E. Hope and Fostering the Well-Being of Refugees from Iraq

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Introduction

Hope theory seems to be useful in understanding the mechanisms for treatment of refugees from Iraq within medical settings. Hope theory has been proposed by Snyder as a useful way to conceptualize how people adjust to psychological and physical distress.[1] For refugees who have histories of trauma and torture,[2,3] hope theory can be a way to understand the mechanisms by which these individuals can be effectively treated within medical settings. As part of a larger project on the health and well-being of refugees from Iraq, the purpose of the current study was to examine links between refugees' feelings of hope and their symptoms of anxiety, depression, and trauma.[4–6]

According to Snyder, hope can be made operational as "…a way of thinking about your goals in which you have the perceived capacity to come up with the pathways to those goals, along with the mental energy to use those pathways". To measure hope as a state, Snyder developed and validated the State Hope Scale (SHS).[7] This measure can be divided into two scales: Agency and Pathways. The *Agency* scale assesses the belief that one has the capacity, motivation and determination to act in one's own behalf. The *Pathways* scale involves the belief that one has the capacity to identify and generate routes along pathways that will allow one to reach their goals. Because refugees have often been found to suffer from histories of depression, anxiety and post-traumatic stress disorder, and because optimism and hope are often considered antidotes to maladaptation and dysfunction, the study of hope in refugees offers promise as one way that clinicians can address their treatment needs.

Objectives

The objectives of this article are: 1) to introduce Snyder's operationalization of the construct of hope as *agency* (the belief in one's own capacity, motivation and self-determination) and *pathways* (the belief in one's own capacity to generate plans that will foster goal attainment); 2) to examine links between refugees' feelings of hope and their symptoms of anxiety, depression and trauma; and 3) to critique the potential promise of hope as an antidote to maladaptation and dysfunction in the treatment of refugees.

Hypothesis

It was expected that self-reports of hope (SHS; Agency, Pathways)[7] would be negatively related to symptoms of depression and anxiety (Hopkins Symptom Checklist-25, HSCL-25),[8] and post-traumatic stress disorder symptom severity.[9]

Methods

After ethical clearance from Wayne State University and from the IRB Review Board of the Detroit-Wayne County Community Health Department, 116 adult Iraqi refugees (46 males, 70 females) were recruited from a community mental health clinic in Michigan. Participants were either seeking or already receiving outpatient services (n=87) or were in a partial hospitalization program (n=29). Interviews using self-report instruments were conducted by two bilingual (Arabic, English) mental health professionals.

The State Hope Scale (SHS)[6] was used to measure Agency and Pathways.

The Post-traumatic Stress Diagnostic Scale (PDS)[9] was used to assess post-traumatic stress disorder symptom severity based on the DSM-IV criteria.[10] The Hopkins' Symptom Checklist 25 (HSCL-25)[8] was used to assess anxiety and depression. Internal consistency was good for each scale (alpha coefficients ranged from .88 to .94).

RESULTS

As anticipated, negative correlations were found between hope: agency and anxiety, $r(116)=-.43$, depression, $r(116)=-.43$, and trauma severity, $r(116)=-.55$, all Ps$<.01$, two-tailed. Similarly, negative correlations were found between hope: pathways and anxiety, $r(116)=-.41$, two-tailed, depression, $r(116)=-.36$, two-tailed, and post-traumatic stress disorder symptom severity, $r(116)=-.54$, all Ps$<.01$, two-tailed.

DISCUSSION

The results imply that clinicians may want to target increasing feelings of hope as an antidote to despair and the after-effects of trauma such as anxiety and depression. Snyder et al[1] suggest that clinicians may accomplish this by attending to the advantages of hope theory for both the client and the clinician (eg, solution rather than problem focus, emphasis on self-worth and dignity, improved rapport).

By focusing on hope, it is possible to assess the strengths in the client's psychological makeup and in the environment to determine how they can be utilized to take constructive action and steps in achieving the client's goals. Being hopeful involves some feelings of uncertainty as one tries to anticipate the outcome and consequences of the actions that have been taken toward achieving a goal.[11]

In conclusion, hope is inversely related to anxiety and depression. Increasing hope involves helping clients clarify their goals toward personal happiness and well-being, and helping them use their personal strengths and supports in their environment to take realistic steps in achieving their goals.

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