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The Impact of Counselor Level of Spiritual Well-Being on the Morale, Global Symptoms, and Global Impairment of Adolescents Receiving Treatment for Substance Use and/or Other Mental Health Disorders: A Pilot Study

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THE IMPACT OF COUNSELOR LEVEL OF SPIRITUAL WELL-BEING ON THE MORALE, GLOBAL SYMPTOMS, AND GLOBAL IMPAIRMENT OF ADOLESCENTS RECEIVING TREATMENT FOR SUBSTANCE USE AND/OR OTHER MENTAL HEALTH DISORDERS: A PILOT STUDY

The Impact of Counselor Level of Spirituality on the Morale, Global Symptoms, and Global Impairment of Adolescents Receiving Treatment for Substance Use and/or other Mental Health Disorders: A Pilot Study

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ABSTRACT

In recent years there has been a movement towards a holistic perspective of human nature in the counseling leading to increased interest in the nature and role of spirituality in counseling and the counseling process. In the present study multiple regression analysis is used to determine whether Counselor Level of Spiritual Well-Being, or aspects thereof, namely, Counselor Level of Existential Well-Being and/or Counselor Level of Religious Well-Being, as measured by the Spiritual Well-Being Scale significantly impacts client outcomes, namely, Morale, Global Symptoms, and Global Impairment as measured by the Health Dynamics Inventory for adolescents receiving treatment for substance use and/or co-occurring psychiatric disorders. A significant relationship was found for only Counselor Level of Religious Well-Being alone and in combination with other variables and client outcomes on Global Impairment. Results and their implications as well as suggestions for further research are discussed.

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Also, special thanks go out in memory of Dr. George Denny whose assistance with statistical analysis was instrumental in bringing this work to its completion.

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DEDICATION

This work is dedicated to my parents whose support through the years made its completion possible.

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CHAPTER ONE: INTRODUCTION

This study was conducted to answer the question of whether there is a relationship between counselor level of spiritual well-being and client outcomes. In recent years there has been a move in the health fields towards a holistic view of human nature (Cashwell, Bentley, & Bigbee, 2007; Matthews, 1998), resulting in the position that all dimensions of a person, (e.g., physical, emotional, social, occupational, intellectual and spiritual), must be addressed to promote client well-being (Hawks, 1994; Morrison, Clutter, Prichett, & Demmitt, 2009). Of these aspects/ dimensions of persons, spirituality has received significantly less attention in the research than the others (Hawks, 1994; Thoresen & Harris, 2002; Young, Wiggins-Frame, & Cashwell, 2007) and this is true as well in the field of counseling (Hickson, Housley, & Wages, 2000).

That spirituality is part of the counseling process (ASERVIC, 2009; CACREP, 2009; Gingrich & Worthington, 2007; Myers & Williard, 2003) is not a new idea (Watkins van Asselt & Baldo Sentock, 2009). In fact, Jung (1933), for example, *reported* human problems to be spiritual in nature and their resolution *to involve* a "spiritual awakening." Though there was a turn away from addressing spiritual issues grounded in a modernist outlook/worldview (MacDonald, 2004; Pargament & Saunders, 2007), in recent years, in light of this holistic view of persons and an increased awareness of spirituality as a real phenomenon (Moberg, 2002; Pargament & Saunders, 2007), there has been renewed interest in spirituality in Counseling and Psychology (Gingrich & Worthington, 2007; Matthews, 2004*;* Moberg, 2002; Pargament & Sanders, 2007; Thoresen & Harris, 2002; Hawks, 1994; Watkins van Asselt & Baldo Sentock, 2009; Young, Cashwell, & Shcherbakova, 2000). Research has begun to establish a relationship between client/patient spirituality and well-being (Calicchia & Graham, 2006; Gray, 2006; Moberg, 2002; Nelson et al. 2009; Pargament & Saunders, 2007; Thoresen & Harris, 2002; Young et al., 2000). In fact, the

Association for Spiritual, Ethical, and Religious Values in Counseling (ASERVIC, 2009) has published "Competences for Addressing Spiritual and Religious Issues in Counseling" that have been accepted by the American Counseling Association and the standards of the Council for Accreditation of Counseling and Related Educational Programs (CACREP) as cited in Morgan (2009) set forth the need to understand the role of spirituality in the process of recovery from addiction and counselors' understanding of the assessment of clients' spiritual histories. In addition, noting that referral of clients in treatment for addiction to 12-step groups such as Alcoholics Anonymous (AA) are a commonly recommended adjunct to therapy as there is empirical evidence that 12-step group attendance enhances therapeutic benefits and supports sobriety, and that spirituality is a cornerstone of 12-step groups, Cashwell, Clarke and Graves (2009) maintain that professional counselors' understanding of the role of spirituality in 12-step groups is essential. Further, according to Morrison et al. (2009), counselors need to include an assessment of their clients' spiritual issues/needs prior to introducing spirituality into the counseling process and report that failure to address spiritual and religious issues in the counseling process is to ignore an essential aspect of clients' lives. This renewed interest in spirituality, then, naturally leads to questions concerning the nature and role(s) of spirituality in the counseling process (Pargament & Saunders, 2007).

ASERVIC (2009) reports counselors' actively exploring their beliefs, attitudes, and values about spirituality and/or religion and continuously evaluating how their spiritual and/or religious beliefs and values influence their clients and the counseling process as competencies for addressing spiritual and religious issues in counseling. Genia (2000) notes that counselors need to be reflective with respect to and aware of their own spiritual issues and be willing to grow spiritually to be productive in promoting clients' well being. In addition, Chandler, Holden, and Kolander (1992)

report that it is a spiritual axiom that counselors cannot help clients achieve what they have not achieved themselves. This view is not novel as Jung (1933) states, "The physician, then, is called upon himself to face the task which he wishes the patient to face. … . At all events the doctor must consistently try to meet his own therapeutic demands if he wishes to assure himself of a proper influence on his patient" (pp. 50-51). For Jung asks, "…, for who can educate others while himself uneducated? Who can enlighten his fellows while still in the dark about himself, and who can purify if he himself is unclean?" (p. 51). In addition, MacDonald (2004) notes the view that counselors can be neutral with respect to value-laden issues, including spirituality, is an unfounded myth.

The above suggests that a counselor's level spiritual well-being can impact his/her clients' outcomes and leads to the question of whether it, in fact, does. A review of the literature yielded only one study (Brooks & Matthews, 2000), that addresses this issue. Their study, however, addresses this issue only with respect to substance abuse counseling, adult clients who receive inpatient counseling, and then, only with respect to the relationship between counselor level of spiritual well-being and client level of spiritual well-being. This study was done to begin to move toward filling this gap in the research.

Statement of the Problem

This study investigates whether there is a relationship between counselor level of spiritual well-being or aspects of counselor level of spiritual well-being, (e.g., counselor level of existential well-being and counselor level of religious well-being), and client outcomes, (e.g., morale, global symptom, and global impairment), for adolescent clients receiving treatment for substance use and/or other mental health disorders at an agency in the Southern United States regardless of the level of intensity of treatment being received, (e.g., outpatient, intensive outpatient, residential, etc.).

Research Question

The following research question will be addressed in the present study:

RQ: Is there a relationship between counselor level of spiritual well-being or aspects of counselor level of spiritual well-being, (e.g. counselor level of existential well-being and counselor level of religious well-being), and client outcomes/well-being (e.g., morale, global symptoms, and global impairment)?

Research Hypotheses

Initially, RH1 through RH12 below were proposed as hypotheses to be tested. However, during the course of the study three supplemental hypotheses were added in light of research suggesting the need to investigate results of subscales on the Spiritual Well-Being Scale, namely, Existential Well-Being and Religious Well-Being, taken together (Genia, 2001), and, results of data analysis revealing models in which no significant results were found for the overall total score on the Spiritual Well-Being Scale was a predictor, but there being significant results when the subscales of the Spiritual Well-Being Scale, namely, Religious Well-Being and Existential Well-Being, were used together as predictors. Thus the following research hypotheses were tested in the present study:

Counselor Level of Spiritual Well Being and Client Outcomes

RH1: There is a relationship between counselor level of spiritual well-being and client outcome/well-being on morale.

RH2: There is a relationship between counselor level of spiritual well-being and client outcome/well-being on global symptoms.

RH3: There is a relationship between counselor level of spiritual well-being and client outcome/well-being on global impairment.

Counselor Level of Existential Well-Being and Client Outcomes

RH4: There is a relationship between counselor level of existential well-being and client outcome/well-being on morale.

RH5: There is a relationship between counselor level of existential well-being and client outcome/well-being on global symptoms.

RH6: There is a relationship between counselor level of existential well-being and client outcome/well-being on global impairment.

Counselor Level of Religious Well-Being and Client Outcomes

RH7: There is a relationship between counselor level of religious well-being and client outcome/well-being on morale.

RH8: There is a relationship between counselor level of religious well-being and client outcome/well-being on global symptoms.

RH9: There is a relationship between counselor level of religious well-being and client outcome/ well-being on global impairment.

Relative Impact of Counselor Level of Existential and Religious Well-Being on Client Outcomes

RH10: The relative impact of counselor level of existential well-being on client outcome/well-being will not equal the relative impact of counselor level of religious well-being on client outcome/well-being on morale.

RH11: The relative impact of counselor level of existential well-being on client outcome/well-being will not equal the relative impact of counselor level of religious well-being on client outcome/well-being Global Symptoms.

RH12: The relative impact of counselor level of existential well-being on client outcome/well-being will not equal the relative impact of counselor level of religious well-being on client outcome/well-being global impairment.

Counselor Level of Existential and Religious Well-Being taken together and Client Outcomes

SRH13: There is a relationship between counselor level of religious well-being together with counselor level of existential well-being and client outcome/well-being on morale.

SRH14: There is a relationship between counselor level of religious well-being together with counselor level of existential well-being and client outcome/well-being on global symptoms.

SRH15: There is a relationship between counselor level of religious well-being together with counselor level of existential well-being and client outcome/well-being on global impairment.

Significance of the Study

Movement towards a holistic understanding of well-being entails the need to address all aspects/dimensions of persons that contribute to individual well-being of which spirituality is one (Hawks, 1994; Morrison et al., 2009). Despite an increased awareness of spirituality as a real phenomenon (Moberg, 2002; Pargament & Saunders, 2007), a renewed interest on the nature and role of spirituality in counseling (Hawks, 1994; Gingrich & Worthington, 2007; Matthews, 2004; Moberg, 2002; Pargament & Sanders, 2007; Thoresen & Harris, 2002; Watkins van Asselt & Baldo Sentock, 2009; Young et al., 2000), researchers maintaining the need for counselors to be aware of their own spiritual issues (Genia, 2000), and the need for counselors to achieve first what they ask of their clients according to Chandler et al. (1992) and Jung (1933), a thorough review of the literature revealed only one study that has addressed the issue of the possible

relationship between counselor level of spiritual well-being and client outcomes/well-being. This study was done to begin to fill this gap in the research.

If a relationship between counselor level of spiritual well-being or aspects of counselor level of spiritual well-being, (e.g. counselor level of existential well-being and counselor level of religious well-being), and client outcome/well-being, (e.g. morale, global symptoms, and global impairment), is found, then the results of the study can have implications in the way counselors are trained and supervised so as to promote client well being. In addition, it will point to the need for further research to determine what factors contribute to counselor level of spiritual well-being or aspects of counselor level of spiritual well-being, and how to incorporate addressing these factors into training programs and post program supervision of counselors in order to ensure maximum possible benefit to clients and to avoid doing them harm. Further, it will point to the need for further research to determine whether there are factors that differentially impact the relationship of counselor level of spiritual well-being or aspects of counselor's level of spiritual well-being, and client outcomes, such as type of counselor, type of client, (e.g., mental health disorder only, substance use disorder only, or co-occurring mental health and substance use disorder), gender of counselor and client, counselor years of experience, counselor level of education, (e.g., BA/BS, MA/MS, Ed.D/Ph.D./ D.Psy, MD), field of counselor, (e.g., counseling, social work, psychology, medicine), type of treatment, (e.g., mental health only, substance abuse only, treatment for co-occurring disorders and whether this was sequential, parallel, or integrated), and length of treatment as well as successful completion of treatment. Finally, it will point to the need to determine whether such a relationship obtains for other populations at various developmental levels of development, (e.g., children, adults, and the elderly), and for which populations the relationship is most significant.

Delimitations

This study was designed to address the aforementioned question only for adolescent clients receiving various levels of treatment, (e.g., outpatient, intensive outpatient, and residential treatment). As such, this study was not designed to investigate whether there is a relationship between counselor level of spiritual well-being or aspects of counselor's level of spiritual well-being, (e.g., counselor level of existential well-being and counselor level of religious well-being), and client outcomes/well-being, (e.g. morale, global symptoms, and global impairment), for children, adults, or the elderly receiving treatment. Nor does this study investigate whether there are other factors that differentially impact the relationship of counselor level of spiritual well-being or aspects of counselor's level of spiritual well-being and client outcomes such as type of counselor, (e.g., mental health or substance abuse), type of client, (e.g., mental health disorder only, substance use disorder only, or co-occurring mental health and substance use disorder), gender of counselor and client, counselor years of experience, counselor level of education, (e.g., BA/BS, MA/MS, Ed.D/Ph.D./D.Psy, MD), field of counselor, (e.g., counseling, social work, psychology, medicine), type of facility, (e.g., psychiatric, residential, inpatient, mental health only, substance abuse only, co-occurring compatible, etc.), type of treatment, (e.g., mental health only, substance abuse only, treatment for co-occurring disorders and whether this was sequential, parallel, or integrated), length of treatment, level of treatment, (e.g. outpatient, intensive outpatient, inpatient, residential, psychiatric), and successful completion of treatment.

Definitions and Operational Terms

For the purposes of this study the following definitions apply:

1. *Client Level of Global Impairment* means client global impairment as measured by the measured by Health Dynamics Inventory, (HDI).

2. *Client Level of Global Symptoms* means client global symptoms as measured by the measured by the HDI.

3. *Client Level of Morale* means client morale as measured by the measured by HDI.

4. *Client Outcomes/Well-Being* means client level of morale, global symptoms, and global impairment taken together as measured by the HDI post-treatment, (POSTMO, POSTGS, POSTGI).

5. *Co-occurring Disorders Counselor* means a person who is either both licensed as a counselor (e.g., Licensed Associate Counselor LAC or Licensed Professional Counselor LPC) in Arkansas or in training to become a licensed counselor providing services during practicum or internship, or licensed as a social worker, (Licensed Master Social Worker LMSW, Licensed Clinical Social Worker LCSW), in Arkansas or in training to become a licensed social worker providing services during practicum or internship, or is a licensed psychologist in Arkansas or in training to become so licensed providing services during practicum or internship; and, is either a certified as a substance abuse counselor in *Arkansas*, (e.g., Certified Alcohol and Drug Abuse Counselor, CADC or Advanced Alcohol and Drug Counselor, AADC), or in training to become so certified, or is a licensed as a substance abuse counselor in Arkansas, (e.g. Licensed Associate Alcohol and Drug Counselor LAADAC, Licensed Alcohol and Drug Abuse Counselor, LADAC), or, is a Certified Co-Occurring Disorder Professional (CCDP) in Arkansas.

6. *Counselor Level of Existential Well-Being (COLEWB)* means existential well-being as measured by the Existential Well-Being subscale (EWBS) of the Spiritual Well-Being Scale (SWBS).

7. *Counselor Level of Religious Well-Being (COLRWB)* means religious well-being as measured by the Religious Well-Being subscale (RWBS) of the SWBS.

8. *Counselor Level of Spiritual Well-Being (COLSWB)* means spiritual well-being as measured by the SWBS as a whole.

9. *Mental Health Counselor* means a person who is either licensed as a counselor (e.g., Licensed Associate Counselor LAC or Licensed Professional Counselor *LPC*) in *Arkansas* or in training to become a licensed counselor providing services during practicum or internship, or licensed as a social worker, (Licensed Master Social Worker LMSW, Licensed Clinical Social Worker LCSW), in Arkansas or in training to become a licensed social worker providing services during practicum or internship, or is a licensed psychologist in Arkansas or in training to become so licensed providing services during practicum or internship.

10. *Person with a Mental Health Disorder* means a person who meets the criteria set forth in the Diagnostic and Statistical Manual of Psychiatric Text Revision, (DSM-IV TR) for a diagnosis of a disorder other than substance use disorders, (e.g., mood disorder, anxiety disorder, etc.).

11. *Person with a Substance Use Disorder* means a person who meets the criteria set forth in the Diagnostic and Statistical Manual of Psychiatric Text Revision, (DSM-IV TR) for a diagnosis of a substance use disorder, (e.g., Substance Abuse or Substance Dependence).

12. *Substance Abuse Counselor* means a person who is either a certified substance abuse counselor in Arkansas, (e.g., Certified Alcohol and Drug Abuse Counselor CADC, Advanced Alcohol and Drug Counselor AADC), or in training to become so certified, or is a licensed substance abuse counselor in Arkansas, (e.g. Licensed Associate Alcohol and Drug Abuse Counselor LADAC, Licensed Alcohol and Drug Abuse Counselor, LADAC) or in training to become so licensed.

Summary

As previously noted, movement towards a holistic understanding of well-being entails the need to address all aspects/dimensions of persons that contribute to individual well being of which spirituality is one (Hawks, 1994; Moberg, 2002). Despite renewed interest on the nature and role of spirituality in counseling (Hawks, 1994; Gingrich & Worthington, 2007; Matthews, 2004; Moberg, 2002; Pargament & Sanders, 2007; Thoresen & Harris, 2002; Watkins van Asselt & Baldo Sentock, 2009; Young et al., 2000), an increased awareness of spirituality as a real phenomenon (Moberg, 2002; Pargament & Saunders, 2007), researchers maintaining the need for counselors to be aware of their own spiritual issues (Genia, 2000), and the need for counselors to achieve first what they ask of their clients according to Chandler et al. (1992) and Jung (1933), a thorough review of the literature revealed only one study that has addressed the issue of the possible relationship between counselor level of spiritual well-being and client outcomes/well-being. This study was done to begin to fill this gap in the research.

This study investigates whether there is a relationship between counselor level of spiritual well-being or aspects of counselor's level of spiritual well-being, (e.g., counselor level of existential well-being and counselor level of religious well-being), and client outcomes, (e.g., morale, global symptoms, and global impairment), for adolescent clients receiving treatment for mental health and/or substance use disorders. It is hypothesized that such a relationship exists.

Results of the study can have implications in the way counselors are trained and supervised so as to promote client well being should a relationship between counselor level of spiritual well-being or aspects of counselor level of spiritual well-being, (e.g., counselor level of existential well-being and counselor level of religious well-being), and client outcomes, (e.g., morale, global symptoms, and global impairment), be found.

Should such a relationship be found, then, this will point to the need for further research to determine what factors contribute to counselor level of spiritual well-being or aspects of counselor's level of spiritual well-being, (e.g., counselor level of existential well-being and counselor level of religious well-being), and how to incorporate addressing these factors in training programs and post program supervision of counselors so as to ensure maximum possible benefit to clients and to avoid doing them harm. In addition, it will point to the need for research to determine whether there are factors that differentially impact the relationship of counselor level of spiritual well-being and client outcomes such as type of counselor, (e.g., mental health, substance abuse, or co-occurring), type of client, (e.g., mental health disorder only, substance use disorder only, or co-occurring mental health and substance use disorder), and gender of counselor and client, counselor years of experience, counselor level of education, (e.g., BA/BS, MA/MS, Ed.D/Ph.D./D.Psy, MD), field of counselor, (e.g., counseling, social work, psychology, medicine), type of facility, (e.g., psychiatric, residential, inpatient, mental health only, substance abuse only, co-occurring compatible, etc.), type of treatment, (e.g., mental health only, substance abuse only, treatment for co-occurring disorders and whether this was sequential, parallel, or integrated), length of treatment, level of treatment, (e.g. outpatient, intensive outpatient, inpatient, residential, psychiatric), and successful completion of treatment. Finally, it will point to the need for research to determine whether such a relationship obtains for clients at other levels of development, (e.g., children, adolescents, and the elderly), as well as for which population the relationship is most significant.

CHAPTER TWO: REVIEW OF THE LITERATURE

Introduction

In this section a review of the literature concerning the nature and role(s) of spirituality in counseling is given. It begins with general issues and then goes on to review specific research that has been done, first, with respect to issues such as approaches to addressing spirituality in counseling, in the counseling process, as well as counselor education, development, and competencies, and then, with respect to specific studies conducted on the various aspects of spirituality as it can manifest in counseling, (e.g., counselor perceptions of the nature and role of spirituality in the counseling process, the role of spirituality in counselor selection, the relationship between counselor and client levels of spirituality, etc.) which points to areas where research is needed. Theory concerning the nature of spirituality is discussed next and points to measures appropriate for use in the study, and these, in turn, are reviewed. Finally a summary of what has been said is given as a means of leading to a discussion of the research design given in chapter three.

General Background Information

General issues

As noted earlier, recently, there has been a move in the health fields towards a holistic view of human nature (Cashwell, Bentley, & Bigbee, 2007; Matthews, 1998) resulting in the position that all dimensions of a person, (e.g., physical, emotional, social, occupational, intellectual and spiritual), must be addressed to promote client well- being (Hawks, 1994; Morrison et al., 2009). To understand the implications of this turn towards a holistic view it is important to understand the historical context in which it is situated. As mentioned earlier, for Jung (1933), all psychological problems are spiritual in nature and their resolution requires a

"spiritual awakening." For Jung, then, psychological problems are essentially religious problems. He claims, **"**A psychoneurosis must be understood, ultimately, as the suffering of a soul which has not discovered its meaning…. the cause of the suffering is spiritual stagnation, or psychic sterility" (Jung, 1978, p. 252).

Due to the field of psychology attempting to legitimize itself as a science (Myers, 1991) there was a turn toward accepting a modernist paradigm in psychology (MacDonald, 2004). As Pargament and Saunders (2007) note:

> Even though religion and spirituality were topics of vital interest to William James and other figures who founded psychology, religion and spirituality were largely neglected as subjects of serious psychological attention for much of the 20th century. Why? In part because psychology as a discipline was eager to detach itself from its philosophical and religious roots in the effort to establish itself as a hard science; … . (p.903).

Inherent in this paradigm is the positivistic principle of verifiability with the result of ruling out the legitimacy of research having to do with anything not perceived as verifiable. In addition a dualist perspective is an aspect of the modernist paradigm in which mental and spiritual aspects are seen as separate from physical aspects of human nature, (e.g., mind/ body dualism, ghost in a machine view of human nature). Further, seeing human beings as machines allowed for their being broken up into discrete parts (MacDonald, 2004). Consequently, it is the verifiable physical aspects of human nature that were seen as the proper objects of investigation. The spiritual aspect of human nature was no longer seen as within the providence of research in psychology and counseling (MacDonald, 2004).

It is worth noting here, then, that the underlying philosophical assumptions made by researchers – in this case those of the modernist's paradigm – concerning the nature of reality (Metaphysics) – in this case materialism (i.e., what exist is matter) – and how we come to know the nature of reality (Epistemology) – in this case empiricism and the principle of verifiability –

can have a substantial impact on research conducted – in this case what is appropriate to investigate (i.e., ruling out of spirituality as an appropriate subject of research). Thus, when considering research with respect to spirituality in counseling Richards and Worthington (2010) caution:

> It is also important for researchers investigating the outcomes of spiritually oriented psychotherapies to be aware that research methods that are based on the philosophical assumptions of scientific (reductive) naturalism may preempt the valid study of spiritual realities if careful thought is not given to prevent this (Slife et al., 1999; Slife & Whoolery, 2006). Scientific naturalism is grounded in the philosophies of objectivism, materialism, and reductionism, and assumes, among other things, that a phenomenon is not real if it cannot be objectively observed and reduced into smaller parts (Slife & Whoolery, 2006). When researchers start with reductive naturalism as their grounding assumption, the possibility that spiritual realities influence human behavior and welfare are ruled out of consideration, a priori, regardless of whether the methods are quantitative or qualitative. (p. 368)

What, for example, does holding materialism to be true entail? Since, according to materialism what is, is matter, it follows that the only material things, (i.e., what is made of matter) are appropriate subjects of research. What, then, of mental properties such as thoughts, feelings/emotions, perceptions, and beliefs all of which are significant subjects of concern in Counseling and Psychology? Prima facie, it would seem that if materialism is true, then they are appropriate subjects of research if and only if a naturalistic reduction of mental properties to physical properties such as neural firings, (i.e., a thought just is a neural firing or a collection of them), can be made. Yet, whether a naturalistic reduction of mental properties to physical properties is possible is anything but clear as evidenced by the fact that it is a highly debated issue in the field of Philosophy, more specifically, in the Philosophy of Mind. It is worth noting here, then, that a holistic view of human nature presupposes the irreducibility of properties of the whole- person as such - to properties of constituent parts – aspects/dimensions of persons.

In recent years, psychology has entered a "post positivistic era" allowing for the exploration of other paradigms (Pargament & Saunders, 2007) including the holistic paradigm. Inherent in a holistic paradigm is the inseparability of parts of the whole. Insofar as spirituality is a part of the whole of human nature, the spiritual aspect of human nature can no longer be set aside and an understanding of human nature be obtained (Hawks, 1994; Moberg, 2002; Pargament & Saunders, 2007). Consequently, with the move towards a holistic view of human nature comes a renewed interest of the spiritual aspect of human nature (Hawks, 1994; Gingrich & Worthington, 2007; Matthews, 2004; Moberg, 2002; Pargament & Sanders, 2007; Thoresen & Harris, 2002; Watkins van Asselt & Baldo Sentock, 2009; Young et al., 2000) and how best to address is in the helping relationship (Pargament & Saunders, 2007).

Further, according to Moberg (2002), "There is a growing consensus that human spirituality is an ontologically existent or "real" phenomenon in contrast to an earlier but still not rare positivistic assumption that it is merely a figment of folklore, myth, or the collective imagination" (p.48). Pargament and Saunders (2007) report that research consistently shows that people turn to spirituality for strength and support when in stressful situations. Further, they claim, "The emerging literature in the psychology of religion and spirituality underscores a key point: There is a spiritual dimension to human problems and solutions" (p. 904), and therefore, addressing spiritual issues in the counseling process is essential to providing culturally sensitive care. Consequently, failure to address spiritual and religious issues in the counseling process is to ignore an essential aspect of clients' lives (Morrison et al. (2009) and, according to Pargament and Saunders (2007), "Psychologists ignore the spiritual dimension of psychotherapy to the detriment of their field and their clients" (p.906). It is within this context of the increased awareness of spirituality as a real phenomenon and its relevance in counseling; and, move

toward a holistic view of human nature, and the resulting interest in the spiritual aspect of human nature that this study was conducted.

In addition, Myers (1991) has argued that the field of counseling should return to its historical roots of a wellness model (see below). Further, according to Matthews (1998) and Myers (1992), the American Association of Counseling and Development adopted a "wellness paradigm" as the philosophical foundation for the counseling profession in 1989. It was within the context of a wellness model, then, that this study was conducted.

Approaches to counseling

Zinnbauer and Pargament (2000) maintain that there is evidence that all counseling is value laden. They note that if counselors are to do more than provide empathy, then counselors must work from within a theoretical framework and that each framework is value laden with respect to what constitutes human nature, and thus, what constitutes lack of health and how health is to be restored. Further, these value assumptions of various theoretical frameworks function as "roadmaps" for counselors in their attempts to help their clients. As such "roadmaps" serve several functions including providing the framework for what constitutes suffering, a successful outcome, how to obtain such an outcome within a session and over time, and, in general, the proper subject matter of counseling itself. Counselors, then, need to be aware of the spiritual and religious assumptions they make.

To promote awareness of such assumptions Zinnbauer and Pargament (2000) set forth four possible approaches to addressing spiritual/religious issues, namely, rejectionism, exclusivism, constructivism, and pluralism. They go on to argue that counselors should adopt either a constructivist or pluralist approach so as to avoid running the risk of unethical behavior and functioning as subversive moral agents.

According to Zinnbauer and Pargament (2000), rejectionists deny that absolute reality includes religious or spiritual elements. Consequently, expressions by clients of such realities are evidence of underlying psychopathology. In a discussion of examples of how expression of such realities are evidence of psychopathology they note that this is the case with psychoanalytic theory, (e.g., religion is described as "defensive primitive idealization"); with behaviorism, (e.g., religious belief being equated with irrational thinking, emotional disturbance, and impaired functioning); and with existentialism, (e.g., belief in immortality as a defense against death anxiety). The goal of counseling, then, is to encourage a more ego-centric and/or rational approach to life.

According to Zinnbauer and Pargament (2000) problems with the rejectionist approach arise out of its rejection of religious and spiritual elements as part of absolute reality as this leads to equating religious and spiritual belief with impaired mental functioning. This, in turn, they claim is inconsistent with research and ethical issues concerning respect for cultural and religious diversity.

The central tenet of the exclusivist approach is the fundamental belief in the reality of a religious/spiritual dimension to reality (Zinnbauer & Pargament, 2000). Counselors who adopt this approach insist that there is one true spiritual reality. The exclusivists' approach is grounded in the central tenet that religious/spiritual worldview, (e.g., God exists and humans have an inherent sinful nature), or some other religious worldview, and that the counselor and client agree as to what this worldview is. Client difficulties are construed as resulting from the client's not acting in accordance with this worldview, (e.g., straying from one's relationship with God, etc.), and there is but one possible way to restore health, (e.g., reconciliation with God through Christ, etc.).

The primary disadvantage of the exclusivist view, according to Zinnbauer and Pargament (2000), is its restrictiveness. For it requires that counselor and client agree concerning the path to the religious reality, and thus, restoring health.

Zinnbauer and Pargament (2000) state that the central feature of the constructivist approach is the denial of any absolute reality whatsoever, (e.g., antirealism). Clients' religious and spiritual expressions as well as any other view on the nature of reality are their constructions as there is no absolute reality to be had. These constructions arise out of peoples' interactions, interpretations, and attempts to understand contexts, situations, and others.

It is noteworthy that this approach, then, does not presuppose a position concerning the nature of the religious/spiritual dimension to reality, since presupposes that there is no objective reality outside and independent of a person's construction of reality – which is to say because it assumes antirealism is true. Consequently, problems/psychological symptoms cannot be due to clients' misperceiving reality, but rather, are due to breakdowns in the internal consistency of a person's belief system or their ability to productively engage in their environment based on it. Problems exist, and it might be added, can only exist when clients claim there are problems. Counseling, then, focuses on the quality of a client's belief system and works from within its framework, (e.g., counselors take on the client's belief system as the frame of reference and help the client work out inconsistencies in it or become better able to function in his/her environment based on it) (Zinnbauer & Pargament, 2000).

A primary difficulty with the constructivist approach, according to Zinnbauer and Pargament (2000), is its relativistic nature as there is nothing to which a counselor can appeal when, for example, a client does not have a problem with beating his/her child on the basis of religious and/or other beliefs. Thus the counselor runs into ethical difficulty. Therefore the fine

line between acceptance of religious and spiritual belief and construing issues as having to do with health becomes apparent.

The final approach proposed by Zinnbauer and Pargament (2000) is the pluralist approach. On this approach the existence of a religious/spiritual dimension is acknowledged but its nature and the means to it are open, (e.g., pluralist). The pluralist recognizes that the nature of the spiritual/religious dimension and means to it are expressed in various ways in various cultures thereby allowing for the counselor to appreciate clients' religious beliefs while maintaining their own. Therefore differences in religious values between counselor and client need not adversely affect the counseling process.

They accomplish this by making apparent their own religious/spiritual bias in the counseling process thereby opening the way to move forward with the client on common religious/spiritual ground. Neither counselor nor their clients have privileged access to the truth and they move forward on equal ground, each benefiting from the exchange (Zinnbauer & Pargament, 2000).

Zinnbauer and Pargament (2000) caution counselors who choose this approach to be aware of their own beliefs, biases, values, and experiences as these are brought into the counseling process as well as their impact on that process. Such awareness, then, allows counselors not to mistakenly assume that they and their clients share other beliefs on the basis of shared beliefs with respect to the nature of the spiritual/religious dimension of reality.

Finally, Zinnbauer and Pargament (2000) claim that either the constructivist or pluralist approach ought to be taken as they are flexible enough to be respectful of the divergent spiritual/religious beliefs with which clients present. For counselors not to do so would entail that they "risk disregarding Bergin's warning and acting as unethical and subversive moral

agents" (Zinnbauer & Pargament, 2000, Conclusion section, para. 1). With respect to working with clients in recovery from an addiction Cashwell et al. (2009) concur.

It seems to this author, that insofar as the belief in the existence of a religious/ spiritual dimension to reality is foundational to the pluralist view it can be difficult to accommodate a client that does not share a belief in the existence of such a dimension to reality. Consequently, it would seem that the constructivist's approach is the approach with the greatest flexibility. Further, Myers and Williard (2003) stress the ethical importance of counselors using a constructivist orientation when addressing spiritual issues in counseling.

Counseling process

Genia (2000) addresses various issues that can arise in the interaction between client religious beliefs and the secular nature counseling practices. Noting that on the whole secular counselors are less religious than the clients they encounter, many issues addressed in counseling are framed within the context of clients' religious beliefs, clients' concerns that their fundamental beliefs – whether religious or nonreligious - not be undermined, lack of training counselors receive concerning how to address religious issues in counseling, and a positive correlation between strong religious affiliation and mental health; Genia (2000), makes suggestions/observations concerning what counselors can do to address religious/spiritual issues in counseling in the areas of assessment, countertransference, and referral with clients who have a strong religious affiliation.

With respect to assessment, according to Genia (2000), there is a need for assessing the extent to which religious/spiritual issues play a role in clients' presenting difficulties (Moberg, 2002) and the resulting need for discussing with clients whether their needs are best met within the context of a secular approach. For example, Genia notes that religious issues can play a role(s)

when grieving the loss of a loved one or in coming to terms with an extramarital affair. Milstein, Manierre, and Yali (2010) note that the spiritual and social support provided by religious communities are often sufficient for helping people through stressful situations such as the loss of a loved one. ASERVIC (2009) reports (a) counselors' striving to understand clients' spiritual and/or religious perspective, (b) awareness of the limits of that understanding, (c) acquaintance with spiritual and religious resources, including spiritual and religious leaders, to whom counselors can appeal for consultation and refer clients, and (d) ability to modify therapeutic techniques to incorporate clients' spiritual and/or religious perspectives, are competencies for addressing spiritual and religious issues in the counseling process.

However, whether to refer a client for, say, pastoral counseling, psychopathological issues need to be taken into consideration. For, according to Genia (2000), spiritual intervention alone may be inadequate to help clients who have serious mental illness (Milstein et al., 2010). Further, members of the clergy may be ill equipped to address issues related to serious mental illness. To whom a client is referred is determined in part by severity of presenting psychopathology (Genia, 2000).

Cashwell et al. (2009) report that people in recovery from an addiction often use 12-step groups for which spirituality is a cornerstone. Though such support can be sufficient to help people stay in recovery, often people in recovery can be in "spiritual by-pass" – "a way to enlist religion and spirituality to avoid the psychological work of healing one's developmental wounds" (p. 39) - and claim that "…, it is imperative that the counselor assess the spiritual life of the recovering client" (p.45) at least in part for the sake of assessing whether clients are in spiritual by-pass and helping them avoid it as part of the counseling process. It is worth noting here that, citing (Zinnbauer & Pargament, 2000), they report working within a pluralist or

constructivist as opposed to either a rejectionist or exclusivist perspective is "essential" when working with clients in recovery from addiction. Finally, ASERVIC (2009) report counselors' recognizing how clients' spiritual and/or religious beliefs can impact their well-being, (e.g., enhance, contribute to client problems, and/or exacerbate symptoms), is a competency for addressing spiritual and religious issues in the counseling process.

According to Genia (2000), counselors also need to be aware of their own spiritual/religious issues when addressing clients' religious/spiritual issues in counseling so as to prevent countertransference. Since, as Genia notes, counselors can be vulnerable to experiencing strong countertransference to religious clients and commonly they have a tendency to react against clients' religiosity (Kochems, 1993). Further, ASERVIC (2009) reports counselors' actively exploring their beliefs, attitudes, and values about spirituality and/or religion and continuously evaluating how their spiritual and/or religious beliefs and values influence their clients and the counseling process as competencies for addressing spiritual and religious issues in counseling. In addition, according to Genia (2000), counselors who do use spiritual interventions need to promote their own spiritual/religious development.

Often, according to Genia (2000), clients will ask counselors about their religious/ spiritual beliefs due to concerns about clients' religious or lack of religious beliefs being undermined. In such situations counselors need to be able to determine whether to reveal their own beliefs to their clients. How and on what basis they might do this Genia does not say. Regardless, it is worth noting here that ASERVIC (2009) reports counselors' (a) recognition of the centrality of client's beliefs about spirituality and/or religion to the client's world view, (b) use of spiritual and/or religious concepts acceptable the client, (c) responding with acceptance and sensitivity to client communications about spirituality and/or religion, and (d) setting goals

that are consistent with client's spiritual and/or religious perspective, are competencies for addressing spiritual and religious issues in the counseling process.

Finally, Genia (2000) notes that counselors who do address spiritual/religious issues in the counseling process need to guard against the possibility of boundary violations and role confusion. Milstein et al. (2010), noting the need to distinguish religious expertise from clinical expertise, and thus the appropriate roles of clergy and psychologists, report that according to the "Resolution on Religious, Religion-Based and/or Religion-Derived Prejudice" adopted by the Council of Representatives of the American Psychological Association 16 August 2007, that it is not within the expertise of, and therefore, not the role of the psychologist "as psychologist" to "adjudicate" spiritual and/or religious beliefs. Further, they go on to state in their concluding remarks, "One purpose of this paper is to remind clinicians, even religious clinicians, to recognize the defacto mental health care provided to individuals through their spiritual and social support of their congregations. As the *Resolution* and others have articulated, it is not the role of the mental health professional to be a spiritual guide" (p. 379).

Counselor education, development, and competencies

In recent years, some counseling and psychology professionals have believed it not appropriate to address spiritual and religious issues either because they believe it is more appropriate to address such issues in other settings such as ecclesiastical (Young, Cashwell, Wiggins-Frame, & Belaire, 2002) or because they continue to maintain a modernist outlook. Consequently, spiritual and religious issues often have been neglected by mental health professionals due at least in part to the scientific, objective perspective of Psychology, which, in turn, is due to the influence of people such as Skinner and Ellis, not to mention Freud. (Young et al., 2007). According to Myers and Williard (2003), "Burke et al. (1999) noted that "spirituality,

religion, and the counseling profession have had an uneasy relationship" (p. 251). … and, in part, it reflects the influence of individuals such as Freud (1912/1959) and Ellis (1991) who, in the past, equated religiosity with mental illness" (p.142).

For the most part, however, counselors and therapists agree that it is appropriate to address spiritual and/or religious issues in the counseling/therapeutic process. Myers and Williard (2003), noting that the claim that human spirituality is a universal phenomena central to growth and development is well-supported, report that spiritual and religious issues are therapeutically relevant in counseling and that it is ethical to address them in counseling. In addition, Gingrich and Worthington (2007) claim spirituality and religion have a place in Psychology and should be included in theory, research, training, and practice. Further, Young et al., (2002) report that *c*onsistent with the findings of Young et al. (1998) in which ACA members rated the spiritual competencies developed at the Summit on Spirituality in October 1995 as being important to effective counseling practice, so, too, did counselor educators rate the competencies. To endorse spiritual competencies as important to effective counseling implies that spiritual issues are relevant to the counseling process and should be addressed therein.

There is mounting evidence that addressing spiritual and religious issues in the counseling process can lead to positive outcomes (Calicchia & Graham, 2006; Gray, 2006; Moberg, 2002; Nelson et al. 2009; Pargament & Saunders, 2007; Thoresen & Harris, 2002; Young, et. al., 2000). And so, it has been argued that failure to address spiritual and/or religious issues in the counseling process is to ignore a substantial aspect/dimension of client lives (Cashwell et al., 2007). For these reasons, it has been claimed that failure to address spiritual and/or religious issues in counseling is to risk doing clients harm (Watkins van Asselt & Baldo Sentock, 2009). Therefore,

many in the counseling profession have argued that it is unethical not to address spiritual and/or religious issues in counseling and this is reflected in the ACA Code of Ethics (2005).

Interestingly, since the counseling profession has embraced as a core philosophy for training and intervention a developmental wellness orientation, there is a move towards a holistic understanding of life and wellness that incorporated spirituality into all aspects of human experience in all helping professions (Myers & Williard, 2003), and, in particular, the American Counseling Association has endorsed a holistic wellness paradigm (Myers 1992). If Cashwell et al. (2007) are correct in claiming spirituality is the core of wellness and cannot be separated from other dimensions of wellness, as this author believes they are (see below), it follows that not addressing spiritual and/or religious issues in counseling constitutes failure to address the core of what is involved in clients being well.

Yet, many helping professionals (Young et al., 2007) including counselors (Young, et. al., 2002) continue not to address their clients'/patients' spiritual and/or religious issues in the helping relationship leading to the question of why this is the case. Some reasons for this have already been noted (see above). There are reported in the literature other reasons why helping professionals fail to address spiritual and/or religious issues such as difficulty with defining just what spirituality is (Hagedorn & Gutierrez, 2009). However, almost universally lack of training is reported in the literature as a reason counselors give for not addressing their clients' spiritual and/or religious issues in the counseling process (Young et al., 2002; Young et al., 2007). According to Pargament and Saunders (2007), "Unfortunately, therapists often feel unequipped to talk about spiritual matters, perhaps because they lack training in this area" (p. 904), and Gingrich and Worthington (2007) report, "Consistent with these results, was the study by Prest, Russell, and D'Souza (1999) that surveyed 52 MFT students in six AAMFT accredited training

programs in the U.S. One of the many relevant findings of the study was that 73% of the respondents believed it was desirable for a clinician to receive supervision and training in dealing with spiritual issues in therapy. Yet less than eight percent had received such training in their clinical program" (p. 350)

With the aforementioned in mind, it is worth mentioning here that Watkins van Asselt and Baldo Sentock (2009) report that counselors' personal spirituality and training in spirituality impacts their choices of treatment themes; and, counselors' spiritual beliefs and training in spirituality impacts their perceived competence in addressing clients' spiritual issues. More specifically, with respect to the former they report that "It seems that when a counselor is more spiritually aware, his or her ability to recognize a client's spiritual concerns is also greater" (p.417), and, with respect to the latter they claim, "… as counselors believe themselves to be more spiritual, they may also perceive themselves to be more competent to work with spiritual issues. [and go on to claim] It is not surprising that as training increased, the counselor felt more competent when working with a spiritual concern*"* (p. 417). It is worth noting here that drawing the conclusion they made in this last claim presupposes that increased training in spirituality results in an increase in the extent to which counselors believe themselves to be spiritual, a presupposition that is not prima facie true.

Regardless, that lack of training is almost universally cited in the literature as a reason why counselors rarely address spiritual and/or religious issues, is not surprising when many graduate programs do not address these issues in their curriculum (Hagedorn & Gutierrez, 2009; Myers & Williard, 2003). According to a study cited by Pargament and Saunders (2007), *"*…, a survey of clinical training directors of programs in the United States and Canada revealed that only 13% of programs offer a course in religion and spirituality (Brawer, Handal, Fabricatore,

Roberts, Wajda-Johnson, 2002)" (p. 904). Young et al. (2002) report that 78% of respondents to their survey of counselor educator programs reported that no specific course addressing spiritual and religious issues in counseling was offered at the institution where they worked, but 70% reported that instruction concerning addressing these issues was provided at some place in the curriculum.

It might be asked why graduate programs have not included training in addressing spiritual/religious issues? As Gingrich and Worthington (2007) note, "The accumulation of findings point in the same direction. Little attention is given to training in spirituality in secular programs. This raises the important research concern: What are the barriers to integration in training and supervision in secular programs?" (p.350). One reason might be that counselor educators feel unprepared and thus uncomfortable addressing spiritual and/or religious issues in educating and training counselors-in-training. There is evidence this might be the case. For example, consistent with the findings of Young et al. (1998) in which ACA members rated the spiritual competencies developed at the Summit on Spirituality in October 1995 as being important to effective counseling practice, so, too, did counselor educators rate the competencies. Further, Young et al. (2002) report that only 46% of respondents viewed themselves to be prepared or very prepared to infuse the competencies into their teaching and supervision of counselors. Finally they report that of those respondents who viewed themselves as unprepared to so infuse the competencies 85% reported the need for additional training and nearly 80% reported the need for curricular guidelines to provide direction for inclusion of spiritual and religious issues in courses and supervision. Consequently, they report their study provides support for the inclusion of spiritual and religious competencies in counselor training, provision of additional training to counselor educators on addressing spiritual and religious issues in

counseling, and the development of curriculum guidelines to assist counselor educators' addressing spiritual and religious issues in their work. Another possible reason for the lack of inclusion of spiritual and/or religious issues in counselor training programs is lack of clarity when it comes to the nature of spirituality. Myers and Williard (2003) report, "The lack of a clear definition and confusion over the meaning of spirituality has been a significant obstacle to the inclusion of spiritual concerns in counselor preparation and counselor practice (Burke et al., 1999; Kelly, 1994; Myers et al., 2000; Pate & Bondi, 1992)" (p.147).

Finally, it is worth noting here that even in cases where addressing spiritual issues in training is possible (i.e., the counselor educator or supervisor is prepared), often these issues are not discussed because students and supervisees do not feel comfortable raising these issues (Gingrich & Worthington, 2007). They note that despite there being eight potential sources by which therapists-in-training can learn how to address spiritual/religious issues, namely, (a) coursework, (b) informal peer discussions, (c) advisors, (d) research training, (e) practicum training, (f) personal therapy, and (g) post-degree training, " …, most S/R training occurred when clients brought up S/R issues in their therapy and counselors then carried such issues in supervision" (p. 342).

There are programs that do incorporate addressing clients' spiritual and/or religious into their curriculum. Young et al. (2002) report that 70% of respondents to their survey of counselor educator programs reported that instruction concerning addressing spiritual and/or religious issues was provided at some place in the curriculum at the institution where they worked. Unfortunately, with respect to programs where spiritual and/or religious issues are addressed in the curriculum Hagedorn and Gutierrez (2009) report there is at best a lack of delivery consistency, which is to say, inconsistent attention is given to spiritual and religious issues in

counselor education curriculum. They go on to note that lack of training and inconsistency in training can have negative consequences such as unethical treatment of clients whose spiritual beliefs are undervalued, missed opportunities to see how clients' spiritual and religious beliefs impact the therapeutic process, not acknowledging essential aspects of clients' concerns, and barriers in the counseling relationship perpetuated by conflicting views on spirituality.

That there is a move towards a holistic understanding of life and wellness that incorporates spirituality into all aspects of human experience in all the helping professions, then, presents new challenges and ethical responsibilities to counselors and counselor educators to be competent in addressing clients' spiritual issues (Myers & Williard, 2003). Consequently, there has been a call in recent literature for infusing programs with spirituality (Gingrich & Worthington, 2007; Myers & Williard, 2003; Watkins van Asselt & Baldo Sentock, 2009; Young et al., 1998; Young et al., 2002).

Actually, the issue of including training on addressing spiritual issues in the counseling process has been pressed as ASERVIC (2009) has set forth nine competencies for addressing spiritual and religious issues in counseling which have been endorsed by the ACA (see Appendix A). Further, CACREP (2009) standards require students preparing to work as addiction counselors, "Understands the role of spirituality in the addiction recovery process" (p. 19), "Understands the assessment of biopsychosocial and spiritual history" (p.21), and that students preparing for work in Higher Education, "Understands postsecondary student development in a multicultural society, including characteristics such as immigrant status, disability, extreme ability or talent, cultural background, spirituality, and family situation" (p. 49).

With standards of competency comes the need for competence, and therefore, the need for providing a means by which competence can be had in graduate programs (Watkins van

Asselt & Baldo Sentock, 2009; Young et al., 1998; Young et al., 2002). Myers and Williard (2003), for example claim counselors and counselor educators need to be aware of their own spiritual constructions and the role(s) these constructions have played in their development processes; and, be able to describe their spiritual belief system and identify life events that led to their developing them as well as how they might "interfere with demonstrating genuine empathy, openness, and acceptance of different spiritual values, beliefs, …" (p.151). Further, they claim that counselors and counselor educators need to be knowledgeable about the possible relationships between spiritual and/or religious beliefs and mental health and "A greater understanding of other spiritual/religious beliefs and traditions through education, training, and exposure to diverse religious communities and activities [in order] both to understand clients' perspectives and to identify possible conflicts with their own values and beliefs" (p.151). In addition, Gingrich and Worthington, (2007) claim that increased interest in the role of spirituality in therapy has yielded increased interest in its role in supervision across a variety of helping professions, including counseling.

All of this, then leads to the question of how counselor education programs might infuse their curriculum with spirituality, (i.e., include training on addressing spiritual and/or religious issues in the counseling process).

According to Hagedorn and Gutierrez (2009), there are two general approaches have been taken in attempting to infuse spirituality into the counselor education curriculum, namely, segregation, (e.g., developing special courses and/or certificate programs on spirituality), and integration, (e.g., addressing spiritual issues as they come up in courses already offered and program). They argue for using an integrative approach asserting that:

> … to segregate such discussions into one course, a certificate program, or even across a couple of specific courses, is to miss the opportunity to address the importance of these

> topics across the educational experience. (Programs often address these content issues in such courses as Multicultural Counseling and / or Ethical and Legal Issues in Counseling). Others who agree have advocated for the integration of these topics into the counselor education curriculum, be it through a wellness lens, an addiction approach, or by attaching them to CACREP core curricular experiences (Briggs & Rayle, 2005; Matthews, 1998; Myers and Williard, 2003) (p. 34).

They then go on to provide ready-to-implement exercises that can be used with respect to each of the competencies a discussion of which is beyond the scope of this endeavor.

Others have argued for the use of theoretical models of development to be used as guideposts for including addressing spiritual and/or religious issues in counselor preparation. For example, noting that despite increasing interest in addressing spiritual and religious issues in counseling in the past decade, little has been written addressing the supervisor directly concerning the dynamics of spiritual and religious issues when they arise in supervisory contexts, Parker (2009) explicates how James Fowler's model of faith development stages can be used to understand these dynamics especially in situations where counselor and client values diverge with respect to these issues and can lead to impasses in the therapeutic process. Further, he claims that supervisors might find Fowler's model helpful insofar as it fits well with developmental models of supervision, and , in particular, Stoltenberg's Integrated Developmental Model. For present purposes, his explication of possible difficulties that can arise in the therapeutic relationship such as the inability of a counselor at a lower level of faith development than his or her client to fully understand the nature of his/her client's spiritual/religious issues is worth noting as well as his going on to say in his discussion of possible directions for future research:

> A very different line of inquiry could explore mean levels of faith development in counselors (or supervisors). This is a neglected area of research. If one tends to understand only one stage above one's own, this has implications for supervisors working with counselors who may have clients above the counselor's stage or for the supervisor's work with counselors who may be above the supervisor's stage. (p. 51)

Still others have argued for the use of paradigms as a foundation for integrating addressing spiritual and/or religious issues in counselor preparation. For example, Myers and Williard (2003), within the context of a discussion of spirituality as a developmental process review psychodynamic, psychosocial and cognitive theories of spiritual development note that:

> "What is lacking, however, is a unified theoretical approach that (a) integrates the unique contributions of each theory to the study of human development in the spiritual dimension and (b) integrates spirituality with other aspects of human growth and change. [and go on to note that] Models of wellness establish a paradigm that provides this integration by incorporating aspects of body, mind, and spirit into a holistic view of human functioning" (p. 145).

In addition Myers and Williard (2003) claim that there is a move towards a holistic understanding of life and wellness that incorporates spirituality into all aspects of human experience in all the helping professions which presents new challenges and ethical responsibilities to counselors and counselor educators to be competent in addressing clients' spiritual issues, the counseling profession has embraced as a core philosophy for training and intervention a developmental wellness orientation, and, a developmental wellness orientation can provide a foundation for preparing counselors to address spiritual and religious needs of their clients. Thus, noting that integration of addressing spiritual issues into counselor education programs is needed, Myers and Wiliard (2003) make recommendations on how this might be accomplished. Their recommendations include : making the foundation of counselor preparation a "developmentally based wellness orientation that promotes human spirituality as the core element of the individual" (p. 152), adopting and stressing the ethical importance of a constructivist orientation towards human spirituality, including opportunities for counselors-in-training to "explore, understand, and articulate the personal meaning of their own spirituality as well as the individual nature of their meaning-making processes," and exposure to "assessment and intervention techniques that are compatible with the philosophy of spiritual and holistic

wellness as well as "diverse spiritual and religious beliefs, values, and phenomena as part of their preparation process" (p. 152), encouraging research involving spiritual/religious issues and development, and educators examining and articulating their own understanding of spirituality and the role(s) it plays in human development so that they can "help students understand their own spiritual issues as well as those of their clients, …" (p.153).

Finally, yet other researchers suggest that the counseling profession is not so far off the mark as some would have us believe. For example, Morgen, Morgan, Cashwell, and Miller (2010) argue that in using the basic core counseling skills spirituality is already being incorporated into the counseling and supervisory processes as these skills are at their core spiritual. So, for example, they report that establishing a relationship with a client that is characterized by genuineness, unconditional positive regard, and empathetic understanding for the sake of promoting healing and health has been described as a spiritual intervention. They go on to claim, "Speaking in the client's visual and emotional imagery demonstrates both acceptance and validation of the [addiction] client's struggle. In short, these counseling behaviors ***embody hope***" (p. 2) which is essential in beginning and maintaining recovery and of which most clients suffering from addiction, presented with the enormous challenge of recovery, have little, if any at all. In any case, counselor educators and supervisors' incorporating the use of these skills in their work with counselors-in-training would constitute infusing spirituality/addressing spiritual issues into counselor preparation curricula/education programs.

It is worth noting here, that in a portion of a video this author often has shown supervisees entitled Dual diagnosis: An integrated model for the treatment of people with co-occurring psychiatric and substance disorders, according to Minkoff (2000), "The most significant predictor of treatment success is the presence of an empathetic, hopeful, continuous treatment relationship,

in which integrated treatment and coordination of care can take place through multiple treatment episodes." That said, in the remaining portion of the video shown the presenter in the video, Dr. Minkoff, goes on to discuss what is meant by empathy and hope, difficulties clinicians often encounter when attempting to provide clients with co-occurring psychiatric and substance use disorders empathy and hope, and ways to overcome these difficulties. Perhaps, then, I have already infused addressing spiritual issues in counseling in the supervision process (Morgen et al., 2010).

In any case, Minkoff (2001) claims, "Treatment success involves formation of empathic, hopeful, integrated treatment relationships" (p. 2). And this principle has found its way into becoming one of the Substance Abuse and Mental Health Services Administration (SAMHSA)'s Center for Substance Abuse Treatment (CSAT)'s "Overarching Principles to Address the Needs of Persons with Co-Occurring Disorders" (2006), "Empathy, respect, and belief in the individual's capacity for recovery are fundamental provider attitudes" (p. 4).These attitudes, it could be claimed arise out of a person's being spiritually well or *are* characteristic of a spiritually well person. If so, counselors' spiritual development, as noted above, involves their development as persons.

With the aforementioned in mind, according to Gingrich and Worthington (2007) claim, "Overall, the research on S/R within supervision is so sparse that the agenda is wide open" (p.352). Despite this they do make some recommendations one of which is, "Ultimately, one of the most important research questions will be, does integrating spirituality into supervision result in better therapists, and in better outcomes for clients?" (p. 353). It is worth noting here, then, that if counselor level of spiritual well-being correlate with client outcomes, and if integrating spirituality into the supervisory process increase counselor level of spiritual well-being, then the answer to this question would seem to be yes.

Studies

Research has been conducted concerning counselor perceptions of the nature and role of spirituality in counseling. So, for example, noting that spiritual issues in counseling historically have been neglected, Hickson et al. (2000) addressed two issues concerning counselors' perception of spirituality, namely, counselors' attitudes and perceptions of spirituality in the counseling process and the impact of counselors' perception of the importance of spirituality in the counseling process has on their practice. More specifically, they asked what are counselors' attitudes and perceptions of the importance of spirituality in counseling and what is the impact of those perceptions on their counseling practice? To do this they conducted a descriptive study in which they sent out 154 (51% returned) surveys consisting of 15 Likert-type items with five possible responses varying from 1 (strongly disagree) to 5 (strongly agree) as well as questions concerning demographic data to counselors in the Southeastern United States. Analysis of counselors' responses was made using frequency distributions and analyses of variance. For the study, Hickson et al. (2000) define spirituality as ".. a way of being in the world that acknowledges the existence of a transcendent dimension. It includes an awareness of the connectedness of all that is and accepts that all life has meaning and purpose and thus is sacred" (Survey instrument section, para. 3)

Of the findings reported by Hickson et al. (2000) they maintain that those of interest included counselor recognition of the importance of their own spiritual beliefs in the counseling process, the universality of spirituality as a phenomenon, and the importance of those phenomena as an agent for change in the counseling process. In addition, according to Hickson et al. (2000), counselors reported a need for training to develop skills of awareness.

It should be noted that sampling was random, though only from the states of Mississippi and Georgia. Thus the results may not be representative of other sections of the United States. Face validity was determined through expert review. Other than this, no other means of determining validity was utilized.

Morrison et al. (2009) surveyed a convenience sample of individuals from two independently owned agencies - one of which was a Christian practice and the other secular – in a Southern city of approximately 166,000 who were providing counseling/psychotherapy services to children and adults and their adult clients "to examine the perceptions of clients and counselors regarding the role of spirituality in the counseling context" (p.186). They report interns in a counseling program at a local university were used to recruit counselors/psychotherapists who, in turn, recruited clients using a written script. Two questionnaires developed by the researchers for the study were used to collect data, namely, Professional Perceptions on Spirituality in Counseling Questionnaire (PPSCQ) - consisting of three open ended questions by means of which demographic data were obtained followed by three 5-point categorical rating items, "(e.g., "To what degree do you view spirituality to be an effective intervention in counseling?" (p. 188), and a final 8-point rating scale on which counselors/psychotherapists self-rated their level of use of spirituality as an intervention – and the Experiences in Counseling Questionnaire (ECQ) – consisting of 18 multiple choice items and one open-ended item for the sake of obtaining demographic data.

Morrison et al. (2009) report that counseling professionals participating in the study "largely viewed incorporating spirituality as a component in counseling to be acceptable, effective, and important relative to their theoretical orientation" (p. 189), though 23.5% reported not using spiritual interventions in their practice. Interestingly, Morrison et al. report that a

substantially greater number of counselors/ psychotherapists reported a high level of use of spirituality as an intervention than reported receiving formal training in the use of spirituality as an intervention.

According to Morrison et al. (2009), most of the clients surveyed, (72.9%) reported they wanted spirituality to be included in the counseling process at the same level as it already was being included and that 73.5% found the inclusion of spiritual interventions "very helpful" in making progress towards their goals in counseling and that no clients reported it was "unhelpful." Further, they report that clients surveyed from the Christian counseling agency reported that spirituality was introduced more often by the counselor than the client, whereas the opposite was true of clients who received services in the secular agency.

Morrison et al. (2009) report that one limitation of their study is that participants may not be representative of the larger population noting the relatively small sample sizes, (e.g., 34 of the 75 counselors, social workers, psychologists, and psychology and counseling trainees, and 73 of the 75 clients initially recruited for the study participated), and no counselors from sites that were not chosen as internship sites were surveyed. Further, a large percentage of client participants were female (78.9%) and Caucasian (94.2%). Finally, it is worth noting that besides for three counseling professionals providing an independent review of the ECQ prior to its use, Morrison et al. report no attempts to ensure validity and reliability of the instruments used.

In addition, studies on the influences of spirituality on counselor selection have been conducted. Belaire and Young (2000), for example, conducted a study of 63 upper level business management students to determine whether client level of spiritual well-being was related to choice of counselor. Participants were given the Human Spirituality Scale (HSS).

According to Belaire and Young (2000) the HSS consists of 20 five - point Likert-type questions with three dimensions including the context/structure in which one's life is viewed, awareness of living things and caring reverently for the welfare of others. Wheat (1991) notes that the construct validity of the HSS was established by means of factor analysis, content validity by means of expert review and has a Cronbach's alpha reliability coefficient of .89.

Participants also were given a Counselor Description Questionnaire (CDQ) containing two descriptions of counselors from which to choose as a means by which participants could indicate their preferences for counselors and of which Belaire and Young (2000) claim that the primary difference between the descriptions of the two counselors was the statement in the description of one noting their expertise in addressing spiritual issues. Otherwise, Belaire and Young claim that the descriptions of the two counselors were similar along "important" dimensions, (e.g., sex and level of experience.)

Belaire and Young (2000) hypothesized that participants with higher scores on the Human Spirituality Scale would have a greater preference for, and thus tendency to select a counselor who tended to address spiritual issues in the counseling process. A one-way analysis of variance (ANOVA) at the .05 level was conducted to determine whether client level of spiritual well-being as measured by the Human Spirituality Scale was related to counselor preference. No significant relationship was found (Belaire & Young, 2000).

In addition, Belaire and Young (2000) used a chi-square analysis was used to determine exactly what participant counselor preference was revealing. They report, "a statistically significant number of participants preferred the counselor without spirituality in the description: $chi^2(43) = 48.86$, $p < .05$ ($n = 45$ for Counselor 1, $n = 18$ for Counselor 2)" (Counselor Selection section, para. 1).

A primary limitation of this study is low external validity all of the participants were in college, (e.g., upper level business management majors). In addition, Belaire and Young (2000) note that differing elements may have confounded the data as participants reported factors other than spirituality that influenced their decision.

Richards and Worthington (2010) review 6 reviews of outcomes studies on the use of spiritually oriented psychotherapies, examples of which they report include "conducting a spiritual assessment, consulting with or referring to a spiritual leader, teaching spiritual concepts, encouraging forgiveness, discussing scriptures, teaching mindfulness meditation, encouraging contemplative meditation and prayer, conducting spiritual imagery, …" (p. 363). They report that though there is evidence for the use of such interventions, there is a lack of methodologically sound outcome studies. They go on to make recommendations concerning the use of methodologically pluralistic research strategy, collaboration between researchers and practitioners, and assessing spiritual outcomes of spiritually oriented psychotherapies.

To date, however, only one study has addressed the issue of whether counselor level of spiritual well-being impacts client outcomes. Brooks and Matthews (2000) conducted a study to investigate whether there is a positive relationship between counselors' spiritual well-being and other factors that contribute to their well-being and whether there is a relationship between counselor level of spiritual well-being and clients' level of spiritual well-being. More specifically, Brooks and Matthews (2000) asked whether:

> … there would be a statistically significant positive correlation between the SA counselors' scores on the Spiritual Well-Being Scale (SWBS); the Inner Harmony, Self Respect, Wisdom, Honesty, and Loving scales of the Rokeach Value Survey (RVS); and the Time-Competence, Self Actualizing, Existentiality, and Self Acceptance scales of the Personal Orientation Inventory (POI); and whether there would be a statistically significant positive correlation between the inpatient SA counselors' scores on the SWBS and the gain score between pre and post scores of their patients SWBS. (para. 6)

To answer the first question they used an ex post facto design R O_1. A random sample of 45 of all certified addiction counselors in the Commonwealth of Virginia were sent a packet containing a cover letter with the instruments used and 34 were returned. To answer the second question Brooks and Matthews (2000) used a convenience sample of eleven certified addiction counselors from three inpatient facilities who were given the same packet who were asked to fill out the SWBS posttest. In addition, ninety-four clients for whom the counselors were the "primary" counselor filled out SWBS pre and posttest and the counselors filled it out posttest:

-R O_1 for the counselors

-R O_2 X O_3 for the patients

Brooks and Matthews (2000) report a stepwise multiple regression with spiritual well-being as the dependent variable was used to answer the first question and finding that the variable of self acceptance from the POI and the variable of loving and wisdom from the RVS accounted for about half of the variance of counselor scores on the SWBS, (e.g., the authors report the multiple correlation squared (R^2) for the equation was .47). No correlation was found between counselors' scores on the SWBS and clients' gain on the SWBS (Brooks & Matthews, 2000).

Limitations of the study include low external validity. With respect to the first question, the results can be generalized only to the class of all substance abuse counselors in the Commonwealth of Virginia or at most to substance abuse counselors in the Southeastern United States. Further, the results with respect to the second question can be generalized only on the three particular inpatient facilities in which the study concerning the second question was conducted. Finally, no other aspects of client well-being were studied other than spiritual and only clients with a substance use disorder were sampled.

Theory

Before an investigation can be made an understanding of the model/theory/ paradigm out of which that investigation emerged is needed to be able to grasp the meaning of its results. For the present purposes, then, an understanding of what is entailed by taking a holistic view/model of human nature within the context of a wellness paradigm is needed, and this is to ask, what is the picture and within what is it framed? However, this will not be enough as the exact nature of what is under investigation, (e.g., "spirituality," or "spiritual well-being"), is needed for more or less the same reason. Here, then, I begin by setting forth what it is to take a holistic perspective within the context of a wellness paradigm, and then go on to review the literature concerning what, exactly, spirituality or spiritual well-being is.

As noted above, inherent in a holistic paradigm is the inseparability of parts of the whole. And this is so because of the idea of the whole being greater than the sum of its parts - there are qualities of the whole that cannot be reduced to the sum of its parts, (i.e., the sum of all of the qualities of the parts of which a whole consists does not capture the nature of the whole as such, as a totality). Taking a holistic view of human nature, then, entails that there are qualities of human beings that are not reducible to the sum of the qualities of the parts of a human being. But how might this be the case?

Consider, for example, any physical object that is solid. Whence its quality of solidity? Physical objects on one view are made up of, consist of, atoms. But nowhere among individual atoms of which the solid physical object is made do we find solidity. Rather, the solidity of the object supervenes or rides on top of a particular arrangement of the atoms, and it might said, the forces that keep the atoms in that particular arrangement. Separate the atoms and no more

solidity. The solidity of the object is not reducible to the sum of the qualities of the atoms of which the object consists. Rather, a physical object's quality of being solid emerges out of a particular arrangement of its constituent parts, (e.g., atoms). In the same/similar way, qualities of persons such as spiritual well-being, it can be said, emerge out of particular relations that obtain between various aspects/ dimensions of persons. I shall return to this issue (see below). For now, it might be asked, what does wellness have to do with spirituality?

As noted above, Myers (1991) has argued the counseling field should return to a wellness paradigm thereby recapturing its historical roots from which it has emerged, namely, being concerned with all aspects of development. What, then, is wellness and what is the wellness paradigm? According to Myers (1991) there are various aspects of human functioning such as mental, physical, and spiritual and wellness has to do with their integration. Myers (1991) claims of the various models of wellness, "…, the most basic being the tripartite definition of wellness as the holism that results from consideration of physical, mental, and spiritual aspects of functioning" (Wellness is not synonymous with health section, para. 1). Myers also notes that on a wellness model positive change in one aspect of functioning will lead to better functioning in all other aspects of functioning. This writer believes it is worth noting that the corollary seems reasonable, (e.g., that negative change in one aspect can lead to decreased functioning in all the others). Finally, Myers (1991) claims that wellness is not the same as health. He claims that whereas health is associated with the components that are integrated, wellness is associated with their integration.

Consider another example, say of an engine and the property of "running." The engine's property of running supervenes on a particular arrangement of its parts. Note, however, that particular arrangement of the parts, though necessary condition for the engine to run, is not in

and of itself a sufficient condition for it doing so. In addition, the parts must be functioning well too. A clogged gas line yields an engine that either does not run at all, or, at the very least, does not run well.

Now consider the human brain and a mental activity, say, thinking. To take a holistic view of the brain is to deny the possibility of a naturalistic reduction of mental activities to physical activities, say, for example, that thoughts just are neural firings in the brain. Since, on the holistic view, thinking well supervenes on a particular arrangement of neurons and their functioning, (e.g., firing, etc).

It should be noted that various relevant considerations in the Philosophy of Mind need not detain us here as we are assuming a holistic perspective. Hannan (1994) among others presents a good discussion of philosophical issues related to the reduction of mental properties to physical properties.

Finally, consider aspects of functioning such as mental, physical, and spiritual. On a holistic model within a wellness paradigm, wellness supervenes on the integration of these components of functioning, their particular relation to each other and the extent to which they are healthy, and thus functioning well. A person is well in so far as these components are healthy, functioning well, and appropriately interrelated. As health is the footstool of well being, a person is able to be well, function well, which is to say live well, provided the health and well being of these various components of health, (i.e**.**, their functioning well). Since unhealthy components of well-being can entail a lack of wellness of the individual, (i.e., a person not living well), in much the same way as a clogged gas line can lead to an engine not running well or a malfunctioning neuron(s) can lead to a person not thinking well.

Note that when one or more aspects/dimensions of persons are not functioning well this can be manifest as global symptoms such as memory impairment. These symptoms can lead to global impairment with respect to a person's functioning in the world, which is to say living well, (e.g., forgetting one has left the stove on resulting in a fire). Further, such impairment can lead to loss of morale, (e.g., negative beliefs about self, others, etc.).

A theoretical framework out of which this wellness as holism model can emerge is multimodal theory. According to Curtis and Davis (1999) the efficacy of multimodal therapy is well documented. Further, they claim spirituality is easily integrated into a multimodal framework, "Because multimodal therapy (MMT; A. A. Lazarus, 1984) is a multidimensional model used to assess and treat many aspects of a person's life, spirituality can be easily incorporated into this holistic approach" (p.???). What, then, is multimodal theory?

According to Lazarus (1992), one effective way to understand human beings and the difficulties they encounter as well as assessing these difficulties is by an appeal to various modes of human functioning of which there are seven: Behavior, Affect, Sensation, Imagery, (e.g., dreams, fantasies, mental pictures, etc.), Cognition, (e.g., attitudes, values, opinions, ideas, and self talk), Interpersonal relationships, and Drugs/biology, (e.g.**,** neurophysiological/biochemical substrate). The acronym for these, then, is BASIC I.D. An underlying assumption to the multimodal approach is that if any of the seven areas are not addressed there is an increased chance of relapse with respect to the presenting difficulty, since each of these modes of functioning interact with, and thus influence, the others as well as intrinsic and psychological difficulties that result/emerge from their interplay with each other and other extrinsic and intrinsic factors.

Within the context of this multimodal theoretical framework, wellness, being well, and in particular spiritual well-being can be seen as emerging or supervening on the integration of these

various modes/dimensions of person. A person is well, and in particular, spiritually well, when each of these modes/dimensions of person are functioning well and appropriately interrelated in much the same way as the property of an engine running well emerges when each of its component parts is functioning well and appropriately interrelated. It is worth noting here that this idea of spirituality emerging and/or riding on top of aspects of human functioning is not novel. Canda (1990) as cited in Rovers and Kocum (2010) held a similar view. Rovers and Kocum (2010) note:

> "At the same time, he conceptualizes spirituality as the gestalt of the total process of human life and development, which encompasses biological, mental, social, and spiritual aspects. He states that spirituality is not reducible to these separate components. In fact, it is the wholeness of what it is to be human. Canda points out that the narrow sense of the term *spirituality* relates to the spiritual component, which concerns a person's search for a sense of meaning, hope, and morally fulfilling relationships …" (p. 7).

Here, "spirituality" in the narrow sense, then, can be seen as one of the modes of functioning out of which a person's being well, and, in particular, being Spiritually well, emerges. Therefore, "spirituality," might be added as a mode of functioning yielding BASIC I. D. S. As noted above, the idea of incorporating spirituality into Multimodal Theory is not new and Curtis and Davis (1999) propose using the following acronym: BASIC ID(Sp).

In the current study the focus is on the interplay of the spirituality/ Spiritual well-being of counselors, their level of Spiritual well-being with all of these modes of functioning in their clients. This naturally leads to the question of exactly what spirituality might be.

The above, then, points to the need for clarity with respect to the nature of spirituality/Spiritual well-being. For as Gray (2006) notes a researcher cannot choose a measure to use in their research without clarity as to its nature. (See below for a more detailed discussion of her views) This would seem to go without saying, one cannot choose a measure until one is clear on what it is that is to be measured.

What, then, is spirituality? According to the American Counseling Association (ACA) "Summit on Spirituality" (1995), “Spirituality is ... a capacity and tendency that is innate and unique to all persons. [It] moves the individual toward knowledge, love, meaning, hope, transcendence, connectedness, and compassion. Spirituality includes one's capacity for creativity, growth, and the development of a values system. Spirituality encompasses the religious, spiritual, and transpersonal” (p. 30). ASERVIC (1998) note that the term “spirituality” is rooted in the Latin word “spiritus” meaning “breath of life” and claim that the word “spirit” “may be defined as the animating life force, represented by such images as breath, wind, vigor, and courage” (para. 3). With this in mind, they claim that “spirituality” “is the drawing out and infusion of spirit in one’s life” (para. 3). In addition, they report that “spirituality” “is also defined as a capacity and tendency that is innate and unique to all persons [which] moves the individual toward knowledge, love, meaning, peace, hope, transcendence, connectedness, compassion, wellness, and wholeness” (para. 4). According to MacDonald (2004) spirituality is central to understanding and ascribing meaning to life. Ellison (1983) claims that spirituality is what motivates people to search for meaning in life. Jung (1933) claimed all human problems are spiritual problems and that healing is not possible without a “spiritual awakening”. In addition he claims that counselors’ world view and their understanding of how counseling fits into it impacts how they come to grips with spirituality. Benner (1991) claims all human beings are spiritual by nature and to describe one person that s/he is more spiritual that another is to say that the former has greater awareness of and response to the innate drive for self-transcendence, integration and identity.

Maslow (1971) proposed that transcendence can be an aspect or kind of self actualization that has spiritual significance. In a review of the various meanings of Transcendence, and in particular, transcending human limits he claims:

> This comes either in the acute end experiences of perfection or in the plateau experiences of perfection, in which one can *be* an end, a god, a perfection, an essence, a Being (rather than Becoming), sacred, divine.
> … . In such acute moments, or to some extent in plateau cognition, one becomes perfect, or can see oneself as perfect, (e.g. on that moment I can love all and accept all, forgive all, be reconciled to the evil that hurts me. I can understand and enjoy the way things are). And I can then even feel some subjective equivalent of what has been attributed to the gods only, i.e., omniscience, omnipotence, ubiquity (i.e., in a certain sense one can *become* in such moments a god, a sage, a saint, a mystic) (pp. 278-279).

To come to an understanding of spirituality as a human phenomenon, Elkins, Hedstrom, Hughes, Leaf, and Saunders (1988) reviewed literature of writers who approached spirituality from a phenomenological perspective. According to Elkins et al. (1988) their review yielded nine components of spirituality and corresponding beliefs spirituial people have: 1. Transcendent dimension, (e.g., the belief that there is more to reality than what is seen and that being in harmony with what is not seen is beneficial); 2. Meaning and purpose in life, (e.g., confidence that life has meaning); 3. Mission in life, (e.g., a sense of having a "calling" to be answered); 4. Sacredness of life, (e.g., that life is "infused" with sacredness); 5. Material values (e.g., appreciation of material goods while understanding that ultimate fulfillment does not come for acquisition of material things); 6. Altruism, (e.g., an understanding that "no man is an island" and that we are our "brother's keeper"); 7. Idealism, (e.g., commitment to ideals yielding a vision of the betterment of the world and a commitment to that vision); 8. Awareness of the tragic, (e.g., awareness of the tragic reality of human suffering as well as an understanding of how the tragic can enhance feelings such as joy, etc.); and finally, 9. Fruits of spirituality, (e.g., an understanding of how true spirituality has an impact on one's relationship to self, others, the world, and the Transcendent).

Finally, McCaroll-Butler (2005), as cited in Rovers and Kocum (2010) completed a meta-analysis of 76 systemic reviews on spirituality from five health care databases resulting in her

discovery of 32 separate definitions of spirituality which she clustered into eight main themes on the basis of the number of times these themes appeared in various articles. The themes, according to Rovers and Kocum are:

> (a) meaning/fulfillment/purpose and other expressions of yearning for meaning which can be seen as the underpinnings of an existential spirituality (used in 29 of the 32 definitions); (b) connection and relationships with self, other and the world where spirituality is manifested in a communal life (used in 26/32); (c) God/god(s) and the transcendent other with theistic themes, often seen as the starting point of spirituality (used in 22/32); (d) vital principle, seen as a nonpersonified creative animating force (used in 14/32); (e) unifying force and integrative energy, seen differently than the vital principle in the sense that this energy unifies while in the vital principle it creates (used in 12/32); (f) transcendent self by means of which a person can transcend human self (used in 12/32); (g) a personal, private thing not meant for public view; and (h) hope as will to live and come through crisis (used in 7/32). (p.4)

So spirituality is central to understanding and ascribing meaning to life (MacDonald, 2004) and according to Ellison (1983) motivates people to search for meaning in life. Hence, it would seem that spirituality cannot be the purpose and meaning of life itself, (e.g., not constitutive of spirituality). On the other hand, according to Jung (1933) all problems are not merely related to spirituality but are of spirituality itself, and therefore all healing requires a "spiritual awakening." It might be asked, to what does one awake? Perhaps one awakes to seeing things in a new light. If so, then understanding and meaning are constitutive of spirituality. Here, then, we have logically inconsistent views, (e.g., purpose and meaning both are and are not constitutive of spirituality). It is not the case, then, that both Jung and Ellison are right.

According to the American Counseling Association Summit on Spirituality (1995) spirituality is a capacity or tendency that moves the individual toward knowledge, love, meaning, hope, connectedness, and compassion. Here note that a judgment is required as to the nature of knowledge, love, etc., to determine whether an individual is being moved by spirituality towards

them. Hence, if it is possible not to move towards them but rather, say, in the opposite direction, it would seem that there must be an answer as to what each of these are, (e.g., standards that apply to all persons, to be able to determine whether persons are spiritual). Many might object to such a view favoring a more relativistic stance.

Further, note that we already have some imposition as to toward what spirituality tends to move people, (e.g., love, transcendence, etc.). But why not say spirituality moves people towards individuality, taking responsibility for one's action, care of self? It would seem, then, that all definitions of spirituality that involve moving toward something, X, are expressions of the person doing the defining. They are, in other words, a kind of confessing by the person defining what spirituality is. It is a kind of confession of what his/her values are, of that by which s/he guides his/her life. Consequently, when considering spirituality as a dimension of health, here the distinction between health and personal values is, at best, blurred. This is especially the case when it comes to using instruments to assess spiritual wellness. According to Moberg (2002):

> The most significant issues in assessment and research on spirituality center around validity. Does each index and scale genuinely measure spirituality or its components? … what is understood as "true" depends upon one's normative frame of reference. Therefore the answer depends upon implicit and explicit values upon which operational definitions, methodologies, and evaluations rest. Whichever of numerous possible indicators are observed and whatever criteria used to determine which ones represent positive and which negative spirituality (spiritual wellness and illness) ultimately depends upon the researcher's, clinician's, or educator's definitional criteria. They in turn are influenced by cultural and subcultural identities, education, personal experience, and religious beliefs and commitments (p. 56).

There is a danger, then, of counselors helping their clients adopt their own values under the guise of helping the client move toward spiritual well-being or health. Further, counselors, according to the American Counseling Association Code of Ethics (2005), have an obligation not to impose their views on their clients and to respect the diversity of their clients. And, as noted above, ASERVIC (2009) reports counselors' recognition of the centrality of client's beliefs about

spirituality and/or religion to the client's world view, use of spiritual and/or religious concepts acceptable the client, responding with acceptance and sensitivity to client communications about spirituality and/or religion, and setting goals that are consistent with client's spiritual and/or religious perspective are competencies for addressing spiritual and religious issues in the counseling process.

Yet according to Benner (1991), all human beings are created as spiritual beings. Spirituality for Benner, then, is at the core of human nature. It would seem that one cannot take the spirituality out of persons without also taking humanity too. In other words, people cannot help but be spiritual in their action. Not to be so would entail not being human. Further, people cannot help but bring themselves to their interactions with others. Insofar as spirituality and its subsequent expression in act is part of what it is for people to be who they are, people cannot remove expression of their spirituality in their interactions with others without removing themselves from those interactions, in which case, there is no interaction. Further, authenticity is valued in counseling and said to be necessary for the counseling process to take place**.** Since counselors attempting to be spiritually neutral in the counseling process would seem to entail their being inauthentic, it follows that insofar as counselors have an obligation to be authentic they have an obligation not to try to keep the expression of their spiritual nature out of the counseling process, values and all, in totality.

Actually, attempting to separate off one's spiritual nature from a holistic viewpoint makes no sense, as on this view it is not possible. If, then, it is not possible to prevent one's spiritual nature from being a part of, and it might be said further, influencing one's interactions with others, then the same must be said for the counseling process. Consequently, it would seem that it is not possible for counselors to remain neutral from a holistic perspective.

In general, then, there are inconsistencies in the literature concerning the nature of spirituality and its role in the counseling process as well as ethical issues related to the latter (Morrison et al., 2009). Rovers and Kocum (2010) developed a holistic model of spirituality which they claim allows for consistent inclusion of various aspects/dimensions of spirituality. However, the most in depth development of a definition of spirituality this author has found to date is that of Hawks (1994).

Noting that there has been a move in recent years towards a multidimensional holistic model of health and wellness that includes physical, emotional, intellectual, occupational, social, and spiritual components, high levels of wellness cannot be achieved without a balance of the dimensions of health, and a lack of attention given to the spiritual component, Hawks (1994) reviews the literature on spiritual health from which he sets forth criteria a good definition must meet, by means of which he offers a "modern definition" of "spiritual health." He goes on to frame spiritual health within a model of holistic health using Maslow's hierarchy of needs and discuss implications of the model.

More specifically Hawks (1994) claims that in the literature to date two aspects of spiritual health have been explored, namely, internal characteristics of spiritually healthy individuals and the ways these characteristics of spirituality are manifest by these individuals. With respect to the former he claims spiritual health provides individuals with meaning or purpose, a sense of connectedness with nature and others and wholeness in life, and strong spiritual beliefs, principles, ethics and values. According to Hawks (1994) a review of the literature reveals that these internal characteristics of spiritual health are expressed by spiritually healthy individuals through trust, honesty, integrity, altruism, compassion, service and a personal

relationship and experience of a “higher power” or “larger reality” that in one way or another “transcend” observable physical reality.

Factors that contribute to spiritual health according to Hawks (1994) include a well defined worldview that provides meaning/purpose and motivation, faith and commitment to the worldview, and selfless concern for others. Hawks (1994) claims, “In looking for the factors that lead to the characteristics of spiritual health described above, it appears to this author that three criteria must be met: a) a well-defined worldview or belief system that provides purpose, meaning, and motivation to life; b) selflessness, connectedness with, and concern for others; and c) high levels of personal faith and commitment in relation to the worldview and belief system” (What is spiritual health section, para. 4).

Hawks (1994) notes that the worldview need not be religious in nature, but it must provide answers to questions having to do with meaning, purpose, fulfillment and means to fulfillment. In so doing the worldview provides the individual with a sense of meaning and purpose and the way to fulfillment which includes values, ethics, and therefore rules of conduct which, when followed, lead to fulfillment. In addition, Hawks (1994) notes that faith and commitment to the worldview are necessary motivating factors without which individuals would not move towards spiritual health.

With the aforementioned in mind Hawks (1994) sets forth the following definition of “spiritual health:"

> A short, but comprehensive definition of spiritual health that takes into account the characteristics and criteria discussed above might be: "A high level of faith, hope, and commitment in relation to a well-defined worldview or belief system that provides a sense of meaning and purpose to existence in general, and that offers an ethical path to personal fulfillment which includes connectedness with self, others, and a higher power or larger reality." (What is Spiritual Health section, para. 7)

Instruments

To provide context and/or as a cautionary note, here, according to Moberg (2002), "To assume that, because all people are spiritual, the spirituality of all adherents to all religions can be evaluated adequately by identical procedures and instruments is at this time an act of faith, not a scientifically based conclusion. But even though research to date is very limited and provisional, much has already been accomplished" (p.52). With that said, the following review is offered.

General review

Standard, Sandhu, and Painter (2000) reviewed various instruments designed to assess spirituality including: Spiritual Assessment Inventory (SAI), Index of Core Spiritual Experiences (INSPIRIT), Spiritual Well-Being Scale (SWBS), Spiritual Health Inventory (SHI), Brown-Peterson Recovery Index (B-PRPI), Spirituality Scale (SS), and the Spirituality Assessment Scale (SAS). According to Standard et al., of these only the SAS does not presuppose a particular religious orientation, (e.g., belief in some sort of higher power) and this is a major strength of the instrument. It was developed using a review of literature from the fields of philosophy, psychology, sociology, theology, and nursing resulting in four concepts: Unifying Interconnectedness, Purpose and Meaning in Life, Innerness and Inner Resources, and Transcendence. The SAI is a measure of spiritual maturity from a Judeo-Christian perspective. The B-PRI was developed to measure progress in recovery of members of Alcoholics Anonymous. It use, then, is somewhat limited. There is difficulty with the validity on the SAS as this has yet to be established by anyone other than the authors. Standard et al. (2000) report the SWBS is the "most researched instrument to date assessing spirituality," maintain that it demonstrates strong test retest reliability with correlation coefficients of .93 (SWB), .96 (RWB), and .86 (EWB); coefficient alphas .89 (SWB), .96 (RWB), and .78 (EWB), but note that the SWBS presupposes a concept of God and has a ceiling effect.

Spiritual well-being scale

According its developers, Paloutzian & Ellison (2009), the Spiritual Well-Being Scale is an indicator of one's "subjective state of well-being"(p. 3) and is an overall measure of one's "perceived spiritual quality of life" (p. 3). Further they maintain that the subscales, RWB and EWB, measure one's perceived spiritual quality of life in the two senses in which people commonly speak about spirituality, "That is, when people talk about their spirituality they ordinarily mean either (a) their relationship with God or what they understand to be their spiritual being, or (b) their sense of satisfaction with life or purpose in life" and go on to state, "In addition to SWBS total scores providing an overall measure of one's SWB, the RWB subscale provides a self-assessment of one's well-being in a religious sense, while the EWB subscale gives a self-assessment of one's sense of life purpose and life satisfaction" (p. 3).

Moberg (2002) claims the Spiritual Well-Being Scale is "unquestionably the most widely applied sociopsychometric instrument on this topic [and] has been validated, standardized, and used in over 100 widely ranging studies …" (p.54). Hawks (1994) claims that in light of what he has set forth concerning the nature of spirituality, spiritual health is a meaningful dimension of health. Hence, it is important to be able to measure spiritual well-being in a humanistic and nonreligious way, determine the relationship(s) that obtain between spiritual well-being and other relevant constructs, and develop interventions designed to promote spiritual well-being. Notably, with respect to the former Hawks (1994) claims the Spiritual Well-Being Scale is particularly well suited:

> As a starting point, two scales have been identified in the professional literature that show promise as valid measures of spiritual well-being as defined in this paper (Elkins et al., 1988; Ellison, 1983, 1991). Both scales measure purpose and meaning in life; connectedness with self, others, and a higher power or larger reality; and levels of commitment and faith in relation to personal belief systems. The Spiritual Well-Being Scale (Ellison, 1983, 1991) has been used extensively and has documented validity and reliability. (Measurement section, para. 1

So, the SWBS, would seem to be a useful instrument to use in this study as the definition of spirituality Hawks (1994) sets forth (see above) is the definition used in this study. What, then, concerning its reliability and validity has been documented?

Gray (2006) notes the need for and the difficulties with measuring spirituality and then goes on to evaluate two instruments that measure spirituality, namely, the Spiritual Well-Being Scale and the Spiritual Perspective Scale. According to Gray (2006), the need for measuring spiritual well-being arises out of evidence that spirituality of individuals is related positively to their overall well being. She notes that patients often turn to their spiritual beliefs when facing an "existential crisis" resulting from pain and suffering associated with terminal illness, life events and aging. As such spirituality is essential to providing holistic care, (e.g., attending to mind, body, and spirit).

When attempting to measure spirituality there are conceptual and methodological difficulties. Conceptual difficulties, according to Gray (2006) arise out of challenges with defining just what spirituality is. Researchers, she claims, often define spirituality within the framework of their own worldview leading to inconsistency with what is meant by spirituality, (e.g., problems of equivocation). Methodological challenges arise out of difficulties with conceptual issues. Gray (2006) notes:

> Without clarity on what spirituality is or which aspect of spirituality is to be measured, the researcher cannot knowledgeably select an appropriate instrument (Ellerhorst-Ryan, 1997). Construct validity requires that the researcher match the measure, or operational definition, to the conceptual definition (Burns & Grove, 2005) The researcher must, therefore, select from those available or create a conceptual definition that fits his or her own worldview and the philosophical and theoretical framework of the study. Instruments can then be evaluated for their fit with this conceptual definition (Jacobson, 1997). Even with a clear conceptual definition, if the researcher's and the subject's worldviews are different, the selected instrument may not adequately describe spirituality of the subject. (p. 59)

Further, Gray (2006) maintains that, often, when faced with choosing between either taking the time needed to develop an instrument or use available instruments researcher opt for the latter, and, often for using either the Spiritual Well-Being Scale (SWBS) or the Spiritual Perspective Scale (SPS). Gray (2006), then, goes on to evaluate each instrument in light of the aforementioned difficulties and argues for their use despites difficulties with their use on the basis of consistency in research for the sake of generalization.

For present purposes some of the strengths and weaknesses Gray (2006) mentions with respect to the SWBS are worth noting. She reports the SWBS developers use a two dimensional construct and resulting subscales to describe and measure spiritual well-being (SWB), namely, Religious Well-Being (RWB) which "describes one's well-being in relation to God" (p. 59) and "measures the subject's relationship with a Higher Power" (p. 60), and, Existential Well-Being (EWB) which "describes well-being in relation to one's sense of life satisfaction and life purpose with no specific religious reference" (pp. 59-60) and "measures the subject's view of life" (p. 60). Further, she reports that the instrument consists of twenty Likert type items with six possible answers ranging from "strongly disagree" = 1 to "strongly agree" = 6, the odd numbers of which measure RWB and the even numbers of which measure EWB. She reports negatively worded items are reversed scored. The total score range for SWBS, then, is 20-120, and for each subscale, (e.g., RWBS and EWBS, 10-60). According to Gray (2006), the validity of the SWBS is well established. Further she reports the SWBS has demonstrated stability as evidenced by high test-retest reliability as well as internal consistency. Further Gray (2006) reports the SWBS has additional strengths including its readability and the time it takes to administer, (e.g., five to ten minutes). In addition, Coleman (2003) reports that the existential well-being subscale of the

SWBS can be used to predict mental health status of African American living with HIV/AIDS and Gray (2006) notes this.

On the other hand, Gray (2006) reports the SWBS has the following weaknesses. She reports that according to early validation studies the SWBS shows bias towards evangelical Christian traditions when compared to "mainline" denominations the latter of which tended to score lower. Further the use of the word God, according to Gray (2006), can be offensive and people who are not Christian have reported difficulty as to how to answer items in which the word God is used. She reports there also is a possible difficulty related to ceiling effects possibly due to subjects' attempts to answer in sociably desirably ways, though there have been mixed results as to whether a ceiling effect exists. Finally, she reports additional research is needed to determine the effect of ethnicity on the results of the SWBS. Finally, it is noteworthy that Gray (2006) reports that the Spiritual Perspective Scale has similar weaknesses associated with use of the concept of a Higher Power and socially desirable responses but that it does not have difficulty with ceiling effects because it also assesses behaviors.

Health Dynamics Inventory

According to Sanders and Wojcik (2003), the Health Dynamics Inventory (HDI) was developed based on the tripartite model of mental health as set forth in the Diagnostic and Statistical Manual of the American Psychiatric Association in accordance with the definition of mental disorder. The three aspects of what is involved with a mental disorder include impairment of functioning in one or more life setting, (e.g., work, family, etc.), symptoms characteristic of the disorder in question, and distress expressed by individuals with respect to the disorder such as hopelessness. Sanders and Wojcik claim that, in general, there are three primary aspects of mental illness which the HDI evaluates, namely, distress, symptoms and impairment.

Further, Sanders and Wojcik (2003) report the HDI was developed to indicate the degree to which treatment has been successful with respect to these three aspects of mental disorder as they are associated with different phases of recovery, remoralization in which clients experience a decrease in distress and increase in hope, remediation in which severity of symptoms are reduced, and rehabilitation in which there is an increase of functioning in life, (e.g., decreased impairment). Sanders and Wojcik (2003) report the HDI measures many of the symptoms related to specific mental disorders and as such can be used as a screening instrument.

There are 11 subscales: morale (Mo), Depression (Dep), Anxiety (Anx), Attention Problems (Att), Psychotic Thinking (Psy), Eating Disorder (ED), Substance Abuse (SA), Behavior Problems (Beh), Occupational Task Impairment (OT) Relationship Impairment (Rel), and Self-Care Impairment (SC). There are three primary subscales, Morale, Global Symptoms which includes Dep, Anx, Att, Psy, ED, SA, and Beh and Global Impairment which includes OT, Rel, and SC.

Morale or subjective well-being, according to Sanders and Wojcik (2003), is the opposite of distress. Since a review of reviews of measures indicated well being is associated with contentment and satisfaction with life, hopefulness, as well as a positive affect and sense of well-being and happiness, the HDI distress is operationalized as the opposite of these, namely, dissatisfaction with life, hopelessness about the future, and negative affect or emotional tone.

Global symptoms are just that, global symptoms. Patterns of global symptoms, according to Sanders and Wojcik (2003) determine whether a person meets criteria for the diagnosis of a particular mental disorder in the DSM-IV. Epidemiological research was used to determine which symptoms to include in the HDI (Sanders & Wojcik, 2003).

Global impairment, according to Sanders and Wojcik (2003), is the extent to which a person has difficulty fulfilling the responsibilities of major life roles. The content of the HDI was limited to what the authors considered "major" life roles, namely, occupation, relationships, and self care (Sanders & Wojcik, 2003).

Summary

A wellness as holism model of human beings entails that a counselor cannot help but bring all of self as a totality including their level of spiritual well-being and the content of their spiritual perspective into the counseling process. Consequently, their level of spiritual well-being may impact client outcomes.

Further, Chandler et al. (1992) assert "An axiom exists in the realm of spiritual development that one cannot help another past one's own level of development" (p. 174**).** It follows, then, that one cannot help a client past one's own level of spiritual development. Counselor level of spiritual well-being, then, is necessary to help clients with spiritual growth. Thus, counselor's ability to help clients with their spiritual growth is limited by their own level of spiritual well-being.

Though counselor level of spiritual well-being would seem to serve as a limiting condition with respect to counselors' ability to help their clients, this author has been able to find only one study that has addressed the issue of the possible relationship between counselor level of spiritual well-being and client outcomes, and this study was limited to substance abuse counseling in an inpatient setting. Consequently, it would seem, additional research is needed not only with respect to the possible relationship between counselor level of spiritual well-being and client outcomes in substance abuse counseling, but also other kinds of counseling such as mental health counseling. Again, to this end, this study was conducted.

CHAPTER THREE: PROCEDURES

Research Design

Counselor level of spiritual well-being as well as aspects of spiritual well-being, (e.g., existential well-being and religious well-being), for the purposes of this study is not a variable that can be manipulated. Further, so as to promote external validity participants will come from natural settings and as such group membership is not within the control of the researcher. Given such circumstances the research design is passive and after the conditions of the study are set, thus ex post facto (Heppner, Kivlighan, & Wampold, 1999).

Participants

Participants were adolescents between the ages of 13 and 18 receiving either outpatient, intensive outpatient, or inpatient treatment for either a substance use disorder and/or other mental health disorders at an agency in the Southern United States and their primary counselors.

Sampling Procedures

Data already collected on adolescent clients by an agency in the Southern United States that provides a variety of services to at risk youth and their families in the Southern United States - including outpatient, intensive outpatient, and residential substance use, mental health, and co-occurring disorders counseling – pre/post test scores on the Health Dynamics Inventory, (HDI) - will be compared with their counselors' scores on the Spiritual Well-Being Scale (SWBS) to determine whether there is a correlation between counselor level of spiritual well-being as measured by the SWBS and client outcomes as measured by the HDI. Data other than test scores may be collected and used, at least in part, to determine the impact of these factors may have on the relationship between counselor level of spiritual well-being and client outcomes should such a relationship be found. Data was collected only on clients who had completed counseling

services at the agency and was collected by agency personnel, and where necessary, by the researcher. Any data collected by researcher was given to a designated representative of the agency to be added to data already collected and each client will be given an identification number by the representative of the agency to ensure that no client identifying information was used. The researcher mailed a packet that included a letter and questionnaire used to obtain demographic data (See Appendix B) as well as a SWBS to all counselors currently working at the agency, [and any counselors who left the agency whose clients were discharged from counseling within a one year time frame], and, those counselors who agreed to participate in the study indicated their agreement by mailing the packet back to the researcher. Each counselor who participated in the study was assigned a number by the researcher so that the agency is blind to counselors' scores on the SWBS, as the agency will be offered the opportunity to use data collected in return for the agency allowing the researcher to use data collected by the agency on clients. Data was collected on all clients who were discharged from counseling services during the year prior to data being collected on counselors. The agency representative was asked to match client data with the last name of the client's primary counselor.

In addition demographic data on clients and, as noted above, their counselors was collected. Demographic data collected on clients included age, gender, number of times to have received treatment prior to most recent treatment received at the agency as well as the level of intensity of treatment, (e.g., outpatient, intensive outpatient, inpatient, etc.) and type of client and previous treatment received, (e.g., substance abuse only, mental health only, or treatment for co-occurring psychiatric and substance use disorders), and type of client and treatment received at the agency, (e.g., substance abuse only, mental health only, or treatment for co-occurring substance use and psychiatric disorders including whether the client was referred in house or outside of the

program to address co-occurring disorders). Demographic data collected on counselors included age, gender, number of years of experience, type of counselor (e.g., substance abuse, mental health, co-occurring disorders), level of education (e.g., bachelors, masters, or doctorate), and field in which the counselor was trained by credentials (e.g., Licensed Professional Counselor, Licensed Clinical Social Worker, Clinical Psychologists, Psychiatrist). Response rate of counselors will also be included.

A convenience sample of counselors who provide counseling services at the agency in the Southern United States and their clients was obtained for the study. A power analysis for a power of .80 and an alpha level of 0.05 using a small effect size, (e.g., .02), indicated a need for 478 participants, with a medium effect size, (e.g., .15) a need for 67 participants, and a large effect size, (e.g., .35), indicated a need for 31 participants.

Instruments

Spiritual Well-Being Scale

For present purposes, some of the strengths and weaknesses Gray (2006) mentions with respect to the SWBS are worth noting. She reports the SWBS developers use a two dimensional construct and resulting subscales to describe and measure spiritual well-being, namely, Religious Well-Being (RWB) which "describes one's well-being in relation to God" (p. 59) and "measures the subject's relationship with a Higher Power" (p. 60), and, Existential Well-Being (EWB) which "describes well-being in relation to one's sense of life satisfaction and life purpose with no specific religious reference" (pp. 59-60) and "measures the subject's view of life" (p. 60). Further, she reports that the instrument consists of 20 Likert type items with 6 possible answers ranging from "strongly disagree" = 1 to "strongly agree" = 6, with odd numbered items measuring RWB and even numbered items measuring EWB. She reports negatively worded

items are reversed scored. The total score range for SWBS, then, is 20-120, and for each subscale, (e.g., RWB and EWB, 10-60). According to Gray (2006), the validity of the SWBS is well established:

> Paloutzian and Ellison developed the SWB scale in studies with over 500 subjects, representing divergent backgrounds and heterogeneous demographics. The instrument developers provided evidence for construct validity through factor analysis, concurrent validity, convergent validity, and hypothesis testing with contrast groups (Ellison, 1983). Borman and Dixon (1998) found positive correlations between spiritual well-being and meaning and purpose of life, self-concept, and other standard traits of well-being. They cited these findings as support for convergent validity of the SWB. An indication of discriminant validity is the scale's negative correlation to traits indicating ill-health and emotional maladjustment (Borman & Dixon). (p. 60).

Gray (2006) reports that the SWBS demonstrates stability as evidenced by high test-retest reliability "with correlation coefficients of 0.88 to 0.99 for RWB, 0.73 to 0.98 for EWB, and 0.89 to 0.94 for SWB" (p. 60). In addition Gray (2006) reports the SWBS demonstrated internal consistency during initial testing as evidenced by "Cronbach's alphas of 0.89 (SWB), 0.87 (RWB), and 0.78 (EWB) (Ellison, 1983; Palouzian & Ellison, 1982)" and that "estimates of internal consistency for the subscales and scales have continued to be at or above acceptable levels (Table 1)" (p. 60). Further Gray (2006) reports the SWBS has additional strengths including its readability and the time it takes to administer, (i.e., five to ten minutes).

On the other hand, Gray (2006) reports the SWBS has the following weaknesses. She reports that according to early validation studies the SWBS shows bias towards evangelical Christian traditions when compared to "mainline" denominations the latter of which tended to score lower. Further the use of the word God, according to Gray (2006), can be offensive and people who are not Christian have reported difficulty as to how to answer items in which the word God is used. She reports there also is a possible difficulty related to ceiling effects possibly due to subjects' attempts to answer in sociably desirably ways, though there have been mixed

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Health Dynamics Inventory

According to Sanders and Wojcik (2003), the Health Dynamics Inventory (HDI) was developed based on the tripartite model of mental health as set forth in the Diagnostic and Statistical Manual of the American Psychiatric Association in accordance with the definition of mental disorder. The three aspects of what is involved with a mental disorder include impairment of functioning in one or more life settings, (e.g., work, family, etc.), symptoms characteristic of the disorder in question, and distress expressed by individuals with respect to the disorder such as hopelessness. Sanders and Wojcik claim that, in general, there are three primary aspects of mental illness which the HDI evaluates, namely, distress, symptoms and impairment:

> The HDI was written to evaluate the three aspects of mental disorders as described in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSMIV): "clinically significant behavioral or psychological syndrome or pattern . . . associated with present distress . . . or disability" (American Psychiatric Association [APA], 1994, p. xxi). Accordingly, the HDI assesses (1) the experience of emotional or behavioral symptoms that define mental illness, such as dysphoria, worry, angry outbursts, low self-esteem, or excessive drinking, (2) the level of emotional distress related to these symptoms, and (3) the impairment or problems fulfilling the major roles of one's life being exhibited. (p. 234).

Further, Sanders and Wojcik (2003) report the instrument was developed to indicate the degree to which treatment has been successful with respect to these three aspects of mental

disorder as they are associated with different phases of recovery, remoralization in which clients experience a decrease in distress and increase in hope, remediation in which severity of symptoms are reduced, and rehabilitation in which there is an increase of functioning in life, (e.g., decreased impairment). Sanders and Wojcik (2003) report the HDI measures many of the symptoms related to specific mental disorders and as such can be used as a screening instrument.

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Global symptoms are just that, global symptoms, (e.g., anxiety, depression, etc.). Patterns of global symptoms, according to Sanders and Wojcik (2003) determine whether a person meets criteria for the diagnosis of a particular mental disorder in the DSM-IV. Epidemiological research was used to determine which symptoms to include in the HDI.

Global impairment, according to Sanders and Wojcik (2003), is the extent to which a person has difficulty fulfilling the responsibilities of major life roles. The content of the HDI was limited to what the authors considered “major” life roles, namely, occupation, relationships, and self-care (Sanders & Wojcik, 2003).

According to Sanders and Wojcik (2004), since its revision in 1998 the HDI has been taken by over 4,500 clients and over 1,500 volunteers, the latter of which for normative purposes. To determine the reliability and validity of the HDI they conducted a study in which a sample of 500 randomly selected clients and subsequently a sample of an equal number volunteers based on matching characteristic of gender, age, and marital status was selected. Further, clinicians whose clients completed the HDI were asked to give client information, (e.g., number of sessions to date, diagnostic, and treatment) as well as a rating of their clients' level of distress and level of impairment.

Sanders and Wojcik (2004) report calculation of the split-half Guttman statistic yielded acceptable reliabilities ranging from .69 to .95 on all scales. In particular they report clients alpha of .88, volunteers alpha of .86 and .90 alpha and .88 Guttman for all participants on the Morale scale. For the Global Symptoms scale they report; clients alpha of .95, volunteers alpha of .94, and .95 alpha and .80 Guttman for all participants; and, clients alpha of .92, volunteers alpha of .89, and .93 alpha and .89 Guttman for all participants on the Global Impairment scale. Further, t-tests using unequal variances contrasting the average scores on all three major scales, (e.g., Morale, Global Symptoms, and Global Impairment), revealed that clients generally had "more pathological" scores than did volunteers. Finally, Saunders and Wojcik (2004) report the Morale scale was negatively correlated with clinician ratings of both client distress and impairment, and positively correlated with client scores on the Global Symptoms scale and subscales.

The HDI is easy to use/user friendly. According to Saunders and Wojcik (2004), the HDI is simple to administer and its completion does not require special instructions. Consequently it can be administered by support staff. Finally, they report it can be completed within 15 minutes.

Variable list

1. Gender of counselor and client: Female = 1, not female = 0

2. Age of client/counselor = their age in years

3. Client number of times receiving inpatient treatment = number of times ever receiving inpatient treatment.

4. Counselor experience = number of years in the profession altogether at any level, (e.g., practicum, internship, certified/licensed, etc.).

5. Field of counselor: Certified and/or licensed alcohol and drug abuse counselor, (CADC/LADAC, etc.) = 1 or 0, Licensed counselor, (LAC/LPC) = 1 or 0, Licensed social worker (LMSW/LCSW) = 1 or 0, clinical psychologist (D.Psy/Ph.D./Ed.D.) = 1 or 0, psychiatrist (MD) = 1or 0, [CADAC/LADAC and (LAC/LPC or LMSW/LCSW or MD)] or CCDP = 1or 0, where "yes" = 1 and "no" = 0.

6. Counselor level of training: HS/GED = 1, BA/BS = 2, MA/MS = 3, PhD/Ed.D./D.Psy = 4, MD = 5.

7. Type of client: Substance use disorder only = 1, mental health disorder only = 2, co-occurring disorders = 3.

8. Type of counselor: substance abuse counselor = 1, mental health counselor = 2, co-occurring disorders counselor = 3.

9. Counselor level of Spiritual Well-Being (COLSWB) = counselor's total score on the SWBS.

10. Counselor level of Religious Well-Being (COLRWB) = counselor's score on the RWB subscale of the SWBS.

11. Counselor level of Existential Well-Being of Counselor (COLEWB) = counselor's score on the EWB subscale of the SWBS.

12. Client Morale at admission to the program (PREMO) = Client's score on the Morale subscale of the HDI at admission.

13. Client Morale at discharge from the program (POSTMO) = Client's score on the Morale subscale of the HDI at discharge from the program.

14. Client Global Symptoms at admission to the program (PREGI) = Client's score on the Global Symptoms subscale of the HDI at admission to the program.

15. Client Global Symptoms at discharge from the program (POSTGS) = Client's score on the Global Symptoms subscale of the HDI at discharge from the program.

16. Client Global Impairment at admission to the program (PREGI) = Client's score on the Global Impairment subscale of the HDI at admission to the program.

17. Client Global Impairment at discharge from the program (POSTGI) = Client's score on the Global Impairment subscale of the HDI at discharge from the program.

Data Collection

The participants in the study were male and female adolescent clients between the ages of 13 and 18 receiving either outpatient, intensive outpatient, or residential treatment for a substance use disorder and/or a mental health disorder as defined by the DSM-IV TR at an agency in the Southern United States and their primary counselors. Counselors were male and female mental health, substance abuse, and/or co-occurring disorders counselors. Instruments used in the study were administered either by the agency in the case of clients or the researcher by mail in the case of counselors.

Analysis

According to Glass and Hopkins (1996), "Pearson correlation coefficient quantifies the magnitude and direction of the linear relationship between two variables" (p.106). Therefore Pearson product-moment correlation r will be obtained to determine whether there is a relationship between COLSWB and/or as aspects of COLSWB, (e.g., COLEWB and COLRWB), and client outcomes, (e.g., POSTMO, POSTGS, and POSTGI). Noting that the relationship between most variables in the behavioral sciences are linear, they report that the value of r will underestimate the relationship between variables if their relationship is curvilinear and recommend the use of scatterplots to ensure the relationship between variables is not curvilinear. Consequently, scatterplots were used to ensure the relationship between variables is linear.

Heppner et al. (1999) report, "Multiple regression can be used with a passive design to describe how multiple predictor variables are related to a single "dependent" (criterion) variable" (p. 225). Therefore, multiple regression was used to determine how COLSWB, aspects of COLSWB, (e.g., COLEWB and COLRWB), and clients' scores on the HDI pre-treatment/at admission, (e.g., PREMO, PREGS, and PREGI), are related to client outcomes, namely, clients' scores on the HDI post-treatment, (e.g., POSTMO, POSTGS, POSTGI). Further, Glass and Hopkins (1996), report multiple regression analysis is the statistical method most often employed in the behavioral sciences to determine the relative impact of more than one independent variable on a dependent variable. Hence, multiple regression analysis was used to analyze the relative impact of COLSWB, aspects of COLSWB, (e.g., COLEWB and COLRWB), as well as clients' scores on the HDI pre-treatment, (e.g., PREMO, PREGS, and PREG), on client outcome/well-being, (e.g., POSTMO, POSTGS, and POSTGI).

Limitations

Given the method of data collection, item analysis, (factor, reliability, etc.), of scores on the instruments used was not possible. In addition, it is possible, though not likely, that COLSWB may be significantly different from when the counselors were actually providing services to the clients as all clients who discharged from counseling within one year prior to when it was measured were included in the study.

CHAPTER FOUR: RESULTS OF THE STUDY

Introduction

Here I present the results of the data collection process and the means by which the final data set was determined. I then go on to present the results of the data analysis and indicate whether these results support the hypotheses of this study.

An agency in Southern United States provided contact information for 34 counselors who had clients discharge from counseling services within the past year in late November 2011. Counselors were mailed a letter requesting their participation in the study along with a demographic questionnaire and the Spiritual Well-Being Scale for them to fill out should they agree to participate in early December 2011 yielding 6 responses (see Appendix B). A second request mailed in January of 2012 yielded an additional 9 responses by the end of March 2012 for a total of 15 and a response rate of 44%. The agency was able to provide complete client datasets (n = 38) with respect to 9 of the counselors who returned the survey. However, given the one year limit with respect to time elapsed between client discharge and the date counselors completed the survey and Spiritual Well-Being Scale (SWBS), 8 clients and 1 counselor were removed from the dataset leaving 8 counselors and 30 clients for a total of 30 client counselor pairings. Of the remaining 8 counselors, one counselor's score of 13/60 on the RWBS of the SWBS was more than 1 SD below the norms for the SWBS provided by Paloutzian & Ellison (2009) in the administration manual. In addition the next lowest score of the remaining counselors on the RWBS was 42. As can be seen in Table 4 below, this counselor's score of 13 on the RWBS is over 7 standard deviations below the mean of 53.57 of the remaining counselors' scores on the RWBS with a standard deviation of 6.19. Consequently

this counselor and the clients associated with this counselor were excluded from the revised data set leaving 7 counselors and 22 clients for a total of 22 client counselor pairs in the final dataset. It is worth noting here that insofar as all but one of the counselors included in the study had more than one client that was included in the study the assumption of independence is violated in this study. For a comparison of counselors scores, (i.e., the 15 counselors who returned the survey, the 8 counselors for whom there were complete client datasets and who had clients discharge within a year of their completing the survey and SWBS, and the 7 counselors included in the study), as well as a comparison of their weighted scores (see Appendix C). For a comparison of the 30 clients in the original dataset scores on the Health Dynamics Inventory (HDI) with the 22 clients in the revised dataset scores (see Appendix D).

Presented here, then, are the results of data analysis on the revised dataset of 7 counselors and 22 clients – 22 client counselor pairs. The results presented include descriptive statistics on the clients and counselors and the results of multiple regression analysis with respect to clients scores on the three outcome measures of the HDI, namely, Post Morale (POSTMO) Post Global Symptoms (POSTGS) and Post Global Impairment (POSTGI) and the possible combinations of clients Pre-Treatment scores on these measures, (e.g., PREMO, PREGS, and PREGI) and their counselors' scores on the SWBS, (e.g., total score SWBS and scores on the subscales, RWBS and EWBS), for the sake of determining whether there is support for the aforementioned hypotheses concerning the relationship(s) between counselors' level of spiritual well-being (COLSWB), counselor level of religious well-being (COLRWB), and/or counselor level of existential well-being (COLEWB) and client outcomes (e.g., POSTMO, POSTGS, and POSTGI).

Demographic Descriptive Statistics

There were 22 clients who were included in the study with an average age of 15.95, SD 1.36. Of these, as detailed in Table 1 below, 18, 82%, were male, and 4, 18%, were female. The type of client of those clients for whom type was attainable, 9, 41%, received substance abuse counseling, 1, 5%, mental health counseling, and 3, 14%, received counseling for co-occurring psychiatric and substance use disorders. With respect to level of intensity of treatment, 10 clients, 55%, received residential treatment and the remaining 12 clients, 45%, received outpatient counseling.

Table 1

Descriptive Demographic Information for Clients

Variable	N	%
Male	18	82
Female	4	18
Substance abuse	9	41
Mental health	1	5
Co-occurring disorder	3	14
Outpatient treatment	12	55
Residential treatment	10	45

For descriptive statistics, (e.g., mean and standard deviations), for clients' pre-test and post-test scores on the HDI see Table 3 below.

There were 7 counselors who participated in the study with an average age of 47.71, SD 16.64, with an average of 7.29 years of experience, SD 4.03, counseling clients. Of these, as detailed in Table 2 below, 18, 82%, were male, and 4, 18%, were female. The number of counselors who self-identified as a substance abuse counselor was 4, 57%, whereas, by certification, only 1 counselor, 14%, was a substance abuse counselor by certification/licensure. This discrepancy was due there being three of the four counselors who were trained primarily in the substance abuse counseling field, which is to say, received certification as substance abuse counselors through the Arkansas Substance Abuse Certification Board, and who later qualified for and received the credential of "Co-Occurring Disorder Professional," thereby for the present study making them co-occurring disorder counselors by certification/licensure, identified themselves as substance abuse counselors. Consequently, though only 1, 14%, counselor self-identified as a co-occurring disorder counselor; 4, 57%, counselors were co-occurring disorder counselors by certification/licensure. Finally, 2, 29%, both self-identified as mental health counselors and were mental health counselors by certification/licensure. High school/GED was the highest level of training for 4, 57%, of counselors who participated in the study and there was 1, 14%, counselor for whom the highest level of training was BA/BS, as well as 1 for each, MA/MS, and Ph.D. The primary field of training for 4, 57%, of the counselors was substance abuse counseling, the remaining 3, 43%, mental health counseling. 5, 71%, counselors self-identified themselves as "spiritual only," 1, 14%, self-identified as both religious and spiritual, and 1 self-identified as "neither spiritual nor religious." None of the counselors who participated in the study self-identified as "religious only."

For descriptive statistics, (e.g., mean and standard deviation), for counselors' scores on the SWBS see Table 4 below.

Table 2

Descriptive Demographic Information for Counselors Only (8 to 15 deleted)

Variable	N	%
Male	2	29
Female	5	71
Counselor type: Substance abuse by self-identification	4	57
Counselor type: Substance abuse by certification/license	1	14
Counselor type: Mental health by self-identification	2	29
Counselor type: Mental health by certification/license	2	29
Counselor type: Co-occurring disorder by self-identification	1	14
Counselor type: Co-occurring disorder by certification/license	4	57
Counselor level of training: HS/GED	4	58
Counselor level of training: BA/BS	1	14
Counselor level of training: MA/MS/MSW	1	14
Counselor level of training: Ed.D./Ph.D./MD	1	14
Counselor field of training: CADC/LADAC	4	57
Counselor field of training: LAC/LPC	3	43
Counselor field of training: LMSW/LCSW	0	0
Counselor field of training: Psychologist	0	0
Counselor field of training: Psychiatrist	0	0
Counselor Self-Identified: Spiritual only	5	72
Counselor Self-Identified: Religious only	0	0
Counselor Self-Identified: Both Spiritual and Religious	1	14
Counselor Self-Identified: Neither Spiritual or Religious	1	14

Table 3

Descriptive Client results Pre and Posttest Variables on Health Dynamics Inventory

Client Type		PREMO	POSTMO	PREGS	POSTGS	PREGI	POSTGI
All	M	14.59	16.77	55.14	47.36	19.77	17.41
n = 22	SD	2.77	1.74	14.27	15.02	5.66	4.24
Male	M	14.56	17.00	53.11	45.67	20.17	17.56
n = 18	SD	2.99	1.64	14.55	14.21	5.74	4.03
Female	M	14.75	15.75	64.25	55.00	18.00	16.75
n = 4	SD	1.71	2.06	9.54	18.42	5.72	5.74
Substance abuse	M	14.22	17.11	48.44	43.55	18.89	17.78
n = 9	SD	2.49	1.05	11.63	10.89	4.43	4.71
Mental health	M	17.00	17.00	37.00	69.00	14.00	19.00
n = 1	SD	Na	Na	na	na	Na	Na
Co-occurring	M	13.00	16.67	61.67	49.67	25.00	17.67
n = 3	SD	3.00	3.51	10.12	27.15	6.24	6.03
Outpatient	M	15.25	16.25	57.08	51.83	18.33	18.58
n = 12	SD	2.77	1.91	15.34	16.82	5.94	5.11
Residential	M	13.80	17.40	52.80	42.00	21.50	16.00
n = 3	SD	2.70	1.35	13.29	11.04	5.06	2.45

For descriptive statistics, (e.g., mean and standard deviations), for clients' and post-test scores on the HDI by counselor type see Table 5 below.

Table 4

Descriptive Counselor Only results on Variables on the Spiritual Well Being Scale

Counselor Type	COLSWB		COLRWB		COLEWB	
	M	SD	M	SD	M	SD
All counselors n = 7	103.86	10.33	53.57	6.19	50.29	5.87
Male n = 2	102.00	7.07	55.50	3.54	40.50	3.54
Female n = 5	104.60	12.05	52.80	7.19	51.80	5.22
Substance abuse by self-identification n = 4	100.60	17.36	51.00	9.22	49.60	8.50
Substance abuse by certification/license n = 1	112.00	na	58	Na	54	na
Mental health by self-identification n = 2	102.00	5.00	53.50	4.50	48.50	0.50
Mental health by certification/license n = 2	102.00	5.00	53.50	4.50	48.50	0.50
Co-occurring disorder by self-identification n = 1	97.00	na	53.00	Na	44.00	na
Co-occurring disorder by certification/license n = 4	102.75	13.07	52.50	7.42	50.25	6.85
Counselor Self-Identified: Spiritual only n = 5	101.60	11.61	51.80	6.61	49.80	6.02
Self-Identified as Religious only n = 0	Na	na	Na	Na	na	na
Self-Identified as both Spiritual and Religious n = 1	107.00	Na	58.00	Na	49.00	na
Self-Identified as neither Spiritual or Religious n = 1	112.00	NA	58.00	Na	54.00	na

Table 5

Descriptive Client HDI Posttest results for Counselor Type

Counselor Type	Client POSTMO M	Client POSTMO SD	Client POSTGS M	Client POSTGS SD	Client POSTGI M	Client POSTGI SD
All counselors *n = 22 clients*	16.77	1.74	47.36	15.02	17.41	4.24
Male *n = 6 clients (2 Counselors)*	17.17	1.83	40.33	6.25	13.50	2.26
Female *n = 16 clients (5 Counselors)*	16.63	1.75	50.00	16.60	18.88	3.88
Substance abuse by self-identification *n = 15 (4 Counselors)*	16.60	1.80	48.73	16.36	18.87	4.02
Substance abuse by certification/license *n = 2 (1 Counselors)*	17.50	0.71	34.00	1.41	15.00	2.83
Mental health by self-identification *n = 4 (2 Counselors)*	16.50	1.29	49.75	0.91	15.75	2.50
Mental health by certification/license *n = 4 (2 Counselors)*	16.50	1.29	49.75	0.91	15.75	2.50
Co-occurring disorder by self-identification *n = 3 (1 Counselors)*	18.00	2.00	37.33	4.04	12.33	2.52
Co-occurring disorder by certification/license *n = 16 (4 Counselors)*	16.75	1.95	48.44	15.77	18.13	4.62
Counselor Self-Identified: Spiritual only *n = 17 (5 Counselors)*	16.76	1.89	49.65	16.07	18.18	4.48
Self-Identified as Religious only *n = 0 (0 Counselors)*	Na	na	na	Na	na	na
Self-Identified as both Spiritual and Religious *n = 3 (1 Counselors)*	16.33	1.53	43.33	7.37	14.67	1.53
Self-Identified as neither Spiritual or Religious *n = 2 (1 Counselor)*	17.50	0.71	34.00	1.41	15.00	2.83

Results of Testing the Research Hypotheses

It should be noted here that in what follows I have given the number of the Research Hypothesis *[RH ##]* associated with the results given, including the 3 Supplemental Research Hypotheses *[SRH]*, as well as whether the result support *[+RH ##]* or do not support *[~RH ##]* rejecting the null hypothesis associated with it.

On Morale

As can be seen from Tables 6 and 7, neither Counselor Level of Spiritual Well–Being (COLSWB) *[~RH 01]*, nor subscales of COLSWB, namely, Counselor Level of Religious Well–Being (COLRWB) *[~RH 07]* or Counselor Level of Existential Well-Being (COLEWB) *[~RH 06]* in and of themselves account for variance in clients' scores on Morale post-treatment (POSTMO) at a significant level of 0.05 or better. Nor do COLRWB and COLEWB taken together either *[~SRH 13]*. On the other hand, all three have a positive relationship with POSTMO which would be expected if increased COLSWB and/or aspects of COLSWB, namely, COLRWB and COLEWB, yielded better client outcomes as measured by the Health Dynamics Inventory (HDI).

Table 6

Summary of Simple Regression Analysis for Variables Predicting Client Morale: SWBS

Variable	*B*	SE *B*	t Value	Pr > |t|	Beta	R^2	Adj. R^2	F Value	Pr > F
COLSWB	0.03	0.04	0.76	0.46	0.17	0.03	-0.02	0.57	0.46
COLRWB	0.05	0.07	0.79	0.44	0.17	0.03	-0.02	0.63	0.44
COLEWB	0.04	0.07	0.56	0.58	0.12	0.02	-0.03	0.32	0.58

Table 7

Summary of Multiple Regression Analysis for Variables Predicting Client Morale: COLRWB and COLEWB

Variable	*B*	SE *B*	t Value	Pr > |t|	Beta	R^2	Adj. R^2	F Value	Pr > F
COLRWB	0.05	0.09	0.55	0.59	0.16	*0.03*	*-0.02*	*0.63*	*0.44*
COLEWB	0.01	0.09	0.10	0.92	0.03	*0.02*	*-0.03*	*0.32*	*0.58*
COLRWB & COLEWB						0.03	-0.07	0.30	0.74

* Here, for each of the components of the model, (e.g., COLRWB and COLEWB), to the right of the standardized parameter estimates and *italicized* is given the R^2, Adj. R^2, F Value, and Pr > F for the model containing only that component. Note for example that what is given to the right of COLRWB and *italicized* is the same as the R^2, Adj. R^2, F Value, and Pr > F and what is given to the right COLEWB and *italicized* is the same as the R^2, Adj. R^2, F Value, and Pr > F in Table 6 above.

Further when COLSWB, COLRWB, COLEWB, and COLRWB together with COLEWB, are controlled for by clients' scores on the Morale pre-treatment (PREMO) neither COLSWB *[~RH 01]* nor any aspect of COLSWB, namely, COLRWB *[~RH 07]* and COLEWB *[~RH 04]*, individually or together *[~SRH 13]* significantly impact clients' scores on Morale post-treatment POSTMO at the 0.05 level (See Tables 8 through 11). It is worth noting here that PREMO is negatively related to POSTMO indicating that the worse clients' scores on Morale are pre-treatment, the better their scores on Morale are post-treatment.

Table 8

Summary of Multiple Regression Analysis for Variables Predicting Client Morale: PREMO and COLSWB

Variable	*B*	SE *B*	t Value	Pr > |t|	Beta	R^2	Adj. R^2	F Value	Pr > F
PREMO	-0.16	0.15	-1.09	0.29	-0.25	*0.03*	*-0.02*	*0.58*	*0.46*
COLSWB	0.04	0.04	1.08	0.29	0.25	*0.03*	*-0.02*	*0.57*	*0.46*
PREMO & COLSWB						0.08	-0.01	0.88	0.43

Table 9

Summary of Multiple Regression Analysis for Variables Predicting Client Morale: PREMO and COLRWB

Variable	*B*	SE *B*	t Value	Pr > |t|	Beta	R^2	Adj. R^2	F Value	Pr > F
PREMO	-0.12	0.14	-0.88	0.39	-0.20	*0.03*	*-0.02*	*0.58*	*0.46*
COLRWB	0.06	0.07	0.91	0.38	0.20	*0.03*	*-0.02*	*0.63*	*0.44*
PREMO & COLRWB						0.07	-0.03	0.70	0.51

Table 10

Summary of Multiple Regression Analysis for Variables Predicting Client Morale: PREMO and COLEWB

Variable	*B*	SE *B*	t Value	Pr > |t|	Beta	R^2	Adj. R^2	F Value	Pr > F
PREMO	-0.18	0.16	-1.16	0.26	-0.29	*0.03*	*-0.02*	*0.58*	*0.46*
COLEWB	0.08	0.08	1.05	0.31	0.26	*0.02*	*-0.03*	*0.32*	*0.58*
PREMO & COLEWB						0.08	-0.02	0.84	0.45

Table 11

Summary of Multiple Regression Analysis for Variables Predicting Client Morale: PREMO, COLRWB, and COLEWB

Variable	*B*	SE *B*	t Value	Pr > |t|	Beta	R^2	Adj. R^2	F Value	Pr > F
PREMO	-0.17	0.16	-1.05	0.31	-0.27	*0.03*	*-0.02*	*0.58*	*0.46*
COLRWB	0.03	0.091	0.33	0.75	0.09	*0.03*	*-0.02*	*0.63*	*0.44*
COLEWB	0.06	0.10	0.60	0.56	0.19	*0.02*	*-0.03*	*0.32*	*0.58*
PREMO & COLRWB						*0.07*	*-0.03*	*0.70*	*0.51*
PREMO & COLEWB						*0.08*	*-0.02*	*0.84*	*0.45*
COLRWB & COLEWB						*0.03*	*-0.07*	*0.30*	*0.74*
PREMO COLRWB & COLEWB						0.09	-0.07	0.57	0.64

Neither client' scores on Morale or Global Symptoms pre-treatment (PREMO or PREGS) in and of themselves significantly impact clients' scores on Morale post-treatment POSTMO (See Tables 12 below). Note that clients' score on Global Symptoms pre-treatment (PREGS) are negatively related with their scores on Morale post-treatment (POSTMO) indicating that the better they are with respect to Global Symptom, (i.e., the fewer symptoms they have), pre-treatment the better they are with respect to Morale post-treatment.

Table 12

Summary of Simple Regression Analysis for Variables Predicting Client Morale: Pre-test HDI

Variable	*B*	SE *B*	t Value	Pr > |t|	Beta	R^2	Adj. R^2	F Value	Pr > F
PREMO	-0.11	0.14	-0.76	0.46	-0.17	0.03	-0.02	0.58	0.46
PREGS	-0.01	0.03	-0.48	0.63	-0.11	0.01	-0.04	0.23	0.63
PREGI	0.13	0.06	2.15	0.04	0.43	0.19	0.15	4.62	0.04

However, clients' score on Global Impairment pre-treatment accounts for 15% of the variance of clients' scores on Morale post-treatment and the possibility of obtaining this by chance is 4% (See Table 12 above). Further, note that here there is a positive relationship between PREGI and POSTMO indicating that the higher clients score on Global Impairment, which is to say, the more impaired clients are, pre-treatment the better they score on Morale post-treatment.

It is worth noting here that whereas by itself PREGS does not account for a significant amount of variance in clients' POSTMO scores, all things considered, which is to say, all things being equal, together with PREGI it does account for 68% of the variance of clients' scores POSTMO at the 0.01 level (See Table 13 below). Further, the amount of additional variance accounted for by adding PREGS to PREGI is significantly > 0 at the 0.05 level. Even more impressive, however, the amount of additional variance accounted for by adding PREGI to PREGS, is significantly > 0 at the 0.01 level.

Table 13

Summary of Multiple Regression Analysis for Variables Predicting Client Morale: PREGS PREGI

Variable	*B*	SE *B*	t Value	Pr > |t|	Beta	R^2	Adj. R^2	F Value	Pr > F
PREGS	0.21	0.07	3.12	0.01	0.68	*0.01*	*-0.04*	*0.23*	*0.63*
PREGI	-0.06	0.03	-2.15	0.04	-0.47	*0.19*	*0.15*	*4.62*	*0.04*
PREGS & PREGI						0.35	0.28	5.04	0.02

As can be seen in Table 14 below, taken together, clients' scores on the scales of the HDI pre-treatment, (e.g., PREMO, PREGS, and PREGI), account for 24% of the variance in clients' scores on Morale post-treatment (POSTMO) and that the possibility of this occurring by chance is 0.05. Notably, the amount of additional variance accounted for by adding the following is significantly > 0 at the 0.05 level: 1. PREGI to PREGS and PREMO, 2. PREGI and PREGS to PREMO, and 3. PREGI and PREMO to PREGS. No other additions are significantly > 0 at the 0.05 level.

Table 14

Summary of Multiple Regression Analysis for Variables Predicting Client Morale: PREMO, PREGS, and PREGI

Variable	*B*	SE *B*	t Value	Pr > |t|	Beta	R^2	Adj. R^2	F Value	Pr > F
PREMO	0.01	0.14	0.04	0.97	0.01	*0.03*	*-0.02*	*0.58*	*0.46*
PREGS	-0.06	0.03	-2.06	0.05	-0.47	*0.01*	*-0.04*	*0.23*	*0.63*
PREGI	0.21	0.08	2.79	0.01	0.69	*0.19*	*0.15*	*4.62*	*0.04*
PREMO & PREGS						*0.06*	*-0.03*	*0.65*	*0.54*
PREMO & PREGI						*0.19*	*0.11*	*2.27*	*0.13*
PREGS & PREGI						*0.35*	*0.28*	*5.04*	*0.02*
PREMO PREGS & PREGI						0.35	0.24	3.18	0.05

COLSWB together with PREGS and PREGI accounted for 24% of the variance in clients scores on POSTMO and the possibility of this occurring by chance is 0.05% (See Table 15 below). However, as was the case with PREMO together with PREGS and PREGI, since the amount of variance in clients' scores POSTMO accounted for by clients' scores on PREGS and PREGI is 28%, the addition of COLSWB to PREGS and PREGI decreased the amount of variance accounted for in clients' scores POSTMO *[~RH 01]*. Further, the amount of variance in clients' scores on POSTMO accounted for by COLSWB *[~RH 01]* all things considered, which is to say, holding all other factors equal, is not significant at the 0.05 level or better. On the other hand, the amount of additional variance in clients' scores on POSTMO accounted for by adding (PREGI and COLSWB) to PREGS is significantly > 0 at the 0.05 level *[+RH 01]*: Further, the additional amount of variance in clients' scores on POSTMO accounted for by adding PREGI to (PREGS and COLSWB) is significantly > 0 at the 0.01 level. No other additions are significantly > 0 at the 0.05 level.

Table 15

Summary of Multiple Regression Analysis for Variables Predicting Client Morale: PREGS, PREGI, and COLSWB

Variable	*B*	SE *B*	t Value	Pr > |t|	Beta	R^2	Adj. R^2	F Value	Pr > F
PREGS	-0.06	0.03	-2.07	0.05	-0.49	*0.01*	*-0.04*	*0.23*	*0.63*
PREGI	0.22	0.07	2.94	0.01	0.70	*0.19*	*0.15*	*4.62*	*0.04*
COLSWB	-0.01	0.04	-0.22	0.83	-0.05	*0.03*	*-0.02*	*0.57*	*0.46*
PREGS & PREGI						*0.35*	*0.28*	*5.04*	*0.02*
PREGS & COLSWB						*0.04*	*-0.07*	*0.34*	*0.71*
PREGI & COLSWB						*0.19*	*0.11*	*2.29*	*0.13*
PREGS PREGI & COLSWB						0.35	0.24	3.21	0.05

COLRWB, PREGS, and PREGI accounted for 24% of the variance in clients scores on POSTMO and the possibility of this occurring by chance is 0.05% (See Table 16 below). However, as was the case with PREMO together with PREGS and PREGI, since the amount of variance in clients' scores POSTMO accounted for by clients' scores on PREGS and PREGI is 28%, the addition of COLRWB to PREGS and PREGI decreased the amount of variance accounted for in clients' scores POSTMO *[~RH 07]*. Further, the amount of variance in clients' scores on POSTMO accounted for by COLRWB *[~RH 07]* all things considered, which is to say, holding all other factors equal, is not significant at the 0.05 level or better. However, the amount of additional variance in clients' scores on POSTMO accounted for by adding the following is significantly > 0 at the 0.05 level: 1. (PREGI and COLRWB) to PREGS *[+RH 07]*, and 2. (PREGI and PREGS) to COLRWB. Further, the additional amount of variance in clients' scores on POSTMO accounted for by adding PREGI to (PREGS and COLRWB) is significantly > 0 at the 0.01 level. No other additions are significantly > 0 at the 0.05 level.

Table 16

Summary of Multiple Regression Analysis for Variables Predicting Client Morale: PREGS, PREGI, and COLRWB

Variable	*B*	SE *B*	t Value	Pr > |t|	Beta	R^2	Adj. R^2	F Value	Pr > F
PREGS	-0.06	0.03	-2.07	0.05	-0.47	*0.01*	*-0.04*	*0.23*	*0.63*
PREGI	0.21	0.07	2.89	0.01	0.68	*0.19*	*0.15*	*4.62*	*0.04*
COLRWB	0.00	0.06	0.01	0.995	0.00	*0.03*	*-0.02*	*0.63*	*0.44*
PREGS & PREGI						*0.35*	*0.28*	*5.04*	*0.02*
PREGS & COLRWB						*0.04*	*-0.06*	*0.43*	*0.66*
PREGI & COLRWB						*0.19*	*0.11*	*2.24*	*0.13*
PREGS PREGI & COLRWB						0.35	0.24	3.18	0.05

COLEWB, PREGS, and PREGI accounted for 24% of the variance in clients scores on POSTMO and the possibility of this occurring by chance is 0.05% (See Table 17 below). However, as was the case with PREMO together with PREGS and PREGI, since the amount of variance in clients' scores POSTMO accounted for by clients' scores on PREGS and PREGI is 28%, the addition of COLEWB to (PREGS and PREGI) decreased the amount of variance accounted for in clients' scores POSTMO *[~RH 04]*. Further, the amount of variance in clients' scores on POSTMO accounted for by COLEWB *[~RH 04]* all things considered, which is to say, holding all other factors equal, is not significant at the 0.05 level or better. The amount of additional variance in clients' scores on POSTMO accounted for by adding the following was significantly > 0 at the 0.05 level: 1. PREGS to (PREGI and COLEWB), and 2. (PREGI and PREGS) to COLEWB. Further, the additional amount of variance in clients' scores on POSTMO accounted for by adding PREGI to (PREGS and COLEWB) is significantly > 0 at the 0.01 level.

On the other hand, neither the amount of additional variance accounted for by adding COLEWB to (PREGS and PREGI) nor (COLEWB and PREGS) to PREGI are significantly > 0 at the 0.05 level *[~RH 04]*.

Table 17

Summary of Multiple Regression Analysis for Variables Predicting Client Morale: PREGS, PREGI, and COLEWB

Variable	*B*	SE *B*	t Value	Pr > |t|	Beta	R^2	Adj. R^2	F Value	Pr > F
PREGS	-0.06	0.03	-2.10	0.05	-0.51	*0.01*	*-0.04*	*0.23*	*0.63*
PREGI	0.22	0.07	3.04	0.01	0.71	*0.19*	*0.15*	*4.62*	*0.04*
COLEWB	-0.03	0.07	-0.43	0.67	-0.09	*0.02*	*-0.03*	*0.32*	*0.58*
PREGS & PREGI						*0.35*	*0.28*	*5.04*	*0.02*
PREGS & COLEWB						*0.02*	*-0.08*	*0.20*	*0.82*
PREGI & COLEWB						*0.20*	*0.11*	*2.31*	*0.13*
PREGS PREGI & COLEWB						0.35	0.25	3.28	0.05

Here it is worth noting that no other model of various combinations of clients scores on the HDI pre-treatment, PREMO, PREGS, and PREGI with COLSWB *[~RH 01]* or subscales of COLSWB, namely, COLRWB *[~RH 07]* and COLEWB *[~RH 04]*, significantly impact clients' scores on Morale post-treatment, POSTMO, at the 0.05 level or better, (e.g., 0.01 level). See Table in Appendix E for a summary comparison of the results multiple regression analysis of various models entertained for the present study.

In general, then, neither COLSWB *[~RH 01]*, nor subscales of COLSWB, namely, COLRWB *[~RH 07]* or COLEWB *[~RH 04]* in and of themselves account for variance in clients' scores on Morale post-treatment (POSTMO) at a significant level of 0.05 or better. Nor do COLRWB and COLEWB taken together either *[~SRH 13]*. Further, neither COLSWB

[~RH 01] nor COLRWB *[~RH 07]* or COLEWB *[~RH 04]* account for a significant amount of variance in clients' POSTMO scores as components of a model all thing considered when combined with one or more of clients' pre-treatment scores on the HDI, namely, PREMO, PREGS, or PREGI *[~RH 01, 04, 07]*. On the other hand, all three have a positive relationship with POSTMO which would be expected if increased COLSWB and/or aspects of COLSWB, namely, COLRWB and COLEWB, yielded better client outcomes as measured by the Health Dynamics Inventory (HDI).

Client's scores on PREGI, however, accounted for 15% of the variance of clients' scores on POSTMO at a significance level of 0.04. Further, though clients' scores on PREGS in and of themselves did not account for a significant amount of variance in clients' POSTMO scores at the 0.05 level, when added to PREGI it did account for a significant amount of variance in clients' POSTMO scores at the 0.01 level all things considered, which is to say, when holding clients' scores on PREGI equal.

Finally, it is worth noting that both PREMO and PREGS were positively correlated with POSTMO whereas PREGI was negatively correlated with POSTMO. Consequently, it can be concluded that, to the extent that clients' scores on the HDI pre-treatment impact their scores on POSTMO, the following can be said: 1. The better a clients are with respect to Morale, (i.e., the higher their Morale), pre-treatment, the better they will be with respect to Morale post-treatment, 2. The better clients are with respect to Global Impairment, (i.e., the less impaired their functioning), pre-treatment the better they are with respect to Morale post-treatment, and finally, 3. The worse clients are with respect to Global Symptoms, (i.e., the more symptoms they have and/or the greater the intensity of their symptoms), pre-treatment, the better they are with respect to Morale post-treatment.

On Global Symptoms

As was the case with clients' scores on POSTMO and can be seen in Table 18, neither COLSWB *[~RH 02]*, nor subscales of COLSWB, namely, COLRWB *[~RH 08]* or COLEWB *[~RH 05]* in and of themselves account for variance in clients' scores on Global Symptoms post-treatment (POSTGS) at a significant level of 0.05 or better. Nor do COLRWB and COLEWB taken together *[~SRH 14]* either (See Table 19). On the other hand, all three in and of themselves have a negative relationship with POSTGS which would be expected if increased COLSWB and/or aspects of COLSWB, namely, COLRWB and COLEWB, yielded better client outcomes as measured by the Health Dynamics Inventory (HDI), (i.e., as COLSWB, COLRWB, or COLEWB increase the number and/or intensity of symptoms clients experience decreases). However, COLEWB is positively correlated with clients' POSTGS scores when added to COLRWB *[+RH 11]*.

Table 18

Summary of Simple Regression Analysis for Variables Predicting Client Global Symptoms: SWBS

Variable	*B*	SE *B*	t Value	Pr > |t|	Beta	R^2	Adj. R^2	F Value	Pr > F
COLSWB	-0.30	0.33	-0.91	0.37	-0.20	0.04	-0.01	0.83	0.37
COLRWB	-0.69	0.58	-1.20	0.24	-0.26	0.07	0.02	1.44	0.24
COLEWB	-0.27	0.62	-0.43	0.67	-0.10	0.01	-0.04	0.19	0.67

Table 19

Summary of Multiple Regression Analysis for Variables Predicting Client Global Symptoms: COLEWB and COLRWB

Variable	*B*	SE *B*	t Value	Pr > |t|	Beta	R^2	Adj. R^2	F Value	Pr > F
COLRWB	-0.86	0.75	-1.15	0.27	-0.32	*0.07*	*0.02*	*1.44*	*0.24*
COLEWB	0.28	0.77	0.36	0.72	0.10	*0.01*	*-0.04*	*0.19*	*-0.67*
COLRWB & COLEWB						0.07	-0.02	0.75	0.49

Further, when COLSWB, COLRWB, COLEWB, or COLRWB together with COLEWB, are controlled for by clients' scores on the Global Symptoms pre-treatment (PREGS) neither COLSWB *[~RH 02]*nor any aspect of COLSWB, namely, COLRWB *[~RH 08]* and COLEWB *[~RH 05]*, individually or together *[~SRH 14]* significantly impact clients' scores on POSTGS at the 0.05 level (See Tables 20 through 23). It is worth noting here that PREGS is negatively related to POSTGS when taken together with COLSWB as well as when taken together with COLEWB indicating that the better clients are with respect to Global Symptoms, (i.e., the fewer the number of symptoms they experience and/or the less the intensity of the symptoms they experience), pre-treatment the worse they are with respect to Global Symptoms, (i.e., the greater the number of symptoms they experience and/or they experience their symptoms with greater intensity), post-treatment (POSTGS); whereas, the opposite is the case when PREGS is taken together with COLRWB *[+RH 11]*.

Table 20

Summary of Multiple Regression Analysis for Variables Predicting Client Global Symptoms: PREGS and COLSWB

Variable	*B*	SE *B*	t Value	Pr > |t|	Beta	R^2	Adj. R^2	F Value	Pr > F
PREGS	-0.03	0.24	-0.13	0.89	-0.03	*0.00*	*-0.05*	*0.00*	*0.99*
COLSWB	-0.31	0.34	-0.90	0.38	-0.20	*0.04*	*-0.01*	*0.83*	*0.37*
PREGS & COLSWB						0.04	-0.06	0.40	0.67

Table 21

Summary of Multiple Regression Analysis for Variables Predicting Client Global Symptoms: PREGS and COLRWB

Variable	*B*	SE *B*	t Value	Pr > |t|	Beta	R^2	Adj. R^2	F Value	Pr > F
PREGS	0.01	0.23	0.03	0.97	0.01	*0.00*	*-0.05*	*0.00*	*0.99*
COLRWB	-0.69	0.59	-1.17	0.26	-0.26	*0.07*	*0.02*	*1.44*	*0.24*
PREGS & COLRWB						0.07	-0.03	0.68	0.52

Table 22

Summary of Multiple Regression Analysis for Variables Predicting Client Global Symptoms: PREGS and COLEWB

Variable	*B*	SE *B*	t Value	Pr > |t|	Beta	R^2	Adj. R^2	F Value	Pr > F
PREGS	-0.03	0.25	-0.14	0.89	-0.03	*0.00*	*-0.05*	*0.00*	*0.99*
COLEWB	-0.29	0.66	-0.44	0.66	-0.11	*0.01*	*-0.04*	*0.19*	*0.67*
PREGS & COLEWB						0.01	-0.09	0.10	0.91

Table 23

Summary of Multiple Regression Analysis for Variables Predicting Client Global Symptoms: PREGS, COLRWB, and COLEWB

Variable	*B*	SE *B*	t Value	Pr > |t|	Beta	R^2	Adj. R^2	F Value	Pr > F
PREGS	0.05	0.26	0.19	0.85	0.05	*0.00*	*-0.05*	*0.00*	*0.99*
COLRWB	-0.90	0.80	-1.12	0.28	-0.34	*0.07*	*0.02*	*1.44*	*0.24*
COLEWB	0.34	0.87	0.40	0.70	0.12	*0.01*	*-0.04*	*0.19*	*0.67*
PREGS & COLRWB						*0.07*	*-0.03*	*0.68*	*0.52*
PREGS & COLEWB						*0.01*	*-0.09*	*0.10*	*0.91*
COLRWB & COLEWB						*0.07*	*-0.02*	*0.75*	*0.49*
PREGS COLRWB & COLEWB						0.08	-0.08	0.49	0.70

Neither clients' scores on Morale, Global Symptoms, nor Global Impairment pre-treatment (PREMO, PREGS, or PREGI) in and of themselves significantly impact clients' scores on POSTGS at the 0.05 level (See Tables 24 below). Note that clients' score on Global Symptoms and Global Impairment pre-treatment, (PREGS and PREGI) are negatively correlated with clients' scores on POSTGS, whereas, the opposite is true with respect to clients' scores on PREMO. Consequently, with respect to all three scales of the HDI, the better clients are with respect to each pre-treatment, which is to say the higher clients' Morale (PREMO), the fewer and/or less intense the symptoms clients experience (PREGS), and the less impaired clients are in functioning (PREGI), the greater number of symptoms and/or the more intense their symptoms are post-treatment (POSTGS). Notably, these results seem counterintuitive.

Table 24

Summary of Simple Regression Analysis for Variables Predicting Client Global Symptoms: Pre-test HDI

Variable	*B*	SE *B*	t Value	Pr > |t|	Beta	R^2	Adj. R^2	F Value	Pr > F
PREMO	0.81	1.20	0.67	0.51	0.15	0.02	-0.03	0.45	0.51
PREGS	-0.00	0.24	-0.01	0.99	-0.00	0.00	-0.05	0.00	0.99
PREGI	-0.76	0.57	-1.35	0.19	-0.29	0.08	0.04	1.81	0.19

Here it is worth noting that no models of various combinations of clients scores on the HDI pre-treatment, PREMO, PREGS, and PREGI with COLSWB or subscales of COLSWB, namely, COLRWB and COLEWB, significantly impact clients' scores on Global Symptoms post-treatment, POSTGS, at the 0.05 level or better, (e.g., 0.01 level) *[~RH 02, 05, 08]*. Again, see Table in Appendix E for a summary comparison of the results multiple regression analysis of various models entertained for the present study.

In general, then, neither COLSWB *[~RH 02]*, nor subscales of COLSWB, namely, COLRWB *[~RH 08]* or COLEWB *[~RH 05]* in and of themselves account for variance in clients' scores on POSTGS at a significant level of 0.05 or better. Nor do COLRWB and COLEWB taken together either *[~SRH 14]*. Further, neither COLSWB nor COLRWB or COLEWB account for a significant amount of variance in clients' POSTGS scores as components of a model all thing considered when combined with one or more of clients' pre-treatment scores on the HDI, namely, PREMO, PREGS, or PREGI *[~RH 02, 05, 08]*. On the other hand, all three, in and of themselves, have a negative relationship with POSTGS which would be expected if increased COLSWB and/or aspects of COLSWB, namely, COLRWB and COLEWB, yielded better client outcomes as measured by the Health Dynamics Inventory (HDI), though, it must be added, with the exception of COLEWB *[+RH 11]* when it is included in a model with COLRWB.

On Global Impairment

As was the case with clients' scores on POSTMO and POSTGS, neither COLSWB, nor subscales of COLSWB *[~RH 03]*, namely, COLRWB *[~RH 09]* or COLEWB *[~RH 06]* in and of themselves account for variance in clients' scores on Global Impairment post-treatment (POSTGI) at a significant level of 0.05 or better (See Table 25 below).

Further, as was the case with clients' scores on POSTMO and POSTGI, since both COLSWB and COLRWB are negatively related to POSTGS, (i.e., as counselors' scores on COLSWB and COLRWB increase, clients' scores on POSTGI decrease indicating that insofar as they account for variance in clients' scores on POSTGI, increase in COLSWB or COLRWB correlates with decrease in client impairment post-treatment). Both COLSWB and COLRWB *[+RH 12]* in and of themselves, then, are related to POSTGI in a way that would be expected if increased COLSWB or COLRWB yielded better client outcomes as measured by the Health Dynamics Inventory (HDI). On the other hand, as can be seen in Table 25 below, unlike what was the case with respect to clients' scores on POSTMO and POSTGS, COLEWB, in and of itself, is not related to POSGI in a way that would be expected if increased COLEWB yielded better client outcomes *[+RH 12]*. Since COLEWB is positively correlated with clients' POSTGI scores.

Table 25

Summary of Simple Regression Analysis for Variables Predicting Client Global Impairment: SWBS

Variable	*B*	SE *B*	t Value	Pr > |t|	Beta	R^2	Adj. R^2	F Value	Pr > F
COLSWB	-0.08	0.09	-0.85	0.41	-0.19	0..03	-0.014	0.72	0.41
COLRWB	-0.30	0.16	-1.90	0.07	-0.39	0.15	0.11	3.61	0.07
COLEWB	0.05	0.17	0.29	0.78	0.06	0.00	-0.05	0.08	0.78

As was the case with clients' scores on POSTGS, this is true of COLEWB when taken together with COLRWB *[+RH 12]* (see Table 36). Note, however, that unlike what was the case with clients' scores on POSTMO and POSTGS, and, as can be seen in Table 26, COLRWB together with COLEWB did account for variance in clients' scores on POSGI at a level of significance of 0.05 or better *[+SRH 15]*. More specifically, taken together, COLRWB and COLEWB accounts for 23% of variance in clients' scores on POSTGI and the possibility of their so doing by chance is 3%. Further, the additional amount of variance in clients' scores on POSTGI accounted for by adding COLRWB to COLEWB is significantly > 0 at the 0.05 level; whereas, the additional amount of variance in clients' scores on POSTGI by adding COLEWB to COLRWB is not significantly > 0 at the 0.05 level *[+RH 12]*. Finally note that whereas the amount of variance in clients' scores on POSTGI accounted for by COLRWB all things considered is significant at the 0.05 level or better, namely, at the 0.01 level *[+RH 09]*, the amount of variance in clients' scores on POSTGI accounted for by COLEWB all things considered is not significant at the 0.05 level or better *[~RH 06] [+RH 12]*.

Table 26

Summary of Multiple Regression Analysis for Variables Predicting Client Global Impairment: COLEWB and COLRWB

Variable	*B*	SE *B*	t Value	Pr > |t|	Beta	R^2	Adj. R^2	F Value	Pr > F
COLRWB	-0.52	0.18	-2.84	0.01	-0.69	*0.15*	*0.11*	*3.61*	*0.07*
COLEWB	0.38	0.19	2.01	0.06	0.49	*0.00*	*-0.05*	*0.08*	*0.78*
COLRWB & COLEWB						0.30	0.23	4.09	0.03

However, when COLSWB, COLRWB, COLEWB, or COLRWB together with COLEWB, are controlled for by clients' scores on the Global Impairment pre-treatment (PREGI) neither COLSWB *[~RH 03]* nor any aspect of COLSWB, namely, COLRWB *[~RH 09]* and COLEWB *[~RH 06]*, individually or together *[~SRH 15]* significantly impact clients' scores on POSTGI at the 0.05 level (See Tables 27 through 30 below). It is worth noting here that PREGI is negatively related to POSTGI when taken together with COLSWB, COLRWB, COLEWB as well as when taken together with both COLRWB and COLEWB indicating that the better clients are with respect to Global Impairment, (i.e., the less impaired their functioning is), pre-treatment (PREGI) the worse they are with respect to Global Impairment, (i.e., the more impaired their functioning is), post-treatment (POSTGI). Further, the relationships that obtained between COLSWB, COLRWB and COLEWB in and of themselves and clients' scores on POSTGI remains unchanged when they are controlled for by clients' scores on PREGI.

As can be seen in Table 30 below, the addition of PREGI to COLRWB and COLEWB does not add to the amount of variance accounted for in clients' scores on POSTGI. Consequently, the addition of a variable in the model may be the only reason for the decrease in the level of significance to 0.06. Regardless, it is worth noting that as a component of this model COLRWB does account for a significant amount of variance in clients' scores on POSTGI at a 0.03 level all things consider, which is to say, holding all other components equal *[+RH 09]*. Further, the additional amount of variance in clients' scores on POSTGI by adding COLRWB to PREGI and COLEWB) is significantly > 0 at the 0.05 level *[+RH 09]*. The additional amount of variance in clients' scores on POSTGI accounted for by adding both COLRWB and COLEWB to PREGI, however, is not significantly > 0 at the 0.05 level *[~SRH 15]*.

Table 27

Summary of Multiple Regression Analysis for Variables Predicting Client Global Impairment: PREGI and COLSWB

Variable	*B*	SE *B*	t Value	Pr > |t|	Beta	R^2	Adj. R^2	F Value	Pr > F
PREGI	-0.23	0.16	-1.38	0.18	-0.30	*0.11*	*0.06*	*2.43*	*0.13*
COLSWB	-0.05	0.09	-0.57	0.58	-0.12	*0.03*	*-0.01*	*0.72*	*0.41*
PREGI & COLSWB						0.12	0.03	1.33	0.29

Table 28

Summary of Multiple Regression Analysis for Variables Predicting Client Global Impairment: PREGI and COLRWB

Variable	*B*	SE *B*	t Value	Pr > |t|	Beta	R^2	Adj. R^2	F Value	Pr > F
PREGI	-0.18	0.16	-1.12	0.28	-0.24	*0.11*	*0.06*	*2.43*	*0.13*
COLRWB	-0.25	0.16	-1.53	0.14	-0.32	*0.15*	*0.11*	*3.61*	*0.07*
PREGI & COLRWB						0.21	0.12	2.46	0.11

Table 29

Summary of Multiple Regression Analysis for Variables Predicting Client Global Impairment: PREGI and COLEWB

Variable	*B*	SE *B*	t Value	Pr > |t|	Beta	R^2	Adj. R^2	F Value	Pr > F
PREGI	-0.25	0.16	-1.56	0.14	-0.34	*0.11*	*0.06*	*2.43*	*0.13*
COLEWB	0.07	0.17	0.43	0.67	0.09	*0.00*	*-0.05*	*0.08*	*0.78*
PREGI & COLEWB						0.12	0.02	1.26	0.31

Table 30

Summary of Multiple Regression Analysis for Variables Predicting Client Global Impairment: PREGI, COLRWB, and COLEWB

Variable	*B*	SE *B*	t Value	Pr > |t|	Beta	R^2	Adj. R^2	F Value	Pr > F
PREGI	-0.15	0.15	-0.98	0.34	-0.20	*0.11*	*0.06*	*2.43*	*0.13*
COLRWB	-0.47	0.19	-2.44	0.03	-0.62	*0.15*	*0.11*	*3.61*	*0.07*
COLEWB	0.36	0.19	1.88	0.08	0.463	*0.00*	*-0.05*	*0.08*	*0.78*
PREGI & COLRWB						*0.21*	*0.12*	*2.46*	*0.11*
PREGI & COLEWB						*0.12*	*0.02*	*1.26*	*0.31*
COLRWB & COLEWB						*0.30*	*0.23*	*4.09*	*0.03*
PREGI COLRWB & COLEWB						0.34	0.23	3.04	0.06

Neither clients' scores on Global Symptoms or Global Impairment pre-treatment (PREGS or PREGI) in and of themselves significantly impact clients' scores on POSTGI at the 0.05 level (See Tables 31 below). Note that clients' score on both PREGS and PREGI are negatively related with their scores on POSTGI indicating that the better they are with respect to Global Symptoms, (i.e., the fewer symptoms they have), and Global Impairment, (i.e., the less impaired their functioning is), pre-treatment the worse they are with respect to Global Impairment, (i.e., the more impaired their functioning is), post-treatment. Here, again, this seems counterintuitive.

However, as can be seen in Table 31 below, clients' scores on Morale pre-treatment (PREMO) accounts for 14% of the variance of clients' scores on POSTGI and the possibility of obtaining this by chance is 5%. Further, note that here there is a positive relationship between PREMO and POSTGI indicating that the higher clients score on PREMO, which is to say, the

better they are with respect to Morale pre-treatment, the higher their scores on POSTGI, which is to say, the worse they are with respect to Global Impairment, (i.e., more impaired in functioning they are), post-treatment. Yet, again, this seems counterintuitive.

Table 31

Summary of Simple Regression Analysis for Variables Predicting Client Global Impairment: Pre-test HDI

Variable	*B*	SE *B*	t Value	Pr > |t|	Beta	R^2	Adj. R^2	F Value	Pr > F
PREMO	0.64	0.31	2.07	0.05	0.42	0.18	0.14	4.29	0.05
PREGS	-0.09	0.06	-1.51	0.15	-0.32	0.10	0.06	2.27	0.15
PREGI	-0.25	0.16	-1.56	0.13	-0.33	0.11	0.06	2.43	0.13

That the variance in clients' scores on POSTGI accounted for by their scores on PREMO is significant leads to the question of whether the variance of their scores on POSTGI is significant at the 0.05 level when their scores on PREMO are combined with COLSWB, COLRWB, COLEWB, or both CORWB and COLEWB. The answer to this question is "yes" for COLSWB *[+RH 03]* accounting for 22% of the variance in clients' scores on POSTGI at the 0.03 level (see Table 32 below), COLRWB *[+RH 09, 12]* accounting for 32% of the variance in clients' scores on POSTGI at the 0.01 level (see Table 33 below), and both COLRWB and COLEWB *[+SRH 15]*again accounting for 32% of the variance in clients' scores on POSTGI at the 0.01 level (See Table 34 below) and "no" for COLEWB *[~RH 06] [+RH 12]*. Further, the relationship each in and of themselves (e.g., PREMO only, COLSWB only, COLRWB only, and COLEWB only), has with respect POSTGI is maintained when combined with PREMO.

Table 32

Summary of Multiple Regression Analysis for Variables Predicting Client Global Impairment: PREMO and COLSWB

Variable	*B*	SE *B*	t Value	Pr > |t|	Beta	R^2	Adj. R^2	F Value	Pr > F
PREMO	0.8	0.31	2.67	0.02	0.55	*0.18*	*0.14*	*4.29*	*0.05*
COLSWB	-0.16	0.09	-1.82	0.09	-0.37	*0.03*	*-0.01*	*0.72*	*0.41*
PREMO & COLSWB						0.30	0.22	4.04	0.03

Here, it is worth noting that the variance accounted for by PREMO all things considered is significant at the 0.02 level. Further, the additional amount of variance in clients' scores on POSTGI accounted for by adding PREMO to COLSWB is significantly > 0 at the 0.05 level. Neither of these claims are true for COLSWB *[~RH 03]*.

Table 33

Summary of Multiple Regression Analysis for Variables Predicting Client Global Impairment: PREMO and COLRWB

Variable	*B*	SE *B*	t Value	Pr > |t|	Beta	R^2	Adj. R^2	F Value	Pr > F
PREMO	0.74	0.28	2.68	0.01	0.49	*0.18*	*0.14*	*4.29*	*0.05*
COLRWB	-0.35	0.14	-2.54	0.02	-0.46	*0.15*	*0.11*	*3.61*	*0.07*
PREMO &COLRWB						0.39	0.32	5.95	0.01

Unlike what was the case with PREMO and COLSWB, here, not only is the amount of variance in clients' scores on POSTGI accounted for by their scores on PREMO significant at the 0.01 level all things considered, but also the amount of variance accounted for by COLRWB all things considered is significant at the 0.02 level *[+RH 09]*. Further, the additional amount of variance in clients' scores on POSTGI accounted for by both by adding PREMO to COLRWB and adding COLRWB to PREMO *[+RH 09]* is significantly > 0 at the 0.05 level.

Table 34

Summary of Multiple Regression Analysis for Variables Predicting Client Global Impairment: PREMO, COLRWB, and COLEWB

Variable	*B*	SE *B*	t Value	Pr > |t|	Beta	R^2	Adj. R^2	F Value	Pr > F
PREMO	0.60	0.32	1.87	0.08	0.39	*0.18*	*0.14*	*4.29*	*0.05*
COLRWB	-0.45	0.18	-2.58	0.02	-0.600	*0.15*	*0.11*	*3.61*	*0.07*
COLEWB	0.20	0.20	0.96	0.35	0.25	*0.00*	*-0.05*	*0.08*	*0.78*
PREMO & COLRWB						*0.39*	*0.32*	*5.95*	*0.01*
PREMO & COLEWB						*0.20*	*0.11*	*2.36*	*0.12*
COLRWB & COLEWB						*0.30*	*0.23*	*4.09*	*0.03*
PREMO COLRWB & COLEWB						0.41	0.32	4.25	0.02

Here, only the variance in clients' scores on POSTGI accounted for by COLRWB all things considered is significant at the 0.05 level or better, namely, at the 0.02 level. *[+RH 09]* Further, the additional amount of variance in clients' scores on POSTGI accounted for by adding the following are significantly > 0 at the 0.05 level: 1. COLRWB to both (PREMO and COLEWB) *[+RH 09]*, 2. Both (COLRWB and COLEWB) to PREMO *[+SRH 15]*, 3. Both (PREMO and COLEWB) to COLRWB *[+RH 06]*, and 4. Both (PREMO and COLRWB) to COLEWB *[+RH 09]*. No other additions are significant at the 0.05 level. Notably, adding COLEWB to both (PREMO and COLRWB) does not account for any additional variance in clients' scores on POSTGI *[~RH 06] [+RH 12]*.

That the variance in clients' scores on POSTGI accounted for by their scores on PREMO combined with COLSWB, COLRWB, and both COLRWB and COLEWB is significant at the 0.05 or better level leads to the question of whether the variance of their scores on POSTGI is significant at the 0.05 level when these models, (e.g., PREMO and COLSWB, PREMO and COLRWB, and PREMO and both COLRWB and COLEWB) are controlled for by PREGI.

The answer to this question is "yes" for (PREMO and COLRWB) *[+RH 09]* accounting for 29% of the variance in clients' scores on POSTGI at the 0.03 level (see Table 35 below) and for [PREMO and both (COLRWB and COLEWB)] *[+SRH 15]* accounting for 28% of the variance in clients' on POSTGI at the 0.05 level (see Table 36 below); and "no" for (PREMO and COLSWB) *[~RH 03]*.

Table 35

Summary of Multiple Regression Analysis for Variables Predicting Client Global Impairment: PREMO, PREGI, and COLRWB

Variable	*B*	SE *B*	t Value	Pr > |t|	Beta	R^2	Adj. R^2	F Value	Pr > F
PREMO	0.83	0.35	2.33	0.03	0.54	*0.18*	*0.14*	*4.29*	*0.05*
PREGI	0.07	0.18	0.38	0.71	0.09	*0.11*	*0.06*	*2.43*	*0.13*
COLRWB	-0.37	0.15	-2.41	0.03	-0.49	*0.15*	*0.11*	*3.61*	*0.07*
PREMO & PREGI						*0.19*	*0.11*	*2.27*	*0.13*
PREMO & COLRWB						0.39	0.32	5.95	0.01
PREGI & COLRWB						*0.21*	*0.12*	*2.46*	*0.11*
PREMO PREGI & COLRWB						0.39	0.29	3.84	0.03

Here, both the amount of variance in clients' scores on POSGI accounted for by PREMO as well as COLRWB *[+RH 09]* all things considered is significant at the 0.03 level. Further, the additional amount of variance in clients' scores on POSTGI accounted for by adding the following is significantly > 0 at the 0.05 level: 1. COLRWB to both (PREMO and PREGI) *[+RH 09]*, 2. PREMO to both (PREGI and COLRWB), 3. both (PREMO and COLRWB) to PREGI *[+RH 09]*. No other additions are significantly > 0 at the 0.05 level. Finally, in this model PREGI is positively related to POSTGI whereas in all previous models considered it was negatively related to POSTGI.

Table 36

Summary of Multiple Regression Analysis for Variables Predicting Client Global Impairment: PREMO, PREGI, COLRWB and COLEWB

Variable	*B*	SE *B*	t Value	Pr > |t|	Beta	R^2	Adj. R^2	F Value	Pr > F
PREMO	0.64	0.42	1.52.	0.15	0.42	*0.18*	*0.14*	*4.29*	*0.05*
PREGI	0.03	0.19	0.15	0.88	0.04	*0.11*	*0.06*	*2.43*	*0.13*
COLRWB	-0.46	0.19	-2.48	0.02	-0.61	*0.15*	*0.11*	*3.61*	*0.07*
COLEWB	0.19	0.22	0.86	0.40	0.24	*0.00*	*-0.05*	*0.08*	*0.78*
PREMO & PREGI						*0.19*	*0.11*	*2.27*	*0.13*
PREMO & COLRWB						0.39	0.32	5.95	0.01
PREMO & COLEWB						*0.20*	*0.11*	*2.36*	*0.12*
PREGI & COLRWB						*0.21*	*0.12*	*2.46*	*0.11*
PREGI & COLEWB						*0.12*	*0.02*	*1.26*	*0.31*
COLRWB & COLEWB						*0.30*	*0.23*	*4.09*	*0.03*
PREMO PREGI & COLRWB						*0.40*	*0.29*	*3.84*	*0.03*
PREMO PREGI & COLEWB						*0.20*	*0.07*	*1.54*	*0.24*
PREMO PREGI COLRWB & COLEWB						0.42	0.28	3.02	0.05

Here, only the variance in clients' scores on POSTGI accounted for by COLRWB all things considered is significant at the 0.05 level or better, namely, at the 0.02 level *[+RH 09]*. Further, the additional amount of variance in clients' scores on POSTGI accounted for by adding the following is significantly > 0 at the 0.05 level: 1. COLRWB to both (PREMO, PREGI, and COLEWB) *[+RH 09]* and 2. both (PREMO and COLRWB) to both (PREGI and COLEWB). No other additions are significantly > 0 at the 0.05 level. Adding COLEWB to (PREMO, PREGI, and COLRWB) decreases the amount of variance in clients' scores on POSGI accounted for by the model *[+RH 12]*.

Not only is the variance in clients' score on POSTGI significant at the 0.05 level or better when (PREMO and COLRWB) and [PREMO and both (COLRWB and COLEWB)] are combined with clients' scores on PREGI, the variance in clients' scores on POSTGI accounted for when they are combined with clients' scores on PREGS is significant at the 0.05 level or better as well. (PREMO and COLRWB) combined with PREGS accounts for 30% of the variance in clients' scores on POSTGI at the 0.02 level *[+RH 09]* (see Table 37 below) and [PREMO and both (COLRWB and COLEWB)] combined with PREGS accounts for 29% of the variance in clients' scores on POSTGI at the 0.04 level *[+SRH 15]* (see Table 38 below)

Table 37

Summary of Multiple Regression Analysis for Variables Predicting Client Global Impairment: PREMO, PREGS, and COLRWB

Variable	*B*	SE *B*	t Value	Pr > |t|	Beta	R^2	Adj. R^2	F Value	Pr > F
PREMO	0.66	0.31	2.15.	0.05	0.43	*0.18*	*0.14*	*4.29*	*0.05*
PREGS	-0.04	0.06	-0.68	0.51	-0.13	*0.10*	*0.06*	*2.27*	*0.15*
COLRWB	-0.34	0.14	-2.42	0.03	-0.45	*0.15*	*0.11*	*3.61*	*0.07*
PREMO & PREGS						*0.20*	*0.12*	*2.45*	*0.11*
PREMO & COLRWB						*0.39*	*0.32*	*5.95*	*0.01*
PREGS & COLRWB						*0.25*	*0.17*	*3.11*	*0.07*
PREMO PREGS & COLRWB						0.40	0.30	4.01	0.02

As was the case with PREGI, the amount of variance in clients' scores on POSTGI accounted for by both PREMO and COLRWB all things considered is significant at the 0.05 level or better, namely, the former at the 0.05 level and the latter at the 0.03 *[+RH 09]*. Further, the additional amount of variance in clients' scores on POSTGI accounted for by adding the following is significantly > 0 at the 0.05 level: 1. COLRWB to both (PREMO and PREGS)

[+RH 09], 2. PREMO to both (PREGS and COLRWB), 3. both (PREMO and PREGS) to COLRWB, and 4. both (PREMO and COLRWB) to PREGS *[+RH 09]*.

No other additions are significantly > 0 at the 0.05 level. Notably, unlike PREGI, the relationship between PREGS and POSTGI does not change when PREGS is combined with PREMO and COLRWB.

Table 38

Summary of Multiple Regression Analysis for Variables Predicting Client Global Impairment: PREMO, PREGS, COLRWB and COLEWB

Variable	*B*	SE *B*	t Value	Pr > |t|	Beta	R^2	Adj. R^2	F Value	Pr > F
PREMO	0.56	0.34	1.65	0.12	0.37	*0.18*	*0.14*	*4.29*	*0.05*
PREGS	-0.03	0.06	-0.44	0.66	-0.09	*0.10*	*0.06*	*2.27*	*0.15*
COLRWB	-0.43	0.19	-2.34	0.03	-0.57	*0.15*	*0.11*	*3.61*	*0.07*
COLEWB	0.17	0.22	0.790	0.44	0.22	*0.00*	*-0.05*	*0.08*	*0.78*
PREMO & PREGS						*0.20*	*0.12*	*2.45*	*0.11*
PREMO & COLRWB						*0.39*	*0.32*	*5.95*	*0.01*
PREMO & COLEWB						*0.20*	*0.11*	*2.36*	*0.12*
PREGS & COLRWB						*0.25*	*0.17*	*3.11*	*0.07*
PREGS & COLEWB						*0.10*	*0.01*	*1.09*	*0.36*
COLRWB & COLEWB						*0.30*	*0.23*	*4.09*	*0.03*
PREMO PREGS & COLRWB						*0.40*	*0.30*	*4.01*	*0.02*
PREMO PREGS & COLRWB						*0.40*	*0.30*	*4.01*	*0.02*
PREMO PREGS & COLEWB						*0.24*	*0.11*	*1.85*	*0.17*
PREMO PREGS COLRWB & COLEWB						0.42	0.29	3.10	0.04

Here, as was the case with PREGI, only the variance in clients' scores on POSTGI ac - counted for by COLRWB all things considered is significant at the 0.05 level or better *[+RH 09] [~RH 06] [+RH 12]*, namely, at the 0.03 level. Further, the additional amount of variance in clients' scores on POSTGI accounted for by adding the following is significantly > 0 at the 0.05 level: 1. COLRWB to (PREMO, PREGS, and COLEWB) *[+RH 09]* and 2. Both (PREMO and COLRWB) to both (PREGS and COLEWB) *[+RH 09]*. No other additions are significantly > 0 at the 0.05 level. Notably, adding COLEWB to (PREMO, PREGS, and COLRWB) does not significantly increase the amount of variance in clients' scores on POSGI accounted for by the model at the 0.05 level or better *[+RH 12]*.

At this point it appears that a pattern/trend is emerging when considering these models, [e.g., PREMO and COLRWB; PREMO and both (COLRWB and COLEWB); PREMO, PREGI, and COLRWB; PREMO, PREGI, and both (COLRWB and COLEWB); PREMO, PREGS, and COLRWB; and PREMO, PREGS and both (COLRWB and COLEWB)], which is this: COLRWB is the only predictor which is such that, for each model in which it is a predictor:

1. The amount of variance in clients' scores on POSTGI accounted for by it all things considered is significant at the 0.05 level or better *[+RH 09]*; *and,*
2. The additional amount of variance in clients' scores on POSTGI accounted for by its addition is significantly > 0 at the 0.05 level or better *[+RH 09]*.

With this trend in mind the question arises as to whether this trend will continue if COLRWB is combined with clients' score on all three scales of the HDI pre-treatment, (e.g., PREMO, PREGS, and PREGI). The answer to this question is yes. When COLRWB is combined with PREMO, PREGS, and PREGI, they account for 28% of the variance in clients'

scores on POSTGI at the 0.05 level *[+RH 09]*. Further, the amount of variance in clients' scores on POSTGI accounted for by COLRWB all things considered is significantly > 0 at the 0.02 level *[+RH 09]* (see Table 39).

Table 39

Summary of Multiple Regression Analysis for Variables Predicting Client Global Impairment: PREMO, PREGS, PREGI, and COLRWB

Variable	*B*	SE *B*	t Value	Pr > |t|	Beta	R^2	Adj. R^2	F Value	Pr > F
PREMO	0.79	0.36	2.20	0.04	0.52	*0.18*	*0.14*	*4.29*	*0.05*
PREGS	-0.06	0.07	-0.91	0.38	-0.20	*0.10*	*0.06*	*2.27*	*0.15*
PREGI	0.14	0.20	0.72	0.48	0.19	*0.11*	*0.06*	*2.43*	*0.13*
COLRWB	-0.39	0.16	-2.47	0.02	-0.51	*0.15*	*0.11*	*3.61*	*0.07*
PREMO & PREGS						*0.20*	*0.12*	*2.45*	*0.11*
PREMO & PREGI						*0.19*	*0.11*	*2.27*	*0.13*
PREMO & COLRWB						*0.39*	*0.32*	*5.95*	*0.01*
PREGS & PREGI						*0.14*	*0.05*	*1.51*	*0.25*
PREGS & COLRWB						*0.25*	*0.17*	*3.11*	*0.07*
PREGI & COLRWB						*0.21*	*0.12*	*2.46*	*0.11*
PREMO PREGS & COLRWB						*0.40*	*0.30*	*4.01*	*0.02*
PREMO PREGI & COLRWB						*0.39*	*0.29*	*3.84*	*0.03*
PREGS PREGI & COLRWB						*0.25*	*0.13*	*2.02*	*0.15*
PREMO PREGS PREGI & COLRWB						0.42	0.28	3.05	0.05

Here, the additional amount of variance in clients' scores on POSTGI accounted for by adding the following is significantly > 0 at the 0.05 level: 1. COLRWB to (PREMO, PREGS, and PREGI) *[+RH 09]*, 2. PREMO to (PREGS, PREGI, and COLRWB), and 3. both (PREMO and COLRWB) to both (PREGS and PREGI) *[+RH 09]*. No other additions are significantly > 0 at the 0.05 level.

No other model of various combinations of clients scores on the HDI pre-treatment, PREMO, PREGS, and PREGI with COLSWB or subscales of COLSWB, namely, COLRWB and COLEWB, significantly impact clients' scores on Global Impairment post-treatment, POSTGI, at the 0.05 level or better, (e.g., 0.01 level). See Table in Appendix E for a summary comparison of the results multiple regression analysis of various models entertained for the present study.

In general, then, as was the case with POSTMO and POSTGS, neither COLSWB *[~RH 03]*, nor subscales of COLSWB, namely, COLRWB *[~RH 09]* or COLEWB *[~RH 06]*, in and of themselves account for variance in clients' scores on POSTGI at level of 0.05 or better. However, unlike with POSTMO and POSTGS, COLRWB and COLEWB taken together did account for a significant amount of variance in clients' scores on POSTGI at the 0.05 level or better, namely, 23% of variance at the 0.03 level *[+SRH 15]*.

Further, as was the case with clients' scores on POSTMO and POSTGI; since, both COLSWB and COLRWB are negatively related to POSTGI, (i.e., as counselors' scores on COLSWB and COLRWB increase, clients' scores on POSTGI decrease), indicating that insofar as they account for variance in clients' scores on POSTGI, increase in either COLSWB or COLRWB correlates with decrease in client impairment post-treatment. Both COLSWB and COLRWB in and of themselves, then, are related to POSTGI in a way that would be expected if

increased COLSWB or COLRWB yielded better client outcomes as measured by the Health Dynamics Inventory (HDI).

On the other hand, unlike what was the case with respect to clients' scores on POSTMO and POSTGS, COLEWB, in and of itself, is not related to POSGI in a way that would be expected if increased COLEWB yielded better client outcomes *[+RH 12]*. Since COLEWB is positively correlated with clients' POSTGI scores. These relationships remained the same regardless of model used, (i.e., regardless of the combination of predictor variables used in a model).

As was the case for both POSTMO and POSGS, the variance in clients' scores on POSTGI accounted for clients' scores on PREGS in and of itself was not significant at the 0.05 level or better. Further, as was the case for POSTGS but not the case with POSGTMO neither was the variance in clients' scores on POSTGI accounted for by clients' scores on PREGI in and of itself. Unlike what was the case for both POSTMO and POSTGS, however, the amount of variance in clients' scores on POSTGI accounted for by clients' scores on PREMO in and of itself was significant at the 0.05 level or better. More specifically, clients' scores on PREMO in and of itself accounted for 14% of the variance in their scores on POSTGI at the 0.05 level.

There was a positive relationship between clients' scores on PREMO and their scores on POSTGI indicating that the higher clients score on PREMO, which is to say, the better they are with respect to Morale pre-treatment, the higher their scores on POSTGI, which is to say, the worse they are with respect to Global Impairment, (i.e., more impaired in functioning they are), post-treatment. Further, clients' scores on both PREGS and PREGI are negatively related with their scores on POSTGI indicating that the better they are with respect to Global

Symptoms, (i.e., the fewer symptoms they have), and Global Impairment, (i.e., the less impaired their functioning is), pre-treatment the worse they are with respect to Global Impairment, (i.e., the more impaired their functioning is), post-treatment. Consequently, as was the case for clients' scores on POSTGS, for all the scales of the HDI the better clients were with respect to what they measure, (e.g., Morale, Global Symptoms, and Global Impairment), pre-treatment the worse they are with respect to POSTGI. This seems counterintuitive.

On the other hand, this was not the case with respect to clients' scores on POSTMO, since both PREMO and PREGS were positively correlated with POSTMO whereas PREGI was negatively correlated with POSTMO. Consequently, it can be concluded that, to the extent that clients' scores on the HDI pre-treatment impact their scores on POSTMO, the following can be said: 1. The better clients are with respect to Morale, (i.e., the higher their Morale), pre-treatment, the better they will be with respect to Morale post-treatment, 2. The better clients are with respect to Global Impairment, (i.e., the less impaired their functioning), pre-treatment, the better they are with respect to Morale post-treatment, and finally, 3. The worse clients are with respect to Global Symptoms, (i.e., the more symptoms they have and/or the greater the intensity of their symptoms), pre-treatment, the better they are with respect to Morale post-treatment.

As was the case with POSTMO and POSTGS, when COLSWB, COLRWB, COLEWB, or COLRWB together with COLEWB controlled for by clients' scores pre-treatment on the relevant HDI scale, in this case, PREGI, neither COLSWB *[~RH 03]* nor any aspect of COLSWB, namely, COLRWB *[~RH 09]* and COLEWB *[~RH 06]*, individually or together *[~SRH 15]* significantly impact clients' scores on POSTGI at the 0.05 level or better.

However, unlike what was the case for both POSTMO and POSTGS when controlling for clients' score on the relevant HDI scale, (e.g., PREMO and PREGS), when the combination of COLRWB and COLEWB was controlled for by clients' scores on PREGI, the amount of variance in clients' scores on POSTGI accounted for by COLRWB all things considered was significant at the 0.03 level *[+RH 09]*. Further, the additional amount of variance in clients' scores on POSTGI by adding COLRWB to (PREGI and COLEWB) is significantly > 0 at the 0.05 level *[+RH 09]*, though, the additional amount of variance in clients' scores on POSTGI accounted for by adding both COLRWB and COLEWB to PREGI *[+SRH 15]*, is not significantly > 0 at the 0.05 level.

Finally, it is worth noting here that PREGI is negatively related to POSTGI when taken together with COLSWB, COLRWB, COLEWB as well as when taken together with both COLRWB and COLEWB indicating that the better clients are with respect to Global Impairment, (i.e., the less impaired their functioning is), pre-treatment (PREGI) the worse they are with respect to Global Impairment, (i.e., the more impaired their functioning is), post-treatment (POSTGI). This seems counterintuitive. However, this relationship between PREGI and POSTGI was not maintained in all models (see Tables 36, 37, and 39 above).

With respect to Morale, the variance in clients' scores on POSTMO accounted for by their scores on PREMO was not significant at the 0.05 level or better whereas their scores on PREGI accounted for 15% of the variance in their scores on POSTMO at the 0.04 level. Similarly, with respect to POSTGI, the variance in clients' scores on POSTGI accounted for by their scores on PREGI was not significant at the 0.05 level or better whereas their scores on PREMO accounted for 14% of the variance in their scores on POSTGI at the 0.05 level.

However, unlike what was the case with respect to POSTMO, where the amount of variance accounted for in clients' scores on POSTMO by the combination of COLSWB, COLRWB, and both COLRWB and COLEWB with PREGI, [e.g., PREGI and COLSWB, PREGI and COLRWB, and PREGI and both (COLEWB and COLRWB)], was not significant at the 0.05 level or better, the amount of variance in clients' score on POSTGI accounted for by the combination of COLSWB and PREMO *[+RH 03]*, 22%, COLRWB and PREMO *[+RH 09]*, 32%, and both (COLRWB and COLEWB) and PREMO *[+SRH 15]*, 32%, was significant at the 0.05 level or better, namely, 0.03, 0.01, and 0.02 respectively. Further, significance at the 0.05 level or better was maintained for COLRWB and PREMO *[+RH 09]* as well as both (COLRWB and COLEWB) and PREMO *[+RH15]*, namely, 0.03 and 0.05 respectively, when controlled for by clients' scores on PREGI as well as clients' scores on PREGS, namely, for the latter, 0.02 and 0.04 respectively.

Finally, a trend emerges when considering these models, [e.g., PREMO and COLRWB; PREMO and both (COLRWB and COLEWB); PREMO, PREGI, and COLRWB; PREMO, PREGI, and both (COLRWB and COLEWB); PREMO, PREGS, and COLRWB; and PREMO, PREGS and both (COLRWB and COLEWB)], which is this: The only factor/variable which is such that: 1. The amount of variance in clients' scores on POSTGI accounted for by it all things considered is significant at the 0.05 level or better; *and,* 2. The additional amount of variance in clients' scores on POSTGI accounted for by its addition is significantly > 0 at the 0.05 level or better, in all of the models is COLRWB *[+RH 09]*. Notably, COLRWB also has these qualities when controlled for by clients' scores on all of the scales of the HDI pre-treatment, (e.g., PREMO, PREGS, and PREGI) *[+RH 09]*.

Summary

Neither COLSWB, nor subscales of COLSWB, namely, COLRWB or COLEWB in and of themselves account for variance in clients' scores on Morale post-treatment (POSTMO) *[~RH 01, ~RH 07, and ~RH 04, respectively]* or Global Symptoms post-treatment (POSTGS) *[~RH 02, ~RH 08, and ~RH 05 respectively]* at a significant level of 0.05 or better. Nor do COLRWB and COLEWB taken together for either POSTMO *[~SRH 13]* or POSTGS *[~RH 14]*. Further, neither COLSWB nor COLRWB or COLEWB account for a significant amount of variance in clients' POSTMO scores *[again, ~RH 01, ~RH 07, and ~RH 04, respectively]* or clients' POSTGS scores *[~RH 02, ~RH 08, and ~RH 05, respectively]* as components of a model all thing considered when combined with one or more of clients' pre-treatment scores on the HDI, namely, PREMO, PREGS, or PREGI. Nor do COLRWB and COLEWB taken together for either POSTMO *[~SRH 13]* or POSTGS *[~RH 14]*. Finally, neither the additional amount of variance accounted for in clients' scores on POSTMO *[~RH 01, ~RH 07, and ~RH 04, respectively; and ~SRH 13]* or clients' scores on POSTGS *[~RH 02, ~RH 08, and ~RH 05, respectively as well as ~SRH 14]* by the inclusion of either COLSWB, COLRWB, COLEWB, or both COLRWB and COLEWB, in any model in which they are so combined, is significantly > 0 at the 0.05 level or better.

However, all three have a positive relationship with POSTMO, (i.e., as COLSWB, COLRWB, or COLEWB increase, clients' Morale post-treatment increases), and a negative relationship with POSTGS, (i.e., as COLSWB, COLRWB, or COLEWB increase the number and/or intensity of symptoms clients experience post-treatment decrease), which would be expected if increased COLSWB and/or aspects of COLSWB, namely, COLRWB and COLEWB, yielded better client outcomes as measured by the Health Dynamics Inventory (HDI); with the

exception of COLEWB *[+RH 11]* when it is included in a model with COLRWB with respect to POSTGS.

As with POSTMO and POSTGS, neither COLSWB *[~RH 03]*, nor subscales of COLSWB, (e.g., COLRWB *[~RH 09]* or COLEWB *[~RH 06])*, in and of themselves account for variance in clients' scores on POSTGI at level of 0.05 or better. However, unlike with POSTMO and POSTGS, COLRWB and COLEWB taken together did account for a significant amount of variance in clients' scores on POSTGI at the 0.05 level or better, namely, 23% of variance at the 0.03 level *[+SRH 15]*.

Further, as was the case with clients' scores on POSTMO and POSTGS; since, both COLSWB and COLRWB are negatively related to POSTGI, (i.e., as counselors' scores on COLSWB and COLRWB increase, clients' scores on POSTGI decrease), indicating that insofar as they account for variance in clients' scores on POSTGI, increase in either COLSWB or COLRWB correlates with decrease in client impairment post-treatment. Both COLSWB and COLRWB in and of themselves, then, are related to POSTGI in a way that would be expected if increased COLSWB or COLRWB yielded better client outcomes as measured by the Health Dynamics Inventory (HDI). Unlike what was the case with respect to clients' scores on POSTMO and POSTGS, however, COLEWB, in and of itself, is not related to POSGI in a way that would be expected if increased COLEWB yielded better client outcomes *[+RH 12]*. Since COLEWB is positively correlated with clients' POSTGI scores. These relationships remained the same regardless of model used, (i.e., regardless of the combination of predictor variables used in a model).

As with POSTMO and POSTGS, when COLSWB, COLRWB, COLEWB, or COLRWB together with COLEWB controlled for by clients' scores pre-treatment on the relevant HDI scale, in this case, PREGI, neither COLSWB *[~RH 03]* nor any aspect of COLSWB, namely, COLRWB *[~RH 09]* and COLEWB *[~RH 06]*, individually or together *[~SRH 15]* significantly impact clients' scores on POSTGI at the 0.05 level or better. However, unlike what was the case for both POSTMO and POSTGS when controlling for clients' scores on the relevant HDI scale, (e.g., PREMO and PREGS), when the combination of COLRWB and COLEWB was controlled for by clients' scores on PREGI, the amount of variance in clients' scores on POSTGI accounted for by COLRWB all things considered was significant at the 0.03 level *[+RH 09]*. Further, the additional amount of variance in clients' scores on POSTGI by adding COLRWB to (PREGI and COLEWB) is significantly > 0 at the 0.05 level *[+RH 09]*, though, the additional amount of variance in clients' scores on POSTGI accounted for by adding both (COLRWB and COLEWB) to PREGI *[+SRH 15]*, however, is not significantly > 0 at the 0.05 level.

With respect to Morale, the variance in clients' scores on POSTMO accounted for by their scores on PREMO was not significant at the 0.05 level or better whereas their scores on PREGI accounted for 15% of the variance in their scores on POSTMO at the 0.04 level. Similarly, with respect to POSTGI, the variance in clients' scores on POSTGI accounted for by their scores on PREGI was not significant at the 0.05 level or better whereas their scores on PREMO accounted for 14% of the variance in their scores on POSTGI at the 0.05 level. However, unlike what was the case with respect to POSTMO, where the amount of variance accounted for in clients' scores on POSTMO by the combination of COLSWB, COLRWB,

and both COLRWB and COLEWB with PREGI, (e.g., PREGI and COLSWB, PREGI and COLRWB, and PREGI and both (COLEWB and COLRWB), was not significant at the 0.05 level or better, the amount of variance in clients' score on POSTGI accounted for by the combination of COLSWB and PREMO *[+RH 03]*, 22%, COLRWB and PREMO *[+RH 09]*, 32%, and both (COLRWB and COLEWB) and PREMO *[+SRH 15]*, 32%, was significant at the 0.05 level or better, namely, 0.03, 0.01, and 0.02 respectively. Further, significance at the 0.05 level or better was maintained for COLRWB and PREMO *[+RH 09]* as well as both (COLRWB and COLEWB) and PREMO *[+RH15]*, namely, 0.03 and 0.05 respectively, when controlled for by clients' scores on PREGI as well as clients' scores on PREGS, namely, for the latter, 0.02 and 0.04 respectively.

Finally, it should be noted here that a trend emerges when considering these models, [e.g., PREMO and COLRWB; PREMO and both (COLRWB and COLEWB); PREMO, PREGI, and COLRWB; PREMO, PREGI, and both (COLRWB and COLEWB); PREMO, PREGS, and COLRWB; and PREMO, PREGS and both (COLRWB and COLEWB)], which is this: COLRWB is the only predictor which is such that, for each model in which it is a predictor:

1. The amount of variance in clients' scores on POSTGI accounted for by it all things considered is significant at the 0.05 level or better *[+RH 09]*; *and,*
2. The additional amount of variance in clients' scores on POSTGI accounted for by its addition is significantly > 0 at the 0.05 level or better, *[+RH 09]*.

In addition to the aforementioned trend, it is worth noting here that COLRWB has these qualities when controlled for by clients' scores on all of the scales of the HDI pre-treatment, (e.g., PRGMO, PREGS, and PREGI) *[+RH 09]*.

Hypotheses

The underlying question of the present study is that of whether the level of counselors' spiritual well-being significantly impacts client outcomes. The underlying answer that characterizes all of the hypotheses of this study is "yes." Here, Counselor Level of Spiritual Well-Being is defined in terms of counselors' scores on the Spiritual Well-Being Scale (SWBS) which has 3 scales/subscales, namely, overall Spiritual Well-Being (COLSWB) which consists of the summation of scores on 2 subscales, Religious Well-Being (COLRWB) and Existential Well-Being (COLEWB). Further, client outcomes are defined in terms of their post-treatment scores on the Health Dynamics Inventory (HDI) which consists of 3 scales, namely, Morale (POSTMO), Global Symptoms (POSTGS), and Global Impairment (POSTGI). For each of the outcome measures on the HDI, (e.g., POSTMO, POSTGS, and POSTGI), then, the underlying question can be answered in two ways: 1. with respect to counselors' scores on the SWBS in and of themselves; *and*, 2. with respect to some combination of counselors' scores on the SWBS and clients' scores on the HDI pre-treatment, (e.g., PREMO, PREGS, and PREGI). Consequently, to determine whether the answer to the underlying question is "yes," two questions need to be answered:

1. Do the results of the data analysis with respect to counselors' scores on the SWBS in and of themselves, [(e.g., ***either*** COLSWB only, COLRWB only, COLEWB only, ***or*** both (COLRWB and COLEWB) taken together only], support a "yes" answer to the aforementioned underlying question for clients' scores on the HDI post-treatment, (e.g., ***either*** POSTMO, POSTGS, ***or*** POSTGI)?
2. Do the results of the data analysis with respect to some combination of counselors' scores on the SWBS and clients' scores on the HDI pre-treatment, [e.g., ***either*** COLSWB and PREMO, COLSWB and PREGS, COLSWB and PREGI, COLSWB and both (PREMO

and PREGS), COLSWB and both (PREMO and PREGI), COLSWB and both (PREGS and PREGI), COLRWB and PREMO, ***or*** etc.], support a "yes" answer to the aforementioned underlying question for clients' scores on the HDI post-treatment, (e.g., ***either*** POSTMO, POSTGS, ***or*** POSTGI)?

Here, 3 things should be noted:

1. If the answer to either of the questions above is "yes," then the answer to the underlying question is "yes."
2. The word "or" in these questions is being used in its ***inclusive*** sense, (i.e., "at least "one," such that a disjunctive statement is true if at least one of its disjuncts is true). So, the answer to the 1st question is "yes" if and only if the answer to at least one of the following questions is "yes":

    1.a. Do the results of the data analysis with respect to counselors' scores on the SWBS in and of themselves, [e.g., ***either*** COLSWB only, COLRWB only, COLEWB only, ***or*** both (COLRWB & COLEWB) taken together only], support a "yes" answer to the aforementioned underlying question for clients' scores on POSTMO?

    1.b. Do the results of the data analysis with respect to counselors' scores on the SWBS in and of themselves, [e.g., ***either*** COLSWB only, COLRWB only, COLEWB only, ***or*** both (COLRWB & COLEWB) taken together only], support a "yes" answer to the aforementioned underlying question for clients' scores on POSTGS?

    1.c. Do the results of the data analysis with respect to counselors' scores on the SWBS in and of themselves, [e.g., ***either*** COLSWB only, COLRWB only, COLEWB only, ***or*** both (COLRWB and COLEWB) taken together only], support a "yes" answer to the aforementioned underlying question for clients' scores on POSTGI?

And, the answer to the 2nd question is "yes" if and only if the answer to at least one of the following questions is "yes"

2.a. Do the results of the data analysis with respect to some combination of counselors' scores on the SWBS and clients' scores on the HDI pre-treatment, [e.g., ***either*** COLSWB and PREMO, COLSWB and PREGS, COLSWB and PREGI, COLSWB and both (PREMO and PREGS), COLSWB and both (PREMO and PREGI), COLSWB and both (PREGS and PREGI), COLRWB and PREMO, ***or*** etc.], support a "yes" answer to the aforementioned underlying question for clients' scores on POSTMO?

2.b. Do the results of the data analysis with respect to some combination of counselors' scores on the SWBS and clients' scores on the HDI pre-treatment, [e.g., ***either*** COLSWB and PREMO, COLSWB and PREGS, COLSWB and PREGI, COLSWB and both (PREMO and PREGS), COLSWB and both (PREMO and PREGI), COLSWB and both (PREGS and PREGI), COLRWB and PREMO, ***or*** etc.], support a "yes" answer to the aforementioned underlying question for clients' scores on POSTGS?

2.c. Do the results of the data analysis with respect to some combination of counselors' scores on the SWBS and clients' scores on the HDI pre-treatment, [e.g., ***either*** COLSWB and PREMO, COLSWB and PREGS, COLSWB and PREGI, COLSWB and both (PREMO and PREGS), COLSWB and both (PREMO and PREGI), COLSWB and both (PREGS and PREGI), COLRWB and PREMO, ***or*** etc.], support a "yes" answer to the aforementioned underlying question for clients' scores on POSTGI?

*Finally, because the **inclusive** sense of **"or"** is being used here it follows that:*

The answer to question *1.a.* is "yes" *if and only if* at least one of the following is true:

1. a-1: The results of data analysis supports the claim that there is a significant relationship between COLSWB and POSTMO *[RH 01]*,
1. a-2: The results of data analysis supports the claim that there is a significant relationship between COLEWB and POSTMO *[RH 04]*,
1. a-3: The results of data analysis supports the claim that there is a significant relationship between COLRWB and POSTMO *[RH 07]*,
1.a-4: The results of data analysis supports the claim that there is a significant relationship between both (COLEWB & COLRWB) and POSTMO *[SRH 13]*,

The answer to question *1.b.* "yes" *if and only if* at least one of the following is true:

1. b-1: The results of data analysis supports the claim that there is a significant relationship between COLSWB and POSTGS *[RH 02]*,
1. b-2: The results of data analysis supports the claim that there is a significant relationship between COLEWB and POSTGS *[RH 05]*,
1. b-3: The results of data analysis supports the claim that there is a significant relationship between COLRWB and POSTGS *[RH 08]*,
1. b-4: The results of data analysis supports the claim that there is a significant relationship between both (COLEWB & COLRWB) and POSTGS *[SRH 14]*,

The answer to question *1.c.* "yes" *if and only if* at least one of the following is true:

1. c-1: The results of data analysis supports the claim that there is a significant relationship between COLSWB and POSTGI *[RH 03]*,

1. c-2: The results of data analysis supports the claim that there is a significant relationship between COLEWB and POSTGI *[RH 06]*,

1. c-3: The results of data analysis supports the claim that there is a significant relationship between COLRWB and POSTGI *[RH 09]*,

1. c-4: The results of data analysis supports the claim that there is a significant relationship between both (COLEWB *&* COLRWB) and POSTGI *[SRH 15]*,

The answer to the *2.a.* "yes" *if and only if* at least one of the following is true:

2. a-1: The results of data analysis supports the claim that there is a significant relationship between [COLSWB **&** (PREMO, PREGS, *or* PREGI)] and POSTMO *[RH 01]*,

2. a-2: The results of data analysis supports the claim that there is a significant relationship between [COLEWB **&** (PREMO, PREGS, *or* PREGI)] and POSTMO *[RH 04]*,

2. a-3: The results of data analysis supports the claim that there is a significant relationship between [COLRWB **&** (PREMO, PREGS, *or* PREGI)] and POSTMO *[RH 07]*,

2. a-4: The results of data analysis supports the claim that there is a significant relationship between [(COLEWB *&* COLRWB) **&** (PREMO, PREGS, *or* PREGI)] and POSTMO *[SRH 13]*,

The answer to the *2.b.* "yes" *if and only if* at least one of the following is true:

2. b-1: The results of data analysis supports the claim that there is a significant relationship between [COLSWB **&** (PREMO, PREGS, *or* PREGI)] and POSTGS *[RH 02]*,

2. b-2: The results of data analysis supports the claim that there is a significant relationship between [COLEWB **&** (PREMO, PREGS, *or* PREGI)] and POSTGS *[RH 05]*,

2. b-3: The results of data analysis supports the claim that there is a significant relationship between [COLRWB **&** (PREMO, PREGS, *or* PREGI)] and POSTGS *[RH 08]*,

2. b-4: The results of data analysis supports the claim that there is a significant relationship between [(COLEWB *&* COLRWB) **&** (PREMO, PREGS, *or* PREGI)] and POSTGS *[SRH 14]*,

The answer to the *2.c.* "yes" *if and only if* at least one of the following is true:

2. c-1: The results of data analysis supports the claim that there is a significant relationship between [COLSWB **&** (PREMO, PREGS, *or* PREGI)] and POSTGI *[RH 03]*,

2. c-2: The results of data analysis supports the claim that there is a significant relationship between [COLEWB **&** (PREMO, PREGS, *or* PREGI)] and POSTGI *[RH 06]*,

2. c-3: The results of data analysis supports the claim that there is a significant relationship between [COLRWB **&** (PREMO, PREGS, *or* PREGI)] and POSTGI *[RH 09]*,

2. c-4: The results of data analysis supports the claim that there is a significant relationship between [(COLEWB *&* COLRWB) **&** (PREMO, PREGS, *or* PREGI)] and POSTGS *[SRH 13]*,

3. The results of data analysis supports the claim that there is a significant relationship between counselors' scores on the SWBS, [e.g., COLSWB, COLEWB, COLRWB, *or* both (COLEWB & COLRWB)], and clients' scores on the HDI post-treatment, (e.g., POSTMO, POSTGS, *or* POSTGI), if and only if at least one of the following, (e.g., a, b, or c below), is true for any model in which counselor's scores on the SWBS are considered in and of themselves; *or*, both [a & (b or c)] are true for any model in which counselors' score on the SWBS are considered in combination with at least one of clients' scores on the HDI pre-treatment, (e.g., PREMO, PREGS, or PREGI):
    a. The predictor(s) in the model account for variance in clients' scores on the HDI post-test at a significance level of 0.05 or better,
    b. As a factor in a model counselors' scores on the SWBS account for variance in clients' scores on the HDI post-test at a significance level of 0.05 or better all things considered, (i.e., holding all other factors equal),
    c. The amount of additional variance in clients' scores on the HDI post-treatment accounted for by adding counselors' scores on the SWBS is significantly > 0 at the 0.05 level or better.

For *clients' scores on Morale post-treatment*, I hope it is apparent from what I have set forth in this chapter that 1.a-1 through 1.a-4, and 2.a-4 are false because, for each of them, neither 3a, 3b, or 3c are true. 3a is true for 2.a-1 for the model with PREGS, PREGI, and COLSWB as predictors, (Table 15, p. 86); 2.a-3 for the model with PREGS, PREGI, and COLRWB as predictors (Table 16, p. 87); and, 2.a-2 for the model with PREGS, PREGI, and COLEWB as predictors (Table 17, p. 88). However, neither 3b nor 3c are true for these models. Consequently, 2.a-1 through 2.a-3 are false also. Since 1.a-1 through 1.a-4 and 2.a-1 through

2.a-4 are false, the answer to both questions 1a and 2a is "no." The results of data analysis, then, do not support the claim that there is a significant relationship between counselors' scores on the SWBS and clients' scores on Morale post-treatment (POSTMO).

For clients' scores on *Global Symptoms* post-treatment, I hope it is apparent from what I have set forth here that neither 3a, 3b, or 3c are true for 1.b-1 through 1.b-4 and 2.b-1 through 2.b-4. Hence, 1.b-1 through 1.b-4 and 2.b-1 through 2.b-4 are all false. Since 1.b-1 through 1.b-4 and 2.b-1 through 2.b-4 are all false, the answer to both questions 1b and 2b is "no." The results of data analysis, then, do not support the claim that there is a significant relationship between counselors' scores on the SWBS and clients' scores on Global Symptoms post-treatment (POSTGS).

For clients' scores on both *Morale and Global Symptoms post-treatment,* then, the results of data analysis do not support a "yes" answer to the underlying question of the present study, which is to say, do not provide support for the claim that counselors' spiritual well-being significantly impacts client outcomes. For clients' scores on *Global Impairment* post-treatment, however, the results of data analysis yields a different conclusion both with respect to counselors' scores on the SWBS in and of themselves and in combination with clients' scores on the HDI pre-treatment. Let us, then, consider these in turn.

For counselors' scores on the SWBS in and of themselves, I hope it is apparent from what I have set forth here that neither 3a, 3b, or 3c are true for 1.c-1 through 1.c-3. Hence, 1.c-1 through 1.c-3 are false (see Table 25, p. 95). However, 3a is true for 1.c-4 (see Table 26, p.96). Hence, 1.c-4 is true. Consequently, the answer to question 1.c., and therefore, the question underlying the present study, is "yes."

For counselors' scores on the SWBS when combined with clients' scores on the HDI pre-treatment, I hope the following is apparent from what I have set forth above.

With respect to all models in which COLSWB is combined with one or more of PREMO, PREGS, or PREGI, the only model for which 3a is true, namely, the model with COLSWB and PREMO are predictors (see Table 32, p. 101). However, both 3b, and 3c are false for this model indicating that it is not so much COLSWB as PREMO that plays a significant role in the amount of variance in clients' scores on POSTGI. It follows that 2.c-1 is false.

Similarly, with respect to all models in which COLEWB is combined with one or more of PREMO, PREGS, or PREGI, the only models for which 3a is true are the models with the following predictors: PREMO, COLEWB, and COLRWB, (Table 34, p. 102); PREMO, PREGI, COLEWB, and COLRWB, (Table 36, p. 104); and, PREMO, PREGS, COLEWB, and COLRWB, (Table 38, p. 106). For all of these models, however, both 3b and 3c are false for COLEWB indicating that it is not so much COLEWB as it is the other predictors in these models that play a significant role in the amount of variance accounted for in clients' scores on POSTGI. It follows that 2.c-2 is false.

However, with respect to all of the models above for which 3a is true and both 3b and 3c are false for COLEWB, not only is 3a true, but also, 3b and 3c are true for COLRWB as well indicating that COLRWB plays a significant role in the amount of variance accounted for in clients' scores on POSTGI in these models. Further, in addition to these models, 3a is true for models with the following predictors as well as both 3b and 3c for COLRWB as a predictor in these models: PREMO and COLRWB, (Table 33, p. 101); PREMO, PREGI, and COLRWB, (Table 35, p. 103); PREMO, PREGS, and COLRWB, (Table 37, p. 105); and, PREMO, PREGS, PREGI, and COLRWB (Table 39, p. 108); again indicating that COLRWB plays a significant role in the amount of variance in clients' scores on POSTGI in these models. Therefore, 2.c-3 is true. Consequently, the answer to question 2.c, and therefore the underlying question in the present study, is "yes."

Finally, for both (COLEWB and COLRWB) taken together 3a is true for models with the following predictors: both (COLEWB, and COLRWB) and PREMO, (Table 34, p. 102); both (COLEWB and COLRWB), and PREMO, as well as PREGI, (Table 36, p. 104); and, both (COLEWB and COLRWB), and PREMO, as well as PREGS, (Table 38, p. 106). However, 3c is true for only the model with both (COLEWB and COLRWB) and PREMO, as predictors. There are no results for 3b in these cases. In any case, it follows that 2.c-4 is true. Consequently, the answer to question 2.c, and therefore, the underlying question in the present study, is "yes."

Since 3a is true for 1.c-4, 1.c-4 is true. Since 1.c-4 is true, it follows that the answer to question 1c is "yes," which is to say, counselors' scores on the SWBS in and of themselves significantly impact clients' scores on Global Impairment post-treatment. Further, since 2.c-3 is true the answer to question 2c is "yes." Also, since 2.c-4 is true, the answer to question 2c is "yes." To say the answer to question 2c is "yes" is to say counselors' scores on the SWBS combined with clients' scores on the HDI pre-treatment significantly impact clients' scores on Global Impairment post-treatment (POSTGI). So, counselors' scores on the SWBS, both in and of themselves and in combination with clients' scores on the HDI pre-treatment, significantly impact clients' scores on Global Impairment post-treatment (POSTGI). The results of data analysis, then, support the claim that there is a significant relationship between counselors' scores on the SWBS and clients' scores on Global Impairment post-treatment (POSTGI). The results of data analysis, then, provide support for answering the underlying question of the study "yes." In general, then, whereas, for clients' scores on both *Morale and Global Symptoms post-treatment*, the results of data analysis do not support a "yes" answer to the underlying question of the present study, for clients' scores on *Global Impairment post-treatment* the results do, which is to say, provide support for the claim that counselors' spiritual well-being significantly impacts client outcomes.

Conclusion

Again, the underlying question of the present study is that of whether counselors' level of spiritual well-being, (e.g., COLSWB, COLEWB, and/or COLRWB), significantly impacts client outcomes, (e.g., POSTMO, POSTGS, and/or POSTGI). *Well, then, does it?* The results of the data analysis here support answering this question with "yes," but with qualifications. What qualifications? There are 3 qualifications and they are as follows:

1. Counselors' level of spiritual well-being significantly impacts client outcomes for global impairment (POSTGI) only,
2. The aspect of counselor level of spiritual well-being that significantly impacts clients' outcome on POSTGI is COLRWB,
3. COLRWB significantly impacts clients' outcomes on POSTGI if and only if either it is combined with at least one additional predictor other than PREGI or PREGS; *or,* it is combined with PREMO and at least one additional predictor; which is to say, models with the following predictors:
    i. Both (COLRWB & COLEWB), *[+RH 09, +SRH 15 and ~RH 06]*;
    ii. COLRWB and PREMO *[+RH 09]*;
    iii. Both (COLRWB & COLEWB), and PREMO *[+RH 09, +SRH 15, ~RH 06]*;
    iv. COLRWB, PREMO, and PREGI, *[+RH 09]*;
    v. COLRWB, COLEWB, PREMO, and PREGI, *[+RH 09, ~RH 06, ~SRH 15]*;
    vi. COLRWB, PREMO, and PREGS, *[+RH 09]*;
    vii. COLRWB, COLEWB, PREMO, and PREGS, *[+RH 09, ~RH 06, ~SRH 15]*;
    viii. And finally, COLRWB, PREMO, PREGS, and PREGI, *[+RH 09]*.

Finally, a pattern or trend that emerges from these models is worth reiterating here. COLRWB is the only predictor in all these models which is such that:

1. The amount of variance in clients' scores on POSTGI accounted for by it all things considered is significant at the 0.05 level or better; *and,*
2. The additional amount of variance in clients' scores on POSTGI accounted for by its addition is significantly > 0 at the 0.05 level or better.

Table 40 below is a summary multiple regression table for all models for which counselor spiritual well-being significantly impacted client outcomes. As with previous tables, R^2, Adj. R^2, F value, and Pr > F is given in *italics* for variables in the model. Unlike previous tables, however, combinations of variables in the model are not given. Rather, in addition to *B,* SE *B,* t Value, Pr > |t|, Beta for each variable, its Uniqueness Index, $U_{VARIABLE}$, as well as an indication immediately prior to the numerical value of U is given concerning whether U is "+" or is not "~" significantly > 0 at the 0.05 level. In addition to these the uniqueness index for COLRWB and COLEWB together, $U_{EWB\ \&\ RWB}$, is given where appropriate. It is hoped that with this information the aforementioned pattern/trend will be apparent.

As has been shown above, the only outcome measure on the HDI for which counselors' scores on the SWBS significantly impacted clients' scores on the HDI post-treatment was Global Impairment (POSTGI). Consequently, for all models presented in Table 40 the variables are predictors of POSTGI. Finally, it is worth noting here that that models are presented in descending order from greatest to least amount of variance, Adj. R^2, accounted in clients' scores on POSTGI by the models.

Table 40

Summary of Multiple Regression Analysis for Models in which Counselor Spiritual Well-Being significantly impacts Client Outcomes[*]

Variables	*B*	SE *B*	t Value	Pr > |t|	Beta	R^2	Adj. R^2	F Value	Pr > F	$U_{VARIABLE}$	$U_{(RWB\ \&\ EWB)}$
COLRWB,	-0.45	0.18	-2.58	0.02	-0.60	*0.15*	*0.11*	*3.61*	*0.07*	+ 21% [***]	
COLEWB,	0.20	0.20	0.96	0.35	0.25	*0.00*	*-0.05*	*0.08*	*0.78*	~ 2%	+ 23%
& PREMO	0.60	0.32	1.87	0.08	0.39	*0.18*	*0.14*	*4.29*	*0.05*	~ 11%	
MODEL						**0.41**	**0.32**	**4.25**	**0.02**		
COLRWB,	-0.35	0.14	-2.54	0.02	-0.46	*0.15*	*0.11*	*3.61*	*0.07*	+ 21%	na
& PREMO	0.74	0.28	2.68	0.01		*0.18*	*0.14*	*4.29*	*0.05*	+ 24%	
MODEL						**0.39**	**0.32**	**5.95**	**0.01**		
COLRWB,	-0.34	0.14	-2.42	0.03	-0.45	*0.15*	*0.11*	*3.61*	*0.07*	+ 20%	na
PREMO,	0.66	0.31	2.15	0.05	0.43	*0.18*	*0.14*	*4.29*	*0.05*	+ 15%	
& PREGS	-0.04	0.06	-0.68	0.51	-0.13	*0.10*	*0.06*	*2.27*	*0.15*	~ 1%	
MODEL						**0.40**	**0.30**	**4.01**	**0.02**		
COLRWB,	-0.43	0.19	-2.34	0.03	-0.57	*0.15*	*0.11*	*3.61*	*0.07*	+ 18%	
COLEWB,	0.17	0.22	0.79	0.44	0.22	*0.00*	*-0.05*	*0.08*	*0.78*	+ 2%	~ 22%
PREMO,	0.56	0.34	1.65	0.12	0.37	*0.18*	*0.14*	*4.29*	*0.05*	~ 9%	
& PREGS	-0.03	0.06	-0.44	0.66	-0.09	*0.10*	*0.06*	*2.27*	*0.15*	~ 1%	
MODEL						**0.42**	**0.29**	**3.10**	**0.04**		
COLRWB,	0.37	0.15	-2.41	0.03	-0.49	*0.15*	*0.11*	*3.61*	*0.07*	+ 20%	na
PREMO,	0.83	0.35	2.33	0.03	0.54	*0.18*	*0.14*	*4.29*	*0.05*	+ 18%	
& PREGI	0.07	0.18	0.38	0.71	0.09	*0.11*	*0.06*	*2.43*	*0.13*	~ 0%	
MODEL						**0.39**	**0.29**	**3.84**	**0.03**		
COLRWB,	-0.39	0.16	-2.47	0.02	-0.51	*0.15*	*0.11*	*3.61*	*0.07*	+ 21%	na
PREMO,	0.79	0.36	2.20	0.04	0.52	*0.18*	*0.14*	*4.29*	*0.05*	+ 17%	
PREGS,	-0.06	0.07	-0.91	0.38	-0.20	*0.10*	*0.06*	*2.27*	*0.15*	~ 3%	
& PREGI	0.14	0.20	0.72	0.48	0.19	*0.11*	*0.06*	*2.43*	*0.13*	~ 2%	
MODEL						**0.42**	**0.28**	**3.05**	**0.05**		
COLRWB,	-0.46	0.19	-2.48	0.02	-0.61	*0.15*	*0.11*	*3.61*	*0.07*	+ 22%	
COLEWB,	0.19	0.22	0.86	0.40	0.24	*0.00*	*-0.05*	*0.08*	*0.78*	~ 3%	~ 23%
PREMO,	0.64	0.42	1.52	0.15	0.42	*0.18*	*0.14*	*4.29*	*0.05*	~ 8%	
& PREGI	0.03	0.19	0.15	0.88	0.04	*0.11*	*0.06*	*2.43*	*0.13*	~ 1%	
MODEL						**0.42**	**0.28**	**3.02**	**0.05**		
COLRWB	-0.52	0.18	-2.84	0.01	-0.69	*0.15*[**]	*0.11*	*3.61*	*0.07*	+ 30%	Na
& COLEWB	0.38	0.19	2.01	0.06	0.49	*0.00*	*-0.05*	*0.08*	*0.78*	~ 15%	
MODEL						**0.30**	**0.23**	**4.09**	**0.03**		

***** COSWB significantly impacted client outcomes at the 0.05 level or better for only Global Impairment (POSTGI) scale of the HDI
** R^2, Adj. R^2, F Value, and Pr > F for each individual variable are in *italics.*
*** "+" indicates that U is significantly > 0 at the 0.05 level or better whereas "~" indicates the opposite.

CHAPTER FIVE: SUMMARY, CONCLUSIONS, AND IMPLICATIONS

Summary of the Study

Statement of the Problem

In recent years there has been a move in the health fields towards a holistic view of human nature (Cashwell, Bentley, & Bigbee, 2007; Matthews, 1998), resulting in the position that all dimensions of person, (e.g., physical, emotional, social, occupational, intellectual and spiritual), must be addressed to promote client well-being (Hawks, 1994; Morrison, Clutter, Prichett, & Demmitt, 2009). Of these aspects/dimensions, spirituality has received significantly less attention in the research than the others (Hawks, 1994; Thoresen & Harris, 2002; Young, Wiggins-Frame, & Cashwell, 2007) and this is true also in the field of counseling (Hickson, Housley, & Wages, 2000).

In recent years, in light of this holistic view of persons and an increased awareness of spirituality as a real phenomenon (Moberg, 2002; Pargament & Saunders, 2007), there has been renewed interest in spirituality in Counseling and Psychology (Gingrich & Worthington, 2007; *Matthews, 2004;* Moberg, 2002; Pargament & Sanders, 2007; Thoresen & Harris, 2002; Hawks, 1994; Watkins van Asselt & Baldo Sentock, 2009; Young, Cashwell, & Shcherbakova, 2000). Research has begun to establish a relationship between client/patient spirituality and well-being (Calicchia & Graham, 2006; Gray, 2006; Moberg, 2002; Nelson et al. 2009; Pargament & Saunders, 2007; Thoresen & Harris, 2002; Young et al., 2000) and spirituality is now accepted as part of the counseling process (ASERVIC, 2009; CACREP, 2009; Gingrich & Worthington, 2007; Myers & Williard, 2003) The Association for Spiritual, Ethical, and Religious Values in Counseling (ASERVIC, 2009) has published "Competences for Addressing Spiritual and Religious Issues in Counseling"(see Appendix A) that have been accepted by the American Counseling Association. Further, the standards of the Council for Accreditation of Counseling and Related Educational

Programs (CACREP) as cited in Morgan (2009) set forth the need to understand the role of spirituality in the process of recovery from addiction and counselors' understanding of the assessment of clients' spiritual histories. In addition, noting that referral of clients in treatment for addiction to 12-step groups such as Alcoholics Anonymous (AA) are a commonly recommended adjunct to therapy as there is empirical evidence that 12-step group attendance enhances therapeutic benefits and supports sobriety, and that spirituality is a cornerstone of 12-step groups, Cashwell, Clarke and Graves (2009) maintain that professional counselors' understanding of the role of spirituality in 12-step groups is essential. Further, according to Morrison et al. (2009), counselors need to include an assessment of their clients' spiritual issues/needs and that failure to address spiritual and religious issues in the counseling process is to ignore an essential aspect of clients' lives. This renewed interest in spirituality, then, naturally leads to questions concerning the nature and role(s) of spirituality in the counseling process (Pargament & Saunders, 2007).

ASERVIC (2009) reports counselors' actively exploring their beliefs, attitudes, and values about spirituality and/or religion and continuously evaluating how their spiritual and/or religious beliefs and values influence their clients and the counseling process as competencies for addressing spiritual and religious issues in counseling. Genia (2000) notes that counselors need to be reflective with respect to and aware of their own spiritual issues and be willing to grow spiritually to be productive in promoting clients' well-being. In addition, Chandler, Holden, and Kolander (1992) report that it is a spiritual axiom that counselors cannot help clients achieve what they have not achieved themselves. This view is not novel as Jung (1933) states, "The physician, then, is called upon himself to face the task which he wishes the patient to face. … . At all events the doctor must consistently try to meet his own therapeutic demands if he wishes to assure himself of a proper influence on his patient" (pp. 50-51). For Jung asks, "…, for who can educate

others while himself uneducated? Who can enlighten his fellows while still in the dark about himself, and who can purify if he himself is unclean?" (p. 51). In addition, MacDonald (2004) notes the view that counselors can be neutral with respect to value-laden issues, including spirituality, is an unfounded myth. The above suggests that a counselor's level spiritual well-being can impact his/her clients' outcomes. Well, then, does it? This is the central underlying question of the present study.

Despite an increased awareness of spirituality as a real phenomenon (Moberg, 2002; Pargament & Saunders, 2007), a renewed interest on the nature and role of spirituality in counseling (Hawks, 1994; Gingrich & Worthington, 2007; Matthews, 2004; Moberg, 2002; Pargament & Sanders, 2007; Thoresen & Harris, 2002; Watkins van Asselt & Baldo Sentock, 2009; Young et al., 2000), researchers maintaining the need for counselors to be aware of their own spiritual issues (Genia, 2000), and the need for counselors to achieve first what they ask of their clients according to Chandler et al. (1992) and Jung (1933), a thorough review of the literature revealed only one study (Brooks & Matthews, 2000) that has addressed the issue of the possible relationship between counselor level of spiritual well-being and client outcomes/well-being. Their study, however, addresses this issue only with respect to substance abuse counseling, adult clients who receive inpatient counseling, and then, only with respect to the relationship between counselor level of spiritual well-being and client level of spiritual well-being.

This study was done to begin to move toward filling this gap in the research by expanding on this research with respect to population, type of client, (e.g., substance abuse, mental health), level of intensity of treatment received, (e.g., outpatient, residential, etc.), as well as aspects of client well-being. More specifically, this study investigates whether there is a relationship between counselor level of spiritual well-being or aspects of counselor level of spiritual well-

being, (e.g., counselor level of existential well-being and counselor level of religious well-being), and client outcomes, (e.g., morale, global symptom, and global impairment), for adolescent clients receiving treatment for substance use and/or other mental health disorders at an agency in the Southern United States regardless of the level of intensity of treatment being received, (e.g., outpatient, intensive outpatient, residential, etc.).

Statement of the Procedures

An agency in the Southern United States provided contact information for 34 counselors who had clients discharge from counseling services within the past year in late November 2011. Counselors were mailed a letter requesting their participation in the study along with a demographic questionnaire (see Appendix B) and the Spiritual Well-Being Scale for them to fill out should they agree to participate in early December 2011 yielding 6 responses. A second request mailed in January of 2012 yielded an additional 9 responses by the end of March 2012 for a total of 15 and a response rate of 44%. The agency was able to provide complete client datasets (n = 38) with respect to 9 of the counselors who returned the survey.

Given the one year limit with respect to time elapsed between client discharge and the date counselors completed the survey and Spiritual Well-Being Scale (SWBS), 8 clients and 1 counselor were removed from the dataset leaving 8 counselors and 30 clients for a total of 30 client counselor pairings. Of the remaining 8 counselors, one counselor's score of 13/60 on the RWBS of the SWBS was more than 1 SD below the norms for the SWBS provided by Paloutzian & Ellison (2009) in the administration manual. In addition the next lowest score of the remaining counselors on the Religious Well-Being Scale was 42. This counselor's score of 13 on the Religious Well-Being Scale is over 7 standard deviations below the mean of 53.57 of the remaining counselors' scores on the Religious Well-Being Scale with a standard deviation of

6.19 (see Table 4, p. 78). Consequently this counselor and the clients associated with this counselor were excluded from the revised data set leaving 7 counselors and 22 clients for a total of 22 client counselor pairs in the final dataset.

According to Glass and Hopkins (1996), "Pearson correlation coefficient quantifies the magnitude and direction of the linear relationship between two variables" (p.106). Therefore Pearson product-moment correlation r was obtained to determine whether there is a relationship between counselor level of spiritual well-being as well as aspects of counselor level of spiritual well-being, (e.g., counselor level of existential well-being and counselor level of religious well-being), and client outcomes, (e.g., morale, global symptoms, and global impairment). Noting that the relationship between most variables in the behavioral sciences are linear, they report that the value of r will underestimate the relationship between variables if their relationship is curvilinear and recommend the use of scatterplots to ensure the relationship between variables is not curvilinear. Consequently, scatterplots were be used to ensure, and did so ensure, that the relationship between variables were linear.

According to Heppner et al. (1999), "Multiple regression can be used with a passive design to describe how multiple predictor variables are related to a single "dependent" (criterion) variable" (p. 225). Further, Glass and Hopkins (1996), report multiple regression analysis is the statistical method most often employed in the behavioral sciences to determine the relative impact of more than one independent variable on a dependent variable. Therefore multiple regression analysis was used to analyze the relative impact of aspects of counselor level of spiritual well-being,(e.g., counselor level of existential well-being and counselor level of religious), on client outcome/well-being, (e.g., morale, global symptoms, and global impairment).

The Specific Research Hypotheses

Initially, RH1 through RH12 below were proposed as hypotheses to be tested. However, during the course of the study three supplemental hypotheses were added in light of research suggesting the need to investigate results of subscales on the Spiritual Well-Being Scale, namely, Existential Well-Being and Religious Well-Being, taken together (Genia, 2001), and, results of data analysis revealing models in which no significant results were found when the overall total score on the Spiritual Well-Being Scale was a predictor, but there being significant results when the subscales of the Spiritual Well-Being Scale, namely, Religious Well-Being Scale and Existential Well-Being Scale, were used together as predictors. Thus the following research hypotheses were tested in the present study:

Counselor Level of Spiritual Well Being and Client Outcomes

RH1: There is a relationship between counselor level of spiritual well-being and client outcome/well-being on morale.

RH2: There is a relationship between counselor level of spiritual well-being and client outcome/well-being on global symptoms.

RH3: There is a relationship between counselor level of spiritual well-being and client outcome/well-being on global impairment.

Counselor Level of Existential Well-Being and Client Outcomes

RH4: There is a relationship between counselor level of existential well-being and client outcome/well-being on morale.

RH5: There is a relationship between counselor level of existential well-being and client outcome/well-being on global symptoms.

RH6: There is a relationship between counselor level of existential well-being and client outcome/well-being on global impairment.

Counselor Level of Existential Well-Being and Client Outcomes

RH7: There is a relationship between counselor level of religious well-being and client outcome/well-being on morale.

RH8: There is a relationship between counselor level of religious well-being and client outcome/well-being on global symptoms.

RH9: There is a relationship between counselor level of religious well-being and client outcome/ well-being on global impairment.

Relative Impact of Counselor Level of Existential and Religious Well-Being on Client Outcomes

RH10: The relative impact of counselor level of existential well-being on client outcome/well-being will not equal the relative impact of counselor level of religious well-being on client outcome/well-being on morale.

RH11: The relative impact of counselor level of existential well-being on client outcome/well-being will not equal the relative impact of counselor level of religious well-being on client outcome/well-being Global Symptoms.

RH12: The relative impact of counselor level of existential well-being on client outcome/well-being will not equal the relative impact of counselor level of religious well-being on client outcome/well-being global impairment.

Counselor Level of Existential and Religious Well-Being taken together and Client Outcomes

SRH13: There is a relationship between counselor level of religious well-being together with counselor level of existential well-being and client outcome/well-being on morale.

SRH14: There is a relationship between counselor level of religious well-being together with counselor level of existential well-being and client outcome/well-being on global symptoms.

SRH15: There is a relationship between counselor level of religious well-being together with counselor level of existential well-being and client outcome/well-being on global impairment.

Results of the this study do not support the claim that counselors' scores on the Spiritual Well-Being Scale (SWBS), [e.g., total score of Spiritual Well-Being (SWB), which is to say Counselor Level of Spiritual Well-Being (COLSWB); score on the subscale of Existential Well-Being (EWBS), which is to say, Counselor Level of Existential Well-Being (COLEWB); and score on the subscale of Religious Well-Being (RWBS), which is to say, Counselor Level of Religious Well-Being (COLRWB); or the two subscales taken together, which is to say, (COLEWB and COLRWB)], in and of themselves or in combination with clients' scores on at least one of the scales of the Health Dynamics Inventory (HDI) pre-treatment, [e.g., Morale (PREMO), Global Symptoms (PREGS), or Global Impairment (PREGI)], significantly impact clients' scores on the HDI post-treatment for client Morale (POSTMO), [i.e., which is to say, did not provide support for RH1, RH4, RH7, or SRH13 respectively] at the 0.05 level or better. Nor do results support the claim that either COLSWB, COLEWB, COLRWB, or both (COLEWB and COLRWB), in and of themselves or in combinations with clients' scores one the HDP post-treatment, (e.g., POSTMO, POSTGS, POSTGI), significantly impact clients' scores on (POSTGS), [i.e., which is to say, did not provide support for RH2, RH5, RH8, or SRH14 respectively], at the 0.05 level.

However, COLSWB, COLEWB, and COLRWB in and of themselves each have a positive relationship with both POSTMO, which would be expected if increased counselor

spiritual well-being yielded better client outcomes on Morale, (i.e., as COLSWB, COLEWB, and COLRWB increase so does POSTMO). Results of this study, then, do not support RH 10. Further, COLSWB, COLEWB, and COLRWB in and of themselves each have a negative relationship with POSTGS, which would be expected if increased counselor spiritual well-being yielded better client outcomes, (i.e., as COLSWB, COLEWB, and COLRWB increase the number and/or intensity of symptoms clients experience post-treatment decreases). This is not the case when COLEWB and COLRWB are taken together as the relationship between COLEWB and POSTGS positive. Consequently, results of this study support RH11.

As was the case with both POSTMO and POSTGS, results of the study did not provide support for the claim that either COLSWB or COLEWB in and of themselves or in combination with at least one of PREMO. PREGS or PREGI significantly impact clients' scores on the HDI post-treatment for Global Impairment (POSTGI), [i.e., which is to say, did not provide support for RH3 and RH6], at the 0.05 level or better. Nor did the results provide support for the claim that COLRWB in and of itself significantly impact POSTGI.

However, whereas results of this study did not provide support for the claim that COLSWB in and of itself, which is the summation of a counselor's score on the EWB subscale of the SWBS, (COLEWB) and his/her score on the RWB subscale of the SWBS (COLRWB), significantly impacts POSTGI, results do provide support for the claim that the combination of (COLEWB and COLRWB) in and of itself significantly impacts POSTGI at the 0.05 level or better, namely, 23% of the variance in clients POSTGI scores at the 0.03 level (see Table 26, p. 96). Further, the additional amount of variance accounted for in POSGI by adding (COLEWB and COLRWB) to PREMO, namely 18%, is significantly > 0 at the 0.05 or better level (see Table 34, p. 102). The results of this study, then, support SRH 15. It is worth noting that (COLEWB and COLRWB) as a

predictor, provided it can be considered a predictor analogous to COLSWB, is the only predictor which both in and of itself and when combined with clients' scores on the HDI pre-treatment, actually only with respect to PREMO, significantly impacts clients' scores on POSTGI.

With respect to the model with (COLEWB and COLRWB) taken together, the amount of variance accounted for by COLRWB all things considered, which is to say holding counselors' scores on COLEWB equal, is significant at the 0.05 level or better, namely, 0.01; and, the additional amount of variance accounted for in clients' scores POSTGI by adding COLRWB to COLEWB is significantly > 0 at the 0.05 level (see Table 26, p.96). Both of these are true COLRWB for the model created by adding (COLEWB and COLRWB) to PREMO (see Table 34, p. 102) as well as COLRWB to PREMO only (see Table 33, p. 101). Consequently, the results of this study support RH9. Neither of these, as already noted above, are true for COLEWB.

Further, all three of these models as well as when COLEWB and COLRWB are considered by themselves, COLRWB is negatively related to POSTGI, which, is in the direction expected if increase in COLRWB yields improvement in client outcomes, (i.e., as COLRWB increases the amount of impairment experienced by clients post-treatment decreases). The opposite is true of COLEWB, since it is positively related to POSTGI. Consequently, COLRWB and COLEWB differently impact clients' outcomes one POSTGI, and therefore, results of this study provide support for RH12.

Notably, when PREMO and COLRWB are used as the only predictors of POSTGI, the amount of variance accounted for by PREMO all things considered, which is to say holding counselors' scores on COLRWB equal, is significant at the 0.05 level or better, namely, 0.01; and, the additional amount of variance accounted for in clients' scores POSTGI by adding PREMO to COLRWB is significantly > 0 at the 0.05 level (see Table 33, p. 101). However,

neither of these are true for PREMO with respect to the model with COLEWB, COLRWB, and PREMO (see Table 34, p.102). As noted above, both of these are true for COLRWB and neither of these are true for COLEWB, for both of these models. The additional amount of variance on clients' scores POSTGI accounted for by COLEWB when added to COLRWB only, (i.e., in the model with only COLEWB and COLRWB as predictors) = 15%, when added to both COLRWB and PREMO = 2%. Similarly, the amount of variance in clients' scores on POSTGI accounted for by adding PREMO to COLRWB only = 24%, whereas, PREMO adds only 11% when added to both COLRWB and COLEWB. However, the additional amount of variance in clients' scores on POSTGI by adding COLRWB to COLEWB only = 30%, to PREMO only = 21%, and to both COLEWB and PREMO = 21%. Further, whereas Adj. R^2 = 32% for both models with (PREMO and COLRWB), and (PREMO, COLRWB, and COLEWB); as noted above, for COLEWB and COLRWB Adj. R^2 = 23%. Finally, for (COLRWB and COLEWB) $R^{2 =}$ 30%, for (COLRWB and PREMO) $R^{2 =}$ 39%, and for (COLRWB, COLEWB, and PREMO) $R^{2 =}$ 41%.

Given these considerations it appears that some of the variance in clients' scores on POSTGI accounted for by COLEWB and PREMO is the same; and, that PREMO accounts for a greater percentage of the amount of variance in clients' scores on POSTGI accounted for by COLEWB than COLEWB does with respect to PREMO. Further, the variance in clients' scores on POSTGI accounted for by COLRWB is relatively independent of COLEWB and PREMO and this is reflected in COLRWB being the only predictor such that for every model in which it is a predictor both the amount of variance in clients' scores on POSTGI accounted for by it all things considered is significant at the 0.05 level or better and the additional amount of variance in clients' scores on POSTGI accounted for by its addition to the model is significantly > 0 at the 0.05 level or better.

In general, then, the results of this study do not support RH1 through RH8, RH10, RH13, and RH14. On the other hand, results of this study do support RH9, RH11, RH12, and SRH15. Further, COLEWB and COLRWB, taken together in and of themselves significantly impacts clients' scores on POSTGI. Here, it is not so much COLEWB as it is COLRWB that accounts for variance in clients' scores on POSTGI. Further, since COLEWB is positively related to clients' scores on POSTGI indicating that as COLEWB increases so does clients' scores on POSTGI, (i.e., as COLEWB increases so does the amount of impairment clients experience post-treatment), and COLRWB is negatively related to POSTGI indicating that as COLRWB increases clients' scores on POSTGI decreases, (i.e., as COLRWB increases the amount of impairment clients experience post-treatment decreases), it follows that it is not so much COLEWB that accounts for clients' improvement with respect to Global Impairment post-treatment as it is COLRWB.

The model which accounts for the greatest amount of variance in client's scores on POSTGI is that with COLEWB, COLRWB, and PREMO as predictors. Here, too, however, it is primarily COLRWB that accounts for variance in clients' scores on POSTGI. Further, the relationships and resulting implications discussed above concerning the relationships COLEWB and COLRWB have with POSTGI are maintained in this model. Notably, in this model PREMO is positively related to POSTGI indicating the better clients are with respect to Morale pre-treatment, the worse they are with respect to Global Impairment post-treatment; or, conversely, the worse clients are with respect to Morale pre-treatment, the better they are with respect to Global Impairment post-treatment.

Conclusions

Again, the underlying question of the present study is that of whether counselor spiritual well-being, [i.e., here defined in terms of counselors' scores on the Spiritual Well-Being Scale (SWBS), namely, overall Spiritual Well-Being (COLSWB), and the subscales of overall Spiritual Well-Being, namely, Existential Well-Being (COLEWB) and Religious Well-Being (COLRWB)], significantly impacts client outcomes, [i.e., here defined in terms of clients' post-treatment scores on the scales of the Health Dynamics Inventory (HDI), namely, Morale (POSTMO), Global Symptoms (POSTGS), and Global Impairment (POSTGI)]. Well, then, does it? The answer to this question is "Yes, but with qualifications?" "What qualifications?" it might be asked.

Before answering, recall that according to Paloutzian & Ellison (2009), the Spiritual Well-Being Scale is an indicator of one's "subjective state of well-being [and is an overall measure of one's] "perceived spiritual quality of life" (p. 3), and the subscales, Religious Well-Being and Existential Well-Being, measure one's perceived spiritual quality of life in the two senses in which people commonly speak about spirituality, "That is, when people talk about their spirituality they ordinarily mean either (a) their relationship with God or what they understand to be their spiritual being, or (b) their sense of satisfaction with life or purpose in life" and go on to state, "In addition to SWBS total scores providing an overall measure of one's SWB, the RWB subscale provides a self-assessment of one's well-being in a religious sense, while the EWB subscale gives a self-assessment of one's sense of life purpose and life satisfaction" (p. 3). Further recall that, according to Sanders and Wojcik (2003), the Health Dynamics Inventory (HDI) was developed based on the tripartite model of mental health as set forth in the Diagnostic and Statistical Manual of the American Psychiatric Association in accordance with the definition of mental disorder noting that the three aspects of what is involved with a mental disorder include *impairment* of functioning in

one or more life settings, (e.g., education, employment, etc.), *symptoms* characteristic of the disorder in question, (e.g., anhedonia, hallucinations, etc.), and *distress* expressed by individuals with respect to the disorder such as hopelessness, to indicate the degree to which treatment has been successful with respect to these three aspects of mental disorders as they are associated with different phases of recovery, namely, *re-moralization* in which clients experience a decrease in distress and increase in hope, *remediation* in which severity of symptoms are reduced, and *rehabilitation* in which there is decreased impairment/increased life functioning.

With that said, "What qualifications?" Results *did not* provide support for the claim that counselors' perceived either 1. overall "spiritual quality of life," 2. "sense of life purpose and life satisfaction," 3. "relationship with God or what they understand to be their spiritual being" or 2 and 3 taken together, whether in and of themselves or in combination with clients' scores on the HDI pre-treatment, significantly impacts either clients' level of distress or symptoms experienced post-treatment. Nor did the results support the claim that counselors' perceived either 1. overall "spiritual quality of life," 2. "sense of life purpose and life satisfaction," or 3. "relationship with God or what they understand to be their spiritual being" in and of themselves significantly impacts clients' impairment in life functioning post-treatment. On the other hand, results *did* support the claim that counselors' perceived "sense of life purpose and life satisfaction," and perception of "their relationship with God or what they understand to be their spiritual being" taken together, in and of themselves significantly impacts clients' impairment in life functioning post-treatment. Here, it is not so much counselors' perceived "sense of life purpose and life satisfaction" as it is counselors' perceptions of "their relationship with God or what they understand to be their spiritual being" that significantly impacts clients' experiencing decreased impairment in life functioning. Notably,

however, the two models that accounted for the greatest amount of variance in clients' impairment in life functioning post-treatment, each accounting for 32%, had the following as predictors:

1. Counselors' perceived "relationship with God or what they understand to be their spiritual being" and clients' level of distress and feelings of hopelessness pre-treatment;
2. Counselors' perceived "sense of life purpose and life satisfaction," together with counselors' perception of "their relationship with God or what they understand to be their spiritual being," and clients' level of distress and feelings of hopelessness pre-treatment.

For these models, results support drawing the following conclusions:

1. For the first model, the greater clients' sense of distress and hopelessness pre-treatment the less impaired in life functioning clients are post-treatment. Here, could it be that greater distress yields greater motivation for change, and hence, better client outcomes?
2. For the second model, it is not so much counselors' perceived "sense of life purpose and life satisfaction" as it is counselors' perception of "their relationship with God or what they understand to be their spiritual being" that significantly impacts clients' decreased impairment/increase of functioning in life post-treatment.
3. For both models, counselors' perception of "their relationship with God or what they understand to be their spiritual being" both when added to the model and as a predictor in the model all things considered significantly impacts clients experiencing less impairment/ increase of life functioning post-treatment, (i.e., the better counselors' perceive "their relationship with God or what they understand to be their spiritual being" to be, the less impaired in life functioning clients are post-treatment). This finding is interesting to the extent the client/counselor relationship accounts for change in the counseling process. The common factor here is relationship. Is there a relationship between them?

Implications

Insofar as a relationship has been found counselor level of religious well-being and client outcomes on global impairment, development and incorporation of ways to cultivate counselor spiritual well-being in counselor education programs is warranted. Further, the same can be said for post-master level supervision of counselors, whether this supervision is part of counselors' formal training prior to obtaining full licensure or in the context of agency settings. Further, institutional policy and procedures will need to be put in place that support counselors' spiritual well-being.

However, by far the most important implication of results found here is the need for further research to confirm results found here. Developing and implementing policies and procedures as described above is both costly and time-consuming. It can be argued that in light of some of the short-comings of the present study that such time and money is not well spent. For example, that a significant relationship was found only on the scale of the HDI for which clients' scores passed the Shapiro-Wilk test for normality (see Appendix D) leads to the question of whether a significant relationship between counselor spiritual well-being and client outcomes on global symptoms and morale exists but was not found. Further, insofar as some of the counselors in the study had more than one client, the assumption of independence was violated here. Further, no one counselor had the same number of clients as any other counselor. A multivariate hierarchical approach would have proved more powerful, but was not possible given the small sample size. Only 7 counselors and 22 clients participated in the study and all of them were from the same community agency in the Southern United States. Only 2 counselors were male, 5 female; and, all self-identified as religious and/or spiritual.

On the other hand, that counselors' level of religious well-being significantly impacts clients' impairment in life functioning post-treatment *despite* these limitations is significant. And its significance does provide a powerful argument for spending the time and money to replicate this study on a larger scale.

Suggestions for Further Research

As noted above, a larger study to confirm the results of the present study. Should such confirmation be found, then it will point to the need for further research to determine what factors contribute to counselor level of spiritual well-being or aspects of counselor level of spiritual well-being, and how to incorporate addressing these factors into training programs and post program supervision of counselors in order to ensure maximum possible benefit to clients and to avoid doing them harm.

Further, it will point to the need for further research to determine whether there are factors that differentially impact the relationship of counselor level of spiritual well-being or aspects of counselor's level of spiritual well-being, and client outcomes, such as type of counselor, type of client, (e.g., mental health disorder only, substance use disorder only, or co-occurring mental health and substance use disorder), gender of counselor and client, counselor years of experience, counselor level of education, (e.g., BA/BS, MA/MS, Ed.D/Ph.D./ D.Psy, MD), field of counselor, (e.g., counseling, social work, psychology, medicine), type of treatment, (e.g., mental health only, substance abuse only, treatment for co-occurring disorders and whether this was sequential, parallel, or integrated), and length of treatment as well as successful completion of treatment. Here it is worth noting that preliminary analysis of data collected for the present study indicate that client age together with both counselor level of existential well-being and counselor level of religious well-being accounts for 25% of the variance in client impairment post-treatment at the 0.04 level. In this case, however, counselors' level of both existential and religious well-being appear to be the most important predictors. Finally, it will point to the need to determine whether such a relationship obtains for other populations at various levels of development, (e.g., children, adults, and the elderly), and for which populations the relationship is most significant.

Summary

Movement towards a holistic understanding of well-being entails the need to address all aspects/dimensions of persons that contribute to individual well-being of which spirituality is one (Hawks, 1994; Morrison et al., 2009).

Despite an increased awareness of spirituality as a real phenomenon (Moberg, 2002; Pargament & Saunders, 2007), a renewed interest on the nature and role of spirituality in counseling (Hawks, 1994; Gingrich & Worthington, 2007; Matthews, 2004; Moberg, 2002; Pargament & Sanders, 2007; Thoresen & Harris, 2002; Watkins van Asselt & Baldo Sentock, 2009; Young et al., 2000), researchers maintaining the need for counselors to be aware of their own spiritual issues (Genia, 2000), and the need for counselors to achieve first what they ask of their clients according to Chandler et al. (1992) and Jung (1933), a thorough review of the literature revealed only one study (Brooks & Matthews, 2000) that has addressed the issue of the possible relationship between counselor level of spiritual well-being and client outcomes/well-being.

The study conducted by (Brooks and Matthews, 2000), however, addresses this issue only with respect to substance abuse counseling, adult clients who receive inpatient counseling, and then, only with respect to the relationship between counselor level of spiritual well-being and client level of spiritual well-being. This study was conducted to begin movement towards filling this gap in the research by expanding what has been done with respect to population, type of client, (e.g., substance abuse, mental health), level of intensity of treatment received, (e.g., outpatient, residential, etc.), as well as aspects of client well-being. More specifically, this study investigates whether there is a relationship between counselor level of spiritual well-being or aspects of counselor level of spiritual well-being, (e.g., counselor level of existential well-being and counselor level of religious well-being), and client outcomes, (e.g., morale, global symptom,

and global impairment), for adolescent clients receiving treatment for substance use and/or other mental health disorders at an agency in the Southern United States regardless of the level of intensity of treatment being received, (e.g., outpatient, intensive outpatient, residential, etc.). It was hypothesized that such a relationship would be found.

Results of the present study, given the aforementioned limitations, which is to say, all things considered, provide support for the claim that such a relationship exists. More specifically, results provided support the claim that counselors' perceived "sense of life purpose and life satisfaction," and counselors' perception of "their relationship with God or what they understand to be their spiritual being" taken together in and of themselves significantly impacts clients' level of impairment in life functioning post-treatment. Here, it should be noted that it is not so much counselors' perceived "sense of life purpose and life satisfaction" as it is "their relationship with God or what they understand to be their spiritual being" that significantly impacts clients' experiencing less impairment/increase of functioning in life. However, the two models that account for the greatest amount of variance in clients' level of impairment in life functioning, each accounting for 32%, were those with the following as predictors:

1. Counselors' perceived "relationship with God or what they understand to be their spiritual being" and clients' level of distress and feelings of hopelessness pre-treatment; *and*
2. Counselors' perceived "sense of life purpose and life satisfaction," together with counselors' perception of "their relationship with God or what they understand to be their spiritual being," and clients' level of distress and feelings of hopelessness pre-treatment.

For these models, results of the present study support drawing the following conclusions:

1. With respect to the first model it can be concluded that the greater clients' sense of distress and hopelessness pre-treatment the less impaired in life functioning clients are post-treatment. Here one might speculate that greater distress leads to greater motivation for change, and hence, better client outcomes.
2. With respect to the second model, it is not so much counselors' perceived "sense of life purpose and life satisfaction" as it is "their relationship with God or what they understand to be their spiritual being" that significantly impacts clients' experiencing less impairment/increase of functioning in life,.
3. With respect to both models, counselors' perception of "their relationship with God or what they understand to be their spiritual being" both when added to the model and as a predictor in the model all things considered significantly impacts clients experiencing less impairment in/increase of life functioning, (i.e., the better counselors' perceive "their relationship with God or what they understand to be their spiritual being" to be, the less impaired in life functioning clients are post-treatment). This finding seems interesting especially to the extent to which the client counselor relationship accounts for change in the counseling process. Might there be a relationship between the quality of each relationship?

By far the most important implication, and therefore suggestion that flows out of the results of the present study is the need for further research. With the present study the book on its subject is just beginning to be opened, and perhaps, at best, a line on one of its leaves has been translated. Even for those who might argue that due to its limitations the present has yet to begin to open the book, let alone begin to translate a line on one of its leaves, that significant results were found is a powerful argument for the claim that the book be opened and its leaves so translated.

Epilogue

My mother, who was instrumental in my bringing this work to its completion, and for whom with my father it is dedicated, earned her doctorate along with him here at the University of Arkansas. During my youth she was a Professor of English and Dean of the Graduate School at Northeastern State University in Tahlequah, OK. I had hoped that she would be here with us to see its completion and I know she desired this too. Unfortunately, she is not, as she has passed from this life to join my father in the next.

I thought I would end this work, then, with a portion of *Meditation XVII* from "Devotions Upon Emergent Occasions" by John Donne, some of which, having to do with islands, she was fond of quoting to me when I was young, as it seems to me relevant to what has been done here. It does have to do with relationships, books, leaves, and translations, the ultimate translation of which, one could say, our translations, are but mere images.

> The church is catholic, universal, so are all her actions; all that she does, belongs to all. When she baptizes a child, that action concerns me; for that child is thereby connected to that head which is my head too, and ingraffed into that body, whereof I am a member. And when she buries a man, that action concerns me; all mankind is of one author, and is one volume; when one man dies, one chapter is not torn out of the book, but translated into a better language; and every chapter must be so translated; God employs several translators; some pieces are translated by age, some by sickness, some by war, some by justice;; but God's hand is in every translation, and his hand shall bind up all our scattered leaves again, for that library where every book shall lie open to one another; … .
>
> … . The bell doth toll for him, that thinks it doth; and though it intermit again, yet from that minute, that that occasion wrought upon him, he is united to God. … who bends not his ear to any bell, which upon any occasion rings? But who can remove it from that bell, which is passing a piece of himself out of this world?
>
> No man is an island, entire of itself; every man is a piece of the continent, a part of the main; if a clod be washed away by the sea, Europe is the less, as well as if a promontory were, as well as if a manor of thy friend's or of thine own were; any man's death diminishes me, because I am involved in mankind, and therefore never send to know for whom the bell tolls; it tolls for thee.

Amen to that!

The Reverend Michael W. Holland

Appendix A

Competencies for Addressing Spiritual and Religious Issues in Counseling (ASERVIC, 2009)

Culture and Worldview

1. The professional counselor can describe the similarities and differences between spirituality and religion, including the basic beliefs of various spiritual systems, major world religions, agnosticism, and atheism.
2. The professional counseling recognizes that the client's beliefs (or absence of beliefs) about spirituality and/or religion are central to his or her worldview and can influence psychosocial functioning.

Counselor Self-Awareness

3. The professional counselor actively explores his or her own attitudes, beliefs, and values about spirituality and/or religion.
4. The professional counselor continuously evaluates the influence of his or her own spiritual and/or religious beliefs and values on the client and the counseling process.
5. The professional counselor can identify the limits of his or her understanding of the client's spiritual and/or religious perspective and is acquainted with religious and spiritual resources and leaders who can be avenues for consultation and to whom the counselor can refer.

Human and Spiritual Development

6. The professional counselor can describe and apply various models of spiritual and/or religious development and their relationship to human development.

Communication

7. The professional counselor responds to client communications about spirituality and/or religion with acceptance and sensitivity.

8. The professional counselor uses spiritual and/or religious concepts that are consistent with the client's spiritual and/or religious perspectives and are acceptable to the client.
9. The professional counselor can recognize spiritual and/or religious themes in client communication and is able to address these with the client when they are therapeutically relevant.

Assessment

10. During the intake and assessment processes, the professional counselor strives to understand a client's spiritual and/or religious perspective by gathering information from the client and/or other sources.

Diagnosis and Treatment

11. When making a diagnosis, the professional counselor recognizes that the client's spiritual and/or religious perspectives can a) enhance well-being; b) contribute to client problems; and/or c) exacerbate symptoms
12. The professional counselor sets goals with the client that are consistent with the client's spiritual and/or religious perspectives.
13. The professional counselor is able to a) modify therapeutic techniques to include a client's spiritual and/or religious perspectives, and b) utilize spiritual and/or religious practices as techniques when appropriate and acceptable to a client's viewpoint.
14. The professional counselor can therapeutically apply theory and current research supporting the inclusion of a client's spiritual and/or religious perspectives and practices.

Appendix B

Letter to Counselors

Dear Colleague,

In partial fulfillment of the requirements for a Ph.D. in Counselor Education at the University of Arkansas I am conducting a pilot study to determine what, if any, role(s) spirituality plays in the counseling process. More specifically, I am attempting to determine whether a counselor's level of spiritual well-being as measured by the Spiritual Well-Being scale correlates with adolescent client outcomes as measured by the Health Dynamics Inventory.

If a relationship between counselor level of spiritual well-being is found, then the results of the study can have implications in the way counselors are trained and supervised so as to promote client well being and point to the need for further research to determine what factors contribute to counselor level of spiritual well-being and how to incorporate addressing these factors into training programs and post program supervision of counselors in order to ensure maximum possible benefit to clients and to avoid doing them harm. Further, it will point to the need for further research to determine whether there are factors that differentially impact the relationship of counselor level of spiritual well-being and client outcomes, such as type of counselor, type of client, (e.g., mental health disorder only, substance use disorder only, or co-occurring mental health and substance use disorder), gender of counselor and client, counselor years of experience, counselor level of education, (e.g., BA/BS, MA/MS, Ed.D/Ph.D./ D.Psy, MD), field of counselor, (e.g., counseling, social work, psychology, medicine).

Youth Bridge, Inc. has agreed to provide client data – pre/post scores on the Health Dynamics Inventory as well as demographic information – on all clients who have discharged from counseling services in the past 12 months and the last name of their primary counselor. I am writing you to request your participation as Youth Bridge, Inc. has reported that you have been a primary counselor of client(s) who have been discharged from counseling services at Youth Bridge, Inc. in the past year.

Rest assured that no identifying information will be used in the study. Your name has been matched with a random number on a list/key which will be destroyed at the conclusion of the study so that no identifying information remains.

It should be noted here that Youth Bridge, Inc., was comfortable with providing me only the last names of counselors, which, I understand and appreciate having been a counselor at Youth Bridge, Inc. in the past. However, as having only the last names of counselors is not enough information for me to mail the surveys myself, Youth Bridge, Inc. has agreed to mail them for me. I provided Youth Bridge, Inc. the survey you received in a sealed envelope so no one at Youth Bridge, Inc. has access to your identification number and a stamped envelope in which to mail it to you. Youth Bridge, Inc., in turn has mailed you the sealed envelope in the stamped envelope I provided them.

Please complete the enclosed demographic data form and Spiritual Well Being Scale and return them in the enclosed stamped envelope. So doing will constitute your indication of consent to participate in the study. I thank you in advance for your participation in this study or consideration to participate whichever the case may be.

Sincerely,

_____

Michael W. Holland, MS, LPC, LADAC, AADC, CCDP-D, IAADC, ICCDP-D
Doctoral Candidate in Counselor Education at the University of Arkansas
P. O. Box 23
Fayetteville, AR 72702

Appendix B cont.

Counselor Demographic Data Form

1. Please indicate the number of years you have been providing counseling services to clients _____

2. Please indicate your age _____

3. Please circle one of the following: Male Female

4. Please circle all that apply: CIT, CADC, ACADC, CCDP, CCDP-D, LAADAC, LADAC MS Counseling Intern, LAC, LPC,

   MSW Intern, LMSW, LCSW,

   LPE, D.Psy, MD

5. Please circle highest level of degree obtained: High School/GED, BA, BS, Bed, MA, MS, Med,

   D.Psy, Ed.D, Ph.D, MD

6. Please indicate the type of counselor you identify yourself to be by circling one of the following:

   Substance Abuse Counselor, Mental Health Counselor, Co-occurring Disorders Counselor

7. Please circle all of the following that you take yourself to be: Spiritual, Religious, Neither

8. Please indicate whether you are currently employed at Youth Bridge, Inc. by circling either:

   Yes - For how long have you been employed ? _____

   No – For how long have you not been employed at Youth Bridge, Inc.? _____

Again, thank you for participating in this study.

Appendix C

Comparison of Counselors' Scores on the Spiritual Well-Being Scale

	Counselor Level of Spiritual Well-Being			Counselor Level of Religious Well-Being			Counselor Level of Existential Well-Being		
	All *N = 15*	Original Data: *N = 8*	Revised Data: *N = 7*	All *N = 15*	Original Data: *N = 8*	Revised Data: *N = 7*	All *N = 15*	Original Data: *N = 8*	Revised Data: *N = 7*
Mean	101.40	99.25	103.86	50.86	48.50	53.57	51.2	50.75	50.29
SD	14.44	16.17	10.33	12.09	15.45	6.19	6.05	4.98	5.19
Median	104.00	102.00	107.00	55.00	54.50	56.00	53.00	51.50	49.00
Mode	97.00	97.00	97.00	58.00	58.00	58.00	54.00	54.00	54.00
Skewness	-1.30	-1.22	-0.65	-2.49	-2.15	-1.28	-0.80	-0.06	0.25
Kurtosis	1.15	1.21	-1.01	7.03	4.87	0.98	0.78	-1.37	-1.34
Range	51.00	47.00	27.00	47.00	46.00	17.00	23.00	14.00	14.00
Interquartile	15.00	20.50	16.00	9.00	12.50	9.00	6.00	7.50	9.00
Shapiro-Wilk/	0.87	0.87	0.88	0.70	0.72	0.86	0.94	0.92	0.94
Pr<W	0.04	0.14	0.24	0.0002	0.003	0.14	0.45	0.45	0.61

Appendix C Cont.

Descriptive Statistics Counselors Weighted Scores on the Spiritual Well-Being Scale

	Counselor Level of Spiritual Well-Being		Counselor Level of Religious Well-Being		Counselor Level of Existential Well-Being	
	Original Data: *N = 30*	Revised Data: *N = 22*	Original Data: *N = 30*	Revised Data: *N = 22*	Original Data: *N = 30*	Revised Data: *N = 22*
Mean	95.53	105.91	43.33	54.36	52.20	51.55
SD	19.43	9.91	19.21	5.61	4.74	5.42
Median	102.00	112.00	54.50	56.00	54.00	54.00
Mode	67.00	114.00	13.00	56.00	54.00	54.00
Skewness	-0.58	-0.97	-0.92	-1.53	-0.59	-0.17
Kurtosis	-1.37	-0.54	-1.02	1.23	-0.89	-1.56
Range	47.00	27.00	46.00	17.00	14.00	14
Interquartile R	46.00	17.00	45.00	5.00	5.00	13
Shapiro-Wilk/	0.79	0.77	0.70	0.74	0.84	0.86
Pr<W	0.001	0.0002	0.0001	0.0001	0.0003	0.0042

Appendix D

Comparison of Clients Scores on the Health Dynamics Inventory

	PREMO		POSTMO		PREGS		POSTGS		PREGI		POSTGI	
	Orig.	Rev.	Orig.	Rev.	Orig.	Rev.	Orig.	Rev.	Orig.	Rev.	Orig.	Rev.
	N=30	*N=22*	*N=30*	*N=22*	*N=30*	*N=22*	*N=30*	*N=22*	*N=30*	*N=22*	*N=30*	*N=22*
Mean	14.17	14.59	16.73	16.77	55.53	55.14	45.17	47.36	19.97	19.77	17.33	17.41
SD	2.70	2.77	2.03	1.74	14.28	14.27	14.56	15.02	5.22	5.66	4.54	4.24
Median	15.00	15.50	17.00	17.00	55.50	55.50	41.50	41.50	19.00	18.50	16.50	17.00
Mode	16.00	16.00	18.00	18.00	39.00	39.00	35.00	35.00	18.00	15.00	13.00	17.00
Skewness	-0.63	-0.90	-1.14	-0.86	0.25	0.11	0.87	1.07	0.56	0.69	1.03	0.85
Kurtosis	-0.35	0.14	1.10	0.64	-1.26	-1.58	0.63	-0.15	-0.39	-0.40	1.26	1.51
Range	11.00	11.00	9.00	7.00	47.00	41.00	65.00	48.00	20.00	20.00	19.00	19.00
Interquartile	4.00	3.00	2.00	2.00	27.00	27.00	14.00	18.00	8.00	8.00	5.00	5.00
Shapiro-Wilk/	0.93	0.89	0.88	0.88	0.91	0.89	0.90	0.83	0.95	0.93	0.92	0.95
Pr<W	0.055	0.021	0.003	0.010	0.015	0.016	0.009	0.002	0.192	0.143	0.026	0.353

Appendix E

Comparison of Results of Multiple Regression Health Dynamics Inventory for Different Models

		Post Treatment Morale				Post Treatment Global Symptoms				Post Treatment Global Impairment			
Model #	Variables	R^2	AdjR^2	F Value	Pr>F	R^2	AdjR^2	F Value	Pr>F	R^2	AdjR^2	F Value	Pr>F
1	COLSWB	0.03	-0.02	0.57	0.46	0.04	-0.01	0.83	0.37	0.04	-0.01	0.72	0.41
2	COLRWB	0.03	-0.02	0.63	0.44	0.07	0.02	1.44	0.24	0.15	0.11	3.61	0.07
3	COLEWB	0.02	-0.03	0.32	0.58	0.01	-0.04	0.19	0.67	0.00	-0.05	0.08	0.78
4	COLRWB COLEWB	0.03	-0.07	0.30	0.74	0.07	-0.02	0.75	0.49	0.30	0.23	4.09	0.03
5	PREMO	0.03	-0.02	0.58	0.46	0.02	-0.03	0.45	0.51	0.18	0.14	4.29	0.05
6	PREGS	0.01	-0.04	0.23	0.63	0.00	-0.05	0.00	0.99	0.10	0.06	2.27	0.15
7	PREGI	0.19	0.15	4.62	0.04	0.08	0.04	1.81	0.19	0.11	0.06	2.43	0.13
8	PREMO PREGS	0.06	-0.03	0.65	0.54	0.03	-0.08	0.25	0.78	0.20	0.12	2.45	0.11
9	PREMO PREGI	0.19	0.11	2.27	0.13	032	-0.01	0.86	0.44	0.19	0.11	2.27	0.13
10	PREGS PREGI	0.35	0.28	5.04	0.02	0.12	0.02	1.24	0.31	0.14	0.05	1.51	0.25
11	PREMO PREGS & PREGI	0.35	0.24	3.18	0.05	0.12	-0.03	0.79	0.52	0.21	0.08	1.58	0.23
12	PREMO &COLSWB	0.08	-0.01	0.88	0.43	0.09	-0.00	0.97	0.40	0.30	0.22	4.04	0.03
13	PREMO & COLRWB	0.07	-0.03	0.70	0.51	0.10	0.01	1.09	0.36	0.39	0.32	5.95	0.01

Model #	Variables	Post Treatment Morale R^2	Post Treatment Morale $AdjR^2$	Post Treatment Morale F Value	Post Treatment Morale Pr>F	Post Treatment Global Symptoms R^2	Post Treatment Global Symptoms $AdjR^2$	Post Treatment Global Symptoms F Value	Post Treatment Global Symptoms Pr>F	Post Treatment Global Impairment R^2	Post Treatment Global Impairment $AdjR^2$	Post Treatment Global Impairment F Value	Post Treatment Global Impairment Pr>F
14	PREMO & COLEWB	0.08	-0.02	0.84	0.45	0.06	-0.04	0.58	0.57	0.20	0.11	2.36	0.12
15	PREMO COLRWB & COLEWB	0.09	-0.07	0.57	0.64	0.10	-0.05	0.69	0.57	0.41	0.32	4.25	0.02
16	PREGS COLSWB	0.04	-0.07	0.34	0.71	0.04	-0.06	0.40	0.68	0.16	0.07	1.76	0.20
17	PREGS COLRWB	0.04	-0.06	0.43	0.66	0.07	-0.03	0.68	0.52	0.25	0.17	3.11	0.07
18	PREGS COLEWB	0.02	-0.08	0.20	0.82	0.01	-0.09	0.10	0.91	0.10	0.01	1.09	0.36
19	PREGS COLRWB COLEWB	0.04	-0.12	0.28	0.84	0.08	-0.08	0.49	0.70	0.33	0.22	2.93	0.06
20	PREGI COLSWB	0.19	0.11	2.29	0.13	0.10	0.01	1.10	0.35	0.12	0.03	1.33	0.29
21	PREGI COLRWB	0.19	0.11	2.24	0.13	0.12	0.03	1.27	0.30	0.21	0.12	2.46	0.11
22	PREGI COLEWB	0.20	0.11	2.31	0.13	0.09	-0.01	0.92	0.42	0.12	0.02	1.26	0.31
23	PREGI COLRWB & COLEWB	0.20	0.06	1.46	0.26	0.12	-0.03	0.82	0.50	0.34	0.23	3.04	0.06
24	PREMO PREGS & COLSWB	0.12	-0.03	0.81	0.50	0.09	-0.05	0.64	0.60	0.33	0.22	2.93	0.067
25	PREMO PREGS & COLRWB	0.11	-0.04	0.76	0.53	0.11	-0.04	0.75	0.54	0.40	0.30	4.01	0.02
26	PREMO PREGS & COLEWB	0.11	-0.04	0.71	0.56	0.06	-0.10	0.38	0.77	0.24	0.11	1.85	0.17

Model #	Variables	Post Treatment Morale R^2	AdjR^2	F Value	Pr>F	Post Treatment Global Symptoms R^2	AdjR^2	F Value	Pr>F	Post Treatment Global Impairment R^2	AdjR^2	F Value	Pr>F
27	PREMO PREGS & COLRWB COLEWB	0.12	-0.09	0.58	0.68	0.11	-0.10	0.53	0.72	0.42	0.29	3.10	0.04
28	PREMO PREGI & COLSWB	0.20	0.06	1.45	0.26	0.11	-0.04	0.75	0.54	0.30	0.18	2.58	0.09
29	PREMO PREGI & COLRWB	0.19	0.06	1.44	0.26	0.12	-0.02	0.84	0.49	0.39	0.29	3.84	0.03
30	PREMO PREGI & COLEWB	0.20	0.06	1.46	0.26	0.09	-0.06	0.60	0.62	0.20	0.07	1.54	0.24
31	PREMO PREGI & COLRWB COLEWB	0.20	0.01	1.03	0.42	0.12	-0.08	0.60	0.67	0.42	0.28	3.02	0.05
32	PREGS PREGI & COLSWB	0.35	0.24	3.21	0.05	0.12	-0.02	0.85	0.48	0.17	0.03	1.23	0.33
33	PREGS PREGI & COLRWB	0.35	0.24	3.18	0.05	0.14	-0.00	0.99	0.42	0.25	0.13	2.02	0.15
34	PREGS PREGI & COLEWB	0.35	0.24	3.28	0.05	0.12	-0.03	0.78	0.52	0.14	-0.01	0.96	0.43
35	PREGS PREGI & COLRWB COLEWB	0.36	0.21	2.36	0.09	0.16	-0.04	0.80	0.54	0.34	0.19	2.21	0.11
36	PREMO PREGS PREGI & COLSWB	0.35	0.20	2.29	0.10	0.13	-0.07	0.64	0.64	0.35	0.20	2.28	0.10

Model #	Variables	Post Treatment Morale R^2	Morale $AdjR^2$	Morale F Value	Morale Pr>F	Post Treatment Global Symptoms R^2	Global Symptoms $AdjR^2$	Global Symptoms F Value	Global Symptoms Pr>F	Post Treatment Global Impairment R^2	Global Impairment $AdjR^2$	Global Impairment F Value	Global Impairment Pr>F
37	PREMO PREGS PREGI & COLRWB	0.35	0.19	2.26	0.11	0.15	-0.05	0.75	0.57	0.42	0.28	3.05	0.05
38	PREMO PREGS PREGI & COLEWB	0.36	0.21	2.37	0.09	0.12	-0.09	0.56	0.70	0.24	0.06	1.32	0.30
39	PREMO PREGS PREGI & COLRWB COLEWB	0.36	0.16	1.82	0.17	0.16	-0.10	0.60	0.70	0.43	0.25	2.39	0.08

Appendix F

University of Arkansas Internal Review Board Approval Letter

UNIVERSITY OF ARKANSAS

Office of Research Compliance
Institutional Review Board

August 19, 2011

MEMORANDUM

TO:	Michael Holland Roy Farley
FROM:	Ro Windwalker IRB Coordinator
RE:	New Protocol Approval
IRB Protocol #:	11-08-051
Protocol Title:	*Impact of Counselor Level of Spiritual Well-Being on the Morale, Global Symptoms, and Global Impairment of Adolescents Receiving Treatment for Substance Use and/or other Mental Health Disorders: An Exploratory Study*
Review Type:	☒ EXEMPT ☐ EXPEDITED ☐ FULL IRB
Approved Project Period:	Start Date: 08/19/2011 Expiration Date: 08/18/2012

Your protocol has been approved by the IRB. Protocols are approved for a maximum period of one year. If you wish to continue the project past the approved project period (see above), you must submit a request, using the form *Continuing Review for IRB Approved Projects*, prior to the expiration date. This form is available from the IRB Coordinator or on the Research Compliance website (http://vpred.uark.edu/210.php). As a courtesy, you will be sent a reminder two months in advance of that date. However, failure to receive a reminder does not negate your obligation to make the request in sufficient time for review and approval. Federal regulations prohibit retroactive approval of continuation. Failure to receive approval to continue the project prior to the expiration date will result in Termination of the protocol approval. The IRB Coordinator can give you guidance on submission times.

This protocol has been approved for 90 participants. If you wish to make *any* modifications in the approved protocol, including enrolling more than this number, you must seek approval *prior to* implementing those changes. All modifications should be requested in writing (email is acceptable) and must provide sufficient detail to assess the impact of the change.

If you have questions or need any assistance from the IRB, please contact me at 210 Administration Building, 5-2208, or irb@uark.edu.

210 Administration Building • 1 University of Arkansas • Fayetteville, AR 72701
Voice (479) 575-2208 • Fax (479) 575-3846 • Email irb@uark.edu

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