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The Role of Optimism and Working Alliance and its Utility in Predicting Therapeutic Outcomes in Counseling Relationships

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**THE ROLE OF OPTIMISM AND WORKING ALLIANCE
AND ITS UTILITY IN PREDICTING THERAPEUTIC OUTCOMES
IN COUNSELING RELATIONSHIPS**

by

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ABSTRACT

THE ROLE OF OPTIMISM AND WORKING ALLIANCE AND ITS UTILITY IN PREDICTING THERAPEUTIC OUTCOMES IN COUNSELING RELATIONSHIPS

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Old Dominion University, 2009
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Achieving positive therapeutic outcomes is the goal of all involved in the mental health field. The last 10 years have seen ever increasing demands for recognition of the elements that constitute empirically supported treatments (EST) and research on those elements, not only by professionals in the mental health field but also by third party providers (health insurance companies) and clients. Yet over the course of this increasing demand, research has repeatedly, and authoritatively, demonstrated that the most significant and consistent contributor to therapeutic outcome is the working relationship between client and counselor, not specific theoretically-bound techniques.

In spite of the recognition of the importance of the working relationship, and the many efforts to isolate the ingredients that insure a therapeutic outcome, there is a dearth of consensus on those ingredients. With that lack of consensus in mind this research project sought to explore the interrelationship of three constructs in achieving therapeutic outcomes. The constructs that were investigated were dispositional optimism, the working alliance, and counselor experience.

Participants were counselors who worked with clients presenting with depression. The research was conducted via an Internet based survey. Participants were asked to complete instruments that measured dispositional optimism and working alliance. The amount of counselor's experience was determined via self-report on a demographic information sheet. The

Working Alliance Inventory (WAI; Horvath & Greenberg, 1989) was used to measure perceived working alliance and the Life Orientation Test – Revised (LOT-R; Scheier, Carver, & Bridges, 1994) was used to measure dispositional optimism.

Both instruments have evidence of validity and reliability in measuring the pertinent constructs, and are easily administered and scored. Upon completion of this study, statistical analyses were completed to determine the degree of relationship among the variables (dispositional optimism, perceived working alliance, and the amount of counselor's experience). In addition to identifying potential relationships, multiple regression analysis was used to determine if either dispositional optimism or the working alliance was useful in the prediction of premature unilateral termination of therapy by clients.

The results indicate that there is a statistically significant relationship among all three of the constructs studied herein. The results gave no support for the use of optimism or working alliance data as a means of predicting premature unilateral client termination. Implications of these results are discussed.

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CHAPTER ONE

INTRODUCTION

Statement of the Problem

For more than 80 years researchers have sought to delineate and describe what Rosenzweig (1936) referred to as the common factors. Common factors are conceptualized as therapeutic components that contribute to therapeutic outcome. The common factors have been determined to be the consistent and dominant influence in achieving beneficial therapeutic outcomes (Lambert & Barley, 2001). The examination of these common factors has resulted to some degree in a schism in the mental health profession. There is a group of scholars who believe that the preponderance of therapeutic outcome can be attributed to variables associated with the common factors, and another group who believe that the preponderance of therapeutic outcome can be attributed primarily to specific (often theoretically bound) techniques. Empirically supported treatments (EST) are increasingly valued by the counseling profession and managed health care providers. Thus, the argument regarding the role of common factors in facilitating therapeutic outcome has taken on added importance.

The working alliance as one of the common factors (Bordin, 1979; Greenson, 1967; Horvath & Greenberg, 1994a; Horvath & Luborsky, 1993; Wolfe & Goldfried, 1988) portends the greatest potential for creating positive therapeutic outcomes (Barber, Connolly, Crits-Christoph, Gladis, & Siqueland, 2000; Castonguay, Constantino, & Holtforth, 2006; Grencavage & Norcross, 1990; Hausner, 2000; Horvath, 2000; Horvath & Symonds, 1991; Lambert & Cattani-Thompson, 1996; Martin, Garske, & Davis, 2000; Stiles, Agnew-Davies, Hardy, Barkham, & Shapiro, 1998). Even though the beneficial influence of the working alliance has been established, other factors that influence therapeutic outcome are less defined. According to

Hanson, Curry, and Bandalos (2002), the process that makes psychotherapy successful has not been satisfactorily established. The literature (Bromberg, 1962; Frank, 2004; Grencavage & Norcross, 1990; Hynan, 1981; Lambert, 1986; Rosenzweig, 1936; Truax & Carkhuff, 1967) offers multiple studies that purport to supply various ingredients, or components of the working alliance that are at work within the common factors. Thus far though, investigators have reached no consensus.

There has been emphasis on the importance of optimism as a *common factor* that has great potential for improving the quality of life and thus facilitating therapeutic outcome (Duckworth, Steen, & Seligman, 2005; Fredrickson, 2001; Fredrickson & Joiner, 2002; Gable & Haidt, 2005; Seligman, 2002; Seligman & Csikszentmihalyi, 2000). While this literature is encouraging, the role of optimism as a common factor warrants further investigation. The majority of studies to date have examined the impact of optimism and pessimism in the lives of clients without considering the possible contribution of the counselor's personal optimism level (or lack thereof) to the creation of a positive therapeutic outcome.

Rationale for the Study

This study involves the exploration of the role of optimism in therapeutic outcome. With working alliance as an established common factor in the literature, investigating the convergence of optimism and working alliance is justified in assessing the nature of optimism in counseling relationships. When clients enter counseling, they may feel that something is not right in their lives and they usually are counting on the counselor to help them navigate presenting and underlying issues. If the working relationship has an impact on the therapeutic outcome, then understanding what the components are that impede or encourage progress is essential. Determining the extent to which a counselor's optimism has an impact on therapeutic outcome

may create opportunities to improve not only the services that counselors render to clients, but also the training programs that prepare new counselors. In addition, understanding how the counselor's optimism interfaces with working alliance may present new areas for self-reflection for practicing counselors. Such new information could also provide the basis for developing self-monitoring exercises by use by counselors and the directors responsible for counselor effectiveness. A final rationale for determining the extent to which a counselor's optimism has an impact on therapeutic outcome may be that optimism can retard the degree to which clients unilaterally terminate therapy early.

This study had two main purposes. The first purpose was to determine if there is a relationship between optimism, working alliance, and a counselor's experience level (this is a measure of the years the counselor has been working in the field). This general objective serves to uncover the relationship between optimism and an established common factor - working alliance - in the context of counselor experience level. The second purpose was to determine whether premature unilateral client termination of therapy could be predicted from the counselor's optimism level or the working alliance during therapy with a client presenting with symptoms of depression.

Depression was selected as the disorder to be studied during this research because this disorder is highly prevalent. According to the World Health Organization (WHO), 121 million people worldwide will endure this disorder (World Health Organization, 2007). The prevalence of this disorder means that finding research participants should be less difficult than perhaps another disorder that is less common. Depression is not usually accompanied by cognitive impairment, therefore making the client-counselor relationship less susceptible to communication issues.

Research Questions and Hypotheses

Research Question 1: What is the relationship among the counselor's degree of optimism, working alliance, and the counselor's experience level?

Hypothesis 1 through 3:

- 1: There will be no significant relationship between the counselor's experience level and the counselor's working alliance score.
- 2: There will be a significant negative relationship between the counselor's experience level and the counselor's optimism score (e.g., as the experience level increases the counselor's optimism score will be lower).
- 3: There will be a significant positive relationship between the counselor's working alliance score and the counselor's optimism score, controlling for counselor experience level.

Hypothesis 1 and 2 will be tested using correlational analyses. Hypothesis 3 will be tested using a partial correlation procedure.

Research Question 2: Does the counselor's optimism score and working alliance score significantly predict premature unilateral client termination from counseling?

Hypothesis 4 through 5:

- 4: The counselor's optimism score is a significant predictor of premature unilateral client termination from counseling.
- 5: The counselor's working alliance score is not a significant predictor of premature unilateral client termination from counseling.

Hypothesis 4 and 5 will be tested using multiple regression procedures.

Definitions of Terms

Common Factors

Common factors, for the purposes of this study, is defined as the counseling elements that are not particular to any specific counseling approach, but are common across a multitude of counseling approaches (Bickman, 2005; Lambert & Ogels, 2004). The definition of common factors has changed over time. To date there is no universally accepted definition of the common factors, nor is there a commonly accepted list of the components that constitute the common factors. That is, “there is little apparent agreement or empirical research on therapeutic commonalities. Without such accord, however, it is difficult to discuss them intelligibly or to apply them clinically. To our knowledge, there are no systematic reviews of the topic”(Grencavage & Norcross, 1990, p. 373). “Common factors are not isolated entities that should be taken out of context, but may more fruitfully be considered as complex multi-dimensional and interactive processes that are affected by context and change over time” (Arkowitz, 1995, p. 94).

Counselor Attributes

Counselor attributes are the particular personality traits or variables that counselors display as they provide counseling services. Personality variables are distinct from counseling techniques or methods. The study of counselor attributes has increased in importance in light of the emphasis on establishing effective working alliances within counseling relationships. Research has found that when the alliance is evaluated in early sessions, the most frequent significant association is between the alliance and outcome (Horvath & Greenberg, 1994b). The implication of these research findings are that the counselor’s personality variables directly influence counseling outcome (Sexton, Hembre, & Kvarme, 1996) in a negative direction

(Ackerman & Hilsenroth, 2001) or a positive direction (Ackerman & Hilsenroth, 2003). Some of the specific traits that have been found to influence outcome are listed in Chapter 2.

Course of Counseling

For this research the course of counseling will refer to the first four sessions of traditional counseling (this does include case management time, or time specifically used to gather information such as the completion of a psychosocial evaluation). Although the counselor is free to continue working with the client as required, this research project seeks to collect data from the first four sessions of counseling. This criterion is based on research that suggests that the working alliance is sufficiently formed as early as the third session (Barber et al., 2001; Joyce, Piper, & Ogrodniczuk, 2007; Kokotovic & Tracey, 1990). Therefore, it is considered unnecessary to continue monitoring developments beyond four sessions.

Depression

A generic working definition of depression, for the purposes of this study, is taken from the WHO. WHO (World Health Organization, 2007) describes depression as follows:

a common mental disorder that presents with depressed mood, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, low energy, and poor concentration. These problems can become chronic or recurrent and lead to substantial impairments in an individual's ability to take care of his or her everyday responsibilities. At its worst, depression can lead to suicide, a tragic fatality associated with the loss of about 850,000 thousand lives every year. (para.1)

Dropout Percentage Rate

The dropout percentage rate is the rate at which an individual counselor has experienced clients who prematurely terminate counseling services during any given period. Unilateral

premature client termination is the term used to describe the client's decision to terminate counseling services before the counselor deems that the client is properly prepared to end those services. For the purposes of this study, the dropout percentage is expressed as a percentage that has been derived from the number of clients that a counselor has seen divided by the number of clients that terminated during the same time period. The time period for this study was the 6 month period prior to completion of the survey. For example, if a counselor had 100 clients and 18 of those clients prematurely terminated services, the percentage would be expressed as .18 for analytical purposes in the database. The dropout percentage will be generated from the data collected in the demographics section and will be completed before the data is imported into SPSS (SPSS, 2008) for analysis.

Optimism

While it is argued that optimism and pessimism are bipolar, two sides of the same continuum (Scheier, Carver, & Bridges, 1994), some argue that the two are actually bivariate, or separate constructs altogether (Bryant & Cvengros, 2004). For this study, optimism will be examined independently from pessimism as a common factor. The word optimism as a psychological construct will be conceptualized for this research according to the description given by Chang (2001):

Optimism reflects an expectation that good things will happen, whereas pessimism reflects an expectation that bad things will happen. Hence, although likely to be interrelated, optimism should be distinguished from other notable psychological variables such as internal control and self-esteem. Likewise, pessimism should not be confused with expressions of lack of control and self-effacement. (p. 5)

This description is sufficiently broad to encompass most of the alternative descriptions suggested by other researchers.

Therapeutic Outcome

Therapeutic outcome will be defined as the measurable outcome or benefit accrued to a client or group of clients resulting from psychotherapeutic intervention. The outcome may in fact result in positive, negative, or negligible gain for the client in terms of the relief of symptoms, but are considered to be positive unless it is otherwise indicated by the author. Often authors will shorten the phrase therapeutic outcome to *outcome* (Baldwin, Wampold, & Imel, 2007) or interchangeably use the phrases *therapeutic benefit* (Ahn & Wampold, 2001) or *therapeutic impact* (Connor-Greene, 1993). In general, researchers discuss therapeutic outcome as the degree to which clients have demonstrated symptom reduction from a specific treatment.

Therapeutic outcome can, to a large degree, be predicted by the formation of the common factors. Since the working alliance is a working component of the common factors (Norcross, 2002), components that form the working alliance (Baldwin et al., 2007; Barber et al., 2001; Gaston, Marmar, Gallagher, & Thompson, 1991; Lambert & Barley, 2001) are assumed to be variables that produce more positive therapeutic outcomes. Some of the working alliance variables considered as part of this research are optimism and counselor experience.

Working Alliance

One of the most widely used conceptualizations of the working alliance has been Bordin's (1979) transtheoretical definition of the alliance. This conceptualization of the working alliance will be used as the basis for references to the working alliance in this research. The terms *working alliance* or simply the *alliance* will be used throughout this research to refer to Bordin's tripartite structure that consists of the goals, bonds, and tasks that exist in collaborative

counseling work. A simpler definition of the counseling relationships that was offered by Gelso and Carter (1994) is, "the feelings and attitudes that counseling participants have toward one another, and the manner in which these are expressed" (p. 159). This definition does not detract from Bordin's definition but can be seen as another view of the same concept.

CHAPTER TWO

REVIEW OF THE LITERATURE

Saul Rosenzweig (1936) challenged the mental health world with an article that, although short in length, has to this day remained conceptually viable. In the article Rosenzweig speaks to the importance of a general set of components, or common factors, in a therapeutic relationship that comprise the therapeutic alliance, or working alliance. More specifically, he asserted that psychotherapies which include these common factors produce approximately similar outcomes. This notion of the presence of common factors in producing similar therapy outcomes across psychotherapies has prompted a continual introduction of new therapies. Further, significant scholarship has presented cross-comparative research of various psychotherapies' use in addressing treatable mental health issues and identifying specific common factors and therapy outcomes. This scholarship has served to strengthen or challenge Rosenzweig's concepts.

One of the therapies that is reliant on the common factors is Client-centered Therapy, introduced by Carl Rogers. Beginning in the 1940s (Rogers, 1946), Rogers presented necessary effective components or conditions of the therapeutic relationship. He wrote extensively on Client-centered Therapy (Rogers, 1951) and the conditions that he thought were most efficacious during therapy (Rogers, 1949, 1957). The conditions espoused by Rogers (Rogers, 1957) are: For constructive personality change to occur, it is necessary that these conditions exist and continue over a period of time:

1. Two persons are in psychological contact.
2. The first, whom we shall term the client, is in a state of incongruence, being vulnerable or anxious.

3. The second person, whom we shall term the therapist, is congruent or integrated in the relationship.
4. The therapist experiences unconditional positive regard for the client.
5. The therapist experiences an empathic understanding of the client's internal frame of reference and endeavors to communicate this experience to the client.
6. The communication to the client of the therapist's empathic understanding and unconditional positive regard is to a minimal degree achieved. (p. 96)

However, Rogers' proposed facilitative conditions have been challenged. For example, Lambert, DeJulio, and Stein (1978) write that:

A number of reviewers (Bergin & Suinn, 1975; Mitchell, 1973) who were once convinced of the primary importance of the therapist interpersonal skills proposed by Rogers now seem less enthusiastic and more tentative in their appraisal. Perhaps the variables of therapist empathy, respect, and congruence are not as important as was once thought or at least do not generalize to all modalities of therapy, as has been suggested by Rogers and his colleagues. (p. 468)

Regardless of the detractors, Rogers work has continued to have a major following throughout the mental health field. The facilitative conditions necessary for effective counseling became the foundation for a major body of work that can be traced through the work of Bordin, Greenson, Bandura, and Horvath, among others, as they have searched for the essential components of therapeutic efficacy, and the most efficacious delivery modes of those components. This body of work seeks to define and refine the essence of the working alliance.

Since Rogers' writing much has been written about the conceptual components that make up the therapeutic alliance, and how it works (Baldwin et al., 2007; Barber et al., 2000; Bordin,

1979; Castonguay et al., 2006; Frank, 2004; Frieswyk et al., 1986; Gaston, 1990; Gelso & Carter, 1985; Horvath, 1981; Horvath & Luborsky, 1993; Kokotovic & Tracey, 1990; Senour, 1982; Tryon, Blackwell, & Hammel, 2007). The present research seeks to add another, often overlooked, component to the working alliance, the construct of optimism.

There is a sufficient volume of literature available on the nature and impact of optimism to illuminate the potential role of optimism for the counselor and its role in therapeutic outcome. To date, however, there is no known literature that specifically addresses optimism from the counselor's perspective, or more specifically, the counselor's optimism as a mitigating force in therapeutic outcome. In presenting how optimism may be construed as a valuable component of the working alliance, this chapter will present extant writings on optimism and related concepts to provide a context for its consideration as a condition or component of therapy. Following the discussion of optimism, other aspects of therapy including therapy outcome, common factors, working alliance, and counselor attributes are outlined. Finally, the mental health issue depression is described in relation to its costs and treatability.

Optimism

The term optimism has a long and rich philosophical history. The Latin phrase *bonum futurum* is alternately translated as hope or optimism. Unfortunately, because of the interchangeable use of hope and optimism over time, there is some confusion generated about these two separate but closely related constructs, even within the mental health literature. In one instance, Tiger (1979) made no distinction between the two constructs. In another instance when Arnau et al. (2007) were discussing hope, they cited a study by Peterson (2000) that was entitled *The future of optimism*. Bryant and Cvengros (2004) observed that:

Although separate lines of theory and research have evolved for each construct, the two terms have frequently been used interchangeably in the literature, with optimists sometimes considered to be “hopeful” toward the future (e.g., Affleck & Tennen, 1996) and pessimists said to exhibit “hopelessness” (e.g., Beck, Weissman, Lester, & Trexler, 1974). Yet it remains unclear whether this mutual substitution of terms reflects their inherent conceptual equivalence or represents a lack of conceptual precision. (p. 279)

Additionally, others (Bailey, Eng, Frisch, & Snyder, 2007) discuss the interrelationship of optimism and hope. Correlations among assessment instruments designed to measure these constructs independently (i.e., Life Orientation Test-Revised) are moderate (Bailey et al., 2007). The following discussion will attempt to draw a distinction between the two constructs in order to clarify the use of optimism in this research.

Hope and optimism are considered to be relatively stable constructs (E. C. Chang, 1998a; O'Connor & Cassidy, 2007) that are concerned with the generation of expectations regarding the future. While both focus on outcome, hope is considered to be an *emotion* influenced by external and collaborative control beliefs, while optimism is considered a *cognitive* process based on rational processes (Scioli et al., 1997).

Hope consists of two components, pathways and agency (Snyder, 1989). Pathways amount to the estimation of the capability to reach a goal, while agency amounts to the motivation to use the aforementioned capability in order to achieve a goal. Essentially, the two components work to conceive a plan and to conceptualize one’s ability to sustain engagement in reaching a goal and are necessary in order to achieve a goal (Bailey et al., 2007).

On the other hand, optimism is conceived of as the tendency to believe that “good rather than bad things will happen” (Scheier & Carver, 1985, p. 219). It is considered to be a more

generalized expectation than hope. According to O'Connor and Cassidy (2007) “optimists . . . are better at identifying suitable goals and more tenacious with respect to goal pursuit” (p. 597). The ability to maintain the perception that good things will occur as the result of certain behaviors has become known as outcome expectancy. The term outcome expectancy should not be confused with Bandura’s (1977) concept of self-efficacy expectancy, which is the belief that one has the personal capacity to carry out an activity or perform a given behavior. It may be true that the self-efficacy expectancy of Bandura and the construct of agency constructed by hope theorists overlap. In measuring these constructs the distinctions are not so clear.

Further efforts to provide distinctions between the construct of hope and optimism are beyond the scope of the present research. The purpose of drawing attention to this is to recognize that the exact nature of these constructs are still being determined, therefore the reader may recognize some overlap of conceptual material. The conduct of this research will endeavor to focus on the more generalized construct of optimism as a personal statement of expecting good things to happen. As a further delineation of purpose this research restricts the application of optimism to the formation of expectations and will restrain from consideration of agency, in as much as possible.

Optimism and Pessimism

The concept of optimism, and other existential questions have been discussed by the humanist school of psychology including Rogers, Maslow, Murray, Allport, and May (Resnick, Warmoth, & Selin, 2001). Victor Frankl’s (1992) book *Man’s Search for Meaning*, included a chapter entitled, “A case for tragic optimism.” Seligman (1975) and Scheier and Carver (1985) renewed interest in the impact of optimism and pessimism on the human experience and quality of life.

Optimism and pessimism are often conceived of as polar opposites (Dember, Martin, Hummer, & Howe, 1989), with optimism being a desirable trait, and pessimism being a less desirable trait. However, that is not actually the case. Pessimism serves as a very distinct and helpful characteristic. In fact, Peterson (2000) maintains the perspective that people may hold both expectations, that is that good and bad things may occur, depending on the situation. What is important when considering these two concepts is that a proper balance of the two traits is desired.

Thus, optimism is a widely researched trait (E. C. Chang, 2001; Gillham, 2000; Hatchett & Park, 2004), with the most dominant offered by Scheier and Carver (1985). The theoretical model of optimism offered by Scheier and Carver has been chosen for use in this research because according, to Bryant and Cvengros (2004) it “has the strongest evidence of construct validity and is the most widely used” (p. 275).

The original conceptualization of optimism by Scheier and Carver (1985) depicted optimism and pessimism as being polar ends of a single dimensional. This conception resulted in hypotheses that suggested that optimism was efficacious because it positively affected an individual’s coping strategy (Scheier et al., 1994). To test this concept and measure optimism Scheier and Carver constructed the LOT. The LOT has been used in many studies (in excess of 50 published reports according to Nes & Segerstrom, 2006) and as a result a body of evidence exists verifying the validity and reliability of the LOT (Scheier & Carver, 1992).

In 1994 the LOT was revised in order to accommodate some changes felt by the authors to result in an overall improvement of the test (Scheier et al., 1994). The resultant test, the LOT-R, is said to be essentially comparable with the LOT based on reported correlations of the two tests “in the .90s” (p. 1073). Much of the research conducted with the LOT and the LOT-R

contest the unidimensional construct of optimism. Rather than having optimism and pessimism as bipolar constructs the research seems to indicate the necessity of having optimism and pessimism represented as separate constructs, although there seems to be a high degree of conceptual and statistical overlap among these constructs (Affleck & Tennen, 1996; Bryant & Cvengros, 2004; E. C. Chang, Maydeu-Olivares, & D'Zurilla, 1997; Mroczek, Spiro, Aldwin, Ozer, & Bossa, 1993; Robinson-Whelen, Kim, MacCallum, & Kiecolt-Glaser, 1997). Based on a study conducted with older men Mroczek et al. (1993) made the following three conclusions:

- (a) Optimism and pessimism seem to be distinct constructs, having differential associations with external constructs;
- (b) optimism and pessimism may be less related in older men than in younger people;
- and (c) neuroticism and extraversion attenuate, but do not eliminate, the relation between optimism and pessimism and self-reports of hassles, psychological severity, and illness severity. (p. 409)

The LOT-R facilitates the use of the bi-dimensional construct by providing a composite score, as well as a separate score for the negatively and positively worded items.

Utility of Optimism in Counseling

In spite of all this research on optimism there is the nagging question of what is the value of it to the practitioner. Because of its relationship to coping styles the research on recognizing and identifying optimism holds the promise of providing the practitioner useful insights into coping strategies. Nes and Segerstrom conducted a meta-analysis on the link between dispositional optimism (Scheier and Carver (1985) define dispositional optimism as generally positive expectations that are not limited to a domain or setting and are relatively stable across time and context) and coping. They stated that their research had important implications regarding how an individual copes with stressful events:

In this quantitative review, optimism was found to be positively associated with approach coping strategies aiming to eliminate, reduce, or manage stressors or their emotional consequences in some way, and negatively associated with avoidance coping strategies aiming to avoid, ignore, or withdraw from stressors or their emotional consequences. (p. 248)

In addition, hopelessness and optimism are closely share a focus on future events . This relationship is of extreme importance to the mental health practitioner because hopelessness is the construct most closely associated with suicidality (E. C. Chang, 2002; O'Connor, Armitage, & Gray, 2006). A third practical application of optimism might be, according to Hatchett and Park (2004) the ability to predict a client's response to counseling. Yet even these important associations have been questioned by researchers such as Coyne and Racioppo (2000) who said, "researchers are left with unfulfilled promises and little in the way of useful, generalizable findings" (p. 656).

Optimism has been associated with several desirable outcomes. Table 1 lists some of the issues associated with optimism.

Table 1

Issues Associated with Optimism

Association	Reference
1. Capacity to deal with stress by reappraising or reframing negative events	(Bryant & Cvengros, 2004)
2. Better mood, higher numbers of helper T cells, and higher natural killer cell cytotoxicity in response to stressors	(Segerstrom, Taylor, Kemeny, & Fahey, 1998)
3. Optimism about one's life decreases a woman's risk for adverse psychological reactions to the diagnosis of, and treatment for, breast cancer.	(Carver et al., 1994)
4. Optimism correlated positively with manifestations of	(Scheier, Matthews,

- problem-focused coping and negatively with the use of denial, faster rate of physical recovery during hospitalization, faster rate of return to normal activities subsequent to discharge, and a strong positive association with postsurgical quality of life at 6 months.
5. Better adjustment to life stressors (Carver, Scheier, & Weintraub, 1989; E. C. Chang, 1998a, 1998b; Scheier, Carver, & Bridges, 2001)
 6. Enhanced social network development (including being liked more, longer friendships, fewer negative social interactions, greater levels of social support, and increased social support during stress) (Brissette, Scheier, & Carver, 2002)
 7. Greater use of more active coping strategies, including emotion-oriented and avoidance coping strategies (Hatchett & Park, 2004)
 8. Increased propensity to complete 90 day substance abuse aftercare program (Strack, Carver, & Blaney, 1987)
 9. Predictor of hopelessness which has strong link to suicidality (Beck et al., 1974; E. C. Chang et al., 1997; O'Connor & Cassidy, 2007)
 10. Strongly associated with the use of more problem-focused strategies (Nes & Segerstrom, 2006; Scheier, Weintraub, & Carver, 1986; Steed, 2002)
-

Optimism and pessimism have been closely associated with various types of coping mechanisms over the course of time, in part because they affect not only how people view the world, but also how they act within the world. In a meta-analysis of the research on dispositional optimism and coping Nes and Segerstrom (2006) concluded that more optimistic people use more problem-focused strategies. Nes and Segerstrom stated that, "Optimism correlated

positively with approach coping and problem focused coping and negatively with avoidance coping and emotion focused coping” (p. 244). They also said that,

The findings presented here indicate that optimism does not lead to rigid, inflexible patterns of coping because optimism is related to different coping strategies in response to different stressors. Instead, optimistic people are likely to cope well with controllable as well as uncontrollable stressors because they use the appropriate kind of approach strategy. (p. 247).

Summary of Optimism

Optimism still has not been described definitively, although often considered related to hope (and thus hopelessness) and inversely related to pessimism. Fortunately, the work of Scheier and Carver (1985) has set the tone for research on optimism by virtue of producing one of the most widely used instruments (LOT and the LOT-R), along with a widely accepted definition and working concept of optimism.

The degree to which one holds an optimistic viewpoint the greater the benefit to one’s well-being, but how this can be put to practical use by practitioners has been questioned. This research accepts the usefulness of optimism, but seeks to understand if the counselor’s level of optimism plays a role in therapeutic outcomes. It is believed that the counselor’s personal level of optimism will improve therapeutic outcomes and may be transferable to the client resulting in improved results.

Optimism may be a crucial link to therapy outcome and other dimensions of the therapy process. Thus, it may be fruitful to encourage the enhancement of optimism in individuals, clients and mental health practitioners. A greater understanding may allow practitioners the

ability to recognize and assess personality characteristics that are relevant to treating those who have impaired coping skills and subsequent mental health concerns such as depression.

Working Alliance

While optimism may be an important component of an effective therapeutic relationship, the therapeutic or working alliance is one of the most frequently studied constructs in psychotherapy (Castonguay et al., 2006) that is noted as significant to the therapeutic process. Freud is credited with the first use of the term alliance in 1912 (as cited in Connor-Greene, 1993), and the first to acknowledge the client-therapist relationship as an agent for treatment in 1913 (as cited in Johnson & Wright, 2002). The term was linked to transference by Freud and psychoanalytic theorists conducted much of the early inquiry into the features of the alliance (Greenson, 1967; Menninger, 1958; Sterba, 1934; Zetzel, 1966). Luborsky (1984), a psychoanalyst, defined the therapeutic alliance as “. . . the degree to which the patient experiences the relationship with the therapist as helpful in achieving his or her goals” (p. 6). According to Johnson and Wright (2002), the term alliance as used in reference to the therapeutic relationship, began to be used in a broader sense than was originally conceived by Freud. This generalized sense of the alliance has, over time, been called many things, including ego alliance (Sterba, 1934), working alliance (Greenson, 1967), therapeutic alliance, treatment alliance (Sandler, Dare, Holder, & Dreher, 1973), and the analytic alliance (Rangell, 1996). Needless to say that no matter what it is called there have been critics of the construct. For instance, Brenner (1979) suggested that the concept was superfluous and irrelevant to the practitioner.

However, psychodynamic theorists still use the terms working alliance and therapeutic alliance in very specific and limited ways, and maintain that they are two separate and distinct constructs (Gaston, Goldfried, Greenberg, & Horvath, 1995; Hausner, 2000). Baldwin,

Wampold, and Imel (2007) state that, “although there is presently no single agreed upon definition of the alliance, many researchers have adopted Bordin’s (1979) pantheoretical definition of the alliance” (p. 842).

It is Bordin’s definition that framed the conception of the alliance in a form that became useful to many theoretical positions. Until Bordin described his version of the alliance it was thought that the alliance was unidirectional. That is that the alliance was something to which either the client or the therapist contributed. With Bordin’s emphasis on the collaboration between therapist and client, the relationship was reframed as bidirectional, something that both participants must contribute to (Horvath, 2000).

The foundation of the alliance is built on four main concepts (Bordin, 1979). The first concept is that all psychotherapies require an alliance of some sort. The second concept is that therapeutic efficacy is dependent on and reflects the strength of the alliance. The third foundational concept is that differing therapies place varying demands on the therapist as well as the client. The final concept is that the strength of the alliance is determined by the compatibility of the personal characteristics of the client and therapist with the demands of the particular therapy. Bordin, at a later date, said that the alliance is not curative in and of itself but can be seen as the ingredient that, “makes it possible for the patient to accept and follow treatment faithfully” (as cited in Horvath & Luborsky, 1993, p. 563).

Bordin stated, “I propose that the working alliance between the person who seeks change and the one who offers to be a change agent is one of the keys, if not *the* key, to the change process” (p. 252). The phrase proved to be prescient because the alliance has undergone much scrutiny since 1979 and has consistently emerged as one of the prime predictors of therapeutic outcome (Frieswyk et al., 1986; Horvath & Bedi, 2002; Horvath & Symonds, 1991; Martin et al.,

2000), and has led one editor to assert that the alliance is an essential component of therapy (Norcross, 2002). One interesting finding emerged from a study that concluded that there was a strong association between the alliance and pharmacotherapy outcome (Krupnick et al., 1996), the suspicion for this efficacy is that a strong alliance may provide the support necessary to enhance the effect of drug therapy, while simultaneously allowing the client the opportunity to work through related issues.

Bordin (1979) conceptualized the alliance as being constituted by three features (a) an agreement on goals, (b) an assignment of tasks or a series of tasks, and (c) the development of bonds (p. 253). Goals consist of the mutual agreement about the degree of investment and effort expended to achieve specific goals. Tasks are related to the therapeutic skill of the therapist and the client's perception of them; to be effective they must be appropriately timed and fit with the client's expectation of therapy. Bonds reflect the human involvement of the client and therapist including the trust, respect, and care exhibited in the relationship (Johnson & Wright, 2002).

Bordin stated that, "psychotherapies . . . vary in their emphasis on the central and enduring qualities of the goals that the therapist defines, either explicitly or implicitly as those on which he is willing to collaborate with the patient" (p. 253). He saw the alliance as a series of collaborative tasks that all therapists, regardless of theoretical positions, engage in with their clients, to a greater or lesser degree. Those tasks should be made explicit so that there can be a degree of agreement between therapist and client such that it becomes a mutual goal. And that the relationship (bond) that exists between the therapist and client is the engine that provides the strength for change based on the goals and tasks. Bordin wrote:

The patient's readiness to accept a particular goal of treatment may turn out to be intimately linked to capacities or dispositions, which in turn are related to how easy it is

for him to collaborate in the particular mode of treatment directed toward the goal. (p. 256)

By making the above statement, Bordin was acknowledging that the degree to which a client can move toward a goal is related to the stressors that the client is currently coping with. Hatcher and Barends (2006) stated the core of Bordin's definition is that the: "alliance describes the degree to which the therapy dyad is engaged in collaborative, purposive work" (p. 293). Indeed, after citing several studies on this issue, Horvath and Luborsky (1993) stated that:

The results of these investigations, however, do not imply that approval of a therapist's style will necessarily result in a stronger alliance. It appears that the therapist has to (a) communicate to the client the important links between therapy-specific tasks and the overall goals of treatment and (b) maintain an awareness of the client's commitment to these activities and effectively intervene if resistance is present. (p. 564)

There is no doubt that this is a complicated construct. Johnson and Wright (2002) wrote that, "as with most relationships, defining the therapeutic relationship is difficult at best" (p. 257). Baldwin et al. (2007) stated that, "The alliance is formed in the complex transaction between the therapist and patient, each of whom brings to therapy his or her own characteristics, personality, and history" (p. 842). Baldwin et al. (2007) further delineated four sources that might account for the variability found in the alliance: (a) the first source is related to the patient's ability to form collaborative relationship, (b) the second is related to the therapist in that some therapists may be more adept at engaging patients in collaborative, purposive work, (c) the third source is related to the interaction between patients and therapists, to the extent that each has their own relational strengths and deficits, and (d) the fourth source of variability in the alliance is related to the idea that a strong alliance is the result of effective therapeutic wrought

changes. In addition to these sources, Johnson and Wright (2002) suggest other factors that complicate the relationship, (a) clients' and therapists' personal issues and problems, (b) professional training, (c) cultural influences, (d) personality traits, (e) gender, and (f) personal values (p. 258).

Baldwin et al. (2007) found that, "therapists who, on average, formed stronger alliances with their patients showed statistically significant better outcomes than therapists who did not form as strong of alliances" (p. 849). It is fair to ask if it is the therapist's action that is related to outcome, what character traits or activities taken by the therapist contribute to this outcome? Ackerman and Hilsenroth (2003) identified therapist attributes and therapist techniques that correlated positively and negatively with strong alliances.

There is also a growing body of work that indicates which variables clients and therapist bring to therapy that do not seem to significantly affect the alliance. Horvath (2000) completed an article of alliance lessons learned and in it he compiled a list of the factors that don't seem to impact the alliance. The first factor is participant gender; there was no single combination of client and therapist gender permutations that seemed to affect the alliance. Secondly, some critics of the alliance have protested that the alliance is really a result of early gains made by the client and the alliance does not in and of itself effect change. Horvath states, "In fact, investigators found that the quality of the alliance was a significant factor over and above the rate of early therapy gains" (p. 172). Lastly, Horvath cautions that all studies that use the same participant to evaluate both the process and outcome may be suspect to a bias similar to the well known halo effect.

Castonguay, Constantino, and Holtforth (2006) summarized five points that are known about the alliance from the hundreds of studies conducted on the alliance: (a) that there is a

positive and robust correlation between the alliance and therapeutic change across a wide variety of modalities; (b) the quality of the alliance correlates positively with various client characteristics and behaviors (e.g., outcome expectancy), negatively with others (e.g., avoidance); (c) the alliance is also correlated with certain therapist behaviors and characteristics that can impact the alliance negatively (e.g., criticalness), or positively (e.g., flexibility); (d) the alliance is predictive of outcome, even when measured early, and also predictive of client termination; and (e) the interest in the alliance has resulted in the construction of multiple psychometrically sound instruments used to measure the construct.

Summary of Working Alliance

There is plentiful information supporting the efficacy of the working alliance in creating positive therapeutic outcomes. However, there is some confusion about how a therapist can intentionally develop a productive working alliance (Castonguay et al., 2006), and some issues with measuring the strength of the alliance. One of the issues associated with measuring the alliance is highlighted by Tichenor and Hill (1989) when they concluded that,

Clients, therapists, and observers clearly did not agree or come to a consensus on what working alliance was, indicating that measures from different perspectives are not interchangeable. These findings are similar to those of other studies measuring consensus, or the degree to which participants' views coincide (Dill-Standiford, Stiles, & Rorer, 1988) (p. 198).

Castonguay et al. (2006, p. 275) state that, “while neophyte therapists are constantly reminded of the need to establish good rapport with their clients, there are few empirically based strategies to guide this essential work.” One study of the alliance indicates that patients’ baseline interpersonal problems negatively effects alliance formation (Constantino, Arnow, Blasey, &

Agras, 2005). Constantino (2000), and Horvath and Greenberg (1994b) warn us that without a better understanding of the mechanics of alliance formation, the correlation between alliance and outcome will surely be of limited use to counselors.

Horvath (2000) closed his conceptual work with a section on the clinical implications of the current state of alliance research. The three major points bear quoting at length:

The major message seems to be that the development of a good alliance with clients includes not only a positive, emphatic disposition by the therapist, but also a collaborative framework, a partnership in which clients see themselves as active, respected participants. Second, building an alliance is one of the most urgent tasks in the beginning of treatment: If a good alliance is not developed by the fifth session, then the likelihood of successful treatment outcome is significantly diminished Third, it seems that disturbances in the therapeutic relationship deserve immediate and careful attention; the resolution of these alliance strains not only smoothes the course of therapy, but may directly contribute to the resolution of the client's emotional difficulties. (p. 171)

The impact of the research on the alliance construct cannot be overstated. According to some, "the alliance occupies such an important place in our conceptualization of what good therapy entails that not paying attention to its quality during practice or supervision could be viewed as unethical" (Castonguay et al., 2006, p. 271).

Counselor Attributes

The research on the alliance has shown the efficacy of the construct, that it directly and positively impacts the therapeutic outcome. However, the research is inconclusive regarding the exact operative agents that deliver the sought after client related change. Despite the vast amount of research on the alliance, research on the clinical implications for the therapist is just

beginning. Horvath (2000) stated that:

Research examining this important issue is at an early stage and results are relatively inconclusive: The amount of training the therapist has does not seem to be directly related to the ability to forge a good therapeutic relationship. However, less trained therapists are more likely to misjudge the relationship than better trained clinicians, and this usually allows better trained therapists to manage the relationship more effectively in the long run. (p. 171)

In 1978 Bergin and Lambert noted that, “the largest variation in therapy outcome is accounted for by pre-existing client factors, such as motivation for change, and the like. Therapist personal factors account for the second largest proportion of change.” (as cited in, Norcross, 2002, p. 5). It is precisely those elements of the therapist’s personal factors that are in question in this research. As Norcross (2002) states, “. . . although most treatment manuals mention the importance of the therapy relationship, few specify what therapist qualities or in-session behaviors lead to a curative relationship” (p. 5).

It would be wrong to assume that therapists are the model of mental health, most therapists have some degree of difficulty understanding and dealing with therapist-client conflicts (Binder & Strupp, 1997). The recognition of this difficulty is precisely what makes the process of identifying therapist characteristics and techniques that interfere with the alliance so important. With sufficient recognition and understanding of the problem behavior therapists can work toward removing that barrier to effective therapeutic outcomes. Ackerman and Hilsenroth (2003) conducted a meta-analysis that identified therapist attributes and techniques that correlated positively with strong alliances and those therapist attributes and techniques that correlated negatively with the alliance (Ackerman & Hilsenroth, 2001). Table 2 combines the

lists of therapist characteristics and techniques that effect the alliance, created by Ackerman and Hilsenroth in the two articles published by them on this subject (2001, 2003).

Table 2

Summary of Therapist's Attributes and Techniques Impacting the Alliance

Therapist's attributes and techniques found to contribute negatively to the alliance	
Personal Attributes	Techniques
Rigid	Over-structuring the therapy
Uncertain	Failure to structure therapy
Exploitive	Inappropriate self-disclosure
Critical	Managing
Distant	Unyielding transference interpretation
Tense	Inappropriate use of silence
Aloof	Belittling
Distracted	Superficial interventions
Therapist's attributes and techniques found to contribute positively to the alliance	
Flexible	Exploration
Experienced	Depth
Honest	Reflection
Respectful	Supportive
Trustworthy	Notes past therapy success
Confident	Accurate interpretation
Interested	Facilitates expression of affect
Alert	Active
Friendly/Warm	Affirming/Understanding
Open	Attends to patient's experience

In a study of alliance fluctuations in short term therapy, Brossart, Willson, Patton, Kivlighan, and Multon (1998) suggested that one of the ways to explain short term fluctuations in the working alliance (often called a rupture) was that therapist's perception about the state of the alliance would influence the patients perception of the alliance. They argued that this hypothesis was supportable and concluded that therapist's perceptions of the alliance in early sessions significantly affected the client's perception in later sessions. This contention seems to find support in Frank and Frank (1991) in their discussion of how expectations can be transmitted by therapists, then appropriated and fulfilled by clients (p. 61). Baldwin, Wampold, and Imel (2007) identified four more potential sources of variability:

The first source is related to the patient. Some patients may be better able to form a collaborative relationship than others. . . The second source of variability in the alliance is related to the therapist . . . effective therapists may be able to engage patients in collaborative, purposive work, whereas ineffective therapists may be less able to do so . . . The third source of variability in the alliance is related to the interaction between patients and therapists. For example, some therapists may be able to form strong alliances with their patients regardless of their patients' abilities to form an alliance, whereas other therapists may be able to form a strong alliance only with those patients who come to therapy able to form strong alliances. Finally, the fourth source of variability in the alliance is related to the hypothesis that the alliance is a consequence of good outcomes . . . change in therapy produces strong alliances, not the other way around. (p. 843)

No matter the explanation, once the working alliance is ruptured an astute counselor can recognize that a rupture has occurred and can work to immediately repair it. This effort to repair an alliance rupture can be educative and may actually result in therapeutic gain if it is caught

early, and handled appropriately by the counselor (Safran & Muran, 2000). In research conducted by Rhodes, Hill, Thompson, and Elliot (1994) on how clients perceived misunderstandings (ruptures) in therapy the patients experienced negative feelings resulting from the behavior of their therapists. In events where the rupture remained unresolved patients suppressed their feelings and blamed themselves. In resolved cases patients reported that their therapist took responsibility for the rupture and engaged in activities aimed at restoring the alliance. In unresolved cases patients reported that therapists were nonresponsive, and pursued their original behavior. In either case the alliance suffered and when enough damage was done the clients usually did not return for further therapy (Piper, Azim, Joyce, & McCallum, 1991; Rhodes et al., 1994).

Several researchers have researched the alliance ruptures from the clients' perspective. Rennie (1994) found that when clients felt uncomfortable or had objections to the therapy, they simply deferred to the therapist and remained silent. Regan and Hill (1992) found that most of the issues that clients left unsaid were negative. Rhodes, Hill, Thompson, and Elliot (1994) found that clients were very adept at hiding their feelings about therapy from the therapist. In another study on hidden processes conducted by Hill, Thompson, Cogar, and Denman (1993) they found that about 65% of the patients left something negative unsaid and were prone to hide their negative feelings. Likewise, experienced therapists were only able to guess that the patients held negative feelings about 45% of the time, and they were accurate in their guesses about what patients were not saying about 27% of the time.

It is possible to pinpoint when and how ruptures happen. Rhodes et al. (1994) pointed out conditions that lead to alliance ruptures (Table 3). Safran, Crocker, McMMain, and Murray (1990)

compiled a list of markers¹ during their research that they suggest foreshadow a rupture (Table 3). Table 3 is a composite list of the research from Rhodes et al. and Safran et al. as cited in Ackerman and Hilsenroth (2001, p. 182).

Table 3

Summary of Precipitants and Markers of Ruptures in the Alliance

Precipitants to ruptures (Rhodes et al., 1994)

(a) Therapist does something the patient does not want or need

Therapist confronts unsupportively; therapist focus is off; therapist gives unwanted advice; therapist interpretation is off; therapist focused on something other than the patient

(b) Therapist fails to do something the patient wants or needs:

Therapist misses importance of issues

Markers of ruptures (Safran et al., 1990)

(a) Confrontational

Overt expression of negative sentiments; disagreement about the goals or tasks of therapy; self-esteem enhancing operations

(b) Nonconfrontational

Compliance; indirect communication of negative sentiments or hostility; avoidance maneuvers; nonresponsiveness to intervention

According to Summers and Barber (2003) technical activities in the therapeutic environment may be some of the most teachable components of the alliance. Knowing how important the therapist's techniques and characteristics are to therapy outcome, knowing what those techniques and characteristics are, and being amenable to instructional intervention makes it clear that therapists should focus heavily on the working alliance construct. Perhaps more

¹ Markers (or process markers) are described as a distinctive type of client verbalization and/or behavior indicating the presence of a distinctive underlying psychological process, and a potential readiness for a particular type of intervention (Safran et al., 1990, p. 157).

appropriately the therapist should focus on avoiding ruptures in the therapeutic alliance.

Baldwin, Wampold, and Imel put it this way:

In situations in which therapists have trouble forming an alliance, it would behoove therapists to attend to their own contributions to the alliance and focus less on characteristics of the patient that impede the development of the alliance. Indeed, therapist attributions of resistance or maladaptive attachment styles as an explanation of a poor alliance, according to our findings, would be irrelevant with regard to outcomes, although these explanations may be grist for therapeutic work. (p. 851)

Summary of Counselor Attributes

It is clear that the formation of a productive working alliance bodes well for creating a productive therapeutic outcome and for client retention. It is not entirely clear what counselor attributes lead to the formation of a productive working alliance. There is a body of research that indicates what is happening when the alliance becomes problematic (or ruptures), which if understood by the counselor can lead to the repair of the rupture in a timely fashion. It would be hopeful to assume that building an alliance is as easy as avoiding those things which produce ruptures, but the research is not clear on that, in part because of the interplay between the counselor's and the client's character traits.

Research on how a counselor effects a constructive alliance is lacking at this point. Creating the alliance, due to its prominence in positive therapeutic outcomes (especially in the early sessions), should be a central focus of the initial counseling sessions. In order to make the alliance a fruitful area of consideration for counselors, and counselor training programs, more research is needed to explicate which counselor attributes contribute to alliance formation.

Ackerman and Hilsenroth (2001) stated that:

We believe the notion that therapists are well adjusted individuals with little negative contribution to the therapeutic process has been overestimated. Therapists . . . often find it difficult to deal constructively with interpersonal conflicts in which they are actively involved (Binder & Strupp, 1997). Therefore, it is important to identify the therapist's personal characteristics that may lead to the emergence of negative process, disrupt the therapeutic process or obstruct the development of a positive and strong alliance. (p. 173)

The most significant aspects of a therapeutic encounter that contribute to a productive outcome are listed in Figure 1. If you consider that the counselor exercises a direct influence over the efficacy of the Common Factors, Expectancy, and Techniques, it then reasonable to suggest that approximately 60% of the factors that lead to productive therapeutic outcomes are under the direct influence of the counselor. The common factors and therapeutic outcomes in general are the next area of inquiry.

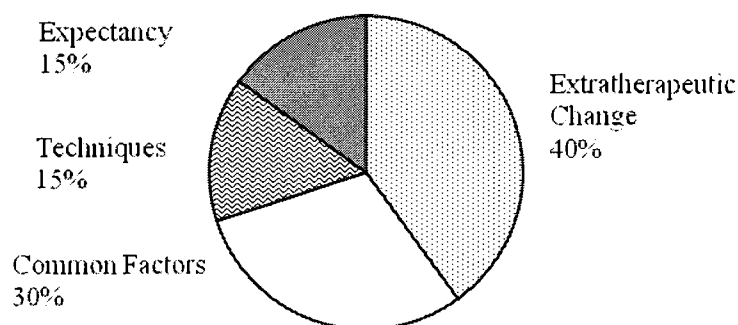


Figure 1. Psychotherapy outcome research. The data are the result of a meta-analysis of more than 100 studies and shows the relative contribution that each segment made to the outcome (Norcross, 2002).

Common Factors

There is no doubt that therapy, as it is currently practiced, is effective. Lambert and Cattani-Thompson (1996) state that by using meta-analytic research:

Smith, Glass, and Miller (1980) found that at the end of treatment the average treated person is better off than 80% of the untreated sample. Subsequent meta-analytic reviews reported comparable positive treatment effects across a variety of treatments and client problems (e.g., Anderson & Lambert, 1945; Dobson, 1989; Hartman, Herzog, & Drinkman, 1992; Robinson, Berman, & Neimeyer, 1990; Shapiro & Shapiro, 1982) (p. 602).

Based on the information presented in Figure 1, it seems that the factors under the control of the counselor that contribute the most to therapeutic outcomes are the common factors. This is true regardless of therapeutic orientation. Therefore, “it is logical . . . that attention should focus on the pantheoretical or generic factors shared by different therapeutic modalities . . . and the alliance in particular, is the quintessential common ground shared by most psychotherapies” (Horvath & Bedi, 2002, p. 37). Ergo, the study of effective therapy requires a consideration of the working alliance and the common factors.

The medical model, or the diagnostic model (Horwitz, 2002), which has increasingly influenced psychotherapy, assumes that there is just one appropriate and most efficacious cure for any diagnosis. Jorgensen (2004) described the medical model in this way:

The vast majority of theories concerning psychotherapeutic mechanisms of eliciting change are embedded in a medical model of psychotherapy. . . According to this model, therefore, specific disorders—or patients in specific diagnostic categories—require specific interventions and specific active ingredients (p. 519)

A long time critic of the medical model, Albee (1998), thinks that the mental health industry has struck up a “Faustian” contract by accepting the medical model. Albee (1998, p. 192) has said that, “Now we have gone so far down this road that we may never escape.”

With the increasing emphasis on empirically validated treatments (EVTs) (alternatively referred to as evidence-based treatments [EBTs] or empirically supported treatments [ESTs]) in psychotherapy, large amounts of energy and research have been expended to determine which treatment is the most appropriate for any given diagnosis. Unfortunately it is becoming clear that the medical model does not apply to mental health. In fact Bohart (2000) said that:

There is so much data for this conclusion [that no one theory is superior] that if it were not so threatening to special theories it [the dodo bird premise] would long ago have been accepted as one of psychology's major findings. Then it would have been built upon and explored instead of continually being debated. The data call for a change in how we view therapy, but the field continues to stick to the old technique-focused paradigm. (p. 129)

Thomas Huxley (1890) coined the maxim, "The great tragedy of science — the slaying of a beautiful hypothesis by an ugly fact." It is appropriate to quote here because the adherence to the medical model in psychotherapy is the beautiful hypothesis, and the ugly fact is represented by the research that indicates that all treatments achieve approximately the same outcome. In discussing the results of a meta-analysis, Ahn and Wampold (2001) said, "The present meta-analysis of component studies produced no evidence that the specific ingredients of psychological treatments are responsible for the beneficial outcomes of counseling and Psychotherapy" and that "Attempts to demonstrate specificity by examining mediating effects have failed to show that specific treatments work through the theoretically hypothesized mechanisms" (p. 254). The beautiful hypothesis that has been slain by current research is that no one theoretical modality is any more effective at reaching desirable therapeutic outcomes than another. Therefore, the researchers must acknowledge the ugly fact that there is something shared in all therapies that produce the desired outcomes.

The concept of common therapeutic factors dates back to a discerning article written by Rosenzweig (1936) that correctly foresaw the current struggle between the pursuit of prescriptive treatments of disorders based on a medical model, and the empirically sound call to base therapy on relational models. As was pointed out previously in this chapter, all theoretical approaches to therapy produce more or less equivalent outcomes. Rosenzweig's point was that some factor, or series of factors that are apparently trans-theoretical (ergo common factors) must be creating the positive outcome results, in spite of a particular school of therapeutic thought. In the years since Rosenzweig's article his position has been repeatedly proven by researchers of therapeutic outcome, that is that there is no one therapeutic position that is clearly superior (Bergin & Lambert, 1978; Lambert, 2001; Lambert & Barley, 2001; Lambert & Cattani-Thompson, 1996; Lambert & Ogels, 2004; Luborsky, Singer, & Luborsky, 1975; Orlinsky & Howard, 1986; Shapiro & Shapiro, 1983; M. L. Smith & Glass, 1977; M. L. Smith, Glass, & Miller, 1980; Wampold, 2001; Wampold, Mondin, Moody, & Ahn, 1997a; Wampold et al., 1997b).

Rosenzweig (1936) pointed out that there is no form of psychotherapy that has not achieved some degree of success. However the fact that a therapy has achieved a degree of success can have two different interpretations. The first is that the operating premise of the therapy is true and all others are false. The second possible interpretation is that the successes, particularly of competing positions, does not constitute sufficient grounds to reliably evaluate the theories. He further points out that:

Not only is it sound to believe that the same conclusion cannot follow from opposite premises but when such a contradiction appears, as seems to be true in the present instance, it is justifiable to wonder (1) whether the factors *alleged to be* operating in a given therapy are identical with the factors *that actually are* operating, and (2) whether

the factors that actually are operating in several different therapies may not have much more in common than have the factors alleged to be operating. (p. 412)

Rosenzweig further believed that all successful therapies do in fact share common elements. These elements may be unrecognizable to the practitioner, but, according to Rosenzweig (1936), “may be even more important than those (factors) being purposely employed” (p. 412). Rosenzweig then offers four factors that he considers common to all therapies. The four factors identified by Rosenzweig as essential avenues of change are paraphrased here by Weinberger:

(a) the therapeutic relationship; (b) provision of a systematic ideology or rationale to help explain the patient’s condition and ways of improving it; (c) integration of systems and subsystems of personality; and (d) the personality of the therapist (2002, p. 69).

Other authors have commented on the common factors since Rosenzweig. Bromberg (1962) and Hynan (1981) both offer only one common factor. Interestingly Bromberg points to the therapist as the common factor, and Hynan (1981) points to the client as the common factor. Truax and Carkuff (1967) suggest that there are three common factors, Frank and Frank (1991), and Frank (2004), listed four general factors, while yet another author (Lambert, 1986) pointed to as many as 20 common factors. Frank (2004) acknowledged that his list of shared therapeutic components was “with minor variations” (p. 59) similar to Rosenzweig’s list.

It seems as though there is implicit agreement regarding the existence of common factors, but there does not seem to be a clear delineation of what constitutes the common factors. Hubble, Duncan, and Miller (1999) published a book with sections from multiple authors who had extensive knowledge regarding the research on the state of the common factors. Although these authors emphasized the contributions of the client, the factors were still very similar to

Rosenzweig's and Lambert's original list of common factors.

Grencavage and Norcross (1990) conducted a meta-analysis of 50 publications from professional books and journals. The number of common factors listed in the publications ranged from 1-20, and when compiled the list of distinct common factors reached a total of 89. The various common factors were then ordered according to the number of authors who listed them. The factors were then broken into five distinct categories. Table 4 contains the categories and the top three most frequently occurring factor along with appropriate percentages.

Table 4

Common Factors Categories and Most Frequently Listed Factors by Category

Client Characteristic (6% of total)	Therapist Qualities (21% of total)	Change Processes (41% of total)	Treatment Structure (17% of total)	Therapeutic Relationship (15% of total)
Positive expectation/ hope or faith (26%)	General positive descriptors (24%)	Opportunity for catharsis/ ventilation (38%)	Use of techniques/ rituals (14%)	Development of alliance/ relationship (general) (56%)
Distressed or incongruent client (4%)	Cultivates hope/enhances expectancies (20%)	Acquisition and practice of new behaviors (32%)	Focus on inner world/ exploration of emotional issues (10%)	Engagement (10%)
Patient actively seeks help (4%)	Warmth/ positive regard (16%)	Provision of rationale (24%)	Adherence to theory (8%)	Transference (10%)

Note: This information was taken from Grencavage and Norcross (1990). The table does not list all of the commonalities listed in their research, only the three most often listed aspects of each category.

Table 4 only represents one way in which researchers have organized the common factors. Grencavage and Norcross (1990) put it this ways:

However, the single most frequent commonality was the development of a collaborative therapeutic relationship/alliance. This emphasis reflects the often asserted notion that

techniques are inextricably embedded within the relationship. In fact, all client, therapist, technical, and relationship elements are unavoidably interrelated. Fine lines of distinction drawn in research do not exist in actual practice. . . . It is evident that different authors were addressing different domains of clinical practice when proposing common factors. Less than half of the authors spoke of client characteristics, and no commonality approached 100% endorsement. Obviously, it is difficult to discuss common factors intelligibly or, more important, to apply them clinically when some authors focus on one level of treatment and other authors focus on a different level. (p. 377)

However, if all the common factors are grouped together, according to Lambert (Lambert, 1986), and Asay and Lambert (1999), the therapeutic relationship factors account for up to 30% of potential outcome efficacy. After years of researching outcome efficacy publications, Asay and Lambert broke out the factors that account for psychotherapeutic efficacy. Extratherapeutic factors contributed 40% to the outcome, therapeutic relationship factors (including the common factors) contributed 30% to the outcome, outcome expectancy contributed 15% to the outcome, and specific therapeutic techniques contributed only 15% to the outcome.

Summary of Common Factors

Ahn and Wampold (2001) captured the current state of research into the common factors when they said:

The results of the present meta-analytic study are not an anomaly in an otherwise uniform field of research results supporting specificity; rather, the preponderance of the research evidence is not supportive of the benefits of specific ingredients. This suggests that the benefits of treatments are probably due to the pathways common to all bona fide

psychological treatments, such as the healing context, the belief in the rationale for and the efficacy of therapy by the client and by the therapist, the therapeutic alliance, therapeutic procedures consistent with the client's understanding of his or her problems, the development of increased self-efficacy to solve one's problems, and remoralization (Frank & Frank, 1991; Garfield, 1992; Wampold, 2001). The research evidence supports the notion that the benefits of counseling and psychotherapy are derived from the common factors (p. 255).

Even if the exact composition of the common factors is not clear, there are implications for rejecting the premise that specific techniques are responsible for outcome efficacy. Those implications include decisions about how counselors are trained, how counselors engage in practice, and what type of research is needed in the field. This does not negate the development of good techniques but it does move them from a position of primacy. Duncan (2002) suggested that, "psychotherapy abandon the empirically bankrupt pursuit of prescriptive interventions for specific disorders based on a medical model of psychopathology" (p. 34).

In the forward to *The heart and soul of change: What works in therapy* (Hubble et al., 1999), John Norcross succinctly stated:

Let's confront the unpleasant reality and say it out loud: The rivalrous warfare among theoretical orientations in psychotherapy has impeded scientific advances and hindered the development of effective treatments. In the dogma-eat-dogma environment of "schoolism," clinicians traditionally operated from within their own particular theoretical frameworks, often to the point of being oblivious to alternative conceptualizations and potentially superior interventions. Although this ideological cold war may have been a necessary developmental stage, its day has come and passed. The era of rapprochement is

upon us. (p. xvii)

In this era of rapprochement this research seeks to explore the nature of optimism. Once the construct of optimism is better known this research intends to introduce optimism as one of the components included in the common factors. One of the components, that when grouped with the other common factors, will offer therapists a means of delivering “potentially superior interventions.”

Therapy Outcome

The constructs of working alliance, common factors and counselor attributes relate to another construct, therapeutic outcome. Therapeutic outcome is the measure of the efficacy of any given treatment, or intervention. With the advent of concerns over empirically supported treatments (EST) much attention and energy has been spent trying to determine what factors deliver the best, or most productive therapeutic outcomes.

Unfortunately, it is a complex task that as of yet there are many too variables to consider in concluding what constitutes the best ESTs. If, as Goldfried and Wolfe (1996) suggest there are at least 250 types of therapy and 300 disorders, it would be difficult to conceive of research wherein every type of therapy could be tested against every type of disorder to find out the most effective therapy. As Wampold et al. (1997b) stated, “it is unrealistic to believe that clinical trials will ever be conducted to cover even a portion of the possible Treatment X Disorder cells. Consequently, an omnibus hypothesis about all treatments with all disorders will never be tested” (p. 211).

One of the major issues revolves around the question about what type of client change is sufficient. If the client achieves therapeutic change how is the change characterized, and what was the causative factors in the change. Author describing this change have used the following

terms, (Lambert, Hansen, & Finch, 2001) clinically significant change, reliable change (or improvement), and statistically significant change, none of which are definitive terms. Essentially then each researcher concludes for themselves how they will measure what constitutes success in treatment.

There are other confounding factors which make it difficult to measure success. The concerns can best be summarized by a series of questions. What was the true state of the client before beginning therapy? Are all subjects accurately diagnosed, and the degree of dysfunction accurately understood? How quickly did the client begin to respond to the treatment? When does the researcher follow-up with the clients to see how long the results lasted? How closely did the therapist adhere to a specific mode of treatment? Does researcher bias result in selecting participation criteria that favors chosen outcome? Are the clients who terminate early considered in the final results? How rigorously are treatment protocols followed? What is the impact of the treatment site? What is the impact of using the same measurement instrument repeatedly? These, along with a host of others, are major concerns when trying to arrive at conclusions about which treatments can be considered to be empirically supported. Since research on human subjects cannot be conducted in the most rigorously scientific fashion it is likely that many of these issues will continue to confound research on ESTs for some time.

This is not to imply that research on empirically supported treatments is not valid. Rather, it is meant to point out that researchers still have some obstacles to overcome in this line of inquiry, and that the preliminary findings need to be approached as works in progress. In spite of these limitations the research on therapeutic outcomes is well worth considering.

One of the earliest and most significant questions for researchers of therapeutic outcomes had to do with the efficacy of psychotherapy in general. This question was initially raised by

Eysenck (1952) when he suggested that the percentage of those who recover as a result of therapeutic interventions is the same as the percentage who recover spontaneously without intervention. Ahn and Wampold (2001) emphatically answered that question by stating that, “It was established in the 1980s that counseling and psychotherapy are remarkably efficacious” (p. 251).

One of the earliest works on the efficacy of therapy comes from Luborsky, Springer, and Luborsky (1975). Among other things this study compared the outcome of therapy against the outcome of control groups, and compared specific forms of therapy outcomes against each other. The first conclusion reached in this study is that, “Most comparative studies of different forms of psychotherapy found insignificant differences in proportions of patients who improved by the end of psychotherapy” (p. 1003). Essentially the authors were saying that not one of the therapy forms that they studied achieved significantly better results than any of the other treatments. The second conclusion from this study was that, “The controlled comparative studies indicate that a high percentage of patients who go through any of these psychotherapies gain from them” (p. 1003). This study was a meta-analysis and showed that about 80% of the studies that they reviewed showed positive results for the clients involved in therapy.

In an often cited meta-analysis, Smith and Glass (1977) reported the results of statistically integrating nearly 400 psychotherapy evaluations. One of the authors stated purpose in conducting this meta-analysis was to determine the magnitude of the effect of therapy. The 375 studies yielded 833 effect size measures, almost 25,000 participants and control subjects. The aggregated conclusion of the study resulted in the superiority of the treatment groups over the control groups by .68 standard deviation. The authors of the study stated that, “the average

client receiving therapy was better off than 75% of the untreated controls” (M. L. Smith & Glass, 1977, p. 754).

In a later study Smith, Glass, and Taylor (1980) increased the number of evaluations included in the research but they found results similar to the original Smith and Glass (M. L. Smith & Glass, 1977) meta-analysis. The average effect size increased from .68 to .85, indicating that the outcome for the average treated person was 80% better than the untreated person. Authors of two other meta-meta-analyses (Grissom, 1996; Lipsey & Wilson, 1993) conducted in the 1990s substantially agreed with the conclusions reached by Smith, Glass, and Miller (1980), although the mean effect size was somewhat lower.

Of course the original Smith and Glass study received some criticism, particularly from those who advocated particular methods or techniques. Eysenck (1978) responded to the Smith and Glass article with this statement, “the most surprising feature of Smith and Glass’s exercise in mega-silliness is their advocacy of low standards of judgment” (p. 517). Shapiro and Shapiro (1983) attempted to answer those criticisms and challenges by performing another meta-analysis, resulting in similar results to the study of Smith and Glass (1977). The mean effect size was near one full standard deviation. One additional piece of information resulting from this study was that differing methods of treatment accounted for less than 10% of the total variance in the overall effect size.

In a review of the literature Lambert and Cattani-Thompson (1996) not only reiterated that therapy was generally effective, but they also determined that 75% of the clients benefited from significant recovery within as few as 26 sessions of therapy or about 6 months of once-a-week therapy, with 50% receiving significant relief with as few as 8-10 sessions. In contrast Lambert, Hansen, and Finch (2001) stated that 50% of patients needed 13 sessions to reach the

criteria for clinically significant change, but if the criteria were switched to reliable change, 50% of the clients needed only 10 sessions.

Nicholson and Berman (1983) also reported that the improvements made by clients over the course of their therapy were retained for extended periods after the therapy. In another study it was concluded that 73% of those who demonstrated an early response to therapy were able to maintain those gains or make further gains after therapy (Haas, Hill, Lambert, & Morrell, 2002). Even those who didn't have early responses to therapy were able to maintain and continue to make gains after therapy was complete. One conclusion that Lambert (2001) made from this research was that long term therapy was not superior to other therapies in helping clients maintain their therapeutic gains.

In a 1997 study conducted to test the Dodo bird conjecture² Wampold et al. (1997b) concluded that:

The results of our analysis demonstrated that the distribution of effect sizes produced by comparing two bona fide psychotherapeutic treatments was consistent with the hypothesis that the true difference is zero. Moreover, the effect sizes produced by such comparisons were not related to the similarity of the treatments compared, nor did they increase as a function of time. (p. 210)

One caveat that came out of this study was that this study looked at the average effect size, therefore it is necessary to recognize that every therapy would not work with every client. The authors stated it this way, "The results of this meta-analysis suggest that the efficacy of the treatments are comparable, not that the treatments are interchangeable" (p. 211).

² The Dodo bird conjecture was first used by Saul Rosenzweig in a 1936 article. The Dodo bird is the well known character from *Alice in Wonderland* (Carroll, 1865/2000) that stated after watching a race in which the contestants had all started in different places, at different times, "Everybody has won, and all must have prizes." Rosenzweig's implication was that all psychotherapies produced equivalent outcomes; therefore there must be some common factors that account for the success of psychotherapy.

According to Wampold (2000) the argument over the effectiveness of psychotherapy has been definitively resolved:

Clearly, the global efficacy issue has been decided, but one has to wonder whether the results applies universally; that is, is counseling and psychotherapy effective for all problems or disorders? The answer appears to be that for problems and disorders that are thought to be appropriate for treatment and to which researchers have turned their attention, the answer is “yes.” (p. 714)

Summary of Therapy Outcome

Since the 1950s when the overall efficacy of psychotherapy was challenged (Eysenck, 1952) a great deal of research has been conducted . Over a thousand studies have been conducted and multiple meta-analyses of those studies have been performed. Lambert and Ogels (2004) summarized their findings on this body of work by stating;

Although the methods of primary research studies and meta-analytic reviews can be improved, the pervasive theme of this large body of psychotherapy research must remain the same—psychotherapy is beneficial. This consistent finding across thousands of studies and hundreds of meta-analysis is seemingly undebatable. As a result, researchers have turned to other important questions that take us beyond the issue of whether an average positive change occurs in treated case. (p. 148).

There are three major findings that should be kept in mind regarding this field of inquiry. The first is that there is a great deal of evidence to support the conclusion that at the end of treatment, the average person in treatment was better off than 80% of those who did not receive treatment (M. L. Smith et al., 1980). The second finding to keep in mind is that there is also evidence that clients make improvements in a short period of time, 75% make significant

improvements in 26 sessions of therapy, and approximately make significant improvements in as little as 8 sessions (Kadera, Lambert, & Andrews, 1996). The final finding to keep in mind is that most of the improvements experienced by clients through therapy are sustained for months and even years after therapy has ended (Nicholson & Berman, 1983).

Depression

A diagnosis of depression often carries a stigma in this country, and by the uninformed may still be considered something other than an illness. The World Health Organization (World Health Organization, 2007) describes depression as:

a common mental disorder that presents with depressed mood, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, low energy, and poor concentration. These problems can become chronic or recurrent and lead to substantial impairments in an individual's ability to take care of his or her everyday responsibilities. At its worst, depression can lead to suicide, a tragic fatality associated with the loss of about 850,000 thousand lives every year. (para. 1)

Depression has been and will be a major cause of economic and social burdens, not only here in the United States, but throughout the world. The World Health Organization (WHO) estimates that worldwide depression is all too common, affecting almost 121 million, with less than 30 million of those having access to any kind of effective interventions (World Health Organization, 2007, p. 1). According to the National Comorbidity Survey (NCS) that uses three classifications: (a) minor depression (mD), (b) major depression with five to six symptoms (MD 5-6), and (c) major depression with seven or more symptoms (MD 7-9) (Kessler, Zhao, Blazer, & Swartz, 1997). The estimated lifetime (LT) prevalence of minor depression (mD, is described as having 2-4 of the Criterion A symptoms necessary to make the diagnose of major depressive

disorder) is 10% ($SD=0.5$), major depression (MD 5-6, is described as having 5-6 of the Criterion A symptoms necessary to make the diagnose of major depressive disorder) is 8.3% ($SD=0.4$), and major depression (MD 7-9, described as having 7 or more Criterion A) is 7.5% ($SD=0.4$). The lifetime prevalence for all three depression categories increase for people in the following groups; homemakers, women, nonhispanic whites, and those classified in a category consisting mainly of the disabled or unemployed (Kessler et al., 1997).

According to a replication of the National Comorbidity Survey (NCS-R), the lifetime prevalence of MDD in the NCS-R sample reached 16.2% (35 million US adults), and 6.6% (14 million US adults) for the 12 months preceding the interview. The risk of encountering MDD is fairly low until the early teen years, and incredibly, by the end of the teen years almost three in four people who eventually were diagnosed (72%) with lifetime MDD had also met the criterion for other DSM-IV disorders, including 59% with anxiety disorders, 24% with substance use disorders, and 30% with impulse control disorders (Kessler et al., 2003).

An important note in interpreting the prevalence of depression is that the definition of depression has changed over time. It is difficult to gain a precise understanding of the prevalence of depression in the literature because there are multiple forms of depression that are studied and often they are not clearly differentiated, or the literature uses arbitrary classifications. For instance one of the articles describing the results of the original National Comorbidity Survey (NCS) chose to use three classifications: (a) minor depression (mD), (b) major depression with five to six symptoms (MD 5-6), and (c) major depression with seven or more symptoms (MD 7-9) (Kessler et al., 1997). The author's reason for doing so implies that depression lies on a continuum from mild, short-lasting syndromes towards the most severe type that includes chronic, recurrent, and disabling symptoms.

In fact since the original NCS was conducted in 1990, changes in the diagnostic criterion for depression have taken place repeatedly, including at least three changes to the Diagnostic and Statistics Manual (DSM-III-R, DSM-IV, and DSM-IV-TR). “Lack of consensus as to the heterogeneity of depression is reflected in the evolving diagnostic categories of depressive disorders” (Chen, Eaton, Gallo, Nestadt, & Crum, 2000, p. 573). The current DSM-IV-TR has Minor Depressive Disorder listed in the section entitled “Criteria Sets and Axes Provided for Further Study” (American Psychiatric Association. Task Force on DSM-IV, 2000), which seems to indicate that changes may be coming in future revisions of the DSM. The fact that depression categories and description have changed over time needs to be kept in mind as the literature is reviewed.

Depression has been, and will continue to be an increasingly costly disease in America. The costs of depression are most dramatically seen in the economic, social, and comorbidity realms. The estimated cost of depression to employers in this country is over \$44 billion per year in lost production time (LPT) (Stewart, Ricci, Chee, Hahn, & Morganstein, 2003). That estimate is almost \$31 billion more LPT than employers lose per year for those employees without depression. This same report estimates that over 80% of the cost for LPT comes from reduced performance while at work as opposed to absenteeism. The estimated lost production time cost does not include the cost that employers incur for replace missing or disabled workers, either on a daily or long term basis.

With respect to social costs, role impairment was a large problem for those reporting 12 month MDD issues, almost 97% reported some degree of role impairment, 87% described the impairment as moderate and 59% reported their impairment was severe or very severe. The greatest degree of role impairment was experienced in the social role domain (43% reporting

severe or very severe impairment) and the least degree of impairment was experienced in the work role domain (28% reporting severe or very severe symptoms). Those with 12 month MDD that missed days of work or were unable to carry out normal functions due to their depression amounted to a mean loss of 35.2 days (range = 26.8-43.6 days). To put this in perspective, those suffering with MDD experienced more than double the amount of days out of role when compared to those who experienced chronic medical conditions (mean for this population is 15 days) (Kessler, Greenberg, Mickelson, Meneades, & Wang, 2001).

Further, “depression is among the most costly³ because it is highly prevalent and comorbid with other conditions” (Stewart et al., 2003, p. 3135). Depression has been linked to a variety of physical health issues including diabetes (Cassano & Fava, 2002), alcohol dependence (Hasin & Grant, 2002), and sleep disturbance (Tylee, Gastpar, Lepine, & Mendlewicz, 1999). In some cases depression has been found to be concomitant to chronic physical problems such as blood pressure related issues, backaches, arthritis, hypertension, and other cardiac related issues (Cassano & Fava, 2002; Tylee et al., 1999). There appears to be a relationship between chronic physical health problems and depression in that approximately 60% of those who had depression also identified that their physical illness was the source and fully 99% stated that they would never recover from depression (Tylee et al., 1999). Cassano and Fava (2002) point out some of the other costs or issues associated with depression in the United States (see Table 5).

Table 5

The Burden of Depression in the United States

Issue	Details
Prevalence of MDD	13-17% LT
Rate of suicide attempts among depressed patients	*21%

³ In terms of costs associated with health related lost labor time.

Ratio of suicides committed by depressed patients	*66%
Yearly cost of depression related disability	\$43.7 billion
Yearly direct cost of depression related disability	\$12.4 billion
Yearly cost of depression related disability due to mortality	\$7.5 billion
Annual health care costs: depressed/nondepressed	\$4246/\$2371
Ranking of diseases with greatest burden worldwide in 2000	4th
Ranking of diseases with greatest burden worldwide in 2020	2nd
Average lost days in month preceding referral for medical services (depressed/nondepressed)	8/2
Normal days of activity lost in 6 months following treatment	30
Working days lost in 6 months following treatment	20
Percentage of depressed patients with chronic medical conditions	*65-71%
Cardiac mortality risk in depressed patients without cardiac disease	+ 1.5 to 3.9
Death rate risk among person with depression and comorbid diabetes	+ 3.8
Mortality risk post myocardial infarction among depressed	+ 4-6.0
People with depression who don't seek treatment	43%
Young diabetics developing a MDD within 10 years	27.5%
Ranking among most common chronic conditions	2 nd
Estimated rate of missed diagnoses of depression	*50%
Lifetime prevalence by gender: women/men	21.3%/12.7%
Risk of recurrence after first/second/third episode of major depressive disorder	> 50%/70%/90%

Note: * indicates that the figure was rounded instead of being the exact figure.

To a large degree it is thought that, despite the availability of effective treatments, depression remains under reported and under treated in this country and most developed nations, in part due to the stigma of having a mental health disorder. Despite the prevalence of depression the dichotomy of professional practices in this country may not be serving sufferers of comorbid depression very effectively. Cassano and Fava (2002) suggest that up to 71% of people who

suffer from depression also have comorbid medical conditions, yet only 57% of those patients seek help for their depression, most of them only seeing their primary care physician (PCP). Of the depressed patients that are seen by PCPs the average functional capacity is 28% lower than the nondepressed. The depressed patient with coronary issues is rated as having a functional level up to 34% less than the nondepressed. The average older patient with depression is also less likely to improve during hospitalization and is subject to greater deterioration than their nondepressed contemporaries (Cassano & Fava, 2002; Covinsky, Fortinsky, Palmer, Kresevic, & Landefeld, 1997). Further, There is a positive correlation between depression and increased mortality risk in older people (Penninx et al., 2001).

The depressed patient being seen for physical health issues is also more likely to have an increased mortality rate. Suicide in the U.S. accounts for roughly 0.09% of all deaths, however in the population of those with recurrent depressive disorders the suicide attempt rate rises to almost 21% (Cassano & Fava, 2002). Approximately 2 of every 3 suicides that occur in America occur in depressed patients (Sartorius, 2001).

Treating Depression

Treating depression has been a successful venture (Lepine, Gastpar, Mendlewicz, & Tylee, 1997). Treatment for depression usually takes one of three forms. One form is the use of prescription medicines, the second form is the use of therapeutic intervention, and the final form is a combination of medicines and therapy. Since some medical conditions (e.g., diabetes or thyroid conditions) give rise to depressive type symptoms, it is always in the best interest of the client to have them undergo a thorough medical screen to alleviate the possibility of a medical condition.

Regarding the first form of depression treatment, overall 63% of patients who have received some form of the newer generation of antidepressants improved by at least 50% (Cassano & Fava, 2002). The response rate from clients receiving placebos was 35%, and for those using the older generation of antidepressants (tricyclic antidepressants, or TCAs) was 60%. It is also deemed unethical to withhold potentially helpful medications from clients who would be well served by their use. Therefore it is unlikely that any research on therapeutic effects in depression can be conducted without the confounding issue of medications, so much so that Cassano and Fava stated that, “the effect of psychotherapy alone in the treatment of depression in primary care has not been studied adequately yet” (2002, p. 854).

Additionally, there is a growing body of literature questioning the efficacy of antidepressants. In a document published by the World Health Organization’s Regional Office for Europe’s Health Evidence Network the authors state, “No matter which is the first (pharmacological) treatment chosen, about one-third of patients will either not respond to or not tolerate it” (Moller & Henkel, 2005, p. 8). Moller and Henkel (2005) also point to evidentiary gaps in the literature regarding pharmacological treatment of depression by concluding that 50% of negative trials are unpublished, and that most of the random controlled trials have been conducted by pharmaceutical companies. Parker, Roy and Evers (2003) and Thase (1999) make similar points.

In a study submitted to the Food and Drug Administration (FDA) Kirsch et al (2008) found that during some controlled trials drug manufacturers sought and were approved to replace test participants mid way through the trial if the participants were not responding to the treatment. All of the trials that were included⁴ in this meta-analysis were conducted on the family

⁴ By federal mandate all trials conducted on a drug must be submitted as part of the approval process for new drugs.

of drugs known as selective serotonin reuptake inhibitors (SSRIs). The conclusion reached in this meta-analysis was:

Using complete datasets (including unpublished data) and a substantially larger dataset of this type than has been previously reported, we find that the overall effect of new generation antidepressant medications is below recommended criteria for clinical significance. We also find that efficacy reaches clinical significance only in trials involving the most extremely depressed patients, and that this pattern is due to a decrease in the response to placebo rather than an increase in the response to medication. (p. 0265).

Most forms of psychotherapy available for use with depression are now time-limited due to the influence of managed care and to meet client preferences (Moller & Henkel, 2005).

Cognitive behavioral therapy (CBT) has become the most researched form of therapy treatment for outpatients depressive disorders (Scott, 1996), but it is far from being the only effective form of psychotherapy for the depressive population. CBT alone is not an effective treatment for the severely depressed according to Klein (1996). Thase (1997) concluded in a meta-analysis that, “Whereas combined therapy was not significantly more effective than psychotherapy alone in milder depressions, a highly significant advantage was observed in more severe recurrent depressions” (p. 1009).

One of the major advantages of using psychotherapeutic interventions, which initially may cost more than pharmaceutical interventions (Gabbard, Lazar, Hornberger, & Spiegel, 1997), is that there is a significantly reduced relapse rate (Scott, Palmer, Paykel, Teasdale, & Hayhurst, 2003). Scott et al. (2003) found that for 158 patients who were in a state of partial

remission, the group using cognitive therapy had a significantly lower relapse rate (29%, as opposed to 47%) than the control group.

Summary of Depression

Depression is a very treatable disorder, yet many of the sufferers go untreated throughout the United States. With sufficient education, pharmacological and psychotherapeutic interventions the burden of this disorder could be significantly reduced.

Summary

This literature review set a course to review the current research on Depression and aspects of therapy, including Therapeutic Outcome, Common Factors, Optimism, Working Alliance, and Counselor Attributes. It was thought that this was a deductive pattern, in that depression is one of the major categories of mental illnesses in this country with a rising trend pattern. It is also considered to be highly treatable. The pattern set in this review was to touch on the factors that would lead to successful resolution of client depression, arriving at the counselor attributes as determining factors in achieving resolution for depression.

It seems that counselor attributes have a direct impact on the working alliance, that the working alliance is the most influential of the common factors, which in turn exercises the highest degree of influence on therapeutic outcomes. This researcher then sees a direct connection between counselor attributes and efficacious therapeutic outcomes that result in the resolution of depressive symptoms.

Although optimism is recognized, especially by the growing positive psychology movement (Seligman & Csikszentmihalyi, 2000; Seligman, Steen, Park, & Peterson, 2005) as a

powerful influence on human behavior, not one piece of research⁵ looks at optimism as a counselor attribute. It is this lack of knowledge that this research seeks to investigate.

⁵ This researcher has filtered through more than 500 references related to this topic, including several meta-analyses and although there have been tangential references to the need for hope and optimism, not one piece of literature has studied the impact that a counselor's ability, or lack thereof, to impart optimism may have on therapeutic outcome.

CHAPTER THREE

METHODOLOGY

This chapter introduces the methodology used in exploring the relationship between optimism and working alliance, two components theorized to influence therapeutic outcome. It includes a description of the research design, a review of the research questions, target population and participant selection procedures, data collection and analysis, and instrument selection. Finally, the limitations of this research methodology are delineated.

Purpose Statement

The design for this study was quantitative and used correlational and prediction methodologies (Gay, Mills, & Airasian, 2009). This study had three purposes. The first purpose was to determine if there is a significant relationship between the counselor's optimism, the counselor's experience level, and therapeutic outcome. The second purpose was to determine if the counselor's optimism has a significant relationship to the working alliance. The third purpose was to determine if the counselor's optimism and the counselor's perception of the working alliance were significant predictors of client termination of therapy.

Research Design

This study presents the results of survey research (Gay et al., 2009) that focused on the development of the relationship from the counselor's perspective. The survey packet included four sections. The first section was an overview containing instructions and Institutional Review Board (IRB) approval information (see Appendix A). The second section was an 11 question demographics section used to gain information about the counselor's experience, professional qualifications, and client load for the 6-month period preceding participation in the survey.

Section three contained the 10-item LOT-R (Scheier et al., 1994). Section four contained the 36-item WAI (Horvath & Greenberg, 1989).

The variables for this research were degree of optimism as measured by the LOT-R (Scheier et al., 1994) and working alliance as measured by the WAI composite score (Horvath & Greenberg, 1989). Another variable was the experience level of the counselors (as measured by the years of work experience in counseling). Additional descriptive information was gathered the counselor's credentials, education level, and clinical work settings as determined from the demographic section of the survey instrument. The final variables included information about the number of clients seen by the counselor during the previous 6 months, and the number of clients who withdrew themselves from counseling before the counselor determined they were fit to do so (premature unilateral client termination). This was derived from self-reports included in the demographic section of the survey instrument.

Research Questions and Hypotheses

The research questions and hypotheses considered in this study included the following:

Research Question 1: What is the relationship among the counselor's degree of optimism, working alliance, and the counselor's experience level?

Hypothesis 1 through 3:

- 1: There is no significant relationship between the counselor's experience level and the counselor's working alliance.
- 2: There is a significant negative relationship between the counselor's experience level and the counselor's optimism (e.g., as the experience level increases the counselor's optimism score will be lower).

3: There is a significant positive relationship between the counselor's working alliance score and the counselor's optimism score, controlling for counselor experience level.

Hypothesis 1 and 2 were tested using correlational analyses. Hypothesis 3 was tested using a partial correlation procedure.

Research Question 2: Does the counselor's optimism score and working alliance score significantly predict premature unilateral client termination from counseling?

Hypothesis 4 through 5:

4: The counselor's optimism score is a significant predictor of premature unilateral client termination from counseling.

5: The counselor's working alliance score is not a significant predictor of premature unilateral client termination from counseling.

Hypothesis 4 and 5 were tested using multiple regression procedures.

Participants

A minimum of 84 participants were sought via convenience sampling for this research study. In order to be eligible to participate in this study, counselors must have been: (a) either students participating in an internship in which they were actively engaged with clients, or working with clients full or part-time as a mental health professional; and (b) working with, or had worked in the past with, at least one client who presented with symptoms of depression. The counselors who agreed to participate were asked to respond to the survey based on their most recent work with a client who presented with symptoms of depression. Since the pool of participants was designed to be taken from advanced students or counselors, the sample was relatively homogenous in that they were required to receive a minimum amount of formal education in the counseling profession in order to be eligible.

The initial solicitation was placed on CESNET-L at the end of February 2009 (CESNET-L had 1,287 registered recipients as of February 25, 2009). CESNET is a listserv serving the international population of counselors, supervisors, and counselor educators who have voluntarily enrolled as listserv members. A brief notice requesting that the reader participate in the study was posted on the site and potential participants were given a link that took them directly to the first page of the survey. In addition, readers of the posting who were educators were asked to forward the letter to any of their students that they deemed to be potentially appropriate participants.

In addition to the use of CESNET-L, another database was constructed that contained the aggregated email addresses of practicing mental health professionals who listed their email addresses in selected public sources. Public sources included the Georgia Secretary of State counselor licensure verification list (Georgia Secretary of State, 2009), the Alabama Mental Health Counselor Association directory listing (Alabama Mental Health Counselor Association, 2009), the Grief and Marriage Counselor directory at Breastfeeding.com (Breastfeeding.com, 2009), the directory provided by the Licensed Professional Counselor Association of Georgia (Licensed Professional Counselors Association of Georgia, 2009), the directory provided by the Seattle Counselors Association (Seattle Counselors Association, 2004), the directory provided by the Arizona Counselors Association (Arizona Counselors Association, 2009), the directory provided by the Washington Mental Health Counselors Association (Washington Mental Health Counselors Association, N.D.), the directory provided by the Arkansas Mental Health Counselors Association (Arkansas Mental Health Counselors Association, 2008), the directory provided by the Montana Licensed Clinical Professional Counselors Association (Montana Licensed Clinical Professional Counselors Association, N.D.), and the directory provided by the

Idaho Mental Health Counselors Association (Idaho Mental Health Counselors Association, N.D.).

The aggregate database was compiled from various sources that were selected with the intention of getting a uniform sampling of counselors from the various geographic regions of the United States. The aggregated database, after the purging of duplicate addresses, resulted in a database of 2,503 email addresses. A standardized request for participation was then emailed to every email address in the database. The initial standardized request was emailed to the available addresses beginning on February 23, 2009, and completed on February 25, 2009. The emails that were returned as undeliverable were purged from the aggregated database resulting in 2,360 remaining potential participants. One month after the initial request for participation was sent, a second request was placed on CESNET-L and all addresses on the aggregated database were contacted with a second request for participation.

To meet the requirements of sampling power and provide a sufficient population to determine a significant statistical effect, it was projected that the initial population of counselors who were solicited for participation would need to be 210 potential participants. Given an assumed return rate of 40%, the 210 participants would allow for the minimum 84 participants to complete the survey. Assuming a moderate effect size at $P = .80$, a sample of 84 participants was needed to assure that the hypotheses were tested at the .05 alpha level (Cohen, 1992). The ideal participant population that was sought would include a range of experience levels, ranging from internship students to counselors with more than 20 years of experience.

Depression was chosen as a criterion for this research project because it is a very treatable disorder, yet many of the sufferers go untreated. With sufficient education and pharmacological and psychotherapeutic interventions, the burden of this disorder could be

significantly reduced. Another reason for choosing this disorder is that unless there is a co-occurring disorder the counselor can easily recognize depression. Additionally, because the prevalence of the disorder is so great, most counselors will have been confronted with clients with depression. A final reason for choosing depression is that clients who present with depression usually have no cognitive impairment that could potentially limit or distort the usefulness of the information gathered during this research.

Instrumentation

An online survey (see Appendix B) containing the WAI (see Appendix C), and the LOT-R (see Appendix D) were used in this research to collect data for the testing of the research hypotheses. Permission was granted by the authors of both questionnaires to use their instruments in this study.

Working Alliance Inventory (WAI)

The working alliance has been described as how well the client and counselor relate and understand each other and has been declared by one theorist as the “quintessential integrative variable” (Wolfe & Goldfried, 1988, p. 449) of effective therapy. The WAI was based on the psychoanalytic Supervisory Working Alliance Model originally conceived by Bordin (1983). Greenson’s psychoanalytic perspective on the working alliance also contributed to item construction for the WAI (Greenson, 1967).

The WAI, designed and tested by Horvath (1981), was used in this research project to measure the counselor’s perspective on the degree of working alliance formed between the counselor and client during therapy. The WAI is one of more than 11 common alliance oriented instruments publicly available (Fenton, Cecero, Nich, Frankforter, & Carroll, 2001), and is one of the most widely used instruments in alliance research (Martin et al., 2000). Busseri and Tyler

(2003, p. 193) stated that, “of the extant therapeutic alliance measures, the WAI has received the most empirical attention . . . Well over 100 published research reports and several meta-analytic reviews (Horvath & Greenberg, 1994a; Horvath & Symonds, 1991; Martin et al., 2000) have explored various aspects of the WAI” (p. 193).

The WAI was chosen for use in this research project because it (a) is a popular instrument for research regarding the working alliance; (b) is transtheoretical (it is not limited by theoretical boundaries and thus is useful in researching the working alliance from a variety of theoretical orientations); (c) is easily administered and rapidly completed (normally completed in less than 20 minutes); (d) is easy to score and interpret; (e) is free and available for use by requesting permission from the author; and (f) generates a composite score. The WAI was also chosen because the scale score results of the WAI share a significant amount of common variance with other alliance instruments (Tichenor & Hill, 1989).

There are three versions of the WAI. The WAI version that was used for this study was the WAI-T (worded for use by the counselor, see Appendix C). This version is essentially the same instrument as other versions but with slight variations on wording so as to be appropriate for the counselor’s use.

The WAI produces results on the Task scale, the Bond scale, and the Goal scale, as well as a Composite scale. Only the Composite scale was used in this research project due to reported subscale overlap (Al-Darmaki & Kivlighan, 1993; Horvath & Greenberg, 1989; Horvath & Luborsky, 1993; Tracey & Kokotovic, 1989). There are 12 items associated with each of the three subscales for a total of 36 items. Each item is measured with a 7 point Likert scale ranging from “Never” to “Always.” For scoring purposes “Never” equals 1 and “Always” equals 7. The minimum score for the Composite score is 36, indicating the weakest possible level of working

alliance has been formed, and the maximum score for the Composite score is 252, indicating the strongest possible working alliance has been formed.

Cronbach's alpha for the composite scale score is .87 on the WAI-T (Horvath, 1981; Horvath & Greenberg, 1986, 1989). The test-retest reliability for the Composite scale for a 3-week period was .80 (Horvath & Greenberg, 1994a). Further, Hanson, Curry, and Bandalos (2002) reported internal consistency estimates of .84 to .95 for the WAI-T ($M = .91$, $SD = .05$, $n = 5$) for the composite total scores.

When considering the construct validity of the WAI scores, the interscale correlations between Bonds, Tasks, and Goals were found to be substantial. The creator of this instrument wrote in his dissertation (Horvath, 1981) that he had achieved interscale correlations for Bonds with Goals of .69, Bonds with Tasks of .78, and Goals with Tasks of .92. There is a degree of reported subscale overlap which complicates the process of determining whether the WAI measures three separate components of working alliance. This was not considered problematic for this study since only the Composite score was used. The dimensions of Bonds, Tasks, and Goals as defined by Bordin (1979) are interrelated and even defined in terms of each other, which negated their usefulness for this study.

Original statistical analysis of this instrument was drawn from a sample pool of 185 supervisors and 178 trainees who were participating in a supervisory relationship at the time of the survey completion (Efstation, Patton, & Kardash, 1990). The initial analysis included a comparison of the WAI with various aspects of the Supervisory Styles Inventory (SSI) (Friedlander & Ward, 1984) and the Self-Efficacy Inventory (SEI) (Friedlander & Snyder, 1983).

In a separate study, Patton (1992) evaluated the SWAI for its psychometric properties and compared it to the Personal Reactions Scale-Revised (PRS-R) (Holloway & Wampold, 1984). At

the time, the PRS-R was the only other measure of the relational issues involved in counseling supervision. In several measures, the results of Patton's study and the original testing of validity for the SWAI achieved similar results (Efstation et al., 1990; Patton, 1992). The internal consistency reliability was .90 for Rapport, and .77 for Client Focus with an *N* of 178. Item scale correlations for the Rapport scale ranged from .44 to .77 and .37 to .53 for the Client Focus scale (Efstation et al., 1990). For a composite list of all the psychometric data given on the WAI in this section see Table 6.

The intercorrelations between the trainee scales were moderate at .47. With these results it was determined that the Working Alliance Inventory had achieved acceptable levels of scale reliability (or interitem consistency) and item-scale correlations (Efstation et al., 1990).

Table 6

Details of Psychometric Evidence for the WAI

Psychometric property	Value	Citation
Cronbach's alpha	.87	Horvath, 1981; Horvath & Greenberg, 1986, 1989
Test-retest reliability (3 weeks)	.80	Horvath & Greenberg, 1994
Internal consistency estimate	.84 to .95	Hanson, Curry, & Bandalos, 2002
Interscale correlations (Bonds with Goals)	.69	Horvath, 1981
Interscale correlations (Bonds with Tasks)	.78	Horvath, 1981
Interscale correlations (Goals with Tasks)	.92	Horvath, 1981
Internal consistency reliability for Rapport scale (compared to Personal Reactions Scale-Rev. [PRS-R])	.90	Efstation, Patton & Kardash, 1990
Internal consistency reliability for Client Focus scale (compared to Personal Reactions Scale-Rev. [PRS-R])	.77	Efstation, Patton & Kardash, 1990

Item scale correlations for the Rapport scale (compared to Personal Reactions Scale-Rev. [PRS-R])	.44 to .77	Efstation, Patton & Kardash, 1990
Item scale correlations for the Client Focus scale (compared to Personal Reactions Scale-Rev. [PRS-R])	.37 to .53	Efstation, Patton & Kardash, 1990

Life Orientation Test-Revised (LOT-R)

The LOT-R (see Appendix D) was used to measure the degree of dispositional optimism held by the counselor. This measure of optimism focused on the expectancy of a successful therapeutic outcome for the work that counselor and client have recently conducted, alternatively called dispositional optimism.

The LOT-R was chosen for use in this research because it: (a) is a popular instrument for research regarding dispositional optimism, (b) is easily administered and rapidly completed (usually completed in less than 10 minutes), (c) is easy to score and interpret, (d) is free and available for use by requesting permission from the author, and (e) generates a composite score.

In its original form, the LOT was composed of 16 total questions. After being administered to 150 college students, a factor analysis reduced the number of questions to 12, four worded in a positive manner, four worded in a negative manner, and four used as fillers in order to disguise the underlying purpose of the questionnaire (Scheier & Carver, 1985). With these revisions made, the test was administered to 1,000 students in four independent samples. With this sample, another factor analysis was completed. There were no significant differences among genders so the population is treated as a homogenous unit.

The LOT was also subjected to tests for internal consistency and test-retest reliability. The overall Cronbach's alpha of .76 indicates a high degree of internal consistency and the test-retest reliability reached a correlation level of .79 (Scheier & Carver, 1985).

After a lengthy analysis, including several factor analyses and a sample of over 1200 people, the authors (Scheier & Carver, 1985) of the LOT concluded that:

The Life Orientation Test appears to provide a psychometrically sound measure of optimism, defined in terms of the favorability of a person's generalized outcome expectancy. The LOT would seem to possess an adequate level of internal consistency, test-retest reliability, and convergent and discriminant validity to make it suitable for use in research when such a measure is desired (p. 232).

The LOT was used for several years and has received a lot of scrutiny, many aspects of the inventory were analyzed including the construct validity, and whether the construct measures one dimension or two (Cheng & Hamid, 1997; McPherson & Mohr, 2005; T. W. Smith, Pope, Rhodewalt, & Poulton, 1989; Steed, 2002). By 1996 there were at least 56 LOT studies that were included in Andersson's (1996) meta-analysis. In 1994 the original authors of the LOT, in response to scrutiny, reviewed the original instrument and determined that the scrutiny was insufficient to merit a revision to the instrument (Scheier et al., 1994). However, the authors did decide to revise the instrument for reasons unrelated to the scrutiny that the test had received. They concluded that some questions were not actually measuring outcome expectancy as intended, but optimism in a broader sense. Therefore minor changes were made to the LOT, resulting in a revised test known as the Life Orientation Test-Revised (LOT-R). The new test now has only 10 questions. The LOT has been translated into at least five other language versions; Spanish, French, Chinese, German, and Japanese (see Cheng & Hamid, 1997; Herzberg, Glaesmer, & Hoyer, 2006; Lai & Yue, 2000; Laranjeira, 2008; Sumi, 2004; Vautier & Raufaste, 2006).

The revised LOT was again subjected to tests for internal consistency and test-retest reliability. The overall Cronbach's alpha rose from .76 to .78 with the revisions. The test-retest reliability remained at a correlation level of .79 at the 28 month time frame (Scheier et al., 1994). For a composite list of all the psychometric data given on the LOT-R in this section see Table 7.

Table 7

Details of Psychometric Evidence for the LOT-R

Psychometric Property	Value
Cronbach's alpha	.78
Test-retest reliability (4 weeks)	.68
Test-retest reliability (12 months)	.60
Test-retest reliability (24 months)	.56
Test-retest reliability (28 months)	.79

Note. All of the above values were derived from Scheier et al., (Scheier et al., 1994). Based on a review of 12 studies dated after the completion of the 1994 revision of the LOT (Burke, Joyner, Czech, & Wilson, 2000; Cheng & Hamid, 1997; Fotiadou, Barlow, Powell, & Langton, 2008; Herzberg et al., 2006; Kivimaki et al., 2005; Korkeila et al., 2004; Kubzansky, Kubzansky, & Maselko, 2004; McPherson & Mohr, 2005; Rauch, Schweizer, & Moosbrugger, 2007; Robinson-Whelen et al., 1997; Terrill, Friedman, Gottschalk, & Haaga, 2002; Vautier, Raufaste, & Cariou, 2003) only three used the LOT-R for their research, the others used the LOT, or the LOT in a foreign language version. Two of the three studies that used the LOT-R studied the effect of using the negatively worded questions as a pessimism subscale and the positively worded question as an optimism subscale, without regard to the composite score. Therefore there is no additional information offered by any of these studies regarding the psychometric values of the LOT-R.

Demographic Information

Each participant was asked to complete a Demographic Information (see Appendix E) section as part of the survey. The demographic form included the following information: (a) the age of the counselor, (b) the counselor's experience level measured in years, (c) gender, (d) marital status, (e) educational attainment, (f) licensure and certification status, (g) race/ethnicity, (h) an estimate of how many clients were seen by the counselor during a 6 month period, (i) an estimate of how many of those same clients seen during the 6-month period prematurely

terminated counseling, (j) an estimation of the percentage of clients seen in the 6 month period that presented with depression, and (k) the professional setting in which treatment occurs. The purpose of collecting the demographic data was to present descriptive information regarding the professional experience level, the academic training, and the client load of the participating sample. From the estimation of the number of clients seen and the number of clients who terminate prematurely a variable was created that was called the dropout percentage rate.

Procedures

Prior to data collection, in compliance with Federal codes (Code of Federal Regulations Title 45 Part 46, [45CFR46]) and State of Virginia regulations (Virginia Code 32.1-162.16 et seq.), the Human Subjects Review Board at Old Dominion University reviewed the proposed procedures and instrumentation. An exemption was requested from the board. The request for exemption was based on the following criteria: (a) the identity of all participants would be kept confidential and (b) the completion of the research was related to ongoing therapy that would have or had occurred regardless of the needs of this research. Data collection was scheduled to begin only after approval was obtained (see Appendix A).

A standardized email was forwarded to potential participants at the beginning of the study. The email briefly described the research and directed participants, who desired to volunteer, to a hyperlink that took them directly to the initial page of the internet based survey. The survey was hosted on SurveyMonkey (www.surveymonkey.com). SurveyMonkey was the collection point for all responses and all collected data were confidential. All participants were given an arbitrary but unique identification number so as to differentiate responses. No personal identification from respondents was collected. SurveyMonkey provided an aggregated database of all responses including those surveys that were begun but not completed.

Once the volunteers had linked to the survey site, they were presented with a more detailed overview of the research contents and given the Institutional Review Board (IRB) approval information. This information constituted Section I of the survey. The participants were presented with informed consent information as appropriate to this research. At the end of the presentation of the informed consent, they were told that clicking on the next button would indicate to the researcher that they had consented to full participation in the study. By clicking on the next button, they were also indicating that they understood the presented informed consent information. Being granted access to the remainder of the survey was contingent upon the participant's action of clicking on the next button.

After the participant had read and complied with the informed consent section they were moved to Section II of the survey. Section II asked the participants for 11 items of demographic information. The demographics section was followed by the LOT-R which comprised Section III. Section IV was comprised by the WAI. The participant was asked to complete Section IV with a specific client in mind. The client that the counselor was asked to keep in mind was one that the counselor had recently worked with who had presented with symptoms of depression. Following Section IV the participant was thanked for their participation and given instructions on how to receive a copy of the final research project if they so desired.

Method

The data analysis procedure consisted of reporting descriptive statistics and correlations of the variables of interest using correlational analysis, multiple regression, and partial correlation analysis procedures. The statistical software, Statistical Package for the Social Sciences (SPSS) 17.0 for Windows (SPSS, 2008), was utilized in processing all of the data after the collection phase was completed. The data that resulted from participant input on the

SurveyMonkey website was initially downloaded in Microsoft Excel (Microsoft Corporation, 2006) format and was then processed to prepare for importation into SPSS. The preparation process included the deletion of irrelevant data such as SurveyMonkey supplied start and stop dates. Additional data were added while the data were in the Excel format. The additional data that were added consisted of processing the original raw LOT-R and WAI data to include scoring information on the composite and subscale scores. On the LOT-R data, this required that information for filler questions be excluded from scoring, and that three of the items be reverse scored before being included in the composite score.

Frequency distributions were utilized to report descriptive data for the counselors including their age, counseling experience, gender, marital status, educational attainment, licensure and certification status, and race/ethnicity information. Additionally, descriptive data were reported for all participants with respect to their test scores (e.g., means, standard deviations, etc.).

The variables for Research Question 1 were the optimism scores derived from the LOT-R, the counselor's working alliance scores derived from the WAI, and the counselor experience level as reported in the demographics form. Correlational analysis was conducted to determine the relationship between the counselor's experience level and the working alliance, and to determine the relationship between the counselors experience level and the degree of optimism. A partial correlation procedure was conducted to control for the counselor's experience level while trying to determine the extent of the relationship between the counselor's perception of the working alliance and degree of optimism.

The variables for Research Question 2 were the counselor's optimism scores derived from the LOT-R, the counselor's working alliance scores derived from the WAI, and the client's

premature termination value as determined by the counselor's estimate in the demographics section of the survey. Multiple regression procedures were used to determine the predictive value of optimism and the working alliance for premature unilateral client termination.

Strength of Design

The strengths of this study include the conduct of the research in the counselor's natural setting, the quality of the measurement instruments utilized in this research, and the research design. The fact that this research was based on therapy that occurred in a completely natural setting is thought to be a strength. With the exception of the survey used to complete this research, the client and counselor were free to conduct therapy in their natural environment as they would normally. Due to the sampling process, this included an array of different clinical settings. Additionally, there was no attempt through the research parameters, to influence the methodology employed by the counselor. Due to the lack of setting and method influence, this would seem to make this research much more representative of what was truly happening in the real world environments than in some sterilized clinical setting.

The wide acceptance and high quality of the instruments used in this research impacted the quality of this research. Both instruments have demonstrated reliability and validity scores. Additionally, both instruments were among the most widely used instruments to measure the specific constructs they were designed for and they are well known by researchers working in those areas of inquiry.

The structure of this survey based research design was deemed appropriate because the underlying behavior of the client was unlikely to change on its own (Gay & Airasian, 2003), which seemed to be true in this case because the clients felt the need to seek counseling. The working alliance was unlikely to change without engagement in a therapeutic relationship.

Limitations

According to Gay et al. (2009), “any uncontrolled extraneous variables affecting performance on the dependent variable are threats to the validity of the experiment” (p. 242). Internal validity threats were those threats resulting from the manipulation of the independent variable that created differences on the dependent variable. According to Campbell and Stanley (1963), there are eight main threats to internal validity. Those eight threats to internal validity are history, maturation, testing, instrumentation, statistical regression, selection bias, experimental mortality, and selection-maturation interaction.

The potential internal validity threats to this research project included history, maturation, testing, instrumentation, and regression (Gay et al., 2009). Due to the fact that this study likely covered a long period of time, from the initiation of therapy to the completion of the survey, there was a potential of incurring the validity threat of history. The longer a study takes the more likely it is that the participants encountered something that changed their outlook and thus threatened validity (Gay et al., 2009). Although the instruments chosen for this research demonstrated high reliability and validity scores there was a potential for a testing validity issue. There was some potential for social-desirability traits to become issues in this research as well. Because the counselors were being asked to identify a client who presented with depression, there was a possibility that the client’s symptomology was incorrectly classified by the counselor.

The sample represented in this research was a sample of convenience. To the degree that there was no random sampling involved, and that the sample was entirely made up of volunteer participants, selection became a concern for this research. The final internal validity threat for this sample is that of experimental mortality. Due to the delicate nature of the counseling

environment there was always a chance for the loss of the client. To an extent, experimental mortality was assumed for this research and that was reflected in Research Question 2. If there was no experimental mortality, that question could not have been investigated during this research.

External validity threats (also called ecological validity) are those threats which affect the degree to which experiments are generalizable to environments outside of the experimental setting. According to Campbell and Stanley (1963), there are four main threats to external validity. Those four threats to external validity are reactive or interaction effect of testing (also called pretest-treatment interaction), selection-treatment interaction, multiple-treatment interference, and reactive effects of experimental arrangements (also called specificity of variables).

The external validity threats that may have affected this research were pretest-treatment interaction, selection-treatment interaction, and specificity of variables. To the degree that the participants determined the construct which was being investigated and deemed one to be more socially desirable than another the participants may in fact have reacted differently to the treatment offered than if the variations had never been offered. The fact that the sample was entirely dependent on voluntary participation and no selection process had been incorporated into this study, there was a possibility of incurring a selection-treatment threat. To some extent, the criteria for participation in this research serve as a selection filter, in that all counselors would have similar educational and professional backgrounds and all of the clients will have had similar diagnostic histories through the required focus on clients that had displayed symptoms of depression. However, within each of those categories there existed the potential for huge variations.

The final external threat to this research was the specificity of variables threat. The WAI instrument tested for the working alliance established between the client and counselor. The LOT-R tested for the degree of dispositional optimism manifested by the participants. The constructs of these variables is not entirely set in concrete. There is some theoretical disagreement regarding both of these constructs. However, because of the popularity of each of the instruments in the particular fields of inquiry, it was deemed appropriate for this research that the constructs that emerged were sufficiently specific to conduct this research.

The scoring procedure for the LOT-R does not include a threshold that can be used to declare that a participant is an optimist, or a pessimist. The score given to someone who completes the LOT-R is relative, someone who has a higher score than another is more optimistic than a person with a lesser score. However, it is not possible to separate an optimist from a pessimist. A person may also take the LOT-R at two different times and be considered to be more optimistic at one time than the other. This lack of a threshold that differentiates between optimists and pessimists limits the statistical procedures that can be used with the LOT-R, and perhaps to some degree may limit the understanding of the results from the statistical analysis conducted in this study.

The criterion used in determining the threshold for participation in this study was left to the judgment of the potential participants. The resolution of what constituted depression and premature client termination were not operationalized. This was done so as to maximize the number of participants who qualified. The participants may have used different standards to determine if they met criterion for participation. This was not considered to be potentially detrimental to the outcome of the study since the pool of participants would have undergone academic training that was based on professional standards.

Assumptions

There were three assumptions that were made in designing this research. The first and foremost working assumption in this research was that the working alliance was an appropriate proxy for therapeutic outcome. Due to the literature available on the working alliance as a precursor to therapeutic outcome and as a predictor of therapeutic outcome, it was believed that the state of the working alliance attained by the participants in this research was a sufficient, short term indicator of potential therapeutic outcome. In order to compress the time frame needed for this research, it was thought that it would be appropriate to use the state of the working alliance as an indicator of outcome versus waiting to complete research at such a time as therapy was completed, or at some specified timeframe post intervention. In part, this was so because interventions would have taken various lengths of time and various numbers of sessions to complete. Defining what constituted an appropriate post intervention period to wait before surveying the participants would have been problematic in many ways. It would have further complicated the research to spend time trying to track or find all of the participants at a specified time period after the completion of therapy.

The second assumption made for this research was that there would be a degree of mortality (client's who terminate services with the counselor before the counselor thinks it is appropriate to do so) during this research. Based on historical tendencies regarding premature termination rates during the course of therapy (Edlund et al., 2002; Takeuchi, Sue, & Yeh, 1995), there was ample reason to believe that there was going to be a degree of mortality, even with a relatively small sample. Without mortality there would be no way in which to complete the investigation of Research Question 2. Therefore Research Question 2 could not be addressed in this study no mortality was reported.

The third assumption made for this research was that the participants would recognize and be honest in their responses. This assumption was based on the fact that the participants were given complete anonymity throughout the data collection process. The assumption was also based on the professional mandate that counselors be trained to be self-reflective throughout their training and encouraged to remain reflective throughout their professional lives.

CHAPTER FOUR

RESULTS

This study used nonexperimental survey methodologies to obtain quantitative information regarding several variables that might have a relationship to therapeutic outcome, including the counselor's optimism, the counselor's experience level, and the quality of the working alliance. In addition, the study sought to determine significant predictors of premature unilateral client termination of therapy. This chapter outlines the results of the study, beginning with a summary of demographic information about the study participants. Following the survey participant's demographic information, an overview of the results for Section III (LOT-R) and Section IV (WAI) of the survey will be presented. The following section presents the results of the statistical analysis for the research questions. In the final section the results of the analysis of the hypotheses are presented. Pertinent information from the analyses will be presented in tabular or graphic form.

Demographics

The target population for this study, as indicated in Chapter 3, was practicing mental health practitioners or advanced students working with clients in their internship. The participants were required to have recently worked with clients who had presented with symptoms of depression. Due to the fact that this study was conducted with an Internet based survey format, the pool of participants was a convenience sample. Beginning in late February 2009, solicitations for participants were placed on the CESNET-L listserv that had 1,287 enrolled members at the time of placement. At approximately the same time 2,503 emails requesting the participation of potential respondents were sent to individual email addresses.

From the list of email recipients 143 were returned as undeliverable, leaving 2,360 recipients who were potential participants in the study.

Four weeks later, toward the end of March 2009, the same procedure occurred by placing follow-up messages on CESNET-L and sending emails to 2,360 email addresses. The standardized follow-up message requested participation and reminded all potential participants that the deadline for the closure of the collection phase of the study was approaching. In this manner 3,657 direct appeals for participants were initially made with a subsequent follow-up four weeks later. The return rate is impossible to determine because it is unknown how many of the recipients met all the criteria for participation, and it is unknown how many people received appeals by indirect means. All recipients of the direct appeals were encouraged to pass along the survey link to others who might be appropriate candidates for participation in the study. The survey link on SurveyMonkey was closed to all participants at 3:00 p.m. on March 31, 2009. The site was closed because the number of new participants had diminished to less than one per day, and an adequate number of participants had been collected (256), which was roughly three times the number needed (84) to reach statistical power estimates.

Because the procedure used to solicit participants lacked any means for controlling or recording the actual degree of dissemination, it is impossible to determine the exact return rate of participants. The setup of the survey website did not provide any means to guarantee that all participants would answer all of the questions in the survey prior to signing off of the survey session. Therefore, there were a number of completed surveys that did not meet criteria for inclusion in the analysis phase of this study. It is impossible to state how many of the 3,657 who received an email with the survey link, did not fully meet criterion for participation in the survey. As of the close of the survey link, 256 volunteers had started the survey and 224 had completed

the survey, therefore 32 entries were eliminated from the database. Thus, 87.5% of those who started the survey had completed it. This is not to say that all 224 who completed the survey answered every question. Many of the participants chose not to answer one or more of the questions. Those considered to have completed the survey were those who had navigated through the multiple sections of the survey and finally clicked on the final navigation button of the survey to indicate that they were done with the survey regardless of the number of questions that they had answered.

Of those who were included in the database as having completed the survey, 8 were eliminated from the spreadsheet because they had completed an insufficient number of questions to allow for use in the analysis of any of the research questions. Therefore, for analysis purposes there were a total of 216 participants who had completed the survey with sufficient detail to allow proper statistical analysis of the research questions. Of the 57 questions included in the survey that were necessary for full statistical analysis, 43 questions (75%) had one or more blank spaces from participants who chose not to answer that particular question. However there was no question in the survey that had more than five blank responses. This represented 2.3% or less of the total number of answers on the surveys. To put that another way, every question essential to the analysis of the research questions had at least a 97% response rate by the 216 participants.

Due to the limited personal information that was collected for the demographics section of the survey, and the fact that the participant pool was voluntary, it is impossible to state a conclusion regarding how generalizable the results of this study may be. In light of the number of people contacted and the resultant sample size, it can be estimated that the results of this study are fairly representative of the larger population of mental health counselors working with clients presenting with depressive symptoms.

The participants were asked to indicate their age in the survey demographics section. The youngest participant was 24 years of age and the oldest was 75 years of age. The mean age for participants in this study was 44.97 years of age, with a standard deviation of 12.39. The ages of the entire population were unevenly distributed with clusters of participants around age 32 and age 58 (see Figure 2).

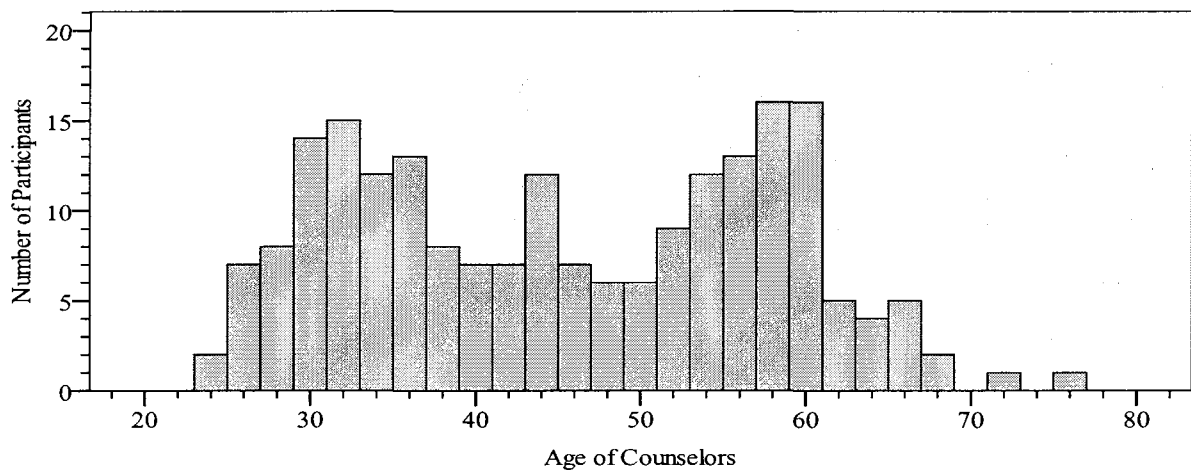


Figure 2. Distribution for the ages of the counselors participating in the study.

Participants were asked to indicate the level of experience that they had accumulated in the mental health counseling field at the time of survey participation. Descriptive data for participants' responses are shown in Table 8. The experience level for counselors participating in this study included 59.7% ($N = 129$) of participants having greater than 5 years of experience in the field. The mean experience level for the participants of this study was 4.63 years, and the standard deviation was 1.98 years.

Table 8

Experience Level of Counselors

	Frequency	Percent
Master level student	24	11.1

Advanced student	18	8.3
Graduate to 2 years	18	8.3
2+ years to 5 years	27	12.5
5+ years to 10 years	40	18.5
10+ years to 20 years	44	20.4
20+ years	45	20.8

The gender of each participant was requested in this study. The Gender distribution was comparable to the counselor population at large, reflecting a large female contingent of 171 (79.2%), compared to 45 (20.8%) males. Females comprised 79.2% (171) of the total sample and males comprised 20.8% (45) of the sample.

The dominant sample represented in this study was married, accounting for 54.6% of all the categories. Descriptive data for participants' responses to Marital Status are shown in Table 9. It is unknown what "Other" means in the case of the 15 participants who made that response.

Table 9

Marital Status of Counselors

	Frequency	Percent
Never Married	41	19.0
Married	118	54.6
Separated	7	3.2
Divorced	30	13.9
Widowed	5	2.3

Other	15	6.9
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The participants were asked to indicate the highest education levels they had attained at the time of their participation. By far, the holders of masters degrees outnumbered all other categories with 63% ($N = 136$). Due to the criteria used to solicit participants, it can be assumed that the 18 (8.3%) participants who were holders of Bachelor's degrees were students participating in an internship that allowed them to work with clients with symptoms of depression. Those participants holding specialist degrees accounted for 8.8% ($N = 19$) of the population while participants with doctoral degrees accounted for the remaining 18.1% ($N = 39$) of the population.

With respect to racial/ethnic identity categories, the largest category was White (74.5%, $N = 161$) and the next largest category self-identified as Black (17.6%, $N = 38$). Descriptive statistics for participants' responses to racial/ethnic identity are shown in Table 10.

Table 10

Racial/Ethnic Identity Composition of Participants

	Frequency	Percent
Black	38	17.6
Hispanic	3	1.4
White	161	74.5
Asian	3	1.4
Native American	2	.9
Multiracial	2	.9
Other	5	2.3

Participants were asked to provide information regarding the setting in which their work with clients took place. Four participants chose not to answer the question. The largest percentage of participants (46.8%, $N = 101$) was in a private practice setting. The participants who worked in an agency setting accounted for 39.4% ($N = 85$) of the total population, while 12.0% ($N = 26$) of the survey participants responded by indicating that they worked in other professional settings.

To complete the demographics section, the participants were asked to answer three questions regarding their client population for the past six months. The three questions requested that the participants estimate the number of clients they served, the number of clients who dropped out of counseling prematurely, and the number of clients that presented with depression. Once the survey data was collected, a variable for the percentage of clients who dropped out of counseling prematurely was generated in a Microsoft Excel (Microsoft Corporation, 2007) spreadsheet. To do this, the number of clients who dropped out of counseling prematurely was divided by the total number of clients seen, in order to generate a percentage rate. This data became the dropout percentage variable. The combined data, including the dropout percentage, was then imported into SPSS 17.0 (SPSS, 2008). Descriptive data for participants' responses to the client information questions are shown in Table 11.

A small percentage (8.0%, $N = 17$) of the respondents indicated they had seen over 300 clients in the last six months, three indicated they had seen 600 clients or more, and one of those counselors indicated they had seen an estimated 720 clients. The mean number of estimated clients seen by counselors over the six month period was 82.20 clients, the mode was 20 clients, and the median was 40 clients.

Table 11

Self-Reported Statistics Regarding Their Client Population in the Past 6 Months

	Number of Clients	Number of Dropouts	Number of Clients with Depression	Percentage of Dropouts
Mean	82.20	15.16	42.21	.19
Median	40.00	5.00	34.00	.15
Mode	20	10	30	.00
Std. Deviation	119.97	38.15	35.91	.18
Minimum	2	0	1	.00
Maximum	720	300	250	.86

A small percentage (2.80%) of the respondents indicated that they had experienced 100 or more clients who had dropped out of counseling services prematurely. Four counselors estimated that they had 100 clients dropout of counseling services, and 2 participants estimated that 300 had dropped out in the past six months.

Nine participants in the study (4.20%) indicated that they had over 100 of their clients who presented with symptoms of depression, with one participant indicating that he or she had an estimated 250 clients presenting with symptoms of depression. The mean number of clients who presented with symptoms of depression was 42.21.

The final piece of demographic information used in this study is the percentage of premature client dropout that counselors experienced. Data were derived by generating a variable that represented the percentage of client dropouts by dividing the estimated number of dropouts by the estimated number of clients, resulting in a percentage. The range of percentages derived

from this procedure is 0-86% and the mean percent of clients who dropped out of counseling prematurely reached nearly 19%.

Scoring Responses on the Instruments

One of the variables collected for use in this research was the optimism score of counselors as measured by the first instrument used in this study, the LOT-R (Scheier et al., 1994). The complete LOT-R consists of 10 items. Four of the questions on the LOT-R are fillers (items 2, 5, 6, and 8) and not used in the final scoring (see Appendix D for the annotated form), while three of the remaining six questions are reverse scored (Items 3, 7, and 9). The scoring of LOT-R results was accomplished in Microsoft Office Excel (Microsoft Corporation, 2007) prior to the importation of the data into SPSS (SPSS, 2008).

The maximum score available on the LOT-R is 30 and the minimum is 5, therefore the maximum available range is 25. The LOT-R has no cutoff score that would indicate whether the participant was optimistic or not. Rather it represents a relative score resulting from a continuous variable, one that is subject to change over various time intervals. A higher score on the LOT-R indicates that the participant is relatively more optimistic than a participant with a lower score. The LOT-R was not designed for, nor should it be used to draw a line that indicates that one participant is an optimist and another, with a lower score, is a pessimist.

In Table 12 the frequency distribution of participant scores on the LOT-R is given. If one considers that the midrange of this instrument is between 17 and 18, only 3.2% of the participants score on the low side of the median point of available scores. The results seem to indicate that the participants are a relatively optimistic group, with over 61% of the sample scoring in the top 20% of the available scoring range (26-30).

Table 12

Total LOT-R Scores

LOT-R Score	Frequency	Percent	Cumulative Percent
18	4	1.9	5.1
19	5	2.3	7.4
20	3	1.4	8.8
21	10	4.6	13.4
22	15	6.9	20.4
23	4	1.9	22.2
24	24	11.1	33.3
25	11	5.1	38.4
26	23	10.6	49.1
27	22	10.2	59.3
28	32	14.8	74.1
29	30	13.9	88.0
30	26	12.0	100.0

The following histogram (with normal curve) reveals the skewed results more graphically (see Figure 3). All 216 participants in the study completed the LOT-R. The mean score for the LOT-R was 25.69 (with a standard deviation of 3.75). The mean score of 25.69 indicates that participants viewed themselves as highly optimistic.

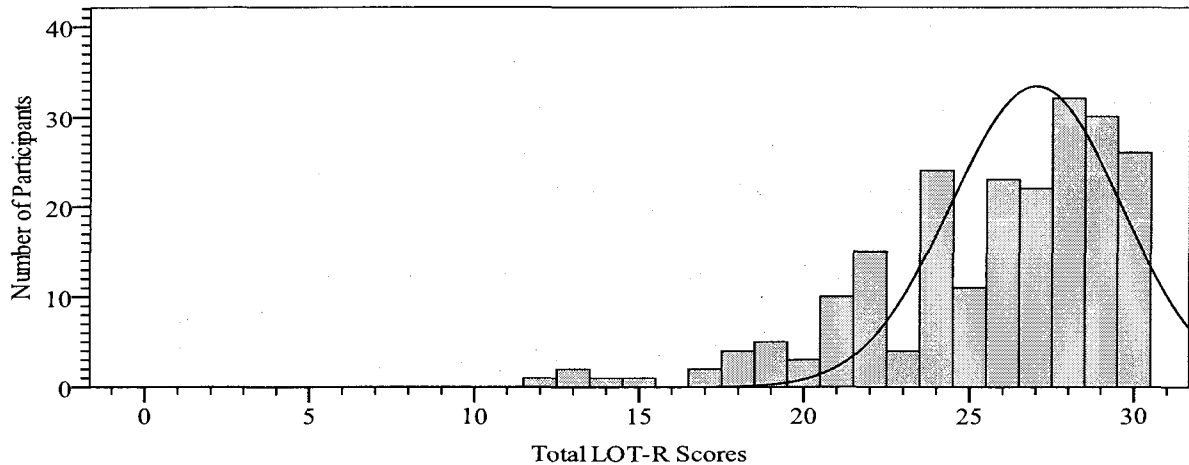


Figure 3: Distribution of participant's LOT-R Scores

Another variable of interest that was collected for use in this research was the Composite score of the WAI (Horvath, 1981). Each of the 36 questions in the WAI has a range of answers of 1 through 7. The scores available on the Composite scale (the total of all 36 questions) have a minimum value of 36 and a maximum value 252. The higher the score the greater the perceived strength of the total working alliance as viewed from the perspective of the counselor. It is important to note that this score does not reflect the perception of the client or an observer about the strength of the working alliance; it only reflects the counselor's view of the state of the working alliance. An achieved value of 252 indicates that from the counselor's perspective the strength of the relationship is as strong as is possible to achieve. Based on the literature discussed in Chapter Two a composite score of 252 would seem to indicate that the working alliance will result in a positive therapeutic outcome.

In general there was not a single participant who achieved the maximum or minimum possible scores on any of the scales. In fact, not one participant was within 20% of the maximum or minimum possible score on the composite scale. Thus the range of total responses was compressed to 60% of the available range. The descriptive statistics for the Composite score

reveal that the range of participants scores was small (range = 63) in comparison to the possible range of 216. The mean score for the WAI was 149.37, with a standard deviation of 11.89. Data for the composite scale have a normal distribution and very little skewness. Essentially, the result reveals that there is an even distribution of scores clustered around a central point, with small evenly dispersed standard deviations.

Results of Statistical Analyses

This study was designed with two research questions. The results of the detailed statistical analyses of those two questions appear in the following section. The analytical procedure for each question will be presented in this section and the results of the analysis upon the individual hypothesis formulated for each question will be presented in the following section.

Research Question 1

Research question 1 states, “What is the relationship among the counselor’s degree of optimism, working alliance, and the counselor’s experience level?” For the purposes of analysis the question needed to be broken into three parts. The first part will consist of analysis of the relationship between the counselor’s experience level and the counselor’s working alliance score, including the subscales. The second part will consist of an analysis of the relationship between the counselor’s experience level and the counselor’s optimism score. The third part will consist of analysis of the relationship between the counselor’s working alliance score and the counselor’s optimism score, controlling for counselor experience level.

The result of the analysis of the relationship between counselor experience level and counselor working alliance score is shown in Table 13. The analysis consisted of a Pearson product-moment correlation coefficient (see Green & Salkind, 2008) computed using the

counselor's experience level, and the WAI composite scale as variables. The correlation did not obtain statistical significance, $r(214) = .09, p = .17$ (see Table 13).

Table 13

Descriptive and Correlation Statistics Between the Counselor's Experience and the WAI

	Mean	Std. Deviation	N
Counselor's Experience	4.63	1.977	216
WAI Composite	149.37	11.894	216
		Counselor's Experience	WAI
Counselor's Experience	Pearson Correlation	1	.09
	Sig. (2-tailed)		.17
	<i>N</i>	216	216
WAI Composite	Pearson Correlation	.09	1
	Sig. (2-tailed)	.17	
	<i>N</i>	216	216

*. Correlation is significant at the 0.05 level (2-tailed).

The result of the analysis of the relationship between the counselor's experience level and the counselor's optimism score is shown in Table 14. The analysis consisted of a Pearson product-moment correlation coefficient computed using the counselor's experience level, and the LOT-R scores as variables. The resulting correlation obtained statistical significance. The correlation between counselor experience and the LOT-R scores indicated a small statistical significance, $r(214) = .17, p = .05$. That value is highlighted in gray in Table 14.

Table 14

Descriptive and Correlation Statistics Between the Counselor's Experience and the LOT-R

	Mean	Std. Deviation	N
Counselor's Experience	4.63	1.977	216
LOT-R Score	25.69	3.747	216
		Counselor's Experience	LOT-R Score
Counselor's Experience	Pearson Correlation	1	.17*
	Sig. (2-tailed)		.02
	N	216	216
LOT-R Score	Pearson Correlation	.17*	1
	Sig. (2-tailed)	.02	
	N	216	216

*. Correlation is significant at the 0.05 level (2-tailed).

The analysis of the relationship between counselor working alliance score and the counselor's optimism score, controlling for counselor experience level was conducted using a partial correlation. Before conducting the partial correlation the assumptions required for proper completion were considered. According to Green and Salkind (2008) there are two assumptions that must be met before conducting a partial correlation. The assumptions are: (a) the variables are multivariately normally distributed; and (b) the cases represent a random sample from the population, and the scores for one case are independent of scores on variables for other cases. Those assumptions were tested in previous sections and were not violated with respect to this sample. Therefore the partial correlation was completed and the results are shown in Table 15.

A partial correlation was computed among the LOT-R, the WAI, and the Counselor Experience level variables. A partial correlation was used because it controls for the potential influence of a third variable that may be shading the influence of the two variables of concern (Pallant, 2007). In this study in order to get a clearer picture of the relationship between the LOT-R and the WAI scores the influence of the Counselors Experience was controlled for. A Bonferroni approach was also utilized to control for potential Type I errors across the correlations resulting in a required p value of .017 ($.05/3 = .017$) in order to show significance.

Table 15

Partial Correlation of the LOT-R, WAI, Controlling for Counselor Experience

Descriptive Statistics		Couns Exp	LOT-R Score	WAI Composite
N		216	216	216
Mean		4.63	25.69	149.37
Std. Deviation		1.977	3.747	11.894
Correlations Statistics for Control Variables			LOT-R Score	WAI Comp
Couns Exp	LOT-R Score	Correlation	1.00	.18**
	WAI Composite	Correlation	.18**	1.00

** . Correlation is significant at 0.01 level

The results of the partial correlation indicate that there is a statistically significant positive correlation between the LOT-R scores and the WAI scores. The magnitude of the partial correlation is small, $r(214) = .18, p = .01$). As the LOT-R scores rose so did the WAI scores when the influence of the Counselors Experience level was controlled for.

Research Question 2

Research question 2 states, “Does the counselor’s optimism score and working alliance score significantly predict premature unilateral client termination from counseling?” This question was answered by conducting a multiple linear regression procedure. A multiple linear regression with one set of predictors was chosen because multiple regression procedures are an extension of bivariate correlation analyses (Green & Salkind, 2008) and are considered appropriate for nonexperimental methods.

The underlying assumptions for multiple linear regression procedures vary depending on the methods used in the study. Since this study used nonexperimental methodologies, the random-effects model assumptions were used. There are two assumptions for the random-effects model. The assumptions are that “the variables are multivariately normally distributed in the population,” and that “the cases represent a random sample from the population, and the scores on variables are independent of other scores on the same variables” (Green & Salkind, 2008, p. 288). These assumptions were considered, tested, and found to be within tolerances during the analysis for research question 1, therefore need not be reassessed for this research question.

The results from the multiple regression procedure are shown in Table 16. The results indicate that neither the counselor’s optimism scores nor the counselor’s working alliance scores are statistically significant in predicting premature unilateral client termination. The predictors (WAI Composite and LOT-R) achieved no statistical significance $R^2 = .02$, Adjusted $R^2 = .01$, $F(2,206) = 1.64$, $p = .20$. The collinearity diagnostics run in conjunction with the multiple regression are well within acceptable ranges, *Tolerance* = .97, and *Variance Inflation Factor (VIF)* = 1.04 (see Meyers, Gamst, & Guarino, 2006, p. 212). The appropriate statistics are highlighted in gray in Table 16.

Table 16

Summary of Multiple Linear Regression Predicting Client Termination Factors

Model	<i>R</i>	<i>R</i> ²	Adjusted <i>R</i> ²	Std. Error of the Estimate
1	.13 ^a	.02	.01	.18

a. Predictors: (Constant), LOT-R Score, WAI Composite

ANOVA^b

Model		Sum of Squares	<i>df</i>	Mean Square	<i>F</i>	<i>Sig.</i>
1	Regression	.11	2	.05	1.64	.20 ^a
	Residual	6.72	206	.03		
	Total	6.83	208			

a. Predictors: (Constant), LOT-R Score, WAI Composite

b. Dependent Variable: % Dropout

Coefficients^a

Model		Unstandardized Coefficients		Standardized Coefficients		Collinearity Statistics		
		<i>B</i>	<i>Std. Error</i>	<i>Beta</i>	<i>t</i>	<i>Sig.</i>	<i>Tolerance</i>	<i>VIF</i>
1	(Constant)	.48	.17		2.832	.00		
	WAI Composite	-.00	.00	-.08	-1.13	.26	.97	1.04
	LOT-R Score	-.00	.00	-.08	-1.18	.24	.97	1.04

a. Dependent Variable: % Dropout

Results of Hypothesis Testing

The following section provides a summary of the hypothesis testing based on the completion of the relevant statistical analysis. The discussion is based on the results posted in the previous sections of this chapter.

Research Question 1

Research question 1 asked, “What is the relationship among the counselor’s degree of optimism, working alliance, and the counselor’s experience level?” This question is the combination of three associated hypothesis. Each hypothesis will be dealt with independently in the following section.

Hypothesis 1

Hypothesis 1 stated, “There is no significant relationship between the counselor’s experience level and the counselor’s working alliance score.” Based on the results shown in Table 13, this hypothesis appeared to be true and should be accepted. The analysis was based on the interaction between the counselor experience variable and the WAI Composite variable.

Hypothesis 2

Hypothesis 2 stated, “There will be a significant negative relationship between the counselor’s experience level and the counselor’s optimism score (e.g., as the experience level increases the counselor’s optimism score will be lower).” Based on the results shown in Table 14, this hypothesis should be rejected because there was a small, but statistically significant positive correlation between the counselor experience variable and the LOT-R score. This indicates that as the counselor’s experience level increases so does their level of optimism.

Hypothesis 3

Hypothesis 3 stated, “There will be a significant positive relationship between the counselor’s working alliance score and the counselor’s optimism score, controlling for counselor experience level.” The results of the analysis for this hypothesis are shown in Table 15 and indicated that the hypothesis is supported. Results indicate a small but significant positive correlation between the LOT-R and the WAI scores, while controlling for Counselor Experience

level. This suggests that the observed relationship between the counselor's optimism and the counselor's working alliance perceptions are not entirely due to the influence of the counselor's level of experience.

Research Question 2

Research question 2 asked, "Does the counselor's optimism score and working alliance score significantly predict premature unilateral client termination from counseling?" This question was analyzed using a multiple regression procedure using one set of predictors. The predictors used for this analysis were the LOT-R and WAI variables. The criterion variable for this analysis was the percentage of dropouts. The dropout percentage variable resulted from creating a percentage based on the total number of clients who dropped out of the total client population.

Hypothesis 4

Hypothesis 4 stated, "The counselor's optimism score is a significant predictor of premature unilateral client termination from counseling." The results of statistical analysis are shown in Table 16. The results indicated that this hypothesis is not supported; there is no statistically significant finding in the interaction of the LOT-R variable and the client dropout variables.

Hypothesis 5

Hypothesis 5 stated, "The counselor's working alliance score is not a significant predictor of premature unilateral client termination from counseling." The results of statistical analysis are shown in Table 16. The results indicate that this hypothesis is supported that there is no statistically significant finding in the interaction of the WAI variable and the client dropout variables.

Summary of Results

This study examined the interaction of the counselor's experience level, the counselor's optimism level (LOT-R score), and the counselor's working alliance perception (WAI score). The LOT-R and the WAI were pre-existing instruments that have demonstrated psychometric strengths for measuring the constructs of concern in this study. Participants were volunteers with a variety of experiences in dealing with clients who presented with depression. The experience level ranged from students serving in an internship to counselors with more than 20 years of experience in the field.

Results showed that there are significant interactions between some of the variables. The analysis of the variables demonstrated that there is a small positive correlation between the counselor's experience variable and the counselor's optimism variable. There is also a small positive correlation between the counselor's optimism and the working alliance variables, when controlling for the counselor's experience level. The results of the analysis demonstrated that there is no basis for being able to predict premature unilateral client termination from counseling from the counselor's optimism or the counselor's working alliance perceptions.

CHAPTER FIVE

DISCUSSION

Summary of Findings

This study examined the interaction of the counselor's experience level, the counselor's optimism level (LOT-R score), and the counselor's working alliance perception (WAI score). This study used the LOT-R and the WAI instruments, in conjunction with an 11-item demographics questionnaire to gather information from participants in an online survey format. The LOT-R and the WAI were pre-existing instruments that have demonstrated psychometric integrity for measuring the optimism and working alliance constructs, respectively. Participants were a convenience sample with a variety of counseling experiences in dealing with clients who presented with depression. The experience level ranged from students serving in an internship to counselors with more than 20 years of experience in the field.

Results showed that there are significant interactions between some of the variables. The analysis of the variables demonstrated that there is a small positive correlation between the counselor's experience variable and the counselor's optimism variable. There is also a small positive correlation between the counselor's optimism and the working alliance variables, when controlling for the counselor's experience level. The results of the analysis demonstrated that there is no basis for being able to predict premature unilateral client termination from counseling from the counselor's optimism or the counselor's working alliance perceptions.

Relationship of the Findings to Findings of Prior Studies

There are no previous studies that have used these variables in the combination used in this study. A reference list of over 500 documents has been searched and there is no study that examines the impact of the counselor's optimism on the working alliance. The working alliance

and optimism as individual constructs have been researched at great length, but have never been researched in the combination and from the perspective used in this study. In addition, of the five analytical procedures used for this study only reached statistical significance, and that one achieved only a small significance. Therefore, it is difficult at best to determine the relationship of previous studies on the results attained during this study.

Research Question One

Research question one asked “What is the relationship among the counselor’s degree of optimism, working alliance, and the counselor’s experience level?” This question consisted of three parts: (a) there is no significant relationship between the counselor’s experience level and the counselor’s working alliance, (b) there is a significant negative relationship between the counselor’s experience level and the counselor’s optimism, and (c) there is a significant positive relationship between the counselor’s working alliance score and the counselor’s optimism score, controlling for counselor experience level.

The Pearson product-moment correlation computed to answer the first part of research question one did not reach statistical significance (see Table 13). The hypothesis, “there is no significant relationship between the counselor’s experience level and the counselor’s working alliance,” is supported. The lack of significance indicated that there is no significant relationship between the counselor’s experience level and their perceived working alliance with their client. The counselor’s perception of the working alliance formation is not based on their professional experience level.

The second part of research question one was also analyzed by performing a Pearson product-moment correlation. This analysis resulted in a statistically significant positive relationship between the two variables. The hypothesis, “there is a significant negative

relationship between the counselor's experience level and the counselor's optimism," was not supported. The relationship of the variables is in fact in the opposite direction: there is a positive correlation between the variables. When the counselor's professional experience increases so does their degree of optimism. The original hypothesis was not supported because it assumed that the counselor would adapt a degree of cynicism regarding their professional role as their level of experience increased.

The third part of research question one was computed by using a partial correlation. The third part of research question one posited that as the counselor's optimism increased the counselor's perception regarding the working alliance, and ultimately therapeutic outcome, would also increase. This analysis sought to control for any impact that the counselor's experience level might have had on the other two variables. Table 15 shows that when controlling for the counselor's experience level the LOT-R and WAI scores achieved a small positive statistically significant correlation. Hence the original hypothesis that, there is a significant positive relationship between the counselor's working alliance score and the counselor's optimism score, controlling for counselor's experience level, is supported by these results.

Research Question Two

Research question two was, "Does the counselor's optimism score and working alliance score significantly predict premature unilateral client termination from counseling?" The two hypotheses were tested by a multiple regression procedure. The procedure did not produce any statistical significance. Therefore the statement that, the counselor's optimism score is a significant predictor of premature unilateral client termination from counseling, could not be supported. In contrast the statement that, the counselor's working alliance score is not a

significant predictor of premature unilateral client termination from counseling, was supported in that the multiple regression procedure produced no support for the premise that the counselor's working alliance score was a sufficient predictor of premature unilateral client termination of counseling services.

Limitations of Study

This study included several mitigating limitations that should be considered when interpreting the results of this study:

1. Of the 3,657 potential participants who received direct emails solicitation only 216 surveys met all criteria for participation and were used in the analyses. The participation rate was extremely low (5.92%). Due to the manner in which the data was collected it was impossible to identify those who initially didn't meet criterion for participation. All participants were asked to pass along the survey link to others whom they thought might meet criterion, therefore there may have been second-party recipients of the request for participation, thus lowering the participation rate to an even smaller percentage. The return rate would seem to make any generalization of this data a tenuous proposition at best, even though the participation rate far surpassed the estimated power calculation need for 84 participants.
2. The population sample was primarily White (74.5 %), and female (79.2%); therefore the results are may be less generalizable to other gender and race combinations that constitute the counseling population.
3. Access to computers, current email addresses, and the lack of participation in forums from which the email addresses were extracted for the direct solicitation for participation

may have precluded the participation of a large segment of those in the counseling profession.

4. The data were gathered through means of an online survey and relied on self-reports therefore the results may have been skewed because of social desirability issues.

Concerns about this issue will be addressed in the “Implications for Counselors” section that follows.

5. Participants may not have had accurate answers to some survey questions, particularly in the demographics section. As an example there were three questions in the demographics section that asked for estimations of client participation information. This data may not have been as accurate as would have been desirable. This concern will also be addressed in the “Implications for Counselors” section that follows.

6. Because participants were asked to recall experiences from as much as 6 months prior, regarding interaction with a particular client, faulty recall of all of the pertinent details and impressions regarding the information in this study may have resulted in skewed data. The sheer length of time involved in this study may have challenged the participant to recall information that was subject to reflections or interpretations that were impossible to assess accurately.

7. The population that responded to this study may not be representative of the entire counseling profession. This sample was a sample of convenience and there was no attempt by the researcher to conceal or mislead regarding the character trait being researched, which may have lead only those who believed that they possessed such a trait to respond to the solicitation. This issue is related to limitation 4 and will be discussed in the following section.

8. The instruments (LOT-R and WAI) selected for use in this study may have been problematic. A discussion of potential issues associated with the instruments, and the survey in general, will be discussed in the “Implications for Counselors” section that follows.

Implications for Counselors

The LOT-R and Social Desirability Issues

Online surveys are subject to method biases which are major problems because they are sources of measurement error, and measurement errors threaten the validity of the conclusions about the relationships between variables (see Podsakoff, MacKenzie, Lee, & Podsakoff, 2003). According to Bagozzi, Yi, and Phillips (1991),

Any measure often reflects not only a theoretical concept of interest but also measurement error. Measurement error, commonly recognized as a serious problem throughout the social sciences (e.g., Fiske, 1982), can be partitioned into random error and systematic error, such as method variance. Method variance refers to variance attributable to the measurement method rather than to the construct of interest, and examples include archival biases, key-informant prejudices or limitations, halo effects, social desirability, and acquiescence. (p. 421)

Social desirability has been defined as, “the need for social approval and acceptance and the belief that it can be attained by means of culturally acceptable and appropriate behaviors,” (Crowne & Marlowe, 1964, p. 109). In general, social desirability can be viewed as,

The tendency on the part of individuals to present themselves in a favorable light, regardless of their true feelings about an issue or topic. This tendency is problematic, not only because of its potential to bias the answers of respondents (i.e., to change the mean

levels of the response) but also because it may mask the true relationships between two or more variables (Ganster, Hennessey & Luthans, 1983). Ganster et al. (1983) have noted that social desirability can produce spurious relationships, serve as a suppressor variable that hides the true relationship between variables, or serve as a moderator variable that influences the nature of the relationships between the variables. (Podsakoff et al., 2003, p. 881)

Those in the mental health profession often recognize the benefits and desirability of being optimistic. During the analysis of the data for this study the descriptive statistics (see Figure 3) indicated that the results from the LOT-R were dramatically skewed. The counselor's who scored 15 or under (the lower half of the scale) on the LOT-R accounted for only 2.3 % of the sample, therefore 97.7% of the sample scored on the higher end of the optimism scale. Of the participants in this sample fully 25.9% of them scored in the upper 10% of the optimism scale. There is no reason to believe that counselor's as a group are any more optimistic than any other group, yet the scores were substantially skewed toward the optimism side of the scale.

Vautier, Raufaste, and Cariou (2003) called into question the influence of social desirability in LOT-R results. Terrill, Friedman, Gottschalk, and Haaga (2002) have suggested that because the LOT-R is a self-report inventory that it is highly "fakable," or susceptible to social desirability influences.

Further discussion regarding the impact of social desirability on this study is beyond the scope of this study, however it is introduced here as a potential confounding influence on the outcome. It is conjectured by this researcher that if the contents of the survey and letters had deleted references to optimism, and further efforts had been made to conceal optimism as a construct of interest the LOT-R scores may have been less skewed. It is also felt that some

potential participants may have chosen not to participate because of their perceptions about their optimism level, therefore deleting references to optimism may have enticed more varied participants, thus creating a broader base for generalizing the final results.

One other comment on the optimism scores may be appropriate in regards to this study. Rauch, Schweizer, and Moosbrugger (2007, p. 1599) state that, "In accordance with the method effects explanation, lack of fit of a unidimensional model is a common finding for questionnaires with positively and negatively worded items." The LOT-R has three negatively worded items, three positively worded items, and 4 filler items. This may account for the suggestion of several researchers that the optimism construct in the LOT-R may actually be a bivariate construct, rather than a bi-polar construct (see Burke et al., 2000; L. Chang & McBride-Chang, 1996; Creed, Patton, & Bartrum, 2002; Herzberg et al., 2006; Kubzansky et al., 2004; Rauch et al., 2007; Robinson-Whelen et al., 1997). It has been suggested by many of those researchers that the positively worded questions constitute an optimism subscale, and that the negatively worded questions constitute a pessimism subscale (see Marsh, 1996). This research may have achieved different results by using the LOT-R results as two subscales, as opposed to a composite score.

Client Demographics Issue

The failure to procure accurate or sufficiently detailed client participation information from the demographics section of the survey may have created issues during the conduct of this study. A small percentage (5.2%) of the participants estimated that they had 300 or more clients during the six month period covered by this study. Three of the participants estimated that they had more than 600 clients. Essentially these estimates may be considered outliers and potentially skewed the resulting data.

Due to the large numbers of estimated clients for some of the participants it is difficult to believe that those participants were actually rendering direct counseling services. The researcher conjectures that these participants were more likely functioning in a case manager role, rather than in a counseling capacity. For example, the participant who estimated they had 720 clients during the previous 6 months would have only been able to see each client a maximum of 1.4 hours, if the counselor was in session for 8 hours a day, five days a week for the six month period. These large outliers may have skewed the data in significant ways. One solution would have been to limit the database to those who had more reasonable numbers, but that would have required a completely arbitrary decision on the part of the researcher regarding what constituted an appropriate cutoff point.

The two points listed above are expressed as implications because they may have affected the data in this study in such a way as to mask or hide true relationships among the variables. Since this study was essentially a preliminary look at this combination of variables there are potential relationships that exist that among these variables that could come to light in future studies. If the social desirability influences and the client demographics deficits are controlled for in future studies the true relationship among these variables should be clarified.

Although the counselor's optimism level only demonstrated a small statistical relationship to the working alliance there is no reason to think that optimism can be readily dismissed. Research suggests that the individual is benefitted in many ways by the adoption of an optimistic outlook (see Karren, Haffen, Smith, & Frandsen, 2002). Therefore, even though the relationship was not entirely clarified by this study there are sufficient reasons to adopt an optimistic stance.

Another implication of the social desirability issue is that it is often a complicating factor in counseling relationships. The influence is reciprocal in most cases, both the counselor and client often demonstrate “the tendency on the part of individuals to present themselves in a favorable light, regardless of their true feelings about an issue or topic” (Podsakoff et al., 2003, p. 881). This can have a detrimental effect on therapeutic efficacy if not understood and recognized by the counselor.

Implications for Counselor Educators

This research was constructed on the conception that dispositional optimism on the part of the client is a significant factor in creating favorable therapeutic outcomes. This study sought to identify if the counselor’s optimism level might also be considered one of the common factors that counselors bring to the counseling environment that could enhance therapeutic outcomes. The premise was that if optimism, on the counselor’s part, could be considered a common factor that helps create a therapeutic environment that facilitates positive therapeutic outcomes then counselor educators should take note of it as a means to increase the effectiveness of their students. That is that students could be taught to monitor their optimism levels, taught to reflect on their optimism levels, and taught how to enhance their own effectiveness through manipulation of their optimism level. This study provided sufficient statistical reasons to believe that the counselor’s optimism level played a role in the establishment of a working alliance that was conducive to positive outcomes. However, the counselor’s optimism did not prove to be a reliable predictor of premature unilateral client termination. The implication for the counselor educator is that optimism, at least as conceptualized in this study, does merit increased research. Additionally, the counselor’s optimism does merit consideration for inclusion on the list of common factors.

The significance achieved in this study should lead to more research on optimism as a potential benefit to the counseling student. The adoption of an optimistic lifestyle has a multitude of benefits (see Frank & Frank, 1991; Karren et al., 2002; Seligman, 2006) for those who embrace it. When professionals have been tested for optimism there was a significant correlation between those who were rated high in optimism and those who were rated as better employees by their bosses (see Seligman, 2006). Those professionals who were trained to monitor and increase their own optimism levels performed significantly better with less job burnout. This same effect seems to be reproducible among other professionals and could benefit the entire mental health field.

An additional implication is that there seems to be a correlation among patients perception of counselor's attributes and therapeutic outcome (Heppner & Dixon, 1981; Heppner & Heesacker, 1982, 1983). The broad categories investigated by Heppner include counselor expertness, attractiveness, and trustworthiness. It is entirely possible that the optimism construct has been subsumed in these studies by the broader category of expertness and, or attractiveness. To many the outward manifestation of optimism can be an attractive quality and can enhance the appearance of expertness. Due to the difficulty of separating human attributes into clean and distinct categories there is the possibility that optimism is actually appearing in some studies under a separate broader category. Therefore the research on optimism would be enhanced by the creation of instruments that are capable of making finer distinctions among human attributes.

A final implication appears in recent research "The major emphasis has been on studies comparing different forms of psychotherapy" (Garfield, 1997, p. 40). Yet there is the recognition that the client-counselor relationship is more influential in achieving positive therapeutic outcomes than the particular form of psychotherapy that is used. It is hoped that this study may

influence counselor educators approaching research opportunities to look more closely at the attributes that facilitate the formation of a closer alliance than at the therapeutic model.

Implications for Future Research

Perspectives on the Working Alliance

According to multiple researchers (Fenton et al., 2001; Hatcher, Barends, Hansell, & Gutfreund, 1995; Hatcher & Barends, 1996; Tichenor & Hill, 1989) the various versions of the WAI achieve different results. There is a version of the WAI designed specifically for counselors (WAI-T), clients (WAI-C), and observers (WAI-O). These versions are relatively similar but have the wording changed to be applicable to different users. For instance, question two of the clients forms states, “_____ and I agree about the things I will need to do in therapy to help improve my situation,” while the therapists form statements, “_____ and I agree about the steps to be taken to improve his/her situation.” Tichenor and Hill (1989) stated that,

The WAI-C and WAI-T both had high internal consistency, but were not related to each other or to other measures of working alliances. Clients, therapists, and observers clearly did not agree or come to a consensus on what working alliance was, indicating that measures from different perspectives are not interchangeable. These findings are similar to those of other studies measuring consensus, or the degree to which participants' views coincide (Tichenor & Hill, 1989, p. 198).

Due to the lack of interchangeability future research might reach more compelling conclusions by including the client's, or an observer's perspective regarding the formation of the working alliance, which could provide additional information, and perhaps different results. Often the least insightful person, as it regards the formation of the working alliance, proves to be the counselor (Horvath & Symonds, 1991). To include a client's, or an observer's, perspective,

may provide different statistical outcomes during the course of future research. Admittedly to do so would add an additional burden to the research, complicating collection and analysis.

Safran and Wallner (1991) have suggested that the working alliance is formed by the third working session between the counselor and the client. It may have been helpful to include a question in the demographic section regarding how many sessions with the client had been conducted at the time of survey completion. The inclusion of number of sessions as a variable in future research may provide additional useful information. In future research the participants could be subjected to another criterion which could be used to exclude those who have not had at least three sessions with their client, therefore assuring a more solid foundation for the evaluation of the working alliance.

During future research on the optimism construct the researcher could use a different instrument, or a combination of instruments that approach the construct in different ways. The use of the Attributional Style Questionnaire (ASQ) (Peterson, von Baeyer, Abramson, Metalsky, & Seligman, 1982) might have been a preferable instrument. The LOT-R was used in this survey for three reasons (a) the LOT-R is brief, (b) it is easy to score, and (c) it renders a single composite score. The ASQ is longer and more complicated to score but may be less susceptible to some of the issues associated with the LOT-R.

Future research would do well to consider and control for the influence of social desirability. In retrospect optimism seems to be a characteristic that has considerable esteem in the American mindset. To ask individuals to evaluate themselves on such a characteristic would seem to invite some distortion of reality. One means of controlling for the influence of social desirability in this study would have been to remove references to optimism in the documents given to participants. Unless the participant was familiar with the LOT-R and the construct of

interest being tested by it, the influence of social desirability might have been curtailed to some degree.

Implications of the Counselor's Experience Level

In this study there was a statistical significance found in the relationship among the counselor's optimism score and the counselor's experience level. The correlation coefficient reached the .17 level which is usually considered to be small. The correlation does not indicate a cause-effect relationship between these variables, rather it simply indicates that there is a relationship between the two, and in this case it is a positive correlation indicating that as the counselor's experience increases so does their level of optimism. This premise may be held by some as general knowledge, but research enhances that view. In their analysis of the WAI, Ackerman and Hilsenroth reported that,

Both patients and therapists rated therapists with greater levels of training higher on the Tasks and the Goals subscales of the WAI. . . . These findings suggest that less experienced therapists are capable of forming a bond with the patient but may be less effective at establishing treatment goals and performing the tasks necessary to achieve these goals early in the treatment process. (p. 5)

It would seem appropriate to infer from these findings that counselors who achieve greater degrees of experience are able to form better bonds with their clients, which leads to better therapeutic outcomes. The consistent attainment of better therapeutic outcomes would seem to lead to an increase in dispositional optimism. That is that the counselor with greater experience will come to have an increased expectancy that they will produce good results. That seems logical, and may be a self fulfilling circular movement in that experience leads to better

bonds, which leads to better outcomes, which leads to greater optimism, which in turn leads to more substantial learning and experience.

Conclusion

In the introduction to a recent article researching the working alliance and therapy outcome Baldwin, Wampold, and Imel (2007) informed us that,

The effectiveness of psychotherapy is well established (Lambert & Bergin, 1994; Lambert & Ogles, 2004), although identifying the therapeutic factors that account for patient improvement has proved difficult (cf. Castonguay & Holtforth, 2005; Craighead, Bjornsson, & Amarson, 2005; DeRubeis, Brotman, & Gibbons, 2005; Kazdin, 2005; Wampold, 2005). One viable therapeutic factor is the therapeutic alliance, which has emerged as a consistent predictor of outcome (Horvath & Bedi, 2002; Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000), leading many to conclude that it is an essential aspect of therapy (Norcross, 2002). (p. 842)

It was with this understanding that this study sought to test and identify potential components of the therapeutic alliance. Knowing that a therapeutic alliance is useful in attaining good therapeutic outcome, however, it is not very helpful information unless one also knows what factors facilitate the creation of a productive therapeutic alliance. The task of identifying useful components of the working alliance was complicated by the fact that at least two potentially very different people are involved in any counseling session. As Baldwin et al. (2007) told us,

The alliance is formed in the complex transaction between the therapist and patient, each of whom brings to therapy his or her own characteristics, personality, and history (Gelso & Carter, 1994). The correlation between alliance and outcome does not account for this

complexity, making it difficult to understand why the alliance is important to outcome.

(p. 842)

Understanding what elements help form the alliance was the essence of this study.

Possible components of a therapeutic alliance were tested. The components of interest were the counselor's experience level, the counselor's optimism, and the counselor's perspective on the state of the working alliance formed between themselves and the client. The counselor's experience, the optimism scores, and the working alliance scores were tested to determine if there were any relationships among those variables. There was a significant relationship found among all three of these variables. Ackerman and Hilsenroth (2003) identified various therapist attributes that have been correlated with strong alliances, and that list included therapist experience which is consistent with the findings of this study. Ackerman and Hilsenroth (2003) did not find a place for optimism on their list. Perhaps the recent influence of, and research by the positive psychology movement will result in the future inclusion of optimism on a similar list of counselor attributes that serve to enhance the therapeutic alliance, ergo therapeutic outcome.

In an article describing what is known, and what else still needs to be known about the working alliance, Castonguay, Constantino, and Holtforth (2006) stated that,

Although substantial evidence points to the importance of a good alliance for treatment success, we need to have a better understanding of how it develops. This is a particularly crucial issue for training. While neophyte therapists are constantly reminded of the need to establish good rapport with their clients, there are few empirically based strategies to guide this essential work. (p. 275)

This study provided a modicum of information that could help fulfill the need for empirically based strategies that will serve to guide future training efforts. It is hoped that in the

future optimism may be considered a constituent part of a productive working alliance. Perhaps the greatest benefit of this study was that it in some small way served to increase the dialogue about potential elements that more narrowly focuses future research. Research needs to continue to develop a knowledge base that helps counselor educators and counseling students understand how a good alliance is formed.

CHAPTER SIX

MANUSCRIPT

The Relationship of Optimism, Working Alliance, and Experience to Therapeutic Outcomes

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Abstract

This study examined the relationship of dispositional optimism and working alliance to therapeutic outcomes from counselors and counselor trainees ($N = 216$). There was a significant relationship with therapeutic outcomes, indicating that dispositional optimism may merit a position on the common factors list. Implications for research, practice, and training are provided.

The Relationship of Optimism and Counselor Experience to Therapeutic Outcomes

For more than 80 years researchers have sought to delineate and describe what Rosenzweig (1936) referred to as the common factors. Common factors are conceptualized as therapeutic components that contribute to therapeutic outcome, regardless of theoretical orientation. They have been determined to be the consistent and dominant influence in achieving beneficial therapeutic outcomes (Lambert & Barley, 2001). The examination of these common factors has resulted in a schism; one group of scholars believe that the preponderance of therapeutic outcome can be attributed to variables associated with common factors, while another group believes that the preponderance of therapeutic outcome can be attributed primarily to theoretically bound techniques. Compounding this division is the search for empirically supported treatments (ESTs) that are valued by the counselors, clients, and managed care providers alike. Thus, the research regarding the definition and the role of common factors in facilitating therapeutic outcome has taken on new dimensions as well as added importance.

The working alliance as one of the common factors (see Bordin, 1979; Greenson, 1967; Horvath & Greenberg, 1994b; Horvath & Luborsky, 1993; Wolfe & Goldfried, 1988) portends the greatest potential for creating positive therapeutic outcomes (see Barber, Connolly, Crits-Christoph, Gladis, & Siqueland, 2000; Castonguay, Constantino, & Holtforth, 2006; Grenavage & Norcross, 1990; Hausner, 2000; Horvath, 2000; Horvath & Symonds, 1991; Lambert & Cattani-Thompson, 1996; Martin, Garske, & Davis, 2000; Stiles, Agnew-Davies, Hardy, Barkham, & Shapiro, 1998). In this study the working alliance is used as proxy for therapeutic outcome because the working alliance has been found to be a strong predictor of client change (Martin et al., 2000). The use of the working alliance as a proxy was done in order to shorten the period of time required to conduct this study.

Though the influence of the working alliance has been well established, the components that establish a working alliance and other factors that influence therapeutic outcome are not well delineated or defined (Hauser & Hays, in press). According to Hanson, Curry, and Bandalos (2002), the processes that make psychotherapy successful have not been satisfactorily established. The literature (Bromberg, 1962; Frank, 2004; Grencavage & Norcross, 1990; Hynan, 1981; Lambert, 1986; Rosenzweig, 1936; Truax & Carkhuff, 1967) offers multiple studies that purport to supply various ingredients, or components of the working alliance that are at work within the common factors.

There has been some emphasis placed on the importance of optimism as a common factor with a potential for facilitating therapeutic outcomes (Duckworth, Steen, & Seligman, 2005; Fredrickson, 2001; Fredrickson & Joiner, 2002; Gable & Haidt, 2005; Seligman, 2002; Seligman & Csikszentmihalyi, 2000). While this literature is encouraging, the role of optimism as a common factor warrants further investigation. Studies to date have examined the role of optimism in clients without considering the possible contribution of the counselor's optimism level in the creation of positive therapeutic outcomes.

This study explored the role of optimism and counselor experience levels in affecting therapeutic outcome. Counselor experience was used as a variable in this study because it was believed that it might play a moderating effect on the other variables of interest and it is an obvious factor that is common to all therapeutic interventions. If the working relationship between counselor and client has a role in the therapeutic outcome, then determining and understanding the factors that impede or encourage progress becomes an imperative for the profession. Determining the extent to which counselor's optimism affects therapeutic outcome could create opportunities to improve not only the services that counselors render to clients, but

also the training programs that prepare new counselors. In addition, understanding how the counselor's optimism interfaces with working alliance may present new areas for self-reflection for practicing counselors. Such information could also provide the basis for developing self-monitoring exercises by counselors and directors responsible for counselor effectiveness. A final rationale for determining the extent to which a counselor's optimism has an impact on therapeutic outcome may be that optimism can be used to retard the degree to which clients prematurely and unilaterally terminate therapy.

This study had two main purposes. The first purpose was to determine if there is a relationship between optimism, working alliance, and a counselor's experience level. This general objective serves to uncover the relationship between optimism and an established common factor - working alliance - in the context of counselor experience level. The second purpose was to determine whether premature unilateral client termination of therapy could be predicted from the counselor's optimism level or the working alliance perceptions.

The research questions and hypotheses considered in this study included Research Question 1: What is the relationship among the counselor's degree of optimism, working alliance, and the counselor's experience level? Research question 1 contained 3 related hypotheses; including Hypothesis 1: There is no significant relationship between the counselor's experience level and the counselor's working alliance; Hypothesis 2: There is a significant negative relationship between the counselor's experience level and the counselor's optimism (e.g., as the experience level increases the counselor's optimism score will be lower); and Hypothesis 3: There is a significant positive relationship between the counselor's working alliance score and the counselor's optimism score, controlling for counselor experience level.

Research Question 2 asked: Does the counselor's optimism score and working alliance score significantly predict premature unilateral client termination from counseling? Research question 2 contained 2 hypotheses; including Hypothesis 4: The counselor's optimism score is a significant predictor of premature unilateral client termination from counseling; and Hypothesis 5: The counselor's working alliance score is not a significant predictor of premature unilateral client termination from counseling.

Method

Participants and Procedure

The sample for this study consisted of 216 counselors who completed an internet based survey (256 participants started the survey, but 40 were eliminated from the database because they did not complete the survey to the extent needed for meaningful analysis). Direct appeals were sent to 2,503 email addresses requesting participation. A request for participation was also posted at CESNET-L, a listserv serving counselor educators (at time of posting there were 1,297 members). There were 143 email solicitations that were returned as invalid addresses, thus there were 3,657 direct appeals for participants.

One of the criteria for selecting the study sample was that the counselor must have worked with a client who displayed symptoms of depression, with no co-occurring disorder that impaired the clients cognitive functioning. This was done for several reasons, including the fact that this disorder is so prevalent. According to the WHO, 121 million people worldwide will endure this disorder (World Health Organization, 2007). The prevalence of the disorder meant that finding research participants would be less difficult than another disorder that is less common. Depression is not usually accompanied by cognitive impairment therefore making the client-counselor relationship less susceptible to communication issues.

There were 171 (79.2%) females in this sample, compared to 45 (20.8%) males. The age range was 51 (from 24 to 75 years of age; $M = 44.97$ years, $SD = 12.39$). The racial/ethnic identity of this sample was composed of 38 African American (17.6%), 3 Hispanic (1.4%), 161 White (74.5%), 3 Asian (1.4%), 2 Native American (.9%), 2 Multiracial (.9%), 5 who responded as Other (2.3%), and 2 who did not respond to this question. The experience level for counselors participating in this study included 59.7% ($N = 129$) of participants having greater than 5 years of experience in the field ($M = 4.63$ years, $Mdn = >5-10$ yrs experience, $SD = 1.98$).

Instruments

Working Alliance Inventory (WAI; Horvath & Greenberg, 1989). The working alliance has been described as how well the client and counselor relate and understand each other and has been declared as the “quintessential integrative variable” (Wolfe & Goldfried, 1988, p. 449) of effective therapy. The WAI shares a significant amount of common variance with other alliance instruments (Tichenor & Hill, 1989). The WAI contains three subscales but only the Composite scale was used in this research due to reported subscale overlap (Al-Darmaki & Kivlighan, 1993; Horvath & Greenberg, 1989; Horvath & Luborsky, 1993; Tracey & Kokotovic, 1989). Each item is measured with a 7-point Likert scale ranging from 1= “Never” to 7= “Always” with higher scores indicating a stronger working alliance.

The WAI demonstrates strong reliability, with a Composite Cronbach’s alpha of .87 (Horvath, 1981; Horvath & Greenberg, 1986, 1989) and a test-retest reliability for the Composite scale for a 3-week period of .80 (Horvath & Greenberg, 1994a). Further, Hanson, Curry, and Bandalos (2002) reported Composite internal consistency estimates of .84 to .95 ($M = .91$, $SD = .05$, $n = 5$). The data from this sample was subjected to a reliability analysis of all of the WAI items, resulting in a Cronbach’s alpha of .74.

Life Orientation Test – Revised (LOT-R; Scheier, Carver, & Bridges, 1994). The LOT-R is a 10-item, 7 point Likert type instrument used to measure the degree of dispositional optimism held by the counselor. This measure of optimism focuses on the expectancy of a successful therapeutic outcome for the work between the counselor and client (i.e., dispositional optimism). The LOT-R demonstrated an acceptable level of internal consistency (Cronbach's alpha = .78) and the test-retest reliability for a 28-month period is .79 (Scheier et al., 1994). The data from this sample was subjected to a reliability analysis of all of the LOT-R items, resulting in a Cronbach's alpha of .72.

Demographic information. The purpose of collecting the demographic data was to present descriptive information regarding the professional experience level, the academic training, and the client load of the participating sample. The demographic form solicited information on the counselor's age, counselor's experience level measured in years, gender, relationship status, educational attainment, licensure and certification status, race/ethnicity, an estimate of how many clients were seen by the counselor during a 6 month period, an estimate of how many clients prematurely terminated counseling, an estimation of the percentage of clients that presented with depression, and the professional setting in which treatment occurred. From the estimation of the number of clients seen and the number of clients who terminated prematurely, a variable was created that was labeled the dropout percentage rate.

Results

Relationship among Optimism, Working Alliance and Experience Level

The relationship among counselor's optimism, working alliance, and experience level was addressed using correlational analysis. There was no significant relationship between the counselor's experience level and the counselor's working alliance $r(214) = .09, p = .17$, thus

providing support for Hypothesis 1. Analysis of the second part of the research question examining the relationship between counselor experience level and optimism, resulted in a statistically significant positive relationship between the two variables, $r(214) = .17, p = .02$. Thus, Hypothesis 2 was not supported by this study, however, the inverse was supported. Hypothesis 2 predicted a negative relationship and the analysis resulted in a positive correlation between counselor experience level and optimism.

Analysis of the third part of research question one regarding the relationship among the LOT-R, the WAI, and the counselor's experience level, involved a partial correlation to control for the influence of counselor experience on the relationship between working alliance and optimism. A Bonferroni approach was utilized to control for potential Type I errors across the correlations resulting in a meaningful p value of .017 ($.05/3 = .017$), which was required to show significance. The results of the partial correlation indicate that there is a statistically significant positive correlation between the LOT-R scores and the WAI scores, $r(214) = .18, p = .01$). Thus hypothesis 3 is supported indicating that there is a statistically significant positive relationship between the counselor's optimism level and the working alliance perceptions, while controlling for the counselor's experience level.

The Role of Optimism and Working Alliance in Predicting Client Termination

Research question two asked, "Does the counselor's optimism score and working alliance score significantly predict premature unilateral client termination from counseling?" The two hypotheses were tested by a multiple regression procedure. The analysis did not produce any statistical significance ($R^2 = .01, \text{Adj } R^2 = .00, F[2,206] = 1.64, p = .20$). The results indicate that neither the counselor's optimism scores nor the counselor's working alliance scores can be considered statistically significant in predicting premature unilateral client termination.

Discussion

The results from the statistical analysis did not support hypothesis 1, which posited a relationship between the counselor's experience level and the counselor's perception of the working alliance. Hypothesis 2 was supported, demonstrating that there is a positive relationship between the counselor's dispositional optimism and the counselor's experience level. Hypothesis 3 was also supported, indicating that there is a positive relationship between the counselor's optimism and the counselor's perception of the working alliance, when controlling for the counselor's experience level. Hypotheses 4 and 5 were not supported in this study. Hypothesis 4 and 5 conjectured that the counselor's optimism and the counselor's perception of the working alliance could be used to predict unilateral premature client termination of services. This study represents a preliminary analysis of the connection between these variables.

These findings provide initial support for the relationship among counselor's experience, optimism, and the working alliance. One possible inference from this study is that if all other elements in a counseling relationship were equal, a counselor with a higher degree of optimism would produce a stronger working alliance and thus better therapeutic outcomes. Other research suggests that the individual is benefitted in many ways by the adoption of an optimistic outlook (see Karren, Haffen, Smith, & Frandsen, 2002). Therefore, though the relationship of the variables of interest in this study to therapeutic efficacy merit further study, there are sufficient reasons presented in this study for a counselor to adopt an optimistic stance.

One premise of this study was that if optimism, on the counselor's part, could be considered a common factor that helps create a therapeutic environment facilitating positive therapeutic outcomes, then educators should take note of it as a means to increase student effectiveness. That is, students could be taught to monitor their optimism levels, taught to reflect

on their optimism levels, and taught how to enhance their own effectiveness through manipulation of their optimism level. This study provided sufficient statistical reasons to believe that the counselor's optimism level was conducive to the establishment of a working alliance.

This study did not find any support for the hypothesis that the counselor's optimism level was effective in predicting premature unilateral client termination. It also did not find any support for the hypothesis that the counselor's working alliance perceptions were effective in predicting premature unilateral client termination.

Implications for Future Research

Since this study represents a preliminary analysis of this combination of variables, more research seems to be merited. Specifically, a more nuanced look at the influence of optimism in facilitating positive therapeutic outcome is encouraged. The positive psychology movement informs us that optimism can be monitored, manipulated, and enhanced (see Seligman, 2006) but research on how optimism can best be intentionally incorporated into a curriculum for counselors is seemingly non-existent. Future research could overcome that gap in knowledge.

In light of the research that suggests that client perceptions of counselor attractiveness (see Heppner & Heesacker, 1982) influences therapeutic outcome a more precise tracking of client-counselor pairings might reveal how optimism is perceived differently through various multicultural lenses. Do some multicultural pairings of client-counselor combinations respond better to optimism. For instance, is it possible that cultures that approach life more stoically perceive optimistic counselors as being unrealistic, insensitive, etc.

Future research would do well to control the influence of social desirability. In retrospect optimism seems to be a characteristic that has considerable esteem in the American mindset. To ask someone to evaluate themselves on such a characteristic would seem to invite a distortion in

reality. One means of doing so in this study would have been to remove references to optimism in the research documents. Unless the participant was familiar with the LOT-R, the influence of social desirability might have been curtailed to some degree.

Implications for Counseling Practice

In this era when ESTs are being encouraged and indeed demanded, it is incumbent on counselors to adopt practices that enhance efficacy, advocate for tools that increase therapeutic outcomes, and encourage research that reveals specific tools to serve clientele in achieving the greatest gains. The tools or techniques that we know are most effective are not theoretically bound, but tend to result from the incorporation of common factors. This study provided evidence that optimism is positively related to working alliance formation. In turn the formation of a strong working alliance is positively related to increased therapeutic outcomes.

Although dispositional optimism is generally considered to be relatively stable across time and context there is no doubt that it can be measured and improved (see Seligman, 2006). Counselors would benefit personally from learning to monitor, reflect on, and nurture their own optimism. Additionally clients would benefit through the enhanced efficacy of therapy and from having appropriate role models. The counseling profession could benefit from advocating for dispositional optimism by having healthier practitioners and a more productive constituency. However, to reap these rewards will require more research on the construct, education of the constituency, and advocacy for the use of the common factors as the foundation for EST.

Implications for Counselor Training

This study has a basis in the conception that optimism on the part of the client is a significant factor in creating favorable therapeutic outcomes. This study sought to identify whether the counselor's optimism level might also be considered one of the common factors that

enhance therapeutic outcomes. The premise was that if the counselor's optimism could facilitate a therapeutic environment that achieves positive therapeutic outcomes, counselor educators should take note of optimism as a means of increasing the effectiveness of their students. That is, students could be taught to monitor their optimism levels, taught to reflect on their optimism levels, and taught how to enhance their own effectiveness through manipulation of their optimism level. Although optimism is fairly stable characteristic of time, it can ebb and flow throughout the lifetime of a counselor. Tools to reflect on and enhance optimism levels can make the work of the counselor more effective, while at the same time enhancing the life of the counselor in general. Counselors could benefit from the correlation between optimism and the ability to persevere when experiencing a difficult situations, while at the same experiencing less stress from the situation (Scheier, Carver, & Bridges, 2001).

This study provided sufficient statistical reasons to believe that the counselor's optimism level plays a role in the establishment of a working alliance that is conducive to positive outcomes. However, the counselor's optimism did not prove to be a reliable predictor of premature unilateral client termination. The implication for the counselor educator is that optimism merits increased research and that optimism merits inclusion in common factor lists.

The results attained in this study should lead to more research on the counselor's optimism level as a source of benefit to the counseling student, ultimately benefitting the client. The adoption of an optimistic lifestyle has a multitude of benefits (Frank & Frank, 1991; Karren et al., 2002; Seligman, 2006) for those who embrace it. When professionals were tested for optimism, there was a significant correlation between those who were rated high in optimism and those who were rated as the more productive employees by their bosses (see Seligman, 2006). Those professionals who were trained to monitor and increase their own optimism levels

performed significantly better with less job related stress and burnout. This same effect would seem to be reproducible among counselors and could benefit the entire mental health field.

An additional implication is that there seems to be a correlation among patient's perception of counselor's attributes and therapeutic outcome (Heppner & Dixon, 1981; Heppner & Heesacker, 1982, 1983). The broad categories investigated by Heppner include counselor expertness, attractiveness, and trustworthiness. It is entirely possible that the optimism construct has been subsumed in these studies by the broader category of expertness or attractiveness. To many, the outward manifestation of optimism can be an attractive quality and can enhance the appearance of expertness. Due to the difficulty of separating human attributes into clean and distinct categories, there is the possibility that optimism is actually appearing in some studies under some broader category. Therefore the research on optimism would be enhanced by the creation of instruments that are capable of making finer distinctions among human attributes.

A final implication appears in recent research, "The major emphasis has been on studies comparing different forms of psychotherapy" (Garfield, 1997, p. 40). Yet, there is the recognition that the client-counselor relationship is more influential in achieving positive therapeutic outcomes than the particular form of psychotherapy that is used. It is hoped that this study may influence counselor educators approaching research opportunities to look more closely at the attributes that facilitate the formation of a closer alliance than at specific therapeutic models.

Conclusion

In the introduction to a recent article researching the working alliance and therapy outcome, Baldwin, Wampold, and Imel (2007) inform us that,

The effectiveness of psychotherapy is well established (Lambert & Bergin, 1994; Lambert & Ogles, 2004), although identifying the therapeutic factors that account for patient improvement has proved difficult (cf. Castonguay & Holtforth, 2005; Craighead, Bjornsson, & Amaron, 2005; DeRubeis, Brotman, & Gibbons, 2005; Kazdin, 2005; Wampold, 2005). One viable therapeutic factor is the therapeutic alliance, which has emerged as a consistent predictor of outcome (Horvath & Bedi, 2002; Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000), leading many to conclude that it is an essential aspect of therapy (Norcross, 2002). (p. 842)

It was with this understanding that this study sought to examine and identify potential components of the therapeutic alliance. Knowing that a therapeutic alliance is useful in attaining good therapeutic outcome, however, is not very helpful information unless one also knows what components facilitate the creation of a productive therapeutic alliance. Understanding what elements help form the alliance was the essence of this study. In this study potential components of a therapeutic alliance were tested. The components of interest were the counselor's experience level, the counselor's optimism, and the counselor's perspective on the state of the working alliance. Statistical analysis indicated that there was a significant relationship found between all three of these variables.

Ackerman and Hilsenroth (2003) identified various therapist attributes that have been correlated with strong alliances and that list included therapist experience, which is consistent with the findings of this study. Ackerman and Hilsenroth (2003) did not, however, find a place for optimism on their list. Perhaps the recent influence of, and research by, the positive psychology movement will result in the inclusion of optimism on a future list of counselor attributes that serve to enhance the therapeutic alliance, ergo therapeutic outcome.

In an article describing what is known, and what else still needs to be known about the working alliance, Castonguay, Constantino, and Holtforth (2006) stated that,

Although substantial evidence points to the importance of a good alliance for treatment success, we need to have a better understanding of how it develops. This is a particularly crucial issue for training. While neophyte therapists are constantly reminded of the need to establish good rapport with their clients, there are few empirically based strategies to guide this essential work. (p. 275)

This study provided a modicum of information that could help fulfill the need for empirically based strategies that will serve to guide future training efforts. It is hoped that in the future, optimism may be considered a constituent part of a productive working alliance. Perhaps the greatest benefit of this study was that it, in some small way, served to increase the dialogue about potential elements that more narrowly focus future research. Research needs to continue to develop a knowledge base that helps counselor educators and counseling students understand how a good alliance is formed.

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APPENDICES

Appendix A: Human Subjects (IRB) Application

Appendix B: Online Survey Form

Section I: Human Subjects Approval/Informed Consent

Section II: Demographic Information

Section III: Life Orientation Test-Revised (LOT-R)

Section IV: Working Alliance Inventory (WAI)

Appendix C: Working Alliance Inventory – (WAI)

Appendix D: Life Orientation Test – Revised (LOT-R)

Appendix E: Demographics Information

Appendix A

IRB Application

OLD DOMINION UNIVERSITY APPLICATION FOR EXEMPT RESEARCH

Note: For research projects regulated by or supported by the Federal Government, submit 10 copies of this application to the Institutional Review Board. Otherwise, submit to your college human subjects committee.

Responsible Project Investigator (RPI)		
The RPI must be a member of ODU faculty or staff who will serve as the project supervisor and be held accountable for all aspects of the project. Students cannot be listed as RPIs.		
First Name: Danica	Middle Initial: G.	Last Name: Hays
Telephone: 757-683-6692	Fax Number: 757-683-5756	E-mail: dhays@odu.edu
Office Address: Darden College of Education Building, Room 166-2		
City: Norfolk	State: Virginia	Zip: 23529
Department: Educational Leadership & Counseling		College:
Complete Title of Research Project: The Role of Optimism and Working Alliance and its Utility in Predicting Therapeutic Outcome in Counseling Relationships		Code Name (One word): haysoptimism2
Investigators		
Individuals who are directly responsible for any of the following: the project's design, implementation, consent process, data collection, and data analysis. If more investigators exist than lines provided, please attach a separate list.		
First Name: Michael	Middle Initial: A.	Last Name: Hauser
Telephone: 706-980-9366	Fax Number: N/A	Email: mhaus002@odu.edu
Office Address: 400 Woodlawn Ave		
City: Dalton	State: Georgia	Zip: 30721
Affiliation: ___ Faculty <input checked="" type="checkbox"/> Graduate ___ Undergraduate Student ___ Staff ___ Other _____		
First Name:	Middle Initial:	Last Name:
Telephone:	Fax Number:	Email:
Office Address:		
City:	State:	Zip:
Affiliation: ___ Faculty ___ Graduate ___ Undergraduate Student ___ Staff ___ Other _____		
List additional investigators on attachment and check here: _____		

Type of Research
<p>1. This study is being conducted as part of (check all that apply):</p> <p> <input type="checkbox"/> Faculty Research <input type="checkbox"/> Non-Thesis Graduate Student Research <input checked="" type="checkbox"/> Doctoral Dissertation <input type="checkbox"/> Honors or Individual Problems Project <input type="checkbox"/> Masters Thesis <input type="checkbox"/> Other </p>
Funding
<p>2. Is this research project externally funded or contracted for by an agency or institution which is independent of the university? Remember, if the project receives ANY federal support, then the project CANNOT be reviewed by a College Committee and MUST be reviewed by the University's Institutional Review Board (IRB).</p> <p> <input type="checkbox"/> Yes (If yes, indicate the granting or contracting agency and provide identifying information.) <input checked="" type="checkbox"/> No </p> <p> Agency Name: Mailing Address: Point of Contact: Telephone: </p>
Research Dates
<p>3a. Date you wish to start research (MM/DD/YY) <u>01/15/2009</u></p> <p>3b. Date you wish to end research (MM/DD/YY) <u>12/31/2009</u></p>
Human Subjects Review
<p>4. Has this project been reviewed by any other committee (university, governmental, private sector) for the protection of human research participants?</p> <p> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No </p> <p>4a. if yes, is ODU conducting the primary review?</p> <p> <input type="checkbox"/> Yes <input type="checkbox"/> No (If no go to 4b) </p> <p>4b. Who is conducting the primary review?</p> <p>N/A</p>
<p>5. Attach a description of the following items:</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Description of the Proposed Study (see attached Appendix) <input checked="" type="checkbox"/> Research Protocol (see attached Appendix) <input checked="" type="checkbox"/> References (see attached Appendix) <input type="checkbox"/> Any Letters, Flyers, Questionnaires, etc. which will be distributed to the study subjects or other study participants <input type="checkbox"/> If the research is part of a research proposal submitted for federal, state or external funding, submit a copy of the FULL proposal <p>Note: The description should be in sufficient detail to allow the Human Subjects Review Committee to determine if the Study can be classified as EXEMPT under Federal Regulations 45CFR46.101(b).</p>
Exemption categories

6. Identify which of the 6 federal exemption categories below applies to your research proposal and explain why the proposed research meets the category. Federal law 45 CFR 46.101(b) identifies the following EXEMPT categories. Check all that apply and provide comments.

SPECIAL NOTE: The exemptions at 45 CFR 46.101(b) do not apply to research involving prisoners, fetuses, pregnant women, or human in vitro fertilization. The exemption at 45 CFR 46.101(b)(2), for research involving survey or interview procedures or observation of public behavior, does not apply to research with children, except for research involving observations of public behavior when the investigator(s) do not participate in the activities being observed.

(6.1) Research conducted in established or commonly accepted educational settings, involving normal educational practices, such as (i) research on regular and special education instructional strategies, or (ii) research on the effectiveness of or the comparison among instructional techniques, curricula, or classroom management methods.

Comments:

(6.2) Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures or observation of public behavior, unless: (i) Information obtained is recorded in such a manner that human subjects can be identified, directly or through identifiers linked to the subjects; AND (ii) any disclosure of the human subjects' responses outside the research could reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, or reputation.

Comments:

(6.3) Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior that is not exempt under paragraph (b)(2) of this section, if: (i) The human subjects are elected or appointed public officials or candidates for public office; or (ii) federal statute(s) require(s) without exception that the confidentiality of the personally identifiable information will be maintained throughout the research and thereafter.

Comments:

Each participant will be directed to the research website where they will be presented informed consent information apprising them of their rights should they choose to volunteer for participant in this research project. To indicate that they have understood the informed consent document, and wish to continue as a volunteer participant in this project each participant will be asked to check a block before they can proceed to the rest of the research material. Checking the block indicates that they have read and understand their rights as participants.

No personal identification information will be collected at the website. All information collected at the website will be aggregated and compiled into raw quantitative data. That data will be downloaded by the researcher at the completion of the data collection phase. The collected data will provide no means for the researcher to identify any of the participant's personal identity information. All downloaded data will be stored on a password secured computer that will be locked in a filing cabinet when not in use. The data will be placed in an electronic, password protected spreadsheet. The archived (backup) password protected spreadsheet will be maintained on a password protected external hard-drive, and locked in a fireproof safe. The investigator will be the only person to handle all documentation throughout the duration of this research, and will be the only person to maintain all of the passwords for the spreadsheet as well as the computer and external hard-drive on which the spreadsheet is maintained.

(6.4) Research, involving the collection or study of existing data, documents, records, pathological specimens, or diagnostic specimens, if these sources are publicly available or if the information is recorded by the investigator in such a manner that subjects cannot be identified, directly or through identifiers linked to the subjects.

Comments:

(6.5) not applicable

(6.6) Taste and food quality evaluation and consumer acceptance studies, (i) if wholesome foods without additives are consumed or (ii) if a food is consumed that contains a food ingredient at or below the level and for a

use found to be safe, or agricultural chemical or environmental contaminant at or below the level found to be safe, by the Food and Drug Administration or approved by the Environmental Protection Agency or the Food Safety and Inspection Service of the U.S. Department of Agriculture.

Comments:

PLEASE NOTE:

1. You may begin research when the College Committee or Institutional Review Board gives notice of its approval.
2. You **MUST** inform the College Committee or Institutional Review Board of ANY changes in method or procedure that may conceivably alter the exempt status of the project.

Responsible Project Investigator (Must be original signature)

Date

Description of the Proposed Study

There will be a minimum of 84 participants sought via convenience sampling for this research. To meet the requirements of sampling power and provide a sufficient population, while at the same time considering a 40% return rate, it is projected that the initial population of counselors who will be contacted as potential participants will need to be 210 at a minimum.

The initial solicitation will be placed on CESNET, which is a listserv serving the international population of counselors and counselor educators who have voluntarily enrolled as listserv members. A letter listing criteria for participation will be posted on this site, and any potential counselors may reply individually, or counselor educators may choose to forward the letter to entire classes that they are teaching. In addition Lists of potential candidates will be gathered from rosters of members of state counseling associations, and from insurance company panels that list active counselors. From this list, direct appeals for participation will be made to counselors via emails directing them to the specific SurveyMonkey site that is hosting the survey instrument.

All potential participants who seek to participate will be directed to the appropriate Survey Monkey website. The Survey will consist of four sections. Section I will provide

informed consent information and Institutional Review Board approval information. Section II will consist of a brief demographic section, seeking primarily the participant's professional training and practice information. Section III will consist of the Life Orientation Test-Revised (LOT-R), and Section IV will consist of the Working Alliance Inventory. The survey instrument is attached (see Appendix A). Note: The survey instrument will appear somewhat differently once placed online in order to comply with the site providers formatting constraints.

The Working Alliance Inventory-Client (WAI) (see Section IV, Appendix A) and the Life Orientation Test-Revised (LOT-R) (see Section III, Appendix A) are used in this research to collect data for the testing of the research hypotheses. Permission has been granted by the authors of both questionnaires for use in this study.

Working Alliance Inventories (WAI)

The working alliance has been described as how well the client and counselor relate and understand each other and has been declared by one theorist as the “quintessential integrative variable” (Wolfe & Goldfried, 1988, p. 449) of effective therapy. The WAI was based on the psychoanalytic Supervisory Working Alliance Model originally conceived by Bordin (1983). Greenson's psychoanalytic perspective on the working alliance also contributed to item construction for the WAI (Greenson, 1967).

The Working Alliance Inventory (WAI) designed and tested by Horvath (1981), will be used in this research to measure the degree of working alliance that the counselor and client achieve during therapy. The WAI is one of more than 11 common alliance oriented instruments publicly available (Fenton, Cecero, Nich, Frankforter, & Carroll, 2001), and is one of the most widely used instruments in alliance research (Martin, Garske, & Davis, 2000). Busseri and Tyler (2003) state that, “of the extant therapeutic alliance measures, the WAI has received the most

empirical attention . . . Well over 100 published research reports and several meta-analytic reviews (Horvath & Greenberg, 1994; Horvath & Symonds, 1991; Martin, et al., 2000) have explored various aspects of the WAI.”

The WAI was chosen for use in this research for several reasons: (a) it is a popular instrument for research regarding the alliance; (b) it is pantheoretical; (c) it is easily administered and rapidly completed; (d) it is easy to interpret; (e) it is readily available; (f) it generates a composite score; (g) the scale score results of the WAI share a significant amount of common variance with other alliance instruments (Tichenor & Hill, 1989); and (h) there is a significant link between the client’s estimate of the working alliance and therapy outcome when measured with the WAI (Horvath & Greenberg, 1994; Horvath & Symonds, 1991).

The WAIs produce results on the Task scale, the Bond scale, and the Goal scale, as well as a Composite scale. Only the Composite scale will be used in this research. There are 12 items associated with each of the three subscales for a total of 36 items. Each item is measured with a 7 point Likert scale ranging from “Never” to “Always.” For scoring purposes “Never” equals 1, and “Always” equals 7. The minimum score for the Composite score is 36, indicating the weakest possible level of working alliance has been formed, and the maximum score for the Composite score is 252, indicating the strongest possible working alliance has been formed.

Cronbach’s alpha for the composite scale score is .93 for the WAI-C and .87 on the WAI-T (Horvath, 1981; Horvath & Greenberg, 1986, 1989). The test-retest reliability for the Composite scale for a 3-week period was .80 (Horvath & Greenberg, 1994). Further, Hanson, Curry, and Bandalos (2002) reported internal consistency estimates for the WAI-C ranged from .83 to .97 ($M = .93$, $SD = .04$, $n = 13$) and .84 to .95 for the WAI-T ($M = .91$, $SD = .05$, $n = 5$) for the composite total scores.

When considering the construct validity of the WAI scores, the interscale correlations between Bonds, Tasks, and Goals have been found to be substantial. The creator of this instrument wrote in his dissertation (Horvath, 1981) that he had achieved interscale correlations for Bonds with Goals of .69, Bonds with Tasks of .78, and Goals with Tasks of .92. There is a degree of reported subscale overlap which complicates the process of determining whether the WAI measures three separate components of working alliance. This should not be problematic for this research since only the Composite score will be used. The dimensions of Bonds, Tasks, and Goals as defined by Bordin (1979) are interrelated and even defined in terms of each other.

Original statistical analysis of this instrument was drawn from a sample pool of 185 supervisors and 178 trainees who were participating in a supervisory relationship at the time of the survey completion (Efstation, Patton, & Kardash, 1990). The initial analysis included a comparison of the WAI with various aspects of the Supervisory Styles Inventory (SSI) (Friedlander & Ward, 1984) and the Self-Efficacy Inventory (SEI) (Friedlander & Snyder, 1983).

In a separate study, Patton (Patton, 1992) evaluated the SWAI for its psychometric properties and compared it to the Personal Reactions Scale-Revised (PRS-R) (Holloway & Wampold, 1984). At the time, the PRS-R was the only other measure of the relational issues involved in counseling supervision. In several measures, the results of Patton's study and the original testing of validity for the SWAI achieved similar results (Efstation, et al., 1990; Patton, 1992). The internal consistency reliability was .90 for Rapport, and .77 for Client Focus with an *N* of 178. Item scale correlations for the Rapport scale ranged from .44 to .77 and .37 to .53 for the Client Focus scale (Efstation, et al., 1990).

The intercorrelations between the trainee scales were moderate at .47. With these results it was determined that the Working Alliance Inventory had achieved acceptable levels of scale reliability (or interitem consistency) and item-scale correlations (Efstation, et al., 1990).

Life Orientation Test-Revised (LOT-R).

The LOT-R (Appendix D) will be used to measure the degree of dispositional optimism held by the counselor or the client. This measure of optimism will focus on the expectancy of a successful therapeutic outcome for the work that counselor and client are currently conducting, alternatively called dispositional optimism.

The LOT-R was chosen for use in this research for the following five reasons (a) it is a popular instrument for research regarding dispositional optimism, (b) it is easily administered and rapidly completed, (c) it is easy to grade, (d) it is readily available, and (e) it generates a composite score.

In its original form, the LOT was composed of 16 total questions. After being administered to 150 college students, a factor analysis reduced the number of questions was reduced to 12, four worded in a positive manner, four worded in a negative manner, and four used as fillers in order to disguise the underlying purpose of the questionnaire (Scheier & Carver, 1985). With these revisions made the test was administered to 1,000 students in four independent samples. With this sample, another factor analysis was completed. There were no significant differences among genders so the population is treated as a homogenous unit.

The LOT was also subjected to tests for internal consistency and test-retest reliability. The overall Cronbach's alpha of .76 indicates a high degree of internal consistency and the test-retest reliability reached a correlation level of .79 (Scheier & Carver, 1985).

After a lengthy analysis, including several factor analyses and a sample of over 1200 people, the authors (Scheier & Carver, 1985) of the LOT conclude that,

. . . the Life Orientation Test appears to provide a psychometrically sound measure of optimism, defined in terms of the favorability of a person's generalized outcome expectancy. The LOT would seem to possess an adequate level of internal consistency, test-retest reliability, and convergent and discriminant validity to make it suitable for use in research when such a measure is desired (p. 232).

The LOT was used for several years and received a lot of scrutiny (Andersson, 1996; Cheng & Hamid, 1997; McPherson & Mohr, 2005; Smith, Pope, Rhodewalt, & Poulton, 1989; Steed, 2002). In 1994 the original authors of the LOT, in response to scrutiny, reviewed the original instrument and determined that the scrutiny was insufficient to merit a revision to the instrument (Scheier, Carver, & Bridges, 1994). However, the authors did decide to revise the instrument for reasons unrelated to the scrutiny that the test had received. They concluded that some questions were not actually measuring outcome expectancy as intended, but optimism in a broader sense. Therefore minor changes were made to the LOT, resulting in a revised test known as the Life Orientation Test-Revised (LOT-R). The new test now has only 10 questions.

The Revised LOT was again subjected to tests for internal consistency and test-retest reliability. The overall Cronbach's alpha rose from .76 to .78 with the revisions. The test-retest reliability remained at a correlation level of .79 at the 28 month time frame (Scheier, et al., 1994).

Completion of the online survey will conclude the participants contribution to this research. Participants will be provide an opportunity to request a final copy of the research, should they so desire.

The investigator will be the only one to handle the raw data resulting from the aggregated participant input. The researcher will maintain the data in an electronic, password protected spreadsheet. After entering the data into the spreadsheet the spreadsheet and data will be archived on a password protected external hard drive that will be maintained in a locked in a fireproof safe as backup in case of loss of the original data. All work will be compiled and completed on a password protected laptop computer that is locked in a filing cabinet when not in use by the investigator. The investigator will be the only person to handle all documentation throughout the duration of this research, and will be the only person to maintain all of the passwords for the spreadsheet as well as the computer and external hard-drive on which the spreadsheet is maintained.

Approval Notification

From: Gomez, Edwin
Sent: Monday, February 23, 2009 7:31 AM
To: Hays, Danica G.
Cc: Gomez, Edwin; Watson, Silvana R.; Tomovic, Cynthia L.; Hager, Jane
Subject: Exempt Study

Dr. Hays,
Your proposal submission titled, "The Role of Optimism and Working Alliance and its Utility in Predicting Therapeutic Outcome in Counseling Relationships" has been deemed EXEMPT by the Human Subjects Review Committee of the Darden College of Education. You may begin your research. Please send a signed hardcopy of your application submission to the address below. Thank you.

Edwin Gomez, Ph.D.
Associate Professor
Graduate Program Director
Old Dominion University
2010 Student Recreation Ctr
Norfolk, VA 23529-0196

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Appendix B

Online Survey Form

Note: The appearance of this form will change when placed on the internet site. The change in appearance will be necessitated in order to comply with the formatting requirements of the internet site. The information and order displayed herein will be the same when placed on the internet site.

Optimism, Working Alliance and Its Utility in Predicting Therapeutic Outcomes

Section I

Introduction to Research Study

Old Dominion University
Norfolk, Virginia

RESEARCH TITLE: The Role of Optimism and Working Alliance and Its Utility in Predicting Therapeutic Outcomes in Counseling Relationships

This information sheet explains the research study. Any questions or concerns may be addressed to: Principal Researcher: Mike Hauser, NCC, Phone: (706) 428-0801, Email: mhaus002@odu.edu, or Faculty Advisor: Danica G. Hays, PhD, LPC, NCC, Phone: (757) 683-6692, Email: dhays@odu.edu

This research has been reviewed and approved by the Institutional Review Board of Old Dominion University.

CRITERIA FOR PARTICIPATION: In order to complete the survey, it is requested that you are either an intern in a counseling program or a counselor who has previously graduated from an accredited program. Additionally, it is important that you are currently working with a client who has presented with symptoms of depression, or have worked with such a client in the last 6-12 months.

PURPOSES AND PROCEDURES: You are invited to participate in a research project that examines the relationship between optimism, working alliance, and therapeutic outcomes in the counseling relationship. If you agree to participate in this study, you will complete a series of questions that include demographic information (e.g., age, gender, working experience, etc.), the Life Orientation Test-Revised (LOT-R), and the Working Alliance Inventory (WAI). Completing the survey should take approximately 15-30 minutes. You are free to refuse to answer any questions that you do not wish to answer. You may withdraw from the study at any time by closing your browser window.

CONFIDENTIALITY: The information you provide by filling out the on-line survey is completely anonymous. No identifying information will be collected. Data will be compiled using computer software (e.g., SPSS) and will be stored on a password-protected computer.

Only the listed researchers will have access to the data. To assure anonymity, no information regarding participant internet addresses will be recorded. Research findings (in aggregated form) may be presented at professional conferences and/or in scholarly journals.

RISKS AND BENEFITS: This study poses negligible risk to the participants. You will be asked to answer a series of questions. You may refuse to answer any questions that you do not wish to answer. Furthermore, you may terminate participation at any time without penalty. You may benefit from this research in that the results may be released to the public. You may also choose to contact the primary researcher at the above listed email address for any resultant publications related to this research. In addition, you may benefit from a sense of helping the public at large by contributing to knowledge in this area of research and by helping educators gain a better understanding of therapeutic efficacy.

COSTS AND COMPENSATION: There is no cost to you nor any compensation provided for participation.

VOLUNTEERING FOR THE STUDY: Participation is voluntary. Refusal to participate involves no penalty or loss of benefits. There is no way that your response can be identified once you submit your answers.

By clicking the "NEXT" button below, you agree that you have read and understood the explanation provided and voluntarily agree to participate in this study.

Section II

Demographics

1. Age of counselor

Age:

2. Counselor Experience Level

- Masters level Intern in counseling program
- Student in advanced program (e.g., Doctoral program)
- Graduate from degree program to 2 years of experience
- More than 2 years to 5 years of experience
- More than 5 years to 10 years of experience
- More than 10 years to 20 years of experience
- More than 20 years of experience.

3. Gender

- Female
- Male

4. Marital Status

- Never Married
- Married
- Separated
- Divorced
- Widowed
- Other

5. Educational attainment: Highest level completed

- Bachelor Degree
- Masters Degree
- Specialty Degree
- Doctoral Degree

6. Licensure and certification status: please check all that apply

- Student
- Insufficient hours for licensure
- LAPC
- LPC
- LMFT
- NCC
- LCSW
- CAC
- RPT
- LMHC
- MFCC
- MD
- PHD
- CRC
- CCC
- CADAC
- Other
- Psychiatrist
- Psychologist

7. Race/Ethnicity:

- Black
- Hispanic
- White
- Asian
- Native American
- Multiracial
- Other

8. Professional Setting:

- Agency
- Private practice
- Other

9. Estimated number of clients seen by counselor in the last 6 months?

Enter value: _____

10. Estimated number of clients seen in the last 6 months who withdrew prematurely from counseling? (Clients who withdrew before counselor thought they were ready)

Enter value: _____

11. Estimation of the percentage of clients seen in the last 6 months who present with depression.

Enter value: _____

Section III**Life Orientation Test - Revised (LOT-R)***

Please be as honest and accurate as you can throughout. Try not to let your response to one statement influence your responses to other statements. There are no "correct" or "incorrect" answers. Answer according to your own feelings, rather than how you think "most people" would answer.

Rating Scale: [1] = I DISAGREE a lot, [2] = I DISAGREE a little, [3] = I neither AGREE nor DISAGREE, [4] = I AGREE a little, [5] = I AGREE a lot

1. In uncertain times, I usually expect the best.

- I DISAGREE a lot
- I DISAGREE a little
- I neither AGREE nor DISAGREE
- I AGREE a little
- I AGREE a lot

2. It's easy for me to relax.

- I DISAGREE a lot
- I DISAGREE a little
- I neither AGREE nor DISAGREE
- I AGREE a little
- I AGREE a lot

3. If something can go wrong for me, it will.

- I DISAGREE a lot
- I DISAGREE a little
- I neither AGREE nor DISAGREE
- I AGREE a little
- I AGREE a lot

4. I'm always optimistic about my future.

- I DISAGREE a lot
- I DISAGREE a little
- I neither AGREE nor DISAGREE
- I AGREE a little
- I AGREE a lot

5. I enjoy my friends a lot

- I DISAGREE a lot
- I DISAGREE a little
- I neither AGREE nor DISAGREE
- I AGREE a little
- I AGREE a lot

6. It's important for me to keep busy.

- I DISAGREE a lot
- I DISAGREE a little
- I neither AGREE nor DISAGREE
- I AGREE a little

- I AGREE a lot
7. I hardly ever expect things to go my way.
- I DISAGREE a lot
- I DISAGREE a little
- I neither AGREE nor DISAGREE
- I AGREE a little
- I AGREE a lot
8. I don't get upset too easily.
- I DISAGREE a lot
- I DISAGREE a little
- I neither AGREE nor DISAGREE
- I AGREE a little
- I AGREE a lot
9. I rarely count on good things happening to me.
- I DISAGREE a lot
- I DISAGREE a little
- I neither AGREE nor DISAGREE
- I AGREE a little
- I AGREE a lot
10. Overall, I expect more good things to happen to me than bad.
- I DISAGREE a lot
- I DISAGREE a little
- I neither AGREE nor DISAGREE
- I AGREE a little
- I AGREE a lot

* Scheier, M. F., Carver, C. S., & Bridges, M. W. (1994)

Section IV

Working Alliance Inventory (WAI)*

On the following pages there are sentences that describe some of the different ways a person might think or feel about his or her client.

THIS FORM SHOULD BE COMPLETED BASED YOUR MOST RECENT WORK WITH A CLIENT PRESENTING WITH SYMPTOMS OF DEPRESSION. AS YOU READ THE SENTENCES MENTALLY INSERT THE NAME OF THIS CLIENT IN THE PLACE OF _____ IN THE TEXT.

Rating Scale: [1] = Never, [2] = Rarely, [3] = Occasionally, [4] = Sometimes, [5] = Often, [6] = Very Often, [7] = Always. If the statement describes the way you always feel (or think) circle the number 7; if it never applies to you circle the number 1. Use the numbers in between to describe the variation between these extremes.

Work fast, your first impressions are the ones we would like to see.

1. How many months ago did this client first present for services?
 - 1 month
 - 2 month
 - 3 month
 - 4 month
 - 5 month
 - 6 month
 - 7 months or more
2. I feel uncomfortable with _____.
 - Never
 - Rarely
 - Occasionally
 - Sometimes
 - Often
 - Very Often
3. _____ and I agree about the steps to be taken to improve his/her situation.
 - Never
 - Rarely
 - Occasionally
 - Sometimes
 - Often
 - Very Often
4. I am worried about the outcome of these sessions.
 - Never
 - Rarely
 - Occasionally
 - Sometimes
 - Often
 - Very Often
5. My client and I both feel confident about the usefulness of our current activity in therapy.
 - Never
 - Rarely
 - Occasionally
 - Sometimes
 - Often
 - Very Often
6. I feel I really understand _____.
 - Never
 - Rarely
 - Occasionally
 - Sometimes
 - Often
 - Very Often
7. _____ and I have a common perception of her/his goals.
 - Never
 - Rarely

- Occasionally
 - Sometimes
 - Often
 - Very Often
8. _____ finds what we are doing in therapy confusing.
- Never
 - Rarely
 - Occasionally
 - Sometimes
 - Often
 - Very Often
9. I believe _____ likes me.
- Never
 - Rarely
 - Occasionally
 - Sometimes
 - Often
 - Very Often
10. I sense a need to clarify the purpose of our session(s) for _____.
- Never
 - Rarely
 - Occasionally
 - Sometimes
 - Often
 - Very Often
11. I have some disagreements with _____ about the goals of these sessions.
- Never
 - Rarely
 - Occasionally
 - Sometimes
 - Often
 - Very Often
12. I believe the time _____ and I are spending together is not spent efficiently.
- Never
 - Rarely
 - Occasionally
 - Sometimes
 - Often
 - Very Often
13. I have doubts about what we are trying to accomplish in therapy.
- Never
 - Rarely
 - Occasionally
 - Sometimes
 - Often
 - Very Often

14. I am clear and explicit about what _____'s responsibilities are in therapy.
- Never
 - Rarely
 - Occasionally
 - Sometimes
 - Often
 - Very Often
15. The current goals of these sessions are important for _____.
- Never
 - Rarely
 - Occasionally
 - Sometimes
 - Often
 - Very Often
16. I find what _____ and I are doing in therapy is unrelated to her/his current concerns.
- Never
 - Rarely
 - Occasionally
 - Sometimes
 - Often
 - Very Often
17. I feel confident that the things we do in therapy will help _____ to accomplish the changes that he/she desires.
- Never
 - Rarely
 - Occasionally
 - Sometimes
 - Often
 - Very Often
18. I am genuinely concerned for _____'s welfare.
- Never
 - Rarely
 - Occasionally
 - Sometimes
 - Often
 - Very Often
19. I am clear as to what I expect _____ to do in these sessions.
- Never
 - Rarely
 - Occasionally
 - Sometimes
 - Often
 - Very Often
20. _____ and I respect each other.
- Never
 - Rarely

- Occasionally
 - Sometimes
 - Often
 - Very Often
21. I feel that I am not totally honest about my feelings toward _____.
- Never
 - Rarely
 - Occasionally
 - Sometimes
 - Often
 - Very Often
22. I am confident in my ability to help _____.
- Never
 - Rarely
 - Occasionally
 - Sometimes
 - Often
 - Very Often
23. We are working towards mutually agreed upon goals.
- Never
 - Rarely
 - Occasionally
 - Sometimes
 - Often
 - Very Often
24. I appreciate _____ as a person.
- Never
 - Rarely
 - Occasionally
 - Sometimes
 - Often
 - Very Often
25. We agree on what is important for _____ to work on.
- Never
 - Rarely
 - Occasionally
 - Sometimes
 - Often
 - Very Often
26. As a result of these sessions _____ is clearer as to how she/he might be able to change.
- Never
 - Rarely
 - Occasionally
 - Sometimes
 - Often
 - Very Often

27. _____ and I have built a mutual trust.
- Never
 - Rarely
 - Occasionally
 - Sometimes
 - Often
 - Very Often
28. _____ and I have different ideas on what his/her real problems are.
- Never
 - Rarely
 - Occasionally
 - Sometimes
 - Often
 - Very Often
29. Our relationship is important to _____.
- Never
 - Rarely
 - Occasionally
 - Sometimes
 - Often
 - Very Often
30. _____ has some fears that if she/he says or does the wrong things, I will stop working with him/her.
- Never
 - Rarely
 - Occasionally
 - Sometimes
 - Often
 - Very Often
31. _____ and I have collaborated in setting goals for these session(s).
- Never
 - Rarely
 - Occasionally
 - Sometimes
 - Often
 - Very Often
32. _____ is frustrated by what I am asking her/him to do in therapy.
- Never
 - Rarely
 - Occasionally
 - Sometimes
 - Often
 - Very Often
33. We have established a good understanding between us of the kind of changes that would be good for _____.
- Never

- Rarely
 - Occasionally
 - Sometimes
 - Often
 - Very Often
34. The things that we are doing in therapy don't make much sense to ____.
- Never
 - Rarely
 - Occasionally
 - Sometimes
 - Often
 - Very Often
35. ____ doesn't know what to expect as the result of therapy.
- Never
 - Rarely
 - Occasionally
 - Sometimes
 - Often
 - Very Often
36. ____ believes the way we are working with her/his problem is correct.
- Never
 - Rarely
 - Occasionally
 - Sometimes
 - Often
 - Very Often
37. I respect ____ even when he/she does things that I do not approve of.
- Never
 - Rarely
 - Occasionally
 - Sometimes
 - Often
 - Very Often

*Horvath, A. O. (1981, 1984)

This completes the survey. Thank you for taking the time to participate in this research. If you would like a copy of the completed research please send an email to mhaus002@odu.edu, with your request in the subject line.

Appendix C

Working Alliance Inventory – (WAI)

Instructions

On the following pages there are sentences that describe some of the different ways a person might think or feel about his or her client. As you read the sentences mentally insert the name of your client in place of _____ in the text.

Below each statement inside there is a seven point scale:

①	②	③	④	⑤	⑥	⑦
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

If the statement describes the way you always feel (or think) circle the number 7; if it never applies to you circle the number 1.

Use the numbers in between to describe the variations between these extremes.

This questionnaire is **CONFIDENTIAL**; neither your therapist nor the agency will see your answers.

Work fast, your first impressions are the ones we would like to see.
(PLEASE DON'T FORGET TO RESPOND TO EVERY ITEM.)

Thank you for your cooperation.

Copyright A. O. Horvath, 1981, 1984.

1. I feel uncomfortable with _____.	①	②	③	④	⑤	⑥	⑦
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always	
2. _____ and I agree about the steps to be taken to improve his/her situation.	①	②	③	④	⑤	⑥	⑦
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always	
3. I am worried about the outcome of these sessions.	①	②	③	④	⑤	⑥	⑦
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always	
4. My client and I both feel confident about the usefulness of our current activity in therapy.	①	②	③	④	⑤	⑥	⑦
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always	
5. I feel I really understand _____.	①	②	③	④	⑤	⑥	⑦
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always	
6. _____ and I have a common perception of her/his goals.	①	②	③	④	⑤	⑥	⑦
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always	
7. _____ finds what we are doing in therapy confusing.	①	②	③	④	⑤	⑥	⑦
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always	
8. I believe _____ likes me.	①	②	③	④	⑤	⑥	⑦
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always	
9. I sense a need to clarify the purpose of our session(s) for _____.	①	②	③	④	⑤	⑥	⑦
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always	
10. I have some disagreements with _____ about the goals of these sessions.	①	②	③	④	⑤	⑥	⑦
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always	
11. I believe the time _____ and I are spending together is not spent efficiently.	①	②	③	④	⑤	⑥	⑦
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always	
12. I have doubts about what we are trying to accomplish in therapy.	①	②	③	④	⑤	⑥	⑦
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always	
13. I am clear and explicit about what _____'s responsibilities are in therapy.	①	②	③	④	⑤	⑥	⑦
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always	
14. The current goals of these sessions are important for _____.	①	②	③	④	⑤	⑥	⑦
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always	

15. I find what _____ and I are doing in therapy is unrelated to her/his current concerns.
 ① Never ② Rarely ③ Occasionally ④ Sometimes ⑤ Often ⑥ Very Often ⑦ Always
16. I feel confident that the things we do in therapy will help _____ to accomplish the changes that
 ① Never ② Rarely ③ Occasionally ④ Sometimes ⑤ Often ⑥ Very Often ⑦ Always
17. I am genuinely concerned for _____'s welfare.
 ① Never ② Rarely ③ Occasionally ④ Sometimes ⑤ Often ⑥ Very Often ⑦ Always
18. I am clear as to what I expect _____ to do in these sessions.
 ① Never ② Rarely ③ Occasionally ④ Sometimes ⑤ Often ⑥ Very Often ⑦ Always
19. _____ and I respect each other.
 ① Never ② Rarely ③ Occasionally ④ Sometimes ⑤ Often ⑥ Very Often ⑦ Always
20. I feel that I am not totally honest about my feelings toward _____.
 ① Never ② Rarely ③ Occasionally ④ Sometimes ⑤ Often ⑥ Very Often ⑦ Always
21. I am confident in my ability to help _____.
 ① Never ② Rarely ③ Occasionally ④ Sometimes ⑤ Often ⑥ Very Often ⑦ Always
22. We are working towards mutually agreed upon goals.
 ① Never ② Rarely ③ Occasionally ④ Sometimes ⑤ Often ⑥ Very Often ⑦ Always
23. I appreciate _____ as a person.
 ① Never ② Rarely ③ Occasionally ④ Sometimes ⑤ Often ⑥ Very Often ⑦ Always
24. We agree on what is important for _____ to work on.
 ① Never ② Rarely ③ Occasionally ④ Sometimes ⑤ Often ⑥ Very Often ⑦ Always
25. As a result of these sessions _____ is clearer as to how she/he might be able to change.
 ① Never ② Rarely ③ Occasionally ④ Sometimes ⑤ Often ⑥ Very Often ⑦ Always
26. _____ and I have built a mutual trust.
 ① Never ② Rarely ③ Occasionally ④ Sometimes ⑤ Often ⑥ Very Often ⑦ Always
27. _____ and I have different ideas on what his/her real problems are.
 ① Never ② Rarely ③ Occasionally ④ Sometimes ⑤ Often ⑥ Very Often ⑦ Always
28. Our relationship is important to _____.
 ① Never ② Rarely ③ Occasionally ④ Sometimes ⑤ Often ⑥ Very Often ⑦ Always

29. _____ has some fears that if she/he says or does the wrong things, I will stop working with him/her.

①	②	③	④	⑤	⑥	⑦
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

30. _____ and I have collaborated in setting goals for these session(s).

①	②	③	④	⑤	⑥	⑦
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

31. _____ is frustrated by what I am asking her/him to do in therapy.

①	②	③	④	⑤	⑥	⑦
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

32. We have established a good understanding between us of the kind of changes that would be good for _____.

①	②	③	④	⑤	⑥	⑦
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

33. The things that we are doing in therapy don't make much sense to _____.

①	②	③	④	⑤	⑥	⑦
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

34. _____ doesn't know what to expect as the result of therapy.

①	②	③	④	⑤	⑥	⑦
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

35. _____ believes the way we are working with her/his problem is correct.

①	②	③	④	⑤	⑥	⑦
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

36. I respect _____ even when he/she does things that I do not approve of.

①	②	③	④	⑤	⑥	⑦
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

Appendix D

Life Orientation Test – Revised (LOT-R)

Please be as honest and accurate as you can throughout. Try not to let your response to one statement influence your responses to other statements. There are no "correct" or "incorrect" answers. Answer according to your own feelings, rather than how you think "most people" would answer.

①	②	③	④	⑤
I DISAGREE a lot	I DISAGREE a little	I neither AGREE nor DISAGREE	I AGREE a little	I AGREE a lot

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

* = Reverse scored, ** = Fillers

Scheier, M. F., Carver, C. S., & Bridges, M. W. (1994)

Appendix E

Demographics Information

1. Age of counselor:

Enter value [____]

2. Counselors experience:

[1] = Masters level Intern in counseling program, [2] = Student in advanced program (e.g., Specialist, or Doctoral programs), [3] = Graduate from degree program to 2 years of experience, [4] = more than 2 years to 5 years of experience, [5] = more than 5 years to 10 years of experience, [6] = more than 10 years to 20 years of experience, [7]= more than 20 years of experience.

3. Gender:

[1] = Female, [2] = Male

4. Marital status:

[1] = Never Married, [2] = Married, [3] = Separated, [4] = Divorced, [5] = Widowed, [6] = Other

5. Educational attainment: Highest level completed

[1] = Bachelor Degree, [2] = Masters Degree, [3] = Specialty Degree, [4] = Doctoral Degree

6. Licensure and certification status: please check all that apply

[1] = Student, [2] insufficient hours for licensure, [3] = LAPC, [4] = LPC, [5] = LMFT, [6] = NCC, [7]= LCSW, [8] = CAC, [9] = RPT, [10] = LMHC, [11] = MFCC, [12] = MD, [13] = CRC, [14] = CCC, [15] = CADAC, [16] = Other, [17] = Psychologist, [18] = Psychiatrist

7. Race/Ethnicity:

[1] = Black, [2] = Hispanic, [3] = White, [4] = Asian, [5] = Native American, [6] =
Multiracial, [7] = Other

8. Professional Setting:

[1] = Agency, [2] = Private practice, [3] = other

9. Estimated number of clients seen by counselor in the last 6 months?

Enter value [____]

10. Estimated number of client's seen in the last 6 months who withdrew prematurely from counseling? (Clients who withdrew before counselor thought they were ready)

Enter value [____]

11. Estimation of the percentage of client's seen in the last 6 months who present with depression.

Enter value [____]

Personal Vita

Mike Hauser earned an Associates of Arts degree Journalism in 1976 from Northeast Technical College and a Bachelor of Science degree in General Liberal Arts in 1992 from the University of Arizona. He earned a Masters of Science degree in Strategic Intelligence in 1994 from the Joint Military Intelligence College, a Masters of Theology degree in 2003 from Covington Theological Seminary, and a Masters of Education in Community Counseling in 2006 from the University of Tennessee at Chattanooga. Mike was named the Outstanding Graduate Student in 2006 while attending the University of Tennessee at Chattanooga. At Old Dominion University in 2008 Mike was on a team that won the ACA Student Ethics Competition, 4th Annual Ethics Case Study Competition, Second Place. At Old Dominion University, as a PhD student, Mike was granted the Darden College of Education Doctoral Fellowship for 2007-2008.

Mike has an extensive career record that includes being retired from the US Army, serving over 20 years in the Military Intelligence field. Mike also spent 7 years in the corporate world as business manager and supervisor before he sought an education in the counseling field. In both fields he was recognized as a leader and innovator. While in the US Army he was recognized with multiple medals including 3 Meritorious Service Medals, Master Aviator, and Senior Instructor. He is a National Certified Counselor (NCC), and a Licensed Associate Professional Counselor (LAPC) in the state of Georgia.

Mike has published in national peer-reviewed journals and has two articles in review. He has presented at national and state level conferences on a variety of subjects, including crisis counseling, and ethical and legal issues in counseling. He is an active member of several professional organizations, including local positions in Chi Sigma Iota (CSI), the American Counseling Association (ACA), and the National Board of Certified Counselors (NBCC).