HOPELESSNESS AND TEMPERAMENT OF YOUTH

IN RESIDENTIAL TREATMENT

by

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ABSTRACT

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The importance of hopelessness and temperament within the study of youth psychiatric disorders is becoming increasingly apparent. Analysis of these two constructs further elucidates the factors that are correlated with psychopathology in children and adolescents. The present study examines the relationship between hopelessness and temperament. Two scales, the Beck Hopelessness Scale (Beck, 1974) and the Revised Dimensions of Temperament Survey Child (Windle & Lerner, 1986), were administered to 32 participants and the scores were correlated to determine whether a relationship exists between the two constructs.

Data analysis using Pearson's *r* correlation coefficients suggests a positive correlation exists between hopelessness and temperament, as well as a positive correlation between elevated levels of hopelessness and a difficult temperament.

When utilizing the t-test for independent means to determine differences in BHS and DOTS-R Child scores in relation to internalized disorders and externalized disorders, no statistical differences were indicated. Implications of these findings are discussed as well as recommendations for future studies on hopelessness and temperament.

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CHAPTER I

Introduction

An estimated 20 percent of American children and adolescents, 11 million in all, have serious diagnosable emotional or behavioral disorders, which range from attention deficit disorder and depression to bipolar disorder and schizophrenia. Between 9 percent and 13 percent of children ages 9 to 17 have serious mental or emotional disturbances that substantially interfere with or limit their ability to function in the family, school, and community and are placed in residential treatment centers (Children's Defense Fund, 1998).

Children and adolescents in care today tend to exhibit a wide range of psychopathologies that can be classified dichotomously into internalized disorders and externalized disorders. The internalized disorders are characterized by symptoms of overcontrol, depression, social withdrawal, inhibition, and anxiety. The externalized disorders are characterized by symptoms of undercontrol, conduct disorder, aggression, delinquency, hyperactivity, and substance abuse. This suggests that compared to children and adolescents in the past, youth in placement today are significantly more disturbed. The monetary cost of caring for these youth is also overwhelming. It has been estimated that for adolescents alone, residential treatment accounts for 1.05 billion dollars of the 3.5 billion dollars spent on adolescent mental health services. Thus, the issue of how best to help children and adolescents facing mental health problems is clearly relevant from a fiscal as well as a humanitarian perspective (Bates, English, & Kouidou-Giles, 1997).

Adolescence is often described as a phase in the life span involving confrontation with numerous challenges, psychosocial tasks, and novel events. Because high levels of

stressful life events and novel demands characterize adolescence, it is important to identify individual difference attributes (e.g., temperament, coping styles) that may potentiate healthy outcomes or ameliorate unhealthy outcomes. Garmezy and Rutter (1983) suggest that temperament is one of three major variables associated with healthy, adaptive functioning among children growing up. The other two significant predictors of healthy, adaptive functioning are family support and external (community) support, both of which are posed as influenced by temperament (Rutter, 1983; Werner, 1986).

Strongly associated as being a risk factor for the development of emotional and behavioral disorders is temperament. Temperament can be equated to the term behavioral style. Each refers to the *how* rather than the *what* (abilities and content) or the *why* (motivations) of behavior (Thomas & Chess, 1977). Individual differences in temperament play a critical role in the development of behavior disorders. Three clusters of temperamental traits are identified in children: easy, slow-to-warm-up, and difficult. The concept of the "easy temperament" denotes children characterized by positive mood, highly regular, low or mild in the intensity of their reactions, rapidly adaptable, and unusually positive in their approaches to new situations. Children characterized with a "slow-to-warm-up temperament" show low activity level, initial withdrawal responses, slow adaptability, low intensity of reactions, and a relatively higher frequency of negative mood responses. Finally, the term "difficult temperament" denotes behaviors and affective states in children characterized by irritability, withdrawal from novel stimuli, negative mood, intense reactions to stimuli, low adaptability to change, distractibility, irregularities in biological functions, and poor attention and persistence (Thomas, Chess, & Birch, 1968).

More specifically, the concept of the difficult temperament is useful for the prediction of behavior disorders among children and adolescents. Thomas and Chess (1977) report that children with a difficult temperament profile are more likely to have negative social interactions with significant others (e.g., parents, teachers, peers) with resultant increased risk for adverse psychosocial development and maladjustment. A difficult temperament is associated with a greater degree of anti-social behavior, including violence and a hostile interpersonal style in male adults. It is also linked with behavior problems, delinquency, and aggression in young children, preadolescents, and adolescents. Finally, a large study by Henry, Caspi, Moffitt, and Silva (1996) demonstrates that difficult temperament measured in 3- to 5- year old boys predicted convictions for violent offenses at age 18.

Children with the difficult temperament have the greatest risk for developing a behavior problem. Therefore, there is a need to further assess the processes involved in the development and maintenance of the difficult temperament so that future behavior problems that result in placement of residential treatment facilities may be prevented.

Only one study has investigated the relation between hopelessness and the construct of temperament characteristics. A major finding in this study by Kashani, Soltys, Dandoy, Vaidya, and Reid (1991) shows that children with high hopelessness have a temperamental constellation that resembles that of the difficult child: negative mood, low adaptability, and withdrawal. Hopelessness, defined as negative expectancies toward oneself and toward the future, is also a factor in a variety of psychopathological conditions.

The difficult child characteristic previously mentioned can be construed as being consistent with the negative outlook of the hopeless child. Negative mood is descriptive of the hopeless child and the child who is consistently in a bad mood is more likely to provoke the

displeasure of parents, teachers, and peers. The hopeless child--who by definition has negative expectations for his or her environment--is also likely to be more withdrawn than those children

with low hopelessness. Such negative expectations toward self, future, and environment may cause the child to become more vulnerable to stressors, resulting in behavior disorders. Given the pressures and stressors that are connected to the negative child, the child can be viewed as "obstinate" by others, thus supporting a difficult temperament characteristic.

The implications of the relation between temperament and hopelessness are important in terms of prevention of future behavior difficulties that result in placement in residential treatment facilities. If it could be shown with youth placed in residential treatment facilities that a high level of hopelessness is related to a difficult temperament, it may be possible to get to the core of some behavior difficulties that result in placement in residential treatment. Few studies have investigated the relation between hopelessness and temperament. Therefore the proposed research will assess the relationship between hopelessness and difficult temperament in children and adolescents residing in a residential treatment facility. Along with assessing hopelessness and difficult temperament relations, the differences between internalized and externalized disorders

with higher self-report inventory scores for hopelessness and difficult temperament will be investigated.

Statement of the Problem

The purpose of this study is to determine if a relationship exists between hopelessness and difficult temperament in children and adolescents residing in a residential treatment center. In addition, this study will determine any differences between internalized and externalized disorders with high levels of hopelessness and difficult temperament.

These variables will be measured by administering the Beck Hopelessness Scale and the Revised Dimensions of Temperament Survey Child (DOTS-R Child). Scores on each self-report inventory will be compared to determine whether a correlation exists.

Hypotheses

Four null hypotheses are proposed in this study. They are as follows:

Ho1: There will be no correlation between scores on the Beck Hopelessness Scale (BHS) and the Revised Dimensions of Temperament Survey Child (DOTS-R Child).

Ho2: There will be no correlation between scores of elevated levels of hopelessness on the BHS and a difficult temperament on the DOTS-R Child.

Ho3: There will be no statistically significant difference between the internalized disorders group and the externalized disorders group with elevated scores on the BHS.

Ho4: There will be no statistically significant difference between the internalized disorders group and the externalized disorders group with elevated scores on the DOTS-R Child, indicating a difficult temperament.

The hypotheses for this study are that there is a positive correlation between hopelessness and temperament in children and adolescents residing in a residential treatment center. Also, there are statistically significant differences between the internalized disorders group with elevated scores on the BHS and the externalized disorders group with elevated scores on the DOTS-R Child.

Definition of Terms

Behavior Disorders: A general term describing disorganized, disturbed, and deranged

behavioral patterns. They usually involve symptoms that are likely to bring the sufferer into conflict with society.

Emotional Disorders: A term used to refer to a wide range of psychological disturbances

which involve inappropriate emotional experiences.

Externalized Disorders: A term used to refer to emotional or behavioral disorders characterized by symptoms of undercontrol, conduct disorder, aggression, delinquency, hyperactivity, and substance abuse.

Hopelessness: Negative expectancies toward self, future, and environment.

Internalized Disorders: A term used to refer to emotional or behavioral disorders

characterized by symptoms of overcontrol, depression, social withdrawal, inhibition, and anxiety.

Psychopathology: A general term used to describe a wide range of psychological disorders.

Residential Treatment Facility: A residential program that concentrates on delivering therapeutic services to the residents while providing for the basic needs of the residents.

Temperament: A latent construct comprising a series of trait dimensions depicting individual differences in various types of behavioral and affective responsivity and self-regulatory styles.

CHAPTER II

Review of Literature

General Information

Giancola, Mezzich, & Tarter, 1998; Kashani et al., 1990; Thomas & Chess, 1977; and Windle, 1991/1992b, have examined factors which contribute to the development of behavior disorders in children and adolescents that result in placement in residential treatment facilities. This review will focus on the child's temperament and on the role it plays in the emergence and elaboration of behavior problems. Despite this focus, however, temperament cannot be considered in isolation as the cause for behavior problems. Hopelessness has also been found to be a key component in the severity of various behavior disorders. Therefore, this review of literature focuses on the relation of hopelessness to temperament, and its implications on behavior disorders in children and adolescents.

Adolescence is generally recognized as a transitional period between childhood and maturity, and of growth arising from both biological maturation and efforts at socialization. This developmental period is characterized by rapid physical change, striving for independence, exploration and implementation of new behaviors, strengthening peer relationships, sexual awakening and experimentation, and seeking clarity relating to self and one's place in the larger society. Add to this the pressures exerted by family, school, peers, and society to conform to or react against established standards, and it is not difficult to understand the highly pressured environment of adolescents and the degree of vulnerability that exists for them (Capuzzi & Gross, 1989). For some young people, adolescence is an extended period of struggle; for others the

transition is marked by alternating periods of struggle and quiescence. During periods of stress and tumult, this latter group's ability to draw on effective adaptive coping behaviors is taxed. The resulting maladaptive behavior risks compromising physical, psychological, or social health (Capuzzi & Gross, 1989).

Thomas and Chess (1986) have proposed a model that differentiates the individuals who pass through this developmental process seemingly unscathed and those who, in an attempt to meet the challenges, either by choice or by circumstances, are unable to deal with the challenges effectively. An interactional person-environment model, referred to as the "goodness-of-fit" model, accounts for the functional significance of temperament on psychosocial adjustment. According to the goodness-of-fit model, temperament is a relational concept and will optimally predict outcomes when the environmental demands are appropriately conceptualized. This model postulates that healthy functioning and development occurs when there is a goodness of fit (compatibility) between the capacities and characteristics of the individual and the demands and expectations of the environment. If, on the other hand, there is a poorness of fit (incompatibility) between individual and environment, psychological functioning is impaired, with the risk of behavior disorder development (Chess & Thomas, 1986).

Goodness or poorness of fit includes the possibility that various types of interactional patterns may produce either adaptive or maladaptive functioning. The behavioral responses associated with temperament characteristics are significant with regard to their role in promoting either a goodness or poorness of fit in specific person-environment interactions. This in no way implies a judgment that temperament is always a prominent factor in a poorness of fit that leads to a behavior disorder. While not the

focus of the present study, other characteristics of the person, such as motivation, pathogenic defense mechanisms, and handicaps or illnesses, may also play important roles in the evolution of poorness of fit resulting in a behavior disorder.

Temperament Characteristics

Temperament may best be viewed as a general term referring to the *how* of behavior. It differs from ability, which is concerned with the *what* and *how well* of behaving, and from motivation, which seeks to account for *why* a person does what he or she is doing. Thus, temperament is the *behavioral style* of the individual (Thomas, Chess, & Birch, 1968). Thomas, Chess, and Birch (1968) have generated the following list of nine characteristics of temperament in children:

1. *Activity Level*. This dimension describes the level, tempo, and frequency with which a motor component is present in the child's functioning. An example of high activity is a child who kicks and splashes in the bathtub. An example of low activity behavior is a child who lies quietly and does not kick in the bathtub.

2. *Rhythmicity*. This dimension describes the degree of rhythmicity or regularity of repetitive biological functions. It can be analyzed in relation to the sleep-wake cycle and hunger. A child's sleep-wake cycle is considered to be regular if the child falls asleep at approximately the same time each night and awakes at approximately the same time each morning. Eating and appetite behavior is considered regular if the child demands or readily accepts food at the same time each day and consumes approximately the same amount of food.

3. *Approach and Withdrawal*. This dimension describes the child's initial

response to a new stimulus, be it a new toy, food, or person. Approach responses are positive and withdrawal responses are negative.

4. *Adaptability*. This dimension describes the responses to new or altered situations. The emphasis is on the ease or difficulty with which the initial pattern of response can be modified in the direction desired.

5. *Intensity of Reaction*. This dimension describes the energy level of response, irrespective of its direction. An example of an intense reaction is a child jumping with joy when excited. An example of a mild reaction is a child screaming and yelling when frustrated.

6. *Threshold of Responsiveness*. This dimension refers to the intensity level of stimulation that is necessary to evoke a discernible response. The explicit form of response that occurs is irrelevant and may be of any quality (e.g., approaching or withdrawing, intense or mild). The behaviors utilized are those concerning reactions to sensory stimuli, environmental objects, and social contacts. An example of low threshold is a child complaining if his or her pants feel the slightest bit tight. An example of high threshold is a child not complaining of feeling cold even though he or she may be shivering.

7. *Quality of Mood*. This dimension describes the amount of pleasant, joyful, and friendly behavior, as contrasted with unpleasant, crying, and unfriendly behavior.

8. *Distractibility*. This dimension refers to the effectiveness of extraneous environmental stimuli in interfering with or in altering the direction of the ongoing behavior. An example of high distractibility is a child taking a long time doing homework because his or her attention is repeatedly sidetracked. Low distractibility

might be shown by a child reading a book and efforts to alter his or her behavior are unsuccessful.

9. *Attention Span and Persistence*. This dimension includes two categories that are related. Attention span concerns the length of time a particular activity is pursued by the child, and persistence refers to the continuation of an activity in the face of obstacles to the maintenance of the activity direction (Thomas, Chess, & Birch, 1968).

Three Temperamental Constellations

The Easy Child. This constellation is characterized by regularity, positive approach responses to new stimuli, high adaptability to change, and mild or moderately intense mood which is preponderantly positive. This child quickly develops regular sleep and feeding schedules, takes to most new foods easily, smiles at strangers, adapts easily to a new school, accepts most frustration with little fuss, and accepts the rules of new games with no trouble (Thomas & Chess, 1977).

The Slow-To-Warm-Up Child. This constellation is marked by a combination of negative responses of mild intensity to new stimuli with slow adaptability after repeated contact. This child is characterized by mild intensity of reactions, whether positive or negative, and by less tendency to show irregularity of biological functions. The negative mild responses to new stimuli can be seen in the first encounter with the bath, a new food, a stranger, a new place, or a new school situation. If given the opportunity to re-experience such new situations over time and without pressure, such a child gradually comes to show quiet and positive interest and involvement (Thomas & Chess, 1977).

The Difficult Child. This constellation is characterized by negative withdrawal responses to new stimuli, non-adaptability or slow adaptability to change, intense mood

expressions which are frequently negative, and irregularity in biological functions. This child shows irregular sleep and feeding schedules, slow acceptance of new foods, prolonged adjustment periods to new routines, people or situations, and relatively frequent and loud periods of crying. Laughter is also characteristically loud, and frustration typically produces a violent tantrum (Thomas & Chess, 1977).

Temperament and Behavior Disorders

Behavior disorders have multiple causes, and temperament, as such, is a style of functioning, not a behavioral disturbance. For a given temperamental pattern to contribute to the development of a behavioral disturbance, it requires particular kinds of interaction between the child with the temperamental pattern and his or her effective environment.

Behavioral issues in which temperamental characteristics play a significant role may come to attention in a number of ways. For example, extremes of one or other temperamental traits that are within the normal range may appear deviant and abnormal. Also, an unfavorable interaction between the individual and the environment occurs so that one or other temperamental characteristics become exaggerated to the point where it is pathologic. Similarly, a more extensive unfavorable temperament-environment interaction occurs so that a more generalized behavior disorder develops (Chess & Thomas, 1986).

Chess and Thomas (1986) assert that a behavior disorder in a child or adolescent develops out of a substantial incompatibility between the individual's capacities, coping abilities, and the expectations and demands of the environment. Such incompatibility may result from many different patterns of interaction between the

individual and the environment, and the consequences of the incompatibility may take many different forms. The role of temperament in such a pathogenic developmental process can be varied. In some children a behavior disorder begins and evolves first with a pathologic exaggeration of a temperamental characteristic, followed by an interaction with the environment that leads to further unhealthy consequences.

In their highly influential New York Longitudinal Study, Thomas and Chess (1968) identified the temperament profile that emerged as most highly associated with behavioral disturbance. The difficult temperament constellation previously described is associated with children who have more severe difficulties in their behavioral interactions with significant others (e.g., parents, peers, teachers), and are at an increased risk for adverse psychosocial development and maladjustment.

Temperament and Internalized and Externalized Disorders. Temperamental difficulty is widely cited as being a risk factor for the development of emotional and behavioral disorders in both normal and high-risk samples (Rutter, 1986). Kashani et al. (1990/1991) have documented significant associations between extreme difficult temperament and clinical behavior disorders among children admitted to a child psychiatric facility. A disproportionate number of such clients had extreme difficult temperament, and extreme difficulty was associated with externalizing disorders such as oppositional-defiant, conduct, and attention-deficit disorders (Maziade, Caron, Cote, Merette, Bernier, Laplante, Boutin, & Thivierge, 1990). Among adolescents, difficult temperament factors are associated with externalizing behaviors such as higher levels of substance use (e.g., cigarettes, alcohol, marijuana), childhood behavior problems (e.g., hyperactivity, conduct problems), delinquent activities, and internalizing behaviors such

as depressive symptoms (Tubman & Windle, 1995). Furthermore, Windle (1991) reports that difficult temperament characteristics at age 5 and in early adulthood are associated with higher levels of alcohol, tobacco, and marijuana use (externalizing symptomatology) in young adulthood. This can be attributed to a failure to successfully cope with ongoing stressful life events, which may result in the use of mind-altering substances as an "escapist" coping strategy. As such, adolescents with difficult temperamental styles may have more problems in coping with the interpersonal demands of adolescence and may use alcohol and/or other substances to temporarily relieve the perceived demands (Windle, 1991).

Temperament is significantly related to depressive symptoms (internalized disorder) and delinquency (externalizing symptomatology). Windle (1992b) reports that a temperamental style characterized by arrhythmicity, withdrawal from new persons, objects, or situations, inflexibility, negative mood quality, high distractibility, and low persistence is related consistently to depressive symptoms. The temperament profile that emerges as most highly associated with depressive symptoms and delinquency generally conforms to the difficult temperament constellation proposed by Thomas and Chess (1977). Thomas and Chess proposed that a temperament profile characterized by arrhythmicity, withdrawal responses to new stimuli, poor adaptation to change, and intense, negative mood is associated with children who have more severe difficulties in their behavioral interactions with significant others (Thomas & Chess, 1977). In addition, risk for more serious depression and involvement in delinquency is especially salient for those adolescents with four or more difficult temperament factors (Windle, 1992b).

Many factors influence the course of normal and deviant behavioral development; temperament, in and of itself, does not produce a behavior problem. The importance of hopelessness with the study of child and adolescent behavioral disorders is becoming increasingly apparent. Therefore, the next section will examine the role of hopelessness in future psychopathology.

Hopelessness

It is widely accepted that with hope, human beings act, move, and achieve. Individuals who are hopeful are usually described as active, vigorous, and energetic. Conversely, individuals who are hopeless are described as inactive, apathetic, and dull (Stotland, 1969). Hope and hopelessness are two experiences that represent opposite expectations. The concept of hope can be expressed as a way of feeling (affectively), as a way of thinking (cognitively), and a way of behaving or relating (behaviorally). As a way of feeling, hope has been described as an energizing force. It propels persons forward when the odds seem to be against them. As a way of thinking, hope is associated with a sense of fortitude, as described as an assumed certainty that a dreaded possibility will not happen. As a way of behaving, hope expresses itself as an active process in which the individual seeks possible and appropriate alternatives (Farran, Herth, & Popovich, 1995)

Like hope, hopelessness expresses a way of feeling (affectively), a way of thinking (cognitively), and a way of acting (behaviorally). As a feeling, hopelessness is expressed as discouragement, despair, or a deenergizing force. When people feel hopeless, their thinking is also impaired. They have difficulty making their plans

concrete and realizing alternative methods of resolving issues. These feelings and ways of thinking also influence the way persons behave. Hopeless individuals generally experience an inability to act (Farran, Herth, & Popovich, 1995).

The presence of hopelessness generally signals that something is wrong—that one's needs or goals have not been met, that life or one's situation has become difficult or unbearable (Farran, Herth, & Popovich, 1995). Hopelessness can function as both a temporary state and an ingrained trait. As a temporary state, hopelessness consists of a temporary affective, cognitive, and feeling state that may be a response to some life situation in which the individual's goals and/or needs have not been met. This type of hopelessness might be seen in response to loss and grief experiences or major life changes such as illness. Generally, with activation of internal and external resources, this type of hopelessness resolves or recedes over time (Farran, Herth, & Popovich, 1995). As a personality trait, hopelessness can be described as a way of relating and expressing oneself, and as a deep personal orientation that nothing one can do and nothing that happens externally can bring meaning or enthusiasm to life. What marks the difference between hopelessness associated with "normal" responses to difficult experiences and hopelessness associated with psychiatric disorders is that persons have succumbed to the challenge and have given up. These feelings of hopelessness last longer, are more persistent, have more associated symptoms, and more profoundly interfere with routine activities and tasks (Farran, Herth, & Popovich, 1995).

Hopelessness reflects an individual's estimate of the probability of achieving certain goals in regards to the ability to maintain successful plans of action in pursuit of present and evolving goals. With the affect of hopelessness there is a feeling that it is

most improbable that plans will achieve goals. With hopelessness, failure is anticipated (Melges & Bowlby, 1969).

Antecedents and sources of hopelessness can be identified as intrapersonal, interpersonal, or environmental/sociological. Schmale (1964) presents the development of hopelessness from a psychoanalytic point of view and postulates that it takes place in early childhood. He associates the origin of hopelessness with anxiety, the most primal affect and undifferentiated psychic state in individuals. He suggests that when the child's emotional needs are not gratified, the effects of anger, fear, and helplessness become differentiated from anxiety. If the child's emotional needs are met, affective states of goodness, pride, and hope are differentiated and emerge. If, on the other hand, the child's emotional needs are not met, effects of guilt, shame, and hopelessness are differentiated.

Stotland (1969) suggests that the roots of hopelessness lie in personal experiences or attitudes, suggesting that hopelessness, like hope, can be learned. The process of learning hopelessness rests upon rigid, absolutized thoughts, feelings, and actions that lead to a self-enclosure in despair. The major cause of this sense of hopelessness and futility is the individual's inability or refusal to face actual hopelessness as it occurs in daily lives. Part of the refusal to accept this reality comes from within the individual, and other aspects may come from external sources, in that hopelessness is often labeled as unacceptable to others.

Melges and Bowlby (1969) take a more environmental/sociological perspective concerning the antecedents and sources of hopelessness. They suggest that it is associated with feelings of alienation from society. Hopeless individuals believe their personal future is largely out of their control and others cannot be counted on.

Outcomes associated with hopelessness have ranged from negative emotional responses to physical and mental illness and premature death. Feelings of hopelessness have consistently been shown to be one of the best predictors of depression and suicidal ideation (Beck, Steer, Kovacs, & garrison, 1985). The next section discusses the presence of hopelessness in depression and other psychopathological conditions.

Hopelessness and Behavior Disorders

Considerable research in the past within adult populations has focused on the importance of hopelessness as a factor in a variety of psychopathological conditions (e.g., depression, suicide). Recent investigations have studied children to understand continuities and/or discontinuities in hopelessness or depressive tendencies across the developmental spectrum (Kashani et al., 1991). In research pertaining to childhood psychopathology, risk factors have been identified as those factors, which, if present, increase the likelihood of a child's developing a behavior disorder (Kashani et al., 1990). Hopelessness has been identified as such a risk factor, and a child with negative expectations toward self, future, and environment may be more vulnerable to stressors, resulting in behavior disorders. A study by Kashani, Reid, and Rosenberg (1989) revealed that children with high hopelessness scores were found to be at greater risk for depression, suicide, and overall psychopathology. Suicidal thoughts and depression may be a precursor or a consequence of this hopelessness. As stated earlier, this pathological type of hopelessness is associated with psychiatric disorders such as depression, suicidal ideation, or sociopathic disorders (Beck et al., 1985).

Hopelessness and Internalized Disorders. Internalized disorders may include mood disorders such as depression or bipolar disorder, adjustment disorder, or anxiety disorder. As stated earlier, hopelessness has been found to be an important factor in various psychopathological problems, especially depression and suicide; the more severe the depression the greater is the feeling of hopelessness. The hopelessness of a severely depressed individual is characterized by the following beliefs and expectations: 1) the individual believes that personal skills and plans of action are no longer effective for reaching goals set; 2) the individual attributes personal failures to own incompetence so that he or she must now rely more on others; and 3) the individual deems previous investments in long-range goals to have been met with numerous frustrations and failures (Melges & Bowlby, 1969). Prior to their depressive episode, most individuals are largely future-oriented and trust in the efficacy of their plans of action to achieve their goals; the individual has hope and strives actively (Melges & Bowlby, 1969).

According to Beck's (1967) cognitive theory, hopelessness is at the core of depression. This model emphasizes the role of negative self-perceptions in the development and maintenance of depressive symptoms. The distorted style of thinking is encompassed within a cognitive triad: an unrealistic negative and systematically biased view of self, experiences, and future.

The first component of the triad is the pattern of the individual viewing oneself in a negative way. The individual is regarded as deficient, inadequate, or unworthy, and tends to attribute unpleasant experiences to a personal physical, mental, or moral defect. Furthermore, the individual regards him or herself as undesirable and worthless because of the presumed defect, and tends to reject oneself because of it (Beck, 1967).

The second component of the triad is the pattern of construing experiences in a negative way. The individual consistently interprets personal interactions with the environment as representing defeat, deprivation, or disparagement. Life is viewed as a succession of burdens, obstacles, or traumatic situations, all of which detract from the individual in a significant way (Beck, 1967).

The third component consists of viewing the future in a negative way. The individual anticipates that current difficulties or suffering will continue indefinitely. As he or she looks ahead, life is seen as filled with unremitting hardship, frustration, and deprivation (Beck, 1967).

These cognitive distortions of Beck's (1967) cognitive triad can lead to the affective and motivational symptoms that are characteristic of depression. For example, Beck suggests the following sequence: the individual interprets an experience as representing a personal defeat. He or she attributes this defeat to some personal defect, and regards oneself as worthless for having this trait. The individual blames him or herself for having acquired the trait and dislikes him or herself for it. The individual regards the trait as an intrinsic part of oneself, and sees no hope of changing, and views the future as devoid of any satisfaction or filled with pain (Beck, 1967).

Various correlates of hopelessness are identified. For example, hopelessness scores from the Hopelessness Scale for Children (Kazdin, French, Unis, Esveldt-Dawson, & Sherick, 1983), modeled after the Beck Hopelessness Scale, are significantly and positively correlated with scores on the Children's Depression Inventory, the Bellevue Index of Depression, and a Depression Symptom Checklist and are negatively correlated with scores on the Self-Esteem Inventory (Kazdin et al., 1983). Furthermore,

hopelessness is strongly related to suicide intent and accounted for the relationship between depression and suicide intent (Kazdin et al., 1983). Although suicide intent is correlated with depression, this relationship disappears when hopelessness is taken into account. Beck et al. (1985) also clarified the role of hopelessness in relation to depression and suicide by asserting that hopelessness is related more to completed suicide than is depression. As stated earlier in his cognitive triad model (1967), a sequence of events relates to how individuals misconstrue their experiences in negative ways and anticipate dire outcomes resulting from their problems. These persons may be drawn to suicide as the only way out of their unsolvable problems (Beck et al., 1985).

Kashani, Suarez, Allan, and Reid (1997) found that children and adolescents with high levels of hopelessness may show an array of internalizing, as well as externalizing behaviors. Among the internalizing behaviors, these individuals may show self-harm behaviors as well as withdrawal from others. The self-harm behavior may be similar in nature to the suicidal behavior just stated. Also found in this study was that children and adolescents with high levels of hopelessness tend to feel an array of negative emotions, such as shame, fear, guilt, and hostility. In contrast, they tend not to experience positive emotions, such as interest and joy (Kashani et al., 1997).

Hopelessness and Externalized Disorders. Externalized disorders may include disruptive behavior disorders such as attention-deficit hyperactivity disorder (ADHD), oppositional defiant disorder (ODD), conduct disorder (CD), intermittent explosive disorder, impulse control disorder, and substance abuse. Hopelessness associated with externalized disorders is characterized by disruptive behavior that in adolescence may be marked by the following symptoms: truancy, expulsion, or suspension from school;

delinquency; running away from home; persistent lying, thefts, vandalism; promiscuity; substance abuse; chronic violation of rules; and initiation of fights (Farran, Herth, & Popovich, 1995). Also among the externalizing behaviors, children and adolescents with high levels of hopelessness display a defiant attitude, are hurtful to self and others, exhibit socially inappropriate behaviors, and are likely to express their anger openly and aggressively without considering a less impulsive approach. Furthermore, anger is associated with suicidal behavior in youth, and adolescent suicide attempters experience significantly higher levels of both internalized and externalized anger. Therefore, adolescents who attempt suicide tend to use verbal or physical aggressive behavior, as well as internally directed anger, to deal with their negative mood state (Kashani et al., 1997). Given the relationship between suicidality and hopelessness, anger may be an important variable to examine in children and adolescents with high levels of hopelessness. These findings reveal that youth with high levels of hopelessness are potentially dangerous, not only to others, but also to themselves.

In contrast to internalized disorders, the type of hopelessness characteristic of externalized disorders derives from a different set of beliefs and expectations regarding goals and outcomes. An individual with an externalized disorder tends to believe that 1) personal skills have not had and will not have much influence on his or her future; 2) others cannot be trusted and are often to blame for the individual's failures; and 3) continuing and long-range goals are useless to strive for. These individuals are thus in a chronic state of hopelessness and have little orientation to the future. Essentially, he or she avoids the experience of feeling hopeless by seeking rewards in the present with little regard either for future consequences or for continuing long-range goals (Melges &

Bowlby, 1969). An individual engaging in disruptive behaviors as characterized by externalized disorders often feels alienated from society because he or she believes that opportunities open to others are blocked for him or herself. As a consequence, whatever skills the individual has are restricted to achieving short-term goals. These individuals often feel oppressed by authority, yet feel unable to do anything about it. The more powerless he or she feels, the greater is the tendency to act on impulse and to seize satisfactions in the present (Melges & Bowlby, 1969).

Hopelessness and Difficult Temperament

A study that investigated the relation between hopelessness and temperament found that children with high hopelessness are more likely than the low-hopelessness group to have temperament dimensions characteristic of a difficult child: negative mood, low adaptability, and withdrawal (Kashani et al., 1991). As mentioned earlier, children with the difficult temperament have the greatest risk for developing a behavior problem. The three difficult child characteristics mentioned above can be interpreted as being consistent with the negative outlook of the hopeless child. Negative mood is descriptive of the hopeless child and the child who is always in a bad mood is more likely to provoke the displeasure of parents, teachers, and peers. The hopeless child, who by definition has negative expectations for his or her environment, is also likely to be more withdrawn than those children with low hopelessness. Because the hopeless child withdraws from new aspects of the environment, any change may create a great deal of stress. Consequently, the stressful interaction may intensify the difficulty, causing the child to be more vulnerable to a behavior problem. Finally, the low adaptability finding suggests that

hopeless children are uneasy when making adaptations to their environment (Kashani et al., 1991).

Such negative expectations of the hopeless child toward self, future, and environment may cause the child to become more vulnerable to stressors, resulting in behavior disorders. Given the pressures and stressors that are connected to the negative, hopeless child, the child can be viewed as obstinate by others, thus supporting a difficult temperament characteristic.

The implications of the relation between temperament and hopelessness are important in terms of prevention of future behavior difficulties. Development, whether deviant or normal, results from the interaction between the child's individual makeup and aspects of individuality (e.g., negative expectations toward self, future, and environment). Hence, any temperamental pattern could significantly contribute to the development of a behavior disorder if the contextual demands and expectations are sufficiently incompatible with a child's behavioral style. Given that children with high levels of hopelessness have a temperamental constellation that resembles that of the difficult temperament, this study will investigate what correlation exists between hopelessness and temperament of youth residing in a residential treatment facility.

CHAPTER III

Methodology

Introduction

This chapter will describe the participants and how they were selected for inclusion in this study. In addition, the instruments being used to collect information will be discussed as to their content, reliability, and validity. The procedures for data collection and data analysis will then be presented. This chapter will include some of the methodological limitations as well.

Participants

This study was conducted in the spring of 2000 using participants residing at a residential treatment facility in the western region of Wisconsin. Ninety-five children and adolescents with emotional or behavioral difficulties were asked to participate. After parental/guardian permission had been granted, 32 individuals successfully completed the self-report inventories. Ages of these participants ranged from 11-17, with the mean age of 15. Ethnic minority participants made up 28% of the sample, while Caucasian participants consisted of 72%. Females made up 59% of the sample; males made up 41%.

Axis I clinical diagnoses were collapsed into two groups according to whether they were internal or external in nature. Of the internalized disorders group, 11 participants were identified with the diagnosis of either depression, bipolar disorder, adjustment disorder, or an anxiety disorder. Of the externalized disorders group, 21 participants were identified with the diagnosis of either oppositional defiant disorder,

conduct disorder, impulse control disorder, attention deficit hyperactivity disorder, intermittent explosive disorder, or substance abuse.

Instrumentation

To measure the level of hopelessness within the participants, the Beck Hopelessness Scale (BHS) was utilized. This scale was developed in 1974 and revised and published during the years of 1978-1988 (Beck & Steer, 1993). This scale is a self-report instrument composed of 20 true-false items assessing negative expectancies or hopeless ideation about the future and the self. Nine of the items are keyed false, and 11 are keyed true with ones being assigned to negative expectations and zeros being assigned to positive expectations. The item responses are summed to yield total scores ranging from 0 to 20, with higher scores indicating greater hopelessness. In a study conducted by Steer and Kumar (1993), it was found that the BHS is appropriate for use with adolescent inpatients and showed quantifiably that the scale is useful.

The internal consistency reliability for the BHS is represented by Kuder-Richardson (KR-20) coefficients between .82 and .93 for seven different norm groups. The Pearson product-moment correlation between the test-retest scores was reported at .69 ($p<.001$) after one week and .66 ($p<.001$) after six weeks (Beck & Steer, 1993).

The BHS was developed to study hopelessness as a system of negative attitudes concerning the person's future. "Most of the items were selected from a large pool of statements made by patients who were asked to describe their expectancies when they were depressed and not depressed" (Beck & Steer, 1993, p.13). The BHS was also developed to screen for suicidal intentions, and "the majority of the studies conducted

with the BHS have been performed with patients displaying a variety of suicidal behaviors" (Beck & Steer, 1993, p.16). Evidence of construct validity and predictive validity was found in the fact that hopelessness was a positive predictor of suicide (Beck & Steer, 1993).

To measure type of temperament, the Revised Dimensions of Temperament Survey Child (Self) was used. Due to limitations of an extant temperament measure developed in 1982, the Dimensions of Temperament Survey, a new instrument (DOTS-R) was constructed in 1986 by Windle and Lerner. There are three versions of the DOTS-R, referred to as the DOTS-R Child , the DOTS-R Child (Self), and the DOTS-R Adult. The DOTS-R Child is suitable for use with children from the preschool level through the middle elementary school level (e.g., through third to fourth grades); this version of the DOTS-R is designed to be completed by a parent (or another caregiver who has extensive experience with the child). The DOTS-R Child (self) is suitable for use with children from the late elementary school age level through the high school years (i.e., from early to late adolescence); it is designed to be completed by the subject himself or herself. The DOTS-R Adult is suitable for use with adults and is completed by the subject himself or herself (Windle & Lerner, 1992).

All three versions on the DOTS-R use the same 54 items. The only two differences among the three versions are: (1) minor variations in the instructions; and (2) in respect to the items, the switching of pronouns and verbs to reflect the person who is the source of the ratings (e.g., "I seem to get sleepy at the same time every night" vs. "My child seems to get sleepy at the same time every night").

The DOTS-R Child (Windle & Lerner, 1992) is composed of 9 scales: (a) Activity Level-General (elevated scores indicate increased levels of energy and motor activity); (b) Activity Level-Sleep (elevated scores indicate increased motor sleep activity); (c) Approach-Withdrawal (elevated scores indicate an approach style to new objects and persons); (d) Flexibility-Rigidity (elevated scores indicate increased adaptability to changes in the environment); (e) Mood (elevated scores indicate a more positive quality of mood); (f) Rhythmicity-Sleep (elevated scores indicate more regularity in sleep behavior); (g) Rhythmicity-Eating (elevated scores indicate more regularity in eating behavior); (h) Rhythmicity-Daily Habits (elevated scores indicate more regularity in performing daily habits); (i) Task Orientation (elevated scores indicate increased levels of persistence and decreased distractibility).

Each item has a 4-point response format, from *usually false* to *usually true*. Summary scores for each of the temperamental dimensions are formed by summing individual items (after recording reversed items). Higher subscale scores indicate higher levels of that temperamental characteristic. A difficult temperament index is created by summing all of the subscale scores.

The internal consistency reliability for the DOTS-R is represented by Cronbach Alpha coefficients between .62 and .81. The Pearson product-moment correlations between the test-retest scores across a six-week interval ranged from .59 to .75 (Windle & Lerner, 1986). A confirmatory factor analysis supported the convergent and discriminant validity and their factor structure has been adequately cross-validated (Windle, 1989). The validity of this index has been indirectly supported by its ability to predict delinquency in male and female adolescents (Windle, 1992b).

Procedures

The children or adolescents were asked to participate after permission had been granted by the parents/guardians of each individual. Each participant was given an overview of the study and was informed that participation was strictly voluntary and confidentiality was emphasized. The therapist assigned to each participant administered the Beck Hopelessness Scale and the Revised Dimensions of Temperament Survey Child (Self) individually. After the inventories were completed, the clinical diagnoses of each participant were recorded by the therapist on each corresponding inventory. Twenty-five minutes were allowed for volunteers to complete both inventories.

Data Analysis

The data for this study was analyzed by using Pearson's *r* correlation coefficient. Hopelessness scores were correlated against temperament scores to determine if any significant relationship exists. In addition, a correlation of elevated levels of hopelessness and a difficult temperament was explored.

Two t-tests for independent means were utilized to determine if there were any statistically significant differences between the internalized and externalized disorders group in terms of their levels of hopelessness and difficult temperament.

Limitations

Methodological limitations of this study are as follows:

1. The reading level of the instruments may have been difficult and not all questions may have been understood by the children and adolescents.
2. The generalizability of these results may be limited by the fact that this study was conducted using an inpatient sample of children and adolescents.
3. The use of volunteers may not accurately represent all children and adolescents residing at this residential treatment facility.
4. Because of the relatively small sample size the results of this study may be viewed as tentative.
5. Not all therapists may have explained the procedure uniformly and other differences may have been presented in assessment procedures.

CHAPTER IV

Results

Introduction

This chapter will present the results of this study which investigated the relationship between hopelessness and temperament. In addition, this section will present data pertaining to findings related to differences in internalized and externalized disorders with elevated levels of hopelessness and a difficult temperament.

Findings

Ho1: There will be no correlation between scores on the BHS and the DOTS-R Child.

Data analysis rejects the first null hypothesis. There is a positive correlation between hopelessness and temperament scores within the population of children and adolescents who reside in a residential treatment facility. The correlation coefficient was found to be .750, which is significant at the $p<.01$ level (see Table 1).

Table 1

Pearson's *r* Correlation Coefficients

	Difficult Hopelessness	Hopelessness Temperament	Elevated Temperament	
Hopelessness	1.000	.750*	-----	-----
Temperament	.750*	1.000	-----	-----
Elevated Hopelessness	-----	-----	1.000	.760*

Difficult Temperament	-----	-----	.760*	1.000

*Significant at p<.01

Ho2: There will be no correlation between scores of elevated levels of hopelessness on the BHS and a difficult temperament on the DOTS-R Child.

Data analysis also rejects the second null hypothesis in this investigation. There is a positive correlation between elevated levels of hopelessness and a difficult temperament within the population of children and adolescents who reside in a residential treatment facility. The correlation coefficient was found to be .760, which is significant at the p<.01 level (see Table 1).

Ho3: There will be no statistically significant difference between the internalized disorders group and the externalized disorders group with elevated scores on the BHS.

Means and standard deviations of the two groups on the BHS were computed and results are presented in Table 2. The data found in Table 2 indicates that the internalized disorders group scored slightly higher on hopelessness (M = 7.6364) than did the externalized disorders group (M = 6.5714). Both of these mean scores indicate mild levels of hopelessness within a population of children and adolescents residing in a residential treatment facility. The t score indicates no significant difference between the internalizing disorders group and the externalizing disorders group (t = .539) on elevated levels of hopelessness. These findings provide support for the third null hypothesis in this study, therefore the null hypothesis is not rejected (see Table 2).

Ho4: There will be no statistically significant difference between the internalized disorders group and the externalized disorders group with elevated scores on the DOTS-R Child, indicating a difficult temperament.

Data analysis of Table 2 also indicates no statistically significant difference between the internalizing disorders group and externalizing disorders group with elevated scores on the Revised Dimensions of Temperament Survey Child (DOTS-R Child). A further examination of Table 2 indicates that the externalized disorders group scored slightly higher with a difficult temperament (M = 2.5238) than did the internalized disorders group (M = 2.1818). Both of these mean scores indicate mild levels of a difficult temperament within a population of children and adolescents residing in a residential treatment facility. The t score indicates no statistically significant difference between the internalized disorders group and externalized disorders group (t = -.574) with a difficult temperament. These findings provide support for the fourth null hypothesis in this study, therefore the null hypothesis is not rejected (see Table 2).

Table 2

Means and Standard Deviations for Internalized Disorders Group and Externalized Disorders Group on Elevated Levels of Hopelessness and Difficult Temperament

	Internalized Disorders Group	Externalized Disorders Group

	N = 11		N = 21			
Scale	M	SD	M	SD	t	p
Elevated Hopelessness	7.6364	4.3880	6.5714	5.7146	.539	.594
Difficult Temperament	2.1818	1.5374	2.5238	1.6315	.-574	.570

Summary

Data analysis revealed a high correlation between elevated levels of hopelessness, as measured by the Beck Hopelessness Scale, and a difficult temperament, as measured by the Revised Dimensions of Temperament Survey Child. Although the internalized disorders group and the externalized disorders group differed slightly between elevated hopelessness and a difficult temperament, there were no statistically significant differences between the two groups. Implications of these findings are discussed in the following chapter, as well as recommendations for future studies on hopelessness and temperament.

CHAPTER V

Summary, Conclusions, and Recommendations

This chapter provides a brief overview of the study, conclusions that were obtained and recommendations for further research.

Summary

Adolescence is generally recognized as a transitional period in which adolescents are confronted by a range of novel demands. Garmezy and Rutter's (1983) review of childhood stressors indicate that temperament is a consistent predictor of healthy adjustment in response to these novel demands.

Thomas and Chess (1977) identify three clusters of temperament traits: easy, slow-to-warm-up, and difficult. More specifically, children with a difficult temperament manifest a behavioral style characterized by biological arrhythmicity, withdrawal from persons and novel stimuli, low adaptability or inflexibility to changes in the environment, high intensity responses, and negative (irritable) mood quality. The persistent manifestation of this constellation of difficult temperament behaviors contributes to negative social interactions with significant others and may undermine healthy psychosocial development and adjustment. A difficult temperament is associated with behavior problems, and children with the difficult temperament have a greater risk for developing an emotional or behavioral disorder.

A study by Kashani et al. (1991) shows that children with high hopelessness have a temperamental constellation that resembles that of the difficult child: negative mood, low adaptability, and withdrawal. Hopelessness, defined as negative expectancies toward

oneself and toward the future, may cause the child to become more vulnerable to stressors, resulting in behavior disorders. Kashani et al. (1989) reveals that children with high hopelessness are found to be at greater risk for depression, suicide, and overall psychopathology.

Only one study has investigated the relation between hopelessness and temperament (Kashani et al., 1991). The implications of the relation between hopelessness and temperament are important in terms of prevention of future behavior difficulties that result in residential treatment. Therefore, the purpose of this study was to determine if a relationship exists between hopelessness and temperament. Children and adolescents residing in a residential treatment center participated by completing two self-report inventories: the Beck Hopelessness Scale (BHS) and the Revised Dimensions of Temperament Survey Child (DOTS-R Child). Data analysis utilized the Pearson's *r* correlation coefficient to determine what correlations exist between hopelessness and temperament. In addition, this study examined the differences between internalized and externalized disorders with elevated levels of hopelessness and a difficult temperament. This was completed by utilizing two t-tests for independent means.

The results of the data analysis indicate there is a strong positive correlation between hopelessness and temperament. There is also a positive correlation found between elevated levels of hopelessness and a difficult temperament. Analyses revealed no statistical differences found between the internalized disorders group and externalized disorders group in terms of elevated scores on the BHS or DOTS-R Child.

Conclusions

The reviewed literature suggests that children with high hopelessness are more likely to have temperament dimensions characteristic of a "difficult" child: negative mood, low adaptability, and withdrawal. These difficult characteristics can be construed as being consistent with the negative outlook of the hopeless child, and can be interpreted to indicate the consequences of a hopeless condition. Such negative expectations toward self, future, and environment may cause the child to become more vulnerable to stressors, resulting in behavioral disorders.

This study expands the literature about characteristics of children and adolescents with high levels of hopelessness, specifically regarding a difficult temperament. These youth may display more behaviors that are uncooperative, defiant, and offensive to others, which is indicative of a difficult temperament. In addition, they are likely to show socially offensive behaviors, including swearing, lying, threatening others, and breaking the law. This pattern of behaviors may place the individual at greater risk for developing a behavior problem, thus eliciting referral to a residential treatment facility.

The children and adolescents residing in this residential treatment center have various emotional and/or behavioral difficulties for which treatment is necessary. Through this study, it has been illustrated that those individuals who display high levels of hopelessness also show a difficult temperament. The high correlations between hopelessness and temperament are not surprising given the population of children and adolescents assessed. Most of the children and adolescents in this residential treatment facility have met with abuse, family dysfunction, or other unhealthy circumstances that

have threatened their emotional stability. These circumstances have placed these children and adolescents at greater risk for the development of emotional or behavioral disorders.

It is also not surprising that this population of children and adolescents in residential treatment have a difficult temperament characteristic of negative mood. Negative mood is descriptive of the hopeless child and the child who is consistently in a bad mood is more likely to provoke the displeasure of parents, teachers, and peers through acts of delinquency. These acts of delinquency can be linked to the dimensions of hopelessness and negative expectations toward self, future, and environment. How an individual projects oneself into the future is at the core of hopelessness and if an individual looks unfavorably into the future, perhaps actions in the present will be based on the presumption that things will not improve. Therefore it is possible that youth with high hopelessness are only focused on the immediate gratification of the negative behavior he or she engages in and are not cognizant of the long-term consequences of these delinquent acts.

No statistically significant differences were found between the internalized and externalized disorders group in terms of high hopelessness and a difficult temperament. This finding was surprising due to much of the reviewed literature discussing high hopelessness to be more characteristic of internalizing symptomatology and a difficult temperament more characteristic of externalizing symptomatology. Perhaps the internalized and externalized disorders groups are not that different in the underlying problems they possess but rather in the way these problems are displayed. It could be that the internalized disorders group cope with their difficulties by social isolation and withdrawal from novel stimuli, while the externalized disorders group cope with their

difficulties through aggression, delinquent behaviors, and substance use. For example, the delinquent behavior (externalizing symptomatology) may be masking a depressive underlay (internalizing symptomatology) where the individual is in a state of hopelessness which he or she defends against through antisocial behavior. This suggests that hopelessness, as well as temperament, are equally important treatment issues for children and adolescents diagnosed with either an internalized disorder or an externalized disorder.

Given that no significant differences were evident between the internalized disorders group and the externalized disorders group with high hopelessness and a difficult temperament, it could indicate that children and adolescents cannot be neatly classified by this dichotomous nomenclature. For example, several studies have examined the prevalence of conduct disorder (externalized disorder) among depressed (internalized disorder) children. Puig-Antich (1982) noted that 37% of depressed boys also met diagnostic criteria for conduct disorder. Kovacs, Feinberg, Crouse-Novak, Paulauskas, and Finkelstein (1984) reported that 7% of inpatient children with major depressive disorder and 11% with dysthymic disorder also carried diagnoses of conduct disorder. Depression is also common among youths with both conduct disorder and substance problems (Puig-Antich, 1982; Zoccolillo, 1992). Anxiety disorders (internalized disorders) also may be more prevalent among youths with conduct disorder than among those without conduct disorder (Zoccolillo, 1992). Recommendations for treatment and further research will be discussed in the following section.

Recommendations

This study provides some useful data concerning the relationship between hopelessness and temperament within this population of children and adolescents. Although there have been many studies on hopelessness and many studies on temperament, as delineated in the literature review, there have been few to combine the two. This suggests a need for further research and evaluation between hopelessness and temperament. Given that this study yielded a high positive correlation between high hopelessness and a difficult temperament, it could reveal new strategies for treatment prevention of future behavior difficulties that result in placement in residential treatment facilities. Specifically, cognitive techniques could be utilized so that the individual with high hopelessness may become oriented to the present and recognize the cognitive distortions he or she utilizes in maintaining the "hopelessness" situation. Also, behavioral techniques such as goal setting could be explored so that the individual with high hopelessness and difficult temperament may be directed towards the future and not focused on the immediate gratification of delinquent behavior that results in residential treatment.

Replication of this study is highly suggested. Obtaining a larger, more varied sample of participants from numerous residential treatment facilities and/or individuals within an inpatient psychiatric hospital could reveal additional knowledge.

Another suggestion includes future research to assess the specific longitudinal processes involved in the development and maintenance of the difficult temperament and high hopelessness. Also, ways in which prevention and intervention strategies can be used to modify such temperament styles and levels of hopelessness could be explored.

The fact that no statistical differences were found between the internalized and externalized disorders groups indicates further research is needed to fully understand the impact high hopelessness and difficult temperament has on individuals with various disorders. The interaction between hopelessness and temperament manifests itself internally and externally and can be detrimental to a child or adolescent's development. Therefore, assessing these two constructs amongst various disorders is an important factor if treatment is to be effective.

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