a goal is important, is more than likely attainable, and is socially acceptable. This theory is a social context-oriented view of hope, making it difficult to measure.

A second theory of hope, developed by Ezra Stotland, related that the center of hope was "an expectation greater than zero of achieving a goal" (1969, p. 2). He emphasized the person's cognitive analysis of goal-related outcomes. Stotland stated we may best understand others' hope by observing their behavioral outcomes in situations. This



theory of hope is focused on goal-directed thinking and behavior.

Snyder developed an additional theory of hope that has some of the same notions as Stotland's original theory. Snyder asserts that "we are inherently goal-oriented" (p. 4, 1994). He contends that because of our goal orientation, we are constantly thinking of how to get from point A to point B. This cognitive process of attaining goals is broken down into the two subcomponents of agency and pathways.

Agency is defined as "cognitive will power or energy to get moving toward one's goals" (Snyder, 1995, p. 355). It is the sense of mental energy which directs the person toward their goal. Agency is a pool of commitment, determinism, and motivation which evokes such thoughts as "I'll try," "I can," or "I'm ready to do this."

The other subcomponent of hope theory is pathways. This is the "perceived ability to generate routes to get somewhere" (Snyder, 1995, p. 355). Snyder states that pathways or waypower are the mental road maps or plans which guide hopeful thinking. When we cannot reach our goals by our initial pathway, hopeful thinking allows us to see and select alternative roadways or pathways in order to attain the desired goal.



### Personality Traits and Hope

Hope has been related to several personality traits, behaviors, and emotional states. Emotional states have been shown to be more positive than negative in higher hope people. For example, higher hope individuals have been found to be less anxious (Snyder et al., 1991), more alert, inspired, determined, attentive, less angry, nervous, and fearful (Irving, 1991; Snyder et al., 1991). Elliott, Witty, Herrick, and Hoffman (1991) concluded that people with higher hope are less depressed.

Optimism was defined by Sheier and Carver (1985) as the disposition to view life favorably, and to expect good things to happen. Faced with an obstacle, optimists will increase efforts to succeed. Anderson (1988) found that individuals higher in hope were additionally higher in optimism.

Another concept related to hope is perceived locus of control (Anderson, 1988; Snyder et al., 1991); people with higher levels of hope experience more control over their lives. When participants were administered the Hope Scale and a desirability of control scale, the correlation between the two measures was .54 ( $p < .005$ ; Snyder et al., 1991). Anderson (1988) found that those with more hopefulness also tended to have more desire for control. In addition, when



the hope and locus of control instruments were compared, higher hope individuals scored toward the internal source of control.

Social desirability and self-esteem among high and low hope individuals have also been examined. Snyder (1991) asserted the "results suggest a tendency of higher hope people to present themselves in a favorable light" (p. 575). In accord with that research, Anderson (1988) contended higher hope people tended to have scores which reflected higher self-esteem. Other researchers (Munoz-Dunbar, 1993; Sympson, 1993) have confirmed similar findings. This is explained as higher hope people having accomplished their goals in the past believe they can do so in the future.

#### Physical Health and Hope

Hope also has been examined in the domain of health. Irving (1991) conducted research on hope's effect on cancer-related health beliefs, knowledge, and behavior of female college students. She found that those higher in hope had greater knowledge about cancer, tended to perceive cancer as less threatening, and reported greater number of strategies for influencing cancer risks. In a similar study, Irving, Snyder, and Crowson (1998) found that college women who were higher as compared to lower in hope reported more hope-specific coping responses to cancer (i.e., skin



self-examinations, reduction of cigarettes smoked, and reduction of number of hours spent in the sun on average).

People with high hope have also been found to generally exercise more and engage in preventative health to enhance their willpower (Irving, 1991). With more energy to pursue goals and feeling more in control of those goals, we engage in hopeful activities.

### Substance Dependency and Hope

The clinical community generally accepts that substance abusers exhibit negative affective states. For example, chemically dependent individuals tend to have lowered self-esteem due to guilt from their use. Chemically dependent individuals isolate themselves from others, thus experiencing feelings of loneliness (George, 1990). In contrast to those individuals high in hope (Irving, 1991), substance abusers tend to experience unpredictable mood swings (George, 1990) and negative affective states. There seem to be many similarities between substance dependent individuals and those individuals with low hope, although these similarities have not been investigated. Based on the conceptual relationship between low hope and substance dependency, substance abuse/dependency may be a predictor of lowered levels of hope.



## Social Support

The effect of social support has long been recognized as beneficial to both psychological and physical well-being. Many different definitions of social support appear in the literature (Barrera, 1986; Heitzmann & Kaplan, 1988). Although there are subtle differences among these definitions, all agree that social support is beneficial in the recovery from physical illness, mental illness, and chemical dependency.

### Physical Health and Social Support

Social support has a major impact on physical health. Mutran, Damis, Bratton, Sudha, and Hanson (1997) investigated the factors in the desire to prolong life in an older population. They found that among other variables, the close linkage between the individual and family in African Americans resulted in a strong desire to prolong life.

Contradictory reports have emerged regarding social support and physical regimens. Udry (1997) asserted that the social support networks and coping strategies of 25 athletes undergoing knee surgery would predict adherence to rehabilitation following surgery. She found that although these athletes reported high levels of social support, coping strategies were a stronger predictor of rehabilitation adherence. This is contrary to a study



conducted by Duda, Smart, and Tappe (1989). These investigators found social support was directly related to rehabilitation adherence. Similarly, Earp, Ory, and Strogatz (1982) found individuals with hypertension receiving only standard care were less likely to have controlled their blood pressure than those receiving standard care plus periodic home visits from nurses. Although not conclusive, social support appears to positively effect program adherence.

The effects of social support on physical health differ based on gender. Wohlgemuth and Betz (1991) examined the degree to which gender moderated the relationship among stress, social support, and physical well-being. Of 115 undergraduates, stress, social support and their interaction accounted for 29% of the variance in physical symptomatology in women. In men, stress, social support and their interaction accounted for a nonsignificant (4%) amount of the variance. The authors indicated that one possibility for the difference between women and men in their sample was women reported "significantly more stressful life events" than did men (p. 373).

#### Mental Health and Social Support

Severe and persistent mentally ill individuals have long been recognized as being socially isolated. The social



networks of people with psychotic disorders are approximately one-fifth the size of normal subjects (Pattison, DeFrancisco, Frazier, Weed, & Crowder, 1975). Meeks and Murrell (1994) investigated the social networks of clients with severe mental illness. As hypothesized, larger network sizes were positively related to all adjustment variables (i.e., everyday living/personal care, community and occupational involvement, mood, affect, and symptoms). In addition, network size was related to the number of reciprocal links, defined as personal contacts in which the individual received as well as gave support. The authors' conclusion was that many individuals with chronic mental illness have small network sizes, consisting mainly of mental health providers.

Other aspects of mental health have been examined in regard to social support. For example, social support has a negative relationship with anxiety, while a lack of support is positively related to both anxiety and depression (Ray, 1992; Bowers & Gesten, 1986). Sherbourne, Hays, and Wells (1995) explored the outcome and course of depression in a longitudinal study. They found "patients who reported greater levels of social support were less likely to develop a new depressive episode and showed more of a decrease in depressive symptoms over time" (p. 350). Other researchers



have also found that strong family ties are predictive of low relapse rates in depression (Billings & Moos, 1985).

Additional research on social support has focused on anger coping styles. These findings suggest the habitual inhibition of anger has adverse effects on social support systems (Lane & Hobfoll, 1992; Palfai & Hart, 1997). For example, Palfai and Hart (1997) administered questionnaires dealing with coping styles of anger, social support, and social desirability. The results indicated those participants with greater social support systems tended to cope with anger in more positive ways. The research further found that individuals who suppress anger believed they had no one with whom they could discuss their personal problems.

#### Substance Abuse and Social Support

With the emergence of Alcoholics Anonymous (AA) in 1935, the importance of social support and abstinence from alcohol and other drugs has been recognized as a special relationship. Many studies have investigated the support systems of drug users to determine treatment outcomes (Brownell, Marlatt, Lichtenstein, & Wilson, 1986; Hawkins & Fraser, 1987; Westermeyer, 1989). For example, Hoffman and Noem (1976) found that 83% of 37 alcohol "successes" attended AA about once a day, while 46% of "failures"



attended weekly. This shows an association between AA attendance (social support) and a better treatment outcome.

Westermeyer and Neider (1988) examined social networks and psychopathology of substance abusers. They collected data on 168 patients from diverse sources (e.g., referrals by physicians, social workers, courts, and alcohol-drug treatment facilities). Overall, the only significant predictor of social network size was scores on the Modified Michigan Alcohol-Drug Screening Test (MAST). Individuals with high scores on the MAST tended to have smaller social networks. High scores on the MAST are characteristic of individuals who have serious substance use-related problems, which may negatively effect social networks.

Other researchers have linked social support and coping mechanisms to drug abuse. Tucker (1982) collected data on 170 women and 202 men. Interviews were conducted to ascertain social support, coping styles in regard to anger and depression, and substance use. She found men drank when support in general was lacking but women tended to drink when relations with their mate were not optimal.

Other investigators have examined the relationship between social support and relapse. Among them, Havassy, Hall, and Wasserman (1991) investigated individuals' alcohol, opiate, and nicotine dependencies. They found



several pieces of data which suggest social support plays a strong role in relapse. Specifically, among participants who had non-using partners, 56% relapsed. In addition, there was a 75% relapse rate for those not intimately involved. They also found that those who had a drug user in their immediate social network were at a higher risk to relapse. Those participants who were more involved in social systems were less likely to relapse (Brownell et al., 1986).

#### Summary of Hope and Social Support

Stotland (1969) theorized that the support of others determines one's hopefulness throughout the life span. Snyder (1994) reported that higher hope people rely on social support networks. No researchers to date have directly compared social support and hope.

Those high in hope benefit from optimism, less anxiety and depression, internal locus of control, heightened self-esteem, and greater physical health. Individuals with strong social support networks experience many of the same benefits (i.e., physical health, less anxiety, and less depression). Although conceptually related, the empirical relationship between hope and social support has not been examined.

Many characteristics of substance abusers are similar to those experienced by individuals low in hope and who have



few social supports. Therefore, substance dependence may be a predictor of low hope and inadequate social supports.

### Hypotheses

The interrelationship between hope and social support has not been examined, although the two concepts produce similar benefits to individuals. Therefore, a positive correlation between levels of hope and strength of social support networks was hypothesized to exist.

Due to past research indicating that individuals who abuse substances display negative affective states (i.e., lowered self-esteem, loneliness, and mood swings), their levels of hope were hypothesized to be lower than individuals not identified as substance dependent. In addition, past investigations have suggested that individuals who do not have adequate social support networks experience negative affective states, higher risk for relapse, and less concern for physical health. Therefore, individuals who are considered substance dependent were hypothesized to have less adequate social support networks compared to non-substance dependent individuals.



## CHAPTER 2

### METHOD

#### Participants

A total of 51 men participated in the current study. Only men were included due to the low female population seeking treatment for chemical dependency in the geographic region utilized in the study. For better internal validity, participants were generally matched on age and geographic location of residence. Twenty-five of the participants were students enrolled in introductory psychology classes at a small Midwestern university. The other 26 participants received drug and alcohol outpatient group therapy at a local community mental health center for substance abuse and/or dependency. Each participant voluntarily participated in all research activities.

The student population was made up of 80% Caucasian, 8% Asian, 8% Hispanic, and 4% African American participants. The mean age for that group was 26.3 years and ranged from 22 to 44 years. The chemically dependent group was similar in ethnic background (77% Caucasian, 12% African American, 8% Hispanic, and 4% other) with a mean age of 33.8 years, ranging from 19 to 64 years.

#### Instruments

The Hope Scale. The participants were administered the



Hope Scale (Snyder et al., 1991). This is a 12 item Likert-type paper-and-pencil questionnaire. Four statements relate to agency, four relate to pathways, and four are filler items. Participants read each statement and then rate on a scale from one to eight, ranging from definitely false to definitely true, the applicability of each statement to them. The scoring of this scale is additive with scores ranging from 12 to 96. The higher the overall score, the more hope the individual displays.

The Hope Scale (see Appendix A) has shown adequate test-retest reliability. The correlations were reported from .73 over an 8-week period to .85 over a 3-week interval. In addition, it has been reported as internally consistent with Cronbach's alphas ranging from .74 to .84 (Snyder et al., 1991).

The Hope Scale possesses both concurrent and construct validity. It was compared to instruments measuring positive outcome expectancies, the Life Orientation Test (LOT) and the Generalized Expectancy for Success Scale (GESS). The LOT correlated .50 with the Hope Scale, and the GESS correlated .54.

Social Support Questionnaire Short Form(SSQSR). The SSQSR (Sarason, Sarason, Shearin, & Pierce, 1987) is a social support measure derived from the Social Support



Questionnaire (SSQ) developed by Sarason, Levine, Basham, and Sarason (1983). It assesses an individual's number of supports available and the satisfaction of those supports (see Appendix B). Each of the six items of the SSQSR requires a two-part response. Participants are asked to (a) list the people they can count on for support in a given set of circumstances and (b) indicate their overall level of satisfaction with these supports. A sample question is "Whom can you really count on to be dependable when you need help?"

The SSQSR yields three scores. N is the number of supports available, S is the overall level of satisfaction with those supports, and T is an average of N and S. The N score is figured by summing all supports listed and dividing by six, to obtain a mean N. The S scores range from 1 (very dissatisfied) to 6 (very satisfied). For each item, these figures are summed and divided by the total number of items (6).

Reliability studies (Sarason et al., 1983) for the SSQ were based on a normative sample of 602 undergraduate students. Coefficient alphas were .94 for S and .97 for N. Test-retest correlations over a 4-week period were .90 for N and .83 for S, suggesting the SSQSR has been shown to have



internal consistency. The Cronbach's alphas for SSQSR-N and SSQRS-S ranged from .90 to .93, respectively.

Construct validity of the SSQSR was based on comparing it and the SSQ to several other measures. Significant negative correlations occurred between the SSQ-N and the SSQ-S and measures of emotional discomfort (anxiety, depression, hostility) as measured by the Multiple Adjective Affect Check List (MAACL) (-.25 and -.19, respectively). Similarly, the SSQSR-N and SSQRS-S also produced negative correlations (-.26 and -.17) when compared to the MAACL. These results are in accord with past research which has found negative affective states to be negatively correlated with strong social support networks. Results show the validity of the SSQSR is as strong as the original SSQ, suggesting that the short form is a reliable and valid instrument.

### Procedure

After seeking the approval of the Institutional Review Board, the local community mental health center, and acting therapists, participants were approached by the researcher during their routine outpatient group therapy sessions. They were asked to voluntarily participate in this study. In addition, participants from introductory psychology classes were asked to attend a research session at a specific



pre-determined time. All students were briefly screened for their substance use intake and were not used in the study if they reported regular consumption of substances (i.e., more than three times weekly). The researcher explained the nature of the study, read the informed consent document (see Appendix C), and went over the directions for each questionnaire. The questionnaires were then administered.



## CHAPTER 3

## RESULTS

To test the first hypothesis a Pearson correlation coefficient was calculated between hope and social support. Results of the Pearson product-moment correlation yielded a significant positive relationship ( $r(49) = .46, p < .01$ ) between levels of hope and social support networks among all participants ( $N = 51$ ). This finding suggests that higher levels of hope are associated with greater social supports.

Next, two  $t$  tests were used to determine if substance abusers have lower levels of hope than those who do not abuse substances, and substance abusers perceive having inadequate social support networks compared to those not identified as substance dependent. The two  $t$  tests revealed that the difference between individuals not identified as substance dependent and participants identified as substance dependent with regards to hope and social support were significant (see Table 1). The mean hope score for those not identified as chemically dependent ( $M = 52.60, SD = 4.29$ ), was greater than the hope score for individuals identified as chemically dependent ( $M = 43.23, SD = 7.79$ ),  $t(49) = 5.29, p < .01$ . In addition, non-using participants ( $M = 5.40, SD = 1.41$ ) perceived to have higher social support



Table 1

Means and Standard Deviations of Hope and Social Support for  
Non-Substance Abusers and Substance Abusers

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	<u>Non-Substance</u> <u>Abusers</u>		<u>Substance</u> <u>Abusers</u>		<u>Total</u>	
	<u>M</u>	<u>SD</u>	<u>M</u>	<u>SD</u>	<u>M</u>	<u>SD</u>
Hope	52.60	4.29	43.23	7.79	47.82	7.85
Social Support	5.40	1.41	4.35	1.52	4.86	1.55

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than chemically dependent individuals ( $\underline{M} = 4.35$ ,  $\underline{SD} = 1.52$ ),  $\underline{t}(49) = 2.56$ ,  $\underline{p} < .05$ .

These results support the hypothesis that individuals who are chemically dependent have less hope than those not identified as chemically dependent. In addition, the hypothesis that chemically dependent individuals perceive having less social support than non-abusers is supported.



## CHAPTER 4

## DISCUSSION

As hypothesized, a positive relationship was found between hope and social support. Each construct has been discovered to produce similar benefits to individuals. Hope has been related to several positive personality traits, behaviors, and emotional states. For example, higher hope people are less anxious (Snyder et al., 1991), less angry, nervous, and fearful (Irving, 1991; Snyder et al., 1991), less depressed (Elliott et al., 1991), more optimistic (Anderson, 1988), exercise more (Irving, 1991), and take precautions regarding cancer-related risks (Irving et al., 1998).

Similarly, individuals who report adequate social support networks benefit from positive attributes and experiences. Mutran et al. (1997) found a desire to prolong life in individuals with close linkage between them and their family. In addition, people with adequate social supports are less anxious and depressed (Bowers & Gesten, 1986; Ray, 1992), cope positively with anger (Palfai & Hart, 1997), and generally comply with physical rehabilitation regimens (Duda et al., 1989; Earp et al., 1982).

Although the positive correlation between hope and social support is significant, other variables may influence



that relationship. For example, hope and optimism are associated (Anderson, 1988); individuals with more hope may appear to have a positive outlook on life, thus attracting more people to them. This might suggest that it may be easier to gain social support being optimistic.

The present data also suggest hope and social support are lacking in individuals identified as substance dependent, in comparison to non-substance dependent students. Lack of hope in these individuals may be due, in part, to unachieved goals and expectations. Stotland's (1969) theory of hope stated that we may best understand others' hope by observing their behavioral outcomes to situations. Because Snyder's Hope Scale is based on a goal-oriented theory of hope, participants with lower hope may perceive their goals and behavioral outcomes to achieve those goals as negative. Negative affective states associated with low hope are captured by Stotland's statement, "Without hope, he is often dull, listless, moribund" (1969, p. 1).

Substance dependence can often strip an individual of self-esteem and social support. In addition, individuals with chemical dependency have unpredictable mood swings and other negative affective states (George, 1990). Men tend to drink when support in general is lacking (Tucker, 1982).



Without social support, individuals tend to be more anxious and depressed (Bowers & Gesten, 1986; Ray, 1992).

Although these findings are significant, questions still remain as to the causal relationship between hope and social support. One cannot concretely say levels of hope cause adequate or inadequate social supports or vice versa. It may depend on specific personality traits, personal experiences, and/or stress. Although it is difficult to definitely determine how these two factors affect one another, it still stands they are beneficial to possess.

Psychotherapists may have favorable outcomes to therapy if hope is high and social supports are strong, not only among substance abusers but among other persons seeking treatment. Clinicians should assess levels of hope and social support in clients prior to treatment. Adequate levels of both may predict better treatment outcomes or if low, may be foci of therapy.

It is recommended that future research should utilize a larger sample and a more appropriate comparison group. A larger sample will increase statistical power. A comparison group of randomly selected individuals from the community would help to generalize results. Matching abusing and nonabusing participants closely on age and utilizing an in-



depth alcohol and drug screening process for a comparative sample are also recommended.

Although the Hope Scale still merits use, there is one caveat. Cronbach's alphas reported by Snyder et al. (1991) ranged from .74 to .84, which may need to be investigated in future research efforts to determine if this scale is as reliable as other hope measures. These results need to be replicated before concrete inferences can be made from other samples.

An additional recommendation is to longitudinally assess the hope and social support levels of individuals who may be at risk for developing substance abuse problems. Such individuals may be identified based on background information (i.e., family history of substance abuse, problems with primary support group, or lack of coping skills). The utilization of an assessment tool may afford clinicians the opportunity to detect if substance abusers lack hope and social support.



## References

- Anderson, J. R. (1988). The role of hope in appraisal, goal-setting, expectancy, and coping. Ph.D. dissertation, University of Kansas, Lawrence.
- Averill, J. R., Catlin, G., & Chon, K. K. (1990). Rules of hope. New York: Springer-Verlag.
- Barrera, Jr., M. (1986). Distinctions between social support concepts, measures, and models. American Journal of Community Psychology, 14, 413-445.
- Billings, A. G., & Moos, R. H. (1985). Life stressors and social resources affect posttreatment outcomes among depressed patients. Journal of Abnormal Psychology, 94, 140-153.
- Bowers, C. A., & Gesten, E. L. (1986). Social support as a buffer of anxiety: An experimental analogue. American Journal of Community Psychology, 14, 447-451.
- Brownell, K. D., Marlatt, G. A., Lichtenstein, E., & Wilson, G. T. (1986). Understanding and preventing relapse. American Psychologist, 41, 765-782.
- Duda, J. L., Smart, A., & Tappe, M. K. (1989). Predictors of adherence in the rehabilitation of athletic injuries: An application of personal investment theory. Journal of Sport and Exercise Psychology, 11, 367-381.
- Earp, J. L., Ory, M. G., & Strogatz, D. (1982). The



effects of family involvement and practitioner home visits on the control of hypertension. American Journal of Public Health, 72, 1146-1153.

Elliot, T. R., Witty, T. E., Herrick, S., & Hoffman, J. T. (1991). Negotiating reality after physical loss: Hope, depression, and disability. Journal of Personality and Social Psychology, 61, 608-613.

George, P. L. (1990). Counseling the chemically dependent: Theory and practice. Englewood Cliffs, NJ: Prentice Hall.

Greenblatt, M., Becerra, R. M., & Serafetinides, E. A. (1982). Social networks and mental health: An overview. American Journal of Psychiatry, 139, 977-984.

Havassy, B. E., Hall, S. M., & Wasserman, D. A. (1991). Social support and relapse: Commonalities among alcoholics, opiate users, and cigarette smokers. Addictive Behaviors, 16, 235-246.

Hawkins, J. D., & Fraser, M. W. (1987). The social networks of drug abusers before and after treatment. International Journal of the Addictions, 22, 343-355.

Heitzmann, C. A., & Kanplan, R. M. (1988). Assessment of methods to measuring social support. Health Psychology, 7, 75-109.

Hoffman, H., & Noem, A. A. (1976). Criteria for the



differentiation of success and failure in alcoholism treatment outcomes. Psychological Reports, 39, 887-893.

Irving, L. M. (1991). Hope and cancer-related health beliefs, knowledge, and behavior: The advantage of the "negotiated" reality principle. Ph.D. dissertation, University of Kansas, Lawrence.

Irving, L. M., Snyder, C. R., & Crowson, J. J., Jr. (1998). Hope and the negotiation of cancer facts by college students. Journal of Personality, 66, 198-214.

Lane, C., Hobfoll, S. E. (1992). How loss affects anger and alienates potential supporters. Journal of Consulting and Clinical Psychology, 60, 935-942.

Meeks, S., & Murrell, S. A. (1994). Service providers in the social networks of clients with severe mental illness. Schizophrenia Bulletin, 20, 399-406.

Melges, R., & Bowbly, J. (1969). Types of hopelessness in psychopathological processes. Archives of General Psychiatry, 20, 690-699.

Munoz-Dunbar, R. (1993). Hope: A cross-cultural assessment of American college students. Master's thesis, University of Kansas, Lawrence.

Mutran, E. J., Davis, M., Bratton, K. A., Sudha, S., & Hanson, L. (1997). Attitudes of the critically ill toward prolonging life: The role of social support. Gerontologist,



37, 192-199.

Palfai, T. P., & Hart, K. E. (1997). Anger coping styles and perceived social support. Journal of Social Psychology, 137, 405-411.

Pattison, E. M., DeFrancisco, D., Frazier, H., Wood, P., & Crowder, J. (1975). A psychosocial kinship model for family therapy. American Journal of Psychiatry, 132, 1246-1251.

Ray, C. (1992). Positive and negative social support in chronic illness. Psychological Reports, 71, 977-978.

Sarason, I. G., Levine, H. M., Basham, R. B., & Sarason, B. R. (1983). Assessing social support: The social support questionnaire. Journal of Personality and Social Psychology, 44, 127-139.

Sarason, I. G., Sarason, B. R., Shearlin, E. N., & Pierce, G. R. (1987). A brief measure of social support: Practical and theoretical implications. Journal of Social and Personal Relationships, 4, 497-510.

Scheier, M. F., & Carver, C. S. (1985). Optimism, coping, and health: Assessment and implications of generalized outcome expectancies. Health Psychology, 4, 219-247.

Shakespeare, W. (1935). Venus and Adonis: The rape of Lucrece. The Pheonix and the turtle. New York: Dutton.



Sherbourne, C. D., Hays, R. D., & Wells, K. B., (1995). Personalized psychosocial risk factors for physical and mental health outcomes and course of depression among depressed patients. Journal of Consulting and Clinical Psychology, 63, 345-353.

Snyder, C. R. (1994). The psychology of hope: You can get there from here. New York: The Free Press.

Snyder, C. R. (1995). Conceptualizing, measuring, and nurturing hope. "Current Trends" focus article in Journal of Counseling and Development, 73, 355-360.

Snyder, C. R., Harris, C., Anderson, J. R., Holleran, S. A., Irving, L. M., Sigmon, S. T., Yoshinobu, L., Gibb, J., Langelle, C., & Harvey, P. (1991). The will and the ways: Development and validation of an individual differences measure of hope. Journal of Personality and Social Psychology, 60, 570-585.

Stotland, E. (1969). The psychology of hope. San Fransisco, CA: Jossey-Bass, Inc. Publishers.

Struder Wallston, B., Whitcher Alagna, S., McEvoy DeVellis, B., & DeVellis, R. F. (1983). Social support and physical health. Health Psychology, 2, 367-391.

Sympson, S. (1993). Construction and validation of a state hope measure: A month in the lives of college students. Master's thesis, University of Kansas, Lawrence.



Tucker, M. B. (1982). Social support and coping: Applications for the study of female drug abuse. Journal of Social Issues, 38, 117-137.

Udry, E. (1997). Coping and social support among injured athletes following surgery. Journal of Sport and Exercise Psychology, 19, 71-90.

Westermeyer, J. (1989). Nontreatment factors affecting treatment outcomes in substance abuse. American Journal of Alcohol Abuse, 15, 13-29.

Westermeyer, J., & Neider, B. A. (1988). Social networks and psychopathology among substance abusers. American Journal of Psychiatry, 145, 1265-1269.

Wohlgemuth, E., & Betz, N. E. (1991). Gender as a moderator of the relationships of stress and social support to physical health in college students. Journal of Counseling Psychology, 38, 367-374.



## Appendix A

### The Goals Scale

**Directions:** Read each item carefully. Using the scale shown below, please select the number that best describes **YOU** and put that number in the blank provided.

1=Definitely False   2=Mostly False   3=Somewhat False   4=Slightly False   5=Slightly True   6=Somewhat True   7=Mostly True   8=Definitely True

- \_\_\_\_\_ 1. I can think of many ways to get out of a jam.
- \_\_\_\_\_ 2. I energetically pursue my goals.
- \_\_\_\_\_ 3. I feel tired most of the time.
- \_\_\_\_\_ 4. There are lots of ways around any problem.
- \_\_\_\_\_ 5. I am easily downed in an argument.
- \_\_\_\_\_ 6. I can think of many ways to get the things in life that are most important to me.
- \_\_\_\_\_ 7. I worry about my health.
- \_\_\_\_\_ 8. Even when others get discouraged, I know I can find a way to solve the problem.
- \_\_\_\_\_ 9. My past experiences have prepared me well for my future.
- \_\_\_\_\_ 10. I've been pretty successful in life.
- \_\_\_\_\_ 11. I usually find myself worrying about something.
- \_\_\_\_\_ 12. I meet the goals that I set for myself.

**AGE:** \_\_\_\_\_

**GENDER:** ☐ Male

☐ Female

**ETHNICITY:** \_\_\_\_\_

**Do you drink more than three times a week?** ☐ Yes

☐ No

**If yes, how many times a week do you drink?** \_\_\_\_\_

*Thank you for your participation.*



## Appendix B

### Social Support Questionnaire (Short Form)

#### SSQSR

#### INSTRUCTIONS:

The following questions ask about people in your environment who provide you with help or support. Each question has two parts. For the first part, list all the people you know, excluding yourself, whom you can count on for help or support in the manner described. Give the persons' initials, their relationship to you (see example). Do not list more than one person next to each of the numbers beneath the question.

For the second part, circle how satisfied you are with the overall support you have.

If you have had no support for a question, check the words "No one," but still rate your level of satisfaction. Do not list more than non persons per question.

Please answer all the questions as best you can. All your responses will be kept confidential.

#### EXAMPLE:

Who do you know whom you can trust with information that could get you in trouble?

No one	1) T. N. (brother)	4) T.N. (father)	7)
	2) L.M (friend)	5) L.M. (employer)	8)
	3) R.S. (friend)	6)	9)

How satisfied?

6 - very satisfied	5 - fairly satisfied	4 - a little satisfied	3 - a little dissatisfied	2 - fairly dissatisfied	1 - very dissatisfied
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1. Whom can you really count on to be dependable when you need help?

No one	1)	4)	7)
	2)	5)	8)
	3)	6)	9)

2. How satisfied?

6 - very satisfied	5 - fairly satisfied	4 - a little satisfied	3 - a little dissatisfied	2 - fairly dissatisfied	1 - very dissatisfied
-----------------------	-------------------------	---------------------------	------------------------------	----------------------------	--------------------------

3. Whom can you really count on to help you feel more relaxed when you are under pressure or tense?

No one	1)	4)	7)
	2)	5)	8)
	3)	6)	9)



4. How satisfied?

6 - very satisfied	5 - fairly satisfied	4 - a little satisfied	3 - a little dissatisfied	2 - fairly dissatisfied	1 - very dissatisfied
-----------------------	-------------------------	---------------------------	------------------------------	----------------------------	--------------------------

5. Who accepts you totally, including both your worst and your best points?

No one	1)	4)	7)
	2)	5)	8)
	3)	6)	9)

6. How satisfied?

6 - very satisfied	5 - fairly satisfied	4 - a little satisfied	3 - a little dissatisfied	2 - fairly dissatisfied	1 - very dissatisfied
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7. Whom can you really count on to care about you, regardless of what is happening to you?

No one	1)	4)	7)
	2)	5)	8)
	3)	6)	9)

8. How satisfied?

6 - very satisfied	5 - fairly satisfied	4 - a little satisfied	3 - a little dissatisfied	2 - fairly dissatisfied	1 - very dissatisfied
-----------------------	-------------------------	---------------------------	------------------------------	----------------------------	--------------------------

9. Whom can you really count on to help you feel better when you are feeling generally down-in-the dumps?

No one	1)	4)	7)
	2)	5)	8)
	3)	6)	9)

10. How satisfied?

6 - very satisfied	5 - fairly satisfied	4 - a little satisfied	3 - a little dissatisfied	2 - fairly dissatisfied	1 - very dissatisfied
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11. Whom can you really count on to console you when you are very upset?

No one	1)	4)	7)
	2)	5)	8)
	3)	6)	9)

12. How satisfied?

6 - very satisfied	5 - fairly satisfied	4 - a little satisfied	3 - a little dissatisfied	2 - fairly dissatisfied	1 - very dissatisfied
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## Appendix C

### Informed Consent Document

Read this consent form. If you have any questions ask the researcher and s/he will answer the question(s).

The Division of Psychology and Special Education supports the practice of the protection of human subjects participating in research and related activities. The following information is provided so that you can decide whether you wish to participate in the present study. You should be aware that even if you agree to participate, you are free to withdraw at any time, and that if you do withdraw from the study, you will not be subjected to reprimand or any other form of reproach.

You are invited to participate in a study investigating the relationship between goals, support, and substance abuse. You will be given a goals and a social support questionnaire to complete.

Information obtained in this study will be identified only by a code number. Your name will not be associated with the information gathered by the researcher.

Your participation will be completely voluntary. Should you wish to end your participation, you are welcome to do so at any point in this study. There is no risk or discomfort involved in completing this study.

If you have any questions or comments about this study, feel free to ask the researcher. If you have any additional questions, please feel free to contact Julie Moreland (316)343-2211 ext. 514.

Thank you for your participation.

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I have read the above information and have decided to participate. I understand that my participation is voluntary and that I may withdraw at any time without reproach after signing this form should I choose to discontinue participation in this study.

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Name

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Date



I, Julie Moreland, hereby submit this thesis/report to Emporia State University as partial fulfillment of the requirements for an advanced degree. I agree that the Library of the University may make it available to use in accordance with its regulations governing materials of this type. I further agree that quoting, photocopying, or other reproduction of this document is allowed for private study, scholarship (including teaching) and research purposes of a nonprofit nature. No copying which involves potential financial gain will be allowed without written permission of the author.

Julie A. Moreland

Signature of Author

4/19/99

Date

The Relationship Between Hope and Social Support  
Among College Students and Individuals  
with Substance Abuse

Title of Thesis/Research Project

Donna Cooper

Signature of Graduate Office Staff

April 20, 1999

Date Received

original