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Social Support and Well-Being in Early and Mid-Adolescents: The Mediating Role of Hopefulness

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SOCIAL SUPPORT AND WELL-BEING IN EARLY AND MIDADOLESCENTS:
THE MEDIATING ROLE OF HOPEFULNESS

By

Peggy S. Norman

A THESIS

Submitted to
Grand Valley State University
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ABSTRACT

SOCIAL SUPPORT AND WELL-BEING IN EARLY AND MIDADOLESCENTS: THE MEDIATING ROLE OF HOPEFULNESS

By

Peggy S. Norman

Adolescence is known to be a time of transition and special needs. A descriptive correlational study was conducted to examine the impact of hopefulness upon the relationship between perceived social support and general well-being in early and midadolescents in a convenience sample of 61 early adolescents and 54 midadolescents. The Hopefulness Scale for Adolescents, the Adolescent General Well-Being Questionnaire and the Personal Resource Questionnaire Part II were completed by the subjects of a rural, Midwest, high school health class.

The hypothesized and assumed positive relationships between the three variables of perceived social support, hopefulness, and general well-being were supported. Hopefulness was determined to be a mediator in the relationship between perceived social support and general well-being in early and midadolescents.

Further examination of the data indicated that a quarter to a third of the adolescents participated in health risk behaviors like smoking, drug abuse, and frequent thoughts of suicide.

DEDICATION

This thesis is dedicated to the memory of Joshua, a most special adolescent.

*Today, they say there is no more hope and a little boy dies
He leaves this place and is on his way
To a sunny land with joy all day
He didn't know he was leaving, and
The numbness has us all believing
That the pain is too great, we cannot prevail, we cannot see,
We cannot see beyond despair
No hope today.*

*A little boy died today
A little boy who liked to clown, to talk, to laugh, to hang around
We thought we had forever to get to know this child, who was as simple as rain and
as soft as snow
But we were wrong for there is no hope today.*

*Josh, it seems we hardly knew you and we do not know what might have been
Where you would have stood as a man
There are no possibilities, no future dreams to come true,
for there is no hope today
We only have the memory of the laugh we wish we could hear again and again.*

*A little boy died today
He was as simple as rain and as soft as snow*

R. Norman, November 28, 1994

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CHAPTER 1

INTRODUCTION

Adolescence has received increased attention during the last three decades, but the notion of adolescence as a separate stage or period of development in life is relatively new (Meehan, Durlak, & Bryant, 1993). Prior to the establishment of an industrial society, adolescents were considered either children or adults.

Today, adolescence is characterized as having a biological onset (the physical changes of puberty) and a psychological ending (completion of psychosocial tasks). Although there seems to be some disagreement regarding the exact nature of this period and of the tasks that characterize it, most professionals would probably agree adolescence is a time of transition and a stage of unique developmental stress.

Specific stresses associated with adolescence that are different from the stresses of childhood or adulthood are: adapting to rapid physical changes, clarifying sexual values and behaviors, developing a functional and stable self concept and learning new ways to express and negotiate needs, feelings, and desires. In addition, adolescents are

expected to accept new family roles and responsibilities, to formulate personal principles, and to choose a career.

Our culture expects adolescents to organize and make sense of these forces. Yet, our nation is experiencing a time of diverse family ties, economic hardship, and decreased social cohesion. Evidence indicates that in the absence of socially supportive environments, individuals may develop physical and mental illnesses, become aggressive, and resort to chemical abuse (Dworetzky, 1981; Klausmeier, 1985; Yarcheski & Mahon, 1986; Maton & Zimmerman, 1991). When individuals are deprived of meaningful social support they become victims of accidents and commit suicide (Cassel, 1976; Wortman & Dundel-Schetter, 1979; Dakof & Taylor, 1990). Communities across the nation are experiencing an increase in adolescent drug use, academic abandonment, pregnancy, violence, and suicide. In order to acknowledge and effectively support adolescents during this time of health risks, nurses need to determine how social support influences the health or well-being of adolescents.

Social support is believed to play a significant role in the maintenance of health and in the way an individual responds to life stressors. Evidence indicates that a positive response to stressful life events is facilitated by socially supportive environments. Stress-adaptation theory suggests social support buffers stress and reduces the risk of illness in adults and adolescents (Cassel,

1976; Lazarus & Folkman, 1984; Hobfall & Stephens, 1990; Meehan, et al., 1993).

Other studies identify sources (family and friends) of support as critical to adolescent well-being (Olsen, Iversen, & Sabroe, 1991; Bailey, Wolfe, & Wolfe, 1994). Other researchers identify the type of support (emotional, appraisal, information, or tangible aid) provided as essential to an individual's sense of well-being (Brandt & Weinert, 1981; Norbeck, 1981). Yet, others view the costs and benefits associated with giving and receiving support relevant to self-being (Tilden & Galyen, 1987).

As indicated above, the relationship between social support and well-being has been proposed by various authors. Weiss (1974) theoretically proposed this relationship as six elements which establish the conditions necessary for well-being. These six relational provisions are: attachment, nurturance, reassurance of individual worth, social integration, a sense of reliable alliance, and material help and guidance in stressful situations. Weiss proposed that individuals must maintain a number of these relational provisions to establish the conditions necessary for general well-being. This proposition has been tested and supported empirically through the use of various indices in the adolescent population (Yarcheski & Mahon, 1992; Yarcheski, Scoloveno, & Mahon, 1994). Given the existence of a positive correlation between social support and general well-being in the adolescent

population, it now becomes necessary to investigate variables that mediate this relationship. One such variable is hope.

The relationship between hope and social support has been proposed theoretically (McGee, 1984; Dufault & Martocchio, 1985) and supported empirically in adult populations (Foote, Piazza, Holcombe, Paul and Daffin, 1990; Piazza et al., 1991). The relationship between hope and well-being has also been proposed theoretically (Dufault & Martocchio, 1985) and supported empirically in adolescent populations (Hinds, 1988). Yarcheski, Scoloveno, and Mahon (1994) proposed and supported empirically that hope is a mediator in the relationship between social support and general well-being in mid-adolescents.

The research accomplished by Yarcheski et al., (1994) was performed in a middle and upper middle-class suburban high school with mid-adolescents. This research project will replicate the work of Yarcheski et al. with the following exceptions: it will take place in a rural setting and include both early and mid-adolescents. A purpose of replication is to determine if a different setting and inclusion of early adolescents will yield similar results as the original study and add to the generalizability of previous findings.

Purpose of Study

It is an assumption of this study that perceived social support is positively related to adolescent well-being. The purpose of this study is to examine the extent to which hopefulness mediates the relationship between perceived social support and general well-being in early and midadolescents.

CHAPTER 2

CONCEPTUAL FRAMEWORK AND LITERATURE REVIEW

The focus of this descriptive correlation study is to explore the impact of hope on the relationship between perceived social support and general well-being in early and mid-adolescents. An assumption of this study, based on current literature, is that there is a positive relationship between social support and general well-being. Conceptual Framework.

The conceptual framework for this study incorporates various definitions and descriptions of three constructs: (a) social support, (b) hopefulness, and (c) well-being. King's (1981) theory of open systems and model of human interaction is utilized to support the inter-relationships of the three constructs.

Social support. Much attention has been paid in recent years to the effect of social support on the well-being of individuals. During the past decade a rapidly developing body of literature has resulted from a growing research interest concerning the effect of social support on health (Bloom, 1990).

Cassel (1976) and Wilcox (1981) speculated that when individuals are deprived of meaningful social

contact/support, they become susceptible to disease. Vaux (1988) suggested that social support is a dynamic transactional process between person and environment which influences health. Broadhead et al. (1983) proposed conclusive epidemiological evidence showing a link between social support and health. They further suggested four ways social support may affect health: (a) by a direct effect, (b) by buffering adverse health outcomes, (c) by reducing exposure to stress, and (d) by facilitating recovery from health problems.

Other authors suggest that the "buffer" theory offers the most valid evidence linking social support to health. Lazarus and Folkman (1984) stated social support can mediate stress and avert deleterious health outcomes. Alloway and Bebbington (1987) suggested that social support reduces the risk of illness by enhancing an individual's adaptation to stressful events. Schwarzer and Leppin (1990) stated that support from family and friends appears to be the strongest variable in reducing the effects of stress. Hobfall and Stephens (1990) proposed social support has the ability to act as an immediate buffer to multiple stressors.

The options for defining social support appear limitless as the literature is reviewed. Some authors characterize social support as involving an expression of positive affect. Walker, MacBride, and Vachon (1977) defined social support as a positive behavior which assures

people their feelings are understood by others and considered normal in a situation. Kahn and Antonucci (1980) expanded on the concept of positive supportive behaviors by defining social support as interpersonal transactions which involve the affirmation of a person's value and the provision of assistance. Cobb (1976) defined social support as information leading individuals to believe they are loved, cared for, and valued within a mutually obliging network. House (1981) defined social support as a network of supportive individuals and, in functional terms, as the types of resources that are provided within a supportive relationship. Norbeck (1987) expanded on this definition of social support by proposing that the identification of deficit typology may avert negative health outcomes. Tilden and Galyen (1987) detailed social support in terms of its nature and perception of benefits or costs.

Brandt and Weinert (1981) interpreted social support as the nature of interactions within the social network and how they are perceived by the individual as to their supportiveness. Brandt and Weinert cited Weiss's (1974) model of relational functions as their theoretical foundation. For the purpose of this study, the investigation of social support is limited to Weiss's relational dimensions which are considered necessary for health. These relational dimensions are: (a) provision for attachment/intimacy, (b) being a part of a group, (c)

opportunity for nurturance, (d) reassurance of worth, and (e) the availability of informational, emotional, and material help.

To summarize, despite lack of agreement about various aspects of social support, cumulative findings indicate social support has a positive effect on health which is dependent on individual perception. It is logical to assume individuals may have improved health if they believe they will receive aid from supportive relationships within their social network when needed.

Hopefulness. Hopefulness is believed to directly influence health by helping individuals to maintain, regain, or improve their health (Watson, 1979). Korner (1970) stated hope serves to strengthen physiological defenses. McGee (1984) suggested that hopefulness is uniquely human and a vital dimension for sustaining a state of health. Foote, Piazza, Holcombe, Paul, and Daffin (1990) considered hope to be an essential positive phenomenon necessary for acquiring a state of health. Miller (1992) characterized hope as anticipating a "good" state of health and contributing to an improved state of health.

Some authors suggest hopefulness eases the burden of life and its realities. Others believe hope is a necessity for coping with life under situations of extreme duress. Hope assists individuals to bypass ongoing stressful situations (Bloom, 1982). Hope is a key factor influencing

crisis resolution (McGee, 1984). Korner (1970) stated hope is a "tonic remedy" which can defy stress. Frank (1987) suggested that hope gives rise to a sense of well-being and can increase a person's ability to cope with the stress of illness or injury. Piazza, Holcombe, Foote, Love, and Daffin (1991) suggested hope is a necessary phenomenon to successfully adapt to stress and may be a resource to help individuals resist pressure and damage from stressors.

The invisible aspect of hope has complicated conceptualizing and operationally defining it for research. McCorkle and Young (1978) and McGee (1984) unsuccessfully tried to define hope by looking at its counterpart, despair. These authors concluded hope and despair are qualitatively different concepts. Vaillot (1970) suggested hope is a unidimensional trait variable. Miller (1992) detailed hope as a state variable which is influenced by other variables exhibited in the environment at any given time. Dufault and Martocchio (1985) defined hope as a multidimensional life force which is influenced by many variables and as such, may influence other relationships.

Other definitions extracted from literature indicate hope is futuristic, motivating, and involves expectancy. Weiss (1974) defined hope as a desire for some absent good and the capacity to look forward to some event with anticipation. Lynch (1984) and Owen (1989) described hope as having the potential to dissipate powerlessness and contribute to future redefinition. Schneider (1980)

referred to hope as an illusion which creates commitment to life. Smith (1988) delineated hope in terms of probabilities which are a product of the perception of the individual.

According to Hinds (1984), there are four necessary hierarchical levels from which a definition of hope may be derived. These levels include: (a) the degree to which one tries artificially to take on a positive view, (b) the extent to which one believes that second chances exist, (c) the degree to which one has an expectation of a better tomorrow, and (d) an anticipation of a personal future. For the purpose of this study, the investigation of hope is limited to these four levels.

In summary, analysis of the literature suggests hope is composed of many dimensions and is positively correlated with health and meaningfulness in life. One can assume people may have better morale, health, and functioning if they believe in a positive future. As a multidimensional force, hope could be characterized as having an impact on relationships since it is influenced by changing life forces and dependent upon a cognitive appraisal of internal and external resources.

Well-being. Descriptions of health as a human phenomenon pervade the literature. The search for a definition of health has captured the interest of researchers and writers alike for many years. Historically, physical health was of major importance for

acceptance in social groups and the first written conceptualizations of health reflect this idea of wholeness of body (Pender, 1987). Today, health is accepted as more than the absence of disease and is viewed as relative, functional, multidimensional, subjective, and perceptual (Tripp-Reimer, 1984). Health is also viewed as a general sense of well-being (Dunn, 1980). For the purpose of this study, the term health is used synonymously with well-being.

Whitley (1984) used a social organization framework to define health as the capacity to perform socially determined role tasks. Fox (1980) detailed health in relation to socially desirable characteristics and gender role socialization.

Dunn (1980) and Balog (1982) viewed well-being from a functional perspective. These authors discussed health as a method of functioning that affords individuals the ability to strive toward their objectives. Almost three decades ago, Parsons (1953) and Aubrey (1958) determined health functions were dependent on social relationships.

Multidimensional models of health were suggested by Ardell (1977) and Eberst (1984). These authors used the metaphor, dimensions, to indicate different qualities of life and determined health is present when there is a balance among dimensions. This perspective represents the complex nature of individuals functioning within the

environment and implies health is co-created through relationships with others.

Eisen, Ware, Donald, and Brook (1980) cited the World Health Organization's conceptualization of health (a state of physical, mental and social well-being) as the framework for their theory of health. These authors concluded that unique subjective experiences provided by social relations influence the perception of well-being. Schlitt (1983) proposed that general well-being is dependent upon social interaction.

Bradburn (1985) was specifically concerned about the subjective feeling state in formulating his definition of well-being as an indicator of happiness. Aro, Hanninen, and Paronen (1989) were also concerned with the affective/cognitive nature of well-being and detailed health as happiness, a synonym for satisfaction or freedom from stress. Campbell (1976), however, viewed well-being as essentially a cognitive experience, i.e., satisfaction with life. It is within the context of happiness or satisfaction, that these authors linked well-being to social support. Kaplan (1985) stated it is necessary for researchers to pursue defining health in order to define social support. He linked well-being and social support to satisfaction.

Multiple definitions of adult health appear in the literature. Colombo (1986) suggested adolescents have specific requirements for health/well-being. He

conceptualized general well-being composed of physical, social and mental dimensions. Each dimension includes one or more components. The dimension of physical well-being contains components of actual physical health, health behaviors, and perceived health status. The dimension of social well-being is comprised of social participation and social relationships. The dimension of mental/psychological well-being contains components of life events, life satisfaction and happiness. For the purpose of this study, the examination of health/well-being is limited to these dimensions and their specific components.

Nursing theorists agree with many of these authors. They define well-being as a multi-dimensional concept, a value, a subjective state, a cognitive state, and a physical state that is relative to the individual and culturally determined (King, 1981; Newman, 1989; Parse, 1981; Peplau, 1991; and Rogers, 1970).

From this literature, definitions of health have evolved over the years and have taken on different perspectives. Common characteristics found in the literature reviewed are: health is a culturally determined concept and a value derived in part from cognitions. Most authors agree health/well-being is a major concept related to social factors (social functioning, social interaction, and social relationships).

King's (1981) Model. King's (1981) theory of open systems and model of human interaction is presented to

support the inter-relatedness of the constructs of social support, hopefulness, and well-being. King's theory provides a framework for studying the perception of social support in early and midadolescents and the relationship between the structure and function of social support and the outcome of health or well-being.

King (1981) defines interactions as "the acts of two or more persons in mutual presence" (p.85). According to King when individuals come together in any situation, each is perceiving the other, the environment, making mental judgements, taking some mental action, and reacting.

The central focus of King's (1981) theory is the individual interacting with other individuals and with the environment. The concern in this study is adolescents' ability/inability to interact with the environment and to procure resources from within their immediate social network and from the larger social system to maintain a sense of general well-being.

King (1981) describes environment as having two components, internal and external. The internal environment of individuals transforms energy to enable adjustment to change in the external environment. King defined health as a dynamic life experience which implies continuous adjustment to stressors in the internal and external environment through use of an individual's resources. Although King did not use the term well-being,

an assumption of this study is that health and well-being denote the same concept.

Within the metaparadigm concept of person, King (1981) describes three dynamic, open, interacting systems. These systems are the personal system, the interpersonal system and the social system. Individuals and their unique characteristics make up the personal system. Individuals are viewed by King as reacting, time-oriented, social beings with the ability to think, to perceive, and to feel. In this study, the individual adolescent represents a personal system.

Several concepts are described by King (1981) that will help understand the adolescent's ability to interact as an open system: perception, self, space, and time. According to King, human beings react to events in terms of their perception (p. 145). A perception is each individual's interpretation of a subjective world of experience (p. 146). Perceptions are unique for each person because of past experience, concept of self, and availability of resources (tangible aid, information, and nurturance). These perceptions become the basic data for social integration and for measuring the amount of social support available within the context of attachment. Adolescence is thought to be a time of being present-oriented in thoughts and actions (Mercer, 1979; Klausmeier, 1985; Dakof & Taylor, 1990) and as such may influence an individual's perception of situations and experience of

social support. Altered perceptions may impede an adolescent's ability to seek help, information and nurturance.

The self is a dynamic, open system, perceived in relation to another person or object in the environment (King, 1981). Interactions with relevant others gives an individual a sense of self, a unified, complex person (p. 27). King states each person acquires a system of values and goals that give the individual an awareness of personal separateness; yet each person's value system recognizes the influence of significant others and their reaction to the self (p. 28). In this study, adolescence is viewed as a stage of intense, volatile emotions and fluctuating object choices. Adolescence is also a time of critical reassessment of formerly held values and a time of formulating personal values (Mercer, 1979). When there is such an upheaval in self, an inability to interact with others may occur, thus preventing the acquisition of supportive resources.

According to King (1981), space exists in all directions and is the same everywhere (p. 148). It is universal and situational. Space has no boundaries and can be expanded or contracted depending on the quality of the relationship and the behavior of the individuals occupying the space (p. 148). Adolescents may experience an expanded space at one moment and a contracted space at another. This is a period where social crisis is common and peer and

adult relations alternate between being supportive and non-supportive.

Time is defined by King (1981) as a continuous sequence of events moving in successive order. It implies change, a past, and a future (p. 148). Either lengthening or shortening the order or the duration of time determines how individuals perceive the successive order of events in their environment (p. 143). When an individual perceives an orderly flow or arrangement of events, stability and duration are implied. Adolescence is a period during which an individual must master development while receiving contradicting instructions from peers and adults. The awareness of contradictions in the world and a misunderstanding of the feelings and behaviors of others alters perceptions and creates stress which impacts on well-being.

The interpersonal system is defined by King (1981) as "two, three or more individuals interacting in a given situation" (p. 54). In this study, the interpersonal system is composed of the adolescent, basic family members, and close peer relationships. The interaction between the adolescent and members of the interpersonal social system shapes behaviors and influences a sense of personal competence.

King (1981) defined a social system as "units of analysis in a society in which individuals form groups to carry on activities of daily living to maintain life,

health and happiness" (p. 115). A social network is representative of a "unit of analysis" and the terms social system and social network are used synonymously in this study. A network (interpersonal or social) provides the framework for social interaction, defines social relationships, and establishes rules of behavior. Beliefs, attitudes, values, and customs are learned within social systems such as family, school, and church. Social support is representative of the nature of interactions occurring within the social network. Adolescence is a period of socialization that demands completion of many crucial developmental tasks (sexual identity, emotional independence, and preparation for an occupation) and requires varying levels of support from within social networks to achieve and maintain a sense of well-being.

King's (1981) conceptual framework of three interacting social systems with permeable boundaries is compatible with Weiss's (1974) theory of social support. There is a shared assumption that social support comes from a source to a person (system), is available to a person (within a system), and may be passed from one person (system) to another. According to Weiss, social support is emotional, informational, and tangible aid which is available within the context of attachment, social integration, nurturance, reassurance of worth, and reliable alliance. In addition to being necessary as a foundation

for theory, these relational provisions may be viewed as supportive resources.

The permeability of the three systems within the metaparadigm concept of person, identified by King, is depicted in Figure 1 by the broken lines. The broken lines of each system represents the ability of each system to interact with one another and with the environment. Permeable boundaries allow for the flow of resources from the environment, from other systems, and to other systems. This description may imply that resources are received and in this study it is the perception of support given rather than an objective measure of received support that will be measured.

An assumption of this study is: a positive relationship exists between social support and well-being. The literature depicted health as a concept related to social resources and hope as a variable which is dependent upon the perception of internal and external resources. King (1981) proposed that health is determined by social functioning within the three interacting systems through optimum use of one's resources.

In summary, well-being is perceived within King's (1981) personal system as determined by social factors and available resources. Hopefulness is developed within the interpersonal system and the social system, and is perceived in the personal system. Social support is available within the interpersonal system and the social

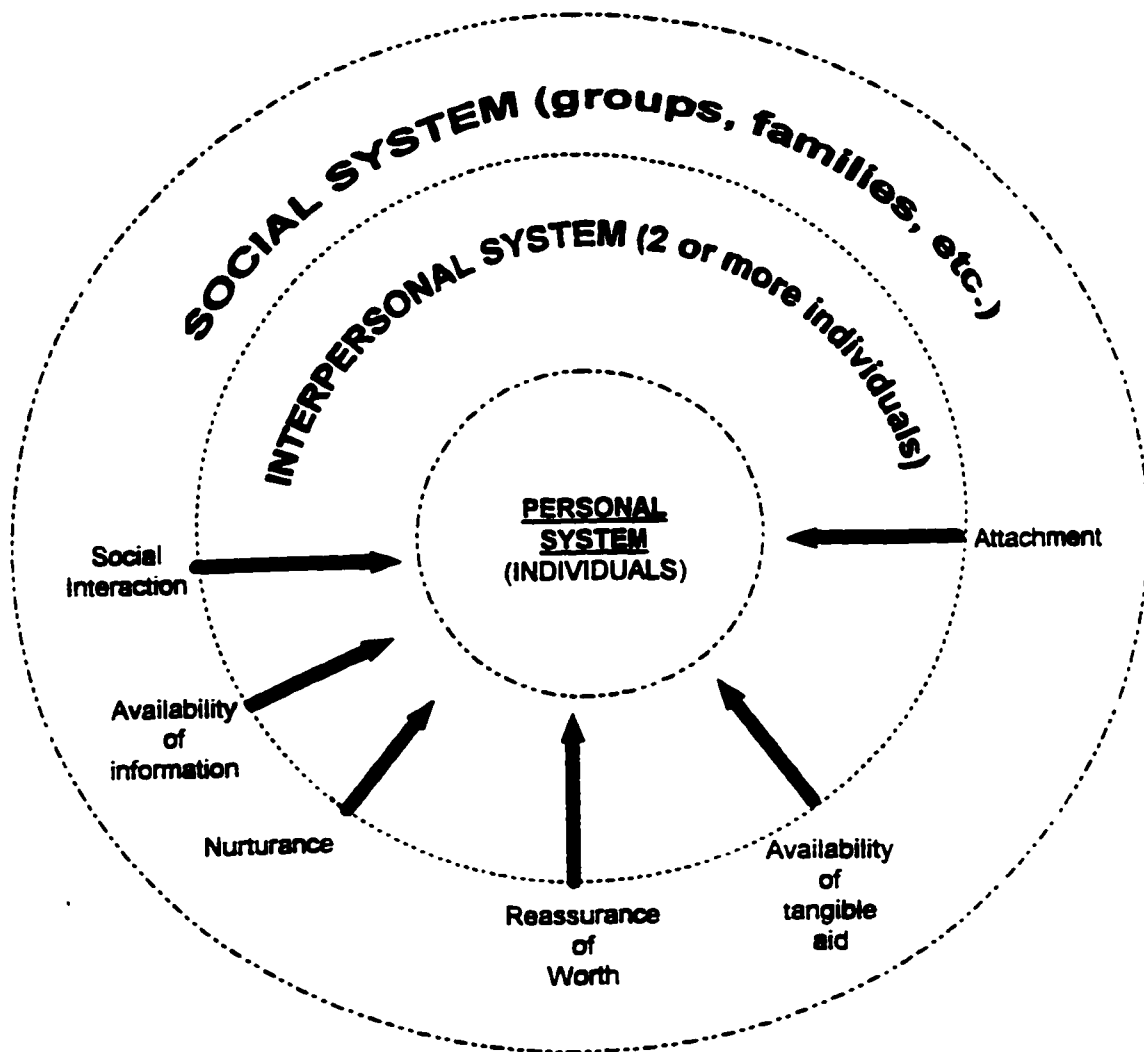


Figure 1. Depiction of the integration of King's (1981) theory of interacting systems and Weiss's (1974) theory of relational provisions.

system, and is perceived in the personal system. King's conceptual framework, encompassing three interacting systems, supports the inter-relatedness of the three constructs under study, social support, hopefulness, and well-being. Figure 2 represents an adaptation of King's framework relative to the constructs.

Literature Review

As a basis for studying the impact of hope on the relationship between perceived social support and general well-being in early and midadolescents, three categories of studies were examined. The first group includes studies that examine perceived social support, its effect on well-being, and explores the idea that variables, such as self-efficacy or hope, may mediate the relationship between social support and well-being. The second set of studies explores the difficulty conceptualizing hope and examines the interrelatedness of hopefulness, social support, and well-being. The last group of studies examines factors that contribute to a sense of well-being.

Social support. A review of studies that address social support and its relationship to general well-being indicates much of the research focuses on perceived support (emotional, tangible and informational) available within a social network. A study by Cwikel, Dielman, Kirscht, and Israel (1988) of an adult convenience sample (N = 854) measured the direct effects of a perceived social support network on physical and mental health. Physical health was

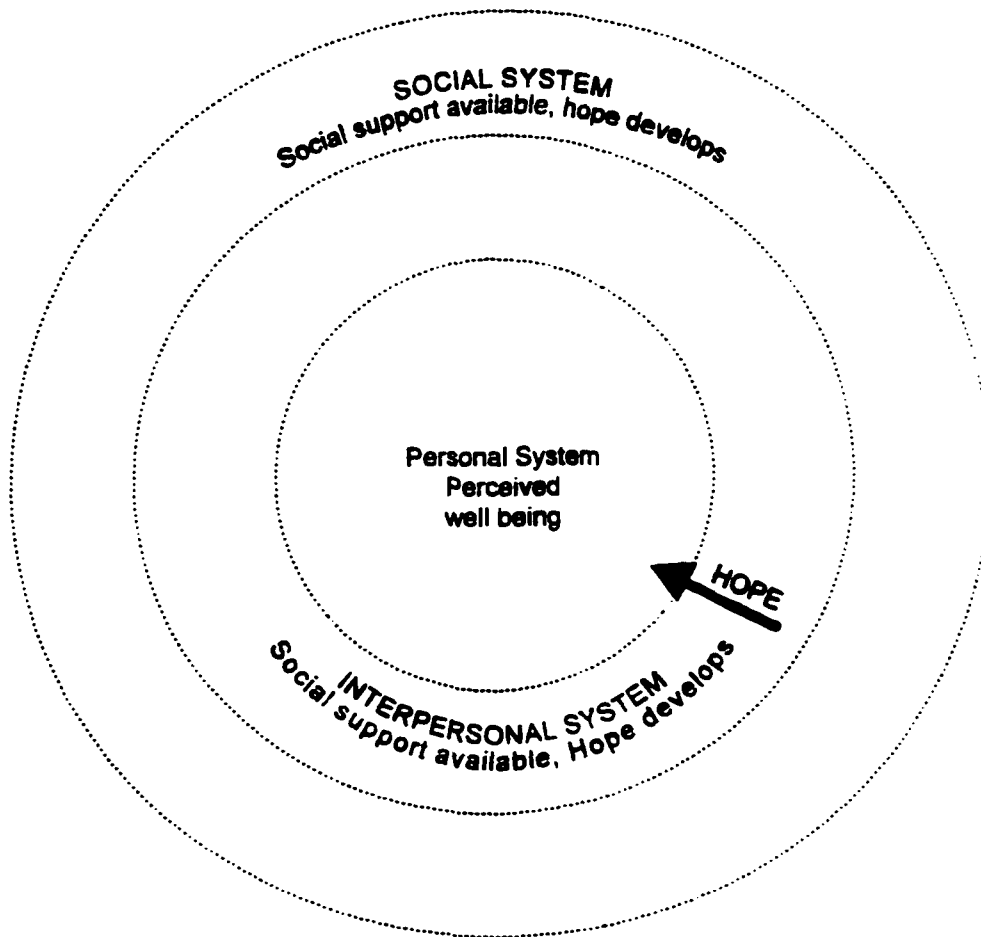


Figure 2. Adaptation of King's (1981) model to integrate study constructs of hope, social support, and well being.

evaluated by two indices: self-rated global health (Global Health Rating Scale) and self reports of chronic disability (Chronic Disability Index). Mental health was assessed using the Center of Epidemiologic Studies Depression Scale. It was hypothesized that perceived social support was related to a sense of "good health" (general well-being) and less depression. Statistically, the overall direct effects of social support were inversely related to depression ($r = -.33, p < .05$) and chronic health conditions ($r = -.19, p < .05$). Persons with less social support were more likely to experience depression. Individuals who perceived less support was available to them from within their social network generally experienced more chronic health conditions. There was a small positive relationship between social support and global health ratings ($r = .16, p < .05$). Individuals who perceived support was available to them from within their social network generally experienced a greater sense of well-being. The hypotheses were supported as the perceived availability of support from a social network was shown to have the predicted direct effects on both physical and mental health status. The results of this study suggest that individuals who believe they can obtain support from within their social network experience greater health.

Cwikel et al. (1988) offered no theoretical foundation to explain the relationships among phenomena. Instead, these researchers favored a path model to explain the idea

of one variable correlating with another. The underlying assumption from which a diagram of correlation was transformed into a model of explanation is the same as the current research: there is a positive relationship between social support and general well-being.

Cwikel et al. (1988) examined the direct effects (access to information or receiving tangible aid) of perceived social support on physical and mental health by focusing only on analyzing the perceived availability of types of support not the enactment of social support or the perception of any negative effects on well-being. This study did not indicate who might provide these types of support nor did the authors examine how integration into the social network increases the ability to draw resources from a network in order to maintain physical and mental well-being. The relationship between social support and global health was not clinically significant. However, this research does provide additional evidence linking perceived social support and physical and mental well-being in the adult population and rationale to pursue the current research within the adolescent population.

A strength of this study is its large sample size. The data reported within this study has three general limitations: data are from self-report measures, data are representative of a single county in Michigan, and data are cross-sectional in nature. The relationships observed in this study may not be generalizable to the extent that

residents of a single county differ with respect to the distribution of scores on and pattern of interrelationships among the variables studied.

To demonstrate how social support functions as a significant element in the general well-being of individuals, Weinert and Brandt (1987) conducted a two-phase research project. Two sets of questionnaires were mailed to 100 adult participants. The questionnaires included the Personal Resource Questionnaire Part II (PRQ-85), the Eysenck Personality Inventory, the Beck Depression Inventory, the Spielberger Self-Evaluation Questionnaire, and the Marlowe-Crown Social Desirability Scale. A second set (retest) was mailed one month later. Pearson correlations were obtained between the total number of resources at Time 1 and the total number of resources at Time 2, and between perceived support at Time 1 and perceived support at Time 2. The test-retest reliability coefficients were $r = .81$, $p < .001$ for the number of resources, and $r = .72$, $p < .001$ for perceived support.

The purpose of this study was to determine if there was a relationship between the number of social support resources and personality and between perceived social support and personality and emotional well-being. No statistically significant correlations were found between social support resources and the respondent's personality. Perceived support was found to be significantly related to the mental health measures and the personality measures. A

weak inverse relationship ($r = -.28$, $p < .001$) was found between neuroticism and perceived social support; persons with more emotional problems are more likely to feel less support. Inverse relationships were also obtained between perceived support and anxiety ($r = -.37$, $p < .001$) and depression ($r = -.42$, $p < .001$). A high score on the perceived support scales was associated with low anxiety and low depression. Non-significant correlations were obtained between the social desirability response scales and perceived social support. In this study, social desirability did not influence how an individual perceives social support. The results of this study suggest the perception of social support or an individual's evaluation of the nature of the interactions occurring within a social network influences health and functioning more than the actual number of resources available to an individual.

In investigating the relationship between perceived social support and well-being, Yarcheski and Mahon (1985) focused on the functional content of relationships within a social network utilizing the theoretical model of Weiss (1974). Yarcheski and Mahon's study supported the theoretical model used for investigation and provides further evidence regarding the relevance of perceived availability and adequacy of social support resources. This study supports the assumption that there is a positive relationship between perceived social support and well-being. The homogeneous sample reduced the

generalizability of the results. Research regarding adults can not automatically be generalized to adolescents and provides rationale for exploring the relationship between social support and well-being within the adolescent population.

Duncan and McAuley (1993) explored social support beyond the individual's perception. This perspective is of value as it contributes to the identification of variables that impact on the relationship between social support and well-being. Duncan and McAuley's research focused on establishing the beneficial effects of social support on well-being by identifying processes by which the social support network influences health promoting behaviors. Thus, the purpose of this study was to determine the extent to which efficacy cognitions and social support influence health promoting behaviors in a population of 85 middle-aged adults. It was hypothesized that social support would not influence health promoting behaviors directly. Social support was expected to influence behaviors indirectly through the mediating effect of self-efficacy.

Two self-efficacy measures were employed to assess individuals' perceptions of their ability to comply with their prescribed exercise regimen. The first measure was composed of hierarchical items relating to level of exercise attainment in terms of intensity, frequency, and duration. The second measure consisted of items relating

to perceived social barriers toward compliance to a program. Reliability of the Barriers to Self-efficacy Measurement was adequate with a standardized alpha coefficient of .93. Perceived social support within the exercise program was assessed by the Social Provisions Scale. This scale was developed to assess three of the six relational provisions of social support identified by Weiss (1974) and required participants to rate the degree to which the exercise group was currently supplying each of the provisions. Cronbach's alpha was calculated to determine the internal consistency of each social provision. These ranged from .69 to .89 in this study. Detailed attendance records were used to create five chronologically ordered attendance scores or five independent sampling periods. During the tenth week of the program, subjects completed the self-efficacy measures and indicated to what degree the exercise group supplied each of the six social provisions by responding to the Social Provisions Scale.

The five chronologically ordered attendance scores represented five independent samples. For analysis, the attendance variables were represented by a single common factor with a mean and variance. To test the hypothesis, the t-statistic was computed and factor regression coefficients were calculated. While social support was hypothesized not to influence exercise behaviors directly, it was expected to influence exercise behaviors indirectly

through the mediating effects of self efficacy. The direct effect of social support on health promoting behaviors (coefficients of factor 1, social support, and factor 3, attendance = .281, $t = 1.537$) was non-significant. The indirect effect of social support on exercise behaviors via self-efficacy (coefficients of all factors, social support, self efficacy and attendance = .417, $t = 3.492$) was determined to be significant and the hypothesis was retained. These results support the contention that there is a relationship between social support and health or well-being. The results also indicate that the identification of mediating variables may help to explain how the effects of social support structures (sources) impact on health or well-being.

Duncan and McAuley (1993) viewed social support and its relationship to well-being as more complex than earlier investigators who viewed social support as influencing health outcomes directly. Although the Duncan and McAuley study demonstrates the complex relationships among social support, self-efficacy and well-being in adults, the use of only three of the social provisions identified by Weiss (1974) suggests judicious use of the findings. While supporting the hypothesized relationship, findings from this study should be regarded as tentative in nature given the small sample size, limited data available for analysis and the non-experimental nature of the design.

Yarcheski and Mahon (1986) studied 136 adolescents to explore the relationships between perceived stress and symptom patterns by examining the effect of two mediating variables, affective-oriented coping and perceived social support. Relevant to this study was Weiss's (1974) proposition that individuals have requirements for well-being that can only be met through social support. Thus, it was expected that symptom patterns would be inversely related to perceived social support.

The Modified Adolescent Life Change Events questionnaire was used to measure the perception of life stress. Reliability computed on test-retest data by using Pearson correlations was satisfactory for an individual's perception of the degree of upset caused by life events ($r = .75$, $p < .001$). The Jalowiec Coping Scale was used to measure affective coping. Test-retest yielded a Spearman rank order correlation coefficient of $r = .80$, $p < .001$. The Personal Resource Questionnaire, Part-II was used to measure perceived social support and the alpha reliability coefficient in this sample of adolescents was .86. The Symptom Pattern Scale measures psychological, physical, and psychosomatic distress. The alpha coefficient reliability of this instrument for this sample of adolescents was .77. Utilizing the median of each variable, it was determined there was a positive relationship between perceived stress and symptom patterns ($\gamma = .40$, $X^2 = 5.76$, $df = 1$, $p < .02$). Affective-oriented coping was positively associated

with symptom patterns ($\gamma = .43$, $X^2 = 7.32$, $df = 1$, $p < .007$) and social support was inversely related to symptom patterns ($\gamma = -.33$, $X^2 = 3.86$, $p < .05$). The authors concluded under the condition of low social support, there was a strong statistical interaction effect between perceived stress and social support, which in turn had an effect on the level of symptom patterns experienced by adolescents. Subjects who perceived life as highly stressful and who experienced low social support manifested a high level of symptom patterns. Under conditions of high perceived social support there was no relationship between stress and symptom patterns. The results of this study suggest that when adolescents perceive life events as stressful and they also perceive a high degree of social support, the stress-buffering effect of social support may avert symptom patterns indicative of reduced well-being.

Yarcheski and Mahon (1986) investigated perceived social support as a variable which may impact on the relationship between perceived stress and well-being in adolescents. The hypothesized relationships were supported. However, limited data were available for analysis given the small sample size and the non-experimental nature of the design. Because variables were measured at one point in time, it was not possible to analyze any changes in perception or changes in symptoms which would be likely to occur in response to changes in life stress. As a result, this cross-sectional approach

provides a rather crude picture of the relationship between life stress, social relationships and adolescent well-being. Despite these limitations, this study does provide rationale for investigating the relationship between social support and well-being in adolescents by identifying variables that may offer an explanation as to how social support influences well-being.

Hopefulness. Throughout the literature, hope and hopefulness are characterized as the same phenomenon. For the purposes of this research project, the terms hope and hopefulness will denote the same concept.

Foote, Piazza, Holcombe, Paul, and Daffin (1990) conducted a study to determine the interrelationships among hope, self-esteem and social support. Three instruments were administered to a sample of 40 adults with multiple sclerosis. These were the Miller Hope Scale (MHS), the Rosenberg Self-Esteem Scale, and the Personal Resource Questionnaire Part II (PRQ-85). The mean MHS score was 157.9, representing a moderately high level of hope among participants. A mean score of 141.13 on the PRQ-II indicates a moderately high level of social support. The mean Rosenberg Self-Esteem Scale score was 29.68 corresponding to a moderate level of self-esteem. Pearson correlation coefficients were used to determine the relationships between hope and social support, hope and self-esteem, and social support and self-esteem. Statistically strong correlations were found between hope

and social support ($r = .74, p < .001$), between hope and self-esteem ($r = .68, p < .001$), and between social support and self-esteem ($r = .43, p < .001$). The only demographic variable found to have a significant influence on hope and self-esteem was employment status. No significant difference in social support was found pertaining to employment status. Individuals who were employed had a higher level of hope and self-esteem than those who were unemployed.

The authors concluded that hope is a multidimensional force which impacts on and is dependent on the perception of social support and is related to personal satisfaction with oneself. Individuals with a higher level of hope perceived a higher level of self-esteem and social support than did those with a lower level of hope. The results suggest supportive relationships may foster hope and self-esteem. Conversely, individuals lacking supportive relationships may view themselves more negatively and have less hope for a positive future. Foote et al. (1990) determined the maintenance of employment may help to foster an individual's feelings of adequacy and self worth, thus increasing one's self-esteem.

Since the sample for the Foote et al. (1990) study was unevenly distributed (32 females and 8 males, 37 caucasian and 3 non-caucasian) and not randomly selected, conclusions can only be applied to this sample. Although the hypothesis for this study was supported, the possibility

exists that individuals with a higher level of hope have a more positive attitude about themselves and as such may be more likely to attract supportive relationships.

Piazza, Holcombe, Foote, Paul, Love, and Daffin (1991) conducted a study with 77 individuals with spinal cord injuries to determine if a relationship existed between hope and self-esteem and between hope and social support. Participants' ages ranged from 18-73 with a mean of 34.79 years. The Miller Hope Scale (MHS), the Rosenberg Self-Esteem Scale, and Personal Resource Questionnaire Part II (PRQ-85) were the instruments used in this study. Strong positive correlations were found between hope and self-esteem ($r = .90$, $p < .001$), between hope and social support ($r = .89$, $p < .001$), and between self-esteem and social support ($r = .79$, $p < .001$). Multiple regression analysis was conducted to determine the best predictor of hope and three variables were found to account for 89% of the variance in hope: self-esteem, social support, and education (beta weights of .532, .466 and .162, respectively). The hypothesis for this study was supported. Higher levels of hope were found in subjects with higher levels of self-esteem and perceived social support. Subjects who demonstrated lower levels of self-esteem and did not believe social support was available to them, demonstrated lower levels of hope. These results support the idea that hope gives rise to a

sense of well-being which is a product of the perception of the individual.

The Piazza et al. (1991) research combined adolescents and adults and no comparisons were made to determine differences or similarities between adolescent and adult levels of hope, social support, or self-esteem. Other limitations of this study include the lack of random procedures in the sample selection and the uneven distribution of sex (58 males, 19 females), and race (54 caucasians and 23 black participants). The degree to which subjects' physical impairments may have influenced their levels of hope, social support, and self-esteem was not addressed by the authors. Despite any limitations, the Piazza et al. work demonstrated strong significant relationships between variables that are of concern in the current research, hope and social support.

In terms of reviewing studies that address hopefulness and its relationship to social support and a positive health status, much of the research available relates to the difficulty in the conceptualization processes to induce a precise construct definition which can be operationalized in research. In a qualitative study, using three samples of adolescents (N = 17, N = 42, and N = 58), Hinds (1984) determined hope to be a positive influence that is future oriented. In this study, two settings served as sources of the three samples: an alternative learning center for secondary education and a 15 bed, in-patient adolescent

treatment unit for substance abuse. Within the in-patient setting, two samples of adolescents were identified: those considered to be "patients" in need of treatment and adolescents who were considered to be "well" and experiencing a situational crisis. The interactive steps of grounded theory methodology were initiated. Each adolescent was interviewed individually by the same investigator utilizing a semi-structured format.

Prior to beginning this work, Hinds (1984) developed two underlying assumptions based on previous research with adult populations: (a) hopefulness is positively correlated with health status and (b) hope is influenced by the behaviors of others. Other underlying dimensions of hope analyzed were attitudes of hope such as positive personal attributes, meaning in life, peace, strength, perceived human family support, energy, and economic assets. The resulting data were analyzed by the grounded theory technique of constant comparative analysis. The result of the interactive research steps of grounded theory methodology was a definition of hopefulness as a life-sustaining belief that a personal and positive future exists for self and others and that this belief spans four hierarchial levels. These levels are: forced effort, personal possibilities, expectations of a better tomorrow, and anticipation of a personal future. This definition suggests adolescents who possess a sense of hope also believe in a positive future and may have better morale,

health, and functioning. No comparisons were drawn between the three groups of adolescents or between adult research findings and adolescents.

The difficulty conceptualizing hope within the adolescent population is described in the Hinds (1984) study. The qualitative approach was utilized to understand the entirety of the phenomenon and capitalize on the subjective as a means for understanding and interpreting the adolescent experience of hope. A limitation of this research is the possibility that the sample does not reflect the parameters of the adolescent population. This research is of value to the current study as adolescence is a period that is different from childhood and adulthood and, as such, hope can be expected to be conceptualized differently for this population. The results imply hope occurs in incremental amounts (hierarchical levels) forming a continuum of degree. This supports the need for current research: determining the role of hope and the degree of hope necessary to influence general well-being in early and middle adolescent populations.

The extent to which hopefulness mediates the relationship between perceived social support and general well-being was investigated by Yarcheski, Scoloveno, and Mahon (1994). The Personal Resource Questionnaire Part II (PRQ-85), the Adolescent General Well-Being Questionnaire (AGWB), and the Hopefulness Scale for Adolescents (HSA) were administered to a sample of 99 midadolescents. Using

Pearson correlations, statistically significant positive correlations were found between perceived social support and general well-being ($r = .55$), between perceived social support and hopefulness ($r = .57$), and between hopefulness and general well-being ($r = .60$).

Hopefulness was hypothesized in this study to be a mediating variable in the relationship between perceived social support and general well-being. To test this hypothesis, three regression analyses were performed. In the first regression equation, perceived social support (the independent variable) positively influenced hopefulness ($F(1, 97) = 45.90, p < .001$), explaining 32% of the variance in hopefulness. In the second regression equation, perceived social support positively influenced general well-being (dependent variable) ($F(1, 97) = 41.84, p < .001$), explaining 30% of the variance in general well-being. In the third regression equation, which included both perceived social support and hopefulness, hopefulness positively affected general well-being ($t = 4.69, p < .001$), explaining 19% of the variance in general well-being. In the third equation, perceived social support added 9% to the explained variance in general well-being beyond the 19% contributed by hopefulness. With hopefulness present, the proportion of variance in general well-being accounted for by perceived social support was reduced from 30% to 9% (second to third equation). The authors concluded that the reduced power in

the test of coefficients from the second to the third equation (Beta weights from .55 to .30) was further evidence that the role of hopefulness was that of a mediating variable in the relationship between social support and general well-being.

According to Yarcheski et al. (1994), perceived social support continued to have a statistically significant effect on general well-being in the third equation. The loss of 21% of explained variance in general well-being by perceived social support was due to the mediation of hopefulness. The magnitude of the effect of perceived social support on general well-being was reduced when hopefulness was present. The authors concluded hopefulness is one mediator in the relationship between perceived social support and general well-being.

The results of this study support Weiss's (1974) proposition that individuals have requirements for well-being that can be met only within the relational provisions of social support. When adolescents perceived these provisions (nurturance, reassurance of worth, tangible aid, etc.) exist, hopefulness takes on greater psychological significance and this belief in a personal, positive future contributes, in turn, to their general well-being.

This study by Yarcheski, Scoloveno, and Mahon (1994) provides direction for the current research. The theoretic propositions of Weiss (1974) were tested with the variables

of social support and well-being. The findings give credence to the theoretical foundation and evidence in support of the relationship between social support and well-being. The findings also give evidence to the assumptions of other authors that hopefulness is influenced by the perception of social support. Instruments specifically designed to assess the concerns of the adolescent population is a particular strength of this study. The major limitation of this study is its use of a cross sectional design. When exploring variables such as social support and hopefulness which can have an impact on a rapidly changing developmental phase, it may be advantageous to use a longitudinal design which would incorporate data collection at pertinent points within the chronological parameters of the developmental phase (early, middle, and late adolescence).

Well-being. Well-being has been studied in a variety of ways. In a study measuring general well-being, Wheeler (1981) investigated five areas of general well-being to determine what factor or factors contributed most to a sense of well-being in a convenience sample of 391 adults. The subjects completed the General Well-Being Questionnaire. This instrument measured feelings, attitudes, lifestyles, physical complaints, and recent events. Factor analysis of the variables within each of the five indices revealed feelings (49% of the variance) contributed most to a sense of well-being. Happiness had

the highest correlation to the other variables within the feelings dimension ($r = .82$). Factor-overall contributions ranked happiness as number 1, social support as number 5, and physical health as number 13 of a total of 130 factors in determining an individual's sense of general well-being. The results of this study suggest psychological well-being makes the greatest contribution to overall general well-being. The results also suggest that how social support is perceived at an emotional level contributes to general well-being.

Wheeler (1981) determined general well-being was a state produced by or associated with a number of subjective factors. A major limitation of this study is the large number of variables identified. These variables are so diverse that it is possible that interpretation of the meaning of their correlations could be as varied as the number of people making those interpretations. Since a probability level of .05 was selected as the significance criterion, it is possible that some of the significant coefficients are due to chance when it is recognized that there are 1,173 correlations to be considered. The sample of people (metropolitan professionals) used in this study is not typical of the country's population and the extent to which these results could be generalized, at the time the study was conducted or now, is questionable.

A major finding of the Wheeler (1981) study was the identification of happiness as the most important single

factor within the dimension of subjective mental health. He then determined happiness was actually psychological mental health, a component of perceived health status. The major results of this early investigation are: identifying that perceptions affect general well-being and demonstrating that it is feasible to determine an adult's level of general well-being. These results provide evidence linking perceptions of social support and a sense of general well-being in an adult population and prompt investigation to determine if there is a parallel relationship between perceived social support and well-being in adolescents.

Eisen, Ware, Donald, and Brook (1980) conducted a study with children 0-13 years of age (N = 1473) to determine if there was a relationship between general well-being, physical health status, age appropriate activity (social health) and mental health (anxiety and depression). Questionnaires were completed by adult proxies. Items within the physical data set included current health, resistance/susceptibility to illness, and mobility. The general health rating scales included items pertaining to adult perceptions of physical health as excellent, good, or poor and positive well-being as happy, lighthearted or enjoys play. Social health was measured by a social relations scale that measured relationships with other children, family, and teacher/classmates. Mental health was measured by anxiety scales (able to relax,

worried) and depression scales (lonely, moody, brooding). Based on the assumption that aspects of general health perceptions (well-being) reflect physical, mental, and social components of health, it was hypothesized that the general health rating scales would be significantly related to all three components (physical, social, and mental health). As hypothesized, the general health rating scales were significantly related to all measures ($r = .39, .42,$ and $.55$ for physical, mental, and social components respectively at $p < .05$). The authors concluded well-being in children and early adolescence is comprised of three components: physical health, mental health, and social relationships; social relationships being the most significant factor. The results of this study support the interrelatedness of social support and general well-being in children and early adolescents and suggest that individuals within these age groups who lack social relationships may be at risk to experience greater physical and mental health problems.

Eisen et al. (1980) empirically supported the link between social support and general well-being in children and early adolescents through the use of objective and subjective measures. The tendency to respond in a socially desirable manner and the parents' own health status may have biased the perceptions and evaluations of children's health status in this study which may reduce the validity of the results. The size of the sample ($N = 1473$) is a

strength of this study; however, network sampling techniques and the cross-sectional design are limitations. This study provides rationale for investigating the relationship between perceived social support and well-being in early and middle adolescent populations.

In a study with 57 early adolescents (average age 12.9 years), Schlitt (1983) hypothesized that the most important factor that contributed to a sense of well-being in this age group was social interaction. The General Well-Being Questionnaire for Children was used to measure four areas of well-being: emotional, mental, physical, and social. Schlitt determined factors from the social and emotional components were the most important areas of general well-being. Correlation coefficients demonstrated statistically significant relationships between social interaction and well-being ($r = .67, p < .05$) and between happiness and well-being ($r = .57, p < .05$). The author concluded that the single most important factor in an early adolescent's well-being is social interaction which encompasses emotional, tangible, informational support available within the context of social integration and attachment. The results of this study suggest early adolescents who lack social interaction/social support may be at risk for reduced physiological and psychological well-being.

Schlitt (1983) empirically supported the link between social support and general well-being through the use of an

instrument that measured both subjective and objective health/well-being. The major limitations of this study were its small (N = 57) conveniently selected sample and that data collection occurred only once. However, even with these limitations, it is logical to apply these findings with early adolescents to midadolescents and the development of a study which encompasses both age groups.

Research Questions

The purpose of this study is to answer the following research questions: (a) to what degree is the relationship between perceived social support and general well-being in adolescents mediated by a perceived sense of hopefulness? and (b) If hopefulness is controlled, how much will the relationship between perceived social support and general well-being be diminished?

Hypotheses

There is a positive relationship between perceived social support and hopefulness in early and midadolescents.

There is a positive relationship between hopefulness and general well-being in early and midadolescents.

The magnitude of the relationship between perceived social support and general well-being in early and midadolescents will be diminished if hopefulness is controlled.

Definition of Terms

Adolescence is defined using Mercer's (1979) view of early adolescence, 13 to 14 years of age and

midadolescence, 15 to 17 years of age. Early adolescents in this study were 13 and 14 years of age. Midadolescents in this study were 15 and 16 years of age.

Perceived Social Support is the adolescent's perception of emotional, tangible, and informational social support available within the context of Weiss's (1974) relational provisions of attachment, nurturance, social integration, reliable alliance, reassurance of worth, and obtaining information, guidance, and tangible aid. No attempts to measure actual support will be made.

Hope/Hopefulness is defined using Hind's (1988) definition of adolescent hopefulness as a comforting life-sustaining belief that a personal and positive future exists for self or others.

Health/Well-Being is defined using Colombo's (1986) definition of adolescent general well-being which is not the sum of three major dimensions (social, physical, and mental/psychological) but is a result of complex interactions between dimensions.

CHAPTER 3

METHODOLOGY

Study Design

A descriptive correlation design was used to examine the relationship between perceived social support and general well-being, between perceived social support and hopefulness, and between hopefulness and well-being in early and midadolescents. The purpose of this study was to examine the extent to which hopefulness mediates the relationship between perceived social support and general well-being. Data were obtained from self-report questionnaires.

Sample and Setting

A non-probability convenience sample, consisting of 61 early adolescents (13 and 14 years of age) and 58 midadolescents (15 and 16 years of age), participated in this study. Of these 119 adolescents, 115 provided usable data (61 early adolescents and 54 midadolescents). Three of those students who did not complete the questionnaires were 17 years of age and the fourth person was 15 years of age. All participants were enrolled in a health education course at a high school located in a rural Midwest community.

Subjects demonstrated a willingness to participate, and could read, write, and speak English. Subjects excluded from the study were those who were unwilling to participate, were under 13 years of age or over 17 years of age, or whose parents objected to their participation in this study. It was anticipated that the inclusion and exclusion criteria utilized in this study would assist in the control of extraneous variables that influence adolescents such as social class and unequal competencies.

Male and female subjects were almost equally represented in the total sample: 57 males and 58 females. In the early adolescent sub-sample (13 and 14 years), there were 38 females and 23 males. In the midadolescent sub-sample (15 and 16 years) there were 20 females and 34 males. The age of participants ranged from 13 years of age to 16 years of age with a mean of 14.5 years ($SD = 0.74$ years). Most of the respondents were high-school freshmen (92% were in the ninth grade). All participants of the early adolescent sub-sample were ninth graders. In the midadolescent sub-sample ($n = 54$), 45 were ninth graders, 3 were tenth graders, and 6 were in the eleventh grade. The ethnic background of the participants was primarily Caucasian (93% of the total sample). A summary of the demographic characteristics for the total sample are listed in Table 1. Table 2 lists the demographic characteristics by sub-sample.

Table 1

Subject Demographic Characteristics

Attribute	Total		13 yrs.		14 yrs.		15 yrs.		16 yrs	
	(N = 115)		(n = 4)		(n = 57)		(n = 41)		(n = 13)	
	N	%	n	%	n	%	n	%	n	%
<u>Gender</u>										
Female	58	50	4	3	34	30	17	15	3	3
Male	57	50	0	0	23	20	24	20	10	11
<u>Race</u>										
Caucasian	107	94	3	3	57	50	34	30	13	11
Black	2	2	0	0	0	0	2	2	0	0
Hispanic	6	5	1	1	0	0	5	4	0	0
<u>Class</u>										
Freshman	106	92	4	3	57	50	40	35	5	4
Sophomore	3	3	0	0	0	0	1	1	2	2
Junior	6	5	0	0	0	0	0	0	6	5
Senior	0	0	0	0	0	0	0	0	0	0

Table 2

Demographic Characteristics by Sub-sample

	Early Adolescents		Midadolescents	
	13 and 14 years		15 and 16 years	
	n = 61		n = 54	
	n	%	n	%
<u>Gender</u>				
Female	38	62	20	37
Male	23	38	34	63
<u>Race</u>				
Caucasian	60	98	47	87
Black	0	0	2	4
Hispanic	1	2	5	9
<u>Class</u>				
Freshman	61	100	45	83
Sophomore	0	0	3	6
Junior	0	0	6	11
Senior	0	0	0	0

Note. Total sample: N = 115.

Instruments

Three instruments were used for this study: (a) the Personal Resource Questionnaire Part II (PRQ-85), completed by the subject, to measure participants' perceived social support (Brandt & Weinert, 1981) (Appendix A); (b) the Hopefulness Scale for Adolescents (HSA), completed by the

subject, to measure participants' level of hopefulness (Hinds, 1984) (Appendix B); and (c) the Adolescent General Well-Being Questionnaire (AGWB), completed by the subject to measure participants' level of general well-being or health (Colombo, 1986) (Appendix C). Demographic data were completed by the subject as part of the AGWB and included age, gender, race, and grade in school. Permission to use the PRQ-85 Part II, the HSA, and the AGWB were obtained from the respective authors (Appendix D).

The Personal Resource Questionnaire Part II. The Personal Resource Questionnaire Part II was developed by Brandt and Weinert in 1981 and modified in 1985. It is a 25 item instrument measuring perceived social support within Weiss's (1974) five dimensions of (a) provision of attachment/intimacy, (b) social integration, (c) opportunity for nurturance, (d) reassurance of worth as an individual, and (e) availability of informational, emotional and material aid. There are five items per dimension. Subjects rate each item on a 7-point scale ranging from strongly agree to strongly disagree. A total score that indicates the level of perceived social support results when all item ratings are summed.

Reliability and validity for the instrument have been established in both adult and adolescent populations (Brandt & Weinert, 1981; Weinert & Brandt, 1987; Mahon & Yarcheski, 1988; Yarcheski & Mahon, 1989). Internal

consistency using Cronbach's alpha has been demonstrated to range from .88 to .93 in adult populations. Test-retest reliability of the PRQ-85 over a four to six week period was reported to be $r = .92$, $p < .001$. Acceptable alpha reliability coefficients have also been reported for Part II of the PRQ-85 in samples of adolescents. The coefficient alphas for early, middle, and late adolescents were .89, .91, and .89 respectively. Reliability of the PRQ-85 Part II for this investigation was established at .92 using Cronbach's alpha.

The establishment of construct and predictive validity for this instrument is ongoing by its authors and by other investigators. Gibson and Weinert (1987) compared the PRQ-85 with five other measures of social support. The Inventory of Socially Supportive Behaviors, the Cost and Reciprocity Index, the Norbeck Social Support Questionnaire, the Social Support Scale and the Interpersonal Support Evaluation List all validated convergence of support measures with the PRQ-85 by demonstrating a positive correlation that ranged from .40 to .74 respectively ($p < .001$).

In the adolescent population, construct validity was established by testing two hypotheses derived from two of Weiss's (1974) theoretical propositions. Yarcheski and Mahon (1986) hypothesized a positive relationship would exist between social support and well-being based on

Weiss's relational provision that social support is a condition necessary for well-being. The second provision indicated that deficits in required relational provisions create a condition of distress. The authors found a positive correlation ($r = .25$, $p < .01$) between the relevant variables of social support and health status. Inverse correlations ($r = -.25$ to $-.39$) were found between the variables of perceived social support and psychosomatic symptom patterns in the same sample of 136 adolescents.

The Hopefulness Scale for Adolescents. The Hopefulness Scale for Adolescents (HSA) was developed by Hinds in 1984. The HSA is a 24-item visual analogue instrument measuring the four categories of hope determined by Hinds to form a continuum proceeding from lower to higher levels of believing. These categories or levels are: forced effort, personal possibilities, expectations of a better tomorrow, and anticipation of a personal future. There are six items per level. Subjects rated each item by placing a slash mark on a 100 mm line to exhibit how often they think like the thought expressed in the item. It is possible for each item to receive a score of 0 to 100. The item score is determined by measuring the distance in mm from the anchor of "I never think this way" to the point where the participant placed the slash mark. Each item's score is summed to determine a total score that

indicates the individual's level of hopefulness. The scores can range from 0 to 2400.

Reliability and validity for the instrument have been established within the adolescent population. Hinds (1984) reported coefficient alphas of .82, .93, and .90 at three separate times for the HSA in a longitudinal study of 25 adolescents. Yarcheski, Scoloveno, and Mahon (1994) reported a coefficient alpha of .90 for the HSA in a study of 99 midadolescents. Reliability of the HSA for this investigation was established at .87 using Cronbach's alpha. To establish content validity, a group of adolescents and a panel of experts were called upon to determine if the categories of hope were related and if so, what was the relationship. The raters had 100% agreement that the categories were related and formed a hierarchy of degree of hopefulness.

The Adolescent General Well-Being Questionnaire. The Adolescent General Well-Being Questionnaire (AGWB) was developed by Colombo in 1986. It is a 39-item instrument measuring adolescent general well-being within the three dimensions of physical, mental, and social health. There are 14 items in the physical dimension, 22 items in the mental dimension, and 3 items in the social dimension. Subjects rate each item on a 5-point scale ranging from strongly agree to strongly disagree. A total score of all dimension items indicates a subject's level of general

well-being and is achieved by summing the responses to each item.

The internal consistency approach was used to estimate the reliability of the AGWB. Colombo (1986) reported a reliability coefficient of .92 in a sample of 1048 adolescents. Yarcheski et al. (1994) reported a coefficient alpha of .93 in a sample of 99 midadolescents. Reliability of the AGWB for this investigation was established at .91 using Cronbach's alpha.

Construct validity of the AGWB was determined by examining the intercorrelations of items to dimensions. The item-to-dimension correlation suggested the items and dimensions were conceptually correct. Item-to-dimension correlations ranged from .09 to .48 for the social dimension, .01 to .62 for the mental dimension, and .18 to .55 for the physical dimension.

The dimension-to-total score was considered the best indicator of construct validity. The score of the subscale mental dimension was the most closely related ($r = .97$) to the total score of existing valid measurement tools for well-being (Quality of Life Scale and Psychiatric Symptom Survey for Adults and for Children). The score of the subscale social dimension was the next most closely related to the total score ($r = .87$) of existing valid measurement tools (Personal Orientation Inventory and Social Well-Being Scales for Children). Factor analysis provided further

support for construct validity of the instrument. The factor which explained the largest amount of the total score variance was an individual's perception of life satisfaction. Life satisfaction accounted for 25% to 27% of the total variance in subject scores. None of the other factors explained more than 4.5% of the total variance. The most explanatory factors were shown to correspond well to and represent items from the AGWB three dimensions of well-being (Satisfaction/mental, loneliness/social, and perceived health/physical health).

Data Collection Procedure

The high school principal and health education teacher were given the opportunity to review the proposed study and the three instruments to be used in the study. Both individuals verbalized an understanding of the process and offered support.

The investigator first met with potential subjects during regular school hours and was identified as a graduate student from Grand Valley State University. The investigator explained that the study was designed to examine how interpersonal relationships and looking toward the future are related to adolescent health. All students were informed that participation in the study was voluntary and that confidentiality and anonymity would be maintained. All potential subjects were given a copy of the informational letter and informed consent form, including

the name and telephone number of the researcher (Appendix E). A date to administer the questionnaires was announced to the potential subjects. Copies of all three instruments were left in the principal's office for parents to review.

At the second visit, questionnaires were administered to students who had given their consent to participate and whose parents did not request exclusion from the study. Student and written permission were matched by the health education teacher. Instructions for completing the three self-report questionnaires were given verbally and examples placed on the black board. All student questions were answered prior to testing. All subjects were given an envelope for their completed surveys and instructed to seal this envelope after they had placed their completed surveys in it. Sealed envelopes were deposited into a slotted box.

Human Subject Considerations

To conduct this study, permission was obtained from the Grand Valley State University Human Subjects Committee (Appendix F) and from the administrative staff of a rural Midwestern high school (Appendix G).

There were no direct benefits to subjects. This research study had the potential for creating a greater understanding of the relationship between perceived social support and general well-being in early and midadolescents. The results may provide direction for nurses in their efforts to design interventions that improve perceived

levels of social support and levels of hopefulness in the early and midadolescent population.

The risks involved for participants were minimal. The investigator and teacher were both aware that the personal nature of some of the items on the questionnaires could prompt feelings of anxiety. The investigator and teacher were available for student questions or concerns following completion of the questionnaires. There were no student concerns.

Confidentiality of all who participated was maintained. No names were placed on questionnaires. All instruments were numerically coded after the administration of the questionnaires was complete. Subjects were informed that all reporting of information gained from the study would be presented in group format (by age group) and available to individuals.

CHAPTER 4

DATA ANALYSIS

The purpose of this study was to examine the extent to which hopefulness mediates the relationship between perceived social support and general well-being in early and midadolescents.

Hypotheses

The hypotheses for this study were: (a) there is a positive relationship between perceived social support and hopefulness in early and midadolescents, (b) there is a positive relationship between hopefulness and general well-being in early and midadolescents, and (c) the magnitude of the relationship between perceived social support and general well-being in early and midadolescents will be diminished if hopefulness is controlled. An assumption of this study was that a positive relationship exists between perceived social support and general well-being.

The assumption and hypothesized relationships between study variables were tested using Pearson correlations. The range, mean, and standard deviation scores of each study instrument are presented in Table 3. Total scores

for the Personal Resource Questionnaire-85 (PRQ-85) Part II were used as the measure of perceived social support. To test the study assumption, total scores of the PRQ-85 Part II were examined in relationship to the total scores for the Adolescent General Well-Being scales. A statistically significant moderate positive correlation was found between perceived social support and general well-being in early and midadolescents ($r = .54$, $df = 113$, $p < .001$).

Table 3

Range, Mean, and Standard Deviation of Study Instruments
(N = 115)

Instrument	Range	Mean	SD
PRQ-85	58-173	138.2	22.6
AGWB	70-186	140.7	21.8
HSA	140-2274	1765.9	386.8

Total scores for the PRQ-85 Part II were examined in relationship to total scores for the Hopefulness Scale for Adolescents (the measure of hopefulness). As predicted in the first hypothesis, a statistically significant moderate positive correlation was found between perceived social support and hopefulness ($r = .62$, $df = 113$, $p < .001$).

Total scores for the HSA were examined in relationship to the total scores for the Adolescent General Well-Being

scale, (the measure of general well-being). As predicted in the second hypothesis, a statistically significant moderate positive correlation was found between hopefulness and general well-being in early and midadolescents ($r = .57, p < .001$).

In this study, as in the Yarcheski, Scoloveno, and Mahon (1994) research, hopefulness was hypothesized to be a mediating variable in the relationship between perceived social support and general well-being. To test this third hypothesis, a series of regression analyses were performed. As in the original study by Yarcheski et al., the regression analyses followed Baron and Kenny's (1986) Mediation Model. According to Baron and Kenny, to establish the role of hopefulness as a mediating variable, the following conditions must be met:

(a) the independent variable must affect the mediator variable in the first equation, (b) the independent variable must affect the dependent variable in the second equation, and (c) the mediator variable must affect the dependent variable in the third equation [in the presence of the independent variable]. If these conditions all hold in the predicted direction, then the effect of the independent variable on the dependent variable must be less in the third equation than in the second equation. There is a reduced power in the test of the coefficients in the third equation (p. 1177).

The following equations were performed to establish mediation: (a) in Equation 1, perceived social support was entered as the independent/predictor variable and hope (the mediator) as the dependent/outcome variable, (b) in Equation 2, social support was entered as the independent variable and general well-being as the dependent variable, and (c) in Equation 3, hope (the mediator) and social support were entered as the independent variables and well-being as the dependent variable.

The results of the regression analyses are presented in Table 4. In Equation 1, perceived social support positively influenced hopefulness. In Equation 2, perceived social support positively influenced general well-being. In Equation 3, hope (the mediating variable) positively affected general well-being (the dependent variable) and the effect of perceived social support (the independent variable) on general well-being was less than in the second equation. In this last equation, the magnitude of the Beta weight for social support was decreased when both perceived social support (the independent variable) and hope (the mediating variable) were regressed on general well-being. The conditions set forth in Baron and Kenny's (1986) Model to establish the role of hopefulness as a mediating variable were met. These equations are consistent with the Yarcheski, Scoloveno, and Mahon (1994) study (Figure 3). In Figure 3,

the results of the Yarcheski et al. research are in bold type.

Table 4

Regression Equations for Statistical Model

Equation #	Dependent Variable	Independent Variable	b	Beta	t	p
1	Hope	Social Support	10.62	.624	8.34	.000
	Constant = 300.454					
	F = 70.45 (df = 1, 110) (p = .000)					
	R ² = .38					
2	Well-being	Social Support	.523	.543	6.80	.000
	Constant = 68.524					
	F = 46.357 (df = 1, 110) (p = .000)					
	R ² = .29					
3	Well-being	Social Support	.298	.309	3.20	.0018
		Hope	.021	.374	3.07	.0002
	Constant = 62.25					
	F = 33.41 (df = 2, 109) (p = .000)					
	R ² = .38					

In addition to the change in the Beta weight, the regression analyses also demonstrates the relative importance of the independent and mediating variables in explaining general well-being. In Equation 2, perceived

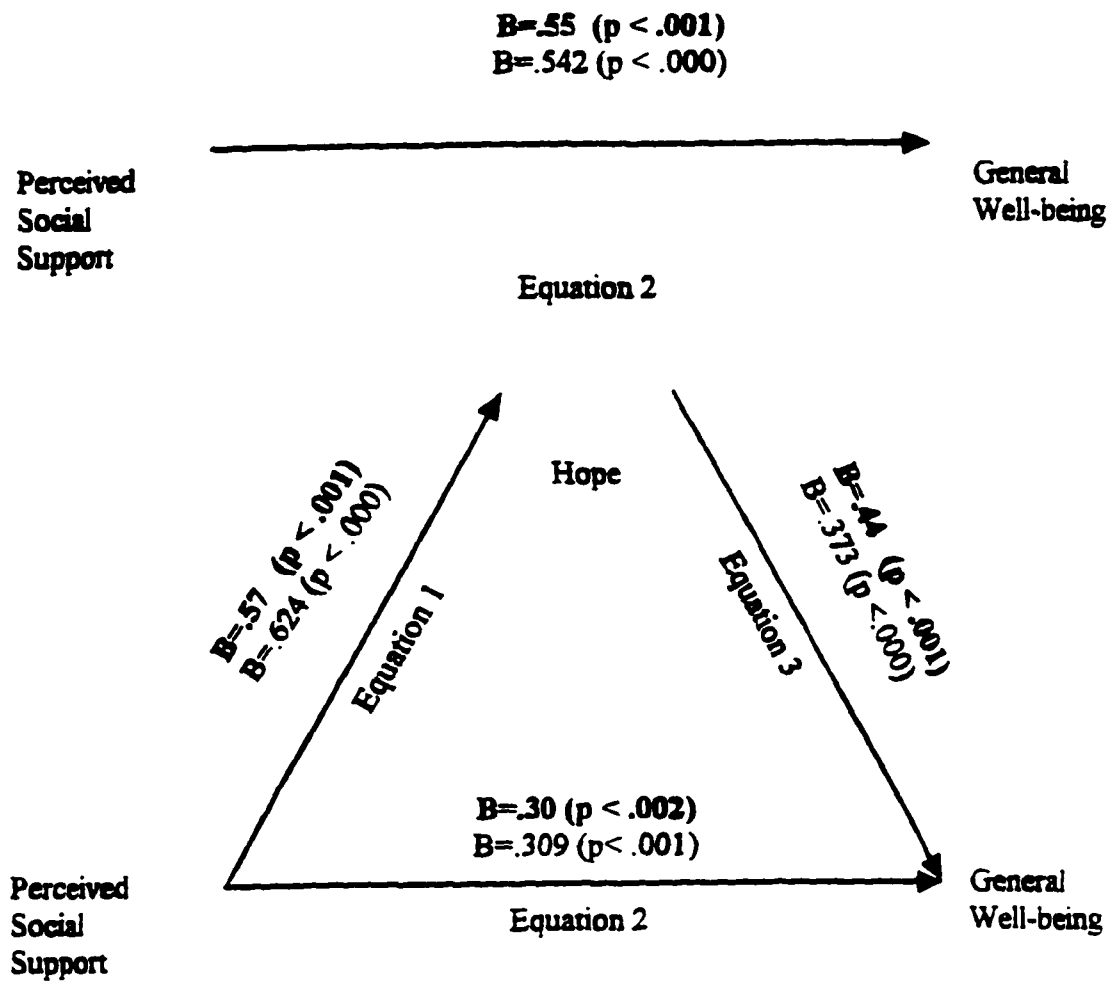


Figure 3. Yarcheski, Scoloveno, and Mahon (1994) Model compared to current research.

Note: Current study values = regular print.

Yarcheski, Scoloveno, and Mahon (1994) values = bold print.

social support alone explains 29% of the variance in general well-being. To understand the relative importance of hopefulness on general well-being, a fourth equation was performed (Table 5). In this equation, hopefulness alone explained 32% of the variance in general well-being. In Equation 3 (Table 4), perceived social support and hopefulness together explained 38% of the variance in general well-being. With hopefulness in the equation, perceived social support adds only 6% to the explained variance in general well-being.

Table 5

The Effect of Hope on General Well-Being

Equation #	Dependent	Independent	b	Beta	t	p
	Variable	Variable				
4	Well-Being	Hope	.032	.570	7.31	.000
	Constant = 83.77					
	F = 53.39 (df = 1, 111) (p = .000)					
	R ² = .32					

Effect of Age on the Hypothesized Model

Data analysis also included a comparison between early and midadolescents and their levels of perceived social support, hopefulness, and general well-being. Using a two tailed t-test, it was determined there were no significant differences in the level of perceived social support or general well-being between early and midadolescents.

However, there was a significant difference in the level of hopefulness experienced by early and midadolescents. These findings are presented in Table 6.

Table 6

Comparison of Age Groups by Variable

Variable	Early Adolescent		Midadolescent		df	t	p
	Mean	SD	Mean	SD			
Social Support	141.6	23.0	134.3	21.8	111	1.17	.09
Hope	1842.1	373.6	1679.7	386.8	111	2.27	.02
Well-Being	144.0	20.3	136.8	23.0	112	1.78	.07

No correlation was found between age and general well-being ($r = -.15$, $p = .09$) or between age and perceived social support ($r = .12$, $p = .19$). However, there was a weak negative correlation between age and hopefulness ($r = -.18$, $p = .04$) indicating a higher level of hope within the early adolescent sub-sample.

Because of these findings, a second regression analysis was performed to determine the effect of age on hopefulness. In Equation 1, age and social support were entered as the independent variables and hope as the dependent variable (age and social support as predictor variables and hope as the outcome variable). In Equation 2, hope (the mediating variable) and social support (the independent variable) were regressed on the dependent variable, well-being. In Equation 1 of the original

statistical model, social support explained 38% of the variance in hopefulness. Age added little explanation to this equation (an increase of 2% in explained variance) and was not a significant predictor variable for hopefulness. This small difference in age does not add to the explanatory power of the model. The results of the regression analyses are presented in Table 7.

Table 7

Regression Equations: The Effect of Age on Hopefulness

Equation	Dependent Variable	Independent Variable	b	Beta	t	p
1	Hope	Age	-56.136	-.106	-1.42	.157
		Social Support	10.389	.611	8.18	.000
		Constant = 1149.17				
		F = 36.56 (df = 2, 109) (p = .000)				
		R ² = .40				
2	Well-being	Social Support	.298	.309	3.203	.0018
		Hope	.021	.374	3.74	.0002
		Constant = 62.25				
		F = 33.41 (df = 2, 109) (p = .000)				
		R ² = .38				

Other Findings

Review of the data for each dimension of social support measured by the PRQ-85 Part II indicated that worth, nurturance, and assistance had the lowest mean scores of the five dimensions among participants. These results reflected less perceived support in these areas. T-tests indicated a difference in perceived social support only within the dimension of assistance experienced by

early and midadolescents. Early adolescents perceived higher levels of social support within the dimension of assistance than midadolescents. Table 8 summarizes these results.

Table 8

PRO-85 Part II Scores by Dimensions of Social Support with t-test between Early and Midadolescent Scores

Dimension	Total	Early	Mid	t	p
	M (SD)	Adolescent M (SD)	Adolescent M (SD)		
Worth	5.11 (1.19)	5.15 (1.21)	5.07 (1.16)	0.36	.71
Nurturance	5.34 (0.95)	5.45 (0.89)	5.22 (1.00)	1.32	.18
Assistance	5.68 (1.08)	5.91 (0.97)	5.41 (1.13)	2.54	.01
Social Integration	5.76 (0.95)	5.87 (0.95)	5.64 (0.91)	1.29	.19
Intimacy	5.80 (1.19)	5.94 (1.17)	5.64 (1.19)	1.35	.18

Hinds (1984) described four levels of hope proceeding from lower to higher levels of believing (forced effort, personal possibilities, expectations of a better tomorrow and anticipation of a positive personal future). Data analysis of HSA scores for the whole sample (N = 115) indicated that these levels did exist and in the order described by Hinds. A comparison of early and midadolescent HSA scores indicated a statistically significant difference in the level of hope experienced by early and midadolescents within the categories of forced effort and anticipation of a personal future. Early adolescents experienced a higher level of hope in these

categories than midadolescents. A summary of these findings are listed in Table 9.

Table 9

HSA Scores by Categories of Hopefulness

Level of Hopefulness	Total		Early Adolescent		Mid Adolescent		t	p
	M	(SD)	M	(SD)	M	(SD)		
Forced Effort	359.24	(109.80)	379.50	(108.75)	336.36	(107.41)	2.14	.03
Personal								
Possibilities	404.10	(187.89)	402.97	(91.11)	389.22	(257.91)	-.19	.85
Expectations								
Better Tomorrow	406.96	(253.45)	411.37	(95.93)	409.64	(355.87)	-.25	.80
Anticipation								
Personal Future	413.71	(102.33)	434.99	(99.99)	423.18	(100.38)	2.43	.02

Table 10 lists the mean scores for the three different dimensions of the AGWB (mental, 22 items; physical, 14 items; social, 3 items). The differences in these scores are based on the number of items. A comparison of early and midadolescent scores indicates a significant difference in the level of general well-being perceived by early and midadolescents within the physical dimension. Early adolescents perceived a higher level of physical health than midadolescents.

Table 10

AGWB Scores and Comparison of Sub-Samples by Dimension

Dimension	Total	Early	Mid		
	Mean Score (SD)	Adolescents (SD)	Adolescents (SD)	t	p
Social	9.26(1.42)	9.29(1.21)	9.22(1.64)	0.27	.78
Physical	48.28(8.10)	49.86(8.07)	46.52(7.82)	2.25	.02
Mental	74.16(13.73)	75.91(12.39)	72.19(14.97)	1.46	.14

Specific Adolescent Health Issues

Further data analysis was done to address specific issues surrounding adolescent health. Item selection for further analysis was based on two factors: (a) items with the lowest mean and median scores from the three dimensions (mental, physical, and social) of the AGWB, and (b) the health risk behaviors discussed in Chapter 1 (suicide, stress, and aberrant social behaviors). For the mental dimension, items were combined under three headings: behaviors, mood, and stress. Low individual items from the physical and social dimensions of health are listed separately. Table 11 summarizes these data for the whole sample. Individual item scores were dichotomized from a five point Likert scale to agree and disagree categories. A neutral response was considered to be in disagreement with the statement which is the most conservative way to categorize the data. There is no attempt to overestimate

problem behaviors but his method may result in some false negatives. Individual items scores for each instrument may be found in the tables in Appendix H.

A chi-square statistic was computed to compare the differences between the early and midadolescent groups for the frequency of the dichotomized responses to the selected questions. There were significant differences between the responses of early adolescents and midadolescents to questions concerning health risk behaviors (drugs, smoking, and getting into trouble with the police) and mood (sadness and wondering about the value of life). More midadolescents responded that they took drugs, smoked, wondered if life was worthwhile, and got into trouble with the police. More early adolescents agreed with the statement regarding feeling sad and downhearted. There were no significant differences in the responses of the two age groups to statements regarding suicide, self-worth, physical health, social health, or stress and the ability to cope with stress/frustration. Comparison data are presented in Table 12.

Table 11

Summary of Frequency of Adolescent Responses to Specific Questions on the AGWB for Total Sample (N = 115)

Individual Item	Agree	Disagree
	n (%)	n (%)
Mental Health: Behaviors:		
I take drugs for reasons other than medical treatment.	28 (24)	87 (76)
I smoke cigarettes regularly.	32 (27)	83 (73)
I take sleeping pills or tranquilizers.	9 (8)	106 (92)
Mental Health: Mood:		
I am frequently sad, downhearted.	56 (49)	59 (51)
I often feel like crying.	45 (39)	60 (61)
I have frequent thoughts about suicide.	34 (30)	81 (70)
I feel worthwhile.	74 (64)	41 (36)
I wonder if anything is worthwhile.	45 (39)	70 (61)
Mental Health: Stress and Coping:		
There is a lot of stress in my life.	30 (26)	85 (74)
I worry about the future and how things will turn out.	29 (25)	86 (75)
I can handle problems without getting frustrated/upset.	32 (28)	83 (72)
Mental Health: Physical Health:		
I feel strong and healthy as I should be.	61 (53)	54 (47)
I am able to resist illness and avoid accidents.	56 (49)	59 (51)
Mental Health: Social Health:		
I feel popular and easy to like.	40 (35)	75 (65)
I have trouble making friends.	18 (16)	97 (84)
I get into trouble with the police.	19 (17)	96 (83)

Table 12

Summary of Frequency of Adolescent Responses to Specific Questions on the AGWB by Age Group

Item	Early Adolescent		Midadolescent		χ^2	df	p
	Agree	Disagree	Agree	Disagree			
	n (%)	n (%)	n (%)	n (%)			
Mental Health: Behaviors:							
Drugs	9 (15)	52 (85)	19 (35)	35 (65)	6.49	1	.01
Smoke	10 (16)	51 (84)	22 (41)	32 (59)	8.45	1	.00
Pills	2 (3)	59 (97)	7 (13)	47 (87)	3.72	1	.05
Mental Health: Mood:							
Sad	35 (57)	26 (42)	21 (39)	33 (61)	3.91	1	.04
Crying	36 (59)	25 (41)	19 (35)	35 (65)	0.40	1	.52
Suicide	16 (26)	45 (74)	18 (33)	36 (67)	0.69	1	.40
Worth	40 (66)	21 (34)	34 (63)	20 (37)	0.85	1	.77
Worthwhile	18 (30)	43 (70)	27 (50)	27 (50)	5.04	1	.02
Mental Health: Stress/Cope:							
Stress	15 (25)	46 (75)	15 (28)	39 (72)	0.15	1	.69
Upset	16 (46)	45 (54)	16 (30)	38 (70)	0.16	1	.68
Worry	13 (21)	48 (79)	16 (30)	38 (70)	1.05	1	.30
Mental Health: Physical Health:							
Strong	30 (49)	31 (51)	31 (57)	23 (43)	0.77	1	.37
Resist Illness	31 (51)	30 (49)	25 (46)	29 (53)	0.23	1	.62
Mental Health: Social Health:							
Popular	23 (38)	38 (32)	17 (31)	37 (69)	0.48	1	.48
Friends	9 (15)	52 (85)	9 (17)	45 (83)	0.07	1	.77
Police	5 (8)	56 (92)	14 (26)	39 (74)	6.77	1	.00

Summary. Data analysis supported the three hypotheses:

there is a positive relationship between perceived social support and hopefulness in early and midadolescents, there is a positive relationship between hopefulness and general well-being in early and midadolescents, and the magnitude of

the relationship between perceived social support and general well-being was reduced when hopefulness was held constant. An assumption of this study is that a positive relationship exists between social support and general well-being and this was upheld during testing of the three hypotheses. Age was identified as having a small, significant relationship with hopefulness but not for social support or general well-being and did not improve the model. Additional data analysis supported the contention that a notable proportion of adolescents question the value of life, think about suicide, abuse chemicals, perceive themselves to be experiencing stress and are worried about the future.

CHAPTER 5

DISCUSSION AND IMPLICATIONS

Discussion Related to Hypotheses

The findings of this study support the hypothesis that there is a positive relationship between perceived social support and hopefulness in early and midadolescents. The relationship in this study is moderately strong ($r = .62$).

The findings of this study support the second hypothesis that there is a positive relationship between hopefulness and general well-being in early and midadolescents. This relationship is also of moderate strength ($r = .57$).

The findings of this study support the third hypothesis that when hopefulness is present, the magnitude of the relationship between perceived social support and general well-being will diminish. The results of the regression analyses indicate that hopefulness is a potent mediator in the relationship between perceived social support and general well-being. According to Baron and Kenny (1986) "mediators explain how external events take on internal psychological significance" (p. 1176). Thus, when there is a perception of greater social support, adolescent

hopefulness takes on greater psychological significance and contributes to adolescent general well-being.

Relationship of Findings to Previous Research

Yarcheski, Scoloveno, and Mahon (1994) investigated the impact of hopefulness upon the relationship between perceived social support and general well-being within a sample of 99 midadolescents. Current research studied the impact of hope upon the relationship of interest within a total sample of 115 early and midadolescents. The purpose of both studies was to examine the extent to which hopefulness mediates the relationship between perceived social support and general well-being in adolescent subjects. In both studies, the results of regression analyses determined the relationship between social support and well-being diminished in the presence of hopefulness as a mediating variable.

Yarcheski, Scoloveno, and Mahon (1994) found a significant positive correlation of moderate strength between perceived social support and general well-being ($r = .55$), between perceived social support and hopefulness ($r = .57$), and between hopefulness and general well-being ($r = .60$). Current research findings in a sample of 61 early and 54 midadolescents paralleled those of the original study. A significant positive correlation of moderate strength ($r = .54$) was found between perceived social support and general well-being, between perceived social

support and hopefulness ($r = .62$), and between hopefulness and general well-being ($r = .57$).

The findings of this study and other research support a positive relationship between social support and well-being in adolescents (Eisen et al., 1980; Yarcheski & Mahon, 1985; Yarcheski & Mahon, 1992). The results of this study and other research support the positive relationship between perceived social support and hopefulness in adults and adolescents (Foote et al., 1990; Piazza et al., 1991; Yarcheski et al., 1994) and between hopefulness and general well-being in adolescents (Hinds, 1984, Yarcheski et al., 1994).

The current research found there was no significant difference in levels of perceived social support or general well-being between early and midadolescents. However, there was a significant difference in the level of hopefulness experienced by early and midadolescents. Other research that was reviewed while developing this study, investigated either early adolescents (Eisen et al., 1980) or midadolescents (Yarcheski & Mahon, 1986; Yarcheski & Mahon, 1992; Yarcheski et al., 1994). In the work by Hinds (1984), 13 to 18 year old individuals were termed "adolescents" but no age groups were defined and no comparisons made. Consequently, no comparisons can be made between other studies and the current research findings.

Other research reviewed while developing a framework for this study explored the idea that other variables, such

as self-efficacy may mediate the relationship between social support and well-being. Other studies attempted to link personality and sources of social support to well-being. Since these were not variables under investigation in the current investigation, no comparisons can be drawn.

An additional group of studies were examined which looked at factors believed to contribute to a sense of well-being within adult and adolescent populations. The results of these studies suggested that psychological well-being (how individuals feel and what their outlook on life is) makes the greatest contribution to overall general well-being. Current research findings support these results. A high percentage (30 to 50%) of the total sample (N = 115) indicated they felt sad, did not feel worthwhile, and wondered about the value of life.

Discussion Related to Other Findings

Hope. Data analysis determined there was no significant difference between early and midadolescents and their levels of perceived social support or general well-being. A weak, significant negative correlation between age and hopefulness indicated a higher level of hope within the early adolescent sub-sample. To determine the effect of age on hopefulness, a second regression analysis was performed. There was a small increase in explained variance (2%) when both age and social support were used to explain hopefulness. This did not improve the model.

Higher levels of hope in the younger group may be due, in part, to the homogeneity of this subsample. All subjects in the early adolescent group were ninth graders and 98% were Caucasian. The older group was composed of ninth (83%), tenth (6%), and eleventh (11%) graders and consisted of Caucasian (87%), Hispanic (9%), and Black (4%) participants. The more homogeneous group of early adolescents may be able to instill hope and positive attitudes in one another. No data were collected about living arrangements or socio-economic status that might contribute to this finding. The HSA was specifically designed for adolescents and may be the most sensitive instrument used in this study.

Hinds (1984) described four levels of hopefulness proceeding from lower to higher levels of believing. Data analysis of the HSA mean scores revealed these four levels of hope in the order described by Hinds: forced effort, personal possibilities, expectations for a better tomorrow, and anticipation of a personal future. The mean scores for the total sample and each sub-sample formed a continuum (of degree). The existence of a continuum implies that hope occurred in incremental amounts in this sample and is consistent with Hinds' theory.

Forced effort is the degree to which an adolescent tries to artificially take on a more positive view. This level resulted in the lowest total mean score for the entire sample and for each sub-sample. There was a significant

difference between early and midadolescent scores. Early adolescents experience a greater intensity of hopefulness within this category and try harder to effect change. Hinds (1984) reported that forced effort may be a category unique to adolescents since it is not discussed in studies about adult hope. It may be that the younger adolescent "naturally" experiences more hope in this category and it diminishes with age until it is no longer experienced or acknowledged in adulthood. In this study, it may be "normal" for the early adolescent to experience greater levels of hope in this category than the midadolescent.

There was a significant difference between early and midadolescents and their experience of hopefulness within the category of anticipation of a personal future. Early adolescents within this sample may be able to identify more personal future possibilities than midadolescents. Midadolescents may be able to identify more factors that contribute to an uncertain future which corresponds with the older group's responses on the general well-being instrument indicating they were worried about the future and how things would turn out.

Social support. Although there was no significant difference in the overall level of perceived social support experienced by early and midadolescents, there was a significant difference between early and midadolescent scores within the PRQ-85, Part II subscale dimension of assistance. Midadolescents perceived less social support

within the dimension of assistance than early adolescents. This difference may be due, in part, to parental expectations that midadolescents begin to accept more responsibility and less aid from adults.

General well-being. There was no significant differences in the level of well-being perceived by early and midadolescents within the social or mental dimensions. There was a significant difference in the level of general well-being perceived by early and midadolescents within the physical dimension. Early adolescents perceived a higher level of physical health. These differences may be, in part, due to the physical changes that mark the period of adolescence, i.e., height, weight, muscle development and strength. These attributes become more important over time as competition increases for sports and status. An adolescent needs a certain amount of skill or desirability to become or stay a member of a desired peer group.

Findings from the AGWB indicate that approximately one-quarter of the total sample acknowledged they participated in high risk health behaviors (drugs and cigarettes). In this sample, the frequency of health risk behaviors increased with age. More midadolescents acknowledged they used drugs for other than medical treatment and smoked cigarettes on a regular basis. In this sample, the increased use of chemicals with age may, in part, be related to perceptions of self-worth and less

assistance (social support). It may be related to social desirability (peer pressure and acceptance).

Approximately one third of the total sample reported significant mood problems and frequent thoughts about suicide. There was a significant statistical difference between groups and their response to the statement "I frequently feel like crying." More early adolescents acknowledged feeling this symptom of distress.

The high number of adolescents agreeing with the statements about sad mood and thoughts of death could be related to the respondents' interpretation of the term "frequently," a subjective term that has a different meaning for each individual. The effect of history may be an alternate explanation. Approximately four weeks prior to data collection, two seniors and a former student were killed in an automobile accident. Although none of the participants in this study were classmates, this is a small rural community where families have resided for years and there are many connections among students and extended family members. The death of these students was a significant event for all members of the school community. Instruments that are more sensitive and designed specifically to address depression and suicidality would need to be administered before a conclusion regarding imminent danger for any individual could be made.

It is logical to assume that mood, suicidal thoughts, a sense of self-worth, value for life, and stress are related.

Approximately one-fourth of the total sample perceived high levels of stress/tension in their lives and were worried about the future. Approximately three-fourths of the total sample acknowledged difficulty handling problems. There was no statistical difference in the perceptions of early or midadolescents. In this sample, the ability to cope with stress did not improve with age. This finding corresponds with lower levels of worth, competency and hope for a positive future noted in the midadolescent subsample.

There was a significant difference between early and midadolescents and social behavior. Approximately one-fourth of the midadolescent subsample agreed with the statement "I get into trouble with the police." Getting into trouble with the police denotes violence or disregard for appropriate social interaction and may be related to the higher numbers of midadolescents who question the value of life, are unable to handle stress, and use chemicals. Midadolescents also perceived less social support (assistance) and experienced lower levels of hope for a positive personal future.

Relationship of Findings to Conceptual Framework

The conceptual framework for this study incorporated various definitions and descriptions of the three constructs, social support, hopefulness, and well-being. King's (1981) general systems framework and theory of human interaction were utilized to support the inter-relationships of the three constructs.

Social support was conceptualized as having necessary components, such as, the availability of informational, emotional, and tangible help when needed. The PRQ-85, Part II captured these facets of social support and demonstrated that early and midadolescents' perceptions are different.

Hopefulness was conceptualized as a multidimensional life force which falls into four hierarchical levels. The findings of this study support this idea and indicate that hope contributes significantly and positively to general well-being.

The concept of health or well-being has evolved over time to include physical and mental components which are related to social factors and dependent on thoughts about the quality of one's life and future possibilities (hopefulness). The findings in this study support that adolescent health is a complex construct made up of different dimensions which are not discrete and may be a result of interaction between dimensions and mediated by other factors.

King's (1981) model of dynamic interacting systems was used as a guide for studying the inter-relatedness of social support, hopefulness, and well-being. This framework incorporated the idea that health is determined by social functioning within three systems (personal, interpersonal and social) through optimum use of one's resources. Various properties of social support (nurturance, tangible aid, reassurance, and information) were considered to be

resources. These resources could only be used if they were perceived as available. Social support was deemed to be available from the interpersonal and social systems but perceived within the personal system. Hopefulness was speculated to be a psychological concept developed within the interpersonal system and the social system but perceived within the personal system. Well-being was conceptualized to be understood within the personal system. Findings of this study support King's (1981) model which implies that the interacting systems form the internal and external environments that influence health.

Findings of this study conveyed King's (1981) sense of the system embeddedness: the personal system embedded in the interpersonal system which is embedded in the social system. Social support, hopefulness, and well-being arise out of the social and interpersonal systems and influence the personal system. In turn, the amount of and quality of influence is dependent on perception within the personal system. Perceived social support positively influences general well-being and the perception of hopefulness mediates this relationship.

Limitations and Recommendations

The findings of this research study are from a non-random sample and therefore cannot be generalized beyond the present study. A research design that incorporated random sampling and included the older adolescent (17 and 18 years of age) would facilitate greater generalizability.

However, because these findings support the Yarcheski et al. (1994) findings in a sample from a different population of adolescents, they do support some extension of the generalizability of the original study.

The sample obtained for this study tended to be homogeneous with respect to race and class. Ninety-three percent of the participants were Caucasian and 92% were Freshmen. In addition, the sample was drawn from only one research site which may contribute to these limitations. Therefore, it would be a recommendation that a sample be drawn from a larger research site or multiple research sites to obtain a more heterogeneous group. Although the age groups of interest for this study were well represented, it would be a second recommendation that future work investigate the relationship between variables of interest utilizing the older adolescent to make comparisons between early, middle, and older adolescents and their levels of perceived social support, hopefulness, and general well-being.

The results indicate that hope is a potent mediator in the relationship between social support and general well-being. However, it may not be the only variable impacting on the relationship of interest. A third recommendation is that other variables, such as self-efficacy, be tested to help explain the relationship between perceived social support and general well-being. It

is possible that other mediators may be relevant in the relationship of interest.

Hinds (1984) indicated that the category of forced effort within the HSA is a phenomenon related to adolescence and disappears by adulthood. A fourth recommendation is to conduct research that compares the levels of hopefulness experienced among early, middle, and older adolescents to determine if the category of forced effort decreases as the adolescent matures.

The last recommendation is that further replication include more demographic information, such as living arrangements and length of time in community or school. It would be interesting to include instruments that measure the source or the benefit of social support and relate these variables to hopefulness and well-being.

Implications for Nursing

Clinical. Findings in this study indicate that an alarming number of the total sample used drugs and smoked cigarettes. These are high risk behaviors that result in chronic illness and premature mortality. The results of this study indicate a significant portion of the total sample frequently felt sad, lacked self-worth, questioned the value of life, and thought about suicide. In general, early adolescents demonstrated higher levels of social support, hopefulness, and general well-being. Early adolescents claimed fewer health risk behaviors.

It is important to recognize these differences and design preventative measures for the younger group since this is when attitudes, values, and behavior patterns may become established. Nurses, because of their recognized expertise, have a unique opportunity to join with student organizations, such as Students Against Drunk Driving, or sports related groups for education, esteem building, and stress reduction.

As more nurses become primary providers of health services, they are in a position to assess the sad, highly stressed or suicidal adolescent. This may be accomplished by the use of existing self-report screening tools to determine health risk behaviors and mood assessment or by addressing risky behaviors and mental status during an individual interview process. The nurse practitioner may also serve as a consultant to schools offering organized, direct screening efforts or education to prevent health problems.

In addition to preventative interventions targeted at the early adolescent, nurses are ideally suited to provide leadership in the design, development, implementation, and evaluation of treatment strategies for the older adolescent. Treatment strategies for drug abuse, mood disorders, and other behavioral problems may result in hospitalization. Efforts during hospitalization and at other points of treatment clearly should consist of family support to enhance coping with the current crisis and decrease the

possible after effects of highly stressful experiences. The development of school and community programs that provide day-to-day support, encourage relationships that promote individual performance, and emphasize activities which are worth-enhancing would be treatment strategies to promote health practices and instill hope. Mentoring programs, self-help groups, support groups (both adolescent centered and family centered), and stress management would be examples of treatment strategies for the older adolescent to decrease the probability of recurrence of problem behaviors.

Education. In addition to routine growth and development, all levels of nursing education should include content related to the assessment of adolescent social support needs, interventions that reduce stress and promote well-being and strategies that instill hope. Further, it is recommended that nursing education include content on teaching health values in decision-making and personal responsibility for health and self-care. There is little awareness among adolescents that a relationship exists between health risk behaviors adopted during teen years and the incidence of illness in adulthood. In addition, as the current focus in health care shifts from the traditional institution to the community, nursing educators must prepare nurses to care for the adolescent population in non-traditional settings (home, school, community).

Administration. The current shift from in-patient services to out-patient services has changed the economic

climate for nursing administrators and the need for acute care nurses. Administrators are in a position to "resocialize" personnel employed in illness care into a culture of health risk identification and illness prevention. Nurse administrators can provide leadership for programming efforts (access to health information, education to alter behaviors, consultations and conferences to advance health promotion concepts) in a wide array of community settings (schools, worksites, service organizations, and health organizations). In addition, administrators are ideally suited to coordinate health resources within a community and to provide appropriate preparation for nurse-managed centers to treat adolescents and their families, to develop equitable plans of reimbursement for nursing services, and to institute collaborative agreements with physicians for the delivery of health care.

Other disciplines. This study took place in a small rural community and within one school year, six adolescents died (three prior to data collection). Ninety percent of those deaths were due to health risk behaviors (alcohol/drug related accidents and the unrecognized danger of medical conditions). The findings of this study indicated a significant portion of adolescents were experiencing stress and symptoms of distress (sadness, thoughts of suicide). It is staggering to consider the possible number of adolescents in distress, practicing risky behaviors, and dying in schools across our nation. It would seem logical that

school-based programs that facilitate self-esteem, promote the acquisition of knowledge and skills for competent self-care and informed decision making about health would be life saving measures for children and adolescents.

In addition to school administrators and teachers, the findings of this study have implications for public and mental health agencies. Community health agencies have a societal responsibility for health. This enlarged scope allows powerful interorganizational systems to coordinate resources which reduce the cost of health promotion programming. Comprehensive programs that lower health risks in adolescents would enhance the quality of life in the adult years and be conducive to successful aging and extended longevity.

Future Research

Future directions for nursing research must include scientific inquiry to develop reliable tools for measuring health perceptions, health attitudes, and health behavior patterns within the adolescent population. Studies with a longitudinal perspective could assist nurse researchers in understanding the changes from positive health habits to risky behaviors (smoking, drug use) that frequently occur in adolescence. The impact of peer pressure and the roles of social support and hope in encouraging or discouraging health behaviors in adolescents need to be investigated further. Practical strategies for the delivery of

prevention and health promotion services to adolescents need inquiry.

Structured and systematic investigations are needed to identify nursing strategies that instill hope and the external factors that move adolescents toward hope. An additional nursing challenge is to identify interventions that foster, maintain, and strengthen relationships that serve as sources of social support for adolescents. The effects of these interventions need to be evaluated and correlated with health status to determine what variables are associated with health practices and preventative health behaviors with different samples of the adolescent population.

The model used in the current research project provided empirical support to explain the relationship between perceived social support and general well-being (health status). The use of the three variable model established the mediating role of hopefulness. This model may serve to identify other variables that help to explain relationships or to guide future research that tries to discover hidden variables and causal connections in other health phenomena.

Summary. The purpose of this study was to examine the extent to which hopefulness mediates the relationship between perceived social support and general well-being. Hopefulness was determined to be one mediator in the relationship of interest. Early adolescents experienced greater levels of hopefulness than midadolescents and, in

selected dimensions, perceived higher levels of social support and general well-being. The findings of this study have implications for nursing practice, nursing research, nursing education, and for other disciplines such as, teachers, school administrators, public health and community mental health personnel.

APPENDICES

APPENDIX A

Personal Resource Questionnaire (PRQ-85) Part II

APPENDIX A

Q-11. Below are some statements with which some people agree and others disagree. Please read each statement and **CIRCLE** the response most appropriate for you. There is no right or wrong answer.

- 1 = **STRONGLY DISAGREE**
- 2 = **DISAGREE**
- 3 = **SOMEWHAT DISAGREE**
- 4 = **NEUTRAL**
- 5 = **SOMEWHAT AGREE**
- 6 = **AGREE**
- 7 = **STRONGLY AGREE**

STATEMENTS

-
- a. There is someone I feel close to who makes me feel secure 1 2 3 4 5 6 7
 - b. I belong to a group in which I feel important 1 2 3 4 5 6 7
 - c. People let me know that I do well at my work (job, homemaking) 1 2 3 4 5 6 7
 - d. I can't count on my relatives and friends to help me with problems 1 2 3 4 5 6 7
 - e. I have enough contact with the person who makes me feel special 1 2 3 4 5 6 7
 - f. I spend time with others who have the same interests that I do 1 2 3 4 5 6 7
 - g. There is little opportunity in my life to be giving and caring to another person 1 2 3 4 5 6 7
 - h. Others let me know that they enjoy working with me (job, committees, projects) 1 2 3 4 5 6 7
 - i. There are people who are available if I needed help over an extended period of time 1 2 3 4 5 6 7
 - j. There is no one to talk to about how I am feeling 1 2 3 4 5 6 7
 - k. Among my group of friends we do favors for each other 1 2 3 4 5 6 7

- 1 = STRONGLY DISAGREE
 2 = DISAGREE
 3 = SOMEWHAT DISAGREE
 4 = NEUTRAL
 5 = SOMEWHAT AGREE
 6 = AGREE
 7 = STRONGLY AGREE

STATEMENTS

- l. I have the opportunity to encourage others
 to develop their interests and skills 1 2 3 4 5 6 7
- m. My family lets me know that I am important
 for keeping the family running 1 2 3 4 5 6 7
- n. I have relatives or friends that will help me
 out even if I can't pay them back 1 2 3 4 5 6 7
- o. When I am upset there is someone I can be
 with who lets me be myself 1 2 3 4 5 6 7
- p. I feel no one has the same problems as I 1 2 3 4 5 6 7
- q. I enjoy doing little "extra" things that make
 another person's life more pleasant 1 2 3 4 5 6 7
- r. I know that others appreciate me as a
 person 1 2 3 4 5 6 7
- s. There is someone who loves and cares
 about me 1 2 3 4 5 6 7
- t. I have people to share social events and
 fun activities with 1 2 3 4 5 6 7
- u. I am responsible for helping provide for
 another person's needs 1 2 3 4 5 6 7
- v. If I need advice there is someone who
 would assist me to work out a plan for
 dealing with the situation 1 2 3 4 5 6 7
- w. I have a sense of being needed by another
 person 1 2 3 4 5 6 7
- x. People think that I'm not as good a friend
 as I should be 1 2 3 4 5 6 7
- y. If I got sick, there is someone to give me
 advice about caring for myself 1 2 3 4 5 6 7

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APPENDIX B

Hopefulness Scale for Adolescents (HSA)

APPENDIX B

THE HOPEFULNESS SCALE FOR ADOLESCENTS

FORM A

1. I see different ways to look at a problem.
I never _____ I always
think think
this way this way
2. There are great things yet to come for me.
I never _____ I always
think think
this way this way
3. I'm not going to get any better than I already am.
I never _____ I always
think think
this way this way
4. I won't let myself spend all of my time feeling sorry for myself.
I never _____ I always
think think
this way this way
5. I let myself focus on the bad.
I never _____ I always
think think
this way this way
6. I have the ability to change my future.
I never _____ I always
think think
this way this way
7. Things really won't get better for me.
I never _____ I always
think think
this way this way

8. I'm getting some self-confidence.

I never
think
this way

I always
think
this way

9. I won't let myself keep worrying about things I can't fix.

I never
think
this way

I always
think
this way

10. Someday I'm going to find someone to love.

I never
think
this way

I always
think
this way

11. I'm pretty sure I can't make problems turn out o.k.

I never
think
this way

I always
think
this way

12. I make myself do something to get my mind off bad thoughts.

I never
think
this way

I always
think
this way

13. I try to make myself believe things will get better.

I never
think
this way

I always
think
this way

14. I'm starting to come up with possibilities for me.

I never
think
this way

I always
think
this way

15. Maybe there will be something going for me.

I never
think
this way

I always
think
this way

16. There's no light at the end of the tunnel.

I never _____
think
this way

I always
think
this way

17. I force myself to try harder.

I never _____
think
this way

I always
think
this way

18. Things will always get better.

I never _____
think
this way

I always
think
this way

19. I make myself think positive thoughts.

I never _____
think
this way

I always
think
this way

20. I believe there is a chance for me.

I never _____
think
this way

I always
think
this way

21. Good can come.

I never _____
think
this way

I always
think
this way

22. I can't handle problems.

I never _____
think
this way

I always
think
this way

23. I'm not positive about my life becoming a good one.

I never _____
think
this way

I always
think
this way

24. I know I'll do o.k. in life.

I never
think
this way

I always
think
this way

THANK YOU VERY MUCH FOR PARTICIPATING

APPENDIX C

Adolescent General Well-Being Questionnaire (AGWB)

APPENDIX C

GENERAL WELL-BEING QUESTIONNAIRE INSTRUCTIONS

The items on this questionnaire refer to how you feel, think, behave, and get along with others, as well as to some past experiences you may have had and some general information about you. Read each one carefully and decide how you feel or think about it and how strongly you agree or disagree with it. Then choose the response that best describes your feelings and fill in the letter of that response on the answer sheet provided. Some items are worded from a positive point of view and some have a negative tone, so please read and think about each one carefully before you mark a response. If not sure about a response, pick the one that best describes how much you agree or disagree with it. There are no right or wrong answers, just your feelings. Even though the first four items deal with general information about you, all responses will be anonymous. Do not put your name on this questionnaire.

- My sex is: A. ___ male B. ___ female
- My age is: A. ___ 13 B. ___ 14 C. ___ 15
 D. ___ 16 E. ___ 17 F. ___ 18
- I am a: A. ___ Freshman B. ___ Sophomore
 C. ___ Junior D. ___ Senior
- My race is: A. ___ Caucasian/white B. ___ Black
 C. ___ Hispanic D. ___ Other

Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
A	B	C	D	E

1. ___ I feel popular and that I am easy to like.
2. ___ I have trouble making friends.
3. ___ There is a lot of stress or tension in my life.
4. ___ I feel dissatisfied with the way things are going.
5. ___ I enjoy my life.
6. ___ I feel as happy as others.
7. ___ I feel my life has meaning and that I am living fully.
8. ___ I frequently have headaches.
9. ___ I feel successful and worthwhile.
10. ___ I frequently feel sick to my stomach or have stomach
 aches or cramps.
11. ___ My heart frequently beats fast.

12. ___ Things usually turn out the way I want.
13. ___ I occasionally feel faint, dizzy, or flushed/hot.
14. ___ My body seems to cause me trouble or interferes with
my life.
15. ___ I am usually free from colds or other illnesses.
16. ___ I feel as strong and healthy as I should be.
17. ___ I am usually able to resist illness and avoid
accidents.
18. ___ I smoke cigarettes regularly.
19. ___ I am satisfied with my health and feel that it does not
prevent me from doing things I like to do.
20. ___ I use drugs for reasons other than medical treatment.
21. ___ I take sleeping pills or tranquilizers.
22. ___ I maintain a consistently good body weight for my
height and build.
23. ___ I get physical exercise regularly and stay in good
physical condition.
24. ___ I am frequently sad, downhearted, or moody.
25. ___ I frequently feel guilty.
26. ___ I have frequent thoughts about death or suicide.
27. ___ I am usually optimistic and look on the bright side of
things.
28. ___ I often feel like crying.
29. ___ I like myself.
30. ___ I worry about the future or how things will turn out.
31. ___ I enjoy competition.
32. ___ I am frequently worried or fearful.
33. ___ I am able to concentrate and maintain a train of thought.
34. ___ My memory is good.
35. ___ I can usually think clearly.
36. ___ I wonder if anything is worthwhile any more.
37. ___ I am frequently irritable or angry.
38. ___ I can handle my problems without frustration or getting
upset.
39. ___ I get in trouble with the police.

APPENDIX D

Instrument Permission Letters

APPENDIX D



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Fax (406) 243-5745

October 13, 1995

Peggy Shaull-Norman
1695 Horizon Drive
Ionia, MI 48846

Dear Ms. Shaull-Norman:

Thank you for requesting the PRQ-85. This letter will serve as permission to use the tool. Enclosed you will find a copy of the tool which you may reproduce in whatever quantity necessary for your study. However, the exact format of the PRQ-85 must be maintained. Any changes to question stems or answer sets must be approved in advance. Translations to other than English must be submitted to this office with a certification that the translation is accurate prior to use of any translated version of the PRQ-85. Also enclosed are instructions for coding and a bibliography. We strongly encourage you to use this bibliography to familiarize yourself with the published literature on the PRQ-85.

If you have not already done so, please send us a brief abstract of your proposed study and the population that you plan to sample in your research. We will include this information in a database. We also ask that you send a check payable to Clarann Weinert in the amount of \$ 3.00 to cover the costs of postage and xeroxing. If you do, in fact, use the PRQ-85 for data collection in your study, we ask that you send us an abstract of your findings and conclusions whenever they are available.

Should you have any questions or need clarification, kindly write or e-mail UNUCW@MSU.OSCS.MONTANA.EDU. We will try to respond in a timely manner by e-mail if you include your address or in writing.

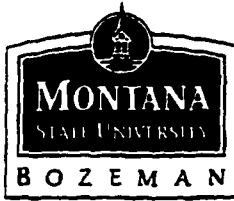
Thank you for your interest in the PRQ-85. We hope that this tool will help you in your work.

Sincerely,

Clarann Weinert, SC, PhD, RN, FAAN
Associate Professor
by Rodney D. Fulton, MS, MEd, Program Assistant

Mountains and Minds • The Second Century

APPENDIX D



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Phone (406) 243-6315
Fax (406) 243-5745

June 6, 1997 (12:02PM)

Peggy Shaul-Norman
1695 Horizon Drive
Ionia, MI 48846

Dear Ms. Shaul-Norman:

In a letter dated October 13, 1995 I gave you permission to use the PRQ85. This permission includes making multiple copies, citing as appropriate, and appending it to the final report of your study. In this case the final report would be your thesis.

Congratulations on completing your research. The best to you.

Sincerely,

[Redacted Signature]

Clarann Weinert, SC, PhD, RN, FAAN
Associate Professor

APPENDIX D



- ST. JUDE CHILDREN'S RESEARCH HOSPITAL

332 North Lauderdale
Memphis, Tennessee 38105-2794
(901) 495-3300

Danny Thomas, founder

Peggy Shaul-Norman, RN,BSN
1695 Horizon Drive
Ionia, MI 48846

October 17, 1995

Dear Ms. Shaul-Norman,

I am very excited for you about your planned replication of the work of Yarcheski, Scoloveno, & Mahon (1994). You certainly have my permission to use the Hopefulness Scale for Adolescents (HSA) in your work and to make the number of copies needed. You also may include a copy of the HSA in the appendix of your thesis. There is no fee for the use of the HSA. I am enclosing a copy of the instrument and the scoring directions.

I wish you much success and pleasure in your research. My very best to you.

Sincerely,

Pamela S.Hinds, PhD,RN,CS
Coordinator of Nursing Research, and
Associate Director of Research for Behavioral Medicine

APPENDIX D



Special Services

November 13, 1995

Peggy Shaul-Norman, RN, BSN
1695 Horizon Drive
Ionia, Michigan 48846

RE: Adolescent General Well-Being Questionnaire

Dear Ms. Shaul-Norman:

I am sending you a copies of both the longer and shorter forms of the Adolescent General Well-Being Questionnaire that I developed a number of years ago. I also am enclosing some summary information from my dissertation that will help explain and provide supportive information for the questionnaires. You have my permission to use either or both forms of the questionnaire in your research.

Although I do not need to charge you for the cost of copying the information I am sending you, I would appreciate your reimbursing me for the cost of the postage; please see the envelope in which I have mailed the information for the cost of the postage. The only other request I will make and condition that I am attaching is for you to send me a copy of your research results/thesis. If you are reluctant to produce and mail an additional copy of your thesis for me, a summary of some sort would suffice.

I am glad to see the interest in and use of my questionnaire. I hope that it provides you with good results and that your thesis turns out well. Please let me know if you have any questions, need additional information, or want to pursue any issues further. Thank you.

Sincerely,


Stephen Colombo, Ph.D., NCSP
Director of Special Services

Home address & phone: 6511 Murdoch Ave.
St. Louis, MO 63109-2657
314-351-1042

APPENDIX D

PARKWAY SCHOOL DISTRICT
Special Services Department
FAX

Date: June 6, 1997

of Pages - Including Cover: 1

To: Peg Shaul-Norman

Fax #: 616-660-3011

Company: Dept. of Veterans Affairs
Medical Center

Phone #: 616-966-5600 (3409)

From: Stephen Colombo

Phone #: 415-8067

COMMENTS: I hereby grant you permission to include a copy of the Adolescent General Well-Being Questionnaire that I developed for my dissertation in the appendix of your thesis. I look forward to receiving your information in return. Thank you and sorry I failed to grant you the needed permission in my original letter. Let me know if you need anything further from me. Good luck.


6/6/97

APPENDIX E

Information and Informed Consent

APPENDIX E

Dear Student and Parent:

I am requesting the participation of students in a study designed to examine how interpersonal relationships and looking toward the future are related to adolescent health. It is believed that this research may help nurses and physicians design strategies to help adolescents cope with stress and/or develop healthier life styles.

Participants will be requested to complete three questionnaires which will take about an hour. The first instrument measures social support (25 items). The second set of 39 questions measures adolescent health/well-being. The third questionnaire measures adolescent hopefulness and consists of 24 items. The items or questions deal with feelings, thoughts, health, and interpersonal relationships. There are no questions about alcohol, pregnancy, or sexual activity among adolescents. The questionnaires do not assess physical or emotional illness. Although some items will seem personal, there will be no way to identify individuals. Every effort will be made to maintain confidentiality. Each set of three questionnaires will be coded with a number and the information analyzed and reported by age groups. No student name is to be placed on any questionnaire.

There are no risks to participating students. The only criteria to participate in this study is that the adolescent must be between 13 and 17 years of age, be able to read and write English, and each student must sign the written informed consent.

The Ionia High Schools' administration and staff are supporting this project and will allow the questionnaires to be completed during health education class. A copy of each questionnaire will be available for parents to review (only) in the principal's office. An envelope will be available in the health education room for returned consent forms. No date has been established as of yet to distribute the questionnaires. However, it will be done before the end of the first semester.

I am a nurse in the area and a masters candidate at Grand Valley State University. If you have any questions about this research or would like information about the results, please contact me by phone (616-527-1591) or by writing (1695 Horizon Drive, Ionia, MI 48846). For a reference, you may contact Dr. Howard Stein, Grand Valley State University, Allendale, MI 49401. Dr. Stein may be reached by calling 616-895-2470.

Please read the attached information and sign as appropriate. Return the completed form to the health education classroom. If you change your mind at any time, you will not be required to participate.

Sincerely,

Peggy Norman, RN, BSN

APPENDIX E

INFORMED CONSENT FOR RESEARCH PROJECT PARTICIPATION

I understand this is a study to examine how interpersonal relationships and looking toward the future are related to adolescent health. I understand that the knowledge gained is expected to help nurses and physicians provide health care in a manner which will be responsive to the needs of early and middle adolescents.

I also understand that:

1. participation in this study will involve a one hour class period where participants will answer questions about general health, social support and hope.
2. selection for participation is based on age (13 to 17 years of age).
3. it is not anticipated that participation in this study will lead to physical or emotional harm to the adolescent.
4. every effort will be made to maintain confidentiality, (Please do not put your name on questionnaires).
5. a summary of the results will be made available to participants and/or parents upon request.

I acknowledge that:

1. participation in this study is voluntary and the student may withdraw at any time without penalty or prejudice.
2. all reports, papers, and articles will report findings in group format - no individual information will be reported.
3. Peggy Norman will be available to answer questions about this research study by phone or letter and this information has been provided.

I have read and understand the information presented above.

I CONSENT to participate
in this study.

I wish to have my child EXCLUDED
from this study.

Signature of Student

Signature of Parent

Date

Date

I would like a copy of the study's results ____ YES ____ NO
Address _____

APPENDIX F

Human Subjects Permission

APPENDIX F



1 CAMPUS DRIVE • ALLENDALE MICHIGAN 49401-9403 • 616/895-6611

November 14, 1996

Peggy Norman
1695 Horizon Drive
Ionia, MI 48846

Dear Peggy:

Your proposed project entitled "*Social Support and Well-Being in Early and Midadolescents: The Mediating Role of Hopefulness*" has been reviewed. It has been approved as a study which is exempt from the regulations by section 46.101 of the Federal Register 46(16):8336, January 26, 1981.

Sincerely,

[Redacted Signature]

Howard Stein, Acting Chair
Human Research Review Committee

APPENDIX G

High School Administrative Permission

APPENDIX G

October 25, 1996

Peggy Norman
1695 Horizon Drive
Ionia, MI 48846

Dear Peg

It was a pleasure to meet with you and discuss your planned research with students of the Health Education Class here at Ionia High School. As you know after your meeting with Principal Snook, I am to be your liaison here at IHS. I am pleased to be of assistance to you and am offering to support you in the classroom with recruitment of subjects, collection of consent forms, and to be in attendance during testing to clarify test language or instructions for students.

Ionia High School administration and staff support this project and have no objections to the instruments that you have selected to administer to students or to the time frames involved with this project (a brief visit to the classroom and one class period for administration).

I understand that the three instruments will constitute a set and will be coded as such. I also understand that no names or identifiers are to be used on the instruments and in this way the confidentiality of the individual student is protected. Per our discussion in September, I recommend the following: (1) copies of all instruments be placed in a folder the principal's office for parents to review, (2) information about the study be explained to students by you one week prior to planned testing, (3) that you provide an informational letter for students and parents, (4) that the informed consent requires student permission only, however, (5) the informed consent allows in writing for parents to exclude their child from the study. This practice of requesting student permission and parental exclusion for IHS administration approved projects has worked well in the past to protect students and promote their awareness of and participation in research studies.

Please request that students take the informational letter and consent form home to their parents and return the consent form to me. I will place these forms in an envelope to be reviewed by you and I the morning of testing. I recommend that you allow students who bring back consent forms as late as the morning of scheduled testing be allowed to participate. I will assist you in matching permission to student and make arrangements for students who do not choose to participate or are excluded to be sent to another area to prevent noise and disruption during administration of the surveys. I will also be available to students following testing in case there are any questions or issues that a student may want to discuss.

Again, welcome to Ionia High School's Health Education Class. If you have any questions please do not hesitate to contact me.

Sincerely


Michael Cooper, LPC
Ionia High School Faculty

APPENDIX H

Individual Item Scores for Each Instrument

APPENDIX H

Table 13

Summary of Respondents Scores for Individual PRO-85 Items

Item	Mean Score	Median Score
Dimension:		
Worth		
I feel no one has the same problems I do.	4.87	5.00
Others let me know they enjoy working with me.	4.88	5.00
My family lets me know I am important for keeping the family running.	5.00	5.00
People let me know I do well at my work.	5.37	6.00
I know that others appreciate me as a person.	5.45	6.00
Dimension:		
Nurturance		
I am responsible for helping provide for another's needs.	4.96	5.00
I have the opportunity to encourage others to develop.	5.47	6.00
There is little opportunity in my life to be giving and caring about another.	5.49	6.00
I have a sense of being needed by another person.	5.54	6.00
I enjoy doing little extra things that make other's life more pleasant.	5.59	6.00
Dimension:		
Assistance		
There are people available if I need help over extended time.	4.74	6.00
I have relatives/friends to help if I can't pay them back.	5.45	6.00
I can't count on my relatives/friends to help with problems.	5.56	6.00
If I get sick there is someone to give me advice.	5.63	6.00
If I need advice there is someone to assist and work out a plan.	5.67	6.00
Dimension:		
Social Integration		
I belong to a group to which I feel important.	5.43	6.00
People think I am not as good a friend as I should be.	5.59	6.00
Among my friends, we do favors for each other.	5.76	6.00
I spend time with others who have the same interest.	5.97	6.00
I have people to share social events and fun activities with.	6.03	7.00
Dimension:		
Intimacy		
I have enough contact with a person who makes me feel secure.	5.47	6.00
There is no one to talk to about how I am feeling.	5.60	6.00
When I am upset there is someone who lets me be myself.	5.77	6.00
There is someone I feel close to who makes me feel secure.	5.87	6.00
There is someone who loves and cares about me.	6.26	7.00

Note. *Mean scores taken from analysis of subject responses ranging from 1 = Strongly disagree to 7 = Strongly agree. Scores on negatively stated items reflect results after recoding.

APPENDIX H

Table 14

Summary of Respondents Scores by Level of Hopefulness

Item	Mean Score	Median Score
Level of Hope:		
Forced Effort		
I won't let myself worry about things I can't fix.	56.76	55.00
I won't let myself spend time feeling sorry for myself.	65.12	77.00
I force myself to try harder.	76.35	85.00
I make myself do something to get mind off bad thoughts.	77.20	84.00
I try to make myself believe things will get better.	80.39	88.00
Level of Hope:		
Personal Possibilities		
I am starting to come up with possibilities for me.	75.53	85.00
I am getting some self-confidence.	76.16	83.00
I let myself focus on bad.	78.14	80.00
I see different ways to look at a problem.	78.17	75.00
I am not going to get any better than I am.	82.27	90.00
I believe there is a chance for me.	84.37	95.00
Level of Hope:		
Expectations for a Better Tomorrow		
I am pretty sure I can't make problems turn out OK.	75.07	80.00
Things will always get better.	75.60	80.00
Maybe there will be something going for me.	79.68	90.00
Good can come.	80.41	93.00
I am not positive about life becoming a good one.	80.69	85.00
There's no light at end of tunnel.	88.75	93.00
Level of Hope:		
Anticipation of a Personal Future		
There are great things to come for me.	77.03	87.00
I can't handle problems.	79.61	85.00
I have the ability to change my future.	81.38	95.00
Someday I am going to find someone to love.	83.29	100.00
I know I'll do OK in life.	87.14	96.50
Things really won't get better for me.	89.14	89.00

Note. *Mean scores taken from analysis of subject responses ranging from 0 to 100.
Scores on negatively stated items reflect results after recoding.

APPENDIX H

Table 15

Summary of Respondents Scores by Individual AGWB Dimension

Item	Mean Score	Median Score
Dimension:		
Mental		
I worry about the future and how it will turn out.	2.54	2.00
There is a lot of stress/tension in my life.	2.76	3.00
I can handle problems without frustration/getting upset.	2.82	3.00
Things usually run out the way I want.	3.29	3.00
I am optimistic and look on bright side of things.	3.29	3.00
I feel dissatisfied with way things are going.	3.36	3.00
I am frequently sad, down, or moody.	3.37	3.00
I am able to concentrate and maintain train of thought.	3.42	4.00
I feel as happy as others.	3.47	4.00
I am frequently irritable.	3.50	4.00
I frequently feel guilty.	3.57	4.00
I am frequently worried or fearful.	3.58	4.00
I feel successful and worthwhile.	3.65	4.00
I enjoy competition.	3.66	4.00
I often feel like crying.	3.67	4.00
I feel life has meaning.	3.73	4.00
My memory is good.	3.74	4.00
I wonder if anything is worthwhile any more.	3.74	4.00
I can usually think clearly.	3.77	4.00
I like myself.	3.86	4.00
I enjoy my life.	3.98	4.00
I have frequent thoughts about suicide/death.	3.99	5.00
Dimension:		
Physical		
I am usually free from colds/other illnesses.	3.28	4.00
I feel as healthy/strong as I should.	3.29	3.00
I frequently have headaches.	3.31	4.00
I frequently feel sick to my stomach or have cramps/aches.	3.46	4.00
I maintain good body weight for height and build.	3.48	4.00
My heart frequently beats fast.	3.48	4.00
I get physical exercise and stay in good physical health.	3.53	4.00
I am able to resist illness and avoid accidents.	3.53	4.00
My body causes me trouble and interferes with life.	3.67	4.00
I occasionally feel faint.	3.70	4.00
I am satisfied with my health, it does not prevent me from doing things I like.	3.76	4.00
I smoke cigarettes regularly.	4.07	5.00
I use drugs for reasons other than medical treatment.	4.27	5.00
I take sleeping pills or tranquilizers.	4.67	5.00
Dimension:		
Social		
I feel popular and easy to like.	3.60	4.00
I have trouble making friends.	4.18	4.00
I get in trouble with police.	4.44	5.00

Note. *Mean scores taken from analysis of subject responses ranging from 1 = Strongly Disagree to 5 = Strongly Agree. Scores on negatively stated items reflect results after recoding.

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