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The Effects of Group Hope Therapy on Depression, Hopelessness and Hope of Female Students in Isfahan University

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The purpose of this study was to evaluate the effects of group hope therapy on depression, hopelessness and hope of female students in Isfahan University. 26 female students who had referred to the counseling center of Isfahan University and had been diagnosed with depression were invited to participate in this study. Participants were assigned to the control and experimental groups, randomly. Hope, depression and hopelessness were measured by Snyder's Hope Scale, Beck's depression Inventory and, Beck's hopelessness scale. It was hypothesized that hope therapy can decrease depression and hopelessness and increase hope and its components in the experimental group. The results of analysis of covariance showed that, after 8 session of group hope therapy, depression was significantly lower ($p< .01$) and hope was significantly higher ($p<.05$) in the experimental group than the control group. The follow-up data showed that these effects have remained for one month ($p< .05$). The results also showed that hope therapy didn't reduce hopelessness, and its effects on agency thinking did not continue for one month. It was concluded that as a useful method of intervention, hope therapy can be applied to clients with depression.

Keywords: group hope therapy, depression, hopelessness, hope, female students

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Depression is one of the most common problems in primary care, with a prevalence of 5–9% for major depression and 6% for dysthymic disorder (Katon and Schulberg, 1992). World health organization (WHO) has placed depression as the fourth most acute general health problem all over the world (Kaplan and Sadock, 2000). It's predicted that this disorder will be placed as the second critical disorder in 2020 (Sampson, 2001). Researches have shown that this disorder causes high costs (Rioto, 2001), suicide, lack of creativity in workplace and deficits in job and social function (Richelson, 2001).

There are several approaches to the treatment of this prevalent disorder. Researches have shown that short term, active psychotherapies are effective for treating it. For example, cognitive therapy, behavior therapy, and interpersonal psychotherapy have all been identified as effective psychosocial treatments for major depression in adults (DeRubeis and Crits- Cristophe, 1998). These therapies, however, have some limitations and some new approaches are needed to remedy depression. To explore depressive symptoms and the related underlying vulnerabilities, researchers recently have focused on individual- differences variables and cognitive processing styles (Snyder, 2000). With the increasing emergence of the positive psychology movement, theorists and researchers have devoted a great deal of energy to the study of human strengths. Rather than focusing entirely on the negative experiences or perceptions of individuals, researchers within the positive psychology movement have examined constructs such as self control, resiliency, benefit finding, spirituality, optimism, and hope (Snyder and McCullough, 2000). The beneficial effects of these positive expectations or perception on both psychological and physical health are well-chronicled (see e.g., Scheier, Carver, and Bridges, 2001 for a comprehensive review).

The construct of hope in particular has received increasing attention (Snyder, 2000). With respect to psychological adjustment, hope has been found to be positively associated with positive affect (Snyder, Sympson, Ybasco, Borders, Babyak, and Higgins, 1996; Chan and Banks, 2007), life

meaning (Macaro, 2006) and feelings of self-worth (Snyder, Cheavens and Sympson., 1997); and negatively associated with depression (e.g., Snyder et al., 1997), feelings of burnout (Sherwin, Elliott, Rybarczyk, Frank, Hanson and Hoffman, 1992), and negative affect in general (Snyder, Harris, Anderson, Holleran, Irving, Sigmon, Yoshinobu, Gibb, Langelle, and Harney, 1991). Beyond psychological measures, hope is also associated with better physical well-being; for example, adolescent burn survivors who were high in hope engaged in fewer behaviors that impeded recovery (Barnum, Snyder, Rapoff, Mani, and Thompson, 1998). Hope is also associated with (1) higher competency in many life areas (e.g., academic; Snyder, Cheavens and Sympson., 1997), (2) use of adaptive coping methods (e.g., Taylor and Armour, 1996), (3) more flexible and positive thoughts (Snyder et al., 1996; Snyder and McCullough, 2000), and (4) more positive appraisals of stressful events (Affleck and Tennen, 1996).

There are several ways to define hope based on both cultural and scientific perspectives. In Snyder's theory of hope, he reasons that hope is not a passive emotion occurring only in life's darkest moments, but rather it is a cognitive process through which individuals actively pursue their goals (Snyder, 1994). Research has shown that hopeful individuals report fewer symptoms of depression and anxiety (Snyder, Harris, Anderson, Holleran, Irving, Sigmon, Yoshinobu, Gibb, Langelle and Harney, 1991) and more life meaning (Feldman and Snyder, in press) than less hopeful individuals. Hopeful individuals also do well in academic and sports performance (Curry, Snyder, Cook, Ruby, and Rehm, 1997), and they generally report accomplishing their goals more frequently than their low-hope counterparts (Feldman, Rand, Kahle, Shorey and Snyder, Unpublished Manuscript). Snyder (1994, 1995) has operationalized hope as a process through which individuals (1) set goals; (2) develop specific strategies by which to achieve those goals, and; (3) build and sustain the motivation to execute those strategies. These three components of

the hope model are referred to as goals, pathways thinking, and agency thinking.

Goals are the endpoints associated with planful behavior (Snyder, 1994; Snyder, Michael and Cheavens, 1999). In other words, much of what one does is directed toward achieving some goal. Goals consist of anything that an individual desires to get, do, be, experience, or create (Snyder, Feldman, Shorey and Rand, 2002). As such, goals vary widely and encompass virtually every life domain (Snyder and Shorey, Unpublished Manuscript). Furthermore, in hope theory, goals are conceptualized as the major source of emotion. Positive emotions result upon perceived achievement of or movement toward one's goals, whereas negative emotions result from perceived goal failure or movement away from one's goals (Snyder, 2002).

Pathways thoughts reflect a person's perceived ability to identify and develop routes to goals (Snyder, 1994). People engage in pathways thinking when they plan out ways to reach their goals (Snyder et al., 1991, Snyder et al., 1996; Irving, Snyder and Crowson., 1998). It is important to note, however, that the beneficial effects of hope do not result from being able to plot pathways, but from the perception that such pathways could be plotted if desired (Snyder et al., 1991).

The third component of hope, agency thinking, is defined as ''the thoughts that people have regarding their ability to begin and continue movement on selected pathways toward those goals'' (Snyder, Michael and Cheavens, 1999, p. 180). As in Piper's (1978) The Little Engine That Could, agency thoughts such as ''I think I can'' are the fuel that powers the goal-pursuit engine (Snyder, LaPointe, Crowson and Early, 1998). Such thoughts are reflected in the positive self-talk such as ''I'm capable of this'' or ''I am not going to be stopped''. Agency thoughts motivate individuals to initiate and sustain movement along pathways toward their goals (Snyder et al., A last aspect of the hope model is the notion that goals, pathways thinking, and agency thinking reciprocally influence one another. For example, setting important or

particularly meaningful goals may lead to increases in motivation (i.e., agency). In turn, the elevated motivation may inspire the plotting of new pathways. In support of such postulations, research has shown reliable correlations of 0.45 to 0.70 between agency and pathways scores on a paper-and-pencil measure of hope (Feldman and Snyder, in press; Snyder et al., 1991).

The treatment protocol was designed to increase hopeful thinking and enhance goal-pursuit activities as described in hope theory (e.g., Snyder, 1994). Group participants first were introduced to the principles of hope theory and thereafter were given suggestions about how to apply these principles to their own lives. In doing so, participants learnt how to (1) set meaningful, achievable, and measurable goals; (2) develop multiple pathways to work toward goals; (3) identify sources of motivation and counteract any drains on motivation; (4) monitor progress toward goals, and; (5) modify goals and pathways as needed (Snyder, 2000, Snyder, Ilardi, Cheavens, Michael, Yamhure and Sympson, 2000, Cheavens, Feldman, Micheal and Snyder, 2006). Additionally, this intervention is conducted in a group setting because it has been theorized that hopeful thinking reflects a transactional process (Snyder et al., 1997).

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

Method

26 female students who had referred to counseling center of Isfahan University in fall semester 2007, and had been diagnosed with mild depression were invited to participate in therapeutic sessions. Eventually, 20 students

participated voluntarily. Participants were assigned to the control and experimental groups, randomly.

The average participant was 22.94 years old (SD=2.11; range=20-27), and 75% were single. None of them used psychological treatment or drug during the study. At the end of the study, two participants dropped in the experimental group so two participants were omitted of the control group, randomly and statistical analysis was performed on the data from 16 Ss (8 Ss in the control group and 8 Ss in the experimental group).

Measures

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

Beck Depression Inventory-II (BDI-II). The BDI-II is a 21-item self-report inventory that assesses symptoms of depression. Each item is scored on a four-point scale (0–3). Scores can range from 0 to 63, with higher scores reflecting greater symptom severity (0 to 13=no to minimal depression, 14 to 19=mild depression, 20 to 28=moderate depression, and ≥29=severe depression; Beck, Steer and Brown, 1996).

The Beck Hopelessness Scale. Beck Hopelessness Scale is a self-rated 20-item scale with a true false response format. Lower scores indicate more hope

and optimism about the future. A score of 0_3 indicates the absence of hopelessness, 4_8 indicates mild hopelessness, 9_12 indicates moderate hopelessness, and greater than 12 indicate severe hopelessness (Beck, Weissman, Lester and Trexler, 1974).

Demographic data form. Demographic data form included age, number of family members, social economic status, parent's education, average and academic term. This information was collected for the purpose of detecting necessary variables that must be used in covariance analysis as covariate variables.

Procedure

After selecting the sample and randomly assigning them to two control and experimental groups, State Hope Scale, Beck Depression Inventory-II (BDI-II) and Beck Hopelessness Scale were administrated before and after the therapeutic sessions. The treatment manual was designed for a group format over eight 2-h sessions based on Snyder's theory (McDermott and Snyder, 1999). State Hope Scale and Beck Depression Inventory were also administrated to the one month follow-up.

Results

The initial step in the data analytic plan was to examine the distribution of the variables in order to evaluate the influence of potential outliers, skewness, and kurtosis. Because the data were normally distributed and were without significant outliers, no transformations were made for the remaining analyses. The means and standard deviations of variables at pre-test, post test and follow- up test are presented in Table 1.

According to Table 1, The means of hope, agency thinking and pathway thinking at post and follow-up tests in the experimental group are higher and the means of depression and hopelessness are lower than those of the control

Table 1
Means and Standard Deviations at Pre, Post and Follow-up Tests in the Two Groups

	Treatment M(SD)			Control M(SD)		
Hope	Pre	Post	Follow	Pre	Post	Follow
	20.13(4.5)	23.75(6.4)	22.75(4.83)	19.25(5.15)	18.13(5.4)	18.5(5.1)
Agency	9.25(2.6)	11.13(3.48)	10.37(2.2)	9.25(2.65)	9.27(2.7)	9.5(2.4)
Pathway	10.87(2.36)	12.75(3.37)	12.62(3.34)	10(2.51)	8.88(2.64)	9.12(2.8)
Depression	24.37(11.61)	20(12.1)	19.63(10.66)	25(10.6)	24.75(11.5)	24.88(11.09)
Hopelessness	9.75(4.5)	8.5(5.73)	-	10.5(3.1)	10.75(3.24)	-

Table 2
Analysis of Covariance Results

		Post				Follow-up			
		F	P	Partial Eta Square	Observed power	F	P	Partial Eta Square	Observed power
Covariate variables (Pretest scores)	Hope	27.85	.0001	.68	.99	38.40	.0001	.75	1
	Agency	32.39	.0001	.71	.999	48.97	.0001	.79	1
	Pathway	18.17	.001	.58	.98	27.89	.0001	.68	.99
	Depression	252.24	.0001	.95	1	94.37	.0001	.88	1
	Hopelessness	58.52	.0001	.82	1	-	-	-	-
Dependent variables	Hope	7.38	.018	.37	.71	7.11	.019	.36	.7
	Agency	4.48	.05	.27	.5	2.57	.13	.17	.32
	Pathway	8.67	.011	.4	.78	7.94	.015	.38	.74
	Depression	9.18	.01	.42	.8	5.67	.03	.31	.6
	Hopelessness	1.91	.19	.13	.25	-	-	-	-

df=1 for all measures

group. Treatment effects were examined with analysis of covariance and results are presented in Table 2.

Since, none of demographic variables was correlated with dependent variables; only pre-test scores were used as covariate variables. Our primary hypothesis was that the group intervention would decrease depression scores in treatment group. As detailed in Table 2, after removing the effect of pre-test scores, there is significant difference between adjusted depression means of wait-list and treatment groups both in post ($p= .01$) and follow-up test ($p= .03$). Observed power is> 0.7 for the most of variables (except agency), and it shows that the number of sample is enough for this analysis. But the results related to agency variables must be considered with precaution.

This analysis was followed by some additional analysis of covariance to determine whether there were significant changes in hope, agency and pathways scores of the State Hope Scale and hopelessness scores over time for each condition, presented in Table 2. The results show that participants in the treatment group increased hope significantly more from pre-test to post-test and follow- up test than participants in the wait-list condition($P= .018$, and $.019$, respectively). The results also show that participants in the treatment group increased agency significantly more from pre-test to post-test(but not in follow up test) than participants in the wait-list condition($P= .05$). Participants in the treatment group also increased pathways scores from pre-test to post-test and follow-up test more than participants in the waiting-list group($p= .011$, and $.015$, respectively). But hopelessness scores did not change significantly.

Discussion

The present study was designed as an initial test of a group therapy protocol to increase hopeful thought in an Iranian sample. Findings indicate that participation in the 8-week treatment program resulted in increased hope, agency and pathway thinking (components of hopeful thinking), as well as in decreased depressive symptoms when compared to the control group. These

findings are very promising; hinting at the potential value of therapies designed around hope and other strength-based constructs.

The results of the present study are congruent with some other similar studies. Klausner, Clarkin, Spielman, Pupo, Abrams and Alexopoulos (1998), and Klausner, Snyder and Cheavens (2000) conducted a hope-based intervention for older adults diagnosed with depression and maintaining residual depressive symptoms after at least 10-weeks of therapy. Using stratified randomization, participants were assigned to either a hope-based group intervention or a reminiscence therapy group intervention (Klausner, et al., 1998). Although all participants demonstrated statistically significant improvement in depressive symptoms, on the average, participants in the hope-based group demonstrated a greater change in Hamilton Rating Scale for Depression (HAM-D; Hamilton, 1960) scores (pre=22.7, post=7.6) than individuals in the reminiscence group (pre=24.8, post=20.2). The hope-based group resulted in significant improvements on all measured outcomes (e.g., hope, anxiety, family interactions) and resulted in stronger effect sizes than reminiscence therapy (i.e.,HAM-D change d=2.51, d=0.57, respectively). Also Irving, Snyder, Gravel, Hanke, Hillberg and Nelson (1997), Cheavens, Gum, Feldman, Micheal and Snyder (2001) and Hankins (2004) have suggested that interventions based on hope theory decrease depression and anxiety symptoms and increase hope scores. Cheavens, Feldman, Woodward and Snyder (2006) also have suggested that hope therapy increases agency thinking (a component of hopeful thinking), life meaning, and self-esteem, and decreases depression and anxiety symptoms.

As the results showed, this protocol has effected on agency thinking but this effect did not continue to the follow-up stage. This may suggest that for maintaining the agency and motivation to move toward goals during the time it is needed to review the learned techniques.

It was found that this protocol did not have any effect on hopelessness. This finding can confirm this opinion that therapies based on relieving hopelessness

are not the same as therapies based on developing hope. In fact, Snyder's hope scale and Beck's hopelessness scale do not measure two opposite sides of the same construct (Snyder and Rand, 2004). According to Beck, Weissman, Lester and Trexler (1974) hopelessness means, a system of cognitive schemata that includes negative expectations about future. This conceptualization is similar to the concept of optimism that Scheier, Carver and Bridges (2001) have propounded rather than Snyder's hope model, Beck (1974) only focused on outcome expectancies and did not pay any attention to efficacy expectancies but Snyder's conception of hope involves both outcome and efficacy expectancies in a reciprocal relationship that leads to goal directed behavior. Outcome expectancies rely on the belief that behaviors will lead to an outcome or a specific goal. Efficacy expectancies involve the belief that an individual has the ability to perform activities that will end in goal attainment. Additionally, in Beck's hopelessness scale, expectancies of the future are evaluated but in Snyder's hope scale expectancies of the past and present are evaluated. Therefore, it seems that hope and hopelessness are separate yet correlated constructs.

There are limitations to the present study. First, the sample size is small, rendering it difficult to draw definitive conclusions. As a pilot trial, this study was conducted to provide initial evidence of possible applicability to an Iranian sample. Thus, larger samples should be used to replicate and determine the stability of the effects. Second, although this trial utilizes a randomized, control methodology, the comparison condition consisted of a waiting-list rather than an active treatment. Later trials that include an active treatment component/attentional control group would increase the rigorousness of the design. As previously stated, in order to further test the strength enhancement model, we also would like to see these trials conducted with individuals who either are non-distressed or have completed traditional psychotherapy. Third, the participants took part in this study voluntarily that might have influenced the results to some extent. Fourth, using self- report instruments has some

limitations; it is useful that in further studies, researchers use concrete behavioral indexes or semi- structure interviews. Fifth, in this research the sample is restricted to female students at university; it is essential to carry out this study with other samples.

Clinical observation suggests that the length of treatment may not have been sufficient for changes in goal setting and goal pursuit to take full effect. Future studies may be designed to include a longer treatment period and follow-up assessments. Inclusion of longer follow-up assessments would allow researchers to determine if significant effects are maintained.

Future studies may use this or a similar intervention with non-distressed adults or individuals who have remitted psychological disorders. If increases in hope are maintained in such a sample, this would provide further evidence that even without symptom reduction per se, increases in mental health and optimal functioning are possible with a relatively short-term, group treatment. Furthermore, a brief group-based hope intervention may be effective as a ‘‘relapse prevention’’ component used in the latter stage of treatment for specific disorders.

In conclusion, this trial provides promising information about the initial applicability of a group intervention to increase hope and enhance strengths in an Iranian sample.

Because of the pervasiveness of pathology-focused models of psychotherapy, strengths-based approaches have been slow to develop (Cheavens, Feldman, Michael and Snyder, 2006). We hope that the present study stimulates further research on interventions that emphasize the development of client strengths. We believe that it is essential to promote mental health in clients, children, individuals who are languishing, and others who are not at their full mental health potential. By turning our attention to hope and other constructs associated with mental health (e.g., self-esteem, social connectedness, resiliency), there is likely to be movement toward increasing human potential individually and collectively. There is likely a

place for such strength-based interventions in treatment and prevention of mental illness and promotion of mental health. Future studies will provide additional information about optimal treatment design, most appropriate participants, and longevity of results.

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