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The Relationship Between Counselor Hope And Optimism On Client Outcome

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THE RELATIONSHIP BETWEEN COUNSELOR HOPE AND OPTIMISM ON CLIENT OUTCOME

by

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ABSTRACT

The counselor is an important contributor to client outcome. Research findings about therapist effects are mixed. In this study positive psychology variables, hope and optimism, were evaluated with client outcome. The sample for this study consisted of 43 graduate-level counselor trainees in the first or second practicum semester and their adult clients in a university's community counseling clinic. Results revealed no statistically significant relationships between student counselors' hope and optimism and client outcomes. Post hoc analysis of student hope and their post-graduation expectations, revealed statistically significant relationships. Implications for counselor educators are presented along with areas for future research.

Dedicated to the memory of Thomas A. Guest,
compassionate and unflagging optimist –
my teacher, colleague, and friend.

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CHAPTER ONE: INTRODUCTION

The qualities of the counselor are crucial to success according to both researchers and practitioners (c. f. Beutler, Machado, & Neufeldt, 1994; Lambert, 2010). In the last decade, empirical research has increasingly focused on therapist characteristics as they relate to counselor efficacy and positive client outcome. Within the literature, counselor characteristics are often referenced as therapist characteristics and therapist variables; the terms counselor and therapist, with regard to characteristics, activities, and roles are herein used interchangeably. Evidence suggests that therapist variables can contribute to and have a significant impact on therapeutic outcome (Beutler et al., 1994; Luborsky, McClellan, Woody, O'Brien & Auerbach, 1985; Okiishi et al., 2006; Lambert, 2010). Counselor characteristics associated with a positive client outcome include empathy (Wing, 2010), positive regard, warmth, genuineness (Teyber & McClure, 2000), verbal fluency, emotional expression, capacity to form an alliance, and focus on problems. (Anderson, Ogles, Patterson, Lambert, & Vermeersch, 2009).

Recent research in positive psychology has led researchers to believe that specific characteristics or "values" play an important role in mental health and improved coping (Peterson, 2006). Among these are hope and optimism (Brissette, Scheier & Carver, 2002; Scheier, Carver, & Bridges, 1994), gratitude (Young & Hutchinson, in press), and happiness (Lyubomirsky, 2007). Hope and optimism, in particular, are positive expectancies for the future that can "shape human behavior and produce positive outcomes" and are "important indicators and potential pathways to positive mental health" (Gallagher & Lopez, 2009, p. 548). One arena that has not been thoroughly studied is the importance of these two variables in the effectiveness

of counselors. It may be that counselors high in hope and optimism are more effective in decreasing client distress because they lend this strength to their clients.

Overview

Researchers offer differing opinions as to how much counselor characteristics influence the therapy process. It is generally agreed that client change occurs as a result of a number of factors, which include client and counselor characteristics, the therapeutic relationship and therapeutic factors, in-session behaviors, and theoretically driven techniques (Lambert & Cattani-Thompson, 1996). Norcross (2002) emphasized the importance of the counseling relationship, "The therapy relationship makes substantial and consistent contributions to psychotherapy outcome independent of the specific type of treatment" (p. 441). By this he meant that there has been too much emphasis on specific techniques and that the client and relationship must also be considered as important predictors of improvement. While there are disagreements, and at times, vigorous debates among researchers about the amount of influence counselors have on counseling outcome, many agree with Norcross (2002) who stated that the counselor as a person is "inextricably intertwined" with their client's outcome (p. 4). Crits-Christoph et al., (1991) acknowledged that differences among counselors are influential in the therapeutic process and outcome, and these differences are important in their own right. What has also come to the attention of researchers as well as practitioners and consumers is that therapists largely manage and maintain the therapeutic relationship, "a primary factor contributing to psychotherapy outcome" (Lambert & Simon, 2008, p. 19).

When counselor or therapist characteristics are evaluated, no single aspect of the therapist emerges and it seems that the client's improvement can be explained in terms of multiple factors including techniques used and client characteristics. Still, counselor traits are part of the

equation. Kim, Wampold, and Bolt (2005) contend that in the counseling treatment process the influence of the counselor ranges from 6-10%. Previous research suggested that counseling treatment (versus no treatment) accounts for approximately "13% of variability in outcomes" (p. 162), helping to elevate the appreciation of the magnitude of the contribution of the counselor in the therapeutic process. Krause and Lutz (2009) argue that nearly all the effects of treatment may be attributable to the counselor because the counselor regulates, manages, influences, mediates, and moderates the treatment they provide. With the counselor considered a contributing factor, this study will examine the influence of two of the more robust positive psychology variables, hope and optimism, in counselors with client outcomes.

Positive Psychology

Positive psychology is an emerging field influenced in part, by the humanistic school of thought including Person-Centered theory (Rogers, 1946, 1951, 1983; Young & Hutchinson, 2009) and existentialism (Norcross, 2002). Positive psychology was established as a response to the observation and concern that psychology focuses on clients' areas of weakness without the same level of focus on clients' strengths and resiliencies. Positive psychology's overarching goal, therefore, is to provide a balanced perspective to traditional psychology's illness focus and include identifying strengths to guide the counselor, help the client achieve success to overcome their problem, improve their situation, or to cope better with life's challenges. The founder of positive psychology, Martin E. P. Seligman, is keen to emphasize the need for empiricism in positive psychology, stating that positive psychology's mission is to scientifically "describe, not prescribe" what contributes to an individual's optimal functioning (Ruark, 2009, p. 2).

Positive psychology's basic assumption "is that human goodness and excellence are as authentic as disease, disorder, and distress" (Peterson, 2006, loc. 75-78). Positive psychology

has identified a number of variables that can lead to personal well-being, living a good life, enjoying improved coping and functioning, and achieving positive outcomes in counseling (Snyder & Lopez, 2009). The individual variables identified in positive psychology are numerous and include, but are not limited to: wisdom, optimism, hope, creativity, empathy, forgiveness, emotional intelligence, flow (Csikszentmihalyi, 1975), humor, gratitude, courage, authenticity, an orientation toward goal attainment, spirituality, subjective well-being, purposefulness in life, and happiness (Snyder & Lopez, 2009). While research supports the association of these characteristics with an individual's well-being, these variables require additional focus to determine to what extent they exist, can be nurtured, and to what degree they strengthen well-being (Ruark, 2009; Lopez & Snyder, 2003; Schneider, 2003; Seligman 2002, 2005).

Three of the positive psychology variables that hold a great deal of promise are happiness, hope, and optimism - qualities associated with a good life (King, 2001). Happiness is an emotionally based construct while hope and optimism are identified as cognitive constructs. Hope and optimism each may be regarded as either a state or trait variable. Hope is considered a *state* variable if an individual displays a general present-tense expectancy of event outcome or a *trait* variable if there is a more enduring view (less dependent upon situational expectancies) forged in past experiences with both a present and future orientation (Snyder, 2000). Optimism is described an explanatory style of events (state-like; Carver & Scheier, 2001) or as a dispositional (trait-like) characteristic. Hope and optimism are related yet distinct constructs that "uniquely predict" aspects of well-being (Gallagher & Lopez, 2009, p. 548). The differences have been explained in that hope focuses on how the assessment of one's personal motivational

state and planning can facilitate goal attainment (Snyder, 2000) whereas Scheier and Carver's (1985) theory of optimism focuses on expectancy for positive outcomes.

While research has focused on the effect of the positive psychology variables from the perspective of the client, there is a paucity of research regarding the benefit to the client if their counselor possesses these qualities or characteristics. Clients acquire the attitudes and values of their counselor (Beutler & Bergin, 1991) and would benefit from the improvement associated with hope and optimism. Gallagher and Lopez (2009) asserted that hope and optimism are positive expectancies that motivate behavior and that all human behavior can be understood in terms of goal pursuits.

Clients' pursuit and achievement of goals is a key target for most counselors. All clients, according to Frank (1973), at the start, suffer from demoralization, a common emotion that follows a person's pervasive failure to achieve goals. Providing encouragement for client through the therapy process is a key element of role definition for many therapists (Corey, 2005). Increased hope and optimism is thus desirable for clients experiencing demoralization not only to move toward a goal, but to do so with positive expectancies.

Hope and optimism are also associated with positive coping. As resiliency factors, hope and optimism may be transmitted from the counselor to the client in the counseling process. If this is so, the client's coping strategies may be enhanced by providing a greater buffer or resilience against demoralization and by providing greater access to strengthening resources through increased hope and optimism. With a decrease in demoralization and discouragement, clients are more likely to be able to advance into exploration of their potential solutions and to achieve goals they can now set and pursue in order to produce the changes we seek in client outcomes. Thus, a primary task of the counselor is to help the client overcome their sense of

helplessness by lending the client hope and an optimistic viewpoint about the client's chances for improvement or recovery. Counselors may experience challenges to instill optimism or hope with their clients if the counselors themselves are lacking in the degree of those attributes that would benefit their client (Miller, 2001). The question is, do these qualities rub off on the client enough to affect improvement in their symptoms?

Client Outcomes

Client outcome research is the gold standard when assessing the value of a particular counseling method (Institute of Medicine, 2001; Ogles, Lambert & Masters, 1996). Client outcomes demonstrate the efficacy of therapeutic treatments, promote confidence in mental health for consumers and professionals, and provide fiscal accountability for services (Ogles, Lambert, & Fields, 2002). To arrive at client outcomes, client changes are measured and quantified by various methods including objective observation, client self-report, and assessment (Ogles, et al., 2002). Client outcomes, therefore, inform counselors about what works.

It seems obvious that the intention of counselors should be to promote and understand clients' betterment yet earlier research was often focused on other factors such as the perceptions of the client and the degree of involvement in the therapeutic relationship. The American Counseling Association (ACA, 2005) has emphasized in its ethical principles that client welfare is among the professional counselor's primary responsibilities. Thus, research leading to improved outcomes by exploring familiar concepts, new ideas, enhanced methodologies, or novel tenets in counseling is both ethical and practical.

Background of the Study

The counselor is "the central figure that facilitates patient improvement" who guides the process of healing (Okiishi, Lambert, Nielsen & Ogles, 2003, p362). Interestingly, studies have

confirmed that some counselors consistently achieve positive client outcomes and some counselors consistently achieve negative outcomes (Crits-Christoph & Mintz, 1991; Norcross, 2002; Okiishi, et al., 2003; Okiishi, Lambert, Eggett, Dayton, & Vermeersch, 2006). Although the explanation for what accounts for the differences between exceptional counselors and insufficient counselors have been studied, the search goes on for the variables that might reliably distinguish these groups.

Counselor Effects

Distinguishing effectiveness among counselors is a conceptual challenge (acknowledging the value and likely impact of counselor variables) and a methodological challenge. The reported strength of the relationship (effect sizes) between counselor variables and client outcome has not been consistent in the literature. Counselor effects are the part of the client outcome measure that is attributable to differences between or among counselors. If counselor characteristics are positively related to client outcome, a reported counselor effect is expected and should represent a contribution (percentage-wise).

Research results are not always as clear as might be expected because of the complexity of the process. In fact, two research groups conducted studies in the large National Institute of Mental Health (NIMH) Treatment of Depression Collaborative Research Program (TDCRP) used the same data and used very similar approaches toward understanding the treatment of depression and reported different findings of counselor effects (Crits-Christoph & Mintz, 2006; Soldz, 2006). Elkin, Falconnier, Martinovich and Mahoney (2006) reported *no* counselor effects and Wampold (2005) reported significant counselor effects.

In some research, moderate to large effects attributed to the counselor have been found. For example, in the statistical procedure used to summarize collections of research data (meta-

analyses), Crits-Christoph et al. (1991) evaluated 15 outcome studies and reported finding an *average* effect of 8.6% across measures. Within the 15 studies were 27 sub-treatment groups that were also compared. In looking at the 27 sub-treatment groups, researchers reported that the effects ranged from 0 to 73% (Crits-Christoph et al., 1991). Crits-Christoph and Mintz (1991) also performed a meta-analysis of 10 studies examining the impact of the counselor on client outcome. They found that the *average* counselor effects ranged from 0 – 13. 5% and from among the 10 studies' *individual* effects, the range was nil to moderate, 0 – 39% (Beck, Hollon, Young, Bedrosian, & Budenz, 1985; Borkovec & Mathews, 1988; Hollon et al, 1983; Luborsky & Crits-Christoph, 1988; Nash et al., 1965; Pilkonis, Imber, Lewis, & Rubinsky, 1984; Piper, Debbane, Bienvenu, & Garant, 1984; Thompson, Gallagher, & Breckenridge, 1987; Woody, McLellan, Luborsky, & O'Brien, 1990; Zitrin, Klein, & Woemer, 1978). Other studies show low effect sizes; for example, Wampold and Brown (2005) analyzed 581 counselors and their 6,146 clients from a managed care treatment setting and reported counselor effect sizes of 5%. Other studies have reported very small to no effects upon client outcome (Elkin et al., 2006; Luborsky, McLellan, Diguer, Woody, & Seligman, 1997; Okiishi, et al., 2003). To more accurately and more consistently capture the influence of the counselor, researchers have recently begun examining their methodological approaches with some expectation of a greater consensus about the impact of counselor variables.

Lambert (2010) reflected that research conducted in the last twenty years interpreted and reported counselor effects inconsistently because the chosen methodologies did not focus on the counselor as an identified variable, thus minimizing the variability shown in the research. When an influence is found, a difference has been detected, and variability is reported, signifying the amount of change detected as a result of the influence of the variable(s) studied. Crits-Christoph

and Mintz (1991) expressed concern that investigators have mistakenly reported treatment effects *instead* of counselor effects by not including the counselor as a contributing factor. Norcross (2002) cited two empirical studies, Huppert et al. (2001) and Project MATCH Research Group (1998), in which the therapist as a variable was controlled, yet in the analysis of data, the therapist as a variable still evidenced an impact on client outcome. Therefore, additional information is needed to understand why counselor influences appear at times to be large, and at others, practically non-existent.

Statement of the Problem

While numerous counselor variables can be identified, fewer consistently show a connection and relationship to client outcome. For example, early in the therapeutic process, variables such as age, gender, cultural affiliation, and religious similarities are likely to be most helpful in establishing rapport (Teyber & McClure, 2000) yet age, gender, and religious similarities are not consistently related to client outcome (Beutler, Machado and Neufeldt (1994); however, a lot of attention has been given to counselor gender as an influence upon both male and female clients in counseling. The research in the literature reveals that females may be attaining slightly greater client outcomes in matched and non-matched studies (Fisher, 1989; Greeson, Guo, Barth, Hurley, & Sisson, 2009; Jones & Zoppel, 1982; Ziegler and Kratz (1989). However one criticism of the gender research is that meta-analytic studies have been tainted because studies were selected or included based on their ability to confirm the hypothesis that females show a slightly greater association with client outcomes (Jurek, 1992). Further methodological concerns (in addition to selection and inclusion bias) include stereotyping by researchers with regard to gendered thinking and behavior and by evaluators relying on self-report measures (Bowman, 1993; Bowman, Scogin, Floyd, McKendree-Smith, 2001). With

regard to culture, no strong evidence is found between culture and diversity factors and direct client outcome measures, such as symptom distress reduction (Sue & Lam, 2002). Some counselor variables which have been shown to be related to positive outcome include professional experience, self-efficacy, and empathy (Larson & Daniels, 1998; Miller, Taylor, & West, 1980; Powell et al., 2010; Wing, 2010). Additional desirable counselor characteristics include those identified by counselors themselves and are strength-based in nature (Kelly, 2005). Positive psychology as a strength-based initiative focuses on qualities such as hope, optimism, happiness, gratitude, and humor as significant to improved well-being, coping, and functioning.

Significance of the Study

This study has significance for counselor educators in their multiple roles training and supervising therapist trainees in conceptualizing and working with clients. Counselor educators may find particular significance of this study during candidacy selection of trainees. Counselor educators are tasked with identifying the best possible counselor trainees based on counseling competencies in their personal, interpersonal, and professional skill sets. Counselor trainees with stronger skill sets including traits, characteristics, and attitudes show greater positive client outcomes in practicum (Goodman & Amatea, 1994). Although there is no consensus on which characteristics to assess, researchers suggest that characteristics associated with being an effective counselor are important considerations for program admissions (Nagpal & Ritchie, 2002). Hope and optimism are positively associated with an individual's functioning (Brissette, Scheier & Carver, 2002; Scheier, Carver, & Bridges, 1994) and if the analyzed data reveals that hope and optimism are positively associated with client outcome, these variables may contribute to candidate selection assessment.

Another significant aspect of this investigation is to contribute to understanding of hope and optimism in the counselor. As positive psychology variables, hope and optimism have received a good deal of attention in research regarding individual coping and functioning. However, research is lacking in evaluating how both counselor hope and optimism may contribute to predicting client outcome.

Hope and Optimism

While hope and optimism are both cognitive constructs in positive psychology, the literature has confirmed that they have demonstrated distinctiveness as individual constructs in research (Leichsenring, 2004). They have similar components and are considered similar with regard to how an individual sets a goal and attempts to achieve it. For example, hope and optimism both have a sense of positive expectancy for the future. Hope is more specifically defined by an individual's "self-efficacy belief that a plan can be carried out" (Bailey Eng, Frisch & Snyder, 2007). According to hope theory, an individual employs two types of energies to achieve a goal. The terms assigned are "agency" and "pathways". Agency is unique to hope and represents and individual's motivational energy to follow through, even with obstacles presented, in an individual's effort to achieve a goal. Pathways' thinking is a mechanism shared by optimism; pathways' thinking is an individual's identification of routes to achieve a goal (Snyder, 2000). After identifying a goal, an individual goes through other processes linked with goal pursuit. An individual with hope and optimism approach the plan/route with a sense of positive expectations. Regarding these expectancies, hope is related to *efficacy* expectancies while optimism is related to *outcome* expectancies (Bailey et al., 2007). That is, individuals with hope have a belief they can carry out a behavior, that there is an ability to follow a plan successfully to completion. An optimistic individual with outcome expectancies, focuses on

what one believes will occur following a behavior - success (Bailey et al., 2007). Hope and optimism are herein described separately as an introduction; however, the concepts are described individually and jointly in the second chapter as the literature review produced a number of common areas of research and association.

Hope

Hope elicits a positive emotional response. Hope was originally defined in the 1950's and 1960's as being based on positive expectations to achieve goals (Snyder, 2000). A more sophisticated definition was derived after hope was linked with how people conceptualized achieving their goals, and thus, more oriented toward a cognitive type of construct (Snyder 1994). The three components of hope theory are *goals*, *pathways* (identification of routes to achieve a goal), and *agency* (motivational energy to pursue and continue pursuing a goal). Therefore, contemporarily, hope is defined as "a positive motivational state based on successful goal-directed energy and planning to meet those goals" (Snyder, Irving & Anderson, 1991, p287). The positive emotional component is a "by-product of goal-directed thought" (Snyder, 2000a, p. 11). In other words, the feeling of hope is caused by thinking positively about one's goals and goal pursuit.

According to hope theory, all individuals experience the same kinds and numbers of barriers to goals; however, high-hope individuals engage in ongoing positive self-talk, establish and re-establish goals as obstacles arise, view obstacles as challenges with fewer negative responding, and believe in their own adaptability to challenges (Snyder, 2000). Low-hope individuals focus on failures when goals are impeded, are stymied by obstacles, are unclear how to move forward to reach impeded goals, have more negative responses to blocked goals, and

proceed quickly through the emotional response chain of disappointment to rage and despair to apathy where they acknowledge defeat and surrender goal pursuits (Snyder, 2000).

Research into hope and the counseling process is in its early stages; however hope has been identified as a common element among successful therapeutic approaches (Frank & Frank, 1993). Studies confirm that hope is an important variable contributing to therapeutic effectiveness across theoretical orientations (Larsen, Edey & Lemay, 2007). High levels of hope are associated with greater academic performance, physical and psychological well-being, and more fulfilling interpersonal relationships (Rand & Cheavens, 2009).

Optimism

Optimism is a cognitive psychological construct related to positive expectancies for future events. Bailey et al. (2007) likened the operation of optimism's thinking to hope's pathways function in that optimists show "elevated problem-focused coping" (p. 169) which has been shown to be both physically and psychologically beneficial (Scheier, Carver, & Bridges, 1994). In fact, researchers found that coping is a major discriminating variable of optimistic thinking and behaving. Optimists tend to display stable coping tendencies and more problem-focused or emotion-focused coping strategies. Pessimists, who expect bad experiences in the future, generally engage in coping using disengagement or denial toward stressors regardless of whether a possible solution exists (Carver, Scheier & Weintraub, 1989). Optimists also tend to use coping strategies that employ humor, positive reinterpretation, and acceptance. Additionally, optimism is associated with less mood disturbance, an ability to perceive and receive greater social support during times of stress, and an enjoyment of greater adjustment to stressful life events (Brissette, Scheier & Carver, 2002).

Purpose of the Study

This research study will examine counselor trainee's state and trait hope scores and dispositional optimism scores to determine if any relationship exists between trait hope, state hope, and optimism on client outcomes operationalized as client symptom distress and client satisfaction at the termination of the counseling. Additionally, this study will utilize the *Counselor Competency Scale (CCS), Part I,* to evaluate skill level in counselors to determine if counselor skill and trait hope, state hope, or optimism are related.

Research Questions

1. What is the relationship among practicum counselor education students' trait hope as measured by the Adult Dispositional Hope Scale and the client levels of symptom distress as measured by the Outcome Questionnaire-45 and client satisfaction as measured by the Client Satisfaction questionnaire?
2. What is the relationship among practicum counselor education students' state hope as measured by the Adult State Hope Scale and the client levels of symptom distress as measured by the Outcome Questionnaire-45 and client satisfaction as measured by the Client Satisfaction questionnaire?
3. What is the relationship among practicum counselor education students' dispositional optimism scores as measured by the Life Orientation Test-Revised and client symptom distress scores as measured by the Outcome Questionnaire-45 and client satisfaction scores as measured by the Client Satisfaction Inventory?
4. What is the relationship among practicum counselor education students' skill as measured by Part I (basic skill assessment) of the Counselor Competencies Scale and counselor education students' trait hope as measured by the Adult

Dispositional Hope Scale, state hope as measured by the Adult State Hope Scale or dispositional optimism hope as measured by the Life Orientation Test-Revised?

Research Hypotheses

Null Hypothesis One

There is no correlation among practicum counselor education students' trait hope scores and client symptom distress and client satisfaction.

Null Hypothesis Two

There is no correlation among practicum counselor education students' state hope scores and client symptom distress and client satisfaction.

Null Hypothesis Three

There is no correlation among practicum counselor education students' dispositional optimism scores and client symptom distress and client satisfaction.

Null Hypothesis Four

There is no correlation among practicum counselor education students' skill and counselor trait hope, state hope, and dispositional optimism

Research Design

The research design for this study will be descriptive and correlational in nature. Counselor trainees will complete a demographic questionnaire which will include questions regarding experience and confidence as an effective counselor. As part of the demographic interest, the counselor's assigned client prognoses will be gathered from the psychosocial. Client demographic information will be gathered from the psychosocial completed by the counselor.

Client outcomes will be assessed by the Outcome Questionnaire 45. 2(OQ-45; Lambert, Burlingame, Umphress, Hansen, Vermeersch, Clouse, & Yanchar, 1996; Lambert & Finch, 1999) measured at intake, every 4th week interval and captured at termination unless client dropout prevents the data collection. Client outcomes also include the clients' ratings of satisfaction, completed at the conclusion of therapy.

The counselor predictor variables, trait hope, state hope, and dispositional optimism, will be compared through multilevel statistical analysis in a mixed design model as the clients' symptom distress and satisfaction scores are nested within the counselor. Counselor skill scores from the 12 items comprising the Clinical Skills section of the Counselor Competency Scales will be compared to counselor trait hope, counselor state hope, and counselor dispositional optimism using Pearson Product moment correlations. The aim of the study is to determine if these counselor variables can predict client symptom change and satisfaction with treatment. Additionally, this study will investigate if any correlations exist between practicum student counselor trainees' skill scores and counselor characteristics trait hope, state hope, or dispositional optimism.

Population and Sample

The population was comprised of mental-health track, marriage and family track, and school counseling track master's level counseling trainees enrolled in a Counsel for Accreditation of Counseling and Related Educational Programs (CACREP) approved counseling program's practicum courses. This is a master's level program training students in theory, skills and technique, and research methodology toward becoming a professional counselor with a concentration in mental health, marriage and family, or schools. The proposed sample size is 50 based upon an estimate of the number of practicum students with adult clients (18 and over)

participating as counselor trainees in the University of Central Florida (UCF) Community Counseling Clinic (CCC) with seven classes meeting weekly and approximately six to eight students per class.

Counseling trainees participating in the Practicum course in the UCF CCC may be in their first or second semester of the required course. Levels of state and trait hope, measured by the Adult State Hope Scale and Adult Dispositional Hope Scale, and dispositional optimism, measured by the Life Orientation Test-Revised, are not likely to be influenced by previous therapy experience. Although global hope measures are likely to be stable across time, the present-focused hope measures may be influenced by the counselor's previous practicum experience, although there are no data to support this supposition.

Assessment Instruments

The assessment instruments include the three from the hope and optimism literature, The *Adult Dispositional Hope Scale (Snyder, 2000), the Adult State Hope Scale (Snyder et al., 1996), and the Life Orientation Test-Revised (LOT-R, Scheier, Carver, and Bridges, 99*

Practicum Counseling Student Demographic Questionnaire: The practicum student demographic questionnaire will include age, gender, ethnicity, counseling program track, and practicum level. Additionally, information regarding students' years of pre-program counseling experience, post-program expectations regarding work, and success as a professional are included. See Appendix A.

Counseling Competencies Scale (CCS, UCF Counselor Education Faculty, 2009*)*: The Counseling Competencies Scale (CCS) is an instrument assessing counselor trainee skill development and professional competencies. The CCS is administered to all practicum students at the mid-term point and at the end of the semester providing counseling students with direct feedback in three

areas: 1) Counseling Skills, 2) Professional Dispositions (dominant qualities), and 3) Professional Behaviors. Feedback identifies practical areas for improvement to support the counselor's development as effective and ethical professional counselors. This investigation will use the first section of the CCS, Counseling Skills, to evaluate counselor trainee skills. This section rates students on 12 primary counseling skills meeting the Council for Higher Education Accreditation (CACREP) required areas of focus Social & Cultural Diversity**,** Helping Relationships, and Assessment.

To score the CCS, two points are assigned for each of the five ratings possibilities: 0 (Harmful), 2 (Below Expectations / Insufficient / Unacceptable), 4 (Near Expectations / Developing towards Competencies), 6 (Meets Expectations / Demonstrates Competencies) and 8 for Exceeds Expectations / Demonstrates Competencies. The CCS demonstrates strong internal consistency reliability for both the individual factors and the overall models. Reliability and validity scores yielded moderate correlations. The inter-rater reliability among raters yielded the following correlations: Skills, r = .436; Dispositions, r = .515; Behaviors, r = .467; and Total, r = .570. An assessment of criterion-related validity yielded a correlation, r = .407, between the final total score on the CCS and the students‟ final grade in the counseling practicum course. (Swank, 2010) See Appendix B.

Life Orientation Test-Revised (LOT-R): The Life Orientation Test-Revised is a brief research instrument used to assess optimism as a dispositional characteristic (Scheier & Carver, 1985). The test was developed to assess individual differences in optimism versus pessimism and distinguish optimism from related dispositional characteristics such as trait anxiety, self-mastery and self-esteem. Research has confirmed the LOT-R is a 2-factor model with optimism and pessimism both represented by positively worded and negatively worded items, respectively

(Bailey et al., 2004). According to the test's authors, the LOT-R is associated with "…a good deal of research on the behavioral, affective, and health consequences of this personality variable", optimism (Scheier & Carver, 1985, p219). In a study of concurrent validity between two questionnaires measuring optimism and pessimism, Burke, Joyner, Czech, and Wilson (2000) concluded that the LOT-R's optimism measure is of "trait" or dispositional optimism.

The LOT-R was revised because original items needed to more closely match the theoretical construct for a future orientation. The test has ten items which include four filler items. Of the six remaining items, three are scored in a positive direction and three are scored in a negative direction. The items are scored on a five-point scale (0= strongly disagree, 1=disagree, 2=neutral, 3= agree, 4=strongly agree) (Scheier, Carver & Bridges, 1994). The test shows adequate internal consistency score and has good test-retest reliability, Cronbach's $\alpha = .88$ (Scheier et al., 1994). See Appendix C.

Adult Dispositional Hope Scale (ADHS): This hope measure is labeled "The Goals Scale" as a state measure of hope in adults. The ADHS measures Snyder's cognitive model of hope (1991) from a global temporal perspective which defines hope as "a positive motivational state that is based on an interactively derived sense of successful (a) agency (goal-directed energy), and (b) pathways (planning to meet goals)" (Snyder, et al., 1991, p. 287). The ADHS contains 12 items. Four items measure pathways thinking, four items measure agency thinking, and four items are filler items. The internal reliability ranges from .70 to .80 and the instrument demonstrates excellent construct validation (Snyder, 2000). Participants respond to each item using a 8-point scale with the following possible choices: 1= Definitely False, 2= Mostly False , 3=Somewhat False , 4=Slightly False , 5=Slightly True , 6=Somewhat True , 7=Mostly True , and

8=Definitely True. See Snyder (2002) for a review of hope theory and research. See Appendix D.

Adult State Hope Scale (ASHS): The Adult State Hope Scale (ASHS) (Snyder, Sympson, Ybasco, Borders, Babyak, & Higgins, 1996) is labeled as the "Goals Scale for the Present" when administered. The ASHS measures Snyder's cognitive model of hope from a global perspective. The ASHS contains six (6) items. Participants respond to each item using a 8-point scale with the following possible choices: 1= Definitely False, 2= Mostly False , 3=Somewhat False , 4=Slightly False , 5=Slightly True , 6=Somewhat True , 7=Mostly True , and 8=Definitely True. Four items measure pathways thinking, four items measure agency thinking, and four items are fillers. The agency subscale score is derived by summing the three even-numbered items; the pathways subscale score is derived by adding the three odd-numbered items. The total State Hope score is derived by summing the three agency and three pathways items. Scores can range from a low of 6 to a high of 48. The internal reliability ranges from .70 to .80 and the instrument has excellent construct validation (Snyder, 2000). See Snyder (2002) for a review of hope theory and research. See Appendix E.

University of Central Florida Community Counseling Clinic Psychosocial- Client Prognosis: The *University of Central Florida Community Counseling Clinic Psychosocial* is completed by each practicum student counselor with each of their clients to understand individual client concern(s) for the present and to asses client history in a number of life domains such as Social, Medical, Mental Health, and Family in order to formulate goals and objectives for achieving the desired measure of success as determined by each client. Components of the psychosocial include the student counselor's assessment of the client's functioning and prognosis toward goal completion. The prognosis ratings are Excellent, Good, Fair, and Poor. For the purpose of this

study, clients' prognoses will be collected as a demographic measure of interest. See Appendix F.

Client Outcome Questionnaire-45.2 (OQ-45.2): The Outcome Questionnaire-45 (OQ-45; Lambert, Burlingame, Umphress, Hansen, Vermeersch, Clouse, & Yanchar, 1996; Lambert & Finch, 1999) is a 45-item self-report questionnaire developed to track and assess global psychological distress in a therapeutic setting. It is designed to be administered repeatedly throughout treatment and at termination to measure client progress in terms of reduced subjective symptom distress and improved functioning in the world (Lambert, et al., 2004). There are three (3) domains assessed in the OQ-45: a) Symptom Distress, b) Interpersonal Relations, and c) Social Role. Response options are according to a 5-point scale (0=never, 1=rarely, 2=sometimes, 3=frequently, 4=almost always), yielding a possible range of scores from 0 to 180. High scores indicate more distress and a cutoff score of 64 or above is used to indicate a significant likelihood of a clinical elevation. As clients' symptom distress decreases, scores likewise decrease. The internal consistency for the OQ-45 is reported to range from .70 to .93 with a three (3) week test-retest value of .84 (Ogles, 1996). See Appendix G for the OQ license agreement.

UCF Community Counseling Clinic Questionnaire (UCF CCCQ): The UCF CCCQ is an 8-item client satisfaction inventory with a free form space for any additional comments. Clients complete the CCCQ following at termination of their treatment. The items are scored according to a 4-point Likert scale with higher number assigned to higher ratings on variable responses including Poor (1) to Excellent (4); Never (1) to Always (4); Not well at all (1) to Very Well (4); No (1) to Definitely (4); and Not satisfied at all (1) to Very satisfied (4). See Appendix H.

Data Collection

The investigator received approval with "Exempt" status from the Institutional Review Board (IRB) Committee of the University of Central Florida (SBE-10-07079) to offer practicum level counselor trainees an opportunity to voluntarily participate in research assessing their goals for the present and globally (hope) and orientation toward life (optimism). All data collected was kept confidential. Trainees reviewed an information form regarding their voluntary participation in this study. The information form required the trainees' names to match with client caseloads and was kept separately from trainee questionnaires which identified participants according to a code number known only to the investigator. Participants were free to withdraw their consent and discontinue participation at any time, without consequence. There are no known risks associated with this study.

Counselor trainees completed a demographic questionnaire. In addition, counselor trainees completed questionnaires assessing the optimism and hope, the Life Orientation Test-Revised and the Adult Dispositional Hope Scale (called the *Future Scale*) and the Adult State Hope Scale (called the *Goals Scale for the Present*), respectively. Client data collected by the counselor trainee in the requisite and normal course of the counseling practicum was reviewed at the conclusion of the semester including the clients' satisfaction questionnaire and the clients' self-reported levels symptom distress on the OQ-45. 2 assessed at intake, at 4-week treatment intervals, and at termination. The clients' prognoses as set forth by the counselor trainee in the psychosocial will be collected as a demographic measure.

Definition of Terms and Assumptions

Definitions

Counselor Variables

Characteristics, attitudes, and values specific to an individual counselor that are evident in and out of therapy-specific settings.

Positive Psychology

An emerging field in psychology focusing on the balance of assessing client strengths and resiliencies in addition to concerns or problems and treating clients proactively by building on client strengths and potentialities for improved coping and functioning.

Optimism

A generalized expectation of positive versus negative outcomes in important domains of life (Scheier & Carver, 1985).

Hope

"A positive motivational state based on a derived sense of successful agency and pathways" (Snyder, Irving, & Anderson, p. 287).

Agency

The aspect of hope that is defined as goal-directed energy.

Pathways

A manner of thinking in which an individual is planning to meet goals.

Counseling Preparation Programs

A master's level program training students in theory, technique, and research methodology toward becoming a professional counselor with a concentration in mental health, marriage and family, or schools.

Counselor Trainees

Students in good standing enrolled in a master's level counseling preparation program.

Counseling Practicum

A counseling course in a counseling preparation program that allows students under close supervision to obtain experience as a professional counselor.

Counseling Practicum Student / Counseling Trainee

Master's level counseling student in good standing who have met curricular pre-requisites and presently enrolled in the practicum class.

Assumptions

Clients will be randomly assigned to counselors with respect to symptom severity. Student caseloads will reflect the same average proportion of dysfunction among assigned clients. Clients who express less severe symptoms may not produce gains as large as those by clients who express more severe symptoms. Counselor hope and optimism will be expressed in a constant and consistent manner with all clients. Counselor trainee skills are assumed to be roughly equivalent.

Ethical Considerations

Permission to perform this study was obtained from the UCF IRB Committee (SBE-10-07079; See Appendix A). Demographic and questionnaire data collected was kept confidentially by utilizing a coding system. Any information obtained about a participant in this study, including identity, was held confidential. Counselor trainees were offered the opportunity to participate in the study voluntarily, with the ability to withdraw consent and discontinue participation at any time, without penalty or consequence. Counselor trainees reviewed an informational participation form which included their name if agreed to participation which was kept separately from completed corresponding coded participant questionnaires. No identifying information connects the participant with the responses in the study. Only the investigator was knowledgeable of the code numbers assigned. Counselors may experience increased anxiety as

self-awareness increases about goals or goal pursuit (hope) and orientation toward life (optimism) however there are no other known risks associated with this study. Benefits to participation in this study include a development of insights to feelings of optimism, hope, or goal-directedness presently or for the future, as a result of completing the survey questionnaires.

Limitations of the Study

The random assignment of clients to counselors does not occur if UCF CCC staff assigns a client to a practicum student trainee based on their counseling track or performance, in some way. This potential non-random assignment would be a limitation. No experimental control was exercised over the Community Counseling Clinic (CCC) client assignment procedure. The UCF CCC clients are assigned to the counselor trainees on the basis of counselor availability and the clients' needs (i. e. couples to marriage and family track trainees, children to school track trainees). Although the clinic staff is directed to evenly distribute cases among practicum counselor trainees, it is improbable, but possible (by chance) that a disproportionate assignment of difficult or easy cases could occur.

Clients who have received previous counseling treatment may express less symptom distress as a result of the therapeutic gains; however, continuing clients may actually be suffering the same or more difficulties evidenced by their need to participate in counseling beyond one semester. New and continuing clients who express greater symptom distress at the start of the semester's treatment may show greater gains than those who begin treatment with lower symptom distress scores which will be a consideration in the analysis of data.

The major limitation of this study is that it evaluates correlations between and among variables. Causality cannot be proven by evaluating the correlation between variables, therefore there is no ability to indicate hope or optimism is directly responsible for client outcome. The

sample size may be a limitation for the study. Self-reported questionnaire responses are subject to socially desirable responding, which is a potential limitation to the study, also. Additionally, while correlational studies can suggest a relationship between two variables, they cannot prove causality.

Summary

The variability among counselor qualities and personal characteristics is of continued interest but many of the specific variables have not been conclusively related to their contribution to client outcome (Teyber & McClure, 2000). Counselor characteristics associated with wellness, improved coping, optimal functioning, and achieving desirable change in therapy include but are not limited to: self-efficacy (Larson and Daniels, 1998), empathy, and capacity to form a working alliance (Norcross, 2002; Powell, et al., 2010; Wing, 2010). The two variables identified for this study are positive psychology constructs, hope and optimism. Hope and optimism are each related to resiliencies in goal achievement and coping in individuals (Brissette, Scheier & Carver, 2002; Scheier, Carver, & Bridges, 1994; Snyder, 2000), however little is known about these characteristics in counselors and the relationship to client outcome. Counselor educators may benefit from the identification of counselor characteristics associated with improved outcome as they make candidacy decisions during the interview selection process (Nagpal & Ritchie, 2002). Furthermore, a greater understanding of hope and optimism and their relationship to client outcome contributes to the application of positive psychology theory.

CHAPTER TWO: LITERATURE REVIEW

Introduction

Research has shifted its focus in recent years from understanding which counselor interventions and techniques improve therapeutic outcomes to understanding how the counselor personally influences counseling outcomes (Norcross, 2002). For many years, the emphasis was on which theory or which techniques were the most powerful. However, as outcome studies focused on examining specific treatment regiments, it was found that some therapists were more effective than others despite delivering the same manualized treatment. This finding suggested that the person of the therapist is crucial to outcomes. Norcross (2002) reported that client outcome is linked with the "*person*" of the counselor, which has been overlooked in previous definitions of what constitutes effective treatment (p. 4).

Theoretical basis of study

This client outcome study research that has pointed to the importance of the therapist is one source of the literature underpinning this study. The second theoretical basis for this study is positive psychology emerging as a scientifically-driven, strength-based theory and practice. Positive psychologists have identified variables representing desirable human qualities, traits and values that are related to experiencing well-being, the good life, improved coping and functioning, and resilience (Lopez & Snyder, 2003). In the context of the therapeutic relationship, positive psychology variables of the counselor may emerge as influential and helpful. While evidence from behavioral observations points to a clear relationship between counselor characteristics and client outcomes, there is very sparse literature connecting positive counselor characteristics and its effects on clients. In this chapter, we will review the findings

related to counselor characteristics that have been shown to be influential in client outcomes. In addition, we will discuss the general findings of counselors' positive psychological which may be influential in client improvement. Before that, it is necessary to take a look at the importance of outcome research in counseling and psychotherapy. Outcome research involves examining changes in client symptoms as a result of treatment. In this case, we are interested in the effect of counselor characteristics that influence this improvement.

Outcome Research

Two major types of studies characterize psychotherapy outcome research: randomized controlled studies (RCTs) and naturalistic studies. Among RCTs, treatment groups are created through random assignment of participants, the use of treatment manuals, and specific treatment protocols to evaluate to a comparison group (Leichsenring, 2004). Naturalistic studies are akin to field experiments where the effectiveness of a treatment is evaluated in a clinical counseling setting.

In recent decades, researchers have begun to recommend naturalistic studies. Naturalistic studies, conducted in a counseling-like setting, appeals to the idea of generalization to the therapist and client population. Researchers recommending naturalistic studies have also proposed that the investigators balance the client caseloads to avoid unintended, yet unequal distribution of difficult caseloads which hamper a therapist's ability to produce desired client outcomes. According to Lambert and Baldwin's (2009) retrospective review of meta-analytic studies (reporting the influence of counselor characteristics), some studies showed a wide variation in therapists' caseload difficulty. Researchers have suggested that where unbalanced therapist caseloads appear and are compared, concerns arise as to the generalizability of the results (Crits-Christoph et al, 1991; Elkin et al., 2006; Larson & Daniels, 1998; Wampold &

Brown, 2005). Another reason naturalistic studies have been recommended more is that in comparison to controlled clinical trials where counselors are selected and trained to conform to specific treatment protocols (i.e. manuals), the therapists skill and technique range is greater and more like counseling settings (Lutz, Leon, Martinovich, & Lyons, 2007).

The use of treatment manuals in experimental research has grown considerably, largely in response to the era of managed care, third party payor concerns, and the effort to successfully treat clients with briefer forms of therapy (Muenzenmeyer, Blau, McGuire, Bowers, & Mills, 1996). The reason for the use of manuals in experimental research is to describe the treatment in detail so that there is confidence that any change is attributable to a standardized treatment and no other variables (Addis, Cardemil, Duncan, & Miller, 2006). Okiishi et al. (2003) reported that among manualized treatment clinical trials, counselor effect sizes are small; however in naturalistic studies, the effect sizes rise to moderate amounts. Regarding manualized treatment's effect upon client outcome, Addis et al. (2006) said, "Manuals provide an empirically incorrect map of the psychotherapy terrain that sends both research and practice in the wrong direction. Although training in manualized psychotherapies does enhance therapist learning of and technical competence in a given approach, no relationship exists between such manuals and outcome" (p. 149). Regarding clinical trials in general, Lambert (2010) pointed out that clinical trial outcome research often homogenizes or flattens naturally occurring counselor differences and their effects on outcome by utilizing counselors with "extensive" training, offering supervision to participating counselors, and using manuals that structure treatment interventions. In general, counselor differences tend to be larger in naturalistic studies than in controlled trials (Crits-Christoph et al., 2003; Elkin et al., 2006).

Unfortunately, the use of naturalistic data also makes the studies more likely to include potential confounds. The potential confounds that appear are centered on the same issues that concern advocates of naturalistic studies. By most measures, ensuring balanced client caseloads means that unbiased random selection did not occur. Random selection is a hallmark of empirical research. Researchers argue that random selection allows for more generalizable conclusions (Crits-Christoph & Mintz, 1991; Serlin, Wampold & Levin, 2003) and has as its goal to limit the threat to internal validity by showing the effects of treatment are a result of treatment and not pre-existing differences. Without random selection, there are concerns about bias – that perhaps some cases are selected, assigned, or included in a study in a specific way. For example in a naturalistic setting, therapists may belong to different insurance panels which may result in different referrals to their caseload. Also in a counseling setting, therapists often specialize in certain client populations or in certain diagnoses that are not equal in their ability to treat. Counselors, therefore, could naturally have an advantage with client outcome if their referrals or specialties were with clients who responded more rapidly to treatment. This creates a foundation for debate of which method of study is most appropriate when evaluating client outcome.

Thus, while there appears to be a lot of evidence that naturalistic studies are a better method to look at therapy effectiveness, some researchers disagree. However, the artificiality of randomized controlled study conditions remains a concern and according to Leichsenring (2004), the "supposed strength of RCTs, especially randomization, can turn out to be their central weakness, because RCTs create artificial conditions that are not representative of clinical practice" (p. 138). Although reviewers and researchers disagree about which type of study is more accurate, they do not emphasize a one-size-fits-all approach, but rather they emphasize the

planning and use of appropriate statistical designs with a focus on scientific rigor and appropriate methodological selection in the assessment process (Crits-Cristoph & Mintz, 1991; Huppert et al., 2001; Luborsky et al., 1986; Lutz, Martinovich, Howard, & Leon, 2002; McLellan, Woody, & Luborsky, & Goehl, 1988; Wampold & Brown, 2005). Overall "a better understanding of the psychotherapeutic process can come from *both* controlled trials of standardized treatment packages, and more naturalistic investigations of the differences between therapists in the process and the outcomes of their treatments". (Crits-Christoph et al., 1991; p. 89).

In sum, both randomly controlled studies and naturalistic studies are useful and beneficial. The use of procedures, methodologically and statistically, should be considered with the question at hand. Randomized controlled studies and naturalistic studies represent types of outcome studies that have been used by researchers included in this review of the literature. Randomized controlled studies are evident in the studies evaluating treatments including the use of treatment manuals. Naturalistic studies are represented by studies examining therapists or clients in the context of a clinical setting. The relevance to this study also is to illuminate the similarities of the shifts in methodology and study focus. Randomized controlled studies share the stage with naturalistic studies as appropriate methods. Similarly there has been a shift from focusing on studying which treatments work using standardized procedures and treatment manuals to valuing the understanding the therapist's personal characteristics in the therapy setting.

Impact of the Counselor

Wampold and Brown (2005) reported on a study of clients pre- and post-therapy regarding counseling and assessment results. The impact of the counselor, i. e., the counselor effects, accounted for between 5% and 8% of the variance. This was similar to results from Kim,

Wampold and Bolt's (2006) analyses of the National Institute of Mental Health Treatment of Depression Collaborative Research Program (NIMH TDCRP) data set (5-10% of the variance) and Crits-Christoph et al.'s 1991 meta-analysis which found that around 8% of the outcome variance could be explained by counselor effects. According to Crits-Cristoph and Gallop (2006) the "best estimate to date on the magnitude of therapist differences in a naturalistic setting was the Okiishi et al., 2003 study" that showed a therapist effect of 4.1%. Kim, Wampold, and Bolt (2006) found therapist effects were approximately of 6% to 10% in their National Institute of Mental Health depression treatment sample study. In conclusion, counselor effect sizes are small when compared with studies of the therapeutic relationship (Norcross, 2002).

Studies have confirmed some counselors achieve greater client outcomes more consistently than others. These effective counselors do not share the same age cohorts, professional background, and subscribe to different theoretical orientations. Meta-analytic reviews have reported varying contributions of both general and specific counselor variables. Lambert and Bergin (1994) grouped general factors, as cited by Lambert and Cattani-Thompson (1996) into three categories: (a) support factors, (b) learning factors, and (c) action factors. The specific variables associated with positive outcome from the general factors include therapist expertness, session structure, therapist/client active participation, therapist modeling, reality testing, and feedback (Lambert & Bergin, 1994). Other specific counselor variables related to client outcome of meta-analyses include counselor attitude and value similarity (Beutler & Bergin, 1991) and therapist competence or skill and experience (Crits-Christoph & Mintz, 1991).

Thus, some counselors differ in demographic characteristics, such as age or theoretical orientation but therapy-oriented factors, including attitudes and behaviors, suggest therapists can

produce significant client progress (Crits-Cristoph & Mintz, 1991; Okiishi, et al, 2003; Orlinsky & Howard, 1980). Identifying effective versus ineffective counselors is not only useful in understanding the influences of the counselor upon psychotherapy but also informative about how to best train counselors to be successful.

Effective Counselors

Lambert & Barley (2002) cited Ricks' 1974 "supershrink / pseudoshrink" comparative study of effective versus ineffective counselors that found the successful counselor "spent more time with the difficult cases, made use of resources outside of the immediate therapy circumstances, was firm and direct with parents, encouraged autonomy, implemented problem solving skills, and had a strong therapeutic relationship with the clients" (p. 22). In addition, effective counselors are reportedly "more psychologically minded [and] eschew biological interventions (i.e., medication and electroconvulsive therapy)" in their ordinary clinical practice (Blatt, Sanislaw, Zuroff, & Pilkonis, 1996, p. 1276).

In their 2003 investigation, Okiishi et al. found significant differences among individual counselors and their clients' outcomes in their study of 56 university counselors and their 1,841 student clients. This study, and their replication study (Okiishi et al., 2006) concluded that type of training, amount of training, theoretical orientation, and gender did not differentiate between the, superior-performing supershrinks, and poor-performing pseudoshrinks. The differences found were attributed to unknown, undefined counselor characteristics, suggesting additional investigation of the individual therapist's contribution was needed. On the other hand, some individual counselor variables have distinguished the more effective counselors including use of common therapy factors such as empathy, positive regard, and genuineness (Teyber & McClure, 2000; Weinberger, 1995).

In sum, some therapists are consistently more effective than others for reasons other than which theoretical orientation and treatment they use. The reasons for success relative to the therapist are the focus of more recent client outcome research. The research supports the idea that the therapist as an individual is integral to achieving positive client outcome (Norcross, 2002). Some research has pointed to therapist attitudes and behaviors such as supporting and encouraging autonomy, problems solving, modeling, and reality testing. Additionally the therapists' contribution to the therapeutic relationship has been shown to be related to positive client outcome (Lambert & Barley, 2002; Norcross, 2002). Other research is less clear about what the therapist effects are specifically, but confirm finding small to moderate therapist effects (Crits-Christoph et al., 1991; Elkin et al., 2006, Wampold & Brown, 2006). Thus, this study seeks what relationships exist between therapist variables (hope and optimism) and client outcome based on research that supports that therapist effects are contributors to outcome.

Counselor Variables

Counselor variables are characteristics, attitudes, values, and personality and coping patterns individual of the counselor. Outcome research and client surveys have examined a number of counselor variables that have been hypothesized to be related to positive counseling outcomes. These include the counselor's age (Beck, 1988; Beutler, et al. 1994; Beutler et al., 2004); gender (Beutler et al., 1994; Beutler, et al., 2004; Bowman, 1993; Greeson, Guo, Barth, Hurley & Sisson 2009; Jones, Krupnik & Kerig, 1987; Sue, Fujino, Hu, Takeuchi, & Zane, 1991); ethnicity (Beck, 1988; Karlsson, 2005; Snyder & Ingram, 2000; Sue et al., 1991); degree of adjustment (Lambert & Baldwin, 2009); theoretical orientation (Vakoch, 1997); professional background (Najavits & Weiss, 1994); years and type of experience (Beutler et al., 2004; Crits-Cristoph et al., 2001; Leon, et al., 2005; Powell, Hunter, Beasley, & Vernberg, 2010; Sharpley &

Ridgway, 1993, Smith & Glass, 1977; Smith, Glass, & Miller, 1980; Stein & Lambert, 1984, 1995); self-efficacy (Larson & Daniels, 1998); empathy and the working alliance (Wing, 2010); empathy, supportiveness and warmth (Lafferty, Beutler & Crago, 1989; Lambert & Bergin, 1994); religiousness (Bowman, 1993); degree of unconditional positive regard (Farber & Lane, 2001); and dominance (Thrower & Tyler, 1986).

Counselor variables have also been studied extensively in relation to measures other than client outcomes including: counselor trainee gender and perception of client (Barrette & McWhirter, 2002; Jones, 1982; Luborsky et al., 1986; Tryon, 1988); age and gender differences between counselor trainees and client (Beutler, et al. 1994); counselor gender, years' of experience, and therapy seeking behavior (Deutsch, 1985); counselor attitudes toward mental health, religious-spiritual values (Kelly, 1995); counselor self-efficacy (Al-Darmaki 2004; Lent, et al., 2006); ratings of counselor effectiveness (Workman & Williams, 1979); and counselors' therapeutic alliance with clients (Baldwin, Wampold, & Imel, 2007).

Counselor variables may be categorized as global (with respect to the individual) or specific (therapy-specific variables) to the setting. Global variables are individual characteristics that can be measured or ascertained at any given time such as age, gender, and ethnicity. On the other hand, therapy-specific variables refer to the counselor's theoretical philosophy as well as their self-efficacy related to in-session behaviors. Regarding how to assess therapist variables, a distinction could be made between the individual demographic-type (global) variables and the therapy-specific in-session therapist characteristics such as the variables that might contribute to the therapeutic relationship – levels of unconditional positive regard, empathy for the client, and warmth (Worthington, 1988). Some authors have proposed that therapy-specific variables may be more likely to be associated with positive client outcome than global variables such as age,

gender, ethnicity or training history (Beutler, Crago, & Arizmendi, 1986). However, there are some considerations such as therapist personal values and how they present themselves and their values professionally in –session that are difficult to completely separate. A values survey of therapists conducted by Kelly (1995) revealed that therapists personally value self-direction, compassion, and responsible self-expression which could be observed in the counseling setting. The person of the therapist is important within the therapy context, thereby making it difficult to completely separate general individual characteristics to those the individual expresses in-session. In fact, writers have supported this concept and stated that it is impractical and "virtually impossible" to differentiate between the personal and professionally expressed variables, including values, that become intertwined and indistinguishable from one another over time (Beutler, et al., 1994, p239). Thus, the variables considered in this study will be inclusive of both personal and professional counselor values.

Age

Meta-analytic research conducted by Beutler, Machado and Neufeldt (1994) revealed "little relationship" of age to client outcome (p. 232). They cited a study by Dembo, Ikle and Ciarlo (1983) that reported that the only time that counselor age was strongly associated with client outcome is when clients, aged 18-30, were 10 years older or 10 years younger than their treating counselor. Furthermore, the authors noted that age similarity may be influenced by a second variable, client-counselor cultural (dis)similarity, which is related to more frequent client attrition or dropout than its association with client gains in counseling (Beutler et al., 1994). The effect of age is difficult to interpret when two other variables, training and experience, are considered. Training and experience confound age effects because there is a relationship with

age; that is, there are greater opportunities for training and experience occur with the passage of time (Beutler, et al., 1994; Wampold & Brown, 2005).

Gender

Gender variables have received a good deal of attention in research (Bowman, 1993) and analyses of these studies suggest a rather small relationship to client outcome (Sue & Lam, 2002). In his meta-analytic study focusing on gender in psychotherapy, Jurek (1992) expressed concern that female therapists and female clients are most often paired and evaluated for relationship to client outcome. Jurek (1992) confirmed that he found a discrepancy among studies that female-focused research "far outweigh[ed]" male-focused research (p. 75). While the gender research slightly favors females in producing better client outcomes, like much of the counselor variable research, overall, findings are mixed and more research is needed to determine how applicable these findings are to the larger population of clients (Bowman, 1993; Bowman, Scogin, Floyd, McKendree-Smith, 2001; Jones, Krupnik, & Kerig, 1987; Jurek, 1992;).

Despite concerns for consistent results and generalizability, gender oriented researchers often cite a study conducted by Jones et al. (1987) who found that clients with female counselors showed greater improvement post-treatment and at follow-up than clients who had male counselors. Research analysts call for a replication of this study due to possible confounds represented by the small number of male clients in the study. In an individual study conducted by researchers, undergraduate students rated female counselor higher on perceptions of expertness and trustworthiness, indirect client outcome measures.

Another finding that may have been compromised because of a methodological concern is one of two studies conducted by Jones and Zoppel (1982) that surveyed male and female

counselors. In that study, therapists' conducted outcome ratings for 160 former clients. Both male and female therapists had equal numbers of male and female clients to review. The findings showed that the female therapists rated themselves more successful, particularly with their female clients. While the writers were careful to balance the outcome analysis between therapists of both gender for both male and female clients, this study's results were quite possibly compromised by counselor subjective self-report measures, possibly influenced by socially desirable responding, and unreliable because of a lack of more objective measures. It is noted that in the second study, 99 former therapy clients were interviewed about their counseling experiences and results showed that regardless of the gender of the client being interviewed, they stated that female therapists were more effective in forming therapeutic alliances, although both male and female therapists were rated significantly effective in helping.

Consistent with the Jones and Zoppel (1982) finding, Fisher (1989) reported that overall, research seemed to be pointing to better outcomes by female counselors. Similarly, in a 2004 meta-analytic study (N=58), Beutler et al. (2004) found a "significant, but small effect size favoring female counselors" (p. 230). Greeson, Guo, Barth, Hurley, and Sisson (2009)'s study of 1,416 youths and 412 counselors found that gender was significantly associated with outcomes. Specifically, Greeson et al. (2009) found that females were more likely to have positive outcome.

Other contemporary researchers, however, agree that no conclusive study has yet been conducted (Beutler, Machado & Neufeldt, 1994; Bowman, 1993). In addition to the concern for selection bias, researchers believe that the mixed results in gender studies occur because of a lack of balanced male-female participation, because investigators engaging in this work start off with incorrect assumptions and stereotypes about gendered thinking and behaving, or because

unreliable assessments are utilized. These flaws lead to conclusions which are less objective and generalizable (Jones et al., 1987; Bowman, 1993; Bowman et al., 2001).

Ethnicity

Recent research suggests that ethnicity may be a major contributing variable with indirect client outcomes, such as client satisfaction and direct client outcomes, such as decreased symptom distress (Karlsson, 2005). Historically however, mixed results have been reported with counselor-client ethnic matching (Snyder & Ingram, 2000). In a study 1,500 African American, Caucasian, and Hispanic client-counselor pairs, Beck (1988) found that Hispanic pairs showed higher client satisfaction but that African-American client-counselor ethnicity similarity was not related to client satisfaction. Overall, researchers report that matching counselor and client ethnic background does not *consistently* predict direct client or indirect outcome measures such as client satisfaction, change in functioning, or attitudes toward the counselor (Sue et al., 1991; Sue & Lam, 2002). Research findings do indicate that an ethnic match may have predictive value regarding the client's dropout rate (Sue et al., 1991). Of course, it is also likely that clients who drop out of counseling make less progress than those who stay in (Federici, Rowa, & Antony, 2010). It may be shown that, in the future, counselor-client *dissimilarity* becomes the focus in ethnicity studies as this area expands because that may show bad results – such as what does not work, where there is greater client drop-out, or greater client dissatisfaction.

Training, Background, and Theoretical Orientation

Counselor training, professional background, and theoretical orientation are commonly investigated counselor variables. The amount and type of training a counselor receives has not been found to be associated with higher skill levels or better outcomes (Beutler et al., 2004). Beutler et al. (2004) observed that it is difficult to evaluate a counselor's training experience and

amount of training received because of how similarly professionals are trained. Other researchers have likewise reported that overall, none of these three variables, counselor training, professional background, or theoretical orientation appear to be related to improved client outcome (Crane, Wood, Law, & Schaalje, 2004; Crits-Christoph, Miller, Taylor, & West, 1980; Lambert & Baldwin, 2009; Luborsky et al., 1985; McLellan et al., 1988; Najavits & Weiss, 1994; Teyber & McClure, 2000).

Professional Experience

Two well-known meta-analyses on the effectiveness of psychotherapy (Smith & Glass, 1977; Smith et al., 1980) both included an examination of the relationship between counselors' years of experience and counseling outcome, and found no statistical relationships. However, more recently, counselor professional experience was found to have a positive impact on therapy skill and outcome (Karlsson, 2005). In a study evaluating the impact of counselor trainee characteristics on trainee skill acquisition, Goodman & Amatea (1994) reviewed trainees' prior therapy experience as a counselor, prior training, learning style, and prior knowledge of therapy on trainee skill acquisition. Of the four variables, previous experience as a counselor was significantly associated with increased skill acquisition student counselors (Goodman & Amatea, 1994). Four studies reviewed by Beutler et al. (2004; Blatt et al., 1996; Huppert et al., 2001; Luborsky et al., 1997; Propst, Paris, & Rosberger, 1994) showed that greater counselor experience was associated with greater counselor effectiveness and in turn, more positive client outcomes. Leon et al., (2005) reported that counselor experience and client outcome have a temporal relationship. That is, client improvement may be more likely if a counselor's new client enters treatment shortly after a "clinically and demographically similar" client (p. 417).

In sum, in contrast to earlier findings, recent research suggests that counselor experience is related to client outcome. Counselors benefit from the time required to gain experience. The more experience a counselor gains in clinical and counseling settings, the greater opportunity for both basic and advanced skills to develop (Breunlin et al., 1989). The relevance to this study is that counselor experience is not quantified well among the literature reviews. Experience is related to time spent performing duties of a counselor, thus, conclusions about counselor experience influencing outcomes are tenuous and weak.

Skill

Specific investigation of counselor skill, the therapist's actual ability to utilize counseling techniques with clients, is not consistently related to client outcome in the literature. Breunlin, Schwartz, Krause, and Kochalka (1989) found that counselor trainees' previous therapy experience was positively related to client outcome whereas being exposed to simple skills-based information (in isolation of experience) was negatively related to performance. Counselor trainee knowledge of skills that are helpful in therapy is not related to counselor performance. However, counselor experience, which would include a use of previously acquired skills over time, may be related to counselor performance.

In sum counselors armed with skills information do not demonstrate significantly positive performance. The literature suggests that counselors benefit from the experience of action related to counseling, not just receiving information. The literature has suggested that a number of counselor skills, such as modeling and reality testing are related to positive outcome (Lambert & Bergin, 1994). However, positive outcome is not likely to occur from counselors simply receiving information about those skills. The practice that generates experience based on knowledge of technique (skills) is likely what leads to desirable counselor performance.

Self-Efficacy

Self-efficacy studies have revealed more consistent and promising associations with client outcome. Bandura (1977, 1986, 1995) defined self-efficacy as person's belief in his capabilities to perform a particular activity in pursuit of a goal. The literature on self-efficacy and its relationship to cognition, motivation, individual functioning, self-control, coping, performance, individual success, effort, and relationship to other physiological mechanisms is vast (Bandura 1977a, 1977b, 1983, 1986a, 1986b, 1995, 2003) and studies span areas of health, work, academics and personal choice.

Regarding the effect of self-efficacy on client health, a meta-analysis of 27 health-related outcome studies for adult and adolescent survivors of trauma (N=8011), concluded that self-efficacy determined health-related outcomes and that self-efficacy is *a* powerful predictor of posttraumatic recovery among collective trauma survivors (Luszczynska, Benight, & Cieslak, 2009). In a longitudinal study of cardio-pulmonary disease patients, higher levels of self-efficacy at baseline predicted significantly reduced psychosocial impact of disease and improved physical activity, total scores for health status, and scores for quality of life as rated by patients (Bentsen, Wentzel-Larsen, Henriksen, Rokne, & Wahl, 2010). In the workplace, self-efficacy has been positively associated with proactive work performance (Parker, Williams, & Turner, 2006) demonstrating initiative (Speier & Frese, 1997) and taking charge (Morrison & Phelps, 1999). Regarding task performance, individuals with a greater sense of self-efficacy are more likely to demonstrate greater effectiveness (Barling & Beattie, 1983; Wood, George-Falvy, & Debowksi, 2001); choose more difficult goals (Locke & Latham, 1990); In a study of working memory capacity and problem-solving efficiency, participants with greater self-efficacy demonstrated increased problem-solving efficiency through strategic performance rather than

faster solution times (Hoffman & Schraw, 2009). High self-efficacy was positively related to the sexual risk reduction in a targeted intervention for women (O'Leary, Jemmott, & Jemmott, 2008).

While high self-efficacy is related to a number of positive events, low self-efficacy scores are related to at-risk behaviors. For example, lower self-efficacy in adolescents in a smoking cessation program predicted the first, second, and succeeding relapses (Van Zundert, Ferguson, Shiffman, & Engels, 2010). Additionally, lower self-efficacy in seventh grade science students was related to the use of more self-handicapping strategies and cheating (Tas & Tekkaya, 2010).

Counselor self-efficacy refers to a demonstration of a positive belief in one's ability as a counselor (Lent et al., 2006) and may be more specifically "conceptualized as encompassing the perceived ability to use helping skills, both individually and integratively, to help direct the counseling process" (Lent, Hill, & Hoffman, 2003, p. 105). Counseling self-efficacy is comprised of two factors: 1) task content self-efficacy, the ability to perform session management tasks, and 2) coping efficacy, the ability to navigate clinically demanding situations (Lent et al., 2006). According to Larson and Daniels (1998), counselor self-efficacy is strongly associated with outcome expectancies, counselor self-evaluation, and positive client outcome. A moderately negative relationship exists between counselor self-efficacy and anxiety; counselors with a stronger sense of counseling ability experience less frequent anxiety related to their counselor identity, work, and relationships (Larson & Daniels, 1998).

Empathy

Empathy has a number of definitions in the literature, and may be best understood as a "complex [and] multidimensional" cognitive and emotional construct operating in the here and now (Bohart, Elliott, Greenberg, & Watson, 2002, p. 90). One comprehensive definition for

empathy is the counselor's experience and expression of "understanding, imagining, sensing, and thinking" the client's presenting or reported experiences, expressions, or behaviors (Elliott, Greenberg, & Lietaer, 2004, p.521). Following a literature review and meta-analysis of 47 studies representing a total of 190 cases with 3,026 clients, Bohart et al. (2002) concluded that counselor empathy is positively associated with client outcome. In fact, they reported that empathy accounted for 7-10% of the variance attributed to client outcome (Bohart et al., 2002) comparable to the reported contribution of whether or not a person receives treatment (13 %;) (Kim et al., 2006). Norcross (2002) reported that empathy was determined by the American Psychological Association (APA) Division 29 Task Force for Empirically Supported Therapy Relationships to be "demonstrably effective" as a general element of the therapy relationship.

Therapeutic alliance

Therapeutic alliance is associated with positive client outcomes (Krupnik et al., 1996; Norcross, 2002). According to the conclusions of APA's Division 29 Task Force Steering Committee (Norcross, 2002), the therapeutic alliance is considered to be "demonstrably effective" as an element of the therapy relationship (p.441). The therapeutic alliance is at the heart of the therapeutic process. The alliance is a "negotiated, collaborative feature of the treatment relationship, composed of three aspects": (1) agreement between patient and counselor on the goals of the therapy; (2) the patient's agreement with the counselor that the tasks of the therapy will address the problems the patient brings to treatment; and (3) the quality of the interpersonal bond between the patient and the counselor (Hatcher & Gillaspy, 2006, p.12). Multiple factors contribute to the alliance including the counselor characteristics, therapy skills, and interpersonal skills including empathy, open and clear communication, and an ability to generate a sense of hope (Hersoug, Hoglend, Monsen, & Havik, 2001; Horvath & Bedi, 2002).

One of the compelling arguments supporting the effect of counselors and counselor variables is that the power of the therapeutic alliance is largely due to conditions provided by the counselor (Norcross, 2002). The therapeutic alliance is at the heart of the therapeutic process. Teyber and McClure (2000) define a working therapeutic alliance as an agreement between the counselor and client on therapeutic goals, how to approach and achieve those goals, and the resulting experience of emotional closeness between the counselor and client as they mutually strive together toward the attainment of goal achievement. The therapeutic relationship is enhanced when a counselor creates immediacy by utilizing "self-involving" (as opposed to self-disclosing) statements that "refer to a direct, present expression by the counselor about the client's current behavior (Teyber & McClure, 2000, p. 68). A study evaluating the relationship between working alliance and counseling outcomes reported that clients who perceived a greater therapeutic alliance with their counselors showed better outcomes (Baldwin et al., 2007). The literature suggests that the therapeutic alliance is positively influenced by the counselor's relational aptitudes and skills such as psychological mindedness, intelligence, and supportiveness, and may be best understood as 'joining' variables that promote joining with the client, which fosters a stronger therapeutic relationship (Alexander, Barton, Schiano, & Parsons, 1976; Bergin & Garfield, 1994; Teyber & McClure, 2000; Norcross, 2002). Often the strength of the counselor's relational skills is activated and enhanced by positive association and relationship with their client. Additionally, the strength of the therapeutic relationship, the ongoing rapport maintained by the counselor, and the fortification of the relationship are often viewed as a result of counselor's use of empathy, positive regard, genuineness (Lambert & Bergin, 1994; Weinberger, 1995) and disinhibiting clients to work interactively utilizing their resources, ultimately to contribute to an improved client outcome (Teyber & McClure, 2000).

Client Matching

One idea that has gained momentum is the notion of matching client and counselor on a shared characteristic. The notion is that that a good match between client and counselor leads to better client outcomes (Krause & Lutz, 2009). Client matching is usually based on counselor and client personality factors, qualities, characteristics, or belief systems. Client matching may either look at opposing variables between counselor and client such as the male-female dynamic or similarity such as shared beliefs between the therapist and client. Client matching may be applied demographically, using age, gender, or culture as variables to examine. Client matching can use philosophical ideas such as the belief about the source of a client's problems.

Another area of matching is treatment agreement - identifying and using interventions that both and client agree will be appropriate and effective for the client's presenting problem. In this example, the counselor and client are finding agreement on a number of matters such as agreement of the client's presenting problem, agreement with certain theoretical tenets, such as the how much a client's past should be involved in resolving a concern. Another area counselors and clients can effectively find agreement is in the belief that use of certain techniques might be helpful such as journaling, bibliotherapy, or the use of homework. Matching holds a great deal of promise because it seems likely that similarities on some dimensions might increase the quality of the therapeutic alliance.

There are two kinds of outcomes that can be affected by clients and counselors sharing (matching each other on) similar characteristics. Direct client outcomes refer to the overall goal of therapy, usually a decrease of client symptom distress. Indirect client outcomes are measureable and desirable, but not necessarily a decrease of client distress. Examples of indirect client outcomes are client satisfaction levels and dropout rates. Client-counselor matching shows

possible influences on direct outcome, including client and counselor similarity in attitudes toward life, morals, or values (Beutler & Bergin, 1991); therapy role expectation agreement (Brennan, 1989); sexual orientation match when dealing with issues of sexual orientation (Sue & Lam, 2002); similar beliefs about the nature and origin of psychological concerns or problems (Torrey, 1972); and ethnicity - specifically among Latino American clients (Sue & Lam, 2002). Lutz, et al. (2007) stated, however, "The hypothesis that counselors are differentially effective with particular types of patients has not received much support in the empirical literature" (p. 37). Sue and Lam (2002) reported no strong relationships on direct counseling outcomes for client and counselor match on gender, ethnicity, or socioeconomic status. Additionally, Atkinson, Worthington, Dana, and Good (1991) examined client-counselor similarity on other dimensions including irrational concerns; vocational or academic challenges; physical illness, trauma, pain; social performance inadequacies; biological imbalances; and experiencing bad luck, bad karma, or being cursed and they described no relationship to client outcome. It is noted that counselor and client match on gender, ethnicity, reveal positive relationships with indirect outcomes such as client satisfaction, length of treatment, and dropout rates (Sue & Lam, 2002).

Beutler et al., (1979) observed that the client's *perception* of similarity is actually more influential on client outcome than the true similarities that may exist between client and counselor. Future research will be improved, according to Krause and Lutz (2009), if counselors are matched sooner with more familiar client populations or client diagnoses similar to the counselor's most recent experience.

Hope and Optimism

To this point, we have looked counselor characteristics that might influence client outcomes. The literature has indicated that a small but significant proportion of treatment outcomes are due to the person of the counselor. Yet the search for specific variables has not been entirely successful. Mixed results have been shown. One arena that has not been studied extensively is the area of positive psychology and the existence of particular values such as hope and optimism that might affect client improvement. In this section, we will look at these two variables because they have been among the best researched in the positive psychology literature, and consider how they might be influential in treatment.

Hope

While hope may be commonly associated with positive emotions, hope is, in essence, a cognitive process that is based on positive expectations for achieving a goal. Before hope theory became established, researchers had already begun to emphasize the importance of positive thinking and positive emotions by showing that negative thoughts and feelings were related to health and difficulty coping with life's challenges (Snyder, 2000). The founder of hope theory, C.R. Snyder, originally conducted research by trying to understand how people somehow positively explained negative events (mistakes) after making poor decisions because he noticed that people tried to distance themselves from their poor choices (Snyder, 2000). He stated that in their excuse-making, people tried to sound positive about their choices. Snyder (2000) began tracking individuals' thoughts that accompanied personal goals and ultimately formulated the definition of hope that incorporated two main factors: a motivational, energy component (agency) and the individuals' assessment of whether workable routes could be created and maintained (pathways) with relation to goal achievement. Agency and Pathways thus became the two defining factors of hope that interact with each other to describe "goal-directed

determination and planning to meet goals" (Snyder 2000, p. 8-9). According to Snyder's hope theory, hope is anchored in goals; goals are hope's object and focus. In order for hopeful thoughts to be successful, they must be attached to and targeted on a goal – with meaningful, plausible routes to those goals and a persistent motivation to fuel the forward movement even in the face of adversity to overcome or circumvent obstacles. Essentially, the individual is concentrating on reaching a desired future with positive, goal-related outcomes (Snyder, 2000). Hope, therefore, is a cognitive construct with goals, pathways, and agency which *leads* to the positive emotions so often associated with hope. Below are definitions of two aspects of hope that have been consistently measured, trait hope and state hope:

Trait hope. Traits are "dimensions of individual differences in tendencies to show consistent patterns of thoughts, feelings, and actions" (McCrae & Costa, 2003, p. 25). Therefore, trait hope is a dispositional characteristic where hopefulness is more evident throughout one's life regarding present and future goals. As a more enduring characteristic, trait hope is measured with the Adult Dispositional Hope Scale, labeled "The Goals Scale".

State hope. Personality *states* are those qualities evoked on a situational basis. State hope can be expressed by any individual in any given situation that may spark a hopeful thought and feeling. Although most individuals do not possess hope as a trait, an enduring characteristic, most individuals could be moved to experience a hopeful thought given the situation at hand. As a state measure, hope is assessed with the Adult State Hope Scale, labeled "The Goals Scale for the Present"; to more accurately focus the participant (Snyder, 2000, p.76). The labeling changes were made from Hope Scale measures to either Future Scale or Goals Scale measures because researchers found that test takers wanted to discuss the concept of hope once they discovered the concept was measureable (Snyder, 2000).

Optimism

The study of optimism grew from Martin Seligman's work with learned helplessness theory (Abramson, Seligman, & Teasdale, 1978). Learned helplessness emphasized how people often adopted a sense helplessness and inability to change the outcome of a (repeated) negative situation. Seligman has since (1991) described a different kind of thinking, an optimistic style, that showed how individuals could explain to themselves that negative events were not paralyzing, catastrophic, and out of their control. In fact, according to Seligman's learned optimism (2006), negative events could be perceived as based on situational events, not global, and attributable to external and variable conditions, not those that were pervasive and ever-lasting. According to Seligman's optimistic attributional style, an individual could attribute *positive* events to the more global, stable, and internal conditions (2006). Learned optimism (2006) recognizes that negative events are valid. Similar to some of hope's early research, learned optimism suggests that people distancing themselves from past negative events when focusing on a new goal (Snyder, 2000). Scheier and Carver (1985) introduced a goal-based approach to optimistic thinking that is evident when the individual considers the outcome to be important and valuable. Scheier and Carver call the primary term for optimism, "expectancy". Expectancy is a motivational, energetic factor that helps drive an individual's thinking toward the end goal.

Optimism has been associated with well-being and positive functioning. Brissette et al. (2002) followed first-year college students through various academic, social and emotional experiences during their first semester. Findings included that student's with higher optimism showed more effective coping and better adjustment to stressful academic life events. Optimistic students reported higher perceptions of social support, greater friendship network size, and

greater increased of social support. Additionally, the students' greater optimism was associated with better psychological adjustment compared to less optimistic students (Brissette et al., 2002).

Dispositional Optimism. In general, optimism described in the literature refers to dispositional optimism, a trait-factor – one that is defined by its' tendency to persist over time as a personality characteristic. Dispositional optimism is defined as a generalized positive outcome expectancy and approach to goals where a high value is placed on the outcome (Scheier & Carver, 1985). Scheier, Carver, and Bridges (1994) reported that dispositional optimism was found to be beneficial for physical and psychological well-being. They cited a study conducted by Aspinwall and Taylor (1992) which found that optimistic individuals adjusted better to important life transitions than pessimistic individuals. Another study of post-operative males found that optimistic men recovered more quickly than pessimistic men (Scheier & Carver, 1992). Overall, dispositional optimists tend to exhibit consistent coping with a solution focus (Scheier, Weintraub & Carver, 1986). Although dispositional optimism is prominent in the optimism literature, another type of optimism is discussed, called explanatory style optimism.

Explanatory Style Optimism. Seligman (1991) introduced optimism as an attributional style where negative events were perceived as external, transitory, and specific to the situation and not internal, stable, and global. Peterson and Vaidya (2003) similarly defined explanatory style optimism as a reliance on reasons that are external, temporary, and situation-specific to account for negative events instead of a more maladaptive or catastrophic reasoning that emphasizes permanent, pervasive, and global accounts for negative events.

Dispositional and Explanatory Style Optimism. The effects of dispositional optimism and optimism as an explanatory style appear to be positively related to physical health. Individuals with high scores in dispositional optimism were more likely to engage and attend a health

treatment program, even if they were not currently diagnosed with a physical health concern (Geers, Wellman, Seligman, Wuyek, & Neff, 2010). In a 2008 meta-analysis of 70 studies, Chida and Steptoe summarized, "The current review suggests that positive psychological well-being has a favorable effect on survival in both healthy and diseased populations" (p741).

Self-efficacy

Self-efficacy literature is rich in its history and contribution to understanding cognitive processes and motivation; it is particularly cogent because it is akin to hope and optimism as a concept regarding personal beliefs. Hope's concept of Agency, which involves a sense of successful goal-directed determination, is represented in Bandura's social cognitive theory which posits that people contribute to their own motivation and action through multiple mechanisms of action, cognition, and emotion. Hope and self-efficacy differ, though, in that self-efficacy does not explicitly include the Pathways component to the success that hope does (Peterson and Byron, 2008).

Bandura (1989) defined self-efficacy as an individual's positive belief about their capacity to influence and control events in their lives. Self-efficacy is also similar to hope and optimism in its relationship to goals. Bandura explained that cognitive processes involve the human ability to exhibit forethought, a kind of goal planning influenced by personal beliefs of competency (1989). According to Bandura's theory, there is a relationship between the level of belief someone has in themselves and the goals they set for themselves. The more an individual believes they are capable (self-efficacious) the higher the goals they will set and the greater commitment they will apply to working toward those goals (Bandura 1989).

Just as with hope theory (Snyder, 2000), individuals with greater sense of commitment, motivation, or hope, the more likely they will persist, exhibiting an efficacious, resilient belief

system so as not to be deterred from naturally occurring self-doubt in the face of obstacles (Bandura, 1989). Bandura also incorporated optimism into his conceptualization of self-efficacy when he stated that positive well-being and successful human attainments require an optimistic sense of personal self-efficacy (Bandura, 1986). Just as Snyder (2000) stated that high hope individuals encountered obstacles naturally and with the same frequency as low hope individuals, Bandura (1989) was certain to emphasize that self-doubt is a naturally occurring tendency, particularly with repeated failure, but an individual's difficulty is in their incapability to quickly recover with self-confidence as this loss of momentum could stymie the momentum of effort needed to keep moving toward goal achievement.

Coping

Research affirms that a high hope, optimistic individual demonstrate adaptive coping resiliencies and approach strategies when encountering obstacles (Brissette et al., 2002). Scheier and Carver (1987) agrees that dispositional optimism affects individuals' well-being through improved coping. While strong coping resources are fortifying, poor coping skills are crippling and performance difficulties become more prevalent across the spectrum of emotional, psychological, and physical requirements. Coping ability creates resiliency which buffers people from the difficulties of stressor in life. Furthermore, dealing more effectively with stressors can strengthen vulnerable individuals who may feel unable to meet life's challenges (Scheier & Carver, 1985).

Expectancy Hypothesis

It would be remiss to discuss hope theory and optimism without exploring their connection to Motivational theory which is largely based in psychology. Hope theory and Motivational theory are both cognitively oriented theories. Hope theory is anchored in goals and

seeks to understand an individual's level of hope by assessing level of motivation to create and pursue goals and the ability to navigate through obstacles to fulfill goal achievement. Cognitive motivational theories are concerned with how individuals make goal-oriented decisions including how to choose a pathway and how to direct internal energies (Pintrich & Schunk, 1996). Motivational theory includes an expectancy-value model. Expectancy beliefs include an individual's beliefs about their achievement ability (self-efficacy), possession of skills or knowledge to succeed (perceptions of confidence), and expectations of what will occur if a task is attempted (expectancy of success; Pintrich & Schunk, 1996).

According to hope theory, an assessment of the past influences how goals are perceived and achieved. According to motivational theory an individual's goals are based on past experience and familiarity with the task at hand (Lewin, Dembo, Festinger, & Sears, 1944). Atkinson (1957) provided the foundation for modern achievement theory with an emphasis on the contribution of three concepts: 1) emotional anticipation for success, 2) estimation of a task's value , and 3) approach or avoidance "motives", moving an individual toward success or away from failure. Motives for success are based on an individual's hope or anticipation of success and reflect the task's estimated value (Pintrich & Schunk, 1996). Later and more contemporary expectancy models do not utilize Atkinson's (1964) concept of motives because research revealed that motives did not predict an individual's choice of task and subsequent goal achievement (Pintrich & Schunk, 1996).

Hope in hope theory has a past-assessment and future-anticipation focus. Expectancy Theory and value in Expectancy-Value Theory are present-focused, task-oriented with an emphasis on cognitive self-concept and perception of task difficulty. Values are based on a combination of an individual's goals, values, and interests, respectively (Pintrich & Schunk,

1996). Hope theory, therefore, is akin to motivational concepts informed by Expectancy-Value models however it is less complex in its approach toward goals and achievement. Hope is more global and aspirational in nature. It is noted that expectancy-value models developed further into academic arenas and educational psychology's achievement goal theory (c.f. Harackiewicz & Linnenbrink, 2005.)

In sum, the models in Expectancy Theory overlap in part with Snyder's (2000) Hope theory. However, this review of Expectancy Theory and its development reveals that it contains many levels of motivational concepts including goals, values, and interests. The model is recognized as also being related to self-efficacy, which is a construct that appears to have a lot of similarity with hope and optimism. With regard to the relevance of this study, Expectancy Theory's complexity reveals, in part, where hope and optimism might be situationally positioned in a qualitative way. Hope and optimism are related but separate from Expectancy theory. A component of hope and optimism are positive expectations but not to the extent that Expectancy theory would also be examined with regard to therapist characteristics.

Locus of Control

Locus of control, a social psychology personality concept developed by Julian Rotter (Rotter, 1966; Rotter, 1990), refers to an individual's belief about how events occur and how they are controlled by them most of the time, attributed to external sources or internal resources. According to Marks (1998), the concept of locus of control was influenced by Western culture's high value on personal autonomy. Individuals with a high internal locus of control are more likely to assume that their efforts will be successful Rotter, 1990. An internal locus of control is demonstrated by an individual who attributes events to their own effort, decision making, and power. An external locus of control is observed in an individual who attributes events to

circumstances beyond their control, including other people, fate, or luck. Locus of control can be applied to both hope and optimism.

Until recently, hope was conceptualized as a construct influenced by an internal locus of control (Bernardo, 2010). According to hope theory, an individual's motivational energy and routing to goals were a result of internal, individual effort, and control (Snyder, 2000). Snyder stated that hope is made up of two elements, agency (motivation and drive) and pathways, (the planning and persistence) in pursuing goals (2000). Together these constructs define how hope is conceptualized and assessed. Both agency and pathways are measured by the instruments assessing hope, the *Adult Dispositional Hope Scale* (Rand & Cheavens, 2009) and the *Adult State Hope Scale* (Snyder, Sympson, Ybasco, Borders, Babyak, & Higgins, 1996). On both hope instruments, an individual must rate "I" statements to describe levels of ability to formulate and achieve goals (Snyder, 2000). According to Bernardo (2010), the use of the "I" statements emphasis an internal locus of control orientation for hope. He also stated that this internal locus of control belief system is reflective of a dominant middle-class American belief system. According to Bernardo (2010) the dominant middle-class American belief system explains that positive results in life are from "the individual's own goals, intentions, and/or preferences" (p. 945).

Other societies, according to Bernardo have a an external locus of control explanation for positive results. (2010). He stated that cultures outside the dominant middle-class American belief system attribute positive results of goals in internal and external (family members, fate, or luck) locus of control ways. Bernardo's observation led him to study the "locus of hope" (2010, p. 945). Bernardo (2010) evaluated two Philippine studies regarding chronically ill adolescents and their families. By observing how they attributed events to both internal and external

influences, Bernardo (2010) validated the locus of hope concept. These other cultures attributed success to their own individual strengths and abilities but also to external sources such as family, peers and the supernatural, such as God or fate.

Locus of control has also been described by Seligman's original theory of learned helplessness, which he later flipped to present learned optimism (Seligman, 2006). According to learned helplessness, an individual is at risk for depression as they increasingly feel powerlessness over their environment, defined by an external locus of control (Abramson et al., 1978). The individual's sense of control becomes attributable to events outside of one's self and immediate control, stable and unchanging over time, and pervasively global. Pessimistic attitudes are defined by an external locus of control, also, whereas an optimistic mindset is demonstrative of an internal locus of control where the individual perceives events as influenced primarily by their internal environment where they exert a great deal of control and where negative events are attributable to singular and transitory causes (Seligman, 2006).

Hope and optimism's locus of control, explains how people explain their success. Self-efficacy is another concept which draws upon the idea of locus of control in explaining how individuals achieve goals. The relevance of this subject to this study is that while hope and optimism have been clearly defined by positive psychology as variables related to positive outcome, the literature has also shown that self-efficacy also is related to positive outcome. While this focus of this investigation is hope and optimism as the therapist variables, self-efficacy continues to emerge as related variable, as shown in the examination of hope and optimism's locus of control.

Differences between Hope and Optimism

Bruininks & Malle (2005) reported that hope has a relationship with wish fulfillment and is different from optimism in terms of the personal control demonstrated in optimism. These authors contend that hope may span situational and other less concrete circumstances whereas optimism is based on situational circumstances (2005). Bernardo's (2010) study of individuals' hope-like thinking and attributional style produced findings that high hope individuals demonstrated both an internal and external locus of control. High hope individuals tended to attribute this goal thinking to their own inner resources and strengths but also to those external to themselves such as other resources including fate or God. According to Seligman's attributional theory, optimists demonstrate an internal locus of control such that their belief about how positive events happen is primarily due to their own inner resources (Seligman, 2006). According to hope theory, hope places an equal emphasis on two factors, Agency and Pathways thinking – the motivational energy toward goal directedness and the route-making and planning toward goal achievement (Snyder, 2000). With regard to those factors, it appears that optimism, while related to goal pursuit, emphasizes and incorporates the Agency factor but not the Pathways factor (Snyder 2000). Lastly, while these differences have been explained largely through theory, additional research has confirmed through statistical processes that hope and optimism while related, are separate and distinct constructs (Leichsenring, 2004). Hope and optimism, thus, can be evaluated in counselors as individualistic variables that may contribute, uniquely, to how they perceive events and goals for the future.

Summary

Counselor variables are important contributors to the therapeutic relationship and the therapeutic outcome. Despite ambiguity in some findings, identified counselor variables are

evolving with time and change in our perspectives. “Interest in age effects is being translated into a concern with ageism, and interest in race is shifting to interest in culture” (Beutler et al., 2004, p. 290). Furthermore, with the advent of positive psychology and other novel theories, the field of ideas and variables to examine expands, thereby offering greater opportunities to identify and enrich individual counselor characteristics that may contribute to improvement for clients. Beutler et al. (2004) also encouraged continued research noting, “recent research is noticeably sparse, or even absent, on the effect of counselor personality, well-being, personal values, and religious viewpoints on outcomes…we look forward to being able to identify ethnic attitudes that affect therapy outcome more directly than racial identity; age-related viewpoints that impact change more than mere years of survival; and gender perspectives that can replace biological sex as an outcome predictor. But that day is not yet here and we urge researchers to accelerate its arrival” (p291).

CHAPTER THREE: METHODOLOGY

Introduction

This chapter presents the methodology, research design, and procedures for this investigation. The purpose of this study was to investigate the relationship of student counselor characteristics viz. trait hope, state hope, and dispositional optimism and their relationship to client outcomes. The research questions (RQ), and corresponding null hypotheses (NH) developed, were:

- RQ1: What is the relationship among practicum counselor education students' trait hope (as measured by the *Adult Dispositional Hope Scale* [*ADHS*]; Rand & Cheavens, 2009) and the client levels of symptom distress (as measured by the *Outcome Questionnaire* [*OQ-45.2*]; Lambert et al., 2004) and client satisfaction (as measured by the *University of Central Florida Community Counseling Clinic Questionnaire,* UCF CQ)
- NH1: There is no correlation among practicum counselor education students' trait hope scores and client symptom distress and client satisfaction
- RQ2: What is the relationship among practicum counselor education students' state hope (as measured by the *Adult State Hope Scale* [*ADHS*]; Snyder et al, 1996)? and the client levels of symptom distress (as measured by the *Outcome Questionnaire* [*OQ-45.2*]; Lambert et al., 2004) and client satisfaction (as measured by the *University of Central Florida Community Counseling Clinic Questionnaire;* UCF CQ)?
- NH2: Null Hypothesis Two. There is no correlation among practicum counselor education students' state hope scores and client symptom distress and client satisfaction.

- RQ3: What is the relationship among practicum counselor education students' dispositional optimism scores (as measured by the *Life Orientation Test-Revised (LOT-R*; Scheier, Carver, & Bridges, 1994) and client symptom distress scores distress (as measured by the *Outcome Questionnaire* [*OQ-45.2*]; Lambert et al., 2004) and client satisfaction scores (as measured by the *University of Central Florida Community Counseling Clinic Questionnaire,* UCF CQ)?
- NH3: Null Hypothesis Three. There is no correlation among practicum counselor education students' dispositional optimism scores and client symptom distress and client satisfaction
- RQ4: What is the relationship among practicum counselor education students' skill (as measured by Part I (basic skill assessment) of the *Counselor Competencies Scale (CCS*; University of Central Florida Counselor Education Faculty, 2009) and counselor education students' trait hope (as measured by the *Adult Dispositional Hope Scale* (*ADHS*; Rand & Cheavens, 2009), state hope (as measured by the *Adult State Hope Scale (ASHS*; Snyder et al., 1996) and dispositional optimism (as measured by the *Life Orientation Test-Revised* [*LOT-R*]; Scheier, Carver, & Bridges, 1994).
- NH4: There is no correlation among practicum counselor education students' skill ratings and counselor trait hope, state hope, and dispositional optimism

Thus, this chapter reviews the research methodology of this investigation and includes the following: (a) the population and sample, (b) setting, (c) data collection, (c) instrumentation, (d) research design, (e) research hypotheses and questions, (f) ethical considerations, and (h) limitations of the study.

Population and Sample

Counselors

This investigation used purposive sampling procedures for the counselors in this study who were master's degree counseling practicum students. All practicum students (44) enrolled in Fall, 2010 were invited to participate in the study. A total of 43 counselor students elected to participate and each provided complete information. All were enrolled in the university's Counselor Education program recognized by the Council for Accreditation of Counseling and Related Program (CACREP). All student counselors, with the exception of one third-semester practicum student, were either first or second-semester practicum counseling students majoring in mental health, marriage and family, or school counseling. Student counselors are expected to complete two semesters of practicum before going to an internship site in the community. Third-semester students are those retained for remedial purposes.

Master's level students admitted to the counselor education program provided consent for program evaluation assessment during their master's studies. Thus, informed consent was obtained previously; however, students were provided information during a mandatory meeting with a slide presentation overview. This investigations' slides were incorporated with the orientation materials presented in this mandatory pre-practicum/clinic meeting held by the clinic director for the practicum students approximately two weeks prior to the Fall 2010. Prior to the practicum students beginning work with their clients at the start of the Fall 2010 they received an information sheet summarizing the study. They also received and completed a demographic questionnaire and three other questionnaires assessing student counselor trait hope, state hope, and dispositional optimism. Student counselor demographics collected are presented in Table 1

in Chapter 4. Throughout the practicum class, the student counselors were supervised by doctoral level counselor education faculty and doctoral students who served as assistants.

Clients

The community counseling center clients in this study were selected based on the fact that they had been assigned to and seen by the student counselors participating in this investigation. Clients were referred by schools, community agencies, and local practitioners for free counseling services. The clinic provided services to adults, couples, families, adolescents, and children. This study included only individual adult clients in its investigation.

When prospective clients contacted the clinic, staff members conducted an intake interview. The intake was reviewed in order to determine the type and level of concern presented and availability of services. Active substance abuse or domestic violence concerns were referred to more appropriate community agencies or providers. During the intake interview, staff provided details about the clinic's free fee schedule, policies and procedures, including the training level of the students' counselors and the live recorded supervision sessions. The client's verbal acknowledgement and consent was required before staff schedules an appointment.

Cases were assigned according to student counselor availability – with additional consideration of the student counselor's track of study. For example, a couple seeking treatment was more likely to be assigned to a marriage and family student counselor, however if there was no availability in that student counselor's schedule, another track student counselor with availability would have received the clients.

Counseling sessions were time-sensitive in that clients were generally set to receive services from the student counselor for once-weekly sessions during one semester

(approximately fifteen weeks). No session limits were imposed; however, student counselors were expected to be as efficient as possible with the understanding of the semester's timeframe. Clients with needs for ongoing care may have a planned pause in treatment between academic semesters and continue to receive treatment the subsequent semester. Most often continuing clients were assigned a new student counselor following approval for continued counseling and after the semester break. Both new clients and clients who were transferred or continued from a previous semester were included in the study.

Clients were administered the *Outcome Questionnaire (OQ-45.2*; Lambert et al., 2004) at the beginning of their treatment, every four weeks or at termination, whichever occurred sooner. The OQ-45.2 was used to assess the client's symptom distress and to track and changes over time. Clients were also provided the *University of Central Florida Community Counseling Clinic Questionnaire* (*UCF CQ*) to determine the level of client satisfaction and to determine if changes needed to be considered to better assist the clients. Both the OQ-45.2 and UCF CQ were conducted by the individual student counselor, who uploaded the information into the clinic's computer, creating a database within the community counseling clinic. Therefore, there was no interaction between the client participants and this researcher.

Setting

Clinic

The university's community counseling clinic offered counseling free of charge as a training facility for master's level Counselor Education students enrolled in at least one of the three tracks of mental health counseling, marriage and family counseling, and school counseling. Clients were generally referred by schools, community agencies, and other practitioners. The clinic is at the university's main campus. Clients received free parking for each session they

attended. Clinic staff was comprised of doctoral level counselor education students and master's level counselor education students who completed their practicum experience previously. Throughout the practicum course, the student counselors were supervised in the clinic by doctoral level counselor education faculty and doctoral students who served as assistants.

Practicum

The master's program in Counselor Education typically includes two consecutive semesters of on-site practicum experience in the counseling clinic. The majority of student counselors in this study were either their first or second practicum class, with the exception of one student in their third practicum class. Each practicum contains approximately six master's students, one counselor education faculty member and a counselor education doctoral student who assists the professor. The counseling sessions were digitally recorded while the student counselor wears a bug-in-the-ear as part of the immediate supervision process. Multiple supervisory modalities aim to help the student counselor increase competencies in basic and advanced therapeutic and professional skills (See the *Counselor Competencies Scale* [CCS] included in Appendix A). All community counseling clinic clients were seen at the university's main campus in the Education complex in private therapy rooms designed for the aforementioned supervisory observation and communication.

Instrumentation

The constructs and instruments that were investigated in the study included: (a) trait hope (*The Adult Dispositional Hope Scale* [ADHS]; Rand & Cheavens, 2009), (b) state hope (*The Adult State Hope Scale* [ASHS]; Snyder et al., 1996), (c) dispositional optimism (*Life Orientation Test-Revised* [LOT-R]; Scheier, Carver, & Bridges, 1994), (d) client prognosis (UCF Community Counseling Clinic biopsychosocial), (e) counselor skill level (*Part I*, *Primary*

Counseling Skills, *Counselor Competency Scale*, [CCS], UCF Counselor Education Faculty, 2009); (f) counselor symptom distress (*Outcome Questionnaire 45.2* [OQ45.2]; Lambert et al. 1994); and (g) client satisfaction (*UCF Community Counseling Clinic Questionnaire*). See Appendix A.

The Adult Dispositional Hope Scale (*ADHS*; Rand & Cheavens, 2009). The dispositional hope scale measures trait hope and is labeled "*The Future Scale*". The instrument originally began with 45 items hypothesized to measure hope. In order to establish psychometric properties, the dispositional hope scale was administered to 187 male and 197 female undergraduate psychology students (Cieslak, 1999). Internal consistency was established by only keeping items that showed a high item-remainder coefficient > .20 (Snyder & Harris et al., 1991). The final number of items in the instrument is comprised of four items measuring Agency thinking and four items measuring pathway thinking. The *ADHS* measures Snyder's cognitive model of hope (1991) from a global time perspective which defines hope as "a positive motivational state that is based on an interactively derived sense of successful (a) agency (goal-directed energy), and (b) pathways (planning to meet goals)" (Snyder, et al., 1991, p. 287). The adult hope scale contains 12 items. Four items measure pathways thinking, four items measure agency thinking, and four items were fillers. The internal reliability ranges from .70 to .80 and has excellent construct validation for this population. (Rand & Cheavens, 2009). Participants respond to each item using a 8-point scale with the following possible choices: 1= Definitely False, 2= Mostly False , 3=Somewhat False , 4=Slightly False , 5=Slightly True , 6=Somewhat True , 7=Mostly True , and 8=Definitely True. See Snyder (2002) for a review of hope theory and research.

The Adult State Hope Scale (ASHS; Snyder et al., 1996) is labeled the "*Goals Scale for the Present*" when administered. The *ASHS* measures Snyder's cognitive model of hope which defines hope as "a positive motivational state that is based on an interactively derived sense of successful (a) agency (goal-directed energy), and (b) pathways (planning to meet goals)" (Snyder, Irving, & Anderson, 1991, p. 287). The *ASHS* contains 6 items. Participants respond to each item using a 8-point scale with the following possible choices: 1= Definitely False, 2= Mostly False , 3=Somewhat False , 4=Slightly False , 5=Slightly True , 6=Somewhat True , 7=Mostly True , and 8=Definitely True. Four items measure pathways thinking, four items measure agency thinking, and four items were fillers. The agency subscale score was derived by summing the three even-numbered items; the pathways subscale score was derived by adding the three odd-numbered items. The total *State Hope Scale* score was derived by summing the three agency and three pathways items. Scores can range from a low of 6 to a high of 48. The internal reliability ranges from .70 to .80 and has excellent construct validation for this population. (Snyder, 2000). See Snyder (2002) for a review of hope theory and research.

The Life Orientation Test-Revised (LOT-R; Scheier, Carver, & Bridges, 1994) is a brief research instrument used to assess optimism as a dispositional characteristic. The LOT-R is made up of 6 of 10 items used to derive an optimism score. The four filler items were not used in scoring. Participants responded with their level of agreement to each of the items using the following response format: 0 = strongly agree, 1 = disagree, 2 = neutral, 3= agree, and 4 = strongly agree. The negatively worded items (i.e. Items 3, 7, 9) were reverse coded before scoring. The items were added to response items 1, 4, and 10 to compute an overall optimism score which can range from 0 to 24.

The original Life Orientation Test (LOT, Scheier & Carver, 1985) was also used to assess dispositional optimism. The LOT contained eight items assessing generalized outcome expectancies (e.g., "In uncertain times, I usually expect the best"). Higher scores indicated greater optimism. The LOT had reasonable internal consistency (Cronbach's alpha .76), and a test–retest reliability of .79. The mean LOT score for a normative sample of female students was 21.41 (*SD* = 5.22; Scheier & Carver, 1985). In a study of optimism related to coping with health concerns, the reliability of the LOT was high (α = .82) for the eight-item scale (Lancastle & Boivin, 2005).

However, the original LOT was criticized and the optimism construct's integrity came under question. The question of the integrity of the construct was based on criticism that the scale involved third variables such as trait anxiety, neuroticism, or negative affectivity (Robbins, Spence, & Clark, 1991; Smith, Pope, Rhodewalt, and Poulton, 1989). Although Scheier and Carver (1994) looked at the concern for a trait anxiety overlap, they found optimism to be an independent predictor of its construct. However, Scheier and Carver (1994) observed that optimism did show an overlap with neuroticism, a sub-construct of chronic anxiety, and related to self-doubt and worry which created interpretation problems for the LOT (Carver, 1989). In further evaluating the optimism construct, overlaps with other variables were observed: (a) self-mastery (the perception of the ability to control events in life), (b) self-esteem (a sense of self-worth), (c) seeking social support; (d) engaging in healthy maintenance behaviors (Robbins et al., 1991), (e) adjustment to college and locus of control (Aspinwall & Taylor, 1992). In sum, although the LOT had been used successfully to evaluate optimism, the authors performed a reevaluation of the LOT for this population.

The reevaluation resulted in a revised version of the LOT measure including an evaluation of two items in particular may have been tapping variables that correlated with anxiety or depression or emotional instability. In order to minimize the concern, the two items "I always look on the bright side of things," and "I'm a believer in the idea that 'every cloud has a silver lining" were eliminated (Scheier and Carver, 1994, p. 1075). For these researchers, these two items were measuring the tendency to engage in positive reinterpretation and growth, not optimism as originally intended. Recalculation of items resulted in the revised instrument that contained one new positively worded expectancy item, increasing the positively worded items to three, equaling the number of negatively (reverse-scored) items.

Client Prognosis. The prognosis rating assigned by the counselor was an expectation for future gains that the client appeared to be able to achieve. The four prognostic ratings were "Excellent", "Good", "Fair", and Poor". The client's prognosis was completed by each practicum student counselor for each of their clients as part of the diagnosis procedure. For the purpose of this study, clients' prognoses were collected as a demographic measure.

Counseling Competencies Scale (*CCS*; UCF Counselor Education Faculty, 2009). Counselor skill acquisition was related to performance in practicum. The practicum utilized the CCS to assess student counselor skill development and professional competencies. The *CCS* was administered to all practicum students at the mid-term point and at the end of the semester providing counseling students with direct feedback regarding their counseling skills, professional dispositions (dominant qualities), and professional behaviors. This feedback included a focus on practical areas for student counselor improvement to support their development as effective and ethical professional counselors.

In Part I of the *CCS (Primary Counseling Skills)*, student counselors were rated on 12 primary counseling skills. The primary counseling skills assessment met several Council for Higher Education Accreditation (CACREP) required areas of focus: Social & Cultural Diversity**,** Helping Relationships, and Assessment. Two points were assigned for each of the five ratings possibilities: "0" (Harmful), "2" (Below Expectations / Insufficient / Unacceptable), "4" (Near Expectations / Developing towards Competencies), "6" (Meets Expectations / Demonstrates Competencies) and "8" for Exceeds Expectations / Demonstrates Competencies**.**

Although the psychometric properties have not been strongly established, in one recent study, the CCS demonstrated strong internal consistency reliability for both the individual factors and the overall models. The inter-rater reliability among raters yielded a low correlation (Skills [r = .436], Dispositions [r = .515], Behaviors [r = .467], and Total [r = .570]). Furthermore, an assessment of criterion-related validity yielded a high correlation (r = .407) between the final total score on the CCS and the students‟ final grade in the counseling practicum course (Swank, 2010).

Positive Treatment Outcomes. There was no single measure utilized in this study to assess positive treatment outcomes. Two measures reflective of positive treatment outcomes would include a decrease of client self-reported symptom distress and high overall satisfaction scores. The client symptom distress score change was assessed by deducting the second OQ45.2 Symptom Distress subscale score from the baseline OQ45.2 Symptom Distress subscale score. Therefore, two measures, the OQ-45.2 (Lambert et al., 2004) change score and the UCF CQ were utilized to determine if any comment could be made regarding positive treatment outcomes. Desirable outcomes included decreasing self-reported symptom distress and observing high client satisfaction ratings.

The Client Outcome Questionnaire 45.2(OQ-45.2; Lambert et al., 2004) is a 45-item self-report questionnaire developed to track and assess global psychological distress in a therapeutic setting. It was designed to be administered repeatedly throughout treatment and at termination to measure client progress in terms of reduced subjective symptom distress and improved functioning in the world (Lambert, et al., 2004). The three domains assessed in the OQ-45.2 include: a) Symptom Distress, b) Interpersonal Relations, and c) Social Role. Response options were according to a 5-point scale (0=never, 1=rarely, 2=sometimes, 3=frequently, 4=almost always), yielding a possible range of scores from 0 to 180. High scores indicate more distress and a cutoff score of 64 or above were used to indicate a significant likelihood of a clinical elevation. The focus of this study was the Symptom Distress subscale. As clients' symptom distress decreased, scores decreased. The internal consistency for the OQ-45.2 was reported to range from .70 to .93 with a 3 week test-retest value of .84 (Ogles, 1996). The OQ-45.2 (Lambert et al., 2004) license for the UCF community counseling clinic can be found in Appendix H.

The University of Central Florida Community Counseling Clinic Questionnaire (UCF CQ) is a non-standardized, 8-item client satisfaction questionnaire with a free form space for any additional comments. Counselors were expected to provide the client satisfaction questionnaire to each client during the termination session. The items were scored according to a 4-point Likert scale with lower numbers assigned to lower ratings and higher number assigned to higher ratings as follows: 1 (Poor/ Never / Not Well at All / No / Not at all satisfied), 2 (Fair / Rarely / Hardly well / Maybe not / Hardly satisfied), 3 (Good / Often / Somewhat well / Maybe / Somewhat Satisfied), and 4 (Excellent / Always / Very Well / Definitely /Very satisfied). Reliability and validity of this instrument has not been determined.

The Practicum Counseling Student Demographic Questionnaire included age, gender, ethnicity, counseling program track, and practicum level. Students were asked about the number of years of pre-program counseling experience. Additionally students were asked about their, post-program expectations regarding work and success as a counseling professional; "*How likely do you think you will work as a professional counselor after graduation from the UCF Counselor Education program"* and *"How confident are you that you would be an effective counselor?"*

Data Collection

Institutional Approval

Prior to the start of the study, the investigator followed and obtained the institutional requirements for research involving human subjects. An application was submitted to the University of Central Florida's Institutional Review Board (IRB.). The IRB approval was obtained (SBE-10-07079), and documentation of the approval is located in Appendix B.

Departmental Approval

The faculty Community Counseling Clinic Director was contacted for approval to conduct research for the Fall 2008 semester and approval was given through an electronic mail communication (See Appendix C). Re-approval was requested from the Community Counseling Clinic's faculty director in May 2009 with the intention of conducting the study in the Fall of 2009 (See Appendix D). The project was further delayed and in the Summer of 2010 the clinic's faculty director was contacted again by this investigator. The study, having previously been approved, was rescheduled for the Fall 2010 semester. In preparation for the study, this investigator also forwarded study-related information that was included in the director's

mandatory pre-semester briefing which was attended by all practicum students and their respective counselor education faculty practicum instructors.

In addition, the doctoral level staff coordinator was contacted to coordinate presentation of the information and questionnaire packets to the individual practicum instructors within the first week of the class or meetings prior to therapy sessions' beginning. The packets included an introduction letter to the practicum instructor (See Appendix C), and an introduction letter to the practicum students which included the planned use of the demographic questionnaires, assessment instruments, the practicum supervisor's mid-term rating of the *Primary Counseling Skills* section of the CCS (University of Central Florida Counselor Education Faculty, 2009), the use of the biopsychosocial to obtain client demographic information and client prognoses, and the collection of the client OQ-45.2 (Lambert et al., 2004), and UCF CQ ratings from the community counseling clinic database (See Appendix D).

Client Data

By utilizing the community counseling center database the client demographic information and prognosis for treatment were obtained from the biopychosocial completed by the student counselor. Additionally, the client self-reported symptom distress scores on the OQ-45.2*;* (Lambert et al., 2004) and UCF CQ responses were collected for each individual adult client attending the clinic in the Fall of 2010 See Appendix A. At the first session or as soon as practicable as determined by the supervising practicum instructor, the adult client was complete the initial OQ-45.2 (Lambert et al., 2004). The OQ-45.2 was required to be re-administered every 4-weeks and at termination, whichever occurred sooner. At termination the client was expected to also complete the UCF CQ.

Counselor Data

To enhance the potential for external validity, only practicum level master's counseling students were invited to participate. The counseling students were informed of this investigation during the orientation phase of practicum prior to the start of the Fall 2010 semester. Formal informed consent was not required following the Exempt Status awarded by the IRB; however a description of the study and opportunity to participate was presented to each student as a preface to deciding whether or not to voluntarily participate. Participating student counselors completed the counselor demographic questionnaire, the trait hope questionnaire (*ADHS,* labeled "*The Future Scale*"; Rand & Cheavens, 2009), the state hope questionnaire (ASHS, labeled "*The Goals Scale for the Present*"; Snyder et al., 1996), and the dispositional optimism questionnaire (*LOT-R;* Scheier, Carver, & Bridges, 1994) during a class meeting within the first week of orientation prior to the first therapy contacts. See Appendix A for the instruments used in the study. The student counselors' individual client prognosis ratings (Excellent, Good, Fair, Poor) from the completed psychosocial were collected as one of the client demographic items. The CCS (University of Central Florida Counselor Education Faculty, 2009) was administered by the student counselors' practicum supervisor at both the semester mid-term and the end of the semester when decisions about a student counselor's promotion to the next phase of the program was decided. Only the mid-term *CCS Primary Counseling Skills (Part I)* scores were collected as the final scores were potentially confounded by the rater's requirement to also determine whether the practicum student passed or not.

To control for internal validity, the hope scales and optimism questionnaire were administered to each student counselor at one point in time, controlling for effects of history, maturation, testing, instrumentation, and experimental mortality. Student counselors in a total of

eight practicum classes were expected to participate; however, only seven classes were filled. Initially, the number of student counselor participating was estimated to be 50 based on a conservative prediction of six to eight practicum student counselors in each of the eight classes; however the total number of participating student counselors was 43.

Research Design

This investigation's analysis included master's level practicum student counselors with client cases which included at least two symptom distress data points, one at intake and the second at the required four-week interval measurement or termination whichever occurred sooner *and* client satisfaction scores. The research design for this study was descriptive and correlational in nature. Correlational research was appropriate for this study as a number of paired variables (such as student counselor hope and client outcome – symptom distress and student counselor hope and client outcome – client satisfaction) were compared to determine the degree of the relationship(s) between them. Follow-up analysis to findings of significant correlation was conducted with regression procedures. For this investigation both Linear Regression (LR; one independent and one dependent variable) and Multiple Linear Regression (MLR; more than independent variables and one dependent variable) were conducted. Linear regression is used to determine how certain evaluators can be that an independent variable predicts or explains a dependent variable. In MLR, two or more independent variables are used to predict a single dependent variable. The intention of using multiple regression is to see how well more than one set of scores predicts a final set of scores (Sivo, 2008). Assumptions of the multiple regression include linearity, homoscedasticity (the constant variance of the error terms), the independence of error terms, and normality of the error term distribution.

Student counselors completed a demographic questionnaire which included questions regarding experience and confidence as an effective counselor post-graduation items. Student counselors' treatment prognoses were gathered from the diagnosis section of the psychosocial, which also provided client age, gender and ethnicity. The student counselor predictor variables, trait hope, state hope, and dispositional optimism, were compared through correlational and regression analysis to the clients' symptom distress and satisfaction scores for the first three research questions. The fourth (and final) research question examined student counselor skill scores from the 12 items comprising the *Primary Counseling Skills CCS* subsection (University of Central Florida Counselor Education Faculty, 2009) and compared the student counselor trait hope, state hope, and dispositional optimism using Pearson Product moment correlations.

Client outcomes were assessed by the OQ-45.2 (Lambert et al., 2004) measured at intake, every fourth week interval and lastly, captured at termination unless client dropout or earlier termination prevented the data collection. Client outcomes also included the client's satisfaction ratings from the UCF CQ, completed at the conclusion of therapy.

Overall, the aim of the study's first three research questions was to determine if these student counselor variables, trait hope, state hope, and dispositional optimism were related to client symptoms and satisfaction with treatment. The fourth research question in this study investigated if any relationships existed between practicum student counselors' skill scores and student counselor characteristics trait hope, state hope and dispositional optimism.

Follow up analysis:

Additional correlational procedures were conducted on items in a post-hoc (after the fact) data analysis. The student counselor trait hope, state hope, dispositional optimism scores and primary skill scores were compared with student counselor demographic items including gender

and age. No significant correlations were found between the student counselor hope, optimism, or skill scores with student counselor demographic items such as gender or age. Furthermore a relationship was sought between the student counselor hope and optimism scores and the student's responses to post-graduation expectations. A significant correlation was found between student counselor state and trait hope and the post-graduation expectation for working as an effective counselor. Where significant correlations were found, follow up analysis was conducted using Linear Regression and Multiple Linear Regression procedures.

Data Analysis

The data from the assessments used in this investigation were analyzed with the *Statistical Program Systems Software 17th edition* (SPSS). Following the collection of the data, the null hypotheses were initially tested with correlation coefficients (Pearson product moment correlation coefficients). Correlations were performed to reveal the amount of linear relationship between a pair of variables. Significant correlations were followed with linear, multiple, and multivariate regression analyses to determine of the nature of the relationships. Linear regression analysis was utilized to further investigate the relationship between two variables (one independent and one dependent variable), multiple regression was an appropriate statistical analysis in the event that two independent variables were paired with one dependent variable and multivariate regression analysis was utilized when one independent variable was utilized to predict two dependent variables.

In these follow up analyses, the regressions were also conducted to assist in understanding the significant correlations found between student counselor optimism scores and gender. The variable used to measure client outcome was the change in the OQ-45.2 symptom distress score from the first administration (baseline) to the second symptom distress score,

which most likely represented client termination. The measurement of change scores from self-reports of symptom distress is a convention of outcome research (Wampold & Bolt, 2006).

Following the correlational procedures, multiple linear regression procedures were conducted in which the data was tested for statistical assumptions including linearity, homoscedasticity, normality, and multicollinearity to ensure the statistical assumptions of these procedures were evaluated and met.

Ethical Considerations

Permission to perform this study was obtained from the UCF IRB Committee (SBE-10-07079; See Appendix B). Demographic and questionnaire data collected was kept confidentially by utilizing a coding system. Any information obtained about a participant in this study, including identity, was held confidential. Student counselors were offered the opportunity to participate in the study voluntarily, with the ability to withdraw consent and discontinue participation at any time, without penalty or consequence. Student counselors reviewed an informational participation form which included their name if agreed to participation which was kept separately from completed corresponding coded participant questionnaires. No identifying information connected the participant with the responses in the study. Only the investigator was knowledgeable of the code numbers assigned. Student counselors may have experienced increased anxiety as self-awareness increased about goals or goal pursuit for the present or future (hope) and orientation toward life (optimism) however there were no other known risks associated with this study. Benefits to participation in this study included a development of insights to feelings of hope, goal-directedness presently or for the future, or optimism as a result of completing the survey questionnaires.

Limitations to the Study

A number of limitations were observed in this study. One major limitation of this study is that it evaluated correlations between and among variables. Causality cannot be proven by evaluating the correlation between variables. While correlational studies can suggest a relationship between two variables, they cannot prove causality therefore there is no ability to indicate hope or optimism is directly responsible for client outcome. Second, the sample selected was a result of purposive sampling which makes it difficult to strongly infer quantitative information to another sample of the population of student counselors. Third, sample size is also a limitation for the study as it limited the statistical power available in data analysis. Fourth, self-reported questionnaire responses were subject to socially desirable responding, which was a potential limitation to the study, also. Social desirability is unable to be measured by any of the questionnaires or assessments given to the student counselors or clients. Social desirability detection has been incorporated into other psychological measures (e.g. *Minnesota Multiphasic Inventory-II* [*MMPI-II*]; Graham, 1993) as a measure of internal validity. Without this indicator, the reliability of the measures, and of the study, can be affected. Although precautions were taken to ensure that the threat to internal validity was minimized by administering the student counselors' questionnaires at one point in time, the clients were administered the OQ-45.2 on more than one occasion which may have created a practice effect related to their familiarity with the items and, in addition to socially desirable responding, clients may have responded inaccurately because of the familiarity with the instrument's questions.

This investigation did not interfere with Community Counseling Clinic client assignment procedures in order to assure random assignment to any given student counselor. The random assignment of clients to counselors does not occur if Community Counseling Clinic staff assigns

a client to a practicum student counselor based on their counseling track or performance, in some way. This potential non-random assignment of clients to student counselors would also be a potential limitation. No experimental control was exercised over the Community Counseling Clinic client assignment procedure. The Community Counseling Clinic clients were assigned to the student counselor on the basis of counselor availability and the clients' needs (i. e. couples to marriage and family track student counselors, children to school track student counselors). Although the clinic staff is directed to evenly distribute cases among practicum student counselors, it is improbable, but possible (by chance) that a disproportionate assignment of difficult or easy cases could occur.

Another possible limitation regards the clients who have received previous counseling treatment. Clients with previous counseling may have expressed less symptom distress as a result of the therapeutic gains; however, experienced clients may actually be suffering the same or more difficulties evidenced by their need to participate in ongoing counseling. Clients who expressed greater symptom distress at the start of the semester's treatment may have shown greater gains than those who began treatment with lower symptom distress scores which was a consideration in the analysis of data.

Conclusion

Participants were selected through purposive sampling. Student counselors were offered participation in the study due to their enrollment in the practicum classes being offered during the Fall of 2010. The clients were selected following their assignment to the student counselors and participation in counseling. Student counselors trait hope, state hope, and dispositional optimism were measured using the ADHS (Rand & Cheavens, 2009), the ASHS (Snyder et al., 1996), and the LOT-R (Scheier, Carver, & Bridges, 1994). Client outcome was determined by

using the difference between two client symptom distress scores measured by evaluating the change between the self-reported OQ-45.2 scores. That is the change score was calculated by deducting the difference from the second OQ-45.2 (Lambert et al, 2004) symptom distress score from the baseline OQ-45.2 (Lambert, et al., 2004) symptom distress score. Additionally client outcome was evaluated by evaluating the UCF CQ total client satisfaction scores as completed by the clients at the conclusion of their therapy. The null hypotheses were evaluated with Pearson product moment correlations and multiple linear regression using SPSS (17th edition, 2008). Additionally, using the same statistical software package, the follow-up analysis included exploratory factor analysis to further understand the construction of the instruments measuring the student counselors' trait hope, state hope, and dispositional optimism. Results of the analysis are discussed in the next chapter.

CHAPTER FOUR: RESULTS

This study investigated the relationship impact of student counselor characteristics of dispositional optimism, trait hope, and state hope on their clients' (change in) symptom distress scores and satisfaction inventory scores. The data were analyzed using the Statistical Package for the Social Sciences (SPSS). The chapter presents the results of the study according to: (a) sampling data collection procedures, (b) descriptive statistics, and (c) data analysis of the research hypotheses.

Sampling and Data Collection Procedures

The population for the present study consisted of two groups: (a) practicum counseling students attending in a master's-level graduate program at a large university, accredited by the Counsel for Accreditation of Counseling and Related Educational Programs (CACREP), and (b) their respective community-based adult clients. Prior to receiving institutional approval to conduct the study, the investigator received departmental approval through communication with the community counseling clinic's director and a letter to the counselor education faculty (Appendix F). The investigator received approval from the University of Central Florida Institutional Review Board (IRB) prior to collecting therapist and client data (SBE-10-07079; Appendix B).

After receiving permission from the IRB, the investigator provided information and questionnaire packets to each of the practicum instructors at the beginning of the Fall 2010 academic semester (See Appendix C). The packets included instructional reminders for each of the practicum supervisors, an information coversheet for each practicum counselor trainee to read prior to voluntarily agreeing to participate in the study (See Appendix D), and the assessment instruments to be completed. The instruments to be completed included:(a) the student demographic questionnaire, (b) the *Adult Dispositional Hope Scale* ("Future Scale"), (c)

the *Adult State Hope Scale* ("Goal Scale for the Present"), (d) the *Life Orientation Test-Revised.* The instruments' responses were collected at the beginning of the 2010 Fall semester. At the student counselors' mid-term, the counselor educator faculty practicum supervisor completed the *Counselor Competencies Scale* (CCS). The total scores from Part One (Primary Counseling Skills) of the CCS were used in this study (representing student skill construct) and can be found in Appendix A.

The individual client data were entered or uploaded into the clinic's computer database by the assigned student counselor(s) throughout the semester. The client data in this study were collected at the conclusion of the Fall 2010 semester by the investigator. The client data were obtained after receiving the clinic coordinator's approval and subsequent training to gather the specified information, including the client symptom distress scores from the *Outcome Questionnaire 45.2* (OQ-45.2; Lambert et al., 2004) and the scores from the University of Central Florida Community Counseling Clinic Questionnaire (UCF CQ), representing the client satisfaction construct. The researcher collected the following information from the client's intake form: gender, age, ethnicity, prognosis, number of sessions attended, and reason for case closure.

Sample Demographics

Practicum Students

The student participants in this study were master's level counseling practicum students enrolled in the one of the three program areas: (a) mental health, (b) marriage and family, and (c) school counseling during the Fall of 2010. Of the 44 practicum students enrolled, 43 (97.73%) participated in the study by completing the questionnaire packets. Student participants ages ranged from 23 to 40, with a mean of 27.49 years (SD = 4.79) with 32 (74.4%) females and 11

(25.6%) males. With regard to race and ethnicity, the students identified themselves as 72.1% Non-Hispanic Caucasian (n = 31), 18.6% Hispanic (n = 8), 7.0% Non-Hispanic African-American (n = 3), and 2.3% Asian (n = 1). Regarding their program of study, 44.2% of the student counselors reported mental health (n=19). Marriage and family program participants were represented by 34.9% (n = 15) students, and 18.6% of the counseling students were enrolled in the school counseling program (n = 8). One student (2.3%) reported having a dual track focus of mental health and school counseling. Twenty-two (51.2%) of the counselor trainees were in their first semester of practicum, 19 students (44.2%) were in their second semester of practicum, and 1 student (2.3%) was in the third practicum semester. Although this program typically involves two practicum semesters, occasionally a student will be required to participate in a third practicum if they require additional assistance, additional experience, or time to demonstrate satisfactorily the identified counselor skill competencies to move forward to internship placement and, ultimately, graduation.

Students were also asked to indicate how much professional counseling experience they had accumulated to date. Fifty-two point 4 percent had served in human services settings (n = 11), 38.1% had been in mental health settings (n = 8), 4.6 % in volunteer settings (n = 7), 19.0% had been in school settings (n = 4), and 5.7% had worked in "other" professional counselor settings (n = 1). Eleven of the 21 students (52%) described having experience in more than one professional arena. Of these 11 students' multiple previous experience settings, 6 (3.9%) worked in volunteer settings, 4 (2.6%) worked in human services settings, and 1 (2.3%) worked in a setting designated "other". Students' professional experience ranged from 1 – 120 months with an average of 15 months (SD = 21.77) experience (see Table 1)

In addition to the demographic data collected, student counselors were asked two questions on the demographic questionnaire regarding their a) confidence that they would work as a professional counselor following graduation and, b) confidence that they would be an effective counselor. The students were provided choices ranging from 1 (Very Unlikely/Extremely Unconfident) to 5 (Very likely/Very confident) and 6 (Unknown). See Tables 2 and 3 for the counseling students' post-graduation expectation items and their respective responses. Regarding their perceived likelihood of working as a professional counselor post-graduation 40 or 93% of the practicum students responded that they believed they were "Very Likely" to work post-graduation as a professional counselor, and 3 students (7%) responded as follows: (a) "Somewhat Likely" (n = 1); (b) "Likely" (n = *1)*; and (c) "Unlikely" (n = *1)*, respectively. Regarding their level of confidence to be an effective counselor 22 students (51.2 %) responded feeling "Very Confident" that they would be an effective counselor while 19 (44.2%) responded feeling "Somewhat Confident". The remaining 2 students (4.7%) responded feeling "Confident" about their likely efficacy as a counselor. It is noted that none of the students reported feeling "unconfident".

Table 1: Counselor Trainee Collective Demographic Characteristics

		N	Percent
Age	20 to 25	20	46.5
	26 to 30	16	37.3
	31 to 35	2	6.9
	36 to 40	5	9.3
Total		43	100.0
Gender	Male	11	25.6
	Female	32	74.4
Total		43	100.0
Ethnicity	Non-Hispanic Caucasian	31	72.1
	Hispanic/Latino	8	18.6
	Non-Hispanic African-American	3	7.0
	Asian	1	2.3
Total		43	100.0
Track	Mental Health	19	44.2
	Marriage and Family	15	34.9
	School	8	18.6
	Dual Mental Health/School	1	2.3
Total		43	100.0
Previous Experience	Human Services	11	7.2
	Mental Health	8	5.3
	Volunteer	7	4.6
	School		
	Other	1	2.3

Table 2: *Student Counselors' Post-Graduation Completion Confidence*

Response Choice	Frequency	Percent
Unlikely	1	2.3
Likely	1	2.3
Somewhat Likely	1	2.3
Very likely	40	93.0
Total	43	100.0

Table 3: *Student Counselors' Post-Graduation Efficacy Expectations*

Response Choice	Frequency	Percent
Confident	2	4.7
Somewhat Confident	19	44.2
Very Confident	22	51.2
Total	43	100.0

Clients

Clients with both comparison OQ-45.2 scores and UCF CQ (satisfaction) scores were available for 27 individual client cases (17.76 %). Of the 27 clients, 59.3% (n = 16) were female and 40.7% (n = 11) were male. Their ages ranged from 20 to 53, with a mean age of 34.04 (SD = 11.06). With respect to the ethnic composure, the client group was represented as 59.3% Caucasian (n = 16), 17.1 % Hispanic/Latino (n = 4), 3.7%, Asian (n = 1), and 3.7% Black/African American (n = 1) with 18.5% (5) unreported. The number of sessions attended by these clients were reported to range from 3 (n = 2; 7.4%) to 12 or greater (n = 6; 22.2%) with a mean of 10.29 (SD = .77) sessions. Three cases (11.1%) did not report number of sessions

attended. The prognoses assigned by the student therapists were Excellent (18.5%, *n* = 5), Good (33.3%, *n* = 9), and Fair (25.9 %, *n* = 7). Although none of these cases were assigned poor prognoses, 6 client cases (22.2) were unassigned. The reasons for therapists to close client cases included: a) planned pause in treatment 74.1% (*n* = 20) which generally meant that the client intended to continue treatment in the subsequent semester; b) goals were achieved (18.5%; *n* = 5); c) no discernable progress made by the client in treatment (3.7%, *n* = 1) and d) referral to additional or more appropriate community services (3.7%, *n* = 1). (See Table 4)

Table 4: *Client Demographic Characteristics*

		N	Percent
Age	20 to 29	10	37.0
	30 to 39	8	29.6
	40 to 49	3	11.1
	50 to 59	4	14.8
	Total	25	92.6
	Missing	2	7.4
Total		27	100.0
Gender	Male	11	40.7
	Female	16	59.3
Total		27	100.0
Ethnicity	Caucasian	16	59.3
	Hispanic/Latino	4	14.8
	Black/African-American	1	3.7
	Asian	1	3.7
	Did not report	4	14.8
Total		27	100.0
Prognosis	Excellent	5	18.5
	Good	9	33.3
	Fair	7	25.9
Total		21	77.8
Missing		6	22.2
Total		27	100.0
Reason for Closure	Planned Pause	20	74.1
	Goals Achieved	5	18.5
	No Progress	1	3.7
	Referral to Community	1	3.7
Total		27	100.0

Descriptive Statistics

Adult Dispositional Hope Scale (Student Counselors)

The Adult Dispositional Hope Scale (ADHS; Rand & Cheavens, 2009). The ADHS is an instrument measuring trait hope (Snyder, 1991). Trait hope is an individual's characteristic tendency to be hopeful which is relatively constant over time. Trait hope is defined by two interacting factors, Agency and Pathways. Agency refers to an individual's goal-directed energies and Pathways refers to the individual's initial and ongoing planning to meet those goals. The score for the ADHS was calculated by summing each of the four Agency and four Pathways items. (See Table 5)

Table 5: *Descriptive Statistics for Adult Dispositional Hope Scale (Trait Hope)*

N	*Range*	*Minimum*	*Maximum*	*Mean*	*Std.Deviation*	*Variance*
43	22	40	62	52.79	4.916	24.169

Adult State Hope Scale (Student Counselors)

The Adult State Hope Scale (ASHS; Snyder et al., 1996). The ASHS is an instrument that measures hope as a state characteristic, that is, a characteristic that an individual expresses at specific times during their life. The scale contains "filler items" which were added by the test authors who included these items to increase possibly to disguise in some way the purpose of the questionnaire. The filler items were not calculated for the total score. Because the dispositional and state hope scales are very similar, measuring the same construct, with the distinction being the emphasis on time, examples of the instrument items are presented below. (See Tables 6 & 7)

Table 6: Trait Hope (*Adult Dispositional Hope Scale / "Future Scale")* and State Hope (*Adult State Hope Scale / "Goals Scale for the Present")* Instrument Items

	Trait Hope / Adult Dispositional Hope Scale	*State Hope / Adult State Hope Scale*
Agency Subscale	I energetically pursue my goals.	At the present time, I am energetically pursuing my goals
	I've been pretty successful in life.	Right now, I see myself as being pretty successful.
	I meet the goals I set for myself.	At this time, I am meeting the goals that I have set for myself
Pathways Subscale	I can think of many ways to get out of a jam.	If I should find myself in a jam, I could think of many ways to get out of it.
	There are lots of ways around any problem	There are a lot of ways around any problem that I am facing now.
	I can think of many ways in life to get the things that are most important to me.	I can think of many ways to reach my current goals.

Table 7: *Descriptive Statistics for Adult State Hope Scale*

N	*Range*	*Minimum*	*Maximum*	*Mean*	*Std. Deviation*	*Variance*
43	17	29	46	39.70	3.864	14.930

Life Orientation Test-Revised (Student Counselors)

The Life Orientation Test-Revised (LOT-R; Scheier, Carver & Bridges, 1994*).* The LOT-R is a measure of dispositional (trait) optimism. The final LOT-R score is made up of 6 of 10 items used to derive a total optimism score. Four filler items are not used in scoring. The negatively worded items (i.e. Items 3, 7, 9) were reverse coded before scoring. The items are added to positively worded response items 1, 4, and 10 to compute an overall optimism score which can range from 0 to 24. Participants responded with their level of agreement to each of

the items using the following response format: 0 = strongly agree, 1 = disagree, 2 = neutral, 3= agree, and 4 = strongly agree. (See Table 8)

Table 8: *Descriptive Statistics for the Life Orientation Test-Revised*

N	*Range*	*Minimum*	*Maximum*	*Mean*	*Std.Deviation*	*Variance*
43	7	7	14	11.26	1.620	2.623

Outcome Questionnaire 45.2 (Clients)

The Outcome Questionnaire-45.2 (OQ-45.2: Lambert, 2004). The OQ-45.2 assessed global psychological distress in three areas: (a) symptom distress, (b) interpersonal relations, and (c) social role. For the purposes of this study, total symptom distress change scores were used as the measure of symptom distress which contributed to the overall definition of client outcome (see Table 9). The change score was calculated by subtracting pre and post test scores for each client.

Table 9: *Descriptive Statistics for Outcome Questionnaire 45.2 Change Score*

N	*Range*	*Minimum*	*Maximum*	*Mean*	*Std.Deviation*	*Variance*
41	66.00	-35.00	31	-.7800	9.876	97.526

University of Central Florida Community Counseling Clinic Questionnaire (UCF CQ; Clients)

The UCF CQ is an instrument used to assess the clients' perception of their counseling experience in the community counseling clinic and the second instrument

used to assess client outcome. The UCF CQ is a non-standardized instrument to survey clients' attitudes and opinions about their therapy experience. Clients completed the UCF CQ items and answered eight questions about their satisfaction with the quality of the treatment, the service received, and how well they felt their needs were met. Clients were asked if they would refer a friend to the clinic for services in addition to their satisfaction with the personal changes they experienced and efficacy of the therapy. Clients answers to each question corresponded to a rating scale ranging from 1 (Poor/Never/Not well at all/No/Not at all Satisfied) to 4 (Excellent/Always/Very well/Definitely/ Very satisfied). See Appendix A.

This study's sample of participants had a mean level of satisfaction of (M = 29.95, SD = 3.33) with a modal satisfactory response of 4.0, the highest satisfaction response available for each item. Clients' mean response regarding (a) their satisfaction with the quality of services was (M = 3.96, SD = .192), (b) receiving the services they desired (M = 3.70, SD = .724), (c) how well their needs were met (M = 3.81, SD = .622), (d) if they would recommend the services of the clinic to a friend (M = 3.89, SD = .320), (e) satisfaction with the amount of help received (M = 3.85, SD = .456), (f) if they were dealing more effectively with their problems after counseling (M = 3.67, SD = .620), (g) overall satisfaction (M = 3.56, SD = 1.086), and (h) if they would return to the community counseling clinic in the future (M = 3.70, SD = 1.068) (See Table 10)

Table 10: *University of Central Florida Community Counseling Clinic Questionnaire Ratings*

Item	Mean	Mode	Standard Deviation
Were you satisfied with the quality of the services you have received?	3.96	4.0	.192
When you came to the Community Counseling Clinic, did you receive the service you wanted?	3.70	4.0	.724
How well did we meet your needs?	3.81	4.0	.622
Would you recommend the services of the Community Counseling Clinic to a friend?	3.89	4.0	.320
Regarding the amount of help you received how satisfied are you?	3.85	4.0	.456
Are you dealing with your problems more effectively as a result of the services you have received?	3.67	4.0	.620
Overall, regarding the services you received, how satisfied are you?	3.56	4.0	1.086
Would you return to the Community Counseling Clinic in the future if you felt you needed help?	3.70	4.0	1.068

Data Analysis and Research Results for Hypotheses

The research data were analyzed using the Statistical Package for the Social Sciences (SPSS). The null hypotheses were evaluated below using Pearson correlations and multiple regressions in order to calculate relationships between variables.

Multiple Regression

Multiple regression analysis was planned for each of the null hypotheses related to student counselors' levels of hope and optimism and client outcomes. The independent variables

included the counselors' trait hope (represented by the total score on the *Adult Dispositional Hope Scale*), the student counselors' state hope score (represented by the total score on the *Adult State Hope Scale*) and the student counselors' dispositional optimism score, (represented by the total score obtained on the *Life Orientation Test-Revised*). The dependent variable, client outcome, was represented by the client's OQ-45.2 change score and the UCF CQ (satisfaction) score. The OQ45.2 scores were collected from the initial assessment at the beginning of counseling and again at least four weeks after the beginning of treatment or at termination, whichever occurred sooner. The change score was calculated by subtracting the final client OQ45.2 scores from the client's initial (baseline) OQ45.2 scores. The UCF CQ scores were determined by the sum total of each of the eight items. In addition, the student counselors' skills score was from Part I, *Primary Counseling Skills* subscale score from the *Counselor Competencies Scale* rated by the Counselor Education faculty practicum supervisor at mid-term.

Null Hypothesis One stated there is no correlation between practicum counselor education students' trait hope scores and client symptom distress and client satisfaction. A review of the correlation matrix revealed that no correlations were found between students' trait hope, client symptom distress scores, and client satisfaction using Pearson's correlation. Additionally, no correlation was found between comparison client symptom distress scores and client satisfaction scores. (See Tables 11 & 12)

Table 11: *Descriptive Statistics of Practicum Student Trait Hope and Client Outcomes (n = 27)*

Item	Mean	Standard Deviation
Student Trait Hope	53.48	4.57
Client Symptom Distress Change Scores	-.7400	11.75
Client Satisfaction	30.15	3.77

Table 12: *Correlation Matrix of Student Counselor Trait Hope, Client Symptom Distress and Satisfaction* [a]

	Variables	(1)	(2)	(3)
(1)	Student Counselor Trait Hope	1.00		
(2)	Client Symptom Distress Change	.216	1.00	
(3)	Client Satisfaction	.226	-.150	1.00

a Product moment correlations of data given in Table 12.
*Correlation is significant at the 0.05 level, $p < .05$

With regard to student's trait hope, there was no significant correlation between students' trait hope (M = 53.48, SD = 4.57) and client symptom distress change (M = -.74, SD = 11.75), r = .216, p = .139, n = 27 and no significant correlation between student's trait hope (M = 53.48, SD = 4.57) and client satisfaction (M = 30.15, SD = 3.77), r = .226, p =.129, n =27. Additionally there was no correlation between client symptom distress change (M = -.74, SD = 11.75) and client satisfaction (M =30.15, SD = 3.77), r = -.150, p = .227, n= *27*). Regarding the variables in research question one, no regression analysis was performed because no significant correlations were found with student counselor trait hope and client symptom distress and client satisfaction

Null Hypothesis Two stated there is no correlation between practicum counselor education students' state hope scores and client symptom distress and client satisfaction.

A review of the correlation matrix revealed no significant correlation between student counselors' state hope and client symptom distress using Pearson's correlation. However, a statistically significant correlation was found between students' state hope and client satisfaction. (See Tables 13&14)

Table 13*: Descriptive Statistics of Practicum Student State Hope and Client Outcomes (n = 27)*

Item	Mean	Standard Deviation
Student State Hope	40.30	3.58
Client Symptom Distress Change Score	-.7400	11.75
Overall Client Satisfaction	30.15	3.77

Table 14: *Correlation Matrix of Practicum Student State Hope and Symptom Distress Outcome Measures and Client Satisfaction* [a] *(n=27)*

	Item	(1)	(2)	(3)
(1)	Student Counselor State Hope	1.00		
(2)	Client Symptom Distress Change	.059	1.00	
(3)	Client Satisfaction	.327*	-.150	1.00

a Product moment correlations of data given in Table 12.
*. Correlation is significant at the .05 level, $p < .05$

A review of the matrix reveals that no significant correlations were found between students' state hope (M = 40.30, SD = 3.58) and client symptom distress (M = -.74, SD = 11.75) using Pearson's correlation r = .057, p = .384. However, a statistically significant correlation was found between students' state hope (M = 40.30, SD = 3.58) and client satisfaction (M = 30.15, SD = 3.77), r = .327, p = .048, n = 27, suggesting roughly a 10.69% overlap between the two variables in terms of the variance shared.

Overall the linear composite of the independent variable entered into the regression procedure predicted (or explained) 10.7% of the variation in the dependent criterion, F (1, 25) = 2.994, p = .096 (See Tables 15 & 16)

Table 15: *Linear Regression Analysis*

						Change Statistics		
R	R Square	Adjusted R Square	Std Error of the Estimate	R Square Change	F Change	df1	df2	Sig F Change
.327	.107	.071	3.6326	.107	2.994	1	25	.096

Table 16: *ANOVA Table*

Models	Sum of Squares	df	Mean Square	F	Sig.
Regression	39.512	1	39.512	2.994	.096
Residual	329.895	25	13.196		
Total	369.407	26			

The confidence interval around the b weight obtained for the independent variable included zero as a probable value among other probable values, so Null Hypothesis Two was not rejected. See Table 17. This suggests that the results for the independent variable should not be retained in the specified model. Because the b weight turned out not to be statistically significant, the overall model (i.e., the regression equation) is not supported.

Table 17: *Coefficients for Independent Variable State Hope and Dependent Variable Client Satisfaction*

Model	Unstandardized Coefficients		Standardized Coefficients	T	Sig.	95.0% Confidence Interval for B		Correlations			Collinearity Statistics	
	B	Std. Error	Beta			Lower Bound	Upper Bound	Zero-order	Partial	Part	Tolerance	VIF
1 (Constant)	16.281	8.044		2.024	.054	-.287	32.849					
State Hope	.344	.199	.327	1.730	.096	-.065	.754	.327	.327	.327	1.000	1.000

Dependent Variable: Client Satisfaction

Null Hypothesis Three stated that stated there is no correlation between practicum counselor education students' dispositional optimism scores and client symptom distress and client satisfaction. A review of the correlation matrix reveals that no significant correlations were found between students' dispositional optimism, client symptom distress, and client satisfaction using Pearson's correlation. (See Tables 18 &19)

Table 18: *Descriptive Statistics of Practicum Student Dispositional Optimism and Client Symptom Distress Outcomes Measures and Client Satisfaction (n = 27)*

Item	Mean	Standard Deviation
Student Dispositional Optimism	10.96	1.85
Client Symptom Distress Change Score	-.7400	11.75
Overall Client Satisfaction	30.15	3.77

Table 19: *Matrix of Practicum Student Dispositional Optimism Symptom and Symptom Distress and Client Satisfaction*[a] *(n = 27)*

	Variables	(a)	(b)	(c)
(a)	Student Counselor Dispositional Optimism	1.00		
(b)	Client Symptom Distress Change Scores	.176	1.00	
(c)	Client Satisfaction	-.203	-.150	1.00

a. Product moment correlations of data given in Table 12.
*.Correlation is significant at the 0.05 level, $p < .05$

There was no significant correlation between student counselor dispositional optimism (*M* =10.96, *SD* = 1.85) and client symptom distress change (*M* =.-74, *SD* =11.74), r = .176, *p* =.190, *n* = 27; no significant correlation between student dispositional optimism (*M* =10.96, *SD* = 1.85) and client satisfaction (*M* =30.15, *SD* =3.77), r = -.203, *p* = .155, *n* = 27.

Null Hypothesis Four stated there is no relationship between practicum counselor education students' skill and counselor trait hope, state hope, and dispositional optimism. A review of the correlation matrix reveals that no significant correlations were found between student skill (as measured by Part I, *Primary Counseling Skills,* of the *Counselor Competency Scale),* trait hope, or dispositional optimism. However, a significant correlation was found between student counselor skill and state hope. Furthermore, a significant correlation was found between student state hope and student trait hope. Student trait hope was also statistically positively correlated with dispositional optimism. (See Tables 20 & 21)

Table 20: *Descriptive Statistics of Practicum Student Skill, Trait Hope, State Hope and Dispositional Optimism (n = 43)*

Item	Mean	Standard Deviation
Student Skill	68.16	8.83
Student Trait Hope	52.79	4.92
Student State Hope	39.70	3.86
Student Dispositional Optimism	11.26	1.62

Counselor education students' skill scores (M = 68.16, SD = 8.83), were not significantly correlated with trait hope (M = 52.79, SD = 4.92), r = .183, p =.120 and counselor education student' skill scores (M = 68.16, SD = 8.83) were not significantly correlated with dispositional optimism (M = 11.26, SD = 1.62), r = .167, p =.142.

However, counselor education students' skill scores (M = 68.16, SD = 8.83) were positively correlated with student counselors' state hope (M = 39.70, SD = 3.86), r = .273, p = .038, n = 43, suggesting that roughly 7.5% overlap exists between the two variables in terms of the variance shared. (See Table 21).

Table 21: *Correlation Matrix Practicum Student Skill, Trait Hope, State Hope and Dispositional Optimism*[a] (*n* = 43)

	Variable	(a)	(b)	(c)	(d)
(a)	Student Skill	1.00			
(b)	Student Trait Hope	.226	1.00		
(c)	Student State Hope	.273*	.851**	1.00	
(d)	Student Dispositional Optimism	.075	.309*	.222	1.00

a Product moment correlations of data given in Table 12.
*Correlation is significant at the 0.05 level, p < .05
** Correlation is significant at the 0.01 level, p < .001

The independent variable was state hope and the dependent variable, counselor skill. Overall, the linear composite of the independent variable entered into the regression procedure predicted 7.5% of the variation in the dependent criterion F (1, 41) = 3.303, = .076 (See Tables 22 & 23)

Table 22: *Linear Regression Analysis*

						Change Statistics		
R	R Square	Adjusted R Square	Std Error of the Estimate	R Square Change	F Change	df1	df2	Sig F Change
.273	.075	.052	8.59369	.075	3.303	1	41	.076

Table 23: *ANOVA Table*

Models	Sum of Squares	Df	Mean Square	F	Sig.
Regression	243.947	1	243.947	3.303	.076
Residual	3027.913	41	73.852		
Total	3271.860	42			

The confidence interval round the b weight obtained for the independent variable, state hope, did include zero as a probable value among other probable values, so the null hypothesis is not rejected; it is not confirmed. See Table 24.

Table 24: *Coefficients for Independent Variable State Hope and Dependent Variable Counselor Skill*

Model	Unstandardized Coefficients		Standardized Coefficients			95.0% Confidence Interval for B		Correlations			Collinearity Statistics	
	B	Std. Error	Beta	T	Sig.	Lower Bound	Upper Bound	Zero-order	Partial	Part	Tolerance	VIF
1 (Constant)	43.403	13.686		3.171	.003	15.762	71.043					
State Hope	.624	.343	.273	1.817	.076	-.069	1.317	.273	.273	.273	1.000	1.000

Dependent Variable: Counselor Skill

In addition, students' state hope (M = 39.70, SD = 3.86) was significantly correlated with students' trait hope (M = 52.79, SD = 4.92), r = .851, p <.001, n = 43 suggesting that roughly 26.4% overlap between the state hope and trait in terms of the variance shared. Theoretically, trait hope is an underlying personality characteristic that is enduring over time and state hope is a characteristic that may be expressed by an individual situationally. Trait hope individuals may be more likely to evince state hope characteristics; however, the expression of hope in any given potentially hopeful moment is not limited to individuals who have a characteristically hopeful

manner as a trait. Therefore, the independent variable was trait hope and the dependent variable was state hope. Overall, the linear composite of the independent variable entered into the regression procedure predicted 72.5% of the variation in the dependent criterion F (1, 41) = 108.825, $p < .001$ (See Tables 25 & 26)

Table 25: *Linear Regression Analysis*

						Change Statistics		
R	R Square	Adjusted R Square	Std Error of the Estimate	R Square Change	F Change	df1	df2	Sig F Change
.851	.725	.718	2.05130	.725	108.025	1	41	.000

Table 26: *ANOVA Table*

Models	Sum of Squares	df	Mean Square	F	Sig.
Regression	454.549	1	454.549	108.025	.000
Residual	172.521	41	4.208		
Total	627.070	42			

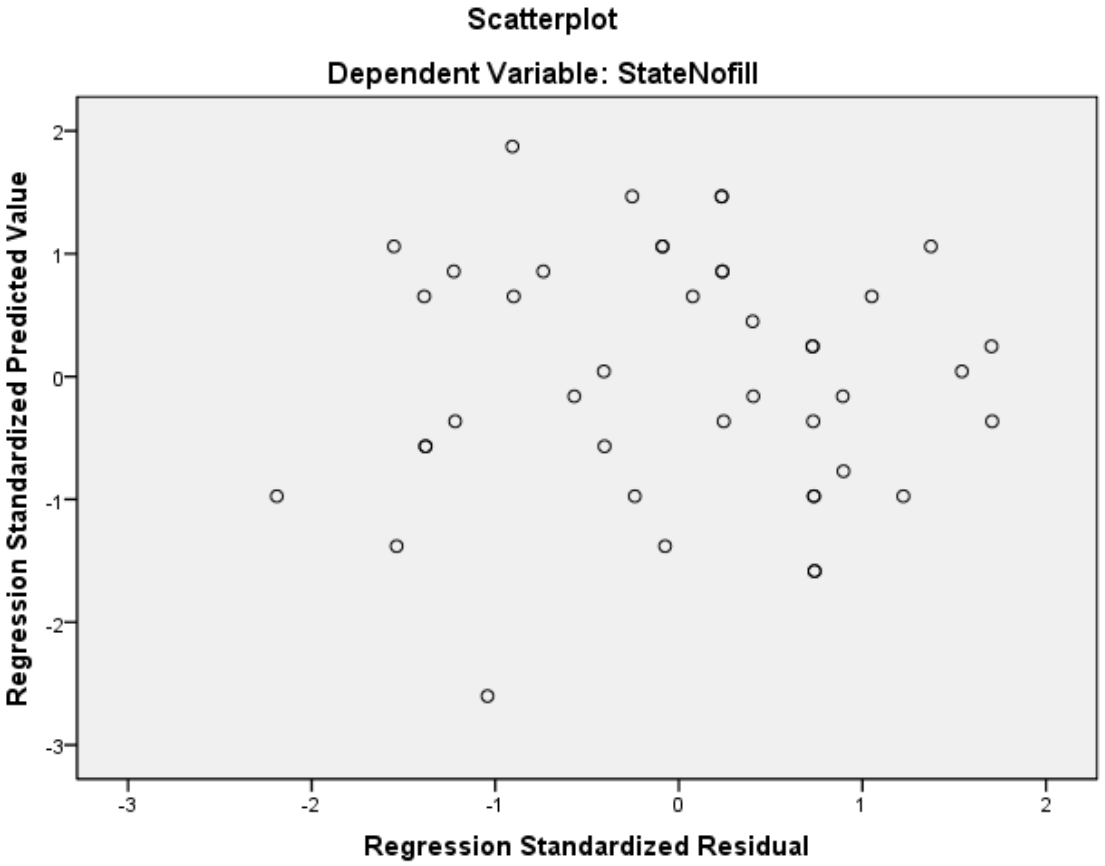
The confidence interval around the respective b weight did not include zero as a probable value, so the estimate is statistically significant. This suggests that the results for the independent variable, trait hope, are precise enough to be retained in the specified model. See Table 27. Inspection of the plot of the standardized residuals against the predicted values did not evidence either a non-linear trend or heteroscedasticity. See Figure 5. Because the b weight is statistically significant, the overall model (i.e., the regression equation) is supported.

Table 27: *Coefficients for Independent Variable Trait Hope and Dependent Variable State Hope*

Model	Unstandardized Coefficients		Standardized Coefficients	T	Sig.	95.0% Confidence Interval for B		Correlations			Collinearity Statistics	
	B	Std. Error	Beta			Lower Bound	Upper Bound	Zero-order	Partial	Part	Tolerance	VIF
1 (Constant)	4.372	3.413		1.281	.207	-2.521	11.265					
Trait Hope	.669	.064	.851	10.393	.000	.539	.799	.851	.851	.851	1.000	1.000

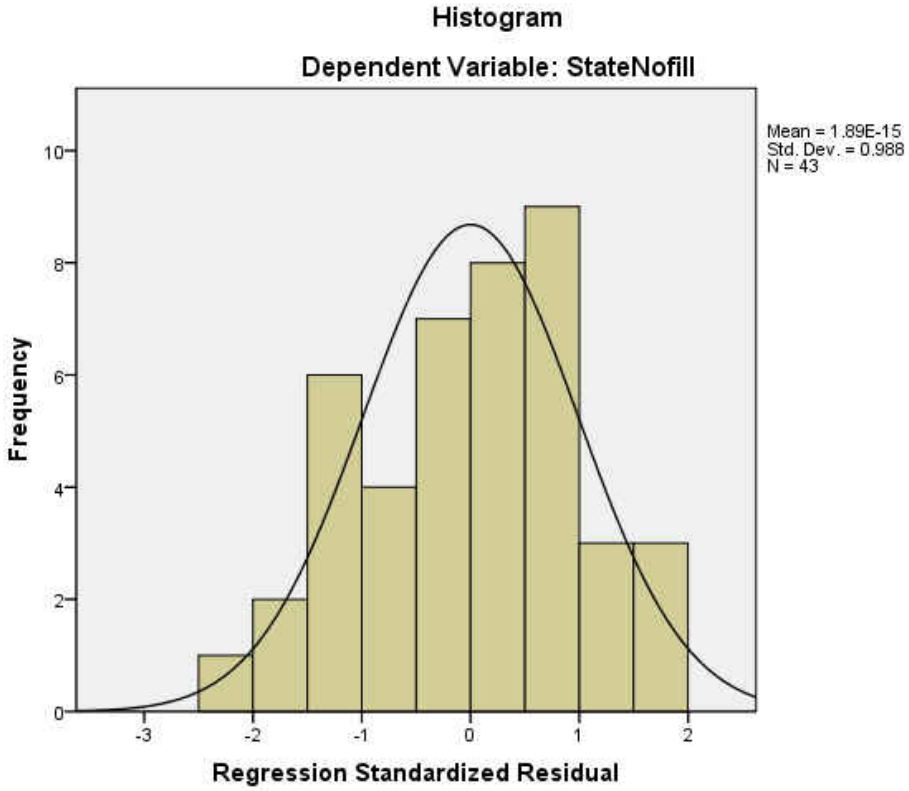
Dependent Variable: State Hope

Figure 1: *Scatterplot*



Moreover, the distribution of the standardized errors sufficiently approximated normality. See Figure 2.

Figure 2: *Histogram*



Students' trait hope (M = 52.79, SD = 4.92) was also significantly correlated with students' dispositional optimism (M = 11.26, SD = 1.62), r = .309, p = .022, suggesting that roughly 6.7% overlap exists between trait hope and dispositional optimism in terms of the variance shared.

The multiple regression performed also found a significant positive correlation. Trait hope and dispositional optimism are two personality traits. A decision was made by the investigator to treat trait hope as the independent variable and dispositional optimism as the dependent variable. Overall, the linear composite of the independent variable entered into the

regression procedure predicted 30.9% of the variation in the dependent criterion F (1, 41) = 4.324, p = .044 (See Tables 28 and 29).

Table 28: *Linear Regression Analysis*

						Change Statistics		
R	R Square	Adjusted R Square	Std Error of the Estimate	R Square Change	F Change	df1	df2	Sig F Change
.309	.095	.073	1.55919	.095	4.324	1	41	.044

Table 29: *ANOVA Table*

Models	Sum of Squares	Df	Mean Square	F	Sig.
Regression	10.512	1	10.512	4.324	.044
Residual	99.674	41	2.461		
Total	110.186	42			

An examination of the confidence intervals around the b weights revealed zero was not a probable value, so the estimate is statistically significant. This suggests that the results for the independent variable are precise enough to be retained in the specified model. (See Table 30).

Table 30: *Coefficients for Independent Variable Trait Hope and Dependent Variable Dispositional Optimism*

Model	Unstandardized Coefficients		Standardized Coefficients			95.0% Confidence Interval for B		Correlations			Collinearity Statistics	
	B	Std. Error	Beta	T	Sig.	Lower Bound	Upper Bound	Zero-order	Partial	Part	Tolerance	VIF
1 (Constant)	5.884	2.594		2.268	.029	.644	11.123					
Trait Hope	.102	.049	.309	2.079	.044	.003	.201	.309	.309	.309	1.000	1.000

Dependent Variable: Dispositional Optimism

Inspection of the plot of the standardized residuals against the predicted values did not evidence either a non-linear trend or heteroscedasticity. See Figure 3. Moreover, the distribution of the standardized errors sufficiently approximated normality. See Figure 4. Because the b weight turned out to be statistically significant, the overall model (i.e., the regression equation) is supported.

Figure 3: *Scatterplot*

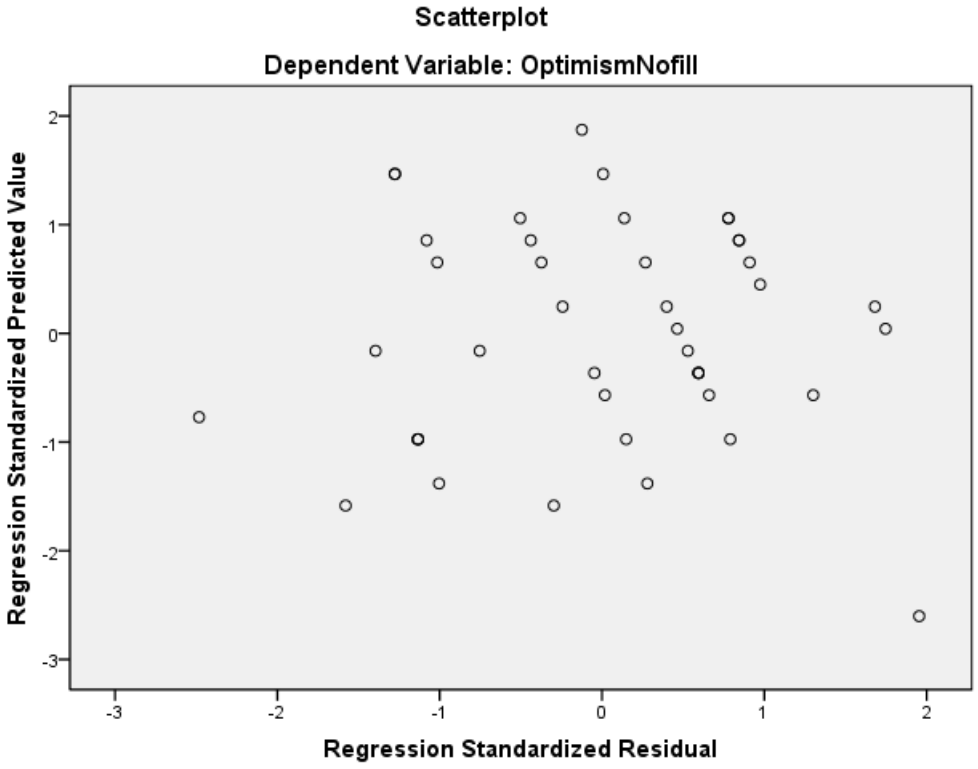
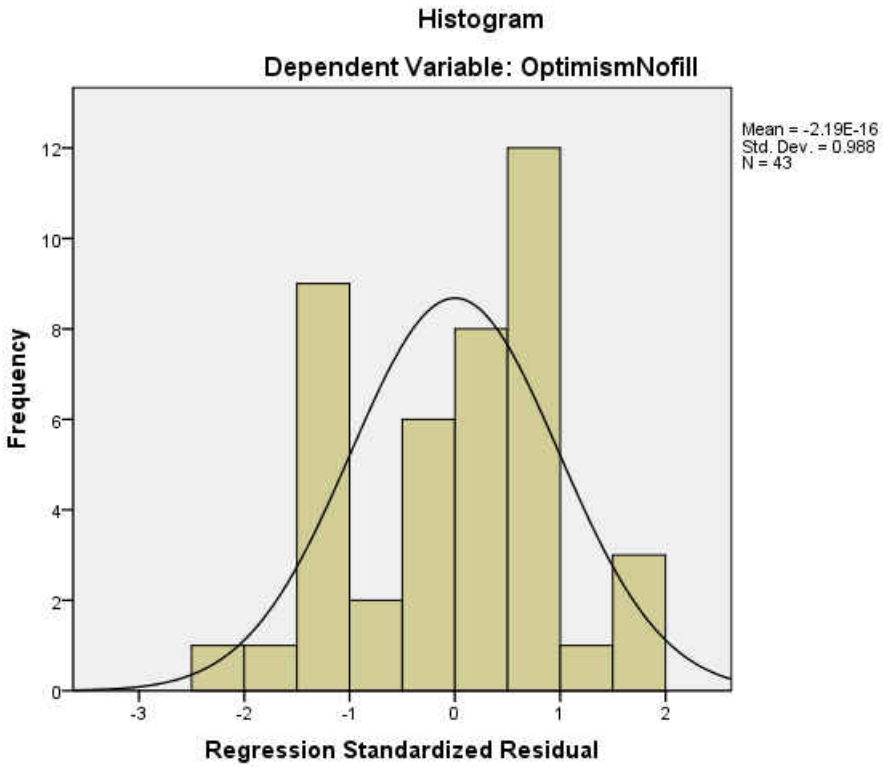


Figure 4: *Histogram*



Follow-up analysis

Follow-up analyses were performed among the students' skill scores, trait hope, state hope, dispositional optimism, and individual counselor variables age, gender, and practicum level. No significant correlations were found.

Additionally, follow-up analyses were conducted between the student counselors' trait hope, state hope, and dispositional optimism and the student counselors' post-graduation demographic responses regarding "Completion Confidence" (confidence to work as a professional counselor post-graduation) and "Efficacy Expectations" (likelihood of being effective as a counselor post-graduation). An examination of the correlation matrix revealed

positive correlations between both trait hope and state hope with both completion confidence and with efficacy expectations. See Table 31.

Table 31: *Descriptive Statistics of Student Counselor Trait Hope, State Hope, and Completion Confidence, and Efficacy Expectations* (*n* = 43)

Item	Mean	Standard Deviation
Student Counselor Trait Hope	52.79	4.92
Student Counselor State Hope	39.70	3.86
Student Counselor Dispositional Optimism	11.26	1.62
Completion Confidence	4.86	.560
Efficacy Expectations	4.47	.592

Trait hope (*M* = 52.79, SD = 4.92) and state hope (*M* = 39.70, SD = 3.86) were positively correlated with student counselors Completion Confidence (*M* = 4.86, *SD* = .560), r = .370, *p* = .007 and r=.409, *p* =.003, respectively. This suggests that trait hope is responsible for roughly 13.69% of the variance shared and state hope is responsible for roughly 16.73% of the variance shared with Completion Confidence. See Table 32

Table 32: Correlation Matrix of Student Counselor Trait Hope, State Hope, Dispositional Optimism and Completion Confidence [a] (n = 43)

	Variable	(a)	(b)	(c)	(d)
(a)	Student Trait Hope	1.00			
(b)	Student State Hope	.851**	1.00		
(c)	Student Dispositional Optimism	.309*	.222	1.00	
(d)	Completion Confidence	-.370**	-.344*	.117	1.00

a Product moment correlations of data given in Table 12.
*. Correlation is significant at the .05 level, p < .05
**. Correlation is significant at the .001 level, p < .001

Overall, the linear composite of the independent variable entered into the regression procedure predicted 16.9% of the variation in the dependent criterion F (2, 40) = 4.073, p = .025 (See Tables 30 and 31). The two confidence intervals around their respective b weights included zero, thus, the overall model (the regression equation) is not supported. See Tables 33, 34, & 35)

Table 33: *Multiple Regression Analysis*

						Change Statistics		
R	R Square	Adjusted R Square	Std Error of the Estimate	R Square Change	F Change	df1	df2	Sig F Change
.411	.169	.128	.523	.169	4.073	2	40	.025

Table 34: *ANOVA Table*

Models	Sum of Squares	Df	Mean Square	F	Sig.
Regression	2.227	2	1.113	4.073	.025
Residual	10.936	40	.273		
Total	13.163	42			

Table 35: *Coefficients for Independent Variables Trait and State Hope and Dependent Variable Post-Graduation Completion Confidence*

Model	Unstandardized Coefficients		Standardized Coefficients			95.0% Confidence Interval for B		Correlations			Collinearity Statistics	
	B	Std. Error	Beta	T	Sig.	Lower Bound	Upper Bound	Zero-order	Partial	Part	Tolerance	VIF
1 (Constant)	3.580	.887		4.035	.000	1.787	5.373					
Trait Hope	-.009	.031	-.077	-.282	.780	-.072	.054	-.370	-.045	-.041	.275	3.635
State Hope	-.050	.040	-.343	-1.250	.219	-.130	.031	-.409	-.194	-.180	.275	3.635

Dependent Variable Post Graduation Completion Confidence

Trait hope (M = 52.79, SD = 4.92) and state hope (M = 39.70, SD = 3.86) were positively correlated with student counselors efficacy expectations (M = 4.47, SD = .592), r = .313, p = .021 and r = .344, p =.012, respectively. This suggests that trait hope is responsible for roughly 9.80% of the variance shared and state hope is responsible for roughly 11.83% of the variance shared with students' efficacy expectations. See Table 36.

Table 36: Correlation Matrix of Student Counselor Trait Hope, State Hope, Dispositional Optimism and Post-Graduation Efficacy Expectations[a] (n = 43)

Item	(a)	(b)	(c)	(d)
Student Trait Hope	1.00			
Student State Hope	.851**	1.00		
Student Dispositional Optimism	.309*	.222	1.00	
Efficacy Expectations	-.370**	-.344*	.117	1.00

a Product moment correlations of data given in Table 36.
*. Correlation is significant at the 0.05 level, $p < .05$
**. Correlation is significant at the 0.001 level, $p < .001$

Overall, the linear composite of the independent variables, trait hope and state hope, entered into the regression procedure predicted 12.0 % of the variation in the dependent criterion $F(2, 40) = 2.724$, $p = .078$ (See Tables 37 & 38).

Table 37: Multiple Regression Analysis

					Change Statistics			
R	R Square	Adjusted R Square	Std Error of the Estimate	R Square Change	F Change	df1	df2	Sig F Change
.346	.120	.076	.569	.120	2.724	2	40	.

Table 38: *ANOVA Table*

Models	Sum of Squares	Df	Mean Square	F	Sig.
Regression	1.762	2	.881	2.724	.078
Residual	12.936	40	.323		
Total	14.698	42			

The confidence intervals, however, around the respective b weights included zero the overall model (the regression equation) is not supported. See Table 39.

Table 39: *Coefficients for Independent Variables Trait and State Hope and Dependent Variable Post-Graduation Efficacy Expectations*

Model	Unstandardized Coefficients		Standardized Coefficients			95.0% Confidence Interval for B		Correlations			Collinearity Statistics	
	B	Std. Error	Beta	T	Sig.	Lower Bound	Upper Bound	Zero-order	Partial	Part	Tolerance	VIF
1 (Constant)	3.711	.965		3.845	.000	1.760	5.661					
Trait Hope	-.009	.034	-.071	-.251	.803	-.077	.060	-.313	-.040	-.037	.275	3.635
State Hope	-.043	.043	-.284	-1.003	.322	-.131	.044	-.344	-.157	-.149	.275	3.635

Dependent Variable: Post-Graduation Efficacy Expectations

Research Questions and Hypotheses

The first research question asked if a relationship existed among practicum counselor education students' trait hope scores (as measured by the *Adult Dispositional Hope Scale) and* client levels of symptom distress (as measured by the *Outcome Questionnaire*) and client satisfaction (as measured by the *University of Central Florida Community Counseling Clinic Questionnaire*). The null hypothesis stated that there was no correlation among student

counselors' trait hope scores and client symptom distress and client satisfaction. There were no correlations found between practicum counselor education students' trait hope scores and client symptom distress change scores and no correlation found between practicum counselor education students' trait hope and client satisfaction scores. Therefore, the first null hypothesis was not rejected.

The second research question asked, "What is the relationship among practicum counselor education students' state hope (as measured by the *Adult State Hope Scale)* and the client levels of symptom distress (as measured by the *Outcome Questionnaire 45.2)* and client satisfaction?" Although the students' state hope was not correlated with the client symptom distress scores, there was a statistically significant positive correlation between student counselor state hope and client satisfaction, r=.327, p =.048, suggesting roughly a 10.69% overlap between the two variables in terms of the variance shared. Therefore the second null hypothesis, which stated there is no correlation among practicum counselor education students' state hope scores and client symptom distress and client satisfaction was tentatively rejected because of the positive relationship found between student counselor state hope and client satisfaction. The follow up multiple regression procedure did not support the inclusion in the regression equation; therefore the second null hypothesis was not rejected.

The third research question asked, "What is the relationship among practicum counselor education students' dispositional optimism scores (as measured by the *Life Orientation Test-Revised (LOT-R*; Scheier, Carver, & Bridges, 1994) and client symptom distress scores distress (as measured by the *Outcome Questionnaire (OQ-45.2*; Lambert, 2004) and client satisfaction scores (as measured by the University of Central Florida Community Counseling Clinic Questionnaire)?" There were no correlations found among practicum counselor education

students' dispositional optimism scores and client symptom distress change scores (as measured by the *Outcome Questionnaire*) and no correlation found between practicum counselor education students' dispositional optimism and client satisfaction scores. Therefore, the third null hypothesis was not rejected.

The fourth research question sought to explore the relationship between practicum counselor education students' primary (as measured by Part I, Primary Counseling Skills of the *Counselor Competencies Scale*) and counselor education students' trait hope (as measured by the *Adult Dispositional Hope Scale*), state hope (as measured by the *Adult State Hope Scale*) and dispositional optimism (as measured by the *Life Orientation Test-Revised*). No correlation was found between counselor students' skill and student counselor trait hope or counselor education student's skill and student counselor dispositional optimism. Student skill was found to be positively correlated with student counselor state hope, $r = .273$, $p = .038$, $n = 43$, suggesting that roughly 7.5% overlap exists between the two variables in terms of the variance shared.

Additional positive correlations were found between student counselor state hope and student counselor trait hope ($r = .851$, $p < .001$, $n = 43$), student counselor trait hope and student counselor dispositional optimism ($r = .309$, $p = .022$, $n = 43$). The follow up multiple regressions for these positive correlations related to research question four revealed that trait hope predicted a relationship with state hope and that trait hope predicted a relationship with dispositional optimism.

Additional correlational procedures were conducted on items in a post-hoc (after the fact) data analysis. The student counselor trait hope, state hope, dispositional optimism scores and primary skill scores were compared with student counselor demographic items including gender

and age. No significant correlations were found between the student counselor hope, optimism, or skill scores with student counselor demographic items such as gender or age.

In an additional follow-up analysis regarding student counselors' confidence regarding completion and efficacy, a significant correlation was found for both state hope and trait hope. However, the multiple regression procedures used subsequent to those findings did not support the independent variables of state hope and trait hope as predictors of student counselor completion and efficacy responses.

Summary

The purpose of this study was to examine the relationship between practicum student counselors' levels of trait hope, state hope, dispositional optimism and client outcome, measured by symptom distress change and client satisfaction. The results yielded no statistically significant relationship between practicum counselor education students' trait hope scores, state hope scores, and dispositional optimism and client symptom distress change scores. Furthermore, no statistically significant relationship was found between practicum counselor education students' trait hope and dispositional optimism with client satisfaction scores. No statistically significant relationships were found between counselor students' skill and student counselor trait hope or counselor education student's skill and student counselor dispositional optimism.

Statistically significant positive relationships were found between (a) student counselor state hope and client satisfaction,(b) student counselor state hope and student counselor skill, (c) student counselor state hope and student counselor trait hope, and (d) student counselor trait hope and student counselor dispositional optimism. The follow up multiple regressions

supported the relationships with trait hope as the independent variable and (a) state hope and (b) dispositional optimism as the dependent variables in separate calculations.

In sum, this chapter presented the results of the data analysis including descriptive statistics of the student counselor participants and their trait and state hope scores, their dispositional optimism scores, and their skill scores. The descriptive statistics of their respective clients, their OQ-45.2 scores, UCF CQ scores were also included. Additionally, multiple linear regression analysis was conducted where significant relationships were found. The following chapter will review the results of the data analysis and also a discussion of the findings, the potential limitations of the study, and questions for future research and implications for counselor educators.

CHAPTER FIVE: DISCUSSION AND CONCLUSION

This chapter summarizes the results of a study that examined the relationship between student counselor trait hope, state hope, and dispositional optimism and client outcome, measured by symptom distress scores and client satisfaction scores. Additionally, the relationships between student counselor skill and trait hope, state hope, and dispositional optimism were also examined. The first section provides a discussion of the results of the research beginning with a review of the research questions and a discussion of the results related to each question. The next sections outline the limitations of the study, implications, and future directions for research.

Discussion

This study focused on examining the relationship between student counselor characteristics and client outcomes. Previously outcome research emphasized comparing treatment methods or techniques to determine if a particular type of intervention led to client improvement. In addition, researchers began paying attention to therapist variables when it became clear that the "person" of the therapist is tied to the therapeutic relationship and the outcomes that follow (Norcross, 2002). Some therapist variables have been shown to be related to client outcome, including therapist expertness, therapist modeling (Lambert & Bergin, 1994), therapist gender (Jones et al., 1987; Sue & Lam, 2002), and self-efficacy (Bentsen et al., 2010; Larson & Daniels, 1998; Luszczynska et al., 2009). Researchers conducting meta-analytic studies have offered varying estimates of the effect of the therapist ranging from low to moderate (Crits-Christoph, 1991; Elkin et al., 1996; Wampold & Bolt, 1996). In the meantime, the therapist and the therapeutic relationship receive attention for their contribution to client

outcomes (Norcross, 2002). It must be emphasized that outcome research has focused on experienced therapists rather than students. Thus it was expected that the power of the subjects to create improvement was likely to be less than the therapist with more experience and who were fully trained.

This study was also designed to include an examination of positive psychology variables, viz. hope and optimism in the counselor. Positive psychology was developed as a response to the medical model's focus on illness by identifying individual strengths, such as optimism, hope, problem-solving appraisal, locus of control, creativity, self-esteem, sense of humor, and gratitude (Snyder & Lopez, 2003). These strengths contribute to increased coping and resilience and well-being in clients but little had been done to look at these values in therapists. Positive psychology aims to investigate the ways in which individual strengths help people to flourish (Seligman, 2011). Hope and optimism were selected for investigation in this study because they have been associated with increased personal well-being (Snyder & Lopez, 2009). In sum, since clients can be affected by a therapist's characteristics (Beutler & Bergin, 1991), this study explored the relationship between counselor hope in optimism and improvement in clients.

Hope and Client Outcome

Hope began to receive a great deal of attention with Snyder's (1991) expanded definition of hope and hope theory. According to hope theory, hope is anchored in goals (Snyder, 2000). The idea is that individuals with higher hope engage and stay engaged in the process of: (a) selecting a goal, (b) pursuing a goal, (c) putting forth energies needed to execute the goal plan, and (d) using skills to overcome obstacles encountered. The two constructs underpinning hope, according to hope theory, are Agency and Pathways. Agency represents an individuals' motivational energy to pursue a goal to achievement. Pathways represent the individual's

identification of routes to achieve the goal identified. Hope is defined by positive expectancies for the future, but also, because it is anchored in goals; it is defined by an individual's "self-efficacy belief that a plan can be carried out" (Bailey, Eng, Frisch, & Snyder, 2007). There are two kinds of hope, trait hope and state hope. Because traits are "dimensions of individual differences in tendencies to show consistent patterns of thoughts, feelings, and actions" (McCrae & Costa, 2003, p. 25); trait hope means the individual has a tendency to express hope in an enduring, stable way over time. State hope, on the other hand, is experienced by individuals during hopeful situations occurring at different points in time. State characteristics are expressed naturally when a certain situation may evoke a thought or feeling representing a characteristic, in this case, hope. Therefore, state hope is more dependent on what is happening in the immediate moment in time.

Both trait and state measures of hope in student counselors were examined in this investigation, based on the positive psychology research supporting hope as strength- based quality associated with an individuals' well-being. The first two research questions asked about the relationship between trait hope and state hope and client outcomes, respectively.

Research Question One: "What is the relationship among trait hope and client symptom distress and client satisfaction". This question generated the first null hypothesis that stated, "There is no correlation between student trait hope and client symptom distress and client satisfaction." In this study, the null hypothesis was not rejected because no significant correlations were found between student trait hope and client symptom distress and client satisfaction.

Research Question Two. The second research question asked if a relationship existed among state hope and client symptom distress and client satisfaction. The null hypothesis stated,

"There is no correlation among student counselor state hope and client symptom distress and client satisfaction." The null hypothesis was not rejected in part because there was no significant correlation found between student counselor state hope and client symptom distress.

However, the null hypothesis was further evaluated when a statistically significant positive correlation was found between counselor state hope and client satisfaction, r = .327, p = .048, *n* = 27 suggesting that roughly 7.5% overlap exists between the two variables in terms of the variance shared. A multiple regression was conducted (N = 27), but yielded no statistically significant relationship between state hope and client outcome measure of client satisfaction. The regression equation did not support state hope as an independent variable and the null hypothesis could not be rejected. The potential implications of this are that perhaps some other variable explains client satisfaction – including the client's dispositional traits and states – that interact with student counselor's state hope.

Optimism and Client Outcome

Optimism, like hope, is a positive psychology variable related to positive health outcomes and well-being (Snyder & Lopez, 2004). Optimism is typically described either as an explanatory style or as a dispositional style. Dispositional optimism is a trait-like characteristic where an individual expresses positive expectations for the future consistently over time. The third research question in this investigation inquires about the relationship between dispositional optimism and client symptom distress and client satisfaction.

Research Question Three: The third research question asked if a relationship existed among state hope and client symptom distress and client satisfaction. The null hypothesis stated, "There is no correlation between student counselor dispositional optimism and client symptom distress and client satisfaction." No statistically significant correlations were found between

dispositional optimism and symptom distress and client satisfaction, thus the null hypothesis could not be rejected.

Counseling Skill, Hope, and Optimism

The fourth research question in this investigation pulls together trait hope, state hope and dispositional optimism, along with student skill. The question asks about the relationship of student skill to the student hope and optimism. Although the research is not clear on the relationship of skill to outcome, it would seem that since hope and optimism are related to improved coping skills, resilience and well-being, that perhaps student counselor primary counseling skills would be as well.

Research Question Four. The fourth research question if a relationship existed among student counselor skill and trait hope, state hope, and optimism. The null hypothesis stated, "There is no correlation among student counselor skill and trait hope, state hope, and optimism. This question yielded the highest number of significant positive correlations. The significant correlations were found between student counselors' (a) skill and state hope, (b) trait hope and state hope, and (c) trait hope and dispositional optimism

Hope, Optimism, and Client Outcome

Research Questions One, Two, and Three. The first three research questions specifically asked about the relationship of the hope and optimism characteristic with client outcomes while the fourth research question asked about the relationships of student counselor skill and the hope and optimism constructs between and among them. Regarding the first three research questions, why were we unable to find significant correlations. One possibility is that counselor hope and dispositional optimism are not as influential as we thought. Although individuals with high optimism have positive expectations for the future, it is difficult to operationalize optimistic

behaviors in counseling. Is optimism really expressed behaviorally or in a way the client is impacted by the therapist? While the therapist may feel hopeful and optimistic, perhaps the client does not perceive hope or optimism. Perhaps, in this investigation, it would have been more helpful to ask the clients if they *perceived* their counselors to optimistic. Beutler and colleagues (1979) suggested that it is the clients' perception that is most valuable, not necessarily the variable being measured.

Additionally, perhaps the individual student counselor variables are not as salient in comparison to the contribution they make to the therapeutic relationship when compared with that of experienced therapists who were the subjects in previous research (Beutler, et al., 2004; Karlsson, 2005; Lambert, 2010). Nearly every theoretical orientation encompasses a focus on establishing and maintaining the therapeutic relationship in order to engage clients (Corey, 2005). Perhaps counselor variables like hope are merely contributors to the therapeutic relationship than as independent influences on client outcome. Clients who have reported a greater therapeutic alliance have shown to experience decreased symptom distress (Norcross, 2002). It may also be possible that it does not matter how hopeful or optimistic the counselor is after all. Perhaps optimism is not expressed overtly in a way that clients do not attend to the optimism of the therapist. Moreover, hope and optimism may not be important to the extent that it rubs off on a client. Additionally, beginning counselors (this study's population) are likely to experience common beginner qualities like high stress, decreased feelings of ability, lower confidence in themselves, and were unable to transmit the characteristics of hope and optimism to the extent that symptom distress was influenced (Barbee, Scherer, & Combs, 2003; Lukas, 1993).

In sum, the relationship of trait hope, state hope and optimism of individual student counselors did not have relationships with client outcome. There are questions about how powerful those variables are with a client and if hope and optimism are more likely to be powerful as part of a larger construct, the therapeutic alliance. The final research question did not look at the relationships of variables to client outcome, but focused instead on the interrelationships of student counselor variables.

Research Question Four. Research question four generated several positive correlations and two significant findings with the follow-up multiple regression analysis. The question asked, "What is the relationship between student counselor skill and student counselor trait hope, state hope, and dispositional optimism?" The null hypothesis stated, "There is no relationship between student skill and student trait hope, state hope, and dispositional optimism." Among the findings, multiple regression analyses were unable to be performed on each of the comparisons because only a few significant correlations were found; therefore, the null hypothesis was not rejected.

One set of variables, student counselor state hope and student skill were positively correlated, $r = .273$, $p = .038$, $n = 43$ using the Pearson correlation; however, the follow-up multiple regression analysis yielded no statistically significant relationship between student counselor state hope and student counselor skill. Student counselor skill was measured using the *Primary Counseling Skills* subscale from the *Counselor Competency Scale* included 12 areas rating student counselors on primary skills such as: (a) Nonverbal Skills, (b) Minimal Encouragers, (c) Appropriate Open and Closed Questions (d) Reflection of Content, (e) Reflection of Feelings, (f) Advanced Reflection of Meaning, (f) Goal Setting, and (g) Facilitating the Therapeutic Environment. In the regression equation the independent variable did not result

in a statistically significant relationship. The potential implications of this are that students present levels of hope and positive expectations for the current goals do not appear to contribute to the actual performance of primary counseling skills acquired. Therefore, immediate hope, with motivation and plans to achieve current goals may not be related to skill acquisition of student counselors. However, additional analysis including the two constructs of hope, trait hope and state hope yielded positive findings that suggest they may be measuring the same construct. These findings are discussed next along with trait hope's relationship to dispositional optimism.

Student counselor trait hope was positively correlated with (a) student counselor state hope($r = .851$, $p < .001$, $n = 43$), and (b) student counselor dispositional optimism ($r = .309$, $p = .022$, $n = 43$). Counselor trait hope predicted counselor state hope and explained 26.4% of the variance. This finding indicates that 26.4% of state hope can be accounted for by the student counselors' levels of trait hope. According to Hair, Black, Babin, Anderson, and Tatham (2006) and adjusted r^2 of .264 represents a moderate effect size. This suggests that there are other contributing factors to counselor state hope. Nonetheless, this finding is of interest because it confirms the likelihood that trait hope and state hope instruments are measuring the same thing. However, it is noted, in the absence of a statistical procedure, such as exploratory factor analysis (EFA), the makeup of the items is speculative. The EFA would provide more conclusive information about what the instruments items are measuring.

Counselor trait hope was significantly correlated with dispositional optimism ($r = .309$, $p = .022$, $n = 43$). Trait hope predicted dispositional optimism and explained 6.7% of the variance. This finding indicates that 6.7% of dispositional optimism can be accounted for by the student counselors' levels of trait hope. An adjusted r^2 of .067 represents a small effect size (Hair et al., 2006).

Trait hope (as an underlying tendency over time to be hopeful) was confirmed through multiple regression analysis as an independent variable predicting the dependent variables state hope and dispositional optimism, respectively. Theoretically, individuals with trait hope would be more likely in situational circumstances to express state hope because of their tendency to already be hopeful. The assessment items for trait and state hope specify that trait hope measures goals overall (*ADHS, "Future Scale")* whereas state hope (*ASHS, "Goals Scale for the Present")* measures goals for the immediate present. Thus state hope could be posited to be representative of trait hope, in part. Regarding the actual items of the trait and state hope scales' similarities and what they are measuring, an exploratory factor analysis of the ADHD/Goals Scale and the ASHS/Goals Scale for the Present

Trait hope was confirmed through multiple regression as an independent variable predicting dispositional optimism. Hope and optimism, according to the literature are closely related and perhaps share Agency thinking in relation to goals. Certainly they both entail positive expectations for the future and perhaps students' counselors' responses reveal the shared variance naturally occurring between hope and optimism. In a follow-up analysis of students' responses to their confidence they would become a successful, effective professional counselor post-graduation, statistically significant positive correlations were found between this assertion and both trait and state hope.

The student counselors in this study were asked the following Completion Confidence question: "*How likely do you think you will work as a professional counselor after graduation from the UCF Counselor Education program?"* Their answers were scored on a 6 point scale and this was positively correlated with trait hope ($r = .370$, $p = .007$) and state hope, ($r=.409$, $p = .003$. This suggests that trait hope is responsible for roughly 13.69% of the variance shared and

state hope is responsible for roughly 16.73% of the variance shared with students' completion confidence. The results of the multiple regression analysis (N = 43) yielded no statistically significant relationship between trait hope or state hope and the likelihood question of working as a professional counselor post-graduation.

Trait hope and state hope were also positively correlated with student counselors' response to post-graduation expectations about confidence as a counselor and effectiveness as a counselor, i.e., *"How confident are you that you would be an effective counselor?"* Trait hope was positive correlated with the student counselors' confidence responses, r = .313, p = .021, *n = 43*. This suggests that trait hope is responsible for roughly 9.80% of the variance shared with students' efficacy expectations. State hope was positively correlated with the student counselors; confidence responses, and r = .344, *p* =.012, *n = 43*. This suggests that state hope is responsible for roughly 11.83% of the variance shared with students' efficacy expectations. The results of the multiple regression analysis (N = 43) yielded no statistically significant relationship between trait hope and state hope and expected effectiveness as a counselor post-graduation. The potential implications of this are that a counselor's with the hope variables do not contribute to the students' post-graduation expectation responses. The two post-graduation responses were about the student counselors' confidence for program completion and to be an effective professional counselor. Thus, the counselors' hopes do not seem to be correlated with an individual's professional plans or expected effectiveness.

Self-Efficacy

While hope and optimism did not show significant correlations with client outcomes, a question arises about how self-efficacy may tie in with these concepts and client outcome. Self-efficacy is defined as a person's belief in his capabilities to perform an activity in pursuit of a

goal (Bandura, 1986). Goals, regarding hope, optimism, or self-efficacy are future-oriented. Self-efficacy has demonstrated a relationship with desirable outcomes with post-traumatic stress recovery (Luszczynska et al., 2009), and work performance tasks (Barling & Beattie, 1983; Morrison & Phelps, 1999; Parker et al., 2006; Wood et al., 2001). Hope's Agency construct (motivation and drive to energetically pursue a goal) and optimism's positive outcome expectancy have similar elements of Bandura's self-efficacy definition. Bandura reported that self-efficacy is domain-specific and it seems that in part hope and optimism factors may still have a relationship with self-efficacy. In fact there appears to be an overlap among self-efficacy, skills, hope, and optimism. All three variables, self-efficacy, hope, and optimism have positive relationships with health outcomes (Luszczynska et al., 2009). In this same vein, Bailing & Beattie (1983) and Wood et al. (2001) reported that greater self-efficacy was related to greater individual task performance effectiveness.

In summary, the positive relationship evidenced by the findings of significant correlations between state and trait hope with the counselor students' post-graduation efficacy question lead to questions about the role of self-efficacy and the positive psychology constructs evaluated in this study. The definition of self-efficacy in the literature is quite similar to hope theory's Agency and optimism's Expectancy. Counselor self-efficacy has been studied (references). Future studies might consider including student counselor self-efficacy in order to see if it is a distinct construct or whether it is measuring hope and optimism.

Limitations

Sampling

The first weakness in this study was the use of a purposive sampling method. Student counselors were selected from a single community counseling clinic where all counselors were

students. Purposive sampling makes it difficult to generalize findings to other populations of student therapists, a threat to external validity. Additionally, a second-round judgment sampling took place. Judgment sampling means that sample cases are chosen on expert knowledge or special requirements of the study (M. Hancock, personal communication, April 6, 2011). In this study, the client symptom distress and client satisfaction scores comprised the dependent variable, client outcome. Thus, there were two fields necessary to investigate the research questions and hypotheses involving client outcome. The requirements of this study dictated that, in order to assess client outcome, both fields (symptom distress [as measured by the OQ-45.2] and client satisfaction) must be present or else the client case could not be used. Therefore, the loss of available cases through the second-order sampling was a major limitation.

Research Design

The second weakness in the present study is the limitation presented by the descriptive correlational research design. While correlational studies can suggest a relationship between two variables, they cannot prove causality therefore there was no ability to indicate that either hope or optimism is directly responsible for client outcomes or student counselor skill. Additionally a limitation of the utilizing correlational data is that it only finds the relationships of paired variables in linear relationships. Possible second-order relationships which are non-linear were not part of the planned design and were not sought. This may have limited the information gathered about the relationships among variables.

Another method for conducting this study would have been to consider the nested nature of the data and thus, employ a more complex analysis of the data. That is, instead of looking at the relationships between two groups with correlations and multiple regressions, the data could have also been recognized as nested where the client data existed within the individual student

counselor data. For each student counselor there was at least one client or more (for that same counselor). This nested data could have been evaluated through a multivariate technique called Hierarchical Linear Modeling (HLM).

Instrumentation

Although several instruments used in this study exhibited strong psychometric properties, another major limitation of this study is the lack of the standardization of the instrument used for the client satisfaction construct. The UCF Community Counseling Clinic Questionnaire (UCF CQ) instrument has been used as a relatively informal questionnaire but has no indices to reference reliability or validity. The UCF CQ is based on similar inventories that have good psychometric properties; however the UCF CQ appears to rely upon the face validity of singular questions to assess the opinions of the client as consumer, to assess satisfaction, and to also alert clinic personnel and practicum supervisors to any extreme responses as a result of individual concerns. It is unfortunate that a better instrument was not available to assess the client satisfaction in this setting where student counselors, clinic personnel, and counselor education faculty would benefit from a sounder instrument, and also one that is reliably administered to every possible client who has participated in treatment. In addition to the UCF CQ, the CCS has demonstrated good psychometric properties in one recent study, however, overall, it has not, over time, demonstrated the validity and reliability indices desirable of a student skills assessment.

Another limitation of the study regarding instrumentation is that none of the instruments utilized in this study included a scale within the instrument that would signal to the investigator to socially desirable responding. Most of the instruments in this study were self-report by the student counselors and by their clients. Self-report measures have limitations and other measures

such as observational report might have been included. Student counselors and their clients may have been influenced by a tendency to give positive self-descriptions (socially desirable responding; Paulhus, 2009). Although the student counselors were only administered the hope and optimism instruments at one point in time to minimize the threat to internal validity (i.e. the effects of history or maturation) counselors may have still responded to items in the way they believed was socially desirable. The clients in this study were administered the OQ-45.2 on at least two occasions and their repeated exposure to the instrument could affect reliability because of the practice effects and familiarity or social desirability that are associated with multiple test administrations.

Data Collection

Another major limitation of this study was the sample size of student therapists. Although nearly every enrolled practicum student participated, the lack of a larger sample was a weakness of the study. Another major limitation of this study was the sample size for client cases that included *both* multiple symptom distress scores *and* satisfaction scores. While the OQ45.2 is administered at the beginning of treatment and at 4-week intervals, it is also to be administered at termination. Likewise the UCF CQ is to be administered at termination. According to the data gathered, counselor trainees did not consistently collect multiple OQ45.2 scores or UCF CQ scores. It appears that the data were collected but in the spirit of maintaining a paperless system, the scores may not have been uploaded into the database. It may be difficult to capture the OQ45.2 and satisfaction scores, when clients terminate therapy prematurely. Certainly beginning student counselors are challenged to manage the myriad of responsibilities towards their clients and their paperwork. Because the end of the semester data collection for

this study and the other course requirements coincided, student counselors may have failed to upload data as required.

Implications for Counselor Educators

The findings of this study did not support a relationship between positive counselor characteristics and client outcome. Although there were no significant findings related to client outcome, there were interesting findings between student hope scores and student counselor expectations for their professional future post-graduation. Significant correlations were found for both trait and state hope and student counselor expectations. Student counselors with higher hope conveyed expectations that were high for themselves and perhaps in other areas relevant to their performance. Student counselors' expectations and performance can be considered in terms of being positive and being related to the future. Self-efficacy is constructs applicable to positive future expectations. The relationship of self-efficacy to positive performance is well established in the literature and it may have been useful to have measured this variable.

Additionally although student counselor characteristics of hope and optimism were not found to contribute to client outcome, those characteristics may be contributors the therapeutic alliance, which is related to improved client outcome. If the therapeutic relationship is related to client outcomes, the attitudes and behaviors of the therapist that contribute to the therapeutic relationship would be helpful to know and identify. Future research should look at the relationship between student counselor hope, optimism and the therapeutic alliance.

Lastly an implication of this study for counselor educators is the finding about student counselors' high in hope and the significant correlations with post-graduation expectations. High expectations may result in positive personal outcomes in a counselor education program.

Although this study did not show a predictive relationship, counselor educators may benefit from attending to student counselors' levels of hope.

Recommendations for Future Research

One of the primary recommendations for future research is related to the significant findings that revealed a relationship between hope and student post-graduation completion confidence and counselor efficacy. Self-efficacy is a well-researched construct, should be strongly considered in future studies involving hope and optimism. Future research may also look at the relationship between positive counselor characteristics and the therapeutic relationship which has been shown to be the most important predictor of client improvement. Although therapist characteristics in this study did not show a relationship to client outcome, the small number of student counselors and clients in the subject pool was a drawback.

In addition, future research should include instruments and assessments with stronger psychometric properties. There are a variety of instruments to measure client satisfaction with some research support; however, there are few instruments that could substitute for the skills assessment (CCS) used in this study.

Additionally, a similar study should probably be conducted with counselors who are a little farther along. Beginning counselors are often coming to terms with performance anxiety, concerns for evaluation, and concern for helping clients in their practicum or internship (Thompson, 2003). Perhaps counselors in internship would be less anxious and better able to access their strengths of hope and optimism. Finally, no attempt was made in this study to follow up with clients beyond their termination point at the end of the semester. If future research identified an effect of hope and optimism, it would be important to look at the length of time the effect endures.

APPENDIX A: INSTRUMENTS USED IN THE STUDY

ID Number _____

Demographic Questions:

1. Your age: _____

2. Your gender: ☐ Male ☐ Female

3. Ethnicity/race (mark one):

☐ Hispanic ☐ Asian
☐ Non-Hispanic Caucasian ☐ Native American / Alaskan Native
☐ Non-Hispanic African-American ☐ Hawaiian Native / Pacific Islander
☐ Other: _____

4. Counseling Track: ☐ Mental Health Counseling
☐ School Counseling
☐ Marriage and Family Counseling

5. Practicum Level: ☐ Practicum I
☐ Practicum II

6. Professional experience related to counseling (please circle all that apply below):

a. I have experience working as a counselor in schools

b. I have provided counseling services to clients in a mental health setting (other than schools).

c. I have worked in human services (housing, casemanagment, career counseling or advising)

d. I have volunteered services

e. Other (please write in): _____

7. How many months of experience in the above response? _____

8. Please circle the appropriate rating response for each of the following 2 questions:

A. How likely do you think you will work as a professional counselor after graduation from the UCF Counselor Education program?

Very likely Somewhat Likely Likely Unlikely Very Unlikely Unknown

B. How confident are you that you would be an effective counselor?

Very confident Somewhat confident Confident Not confident Extremely unconfident Unknown

Adult Dispositional Hope Scale Items and Directions for Administering and Scoring

Future Scale

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

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

___ 1. I can think of many ways to get out of a jam.

___ 2. I energetically pursue my goals.

___ 3. I feel tired most of the time.

___ 4. There are lots of ways around any problem.

___ 5. I am easily downed in an argument.

___ 6. I can think of many ways in life to get the things that are most important to me.

___ 7. I worry about my health.

___ 8. Even when others get discouraged, I know I can find a way to solve the problem.

___ 9. My past experiences have prepared me well for my future.

___10. I've been pretty successful in life.

___11. I usually find myself worrying about something.

___12. I meet the goals I set for myself.

Notes: When administering the scale, it is called The Future Scale. The agency subscale score is derived by summing items 2, 9, 10, and 12; the pathway subscale score is derived by adding items 1, 4, 6, and 8. The total Hope Scale score is derived by summing the four agency and the four pathway items.

Rand, K.L. & Cheavens, J.S. (2009). Hope theory (pp. 323-333). In S.J. Lopez & C.R. Snyder (Eds). Oxford Handbook of Positive Psychology (2nd Ed.). New York: Oxford University Press

Adult State Hope Scale Items and Directions for Administering and Scoring

Goals Scale for the Present

Directions: Read each item carefully. Using the scale shown below, please select the number that best describes *how you think about yourself right now* and put that number in the blank provided. Please take a few moments to focus on yourself and what if going on *in your life at this moment.* Once you have this "here and now" set, go ahead and answer each item according to the following scale:

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

____ 1. If I should find myself in a jam, I could think of many ways to get out of it.

____ 2. At the present time, I am energetically pursuing my goals.

____ 3. There are lots of ways around any problem that I am facing now.

____ 4. Right now, I see myself as being pretty successful.

____ 5. I can think of many ways to reach my current goals.

____ 6. At this time, I am meeting the goals that I have set for myself.

Notes: The agency subscale score is derived by summing the three even-numbered items; the pathways subscale score is derived by adding the three odd-numbered items. The total State Hope Scale score is derived by summing the three agency and the three pathway items. Scores can range from a low of 6 to a high of 48. When administering the State Hope Scale, it is labeled as the "Goals Scale for the Present"

Snyder, C.R., Sympson, S.C., Ybasco, F.C., Borders, T.F., Babyak, M.A., & Higgins, R.L. (1996). Development and validation of the State Hope Scale. *Journal of Personality and Social Psychology,*

Revised Life Orientation Test (LOT-R)

Instructions:
Please answer the following questions about yourself by indicating the extent of your agreement using the following scale:

|0| = strongly disagree
|1| = disagree
|2| = neutral
|3| = agree
|4| = strongly agree

Be as honest as you can throughout, and try not to let your responses to one question influence your response to other questions. There are no right or wrong answers.

_____ 1. In uncertain times, I usually expect the best.
_____ 2. It's easy for me to relax.
_____ 3. If something can go wrong for me, it will.
_____ 4. I'm always optimistic about my future.
_____ 5. I enjoy my friends a lot.
_____ 6. It's important for me to keep busy.
_____ 7. I hardly ever expect things to go my way.
_____ 8. I don't get upset too easily.
_____ 9. I rarely count on good things happening to me.
_____ 10. Overall, I expect more good things to happen to me than bad.

Scoring:
1. Reverse code items 3, 7, and 9 prior to scoring (0=4) (1=3) (2=2) (3=1) (4=0).
2. Sum items 1, 3, 4, 7, 9, and 10 to obtain an overall score.

Note Items 2, 5, 6, and 8 are filler items only. They are not scored as part of the revised scale.

The revised scale was constructed in order to eliminate two items from the original scale, which dealt more with coping style than with positive expectations for future outcomes. The correlation between the revised scale and the original scale is .95.

Reference:
Scheier, M.F., Carver C.S., and Bridges, M.W. (1994). Distinguishing optimism from neuroticism (and trait anxiety, self-mastery, and self-esteem): A re-evaluation of the Life Orientation Test. *Journal of Personality and Social Psychology*, **67**, 1063-1078.

Counselor Competencies Scale (CCS) ©

The *Counselor Competencies Scale* (CCS) assesses counseling students' skills development and professional competencies. Additionally, the CCS provides counseling students with direct feedback regarding their counseling skills, professional dispositions (dominant qualities), and professional behaviors, offering the students practical areas for improvement to support their development as effective and ethical professional counselors.

Scales Evaluation Guidelines

- **Exceeds Expectations / Demonstrates Competencies (8) =** the counseling student demonstrates **strong** (i.e., *exceeding* the expectations of a beginning professional counselor) knowledge, skills, and dispositions in the specified counseling skill(s), professional disposition(s), and professional behavior(s).

- **Meets Expectations / Demonstrates Competencies (6) =** the counseling student demonstrates **consistent** and **proficient** knowledge, skills, and dispositions in the specified counseling skill(s), professional disposition(s), and professional behavior(s). A beginning professional counselor should be at this level at the conclusion of his or her practicum and/or internship.

- **Near Expectations / Developing towards Competencies (4) =** the counseling student demonstrates **inconsistent** and **limited** knowledge, skills, and dispositions in the specified counseling skill(s), professional disposition(s), and professional behavior(s).

- **Below Expectations / Insufficient / Unacceptable (2) =** the counseling student demonstrates **limited** or **no evidence** of the knowledge, skills, and dispositions in the specified counseling skill(s), professional disposition(s), and professional behavior(s).

- **Harmful (0) =** the counseling student demonstrates harmful use of knowledge, skills, and dispositions in the specified counseling skill(s), professional disposition(s), and professional behavior(s).

***Note. Students must earn a score of 6 (*Meets Expectations / Demonstrates Competencies*) in all domains (*skills, dispositions, & behaviors*) prior to their completion of MHS 6803: *Practicum in Counselor Education* & beginning their Internship experience.**

CACREP (2009) Standards relating to the *Counselor Competencies Scale* (CCS)

- Counselor characteristics and behaviors that influence helping processes (Section II, *Standard* 5.b.)
- Essential interviewing and counseling skills (Section II, *Standard* 5.c.)
- Self-care strategies appropriate to the counselor role (Section II, *Standard 1*.d.)
- The program faculty conducts a systematic developmental assessment of each student's progress throughout the program, including consideration of the student's academic performance, professional development, and personal development. Consistent with established institutional due process policy and the ACA *Code of Ethics* and other relevant codes of ethics and standards of practice, if evaluation indicate that s student is not appropriate for the program, faculty members help facilitate the student's transition out of the program and, if possible, into a more appropriate area of study (Section I, *Standard* P).
- Professional practice, which includes practicum & internship, provides for the application of theory & the development of counseling skills under supervision. These experiences provide opportunities for students to counsel clients who represent the ethnic & demographic diversity of their community (Section III, *Professional Practice*).
- Students must complete **supervised practicum experiences** that **total a minimum of 100 clock hours** over a minimum 10-week academic term. Each student's practicum includes all of the following (Section III, *Standard* F. 1-5)
  1. At least **40 clock hours of direct service with actual clients** that contributes to the development of counseling skills.
  2. Weekly interaction that averages of **one hour per week of individual** and/or triadic supervision throughout the practicum by a program faculty member, a student supervisor, or a site supervisor who is working in biweekly consultation with a program faculty member in accordance with the supervision contract.
  3. An average of **1 ½ hours per week of group supervision** that is provided on a regular schedule throughout the practicum by faculty member or a student supervisor.
  4. The development of program-appropriate audio/video recordings for use in supervision or live supervision of the student's interactions with clients.
  5. Evaluation of the student's counseling performance throughout the practicum, including documentation of a formal evaluation after the student completes the practicum.
  6.

Directions: **Evaluate practicum student's counseling skills, professional dispositions, & professional behaviors per rubric evaluation descriptions & record rating in the "score" column on the left.**

Part I (Primary Counseling Skills – CACREP Standards [2009] #2 [*Social & Cultural Diversity*]**, #5** [*Helping Relationships*] **& #7** [*Assessment*]**)**

#	Score	Primary Counseling Skill(s)	Specific Counseling Descriptors	Exceeds Expectations / Demonstrates Competencies (8)	Meets Expectations / Demonstrates Competencies (6)	Near Expectations / Developing towards Competencies (4)	Below Expectations / Insufficient / Unacceptable (2)	Harmful (0)
1.A		Nonverbal Skills	Includes Body Position, Eye Contact, Posture, Distance from Client, Voice Tone, Rate of Speech, Use of silence, etc. (matches client)	Demonstrates effective nonverbal communication skills, conveying connectiveness & empathy (85%).	Demonstrates effective nonverbal communication skills for the majority of counseling sessions (70%)	Demonstrates inconsistency in his/her nonverbal communication skills.	Demonstrates limited nonverbal communication skills.	Ignores client &/or gives judgmental looks.
1.B		Encouragers	Includes Minimal Encouragers & Door Openers such as "Tell me more about...", "Hmm"	Demonstrates appropriate use of encouragers, which supports development of a therapeutic relationship (85%).	Demonstrates appropriate use of encouragers for the majority of counseling sessions (70%)	Demonstrates inconsistency in his/her use of appropriate encouragers.	Demonstrates limited ability to use appropriate encouragers.	Uses skills in a judgmental manner.
1.C		Questions	Use of Appropriate Open & Closed Questioning (e.g., avoidance of double questions)	Demonstrates appropriate use of open & close-ended questions, with an emphasis on open-ended question (85%).	Demonstrates appropriate use of open & close-ended questions for the majority of counseling sessions (70%).	Demonstrates inconsistency in using open-ended questions & may use closed questions for prolonged periods.	Uses open-ended questions sparingly & with limited effectiveness.	Multiple questions at one time
1.D		Reflecting $_a$	Basic Reflection of Content – Paraphrasing	Demonstrates appropriate use of paraphrasing as the primary therapeutic approach (85%).	Demonstrates appropriate use of paraphrasing appropriately & consistently (70%).	Demonstrates paraphrasing inconsistently & inaccurately or mechanical or parroted responses.	Demonstrates limited proficiency in paraphrasing or is often inaccurate.	Judgmental,dis missing, &/or overshoots
1.E		Reflecting $_b$	Reflection of Feelings	Demonstrates appropriate use of reflection of feelings as the primary approach (85%).	Student demonstrates appropriate use of reflection of feelings appropriately (70%).	Demonstrates reflection of feelings inconsistently and is not matching the client.	Demonstrates limited proficiency in reflecting feelings or often inaccurate.	Judgmental, dismissing, overshoots
1.F		Advanced Reflection (Meaning)	Advanced Reflection of Meaning including Values, and Core Beliefs (takes counseling to a deeper level)	Demonstrates consistent use of advanced reflection & promotes discussions of greater depth in sessions (85%).	Demonstrates ability to appropriately use advanced reflection, supporting increased exploration in session (70%).	Demonstrates inconsistent & inaccurate ability to use advanced reflection. Sessions appear superficial.	Demonstrates limited ability to use advanced or switches topics.	Judgmental, dismissing, &/or overshoots
1.G		Advanced Reflection (Summarizing)	Summarizing content, feelings, behaviors, and future plans	Demonstrates consistent ability to use summarization to include content, feelings, behaviors, and future plans.	Demonstrates ability to appropriately use summarization.	Demonstrates inconsistent & inaccurate ability to use summarization.	Demonstrates limited ability to use summarization.	Judgmental, dismissing, &/or overshoots
1.H		Confrontation	Counselor challenges client to recognize & evaluate inconsistencies.	Demonstrates the ability to challenge clients through verbalizing inconsistencies & discrepancies in the client's words or actions in a supportive fashion. Balance of challenge & support (85%).	Demonstrates the ability to challenge clients through verbalizing inconsistencies & discrepancies in the client's words or actions in a supportive fashion (can confront, but hesitant) (70%) or was not needed and therefore appropriately not used.	Demonstrates inconsistent ability to challenge clients through verbalizing inconsistencies & discrepancies in client's words or actions in a supportive fashion. Used minimally/missed opportunity.	Demonstrates limited ability to challenge clients through verbalizing discrepancies in the client's words or actions in a supportive & caring fashion, or skill is lacking.	Degrading client, harsh, judgmental, being aggressive
1.I		Goal Setting	Counselor collaborates with client to establish realistic, appropriate, & attainable therapeutic goals	Demonstrates consistent ability to establish collaborative & appropriate therapeutic goals with client (85%).	Demonstrates ability to establish collaborative & appropriate therapeutic goals with client (70%) or not appropriate and therefore appropriately not used.	Demonstrates inconsistent ability to establish collaborative & appropriate therapeutic goals with client.	Demonstrates limited ability to establish collaborative, appropriate therapeutic goals with client.	Not therapeutic goals
1.J		Focus of Counseling	Counselor focuses (or refocuses) client on his/her therapeutic goals – i.e., purposeful counseling	Demonstrates consistent ability to primarily focus/refocus counseling on client's goal attainment (85%).	Demonstrates ability to primarily focus/refocus counseling on client's goal attainment (70%) or not appropriate and therefore not used.	Demonstrates inconsistent ability to primarily focus/ refocus counseling on client's therapeutic goal attainment.	Demonstrates limited ability to primarily focus/refocus counseling on client's therapeutic goal attainment.	Superficial, &/or moves focus away from client
1.K		Facilitate Therapeutic Environment $_a$	Expresses accurate empathy & care. Counselor is "present" and open to client. (includes immediacy and concreteness)	Demonstrates consistent ability to be empathic & uses appropriate responses (85%).	Demonstrates ability to be empathic & uses appropriate responses (70%).	Demonstrates inconsistent ability to be empathic & use appropriate responses.	Demonstrates limited ability to be empathic & uses appropriate responses.	Creates unsafe space for client
1.L		Facilitate Therapeutic Environment $_b$	Counselor expresses appropriate respect & unconditional positive regard	Demonstrates consistent ability to be respectful, accepting, & caring with clients (85%).	Demonstrates ability to be respectful, accepting, & caring with clients (70%).	Demonstrates inconsistent ability to be respectful, accepting, & caring.	Demonstrates limited ability to be respectful, accepting, & caring.	Conditional or negative

_____: Total Score (*out of a possible 96 points*)

Part 2 (Professional Dispositions – CACREP Standards [2009] #1 [*Professional Orientation & Ethical Practice*] #2 [*Social & Cultural Diversity*], #3 [*Human Growth & Development*], & #5 [*Helping Relationships*])

#	Score	Primary Professional Dispositions	Specific Professional Disposition Descriptors	Exceeds Expectations / Demonstrates Competencies (8)	Meets Expectations / Demonstrates Competencies (6)	Near Expectations / Developing towards Competencies (4)	Below Expectations / Insufficient / Unacceptable (2)	Harmful (0)
2.A		**Professional Ethics**	**Adheres to the ethical guidelines of the ACA, ASCA, & IAMFC, including practices within competencies.**	Demonstrates consistent & advanced (*i.e., exploration & deliberation*) ethical behavior & judgments.	Demonstrates consistent ethical behavior & judgments.	Demonstrates ethical behavior & judgments, but on a concrete level with a basic decision-making process.	Demonstrates limited ethical behavior & judgment, and a limited decision-making process.	Repeatedly violates the ethical codes &/or makes poor decisions
2.B		**Professionalism**	**Behaves in a professional manner towards supervisors, peers, & clients (includes appropriates of dress & attitudes). Able to collaborate with others.**	Consistently respectful, thoughtful, & appropriate within all professional interactions.	Respectful, thoughtful, & appropriate within all professional interactions.	Inconsistently respectful, thoughtful, & appropriate within professional interactions.	Limitedly respectful, thoughtful, & appropriate within professional interactions.	Dresses inappropriately after discussed &/or repeatedly disrespects others, etc.
2.C		**Self-awareness & Self-understanding**	**Demonstrates an awareness of his/her own belief systems, values, needs & limitations (herein called "beliefs") and the effect of "self" on his/her work with clients.**	Demonstrates significant & consistent awareness & appreciation of his/her belief system & the influence of his/her beliefs on the counseling process.	Demonstrates awareness & appreciation of his/her belief system and the influence of his/her beliefs on the counseling process	Demonstrates inconsistent awareness & appreciation of his/her belief system and the influence of his/her beliefs on the counseling process.	Demonstrates limited awareness of his/her belief system and appears closed to increasing his/her insight.	Complete lack of self-awareness &/or imposes beliefs on client
2.D		**Emotional stability & Self-control**	**Demonstrates emotional stability (i.e., congruence between mood & affect) & self-control (i.e., impulse control) in relationships with supervisor, peers, & clients.**	Demonstrates consistent emotional resiliency & appropriateness in interpersonal interactions.	Demonstrates emotional stability & appropriateness in interpersonal interactions.	Demonstrates inconsistent emotional stability & appropriateness in interpersonal interactions.	Demonstrates limited emotional stability & appropriateness in interpersonal interactions.	Inappropriate interactions with others continuously, more emotional than client
2.E		**Motivated to Learn & Grow / Initiative**	**Engaged in the learning & development of his/her counseling competencies.**	Demonstrates consistent enthusiasm for his/her professional and personal growth & development.	Demonstrates enthusiasm for his/her professional and personal growth & development.	Demonstrates inconsistent enthusiasm for his/her professional and personal growth & development.	Demonstrates limited enthusiasm for his/her professional and personal growth & development.	Expresses lack of appreciation for the profession
2.F		**Multicultural Competencies**	**Demonstrates awareness, appreciation, & respect of cultural difference (e.g., races, spirituality, sexual orientation, SES, etc.)**	Demonstrates consistent & advanced multicultural competencies (knowledge, self-awareness, appreciation, & skills).	Demonstrates multicultural competencies (knowledge, self-awareness, appreciation, & skills).	Demonstrates inconsistent multicultural competencies (knowledge, self-awareness, appreciation, & skills).	Demonstrates limited multicultural competencies (knowledge, self-awareness, appreciation, & skills).	Not accepting worldviews of others
2.G		**Openness to Feedback**	**Responds non-defensively & alters behavior in accordance with supervisory feedback**	Demonstrates consistent openness to supervisory feedback & implements suggested changes.	Demonstrates openness to supervisory feedback & implements suggested changes.	Demonstrates openness to supervisory feedback, but does not implement suggested changes.	Not open to supervisory feedback & does not implement suggested changes.	Defensive &/or disrespectful when given feedback
2.H		**Professional & Personal Boundaries**	**Maintains appropriate boundaries with supervisors, peers, & clients**	Demonstrates consistently strong & appropriate boundaries.	Demonstrates appropriate boundaries.	Demonstrates appropriate boundaries inconsistently.	Demonstrates inappropriate boundaries.	Harmful relationship with others
2.I		**Flexibility & Adaptability**	**Demonstrates ability to flex to changing circumstance, unexpected events, & new situations**	Demonstrates consistently strong ability to adapt & "reads-&-flexes" appropriately.	Demonstrates ability to adapt & "reads-&-flexes" appropriately.	Demonstrated an inconsistent ability to adapt & flex to his/her clients.	Demonstrates a limited ability to adapt & flex to his/her clients.	Not at all flexible, rigid
2.J		**Congruence & Genuineness**	**Demonstrates ability to be present and "be true to oneself"**	Demonstrates consistent ability to be genuine & accepting of self & others.	Demonstrates ability to be genuine & accepting of self & others.	Demonstrates inconsistent ability to be genuine & accepting of self & others.	Demonstrates a limited ability to be genuine & accepting of self & others (incongruent).	Incongruent and not genuine

_____: Total Score (*out of a possible 80 points*)

Part 3 (Professional Behaviors – CACREP Standards [2009] #1 [*Professional Orientation & Ethical Practice*]**, #3** [*Human Growth & Development*]**, & #5** [*Helping Relationships*], **#7** [*Assessment*], & #8 [*Research & Program Evaluation*]**)**

#	Score	Primary Professional Behavior(s)	Specific Professional Behavior Descriptors	Exceeds Expectations / Demonstrates Competencies (8)	Meets Expectations / Demonstrates Competencies (6)	Near Expectations / Developing towards Competencies (4)	Below Expectations / Insufficient / Unacceptable (2)	Harmful (0)
3.A		**Attendance & Participation**	**Attends all course meetings & clinical practice activities in their entirety (engaged & prompt).**	Attends all class meetings & supervision sessions in their entirety, is prompt, & is engaged in the learning process.	Misses one class meeting &/or supervision session & is engaged in the learning process & is prompt.	Misses two class meetings &/or supervision sessions, &/or is late at times, but is engaged in the learning process.	Misses more than two class meetings &/or supervisions sessions, &/or is often late, & is not engaged in the learning process.	Misses 4 or more classes or sessions &/or repeatedly late &/or not engaged.
3.B		**Knowledge & Adherence to University & Counseling Site Policies**	**Demonstrates an understanding & appreciation for all university & counseling site policies & procedures**	Demonstrates consistent adherence to all university & counseling site policies & procedures.	Demonstrates adherence to most university & counseling site policies & procedures.	Demonstrates inconsistent adherence to all university & counseling site policies & procedures.	Demonstrates limited adherence to all university & counseling site policies & procedures.	Failure to adhere to policies after discussed with supervisor.
3.C		**Record Keeping and task completion**	**Completes all weekly record keeping & tasks correctly & promptly (e.g., case notes, psychosocial, TX plan, supervision report).**	Completes all required record keeping, documentation and assigned tasks in a through & comprehensive fashion.	Completes all required record keeping, documentation, and tasks in a competent fashion.	Completes all required record keeping, documentation, and tasks, but in an inconsistent & questionable fashion.	Completes required record keeping, documentation, and tasks inconsistently & in a poor fashion.	Failure to complete paperwork &/or tasks by deadline.
3.D		**Knowledge of professional literature**	**Researches therapeutic intervention strategies that have been supported in the literature & research.**	Demonstrates initiative in developing strong knowledge of supported therapeutic approaches grounded in the counseling literature & research.	Demonstrates knowledge of supported therapeutic approaches grounded in the counseling literature & research.	Demonstrates inconsistent knowledge of supported therapeutic approaches grounded in the counseling literature/research.	Demonstrates limited knowledge of supported therapeutic approaches grounded in the counseling literature & research.	No attempt to obtain literature to support interventions.
3.E		**Application of Theory to Practice**	**Demonstrates knowledge of counseling theory & its application in his/her practice.**	Demonstrates a strong understanding of the counseling theory(ies) that guides his/her therapeutic work with clients.	Demonstrates an understanding of the counseling theory(ies) that guides his/her therapeutic work with clients.	Demonstrates inconsistent understanding of the role of counseling theory in his/her therapeutic work.	Demonstrates limited understanding of counseling theory & its role in his/her therapeutic work with clients.	Harmful use of theoretical principles.
3.F		**Case Conceptualization**	**Effectively presents & summarizes client history & demonstrates an appreciation of the multiple influences on a client's level of functioning**	Demonstrates a strong & comprehensive case conceptualization; appreciating the multiple influences on a client's level of functioning.	Demonstrates an comprehensive case conceptualization; appreciating the multiple influences on a client's level of functioning.	Demonstrates basic case conceptualization; appreciating only the influences a client presents in session on his/her level of functioning.	Demonstrates a limited case conceptualization & does not appreciate the influence of systemic factors on the client's level of functioning.	Focus on self without ability to understand client.
3.G		**Seeks Consultation**	**Seeks consultation & supervision in appropriate service delivery**	Takes initiative to consistently seek appropriate consultation & supervision to support the delivery of counseling services.	Seeks appropriate consultation & supervision to support the delivery of counseling services.	Inconsistently seeks consultation & supervision to support the delivery of counseling services.	Seeks limited consultation & supervision to support the delivery of counseling services.	Does not recognize need for or seek supervision.
3.H		**Psychosocial & Treatment Planning**	**Demonstrates ability to construct a comprehensive & appropriate psychosocial report & treatment plan.**	Ability to construct & adhere to a comprehensive & appropriate psychosocial report & treatment plan (e.g., goals are relevant, attainable, & measureable)	Demonstrates the ability to construct a comprehensive & appropriate psychosocial report & treatment plan.	Demonstrates an inconsistent ability to construct a comprehensive & appropriate psychosocial report & treatment plan.	Demonstrates a limited ability to construct a comprehensive & appropriate psychosocial report & treatment plan.	Harmful goals or gaps in psychosocial
3.I		**Appraisal**	**Demonstrates ability to appropriately administer, score, & interpret clinical assessments**	Demonstrates a strong ability to appropriately administer, score, & interpret assessment instruments.	Demonstrates ability to appropriately administer, score, & interpret assessment instruments.	Demonstrates an inconsistent ability to appropriate administer, score, & interpret assessment instruments.	Demonstrates a limited ability to appropriately administer, score, & interpret assessment instruments.	Assessment not reviewed or understood or labeling client
3.J		**Referral**	**Demonstrates ability to identify resources to assist client therapeutically during and following counseling**	Takes initiative to identify resources that may further assist client in reaching treatment goals.	Seeks out resources when recommended by supervisor or others.	Needs prompting to identify and find resources	Inconsistently follows through with assisting client with identifying resources.	Refuses to assist client with identifying resources.

_____: Total Score (*out of a possible 80 points*)

Narrative Feedback from Supervising Instructor

Please note the counseling student's areas of strength, which you have observed:

Please note the counseling student's areas that warrant improvement, which you have observed:

Please comment on the counseling student's general performance during his/her clinical experience to this point:

Counseling Student's Name (print)	*Date*
Supervising Instructor's Name (print)	*Date*
Counseling Student's Signature	*Date*
Supervising Instructor's Signature	*Date*

Date CCS was reviewed with Counseling Student: _____

*** *Note*. If Supervising Instructor is concerned about the Counseling Student's progress, he or she should complete the *Counseling Depth Scale* (Young, 2007) to provide additional feedback to the Counseling Student.**

University of Central Florida Community Counseling Clinic Questionnaire

(Client Satisfaction)

Please help us improve our services by answering the questions below about UCF's *Community Counseling Clinic.* Your honest feedback will help us recognize areas that may need improvement, or where we are doing a good job. Thank you for taking a few minutes to complete this questionnaire. A blank area is provided below for comments, questions, or suggestions.

PLEASE CIRCLE YOUR ANSWERS

1. Were you satisfied with the quality of service you have received?

1	2	3	4
Poor	*Fair*	*Good*	*Excellent*

2. When you came to the Community Counseling Clinic, did you receive the service you wanted?

1	2	3	4
Never	*Rarely*	*Often*	*Always*

3. How well did we meet your needs?

1	2	3	4
Not well at all	*Hardly well*	*Somewhat well*	*Very well*

4. Would you recommend the services of the Community Counseling Clinic to a friend?

1	2	3	4
No	*Maybe not*	*Maybe*	*Definitely*

5. Regarding the amount of help you received, how satisfied are you?

1	2	3	4
Not at all satisfied	*Hardly satisfied*	*Somewhat satisfied*	*Very satisfied*

6. Are you dealing with your problems more effectively as a result of the services you received?

1	2	3	4
No	*Maybe not*	*Maybe*	*Definitely*

7. Overall, regarding the services you received, how satisfied are you?

1	2	3	4
Not at all satisfied	*Hardly satisfied*	*Somewhat satisfied*	*Very satisfied*

8. Would you return to the *Community Counseling Clinic* in the future if you felt you needed help?

1	2	3	4
No	*Maybe not*	*Maybe*	*Definitely*

9. Do you believe that <u>six months</u> from now you will feel as good as you do today?

1	2	3	4
No	*Maybe not*	*Maybe*	*Definitely*

10. **Do you believe that <u>a year</u> from now you will feel as good as you do today?**

1	2	3	4
No	*Maybe not*	*Maybe*	*Definitely*

Please indicate in the space below any additional comments (use reverse side of this sheet as needed). You may wish to include things you liked the best, things you liked the least, things that need improvement and things that worked well.

APPENDIX B: INSTITUTIONAL REVIEW BOARD APPROVAL

University of Central Florida Institutional Review Board
Office of Research & Commercialization
12201 Research Parkway, Suite 501
Orlando, Florida 32826-3246
Telephone: 407-823-2901 or 407-882-2276
www.research.ucf.edu/compliance/irb.htrnl

Approval of Exempt Human Research

From: **UCF Institutional Review Board #1**
FWA00000351, IRB00001138

To: **Michelle M. Glover**

Date: **August 24, 2010**

Dear Researcher:

On 8/24/2010, the IRB approved the following activity as human participant research that is exempt from regulation:

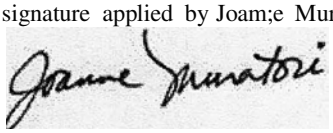
Type of Review: Exempt Determination
Project Title: The Relationship between Counselor Hope and Optimism on Client Outcome
Investigator: Michelle M Glover
IRBNumber: SBE-10-07079
Funding Agency:
Grant Title:
Research ID: N/A

This determination applies only to the activities described in the IRB submission and does not apply should any changes be made. If changes are made and there are questions about whether these changes affect the exempt status of the human research, please contact the IRB. When you have completed your research, please submit a Study Closure request in iRIS so that IRB records will be accurate.

In the conduct of this research, you are responsible to follow the requirements of the Investigator Manual. on

behalf of Joseph Bielitzki, DVM, UCF IRB Chair, this letter is signed by:

signature applied by Joam;e Muratori on 08/24/2010 01:15:13 PM EDT



RB Coordinator

APPENDIX C: PRACTICUM INSTRUCTOR LETTER

To: Fall 2010 Practicum Instructors
University of Central Florida
College of Education
Department of Education and Human Services
Orlando, FL 32826
Cc: Clinic Director, Dr. Bryce Hagedorn
Fr: Michelle Glover, Dr. Mark Young
Dt: August 24, 2010

Re: Therapist Attitude and Perception Dissertation Study and Practicum Student Participation

Dear Drs.,

Following approval from University of Central Florida's (UCF's) Institutional Review Board (IRB(approval of Michelle glover's dissertation investigation (SBE-10-07079), I would like to ask for your kind assistance in distributing to and collecting from your Practicum students the enclosed Consent Form/Questionnaire packets.

Please distribute these questionnaire either the 1st night of Practicum class **or** at the very start of your class before the students see any clients.

On July 22, 2010 a letter of intent and approval was sent to all Counselor Education Faculty regarding the use of UCF's Community Counseling Clinic data for this dissertation project. In addition, during the Fall 2010 Practicum Orientation in early August 2010, Dr. Hagedorn provided information regarding this study in a PowerPoint presentation in order to introduce the purpose and benefit of the investigation.

Because this study is classified "exempt" by the IRB, the Consent Forms do not have to be signed – simply read.

Any practicum student agree to participate should a) complete the questionnaire packet and b) return into the envelope addressed to Dr. Young (to be collected by Michelle Glover).

Please note: by the end of your class, the envelope addressed to Dr. Young should contain all packets (completed or not), sealed, and placed into Dr. Young's Tuesday evening practicum 'mailbox'.

Thank you very much in advance for your assistance. If you have any questions or concerns, please contact Michelle at 321-246-3961 or michellem.334@gmail.com or Dr. Young at myoung @cfl.rr.com

APPENDIX D: STUDENT COUNSELOR INVESTIGATION

PARTICIPATION FORM

Student ID _____
Investigator use only

Student Name: _____
Printed name if agreed to particiapte

Practicum Student Counselor Investigation Participation Form
August 24, 2010

Dear Practicum Student

I am a Counselor Education doctoral student at the University of Central Florida. As part of my coursework, I am completing my dissertation research and collecting data from Master's level Counselor Education program Practicum I and Practicum II counseling students and their individual adult clients. The purpose of this study is to learn about the association of client outcome with counselor attitudes and perceptions of present and future goals; outlook and expectations regarding life events; and the prognoses you apply as part of your treatment plan for each of your adult practicum counseling clients. I will also collect the skills subset scores from the *Counselor Competencies Scale* assigned to you at the mid-term by your practicum supervisor. I will be compiling individual adult client data upon their completion of therapy this Fall 2010 semester regarding their reported symptom distress and satisfaction.

I am asking you to participate in this study because of your unique perspective as a counselor in training. Practicum students interested in participation will be asked to complete a basic demographic questionnaire, a present goal and future goals questionnaire, and questionnaire about their orientation toward life events. These questionnaires are brief and should take no longer than 30 minutes to complete.

You will not have to answer any question you do not wish to answer. After you have read this form, if you wish to participate, you may complete the forms and questionnaires attached (described above). Only I will have access to the completed forms and questionnaires which will be encoded to ensure the confidentiality from any identifiers. The forms will be kept in unmarked file folders and a secure filing system. Your identity will be kept confidential and will not be revealed in the final manuscript.

There are no anticipated risks, compensation or other direct benefits to you as a participant in this interview. You are free to withdraw your consent to participate and may discontinue your participation in this study at any time without consequence.

If you have any questions about this research project, please contact me at (321-246-3961) or by e-mail at michellem.334@gmail.com. My faculty supervisor, Dr. Mark Young, may be contacted by email at myoung@cfl.rr.com.

Research at the University of Central Florida involving human participants is carried out under the oversight of the Institutional Review Board (IRB). Questions or concerns about research participants' rights may be directed to the Institutional Review Board Office, IRB Coordinator, University of Central Florida, Office of Research & Commercialization, 12201 Research Parkway, Suite 501, Orlando, FL 32826-3246. The telephone numbers are (407) 882-2276 and (407) 823-2901. The office is open from 8:00 am to 5:00 pm Monday through Friday except on UCF official holidays.

If you wish to participate, please continue by completing the attached questionnaires and handing them to the individual who is administering the instruments who will have a secure envelope to put them. By completing these questionnaires, you give me permission to report your responses anonymously in the final manuscript to be submitted to my faculty supervisor as part of my course work.

Sincerely,

Michelle Muenzenmeyer Glover, M.S., LMHC, NCC
Principal Investigator
Counselor Education Doctoral Candidate
Department of Education and Human Services

APPENDIX E: STUDENT COUNSELOR PARTICIPATION INSTRUCTIONS

Thank you for participating in this research.

Enclosed in this packet are:

- The Informed Consent
- Demographic Questionnaire
- Life Orientation Test-Revised
- Goals Scale

Please follow these instructions:

1. Read and print your name on the introduction/information letter.

2. Complete the Demographic Questionnaire.

3. Complete the Life Orientation Test-Revised.

4. Complete the Goals Scale.

5. When you are finished place everything back into your envelope and seal it. Give your sealed envelope back to the person who handed out your packet.

Please note:

Your I. D. number is already completed.

Please do not put your name on anything except the Introductory/information letter.

Thank you.

APPENDIX F: PERMISSIONS

Michelle Muenzenmeyer Glover

From: W. Bryce Hagedorn <drbryce@mail.ucf.edu>
Sent: Tuesday, June 10, 2008 1:11 PM
To: Michelle Glover
Cc: Mark Young
Subject: Re: Dissertation and hope to collaborate with clinic

Michelle,

I'd be happy to help you in any way that I can. Your proposal sounds very feasible for the clinic to assist you in any way that we can. Keep us informed of your next steps.

Be well.

W. Bryce Hagedorn, PhD, LMHC, NCC, MAC
Clinic Director, JAOC Editor
University of Central Florida
College of Education, ED 322C
Dept. of Child, Family & Community Sciences
Orlando, FL 32816-1250

Phone: 407-823-2999
Fax: 407-823-4511
Email: drbryce@mail.ucf.edu
Web: http://pegasus.cc.ucf.edu/~drbryce/

>>> Michelle Glover <michelleglo@yahoo.com> 6/6/2008 7:44 PM >>>
Dear Dr. Hagedorn,

I'm planning my dissertation research in the Fall 2008 and would like to administer a few instruments to student counselors Pre seeing clients (pre-semester) and Post- seeing clients (post semester) (not after seeing each client - old or new).

These instruments will likely be measures of constructs such as self-esteem, state/trait anxiety and hope/optimism. Regarding their clients, I need access, upon termination, to the pre/post OQ45 results and the "real" (copyrighted) verstion of the Client Satisfaction Inventory which would incur a cost - but the current satisfaction inventory was kind of made up by me while I was coordinator and discovered the CSI was copyrighted and we weren't paying for the originals for our clients to fill out. When I informed Dr. Robinson and the faculty of the copyright oversight, he required me to make something similar up and to the best of my knowledge, that's what's being used.

Of course I will be requesting IRB approval and the faculty would have to know that I am conducting dissertation research in the Fall involving the clinic and have the student-counselors to sign off for the IRB.

My dissertation purpose is to look at the pre/post variables of clinicians and of clients to see if a positive client outcome is achieved as shown by the student-counselor variables. I am hoping not to have direct contact with the student-counselors during the semester, but have not reached that level of planning yet.

Please let me know what you may require directly from me and/or my chair, Dr. Young. This is the very beginning, so I have yet to encounter too many obstacles.

Thank you,

Michelle Muenzenmeyer Glover

From: W. Bryce Hagedorn <drbryce@mail.ucf.edu>
Sent: Saturday, May 23, 2009 6:19 PM
To: Michelle Glover
Cc: Mark Young
Subject: Re: Dissertation

Hello Michelle!

It is so good to hear from you and to learn that you're on the mend! As for using the clinic counselors and the data, I am fine with that. We'll have one doctoral student using these same resources in the Fall (if all goes as planned) which will hopefully not go into the Spring - this involves the implementation of a training program in Motivational Interviewing for half of the prac students and its impact on client treatment compliance.

Let me know if this will all work out with your plans.

W. Bryce Hagedorn, PhD, LMHC, NCC, MAC, QCS (FL)
Clinic Director, Assistant Professor of Counselor Education
University of Central Florida
College of Education, ED 322C
Dept. of Child, Family & Community Sciences
Orlando, FL 32816-1250

Phone: 407-823-2999
Fax: 407-823-3859
Email: drbryce@mail.ucf.edu
Web: http://pegasus.cc.ucf.edu/~drbryce/

>>> Michelle Glover <michelleglo@yahoo.com> 5/6/2009 6:20 AM >>>
Dear Dr. Hagedorn,

Hi! How are you?

I'm writing because about a year ago, I spoke with you about my dissertation plans to utilize the UCF clinic for my dissertation in the Fall 2008.. Unfortunately, as you know, I became sick and was unable to complete my goals for the Fall. In Spring 2009 I took a leave of absence and underwent major surgery at Mayo clinic. All to say that here, a year later, I am back to making dissertation plans (although I remain on Medical Leave this Summer).

I would like to have access to the clinic's counselors as well as their outcome data in the Spring 2010. I will not be able to move forward as quickly so as to request the clinic in Fall 2009, but I do plan to complete my dissertation proposal and obtain IRB approval for my research in the Fall..

Presently, there is nothing more I need, except to know that I can continue with my timeline planning for dissertation - to include conducting research in the clinic in the Spring 2010. Please let me know if I can be cleared for that work during that semester.

I appreciate your consideration and your time.
I hope you are doing well.
Sincerely,

July 22, 2010

Counselor Education Faculty

University of Central Florida

3000 Central Florida Boulevard

College of Education

Orlando, FL 32826

Dear Counselor Education Faculty,

The purpose of this letter is to request the use of the Counselor Education Program evaluation data for purposes of my dissertation. I previously obtained this permission but due to my medical problems, I had to delay data collection. I wish to collect and utilize date from the Community Counseling Clinic for the upcoming semester. The purpose of my study is to predict or explain the relationship between counselor trainee attitudes and client outcome (change in symptom distress scores) and also to determine if a relationship exists between counselor trainee attitudes and their skill level. I intend to use a minimum of 50 participants.

Participating practicum students' attitudes will be measured by the Life Orientation Test-Revised (LOT-R), the Goals Scale, and the Goals Scale for the Present, and their skill will be evaluated by the Counseling Competency Scale (from the mid-term assessment). I am requesting to use existing client data including the Outcome Questionnaire 45.2 (OQ45) and the client's satisfaction questionnaire. I will have limited contact with the Counselor Education practicum students. I will need to obtain informed consent and to administer the instruments on one occasion. I will have no contact with Clinic clients. All data will be coded to ensure confidentiality and will be kept securely to ensure participants' anonymity.

Your approval for use of the Clinic for my dissertation will be contingent upon my committee's approval of my dissertation. The proposal meeting is scheduled for July 29, 2010 with my committee consisting of the following members: Mark E. Young, Ph.D. (Co-Chair), Stephen A. Sivo, Ph.D. (Co-Chair), Andrew P. Daire, Ph.D., and K. Dayle Jones, Ph.D.

Please let me know if you have any questions. Thank you for your consideration.

Sincerely,

Michelle Glover

Michelle M. Glover, M.S., LMHC, NCC

Doctoral Candidate

University of Central Florida

APPENDIX G: OQ®-PAPER & PENCIL PRODUCT BINDING LICENSE AGREEMENT

OQ®-PAPER & PENCIL PRODUCT BINDING LICENSE AGREEMENT

(20050501 Mail or Fax Form)

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10. Entire Agreement. This Agreement is the entire agreement of the Parties relating to the OQ® Product.

11. Governing Law. This Agreement is made and entered into in the State of Utah and shall be governed by the laws of the State of Utah.

REFERENCES

References marked with an asterisk indicate studies included in a meta-analysis.

Abramson, L.Y., Seligman, E.P. & Teasdale, J.D. (1978). Learned helplessness in humans: Critique and reformulation. *Journal of Abnormal Psychology, 87(1)*, 49-74.

Addis, M.E. & Cardemil, E.V., Duncan, B.L., & Miller, S.D. (2006). Does manualization improve therapy outcomes? In J.C. Norcross, L.E. Beutler, R.F. Levant (Eds.), Evidence-based practices in mental health: Debate and dialogue on the fundamental questions. Washington, DC, (pp.131-160).

Al-Darmaki, F.R. (2004). Counselor training, anxiety, and counseling self-efficacy: Implications for training psychology students from the United Arab Emirates University. Social Behavior and Responsibility, FindArticles.com. http://findarticles.com/p/articles/mi_qa3852/is_200401/ai_n9429761. Retrieved August 26, 2009.

Alexander, J.F., Barton, G., Schaino, R.S., & Parsons, B.V. (1976). Systems behavioral interventions with families of delinquents: Counselor characteristics, family behavior and outcome. *Journal of Clinical and Consulting Psychology*, *44(4),* 656- 664.

Anderson, T., Ogles, B.M., Patterson, C.L., Lambert, M.J., & Vermeersch, D.A. (2009). Counselor effects: Facilitative interpersonal skills as a predictor of counselor success. Journal of Clinical Psychology, 65(7), 755-768.

American Counseling Association. (2005). American Counseling Association Code of Ethics. www.counseling.org. Retrieved March 14, 2010.

Atkinson, J.W. (1957). Motivational determinants of risk taking behavior. *Psychological Review* ***64***, 359–372

Atkinson, D.R., Worthington, R.L., Dana, D.M. & Good, G.E. (1991). Etiology beliefs, preferences for counseling orientations and counseling effectiveness. *Journal of Counseling Psychology*, *38(3),* 258-264.

Bailey, T.C., Eng, W., Frisch, M.B., & Snyder, C.R. (2007). Hope and optimism as related to life satisfaction. *The Journal of Positive Psychology, 2(3)*, 168-175.

Baldwin, S.A., Wampold, B.E., & Imel, Z.E. (2007). Untangling the alliance-outcome correlation: Exploring the relative importance of counselor and patient variability in the alliance. *Journal of Consulting and Clinical Psychology*, *75*(6), 842-852.

Bandura, A. (1977a). Self-efficacy: toward a unifying theory of behavioral change. *Psychological Review, 84(2),* 191-215.

Bandura, A. (1986a). *Social foundations of thought and action: A social cognitive theory.* Englewood Cliffs, NJ: Prentice-Hall

Bandura, A. (1986b). The explanatory and predictive scope of self-efficacy theory. *Journal of Social and Clinical Psychology, 4,* 359-373.

Bandura, A. (1995). Exercise of personal and collective efficacy in changing societies. In A. Bandura (Ed.), *Self–efficacy in changing societies* (pp. 1-45). New York: Cambridge University Press.

Bandura, A. (1997). *Self-efficacy: The exercise of control*. New York: W.H. Freeman and Company.

Bandura, A., & Abel, M. (1983). Self-efficacy beliefs and performance. *Cognitive therapy and*

Research, 7, 265-272.

Bandura, A., & Adams, N.E. (1977b). Analysis of self-efficacy theory of behavioral change. *Cognitive Therapy and Research, 1*, 287-308.

Bandura, A., & Locke, E.A. (2003). Negative self-efficacy and goal effects revisited. *Journal of Applied Psychology, 88(1)*, 87-99.

Barling, J., & Beattie, R. (1983). Self-efficacy beliefs and sales performance. *Journal of Organizational Behavior Management*, 5, 41–51.

** Barlow, D.H., Craske, M.G., Cerny, J.A., & Klosko, J.S. (1989). Behavioral treatment of panic disorders. Behavior Therapy, 20, 261-282.*

Barrett, K.A. & McWhirter, B.T. (2002). Counselor trainees' perceptions of clients based on client sexual orientation. *Counselor Education & Supervision, 41,* 219-232.

Beck, D.F. (1988). *Counselor characteristics: How they affect outcomes*. Milwaukee, WI: Family Service of America.

** Beck, A. T, Hollon, S. D., Young, J. E., Bedrosian, R. C, & Budenz, D. (1985). Treatment of depression with cognitive therapy and amitriptyline. Archives of General Psychiatry, 42, 142-148.*

Bentsen, S., Wentzel-Larsen, T., Henriksen, A., Rokne, B., & Wahl, A. (2010). Self-efficacy as a predictor of improvement in health status and overall quality of life in pulmonary rehabilitation—An exploratory study. *Patient Education and Counseling*, *81*(1), 5-13. doi:10.1016/j.pec.2009.11.019

Bergin, A.E. & Garfield, S.L. (1994). *Handbook of Psychotherapy and Behavior Change.* New York: John Wiley & Sons.

Beutler, L.E. (1979). Values, beliefs, religion and the persuasive influence of psychotherapy. *Psychotherapy: Theory, Research and Practice*, *16*, 432-440.

Beutler, L.E. & Bergin, J. (1991). Value change in counseling and psychotherapy: A search for scientific credibility. *Journal of Counseling Psychology, 38,* 16-24.

Beutler, L.E., Clarkin, J., Crago, M., & Bergan, J. (1991). Client-counselor matching. In C. R. Snyder & D. R. Forsyth (Eds.), *Handbook of social and clinical psychology: The health perspective* (pp. 699-716). Elmsford, NY: Pergamon Press.

Beutler, L.E., Crago, M. & Arizmendi, T.G. (1986). Counselor variables in psychotherapy process and outcome. In S.L. Garfield & A.E. Bergin (Eds.), *Handbook of psychotherapy and behavior change* (3rd ed., pp. 257-310). New York: John Wiley & Sons.

Beutler, L.E., Machado, P.P, & Neufeldt, S.A. (1994). Counselor variables. In A.E. Bergin & S.L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (pp. 229-269). New York: John Wiley & Sons.

Beutler, L.E., Malik, M., Alimohamed, S., Harwood, T.M., Talebi, H., Noble, S., & Wong, E. (2004). In M.J. Lambert (Ed). *Bergin and Garfield's Handbook of psychotherapy and behavior change* (5th ed., pp. 227-306). New York: John Wiley & Sons.

* Blatt, S.J., Sanislow, C.A., Zuroff, D.C. & Pilkonis, P.A. (1996). Characteristics of effective counselors: Further analyses of data from the National Institute of Mental Health Treatment of Depression Collaborative Research Program. *Journal of Consulting and Clinical Psychology*, 64, 1276-1284.

Bohart, A., Elliott, R., Greenberg, L., & Watson, J. (2002). Empathy. In J.C. Norcross (Ed.),

Psychotherapy relationships that work: Counselor contributions and responsiveness to patients (pp. 89-108). New York: Oxford University Press.

* *Borkovec, T. D., & Mathews. A. M. (1988). Treatment of nonphobic anxiety disorders: A comparison of nondirective, cognitive, and coping desensitization therapy. Journal of Consulting and Clinical Psychology, 56, 877-884.*

Bowman, D., Scogin, F., Floyd, M., McKendree-Smith, N. (2001). Psychotherapy length of stay and outcome: A meta-analysis of the effect of counselor sex. *Psychotherapy, 38(2),* 142-148.

Bowman, D.G. (1993). Effects of counselor sex on the outcome of therapy. *Psychotherapy, 30(4),* 678-684.

Brennan, M. J. (1989). Client-counselor role expectations and outcomes of counseling. *Dissertation Abstracts International*, 50, 9007173.

Bruckner, F. (1979). *Therapeutic optimism: Its components and correlates among clinical social workers,* in DSc. Adelphi: Adelphi University School of Social Work.

Breunlin, D.C., Schwartz, R.C., Krause, M.S., Kochalka, J., & Puetz, R. (1989). The prediction of learning in family therapy training programs. *Journal of Marital and Family Therapy, 9,* 37-48.

Brissette, I., Scheier, M.F. & Carver, C.S. (2002). The role of optimism in social network development, coping, and psychological adjustment during a life transition. *Journal of Personality and Social Psychology, 82(1)*, 102-111.

Bruininks, P., & Malle, B.F. (2006). Distinguishing hope from optimism and related affective states. *Motivation and Emotion, 29(4)*, doi: 10.1007/s11031-006-9010-4.

Burke, K., Joyner, A., Czech, D., & Wilson, M. (2000). An investigation of concurrent validity between two optimism/pessimism questionnaires: The Life Orientation Test-Revised and the Optimism/Pessimism Scale. *Current Psychology: A Journal for Diverse Perspectives on Diverse Psychological Issues*, *19*(2), 129-136. doi:10.1007/s12144-000-1009-5

Burlingame, G.M., Fuhriman, A, Paul, S. & Ogles, B.M. (1989). Implementing a time limited therapy program: Differential effects of training and experience. *Psychotherapy, 26,* 303-313.

Byrne, M.K., Sullivan, N.L., Elsom, S.J. (2006). Clinician optimism: Development and psychometric analysis of a scale for mental health clinicians. *Australian Journal of Rehabilitation Counselling, 12(1),* 11-20.

**Carroll, K., Rounsaville, B., & Gawin, F. (1990). Psychotherapy & pharmacology for cocaine abuse. Unpublished manuscript.*

**Carroll, K., Rounsaville, B., & Gawin, F. (1991). A comparative trial of psychotherapies for ambulatory cocaine abusers: Relapse prevention and interpersonal psychotherapy. The American Journal of Drug and Alcohol Abuse, 17(3), 229-247.*

Carver, C.S. & Scheier, M.F. (2001). Optimism, pessimism and self-regulation. In E.C. Chang (Ed.).*Optimism & pessimism: Implications for theory, research, and practice* (pp. 31-51). Washington, DC: American Psychological Association.

Carver, C.S., Scheier, M.F., & Weintraub, J.K. (1989). Assessing coping strategies: A theoretically based approach. *Journal of Personality and Social Psychology*, *56(2),* 267-283.

Chida Y, & Steptoe, A. Positive psychological well-being and mortality: a quantitative review of

prospective observational studies. *Psychosomatic Medicine*. 70(7), 741-56. Epub 2008 Aug 25. http://www.ncbi.nlm.nih.gov/pubmed/18725425 Retrieved June 21, 2010

Cieslak, E. (2010). *Hope in psychotherapy process and outcome*. Ph.D. dissertation, Gannon University, United States -- Pennsylvania. Retrieved July 8, 2010, from Dissertations & Theses: Full Text. (Publication No. AAT 3329772).

Corey, G. (2005). *Theory and practice of counseling and psychotherapy* (8th ed.). Belmont, CA: Brooks/Cole

Crane, D., Wood, N., Law, D., & Schaalje, B. (2004). The relationship between counselor characteristics and decreased medical utilization: An exploratory study. *Contemporary Family Therapy: An International Journal*, *26(1),* 61-69.

Crits-Christoph, P. (1991) Meta-analysis of counselor effects in psychotherapy outcome studies. *Psychotherapy Research, 1,* 81-91.

Crits-Cristoph, P., Baranackie, K., Kurcias, J.S., Beck, A.T., Carroll, K., Perry, K., Luborsky, L., McLellen, A.T., Woody, G.E., Thompson, L., Gallagher D., & Zitrin, C. (1991). Meta-analysis of counselor effects in psychotherapy outcome studies. *Psychotherapy Research, 1*, 81-91.

Crits-Christoph, P., & Gallop, R. (2006). Counselor effects in the National Institute of Mental Health Treatment of Depression Collaborative Research Program and other psychotherapy studies. *Psychotherapy Research*, *16(2),* 178-181.

Crits-Christoph, P. & Mintz, J. (1991). Implications of counselor effects for the design and analysis of comparative studies of psychocounselor. *Journal of Consulting and Clinical Psychology, 59,* 20-26.

Csikszentmihalyi, M. (1975). *Beyond Boredom and Anxiety: Experiencing Flow in Work and Play*. San Francisco: Jossey Bass.

Deutsch, C.J. (1985). A survey of counselors' personal problems and treatment. *Professional Psychology: Research and Practice, 16(2),* 305-315.

Eccles, J.S., Adler, R., Futterman, R, Goff, S.B., Kaczala, C.M., Meece, J.L., & Midgley, C. (1983). Expectancies, values, and academic behaviors. In: J. T. Spence (Ed.). *Achievement and Achievement Motivation* (pp. 75-146). W. H. Freeman: San Francisco.

Elkin, I., Falconnier, L., Martinovich, Z., & Mahoney, C. (2006). Counselor effects in the NIMH Treatment of Depression Collaborative Research Program. *Psychotherapy Research, 16,* 144-160.

**Elkin, I., Shea, M.T., Watkins, J., Imber, S.D., Sotsky, S., Collins, J.F., Glass, D.R., Pilkonis, P., Leber, W.R., Docherty, J.D., Fiester, S.J., & Parloff, M.B. (1989). National Institute of Mental Health Treatment of Depression Collaborative Research Program: General effectiveness of treatments. Archives of General Psychiatry, 46, 971-982.*

Elliott, R., Greenberg, L.S., & Lietaer, G. (2004). Research on experiential therapies. In M.J. Lambert (Ed). *Bergin and Garfield's Handbook of Psychotherapy and Behavior Change* (5th ed., pp. 493-539). New York: John Wiley & Sons.

Farber, B.A., & Lane, J.S. (2001). Positive regard. *Psychotherapy: Theory, Research, Practice, Training*, *38*(4), 390-395.

Federici, A., Rowa, K., & Antony, M. (2010). Adjusting treatment for partial- or nonresponse to contemporary cognitive-behavioral therapy. *Cognitive-Behavioral Therapy for Refractory Cases: Turning Failure into Success* (pp. 11-37). Washington, DC: American

Psychological Association. doi:10.1037/12070-002

Frank, J.D. (1973). *Persuasion and Healing*. Baltimore, MD: Johns Hopkins University Press.

Frank, J.D. (1993). *Psychotherapy and the Human Predicament: A Psychosocial Approach.* Northvale, New Jersey: Jason Aronson.

Frank, J.D. & Frank, J.B. (1993). *Persuasion and Healing.* (3rd ed.). Baltimore, MD: Johns Hopkins University Press.

Gallagher, M., & Lopez, S. (2009). Positive expectancies and mental health: Identifying the unique contributions of hope and optimism. *The Journal of Positive Psychology*, *4*(6), 548-556.

Geers, Wellman, Seligman, Wuyek, & Neff (2010). Dispositional optimism, goals, and engagement in health treatment programs. *Journal of Behavioral Medicine, 33(2),* 123-134.

Goodman, R.L. & Amatea, E.S. (1994). The impact of trainee characteristics on the family therapy skill acquisition of novice counselors. *Journal of Mental Health Counseling, 16(4),* 483-496.

Graham, J.R. (1993). *MMPI-2 Assessing Personality and Psychopathology* (2nd ed.). New York Oxford University Press.

Greeson, J.K., Guo, S., Barth, R.P., Hurley, S. & Sisson, J. (2009). Contributions of counselor characteristics and stability to intensive in-home therapy youth outcomes. *Research on Social Work Practice*, *19(2),* p239-250.

Harackiewicz, J.M. & Linnenbrink, E.A. (2005). Multiple achievement goals and multiple pathways for learning: The agenda and impact of Paul R. Pintrich. *Educational*

Psychologist, 40(2), 75-84.

Hatcher, R.L. & Gillaspy, J.A. (2006). Development and validation of a revised short version of the working alliance inventory. *Psychotherapy Research, 16(1),* 12-25.

Heppner, P.P., Kivlighan, D.M., & Wampold, B.E. (1990). *Research Design in Counseling* (2nd ed.). New York: Brooks/Cole.

Hersoug, A.G., Hoglend, P., Monsen, J.T., Havik, O.E. (2001). Quality of Working Alliance in Psychotherapy. *Journal of Psychotherapy Practice and Research, 10,* 205-216.

Hoffman, B., & Schraw, G. (2009). The influence of self-efficacy and working memory capacity on problem-solving efficiency. *Learning and Individual Differences*, *19*(1), 91-100. doi:10.1016/j.lindif.2008.08.001

* *Hollon, S. D., Tuason, V B., Wiemer, M. J., DeRubeis, R. J., Evans,M. D., & Garvey, M. J. (1983). Cognitive therapy, pharmacotherapy. and combined cognitive-pharmacotherapy in the treatment of depression. Differential outcome in the CPT project. Unpublished manuscript.*

Horvath, A. O. & Bedi, R.P. (2002). The alliance. In J.C. Norcross (Ed.), *Psychotherapy Relationships that Work: Counselor Contributions and Responsiveness to Patients* (pp. 37-69). New York: Oxford University Press.

* *Huppert, J. D., Bufka, L. F., Barlow, D. H., Gorman, J. M., Shear, M. K., & Woods, S. W. (2001). Counselors, counselor variables, and cognitive behavioral therapy outcomes in a multicenter trial for panic disorder. Journal of Consulting and Clinical Psychology, 69, 747–755.*

Institute of Medicine. (2001). *Crossing the Quality Chasm: A New Health System for the 21st*

Century. Washington, DC: National Academy Press..

Jones, E.E. (1982). Psychocounselors' impressions of treatment outcome as a function of race. *Journal of Clinical Psychology, 38,* 722-731.

Jones, E.E., Krupnik J.L., Kerig, P.K. (1987). Some gender effects in a brief psychotherapy. *Psychotherapy, 24(3),* 336-352.

Jones, E., & Zoppel, C. (1982). Impact of client and therapist gender on psychotherapy process and outcome. *Journal of Consulting and Clinical Psychology*, *50*(2), 259-272. doi:10.1037/0022-006X.50.2.259

Jurek, A.W. (1992). *The Outcome of Therapist Gender on Psychotherapy Outcome*. University Microfilms International. Ann Arbor, MI: Bell & Howell.

Karlsson, R. (2005). Ethnic Matching Between Therapist and Patient in Psychotherapy: An Overview of Findings, Together With Methodological and Conceptual Issues. *Cultural Diversity and Ethnic Minority Psychology*, *11*(2), 113-129. doi:10.1037/1099-9809.11.2.113

Khan, J.A., & Cross, D.G. (1983). Mental health professional and client values: Similar or different? *Australian Journal of Sex, Marriage & Family, 4,* 71-78.

Kim, D.M., Wampold, B.E., & Bolt, D.M. (2006). Counselor effects in psychotherapy: A random-effects modeling of the National Institute of Mental Health Treatment of Depression Collaborative Research Program data. *Psychotherapy Research, 16(2),* 161-172.

King, L. (2001). The hard road to the good life: The happy, mature person. *Journal of Humanistic Psychology, 41(1),* 51-72.

Kelly, Jr., E.W. (1995). Counselor values: A national survey. *Journal of Counseling & Development, 73(6),* 48-653

**Klein, D.F., Zitrin, C., Marker, Woemer, M.G., & Ross, D.C. (1983). Treatment of phobias – II: Behavior therapy and supportive psychotherapy: Are there any specific ingredients? Archives of General Psychiatry, 40, 139-145.*

Krause, M.S. & Lutz, W. (2009) Process transforms inputs to determine outcomes: Counselors are responsible for managing process. *Clinical Psychology: Science and Practice,* 16(1) 73-81.

Krupnick, J.L., Sotsky, S.M., Simmens, S., Moyer, J., Elkin, I., Watkins, J., Pilkonis, P.A. (1996). The role of the therapeutic alliance in psychotherapy and pharmacotherapy outcome: findings from the National Institute of Mental Health Treatment of Depression Collaborative Research Program. *Journal of Consulting and Clinical Psychology, 64*, 532-539.

Lafferty, P., Beutler, L., Crago, M. (1989) Differences between more and less effective psychocounselors: A study of select counselor variables. *Journal of Consulting and Clinical Psychology, 57,* 76-80.

Lambert, M.J. (1989). The individual counselors' contribution to psychotherapy process and outcome. *Clinical Psychology Review, 9,* 469-485.

Lambert, M.J. (2010). Counselor effects. In *Prevention of treatment failure: The use of measuring, monitoring, and feedback in clinical practice.* (pp. 175-202). Washington, D.C.: American Psychological Association.

Lambert, M.J. & Baldwin, S.A. (2009). Some observations on studying counselors instead of

treatment packages. *Clinical Psychology Scientific Practice, 16,* 82-85.

Lambert, M.J. & Barley, D.E. (2002). Research summary on the therapeutic relationship and psychotherapy outcome. In J.C. Norcross (Ed.), *Psychotherapy Relationships That Work: Counselor Contributions and Responsiveness to Patients,* (pp. 17-32). New York: Oxford University Press.

Lambert, M.J. & Bergin, A.E. (1994). The effectiveness of psychotherapy. In A.E. Bergin & S.L. Garfield (Eds). *Handbook of Psychotherapy and Behavior Change* (4th ed, pp. 143-189). New York: Wiley.

Lambert, M.J. & Cattani-Thompson, K. (1996). Current findings regarding the effectiveness of counseling: Implications for practice. *Journal of Counseling and Development, 74,* 601-608.

Lambert, M. J., Morton, J. J., Hatfield, D., Harmon, C., Hamilton, S., Reid, R. C., et al. (2004). *Administration and Scoring Manual for the Outcome Questionnaire 45.2*. Salt Lake City, UT: American Professional Credentialing Services.

Lambert, M.J. & Simon, W. (2008). The Therapeutic Relationship. In S.F. Hick & T. Bien (Eds.). *Mindfulness and the Therapeutic Relationship.* (pp.19-33). New York: The Guilford Press.

Larsen, D., Edey, W., & Lemay, L. (2007). Understanding the role of hope in counseling: Exploring the intentional uses of hope. *Counselling Psychology Quarterly, 20(4),* 401-416.

Larson, L.M., & Daniels, J.A. (1998). Review of the counseling self-efficacy literature. *The Counseling Psychologist, 26(2),* 179(40). Retrieved May 23, 2010, from General

OneFile via Gale: http://find.galegroup.com.ezproxy.lib.ucf.edu/gtx/start.do?prodId =ITOF&userGroupName=orla57816.

Leichsenring, F. (2004). Randomized controlled versus naturalistic studies: A new research agenda. *Bulletin of the Menninger Clinic, 68(2),* 137-151.

Lent, R.W., Hill, C.E., & Hoffman, M.A. (2003). Development and validation of the Counselor Activity Self-Efficacy Scales. *Journal of Counseling Psychology, 50(1),* 97-108.

Lent, R.W., Hoffman, M.A., Hill, C.E., Treistman, D., Mount, M. & Singley, D. (2006). Client-specific counselor self-efficacy in novice counselors: Relation to perceptions of session quality. *Journal of Counseling Psychology*, *53(4),* 453-463.

Leon, S.C., Martinovich, Z., Lutz, W., & Lyons, J.S. (2005). The effect of counselor experience on psychotherapy outcomes. *Clinical Psychology and Psychotherapy, 12*, 417–426.

Locke, E. A., & Latham, G. P. (1990). *A Theory of Goal Setting and Task Performance.* Englewood Cliffs, NJ: Prentice Hall.

Lopez, S.J. & Snyder, C.R. (Eds.). (2003). *Positive Psychological Assessment: A Handbook of Models and Measures.* American Psychological Association, Washington, D.C.

** Luborsky. L., & Crits-Christoph. P. (1988, May). A pilot study of psychodynamic psychotherapy for major depressive disorder Paper presented at a National Institute of Mental Health workshop on planning of clinical trials with psychodynamic psychotherapy, Rockville, MD.*

Luborsky, L., Crits-Christoph, P., McLellan, A.T., Woody, G., Piper, W., Liberman, B., Imber, S., & Pilkonis, P. (1986). Do counselors vary much in their success? Findings from four outcome studies. *American Journal of Ortho-psychiatry, 56(4),* 501-512.

* *Luborsky, L., McLellan, , A.T., Diguer, L., Woody, G. & Seligman, D.A. (1997). The psychocounselor matters: Comparison of outcomes across twenty-two counselors and seven patient samples. Clinical Psychology: Science and Practice, 4, 53-63.*

Luborsky, L., McClellan, A.T., Woody, G.E., O'Brien, C.P. & Auerbach, A. (1985). Counselor success and its determinants. *Archives of General Psychiatry, 42,* 601-611.

Lukas, S. (1993). *Where to Start and What to Ask: An Assessment Handbook.* New York: W.W. Norton & Company.

Luszczynska, A., Benight, C., & Cieslak, R. (2009). Self-efficacy and health-related outcomes of collective trauma: A systematic review. *European Psychologist*, *14*(1), 51-62. doi:10.1027/1016-9040.14.1.51

Luthens, F. & Youssef, C.M. (2009). Positive workplaces. In S.J. Lopez & C.R. Snyder (Eds.), *Oxford handbook of positive psychology* (2nd ed., pp. 579-587). New York: Oxford University Press.

Lutz, W., Leon, S.C., Martinovich, Z., & Lyons, J.S. (2007). Counselor effects in outpatient psychotherapy: A three-level growth curve approach. *Journal of Counseling Psychology, 54(1),* 32-39 doi:10.1037/0022-0167.54.1.32.

Lutz, W., Martinovich, Z., Howard, K. I., & Leon, S. C. (2002). Outcomes management, expected treatment response, and severity-adjusted provider profiling in outpatient psychotherapy. *Journal of Clinical Psychology*, *58*, 1291–1304.

Lyubomirsky, S. (2007). *The How of Happiness: A New Approach to Getting the Life You Want.* New York: Penguin Group.

McCrae, R. R. & Costa, P.T. (2003). *Personality in Adulthood: A Five-Factor Theory Perspective (2nd ed.).* New York: Guilford Press 2003.

McLellan, A., Woody, G., Luborsky, L., Goehl, L. (1988). Is the counselor an "active ingredient" in substance abuse rehabilitation? An examination of treatment success among four counselors. *Journal of Nervous and Mental Disease, 176*, 423-430.

Miller, G. (2001). Finding happiness for ourselves and our clients. *Journal of Counseling and Development*, *79,* 382-385.

Miller, W.R., Taylor, C.A., & West, J.C. (1980). Focused versus broad spectrum behavior therapy for problem drinkers. *Journal of Consulting and Clinical Psychology, 48,* 590-601.

Mogul, K.M. (1982). Overview: The sex of the therapist. *American Journal of Psychiatry,* 139(1), 1-11.

Morrison, E. W., & Phelps, C. C. (1999). Taking charge at work: Extra-role efforts to initiate workplace change. *Academy of Management Journal, 42*, 403–419.

Muenzenmeyer, M.M., Blau, B, McGuire, J., Bowers, C., and Mills, H. (1996). Brief therapy: Overview and assessment of training attitudes and practices in applied master's programs. *Journal of Psychological Practice, 2(4*), pp. 25-33

Nagpal, S. & Ritchie, .H. (2002). Selection interviews of students for master's programs in counseling: An exploratory study. *Counselor Education and Supervision, (41),* 207-218

Najavits, L.M. & Weiss, R.D. (1994). Variations in counselor effectiveness in the treatment of patients with substance use disorders: An empirical review. *Addiction, 89,* 679-688.

** Nash, E., Hoehn-Sacric, R., Battle, C., Stone, A., Imber. S., & Frank, J. (1965).*

Systematic preparation of patients for short-term psychotherapy - II: Relation to characteristics of patient, counselor and the psychotherapeutic process. Journal of Nervous and Mental Disorders, 140, 374-383.

Nevo, D. (2005). Theories used in IS research: Expectation confirmation theory. http://www.istheory.yorku.ca/etc.htm Accessed October 23, 2010.

Ogles, B.M. (1996). Assessing outcome in practice. *Journal of Mental Health, 5(1),* 35–46.

Ogles, B.M., Lambert, M.J., & Fields, S. (2002). *Essentials of Outcome Assessment*. Hoboken, NJ US: John Wiley & Sons Inc.

Ogles, B.M., Lambert, M.J., & Masters, K.S. (1996). *Assessing Outcome in Clinical Practice*. Boston: Allyn & Bacon.

Okiishi, J.C., Lambert, M.J., Eggett, D., Nielsen, L., Dayton, D.D., Vermeersch, D.A. (2006). An Analysis of Counselor Treatment Effects: Toward Providing Feedback to Individual Counselors on Their Clients' Psychotherapy Outcome. *Journal of Clinical Psychology*, *62*(9), 1157-1172.

Okiishi, J., Lambert, M.J., Nielsen, S.L., & Ogles, B.M. (2003). Waiting for supershrink: An empirical analysis of counselor effects. *Clinical Psychology and Psychotherapy, 10*, 361-373.

O'Leary, A., Jemmott, L., & Jemmott, J. (2008). Mediation analysis of an effective sexual risk-reduction intervention for women: The importance of self-efficacy. *Health Psychology*, *27*(2), S180-S184. doi:10.1037/0278-6133.27.2 (Suppl.).S180

Orlinsky, D.E. & Howard, K.I. (1980). Gender and psychotherapeutic outcome. In A.M. Brodsky & R.T. Hare-Mustin (Eds.), *Women and Psychotherapy* (pp. 3-34). New York: Guilford

Press.

Parker, S.K., Williams, H.M., & Turner, N. (2006). Modeling the antecedents of proactive behavior at work. *Journal of Applied Psychology, 91(3),* 636-652. doi: 10.1037/0021-9010.91.3.636

* *Perry, K. & Howard, K.I. (1989, June). Counselor effects: In search of the counselors: contribution to psychotherapy outcome. Paper presented at the Society for Psychotherapy Research, Toronto.*

Peterson, C. (2006). *A Primer in Positive Psychology*. [Adobe Digital Editions Version]. Retrieved from Amazon.com.

Peterson, S.J. & Byron, K. (2008). Exploring the role of hope in job performance: Results from four studies. *Journal of Organizational Behaviour, 29*, 785–803.

Peterson, C., & Vaidya, R. (2003). Optimism as virtue and vice. *Virtue, Vice, and Personality: The Complexity of Behavior* (pp. 23-37). Washington, DC US: American Psychological Association.

* *Pilkonis. P. A., Imber. S. D., Lewis, P., & Rubinsky, P. (1984). A comparative outcome study of individual, group, and conjoint psychotherapy. Archives of General Psychiatry, 41, 431-437.*

Pintrich, P.R. & Schunk, D. H. (1996). The Role of Expectancy and Self-Efficacy Beliefs. *Motivation in Education: Theory, Research & Applications* (2nd ed.; pp. 67-104). Englewood Cliffs, NJ: Prentice-Hall.

* *Piper, W.E., Debbane, E. G., Bienvenu, J. P., & Garant, J. (1984). A comparative study of four forms of psychotherapy. Journal of Consulting and Clinical Psychology, 52, 268-*

279.

Piper, W.E., Ogrodniczuk, , J.S., Joyce, A.S., McCallum, M., Rosie, J.S., O'Kelly, J.G., & Steinberg, P.I. (1999). Prediction of dropping out in time-limited, interpretive individual psychotherapy. *Psychotherapy, 36(2),* 114-122.

Powell, J.L., Hunter, H.L., Beasley, L.O., & Vernberg, E.M. (2010). Using fine-grained indexes of therapists' experience and training to predict treatment outcomes in a university-based training clinic for children and families. *Training and Education in Professional Psychology, 4(2)*, 138-144.

** Propst, A. Paris, J., & Rosberger, Z. (1994). Do counselor experience, diagnosis and functional level predict outcome in short-term psychotherapy? Canadian Journal of Psychiatry, 39(3), 168-176.*

Rand, K.L. & Cheavens, J.S. (2009). Hope theory. In S.J. Lopez & C.R. Snyder (Eds.), *Oxford Handbook of Positive Psychology* (2nd ed., pp. 323-333). New York: Oxford University Press.

Ricks, D.F. (1974). Supershrink: Methods of a counselor judged successful on the basis of adult outcomes of adolescent patients. In D.F. Ricks, M. Roff, & A. Thomas (Eds.), *Life History Research in Psychopathology* (pp. 288-308). Minneapolis: University of Minnesota Press.

Rogers, C.R. (1946). Significant Aspects of Client-Centered Therapy. *American Psychologist, (1),* 415-422.

Rogers, C.R. (1951). *Client-Centered Therapy: Its Current Practice, Implications, and Theory.* Boston: Houghton Mifflin.

Rogers, C.R. (1983). *Freedom toLearn.* (3rd ed.). Upper Saddle River, NJ: Prentice-Hall.

Rotter, J.B. (1966). Generalized expectancies for internal versus external control of reinforcements. *Psychological Monographs*, *80(1)*, Whole no. 609.

Rotter, J.B. (1990). Internal versus external control of reinforcement: A case history of a variable. *American Psychologist, 45(4),* 489-493

Ruark, J. (2009). An Intellectual Movement for the Masses. *The Chronicle Review – The Chronicle of Higher Education*. http://chronicle.com/article. Retrieved August 3, 2009.

** Rush, A.J., Beck. A.T., Kovacs, M., & Hollon, S.D. (1977). Comparative efficacy of cognitive therapy and pharmacotherapy in the treatment of depressed outpatients. Cognitive Therapy and Research, 1, 17-37.*

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

Scheier, M.F., Carver, C.S. & Bridges, M.W. (1994). Distinguishing optimism from neuroticism (and trait anxiety, self-master, and self-esteem): A reevaluation of the Life Orientation Test. *Journal of Personality and Social Psychology*, *67(6),* 1063-1078.

Scheier, M. F., Carver, C. S., & Bridges, M.W. (2001). Optimism, pessimism, and psychological well-being. In E. C. Chang (Ed.), *Optimism and pessimism: Implications for theory, research, and practice* (pp. 189–216). Washington, DC: American Psychological Association.

Schneider, K.J. (2003). Existential-humanistic psychotherapies. In A.S. Gurman & S. B. Messer (Eds.), *Essential psychotherapies: Theory and practice* (2nd ed., pp. 149 – 181). New York: Guilford Press.

Seligman, M.E.P. (2002). Positive psychology, positive prevention, and positive therapy. In C.R. Snyder and S.J. Lopez (Eds.), *Handbook of Positive Psychology* (pp. 3-9). New York: Oxford University.

Seligman, M.E.P. (2006). *Learned Optimism: How to Change Your Mind and Your Life*. New York: Vintage Books.

Seligman, M.E.P. & Steen, T.A. (2005). Positive psychology progress: Empirical validation of interventions. *American Psychologist, 60(5),* 410-421.

Serlin, R.C., Wampold, B.E., & Levin, J.R. (2003). Should Providers of Treatment Be Regarded as a Random Factor? If It Ain't Broke, Don't "Fix" It: A Comment on Siemer and Joormann. *Psychological Methods, 8(4),* 524–534.

Sharpley, C., & Ridgway, I. (1993). An evaluation of the effectiveness of self-efficacy as a predictor of trainees' counselling skills performance. *British Journal of Guidance & Counselling*, *21(1),* 73-81.

Smith, M.L., & Glass, G.V. (1977). Meta-analysis of psychotherapy outcome studies. *American Psychologist*, *32*, 752–760.

Smith, M.L., Glass, G.V., & Miller, T.I. (1980). *The Benefits of Psychotherapy*. Baltimore, MD: Johns Hopkins University Press.

Snyder, C. R. (1994). *The Psychology of Hope: You Can Get There from Here.* New York: Free Press.

Snyder, C.R. (2000). *Handbook of Hope: Theory, Measures, and Applications*. San Diego, CA: Academic Press.

Snyder, C. R. (2002). Hope theory: Rainbows in the mind. *Psychological Inquiry, 13,* 249-275.

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

Snyder, C.R., & Ingram, R. (2000). Psychotherapy: Questions for an evolving field. In C.R. Snyder & R. Ingram (Eds.), Handbook *of Psychological Change: Psychotherapy Processes & Practices for the 21st Century* (pp. 707-726). Hoboken, NJ: John Wiley & Sons, Inc.

Snyder, C.R., Irving, L. & Anderson, J.R. (1991). Hope and health: Measuring the will and the ways. In C.R. Snyder & D.R. Forsyth (Eds.), *Handbook of Social and Clinical Psychology: The Health Perspective* (pp. 285-305). Elmsford, New York: Pergamon Press.

Snyder, C.R., Sympson, S.C., Ybasco, F.C., Borders, T.F., Babyak, M.A., & Higgins, R.L. (1996). Development and validation of the State Hope Scale. *Journal of Personality and Social Psychology, 2,* 321-335.

Speier, C., & Frese, M. (1997). Generalized self-efficacy as a mediator and moderator between control and complexity at work and personal initiative: A longitudinal study in East Germany. *Human Performance, 10*, 171–192.

Stein, D.M. & Lambert, M.J. (1984). On the relationship between *counselor* experience and psychotherapy outcome. *Clinical Psychology Review, 4(2),* 127-142.

Stein, D.M. & Lambert, M.J. (1995). Graduate training in psychotherapy: Are therapy outcomes enhanced? *Journal of Consulting and Clinical Psychology, 63*, 182-196.

Sue, S., & Lam, A.G., (2002). Culture and demographic diversity. In J.C. Norcross (Ed.), *Psychotherapy Relationships That Work: Therapist Contributions and Responsiveness to Patients.* New York: Oxford University Press, (pp. 401-421).

Sue, S., Fujino, D., Hu, L., Takeuchi, D. & Zane, N. (1991). Community mental health services for minority groups: A test of the cultural responsiveness hypothesis. *Journal of Counseling Psychology, 59*, 533-540.

Swank, J.M. (2010). *Assessing the Psychometric Properties Of The Counseling Competencies Scale ©: A Measure Of Counseling Skills; Dispositions, and Behaviors*. Unpublished manuscript.

Tas, Y., & Tekkaya, C. (2010). Personal and contextual factors associated with students' cheating in science. *Journal of Experimental Education*, *78*(4), 440-463. doi:10.1080/00220970903548046

Teyber, E. & McClure, F. (2000). Counselor variables. In C.R. Snyder & R.E. Ingram (Eds.), *Handbook of Psychological Change: Psychotherapy Processes & Practices for the 21st Century* (pp. 62-87). New York: Wiley & Sons.

** Thompson, L. W., Gallagher, D., & Breckenridge, J. S. (1987). Comparative effectiveness of psychotherapies for depressed elders. Journal of Consulting and Clinical Psychology, 55, 385-390.*

Thompson, R.A. (2003). *Counseling Techniques: Improving Relationships with Others, Ourselves, Our Families, and Our Environment* (2nd ed.). New York: Routledge.

Thrower, J., & Tyler, J. (1986) Edwards Personal Preference Schedule correlates of addiction counselor effectiveness. *International Journal of Addiction, 21,* 191-193.

Tomakowsky J., Lumley M.A., Markowitz N., Frank C. (2001). Optimistic explanatory style and dispositional optimism in HIV-infected men. *Journal of Psychosomatic Research, 51(4*), 566-587.

Torrey, E.F. (1972). *The mindgame: Witchdoctors and psychiatrists*. New York: Emerson Hall.

Tryon, G.S. (1988). Relationship of counselor attitudes at intake to client premature termination. Paper presented at the Annual Meeting of the Eastern Psychological Association, Buffalo, NY, April 21-24, 1988.

University of Central Florida Counselor Education Faculty (2009). *The Counseling Competencies Scale (CCS): A Measure of Counseling Skills, Dispositions, and Behaviors*. Unpublished instrument. Correspondence regarding the CCS should be addressed to Glenn W. Lambie, Ph.D. at glambie@mail.ucf.edu

Vakoch, D.A. (1997). Predictors of prognosis for patients with interpersonal problems: The role of counselors' epistemology, experience, optimism, and theoretical orientation. *Dissertation Abstracts International: Section B: The Sciences and Engineering*, *57(11-B)*, 7240.

Van Zundert, R., Ferguson, S., Shiffman, S., & Engels, R. (2010). Dynamic effects of self-efficacy on smoking lapses and relapse among adolescents. *Health Psychology*, *29*(3), 246-254. doi: 10.1037/a0018812

Wampold, B.E. & Brown, G.S. (2005). Estimating variability in outcomes attributable to counselors: A naturalistic study of outcomes in managed care. *Journal of Consulting and Clinical Psychology*, *73,* 914-923.

Weinberger, J. (1995). Common factors aren't so common: The common factors dilemma.

Clinical Psychology: Science and Practice, 2, 45-69.

Wigfield, A. & Eccles, J. (1992). The development of achievement task values: A theoretical analysis. *Developmental Review, 12,* 265–310.

Wigfield, A. & Eccles, J.S. (2000). Expectancy–value theory of achievement motivation. *Contemporary Educational Psychology, 25,* 68–81.

Wing, E.H. (2010). The relationship between counselor empathy, the working alliance, and Therapy outcome: A test of a partial mediation model. Ph.D. dissertation, Ohio University, United States -- Ohio. Retrieved July 5, 2010, from Dissertations & Theses: Full Text.(Publication No. AAT 3398120).

Wood, R. E., George-Falvy, J., & Debowski, S. (2001). Motivation and information search on complex tasks. In M.Erez & U.Kleinbeck (Eds.), *Work Motivation in the Context of a Globalizing Economy* (pp. 27–48). Hillsdale, NJ: Erlbaum.

Wood, A.M. & Tarrier, N. (2010). Positive Clinical Psychology: A new vision and strategy for integrated research and practice, *Clinical Psychology Review* (2010)

* *Woody. G., McLellan, A. T., Luborsky, L., & O'Brien, C. (1990). Supportive expressive psychotherapy in the treatment of opiate dependence. Unpublished manuscript.*

Workman, E.A. & Williams, R.L. (1979). A brief method for determining the effect of selected counselor characteristics on clients' expectations of counseling success. *Journal of Behavior Therapy and Experimental Psychiatry, 10(1),* 41-45.

Worthington, Jr., E.L. (1988). Understanding the values of religious clients: A model and its application to counseling. *Journal of Counseling Psychology, 35,* 166-174.

Young, M. E., & Hutchinson, T. S. (2009). *The Rediscovery of Gratitude.* Unpublished manuscript.

* *Zitrin, C. M., Klein, D. E, & Woemer, M. G. (1978). Behavior therapy, supportive psychotherapy, imipramine, and phobias. Archives of General Psychiatry. 35, 307-316.*