

# EXPLORING THE HOPE CONSTRUCT IN PSYCHOTHERAPY

By

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(Under the direction of Linda F. Campbell, Ph.D.)

## ABSTRACT

While hope has been theorized to play an important role in psychotherapy (Fitzgerald, 1979; Frank, 1968; Frank & Frank, 1991; Stotland, 1969; Yalom, 1995), the respective body of literature offers little empirical evidence for this seemingly common belief among mental health professionals. It is the purpose of this paper to explore the role of hope in psychotherapy. A decade ago (1991a), Snyder and colleagues developed a goal based theory and measure of hope, which is use in this study. They define hope as the overall perception that goals can be met, and consider it an interaction of two factors agency (goal-directed energy) and pathways (planning to meet goals). This study primarily examines the question: Does the degree of hope significantly change from pretreatment to five sessions of psychotherapy? Ancillary investigations explore the relationship of hope at pretreatment with premature termination and Stages of Change Scale (SCS), a readiness for change measure (McConaughy, DiClemente, Prochaska, & Velicer, 1989; McConaughy, Prochaska, & Velicer, 1983). Findings support previous theories that hope, normally considered a stable trait, does increase during psychotherapy. However, in the present study no relationships are apparent between hope and premature termination or the readiness for change measure (SCS). Findings support previous theoretical statements in the literature regarding hope as an important part of the psychotherapy process. In addition, findings suggest the need for further inquiry to better understand the involvement of hope in the psychotherapeutic process.

INDEX WORDS: Hope, Psychotherapy, Premature termination, Stages of Change, Readiness for change

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### Dedication

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## Chapter I

### *Introduction*

The concept of hope has been written about for much of recorded history; however there has been disagreement about whether it is a blessing or a curse. This is illustrated by the fable of Pandora's box, when the box was opened evil forces that prey on the body and mind were released. Yet, as Pandora rushed to close the lid one force remained—hope (Smith, 1983). Was hope an antidote for the ills unleashed on humanity or a debilitating cancer of the soul? This tale reflects the debate to come. Sophocles believed the latter, that hope only serves to draw out human suffering, and Euripides labeled hope a curse of humanity. Yet Martin Luther and Saint Paul espoused that hope, much like love and faith, should be held with reverence as the essence of what is true and good. This sampling of views illustrates humanity's strongly held views and ambivalence about hope. Many have seen hope as an illusion that eagerly seduces humankind with false promise and still others have seen it as a gift to combat the ills of life. More recently, Tillich has attempted to rejoin these different views: "Hope is easy for the foolish, but hard for the wise. Everybody can lose himself in foolish hope, but genuine hope is something rare and great," reconciling the opposing views of hope (Tillich, 1965, p. 17).

Throughout history theologians, philosophers, scientists, and clinicians have been interested in the concept of hope. This interest is no doubt a

reflection of hope's powerful interplay with the human condition as well as its enigmatic nature. While hope has been characterized in the past as both a positive and negative entity, hope characterized in the negative light above, as "foolish hope" is no longer being considered as hope. Now hope is viewed in the positive light mentioned above, cherished as a sustaining force for both mind and body. Fitzgerald's declaration that hope is as fundamental to human life as food and water embodied this changed view of hope (Fitzgerald, 1979).

Hope's fundamental importance to us as a dynamic life force has caused it to gain the attention of researchers and professionals from diverse disciplines for more than two decades (Farran, Herth, & Popovich, 1995). Accordingly, what has been written about hope as a human condition has recently been identified as a critical factor for enhancing quality of life and for promoting health and healing (Beck, Steer, & Shaw, 1984; Farran & Popovich, 1990; Miller & Powers, 1988). Further, its absence, hopelessness, is associated with increased mortality, diminished life satisfaction (Beck, Weissman, Lester, & Trexler, 1974; Gottschalk, 1985), and is suggested to be an accurate predictor of suicide, even more so than depression (Beck, Steer, Kovacs, & Garrison, 1985).

As hope's relationship with health has emerged, research of this construct has focused mainly on illnesses, specifically medical and psychiatric illnesses. Hope was earliest and most frequently studied as hopelessness with psychiatric disorders due to the early findings and utility of the Beck Hopelessness Scale (BHS, Beck et al., 1974). This line of research has significantly contributed to psychology's understanding of the association of suicide and hopelessness, and

addressed important questions regarding the relationship of depression and hopelessness. These findings reinforced the utility of the line of research involving hopelessness. Because of the utility of hopelessness research and a pathological paradigm of psychology, the positive power of hope received little attention until more recently.

By contrast, the medical field has devoted more attention to investigating the benefits of hope particularly in the area of cancer. This trend largely began due to research associated with the role of nursing. Nursing often reflects a complex and intimate role with patients and witnessing patients lose or sustain hope during diagnosis and treatment of terminal illnesses (Farran et al., 1995). Three hope scales were specifically developed by nurses for use with cancer patients (Herth, 1991; Herth, 1992; Nowotny, 1989). Hope was also found to be positively correlated with self-report of physical health (McGill, 1991) and related to psychosocial adjustment in women with gynecological cancer (Mishel, Hostetter, King, & Graham, 1984). Also, in psychoimmunology research, hope has been correlated with increased t-cell counts (Udelman, 1982).

#### *Statement of the Problem*

The power of hope has long been a buttress of humankind to help sustain us through the trials of our lives. Progress over the past two decades has been made through empirical investigations in the disciplines of psychology and medicine about the powerful influence hope has on health (Farran et al., 1995; Gottschalk, 1985). While the medical community is still trying to reconcile such findings with its biological foundations, psychotherapy researchers and

practitioners have accepted hope as an integral if not fundamental part of the healing process (Fitzgerald, 1979; Frank, 1968; Snyder, Irving, & Anderson, 1991; Stotland, 1969; Yalom, 1995). However, in an era of greater accountability on psychotherapists, partly due to consumers, government, and insurance companies' demands to clearly demonstrate the efficacy of psychotherapy (Bergin & Garfield, 1994a) psychology has recently investigated the construct of hope and its association with mental health (Elliott & Sherwin, 1997; Harney, 1990; Nunn, 1996; Snyder, Harris, Anderson, Holleran, Irving, Sigmon, Yoshinobu, Gibb, Langelle, Harney, 1991; Snyder, Ilardi, Michael, & Cheavens, 2000; Snyder, Irving, & Anderson, 1991; Snyder, LaPointe, Crowson, & Early, 1998; Snyder & Taylor, 2000; Staats, 1987; Westburg & Boyer, 1999). This development is somewhat ironic considering that for the past twenty-five years, practitioners and psychotherapy process and outcome researchers have continually sought to gain a better and more salient understanding of what makes psychotherapy successful. Jerome Frank, one of the pioneers in this area of research, has also continually endorsed the fundamental role hope plays in successful psychotherapy (Frank, 1968; Frank, 1971; Frank, 1973).

Two recent issues of the *American Psychologist* have been dedicated to positive psychology. In these issues, editorials have called for psychologists and researchers to consider a different perspective from one that is founded in maladaptations and pathology (Sheldon & King, 2001). They suggest examining what works instead of what does not. Hope represents a mental health construct worthy of investigation in this era promoting the study of positive psychology.

Additionally, it seems appropriate for counseling psychology, with foundations based on strengths and individual differences, to adopt and value the paradigm shift of positive psychology.

However, even with the increased interest in the construct of hope over the recent past and the belief about its role in psychotherapy, there is still a void in the literature empirically examining hope's roles in the psychotherapeutic process. For example, hope has just recently begun to receive more theoretical attention as a common factor in the psychotherapy process (Snyder et al., 2000; Snyder, Michael, & Cheavens, 1999; Snyder & Taylor, 2000) even though Frank suggested this consideration 30 years ago (1968). Little empirical research has been done to examine the roles of hope in psychotherapy and the healing process.

The present study explores a recent theory, grown-out of the long held beliefs of hope, through an empirical investigation of the hope construct in psychotherapy process. By empirically investigating the roles of individual hope in the psychotherapeutic process, a greater scientific knowledge may be gained about this accepted enigma of psychotherapy—hope.

#### *Theoretical Framework*

The present study is founded upon C. R. Snyder's theory of hope (Snyder et al., 1989; Snyder et al., 1991). Snyder and his colleagues have developed a comprehensive cognitively-based theory of hope founded on the principle that hope is an *overall perception that goals can be met*. This goal driven theory involves the interaction of two factors: agency (goal-directed energy) and

pathways (planning to meet goals) (Snyder, 1994; Snyder, Cheavens, & Sympson, 1997; Snyder et al., 1989; Snyder et al., 1991).

### Agency and Pathways

Agency thinking, within Snyder's hope theory, is the energy that drives individuals to pursue their goals. It is an individual's level of agency that determines his or her capacity to begin and sustain movement towards a chosen goal. Pathway thinking is the variety of strategies or routes that are selected and if necessary modified or changed en route towards goal attainment. The ability to change and modify pathways when facing obstacles is a critical component of hope, a fundamental characteristic of individuals with higher levels of hope. While both of these factors are cognitive based, there is an affective complement to the cognitions of pathways and agency. It is the cognitive appraisals made in agency and pathway thinking and the interactions of these cognitions that lead to the emotional experience that is the real power of hope. As well, the relationship of agency with personal energy and resolve is another affective element of this hope theory (Snyder, Irving, & Anderson, 1991). In 1991, using their theory of hope, Snyder and his colleagues introduced a validated instrument to the construct of hope that is used to measure individual hope in the present study.

### *Significance of the Study*

As research has established a relationship between hope and mental health (Elliott & Sherwin, 1997), and as correlates between hope and mediating difficult life events have been made (Curry, Snyder, Cook, Ruby, & Rehm, 1997; Elliott, Witty, Herrick, & Hoffman, 1991; Harney, 1990; Snyder et al., 1991;

Snyder et al., 1998; Snyder, Wilklund, & Cheavens, 1999) there is a need to explore empirically the relationship between personal hopefulness and individual psychotherapy due to the void in the literature regarding hope and the psychotherapy process. Also, there has been an increase in the research regarding readiness for change in the area of psychotherapy research (Brogan, Prochaska, & Prochaska, 1999; O'Hare, 1996a; O'Hare, 1996b); however, there is no understanding of how hope is related to readiness for change. Finally, premature termination has long since been an issue of concern to practitioners. There is a continual interest in different factors associated with premature termination. Accordingly, the relationship between level of personal hope and premature termination is an additional area of research that merits exploration.

Research of the hope construct is timely in the area of psychotherapy process and outcome. The current study proposes to examine: (a) changes in hope during the psychotherapy process, (b) the association of hope to readiness for change, and (c) the predictive relationship of hope and premature termination. This line of research holds promise for providing psychology with a preliminary exploration of different ways hope impacts the psychotherapeutic process and outcome. Analysis made within this study help contribute to defining parameters of the hope construct in psychotherapy by way of empirically based conclusions. These empirical conclusions and the body of existing theoretical knowledge also help to guide much needed future research in this area. Ultimately, the intention of the researcher is to identify any impact hope may have in the psychotherapeutic process.



### *Purpose of the Study*

The purpose of this study is to empirically examine multiple aspects of the hope construct in individual psychotherapy. First, measures are taken to determine if in fact individuals' personal level of hope does change during the early course of psychotherapy. Second, hope's relationship with readiness to change is examined. Finally, this study explores the association between premature termination (readiness for therapy) and personal level of hope. This study offers a preliminary view of some roles that individual level of hope play in the psychotherapy process and clients' readiness for psychotherapy.

### *Research Questions and Hypotheses*

A fundamental assumption of psychotherapy, dating back over a quarter of a century to Frank's (1961; 1968) and Stotland's work (1969), is hope must be engendered in clients for treatment to be successful. Since then the belief that hope is an important part of successful psychotherapy has become part of the contemporary paradigm of psychotherapy (Frank & Frank, 1991). Frank (1968) long ago suggested that clients seek therapy because they are demoralized due to an inability to solve their own problems. Yet, there is little empirical evidence supporting this seemingly widely held view. To test the belief that hope does change during psychotherapy the following question is investigated.

- (1) Is the degree of hope of individual psychotherapy clients, as measured by the Hope Scale (Snyder et al., 1991), significantly different between pre-treatment and five sessions of treatment?

Secondly, efficacy studies of psychotherapy treatment have focused on two broad categories of common factors (sometimes referred to as non-specific factors) and specific treatment factors. A meta-analysis by Barker and colleagues (Barker, Funk, & Houston, 1988) confirmed previous research in this area that common factor groups report improvement over control groups (no treatment) and this was attributed to the presence of generalized positive expectations for improvement. Further, the specific treatment factor groups report improvement over common factor groups (Barker et al., 1988). Moreover, the specific treatment groups reported twice as much improvement over the control groups as did the common factor groups. Recall Snyder and his colleagues' (Snyder et al., 1989; Snyder et al., 1991) theory of hope is based on two factors agency (goal directed energy) and pathways (perceived ability to generate plausible routes to goals). Snyder and associates (Snyder, Michael et al., 1999; Snyder et al., 2000; Snyder & Taylor, 2000) consider agency a common factor of treatment and pathways a specific treatment factor. Therefore, the present study hypothesizes that agency may begin to increase even before the intake session; because the presence of generalized positive expectancy that psychotherapy will help as suggested by Barker and colleagues' meta-analysis (Barker, Funk, & Houston, 1988). This process of seeking help activates goal directed energy within clients (Snyder, 2000a; Snyder et al., 2000). Further, since the pathway thinking is more associated with specific treatment factors, the present study hypothesizes that there will be more of a change in pathway thinking than agency, as a byproduct of agency increasing due to the decision to

seek treatment (before pre-treatment measures are even taken). This hypothesis is tested with the following question.

(2) Are the individual psychotherapy clients degrees of agency (factor 1) and pathways (factor 2), as measured by Hope Scale (Snyder et al., 1991), significantly different between pre-treatment and five sessions of treatment?

Snyder and his associates' (Snyder et al., 1991) goal oriented hope theory has found that individuals with higher hope are more engaged in goal obtainment and more likely to attain their goals. In Prochaska's Transtheoretical Model (TTM, Prochaska, 1979), the Stages of Change Scale (SCS) assesses individuals' readiness for change (McConnaughy, DiClemente, Prochaska, & Velicer, 1989; McConnaughy, Prochaska, & Velicer, 1983). This measure assesses willingness for individuals to both identify personal areas in need of change and pursue these identified areas. In this sense, the SCS has intrinsic properties related to goal identification and pursuit. Thus, it is hypothesized that clients pre-treatment hope will be similar to other participants in the same cluster types of readiness for change.

(3) Is there a difference between pre-treatment scores of hope, agency (factor 1), and pathways (factor 2) as measured by the Hope Scale (Snyder et al., 1991) among participants' readiness for change cluster types at pre-treatment as measured by the Stages of Change Scale (SCS) (McConnaughy et al., 1989; McConnaughy et al., 1983)?

Based on the premise that generation of hope is critical in the early stages of psychotherapy, participants who are low in hope at pretreatment are at greater risk to prematurely terminate than those who are higher in hope. It is hypothesized that there is a predictive relationship between hope scores and premature termination.

(4) Are pre-treatment scores of hope, factor one (goal directed energy) and factor two (planning towards meeting ones goal) as measured by the hope scale (Snyder et al., 1991) predictive of premature termination (prior four sessions)?

### *Delimitations and Limitations of the Study*

#### Delimitations

In this section, limitation and delimitations of this study will be presented. While this discussion alludes to research methodology, that subject is more fully addressed in chapter three.

The primary delimitations of this study are determined by the nature of researching outcomes and processes involved in psychotherapy. This study requires that all subjects initiate treatment, with a genuine reason as determined by a variety of referral sources (discussed more in the Methods chapter), at a specific university-based counseling center at a major University in the Southeast. This criterion greatly reduces the potential subject pool. While two research questions (three and four) only require data gathered from clients' pre-treatment visit to the counseling center prior to treatment, the other two questions require clients to be active participants from intake through 10 individual

psychotherapy sessions. In 1976, a study examined 2,551 clients from over a dozen community mental health centers and found that 40.8 percent of the clients did not return after their intake interview (Sue, McKinney, & Allen, 1976) and a similar study examining an eight year history of a university counseling center revealed that 49 percent of students failed to come to their first therapy session (Phillips & Fagen, 1982). These studies and others report that roughly one in four individuals decline services offered to them illustrate the relative likelihood that a client initiate services and continue past the intake and first session (Betz & Shulman, 1979; Marks, 1978). Moreover, even as clients commit to participating in psychotherapy, several studies report clients terminating from 63 to 69.6 percent of the time before the tenth session (Garfield & Kruz, 1952; Sue et al., 1976; Taube, Burns, & Kessler, 1984) compounding the difficulty of collecting ongoing psychotherapy data. Thus, the size of the subject pool in this study is moderate in size due to the number of participants that completed the required treatment. Yet, for a clinical study the size of the treatment subject pool is exceptional. Rationale for choosing five individual psychotherapy sessions will be discussed in the Methods chapter.

Given the restrictive population being studied and the expected attrition of the treatment group, an additional delimitation of this study is the decision not to have a control group. Researchers form control groups in treatment studies by placing them on a waiting list for the treatment, while the treatment subjects undergo the given treatment. The estimated time expected to collect the data would raise ethical issues preventing subjects from receiving treatment for such a

significant and unknown time. Moreover, each member of such a control group represents a potential treatment subject. Thus, the need for treatment subjects outweighs the need for a control group. Also, there are expectations that come with the realization and intrapersonal decision to undergo psychotherapy. The study of hope, given the positive expectation that hope carries, the status of being on a waiting list, anticipating psychotherapy, would represent at best a marginal control group.

Much of the psychotherapy process and outcome research conducted over the past twenty years has focused on the difference in efficacy between different theoretically driven treatments (Bergin & Garfield, 1994a). Yet in 1994, Bergin and Garfield asserted that with few exceptions there is massive evidence that “psychotherapeutic techniques do not have specific treatment effect (p.822).” They are quick to point out that this does not mean therapy does not work, instead that most therapy works and research should focus on “isolating and identifying the ingredients of change and then enhance their influence (Bergin & Garfield, 1994b, p. 822).” Therefore, the intent of this study is to isolate and examine the construct of hope in psychotherapy as a whole, regardless of theoretical orientation. Thus a specific theoretical orientation is not mandated; that is left to the therapist’s discretion.

#### Limitations

Next, the limitations of the study will be enumerated beginning briefly with the assessment measures. An initial limit to the study is all assessment measures are self-report (to be completed by the client). They are written at

approximately a 7<sup>th</sup> grade reading level with simple instructions. Thusly, from self-report instruments some measurement error is to be expected and no attempt is made to corroborate with behavioral presentation.

The area of data collection is also addressed as a limit of this study. Therapists of the subjects are responsible for collecting data and for reasons such as failure to administer the instrument, subjects not properly completing the instruments, or data being left unidentified, missed data points are a factor. In an attempt to lessen attrition related to data collection, the therapists are allowed to collect data on one of the following two sessions if a data collection point is missed, otherwise the participants data is removed from the treatment pool. Additionally, protocol dictates that data be collected before the session, however if the therapist fails to do so data collected after the session is allowed.

All of the therapists who collect data are primarily doctoral students, while a few masters' students. The differing backgrounds, experiences, and training efficacy is expected to vary among therapists. Respectively, administrators and supervisors monitor competency and ill-prepared or incompetent therapists are not allowed to practice at the clinical site. In addition, students are encouraged to find their own style in therapy so variance is expected in regard to therapeutic style

In addition to the variance in therapists, there is also a multitude of variance in the clients. One such variance that creates a limitation is related to the client engagement in psychotherapy. Logistically, clients miss sessions or reschedule sessions, which affects the frequency of weekly sessions. As well,

due to the academic nature of the institution that houses the clinic, school breaks also affect the regularity of session. Thus, the regularity with which clients are seen varies among the subject pool. Furthermore, because of the training schedule of clinical site, the staff turns over annually and clients are transferred to incoming therapists. Thus, some subjects in this study have had two therapists through the course of their treatment constituting another limitation.

#### Assumptions

For the purposes of this study, it is assumed that all clients that present as participants for this study are typical of the client population seeking mental health services. Further it is assumed that the subjects fully understand the assessment instruments instruction so the results accurately reflect the client's presentation, and if needed the therapist or staff member clarify these instructions.



## Chapter II

### *Review of Related Literature and Research*

In this chapter literature will be reviewed in four major areas: (a) hope, (b) psychotherapy process/outcome research and common factors (c) pre-mature termination, and (d) readiness for change. Hope and psychotherapy will receive more attention than the other two areas due to their particular relevance to this study.

### *Hope*

The concept of hope has not been consistently defined. Contrary to the ambivalence toward the concept of hope throughout history, during the 1960's and 1970's a research focus was established supporting hope as a positive force in mental health. Both psychologists (Cantril, 1964; Farber, 1968; Mowrer, 1960; Stotland, 1969) and psychiatrists (Frank, 1968; Melges & Bowlby, 1969) agreed principally that hope was based on positive expectations for goal attainment. During this time, Jerome Frank and Ezra Stotland devoted numerous publications (Frank, 1961; 1968; 1971; 1973; Stotland, 1969; Stotland & Kobler, 1965) to describing hope and its importance to mental health. Stotland's work was mainly descriptive and definitional. Possibly his most important contribution was his hypothesis about hope: that motivation (affective experience) is directly proportional to both the perceived importance and probability of attaining a goal. While Frank is also known for his research in psychotherapy process and

outcome studies, through his work in the area of hope he made compelling hypotheses about the generation of hope as a core element of successful psychotherapies. His belief in the psychotherapeutic power of hope seems to have become common place in most psychotherapies practiced today.

### Defining Hope

While these publications presented a promising line of research for psychotherapy, the scientific community remained skeptical (Frank, 1968). Consequently, research of the hope construct did not gain interest as research surged in other areas related to coping, stress, and illness. In the late 1980's and early 1990's, with the role of positive self-evaluations and perceptions of control were receiving attention (Taylor, 1989; Taylor & Brown, 1988); research across many disciplines began to investigate hope (Curry et al., 1997; Farran & Popovich, 1990; Gottschalk, 1985; Herth, 1991; Miller & Powers, 1988; Nowotny, 1989; Nunn, 1996; Staats, 1987). Psychologists made many valuable contributions during this time, although they were all challenged by trying to develop operational definitions of the hope construct.

*Issues related to defining the hope construct.* One reason for the difficulty of defining the hope construct is the term can be used as a noun, verb, or adjective (Godfrey, 1987). It is most commonly used as a verb, "She hopes to have a child," and there is always some object, either explicit or implicit, of hope. Hope used as a noun suggests that a desired outcome is possible, "There is hope he will walk again." Lastly, as an adjective, "despite the surgery not being successful, I'm still hopeful," the object of hope is not clearly expressed, nor is

the likelihood of being able to walk again possible, but the person still expresses hope.

In addition, the construct of hope is elusive because it can be expressed as a way of behaving or relating (behavioral), as a way of feeling (affective), and as a way of thinking (cognitive) (Averill, Catlin, & Chon, 1990; Nunn, 1996). As a behavior, hope is expressed as a process by which an individual seeks, in a persistent nature, possible and appropriate alternatives toward a desired outcome. Hope, as a way of feeling, is expressed as an energizing force (motivating behavior), yet is not something that is easy to control, similar to the emotions love and anger (Averill et al., 1990). As a way of thinking, hope is the perceived importance and probability of obtaining a goal that determine motivational level (Stotland, 1969). Additionally, the future orientation of the hope construct is seen most prevalently in behavioral and cognitive contexts (Nunn, 1996). The function by which hope operates is seen differently among authors. Some view hope as primarily cognitive with behavioral and affective functions as secondary (Seligman, 1992), others classify hope as an emotion that motivates behavior and cognitions, still others organize hope as both cognitive and affective (Staats, 1987), while another contend it is unclear as to the primacy suggesting that hope be view “as a multidimensional responsiveness to the future” (Nunn, 1996, p. 230).

A further issue in describing the construct of hope is determining if it is a stable or fluctuating personal factor. As a state, hope can reflect the feelings an individual has about a particular situation and may fluctuate over time. As a trait,

the hope construct functions as a more enduring mind-set or perspective, that is less susceptible to environmental forces. Nunn and Lewin (1996) attempted to develop both state and trait measures of hope and found that their instrument measured trait only. Their findings suggest that a measure that examines expectation will be stable due to the enduring quality of expectations as opposed to measures of affects. Consequently, they view the construct of hope as stable. Through Averill and others (1990) emotional model of hope, they describe hope as an episodic disposition. They state, "hope is a relatively short-term response tendency, usually initiated and terminated by specific environmental conditions" (p. 93). Their view on this issue is influenced by their conceptualization of hope experienced as an emotion. Thus depending on the view of the functional process of the hope construct (behavioral, affective, cognitive), impacts conclusion made about how hope is experienced as well as its stability.

A further issue in describing the construct of hope is determining if it is a stable or fluctuating personal factor. As a state, hope can reflect the feelings an individual has about a particular situation and may fluctuate over time. As a trait, the hope construct functions as a more enduring mind-set or perspective, that is less susceptible to environmental forces. Nunn and Lewin (1996) attempted to develop both state and trait measures of hope and found that their state measure was too enduring. Their findings suggest that a measure that examines expectation will be stable due to the enduring quality of expectations as opposed to measures of affects. Consequently, they view the construct of hope as stable. Through Averill and others (1990) emotional model of hope, they describe hope

as an episodic disposition. They state, “hope is a relatively short-term response tendency, usually initiated and terminated by specific environmental conditions” (p. 93). Their view on this issue is influenced by their conceptualization of hope experienced as an emotion. The perspective of the functional process of the hope construct (behavioral, affective, cognitive), impacts the conclusion made about how hope is experienced as well as its stability.

These ambiguous characteristics of the hope construct present difficulties when trying to define it and may be a reason for the lack of pursuit of the promising line of research started by Frank and Stotland. Although, more recently authors have turned their attention to the construct of hope and in turn made progress in providing operational definitions and theories of the hope construct. The next section will review the contemporary view of the hope construct

*Contemporary thought on hope.* Miller and Powers defined hope as a “state of being, characterized by an anticipation of a continued good state, and improved state or a release from perceived entrapment” (1988, p. 6). They base their view of hope and the development of a continuous measure on ten elements, including interpersonal relations, sense of possible, flexibility, positive anticipation, goals, well-being, purpose, freedom, reality surveillance, and energy. Staats (1987) viewed hope as future oriented, with affective and cognitive components based on wished-for events and some expectations of achievement or occurrence of these events. By examining the difference

between expected negative affect and expected positive affect, they proposed an operationalization of the hope construct.

Averill and others (Averill et al., 1990) conducted a series of qualitative and quantitative studies to define hope by means of comparing it to wants and desires. They developed a set of rules and parameters of the hope construct. The parameters represents their conceptualization of the hope construct as an emotion and how it is similar to other emotions, where as their four rules describe the characteristics of a hopeful person. First, hope involves future uncertainties, yet these uncertainties should not be too great. In short, hope should be prudent. Second, the object of hope is circumscribed by what is personally and socially acceptable, it is related to personal values and morals. Hope is not associated with fantasies or desires, it is held more reverently. Third, hope is a vital interest, taking priority over other wants and desires. Lastly, hopeful persons are more willing to take appropriate action to obtain their goals. There was a tendency for subject to hope for things that were somewhat but not totally under their control and subjects consistently reported working harder toward hoped for goals and employing more creativity. Similar to Averill and other's conceptualization of the hope construct as an emotional function, Scioli and colleagues (Scioli, Chamberlin, Samor, Lapointe, Campbell, & Macleod, 1997) believe hope is emotionally rooted in early trust experiences and influenced by external and collaborative control beliefs.

Farren and associates (Farran et al., 1995) describe hope dynamically: A necessary condition for action exists, an expectation about attaining some

desired goal in the future is involved, and a subjective state exists that can influence things to come. They view hope as having four primary features. The first is described as an experiential process. Hope involves some struggle or pain of a situation that challenges a person; this is similar to Averill and others (1990) rule related to a vital interest. Second hope is described as a spiritual process. Hope is described as indivisibly linked to faith. It is characterized by the ability to make expectations fluid in the face of the absoluteness of the present and is likened to hoping for a miracle. Third, they describe hope as a rational thought process. The hope construct is explained as a learned process over time; requiring some sense of control of one's destiny, where one proactively employs physical, emotional, and social resources towards a goal that is realistically possible. Lastly, the construct of hope is defined in a relational process. This is the dynamic of inspiring hope in others through relational processes. It is suggested that hope is initially created in the developmental process of learning to trust in early relationships (Scioli et al., 1997). This relational view of hope is consistent with Frank's (1968) beliefs about the generation of hope in the therapy process. With these four central attributes of the hope construct, Farran and colleagues (1995) provide a comprehensive description of the dynamic construct of hope, accounting for the varied ways hope can be experienced. Yet, while capturing all the possible experiences of hope, it becomes more difficult to operationalize.

Nunn, whose theory of the hope construct is born out of Stotland's work, suggests that hope is the "general tendency to construct and respond to the

perceived future positively” (1996, p. 228). It encompasses three dimensions: temporality, desirability and expectancy. First, hope is future oriented. This perceived future is fundamental. Second, hope is a goal oriented, wished-for future that is of a positive nature experienced as desire. The degree to which the desire is experienced is related to the value one places on the hoped outcome. The third dimension, expectancy, relates to the belief that the desired outcome is likely to happen or come true. This belief is based on subjectively anticipated likelihood. This belief is occasionally distorted due to extreme importance or desire of the outcome, so it is sometimes hoped for even when the probability of the outcome is low. This is similar to some of Farran and other’s (1995) characterization of the fluidity of hope when outcomes appear less likely.

Within all of these descriptions of hope, many commonalities exist. All of these authors view hope as future oriented and founded in positive outcome expectancies (Averill et al., 1990; Farran et al., 1995; Miller & Powers, 1988; Nunn, 1996; Staats, 1987). They explain hope as being predicated on goals (Averill et al., 1990; Farran et al., 1995; Miller & Powers, 1988; Nunn, 1996; Staats, 1987). In relation to this goal orientation, hope is explained primarily as a cognitive operation (Farran et al., 1995; Nunn, 1996; Seligman, 1992; Staats, 1987). Yet there is an understanding of an affective element. This affective component spawns from goal orientation, and is characterized by desire, that is motivating and energizing (Averill et al., 1990; Miller & Powers, 1988; Nunn, 1996; Staats, 1987). In addition, hope is linked to previous experiences of obtaining and striving for desired outcomes that leads to a sense of possibilities



relative to ones past outcomes (Farran et al., 1995; Nunn, 1996). In essence an individuals hope is mediated by their previous experiences striving for goals. It is this previous experience with goals that affirm hope as a stable trait. Finally many authors description of hope captures an empowerment in which individual efforts are a dynamic of hope (Averill et al., 1990; Farran et al., 1995; Nunn, 1996).

#### Hope and Related Constructs

*Similar constructs.* To further describe hope, it needs to be examined in relation to other, similar constructs such as optimism and self-efficacy. Optimism is a research area of psychology that is flourishing and is currently one of the more recognizable constructs in positive psychology (Peterson, 2000). Optimism, like hope, has been linked to desirable characteristics like, happiness, health, achievement, and perseverance (Buchanan & Seligman, 1995; Carvajal, Clair, Nash, & Evans, 1998; Peterson, 2000; Scheier & Carver, 1992; Schneider, 2001; Seligman, 1992). Hope and optimism are extremely similar. Both emphasize the importance of outcome expectancies (the generalized belief about the chances that an outcome will occur) in predicting goal directed behavior. With hope defined, attention is turned to exploring what optimism is and how is similar and yet different than hope.

Similar to hope, optimism is still difficult to operationally define. The Oxford Dictionary offers this definition, inclination to hopefulness and confidence (Abate, 1997). Yet, optimism is not always consistent. Different levels of abstraction may be used to define optimism. Peterson (2000) refers to these

different levels as Little and Big optimism. Little optimism is focused on specific, positive outcome expectancies, whereas big optimism is generally a less specific, global, positive expectation. He considers big optimism more similar to hope. While some researchers would agree with this (Miller & Powers, 1988; Staats, 1987), another would see hope as more specifically focused (Averill et al., 1990), and others view hope less rigidly allowing for both specific and global positive expectancies (Farran et al., 1995; Nunn, 1996). Due to Peterson's (2000) different levels of abstraction his descriptions of optimism possibly operate differently. An additional issue involved of defining optimism, like hope, is how it operates in terms of cognitions, affect, and behavior. Optimism is viewed as a cognitive construct associated with goals and expectations (Scheier & Carver, 1992), yet it is very connected to emotion (Peterson, 2000). The hope construct is not as clearly defined regarding the primacy of cognition, affect, and behavior (Nunn, 1996), but all are believed to be at play (Averill et al., 1990; Nunn, 1996; Staats, 1987).

Accordingly, there are multiple interpretations and theories of what optimism is. One such theory evolved a decade ago. In 1992, Seligman shifted from his earlier work of learned helplessness to the more positive optimism (Buchanan & Seligman, 1995). This theory is based on research of learned helplessness (pessimism) and was used to inform their view of optimism (Peterson, Maier, & Seligman, 1993). Yet, Peterson (2000) states there is fault in the assumption that the absence of pessimism is optimism and vice a' versa, similar to Nunn's (1996) warning not to define hope as merely the absence of

despair/hopelessness. Buchanan & Seligman (1995) objectify optimism by examining the way individuals explain their involvement with bad events. Explanations that are considered external, unstable or from specific causes are considered optimistic and those who use internal, stable, or global causes to explain their experience in bad events are considered pessimistic. Accordingly, the instrument (Attribution Style Questionnaire) used to measure *explanatory optimism*, as it is referred, is influenced by causality and beliefs about how goals are reached.

In a differing view, Scheier and Carver (1992) described *dispositional optimism* as the global expectations that good and not bad things will happen in the future. Dispositional optimism revolves around individual's pursuit of goals always seen as positive and desirable, as is the same with hope. According to Scheier and Carver (1992) individuals whom believe they can achieve their goals in the face of difficulties are optimistic which leads to continue motivation towards goals. Scheier and Carver (1985) used the Life Orientation Test (LOT) to measure optimism. It is a pure measure of expectations based on dictionary definitions of optimism and pessimism, making no distinction about the agency (e.g., luck, hardwork) by which outcomes occur (Magaletta & Oliver, 1999).

Two studies have recently been conducted examining Scheier and Carver's dispositional optimism (1992, 1985; LOT) with the construct of hope, health and well-being. Magaletta and Oliver (1999) investigated hope, optimism, self-efficacy and general well-being. Results of a maximum-likelihood factor analysis indicated that optimism, hope, and self-efficacy are separate and distinct

constructs. These findings were further supported by the results of a multiple regression analysis that indicated optimism, hope, and self-efficacy each made significant and unique contributions to the prediction on well-being. This studies findings illustrate that there is a distinction between the constructs of hope, optimism, and, self-esteem. Additionally, another study corroborated these constructs relationship with well-being by finding optimism, hope, and self-esteem to be negatively correlated to past substance use of middle school children (Carvajal et al., 1998). Further, Tennen and Affleck (1999) found differences in optimism and hope when studying coping and wellness.

Another study investigates the relationship of hope, optimism, and health while controlling for psychological variables (Scioli et al., 1997). Findings indicated that hope is a better predictor of reported health outcomes than optimism. Analysis revealed that while optimism and hope were significantly correlated, “only 16% of the variance in hope scores was explained by the variation in optimism scores (Scioli et al., 1997, p. 730).” Again, these two constructs were found to independent of each other. Additionally chronic illness was correlated with lower levels of optimism and high levels of hope. Conclusions drawn suggested that hope may mediate major life events and more routine or minor hassles may be mediated by optimism. These findings are further explained by Averill and others (1990) who believe that optimism is associated with more confidence in obtaining desired outcomes than with hope. They expect optimistic claims to be based on realistic criteria. Accordingly, they suggest that optimism increases linearly with the probability of attainment.

However, these results found a curvilinear relationship between hope and the probability of attainment. So individuals reporting chronic illness, less likely of becoming free from illness, hope instead of having optimism because their probability is lower due to the persistence of their illness.

Averill and others (1990) view optimism being practiced through terms of rational criteria is not a consistently held view. Several authors are cited for their studies that demonstrate the dangers of optimistic bias, belief in positive outcome without logical basis (Klein & Kunda, 1992; Steele, 1988; Weinstein & Klein, 1996), including a study that suggests cigarette smokers avoid thinking about the dangers of smoking or don't quit because of the unrealistic belief that they will not be susceptible to the inherent dangers of smoking (Gibbons, Eggleston, & Benthin, 1997). Schneider (2001) has recently examined the difficulty of discerning the difference of optimistic illusions or biases, and realistic optimism. Schneider raises an important issue in evaluating reality negotiations mediating function within the construct of optimism. She contends that an important criterion to be considered when differentiating between optimistic bias (self-deception) and realistic optimism is one's evaluation of reality.

Schneider (2001) states that the subjective view of reality and of the future is fuzzy, it is difficult to exactly know truth or reality. Thus, to a degree a subjective evaluation must be made. To define realistic optimism Schneider (2001) uses Baumeister's (Baumeister, 1989) principle, optimal margin of illusion, which states that viewing oneself as slightly better than one really is, is the most beneficial way to negotiating one's reality. It is a positively biased view that a

desired outcome or experience will occur, yet within the fuzzy parameters of what is reasonable to expect. Schneider (2001) suggests three principles of realistic optimism.

First, leniency may be employed when assessing our past performances, which involves a search for positive aspect of a situation to counteract or balance negative aspects, within the bounds of allowing oneself the benefit of the doubt (Schneider, 2001). The second principle of realistic optimism is appreciating the moment. Behaviorists speak of catching children being good so this behavior may be reinforced; this principle is similar in that one practices the behavior of noticing the positive that exist in the present. The third principle of realistic optimism is similar to the business cliché, a problem is merely an opportunity. This brings a positive attitude toward problem solving and goal striving.

Schneider's (2001) realistic optimism, has a different flavor than either Scheier and Carver's (1992) dispositional optimism or Seligman's (1992) explanatory optimism. Patterson (2000) suggests that evaluating optimism via pessimism as is done in explanatory optimism is questionable method. And sense Scheier and Carver's (1992) dispositional optimism is also based on a optimism-pessimism polarization, Schneider's (2001) realistic optimism possibly differs due to the break from the optimism/pessimism paradigm. Currently, however, realistic optimism cannot be compared to these other measures because Schneider has no operational measure of realistic optimism.

Peterson (2000) warns that optimism can have a downside, yet this flourishing area of research rarely qualifies these conditions. For example

Norem and Cantor (1996) explain that optimism has ego enhancing aspects but also can be defensive aspects as well. Yet, (even though it requires qualifiers) Peterson (2000) states that research of optimism deserves to be studied because of its benefits to the human condition, and should not die off like a fad.

Another similar construct to hope is self-efficacy that Rosenberg (1965) explains as an overall assessment of one's self worth. Like optimism and hope, Bandura's (1982) theory of self-efficacy understands goal directed behavior by discerning efficacy expectancies from outcome expectancies. Bandura (1982) describes efficacy expectancy as the degree to which one believes that one has the capacity to successfully attain a desired goal (similar to agency, Snyder, 1991). Outcome expectancies are depicted as beliefs that certain actions will result in a targeted outcome (Bandura, 1986), similar to Snyder's (1991) concept of pathways. Contrary to hope and optimism, self-efficacy theory sees personal efficacy as the most powerful predictors of behavior when examining expectancies (Snyder et al., 1991). Bandura (1982) makes judgments on self-efficacy by assessing how well one performs on a given task at a given time.

*Related but different constructs.* Next, constructs that are dissimilar to hope will be explored. In particular hopelessness will be discussed in relation to hope. Hopelessness has been the most researched and clinically used dynamic of hope. This is attributed to Aaron Beck and his colleagues' development and research of the Beck Hopelessness Scale (BHS) that quantified a polar opposite of hope (Beck et al., 1985; Beck et al., 1974). Therefore, it will briefly be examined to illustrate how it relates to the construct of hope defined thus far.

Hopelessness is conceptualized as generalized global negative expectations of oneself and the perceived future (Beck et al., 1974). The BHS, the most popular instrument associated with the construct of hope, is widely used with depression and anxiety (Abramson, Metalsky, & Alloy, 1989; Beck et al., 1985; Dixon, Heppner, Burnett, & Lips, 1993; Lynd-Stevenson, 1997; Rholes, Riskind, & Neville, 1985). It was found to be apt to predict suicide, even 10 years into the future (Beck et al., 1985), so it has found great utility as a screener for potential suicide and presence of suicidal ideation. Clearly, Beck and his colleagues work in this area have greatly contributed to the field of mental health, but Nunn states that it is unfortunate that via the BHS, hopelessness means global negative expectations instead of a more accurate description, the absence of either global positive or negative expectations. Nunn warns us not to define hope as merely the absence of despair (Nunn, 1996). Nunn and Lewin (1996) as well as Miller and Powers (1988) illustrate this point by their instrument validations finding a  $-.54$  correlation with the BHS. This shows that hope, as researchers describe it, is a related but different construct to Beck's (Beck et al., 1974) hopelessness.

Nunn (Nunn, 1996) argues that hopelessness should be reserved for expressing the absence of positive expectations and despair used to describe negative global expectations. It is suggested that while the absence of hope does not mean despair or *vice versa*, it follows that it is possible they coexist. There are people who do not hope yet are not despairing. Likewise, there are people who do not fear the worst, yet do not expect their hopes to be fulfilled.



Nunn relates that research methodology should not ignore the possibility of positive and negative expectations, as well as affects coexisting. This condition is possible due to the global measurements being subject to different determinants and directed towards all domains of one's experience. This is to say that a given individual may be experiencing positive expectation in one domain of life and negative in another. This should be accounted for in research methodology.

Another issue that must be addressed is denial and its relationship with hope. Vaillant (1977) refers to denial as a method of negating reality. In this context, denial is referring to purposefully not acknowledging, conscious or not, the constraints of reality. The belief that what is desirable is probable may be viewed as hope by some. However, when holding such expectation, regardless of reality, suggesting the desired outcome is extremely improbable should be characterized as denial (Nunn, 1996). Interpreting and negotiating reality are important factors involved in the genuineness of hope (Averill et al., 1990; Farran et al., 1995; Nunn, 1996; Tillich, 1965) and optimism alike (Klien & Kunda, 1992; Peterson, 2000; Schneider, 2001; Weinstein & Klein, 1996). Hopefulness and denial, as coping mechanisms, play complex roles in our negotiating reality that are not yet fully understood (Nunn, 1996). It is also possible to be oversensitive to the constraints of reality and not to have any hopefulness about them (Nunn, 1996; Peterson et al., 1993).

Although, it cannot always be assumed that hope is adaptive and despair is maladaptive. It has been shown that people have successfully used defensive

pessimism to cope with situations that threatened self-esteem and failure (Norem & Cantor, 1996). Likewise, it has been found that hope and gregarious coping styles in their maladaptive forms may emulate histrionic tendencies (Elliott & Sherwin, 1997). Baumeister (1989) has expressed concern that researchers have not establish an “optimal margin of illusion” to indicate at what point hope becomes maladaptive.

### Snyder's Hope Theory

Snyder and his colleagues, consider hope to be a cognitive component that involves an overall perception that goals can be met (Snyder et al., 1991). Their theory of the hope process is developed around a goal directed premise. Goal-thinking is a basic process in hope. Goals are the framework or endpoints upon which the operations of hope act. These primary operations or components are, pathways (planning to meet goals) and agency (goal-directed energy; Snyder, 1995; Snyder et al., 1997; Snyder et al., 1991) and it is their interaction that is the basis for Snyder's hope theory.

*Pathway thinking.* Once a goal is conceptualized, the next cognitive step is to imagine a route to the goal. The pathway component of hope theory reflects perceiving successful pathways or strategies that are available to attain goals (Snyder, 2000a; Snyder et al., 1991). It is both the ability and resourcefulness of an individual in planning to reach goals. Fundamental pathway thinking is coming up with routes to goals. Yet more sophisticated pathway thinking is demonstrated by recognizing when a strategy or route is not working, developing an alternative, and when barriers present themselves developing strategies to

overcome them. It is in this manner that hope influences one's perception of available successful pathways to goals.

*Agency thinking.* The other component of Snyder and his colleagues (Snyder et al., 1991) hope theory is Agency. Snyder describes Agentic thinking, within the hope process as, "a sense of successful determination in meeting goals in the past, present, and future" (Snyder et al., 1991, p. 571). An individual's capacity to begin and continue movement towards a chosen goal determines his or her level of agency. Agency is the fuel that pushes individuals towards their goals and can be thought as motivational will power. An additional aspect of agentic energy is one's perception/appraisal that one can persevere through the undertaking to the end goal. This critical element of agency has important implications not only for one's level of agency but for pathways and hope.

*The relationship of past to future orientation.* Through the developmental process, children can learn to maintain agency and discover pathways that will increase their levels of hope through encouragement and modeling of care givers. Snyder and others (Snyder et al., 1997) propose that our successes or failures negotiating barriers within the hope process, plays a fundamental role in the individual differences of our hope. Hope theory is based on cognitive appraisals. The incorporation of the individual's perceptions of themselves and their past is critical to their schema regarding goal attainment (Snyder, 1995; Snyder et al., 1991; Snyder, Michael et al., 1999). It is the successes and failures that begin to set the tone for one's expectancy of the future and hope. In

this context hope is not a goal-related state but an enduring disposition that is subjectively defined by assessing agency and pathways.

*Agency and pathway interaction—hope.* Both agency and pathways are necessary through the entire goal-attainment process (Snyder, 2000b; Snyder et al., 1991). To elaborate, once a pathway is decided upon, agency can't maintain the process from that point forward in goal-related journeys. Conversely, the will that agency provides to start goal-oriented movement does not end once a pathway for a goal is decided upon. Agency and pathway thinking is needed throughout the process to sustain movement towards a goal. To put a twist on the cliché, "where there is a will there is a way," both a will (agency) and a way (pathway) are needed to maintain successful movement towards goals (hope). Agency and pathways are reciprocal, yet they are not the same. The presence of both and their interaction represents what is necessary to achieve high levels of hope. One must not only have the will (agency) but also the way (pathways) to attain a goal (Snyder et al., 1991). This creates the greater or latent cognitive set of hope, yet an affective element is present.

*Levels of Hope.* Hope is viewed as a cognitive construct, but is related to emotionality (Snyder et al., 1991; Snyder & Taylor, 2000). It is a theory of cognitive appraisals, and conclusions drawn from these appraisals that result in affect—the power of hope. Snyder states the "quality of ones emotions reflect their perceived level of hope in a particular situation" (Snyder, 1995, p. 355). In other words, persons with high hope and low hope will approach a given goal with different emotional qualities, the former with positive emotions and a sense

of impending success and the latter with trepidations from negative emotions and a focus of impending failure instead of success. Put in terms of goals, those who are unimpeded and energetic in the pursuit of their goals will experience positive emotions where those who face barriers and/or are stalled by apathy will experience negative emotions. Again, it is our past successes and failures that set the tone for one's expectancy of the future goal-attainment. In this capacity the affective power of hope is more clearly seen. This dynamic of hope results from cognitive appraisals of past goal related outcomes.

*Findings of high and low hope.* Through use of an assessment measure that Snyder and his associates (Snyder et al., 1991) have developed, research has been conducted that shows clear differences between individuals with high and low hope. Three areas that relate to psychotherapy have been examined in regards to hope: achievement, health, and psychological adjustment. Higher hope is related to better performance on standardized achievement measures (Snyder, Wilklund et al., 1999) and better semester grades (Snyder et al., 1991), graduation rates, even when statistically controlling for ACT scores (Snyder, Wilklund et al., 1999). These findings may also have implication for client achievement in psychotherapy.

Individuals who are high in hope are more likely to engage in physical exercise, a known correlate with good health (Harney, 1990). Further, research has shown after spinal cord injury those with higher hope are associated with lower risk of depression and more adaptive coping (Elliott et al., 1991). Tennen and Affleck (1999) found that women with higher hope who have fibromyalgia

were able to find more benefits from the disease condition and remind themselves of these benefits. Additionally, these findings held true when statistically controlling for optimism and pessimism. These findings suggest hope is related to coping, maintaining positive outlook, and health promoting behavior.

Hope has been linked to other factors of coping and adjustment. Snyder and others (Snyder et al., 1991; Snyder et al., 1996) have found that individuals' with higher hope have more positive thoughts and less negative thoughts than individuals' with lower hope. Additionally, people with low levels of hope think negatively about their goal pursuits and have serious concerns about their ability to cope. Individuals with high levels of hope are more confident and energized by their goals and have higher self-esteem (Snyder et al., 1991). Furthermore, people with high levels of hope generally see themselves and their future in an overly rosy light (Curry et al., 1997), while people with low levels of hope prefer negative self statements and tend to ruminate on the negative aspect of their goal pursuits (Snyder et al., 1998). These conclusions suggest that it may be more difficult for people with low levels of hope to change in the psychotherapy process due to their negative set of characteristics, yet they may be in greater need. Additionally, they may have more difficulty becoming engaged in their therapeutic goals, whereas a person with high hope might find it easier to engage in therapy goals.

#### Hope in Psychotherapy

Hope is seen as a disposition, so a person's level of hope is typically considered a trait (remains stable). Yet, Snyder believes level of hope can be

changed over time citing counseling as a potential vehicle (Snyder, 1995). It has been found that individuals seeking psychological assistance have significantly lower hope than the normal population (Snyder et al., 1991). Studies have found that low hope is related to psychological problems and psych morbidity (Gottschalk, 1974; Snyder et al., 1991; Snyder, Irving, & Anderson, 1991). This research is further supported by Beck and his associates' findings that hopelessness, is a cogent predictor of suicide, even more so than depression (Beck et al., 1985). Elliott and Sherwin (1997) found a clear association between the construct hope and mental health and Frank has further asserted that the essence of successful psychotherapy is generating hope in clients (Frank, 1968). He also contends that the degree to which individuals have hope, directly impacts their treatment prognosis in psychotherapy. Indicating that individuals with higher hope will have better prognosis. So even though Frank (1968) and Snyder (1995) consider hope to be a stable character trait, they view counseling and psychotherapy as a viable way to increase individual's hope (Frank, 1968; Snyder, 1995).

### *Psychotherapy*

#### History

Beginning in the late nineteenth century, psychotherapy began establishing itself as a part of psychology. Certainly, Sigmund Freud and psychoanalysis is commonly thought of as the inception of talk therapy. With the valuable contributions of Adler, Jung, Horney, and Sullivan psychodynamic theory blossomed. John B. Watson's *Behaviorist Manifesto* infused new ideas in

psychotherapy creating a new school of thought—Behaviorism. As with psychoanalysis, this triggered other versions, called neo-behaviorist and radical behaviorist. Much of psychotherapy's growth during the 20<sup>th</sup> century is marked by the evolution and development of different theoretical orientations. Cognitive, Person-Centered, Existential, and Gestalt, represented another generation of theoretical frame works and the schoolism culture of psychotherapy was firmly in place. This has been a custom of psychology and today even more theories of psychotherapy exist including blends (cognitive-behavioral). More recently, there has been a paradigm shift; psychologists have begun integrating these different theories in their practice of psychotherapy (Norcross & Goldfried, 1992).

As psychotherapy has developed as a science, psychologists have also concurrently strived to empirically validate its effectiveness (Bergin & Garfield, 1994a). Historically, researchers, scholars, and practitioners have done this by loyally developing others theoretical orientations by empirically testing its effectiveness or pioneering their own theories. In the past, these different theoretical orientations have been a major criterion by which psychotherapists define their work and to an extent define themselves as psychotherapist. This theoretical basis of psychotherapy has been well established throughout the past century. While there is no questioning the growth and knowledge psychotherapy has gained from these schools of psychotherapy, in the past it has also led to divisions within in the field, especially when used as a vehicle to measure effectiveness.



The convergence of two factors has more recently led this to slowly change. First over the past 20 years, government, consumers and insurance companies, have increasingly demanded that psychologist empirically show what they do works (Bergin & Garfield, 1994a). The second factor is the inability for the accumulation of theoretically based psychotherapy outcome research to differentiate the effectiveness of the different schools of psychotherapy.

Research has shown that the many different theories and specific techniques have not distinguished themselves from one another as being more effective (Hubble, Duncan, & Miller, 1999; Lambert & Bergin, 1994). Further, with few exceptions “massive evidence has shown that psychotherapy techniques do not have specific effects” (Bergin & Garfield, 1994b, p.822). In short, different psychotherapies have not shown that one has a specific effect that another does not. This is not to say that theories of psychotherapy are not effective because researchers have clearly shown they are (Bergin & Garfield, 1994b; Hubble et al., 1999; Lambert & Bergin, 1994) but there is no relative difference among the efficacy of the different theories and techniques. However, it has been a struggle for psychotherapy research to make the shift from its theoretically oriented history to a more atheoretical lens of psychotherapy research. Never the less, the method of research focusing on the efficacy of one theory versus another has changes considerably over the past 20 years (Bergin & Garfield, 1994b).

## Common Factors of Psychotherapy

Now, psychotherapy process and outcome research has shifted towards trying to identify and isolate the factors of change within psychotherapy and then amplify their influence (Bergin & Garfield, 1994b; Hubble et al., 1999; Snyder et al., 2000). These factors that are seen as being influential across the different therapy approaches are referred to as common factors or non-specific factors of therapy (Barker et al., 1988; Bergin & Garfield, 1994b; Lambert & Bergin, 1994). In this paper the term common factors will be used. The idea of common factors was first hypothesized by Rosenzweig (1936) and is not only founded in comparative outcome literature, but it is also based on research intent on identifying the operating elements of psychotherapy (Lambert & Bergin, 1994). Currently, most theorist accept the existence of common factors and that they account for a “substantial amount of improvement found in psychotherapy patients” (Lambert & Bergin, 1994, p.163) and should be a focus of researchers (Bergin & Garfield, 1994a)

*Common factors.* Through reviewing the literature, Lambert and Bergin (1994) developed a list of 32 common factors that they divided into three phases of therapy: support, learning, and action factors. This classification system was devised to represent the sequential process operating in most psychotherapies. Initially, therapies work to increase clients' trust and create a sense of safety. This eases anxiety and tension allowing clients to increase insight and embrace alternative perspectives, which leads to acting differently. Alternatively, common factors can be conceptualized by therapist and client variables. As well, a review

of the literature has found that there are many elements at play in psychotherapy outcome including expectancies (placebo effects) (15%), techniques (15%), extratherapeutic change (40%), and therapeutic relationship (30%) that can be viewed more broadly as categories of common factors (Lambert, 1992). The more frequently investigated common factors involve the therapeutic relationship (Hubble et al., 1999) which Lambert's (1992) review found contribute to 30% of the outcomes of psychotherapy.

The importance of the therapeutic relationship was first noted for its healing and positive functions by Carl Rogers book, *Client-centered Therapy* (1951). The necessary conditions of Roger's client-centered approach such as positive regard, congruence, and accurate empathy have been repeatedly studied as a common factor. These qualities of the client-centered approach are seen as virtually universally and necessary if not sufficient to almost all approaches (Lambert & Bergin, 1973). Accordingly, hundreds of studies have support the correlation between a good therapeutic relationship and positive outcomes (Horvath, 2000). Lambert and Bergin (1994) state that the literature unanimously embraces the therapist-client relationship as critical to psychotherapy success, yet they contend that this body of knowledge is more ambiguous than previously thought. This is attributed partially to methodology, specifically reliance on client self-report of therapeutic relationship differing from objective raters' perception. However, Horvath (2000) interprets the difference between client self-report and objective raters differently. He suggests this body of research indicates that it is the clients' perception of the quality of therapeutic

relationship, regardless of objective raters, that is most significant to positive outcomes.

Therapeutic alliance is an additional common factor that has received considerable attention. Goldfried (2000) states in an *In Session* edition of the *Journal of Clinical Psychology*, "alliance is one of the most essential features of psychotherapy," and it is one of the few areas where there "is clinical consensus and research verification." Lambert and Bergin's (1994) review of the literature concurs, suggesting that the therapeutic alliances in associated with positive change and early alliance ratings may be predictive of psychotherapy outcomes. Therapeutic alliance differs from the therapeutic relationship as it uses a heavier emphasis on client and therapist variables and its closer theoretical association to psychodynamics. Generally referred to as a construct, it was developed as a way to conceptualized the interaction or process between client and therapist variables.

Martin and others' (Martin, Garske, & Davis, 2000) review of the literature found commonalities in the description of the therapeutic alliance: "(a) the collaborative nature of the relationship, (b) the affective bond between patient and therapist, and (c) the patient's and therapist's ability to agree on treatment goals and tasks" (p. 439). Gaston (1990) states therapeutic alliance is comprised of four characteristics: (a) patients' affective relationship towards the therapist, (b) patient's capacity to work towards therapeutic goals, (c) therapist's involvement, empathetic understanding, and agreement on goals and (d) task of therapy (collaboration). Horvath and Symonds (1991) review of 24 studies found

.26 effect size linking quality of therapeutic alliance and psychotherapy outcome. A more recent meta-analysis of 79 studies found a .22 correlation between outcome and alliance (Martin et al., 2000). Both these studies suggested that the relationship might be greater due to the conservative approaches taken in each study. The consensus within this body of research does indicate that the strength of alliances is predictive of outcome

*Client variables.* While the body of research pertaining to therapeutic alliance has led to convincing results regarding outcome, Lambert's (1992) findings indicate extratherapeutic events and client variables are also major contributors to psychotherapy outcome. Review of research has found that client variable such as motivation, severity of disturbance, capacity to relate, ego strength, psychological mindedness, and ability to identify problems are important factors in therapy outcomes. Also, another client variable garnering more attention in the past decade is client readiness for change, which will be explored further in a following section (Prochaska & DiClemente, 1983). While these areas are less under therapist control, the client is more a vehicle in implementing change than the therapist (Bergin & Garfield, 1994b; DiClemente & Prochaska, 1982). This has important implications to psychotherapy outcome research. These findings reiterate the dynamic role of clients in psychotherapy and are important to consider in formulating methodologies and understanding common factors and psychotherapy outcomes.

## Hope as a Common Factor

Recall Lambert's (1992) review found expectancies to contribute 15% to psychotherapy outcomes. A review of 50 studies found client's expectancies that they could affect change in problem areas in their life was a powerful common factor (Grencavage & Norcross, 1990). Hope is founded in positive outcome expectancies. Thus there is a significant overlap between clients' expectancies for success and hope of relief for whatever ails the client. Frank (1968) long ago suggested that clients seek therapy because they are demoralized due to an inability to solve their own problems. Consequently, he advocated the generation of hope as a core element in successful therapy (Frank & Frank, 1991). And Yalom (1995) has long supported instillation of hope as a curative factor in group therapy. This view is supported by findings that 58% of clients surveyed stated installation of hope to be associated with curative factors of cognitive behavioral therapy (Murphy, Cramer, & Lillie, 1984).

The hope construct is also goal oriented much as psychotherapy. In their own ways, the multitudes of psychotherapies practiced today are predicated on a sequential process of evaluation, goal setting, and working towards goals. This relates more specifically to Snyder and others (1991) component of hope—pathway, the perceiving successful pathways or strategies to attain goals. Others (Frank & Frank, 1991) postulate, one of the commonalities at work within psychotherapy is *therapeutic rationale*, which conceptualizes clients' symptom(s) and understands how to treat them. This implicit and explicit understanding is significant. It illustrates to the client that there is an institution that has an

explanation and is perceived by the client as a vehicle to the change they desire. By this belief in *therapeutic rationale*, hope is at work as well as providing clients with ways to their goals.

Another characteristic of hope is the affect experienced as energy and motivation inspired by a possible desired outcome and positive expectancies. This is at play during the different phases of psychotherapy. Its impact can be seen in the early therapy process by the behavioral manifestation of clients doing something to get better such as making the first appointment. An increase in energy and motivation is the part of this positive expectancy. Barker and her colleagues (1988) meta analysis identify this common factor as generalized positive expectations for improvement and demonstrate its effectiveness over control groups. This common factor similar to agency is variable both within clients and has ebbs and flows through the psychotherapy process

#### *Premature Termination*

Client premature termination from psychotherapy or psychotherapy dropout has been studied for decades due to the problems that it presents for practitioners, researchers, and clients (Baekeland & Lundwall, 1975; Howard, Krause, & Orlinsky, 1986; Wierzbicki & Pekarik, 1993). While findings have been mixed in this area, researchers agree that clients who terminate their participation or drop out of the therapeutic process hinders practitioners' efforts to provide effective and efficient mental health services (Garfield, 1994; Pekarik, 1985). Thus psychology, in an attempt to act responsibly toward this problem,

has worked with mixed results toward understanding this problem and identifying its causes.

Within this body of knowledge the least is known about psychotherapy dropouts themselves, however Howard and his colleagues found that within eight sessions approximately 50% of the 2,400 patients studied showed measurable improvement and concluded optimal effects are achieved after participation in minimum of six to eight sessions (Howard, Kopta, Krause, & Orlinsky, 1986). This suggests that those clients who drop out of treatment prematurely are not benefiting from the “dose effect” of psychotherapy Howard and his colleagues found. This is supported by the relatively few studies examining dropouts, which suggests they report low client satisfaction and a substandard outcome (Lebow, 1982; Pekarik, 1985). What is clear is that premature terminators: do benefit from treatment relative to completers, reduce efficacy of treatment, and decrease its cost effectiveness while exposing practitioners to morale, financial, and clinical problems (Garfield, 1994; Pekarik, 1985). Further premature terminators take up appointment time that practitioners could be filling with other clients and contribute to relative size of waiting lists. Compounding this problem is the finding that clients who experience long delays before starting therapy and increased likelihood in premature termination (Roldolfa, Rapaport, & Lee, 1983). In addition, premature termination presents methodological and design problems for evaluating treatment programs and efficacy (Harris, 1998).



## Treatment Duration

To fully understand the issue of premature termination it must be considered in the context of those who complete treatment. In 1994, Garfield reviewed 20 studies from 1948 to 1989 that examined the number of sessions clients attended. The median number of sessions attended ranged from 3-13 and the aggregate mean of these studies results was between six and seven sessions. A separate review in 1986 of 15 studies, spanning 30 years by Howard, Kopta, Krause, and Orlinsky reported means ranging for 4-33 sessions with a collective median of 12 for all the studies. These studies reflect the number of sessions attended by all clients making no distinctions of whether they completed treatment or not. Considering these results suggest the number of sessions attended by clients to be clustered between six and 12 sessions. This does not account for the one in four clients who refuse treatment offered to them without attending any interview, referred to as rejecters. Clearly the length of treatment for most clients is relatively short compared to psychologists' expectations.

## Operational Definitions of Premature Termination

Operationalizing what constitutes premature terminators of psychotherapy is a major problem of effectively examining this issue (Pekarik, 1985). Throughout the literature there are three ways to define premature terminators, by (a) durations, (b) no show for a scheduled appointment, and (c) therapist judgment. The majority of studies have defined premature terminators in terms of treatment duration or the number of treatment sessions (Wierzbicki & Pekarik, 1993). While this somewhat arbitrary method is easy to use, its primary limitation

is that researchers agree that both successful treatment completion and premature termination can occur after virtually any session. By this method, it is possible to include completers in with dropouts and visa versa. The second method is defining premature terminators as those clients who do not show up for a schedule, agreed upon session are seen as conservative. Yet, by this definition at any time a client can decline to schedule another appointment against the clinical recommendation of the therapist and still be considered a completer. The third way to define premature termination is for the therapist to use his or her clinical judgment. The most significant problem with this method is therapist using different criteria for judging appropriateness of client's termination—reliability (Wierzbicki & Pekarik, 1993). However, this method, therapist judgments, is the very basis for concept of evaluation of appropriateness for continuing or discontinuing therapy. This method of defining premature termination is more flexible than the other methods and has face validity. Using therapist judgment to determine appropriateness of termination is the suggested method for identifying premature terminators (Garfield, 1994; Wierzbicki & Pekarik, 1993).

#### Rates of Premature Termination

The rate of premature termination can be explored more clearly now that contexts for the number of sessions and course of psychotherapy treatment have been established and the differing ways psychotherapy dropout and premature termination are defined have been examined. Premature termination has been a problem throughout contemporary psychotherapy treatment (Wierzbicki &

Pekarik, 1993). One studies review of the Berlin Psychoanalytic Institute determined 33% of the cases over a 10 year period prior to 1930 were judged as not completing their treatment (Bergin, 1971).

This trend has generalized across setting and theoretical orientations. A study across settings found that within 2 sessions, 40% of community mental health center clients and 20% of private practice clients terminate therapy and these numbers increase respectively to 75% and 50% by the 10<sup>th</sup> session (Pekarik & Wierzbicki, 1986). In another study of a college counseling center, 24% of the clients failed to return after intake (Betz & Shulman, 1979). Other research of a college counseling center found that 19% of clients failed to return after one visit and this percentage increased to 36% and 59% after the end of three and ten sessions respectively (Richmond, 1992). In a study of private practice, clients who were characterized as educated and committed financially and temporally, 13% of the clients dropped out after the first session and 28% by the eighth session (DuBrin & Zastowny, 1988). Other research found premature termination rates of 34% for drug therapy, 30% for dynamic psychotherapy (McLean & Hakstain, 1979), and 5% for behavioral therapy, and 14 of 32 clients diagnosed with bulimia nervosa dropped out of cognitive-behavioral therapy (Steel, Jones, Adcock, Clancy, Bridgford-West, & Austin, 2000). Further, Sledge and colleagues (Sledge, Moras, Hartley, & Levine, 1990) reported dropout rates of 60% for brief therapy (3-4 months) and open-ended therapy in contrast to a 32% dropout rate for time-limited therapy (12 session).

In 1993, Wierzbicki and Pekarik conducted a comprehensive review of 125 studies on outpatient psychotherapy dropouts from 1974-1990. Their meta-analysis found a mean dropout rate of 46%. This finding was essentially at the midpoint of the results (30%-60%) of three major reviews examining studies of clients prematurely terminating therapy (Baekeland & Lundwall, 1975; Garfield, 1994; Health, 1981). While the breadth of this meta-analysis allows the results to be generalized across the practice of mental health, the authors note limitations. Particularly, results differed by how the studies defined premature termination (Wierzbicki & Pekarik, 1993). Premature terminators defined by duration and therapist judgment resulted in an identical 48% drop out rate, but when defined by failure to attend a scheduled session the rate decreased to 35%. Through these findings the authors illustrate the inherent importance in defining dropouts, suggesting that failure to attend a scheduled session is a conservative and questionable method and that duration based-based definitions while more consistent limit the comparison of studies due to there arbitrary nature. Thus the ability to compare conclusions and replicate studies is limited.

#### Factors Associated with Premature Termination

Researches agree that there has been little success in identifying factors that are associated with premature termination (Garfield, 1994; Wierzbicki & Pekarik, 1993). In fact there have been many conflicting findings which many believe are related to methodological flaws alluded to above (Garfield, 1994; Harris, 1998; Wierzbicki & Pekarik, 1993). Primarily studies have examined demographic (e.g., sex, race, age, education, SES, and marital status),

psychological (disorders, prior treatment, waiting period, diagnosis, and referrals), and therapist variables (sex, race, experience, and level; Wierzbicki & Pekarik, 1993).

Some demographic variables association with therapy dropout have been found including social class (Berrigan & Garfield, 1981; Pinkonis, Imber, Lewis, & Rubinsky, 1984); mixed results with race (Greenspan & Kilish, 1985; Sledge et al., 1990) and education (Rabin, Kaslow, & Rehm, 1985; Sledge et al., 1990), while sex, age, and diagnosis through the years have shown little or no relationship to premature termination (Garfield, 1994). The Wierzbicki and Pekarik (1993) meta-analysis found that only minority racial status, low education, and low SES were associated with premature termination of psychotherapy. Interestingly, Richmond (1992) found premature termination to be associated with different variables by examining when the dropouts occur during different phases of therapy (i.e., intake, evaluation, therapy completed).

Comparing investigation of psychological variables association with premature termination is difficult due to the variations of treatments used, sample differences, variety of test used, variations in the use of the tests, as well as different criteria for defining dropouts. Consequently, due to these factors, research of the Rorschach and MMPI (two of the most studied psychological instruments) has found mixed results in the examining their relationship to premature termination (Hilsenroth, Handler, Toman, & Padawer, 1995). One study by Hoffman (1985) has shown individuals with problems in interpersonal

relationships were found to be associated with terminating from therapy prematurely.

Wierzbicki and Pekarik (1993) suggest that more complex psychological variables be examined in the investigation of premature termination since the simple variables typically studied in premature termination research have found no strong relationships. Additionally, Garfield (1994) suggests that we need to know much more about these variables and their relationship to premature termination. He suggests looking at the different variables in concert within the therapeutic process that there may be interactions among them that would predict this phenomenon (1994). Clients, practice, and treatment evaluation will continue to suffer from the repercussion of premature termination without methodological improvements (Harris, 1998), especially in the operationalizing of the criteria for defining premature termination (Garfield, 1994; Wierzbicki & Pekarik, 1993).

### *Stages of Change*

#### Transtheoretical Model

Pochaska (1979) developed the transtheoretical model out of a comparative analysis of leading theories of psychotherapy and behavior change with the purpose of integrating their strengths. This model was created with several intended goals: (a) emphasizing empiricism, (b) account for how people change both with and without therapy, (c) generalize to a broad range of human problems, (d) encourage psychotherapist as innovators of systems of psychotherapy (e) all while recognizing the need to preserve the rich and unique

contributions of the major theories of psychotherapy. With this model, the intent was to shift the focus from what needs to be changed in people (pathology) to the process of how people change.

The search was performed to identify the processes of change that were operating across the multitude of reputable theories being used at the time. Further analysis resulted in the identification of only six central *processes of change* taking place within the utilization of major theories of psychotherapy (e.g., consciousness raising, catharsis, conditional stimuli, contingency control, choosing, therapeutic relationship; Prochaska & DiClemente, 1982; Prochaska & DiClemente, 1983). As the model was developed, Prochaska and DiClemente (1982) found that the different processes of change that people utilized was dependent on where in the course of change they were at. Thus, the model integrates these designated principles and processes of change with the *Stages of Change*. Later, Prochaska and DiClemente (1983) validated the theory that behavioral change takes place through a progression of stages.

#### Readiness for Change

*Why use stages?* Prochaska and DiClemente (1983) view stages as a fundamental way of conceptualizing the process of change (Prochaska, 2000). Stages symbolize both the temporal nature and sequence of change. Furthermore, stages represent the dualistic nature of change. Stages imply the stable and sometimes chronic nature of the human condition, yet at the same time stages are dynamic and open to change but only through intentional and effortful means. Finally, stages, within the transtheoretical model, allow for a

conceptualization of the different processes of change that occur at different stages of change.

The stages of change are indicative of both an individual's point or progression within the change process and their motivation level for change. The stages are essentially developmental, requiring that tasks of a stage are necessary to complete before moving on to the next stage in the progression. However unlike theories of development, no inherent motivation is recognized for moving through the stages of change (Prochaska, 2000). Research speculates about two factors regarding this motivation. Ironically, the first is developmental. The mean age of smokers who quit is 39, which is indicative of a developmental period during which a considerable amount of reevaluation takes place (Prochaska & DiClemente, 1983). The other is naturally occurring events that are related to problem behavior such as a smoker losing someone close due to lung cancer or having a traumatic crisis related to the problem behavior.

The transtheoretical model calls for another motivating factor to progress through the stages of readiness for change, planned intervention. Through empirical research, Prochaska and colleagues (Prochaska, 2000; Prochaska & DiClemente, 1992) have found that the particular processes of change utilized are dependent on which stage an individual is in. For example to move from an early stage of change to a more advanced stage one must recognize that there is a problem, see the benefits of making a change and utilize processes of change such as consciousness raising and environmental reevaluation to promote this progression (Prochaska, 2000; Prochaska, DiClemente, & Norcross, 1992).



Likewise, an individual who is in a more advanced state of change will be more engaged in the change process. Yet, as change is complex sometimes certain tasks of stages need to be repeated. Thus stages of change are sometimes cycled through. So these stages are predicated on the readiness for change and therefore reflective of an individual's willingness to recognize potential areas of change, take action to make change, and maintain change that has been achieved.

*Stages of Change and the processes of change.* The respective progression of the five stages of change are as follows: Pre-contemplative, Contemplative, Preparation, Action, and Maintenance (Prochaska, 2000; Prochaska & DiClemente, 1992). Individuals in the Pre-contemplative, the first stage, usually are not intending to take action in the foreseeable future due to lack of awareness of the consequences of their problem behavior as well as underestimating the benefits of change. Additionally, they avoid acknowledging their problem behavior. Traditionally treatment has often characterized this group as resistant or unmotivated. In the Contemplation stage people are aware that a problem exists and have some intention to take action but are not committed to take action. There is ambivalence created by the recognition of the benefits of changing while a keen awareness of the effort and cost in changing. Research that has followed a group of 200 contemplators has found their modal response is to remain in the Contemplation stage for two year, illustrating how people can remain stuck in these early stages (Prochaska & DiClemente, 1992). Frank (1968) would consider these two groups as demoralized while Snyder

(2000a) might view them as lacking the agency or pathways to clearly identify and pursue their goals.

Preparation is the first stage where there is an intention for change combined with some behavioral criteria (Prochaska, 2000; Prochaska & DiClemente, 1992). They are intending to make change in the near future as well as have made some minor behavioral change and/or have some plan of action. It is at this point in the stages of change that individuals start to become candidate for treatment that is action oriented. Unfortunately clients and clinicians have been observed to most consistently use processes that are consonant with the earlier contemplation stage (consciousness-raising and self-evaluation) when trying to move clients into action (Prochaska & Norcross, 1999). Individuals in this stage should be lured to the Action stage through using self-liberation and social liberation processes of change.

Action is the stage which people have experienced successful alteration of a behavior for a discrete period of time (Prochaska, 2000; Prochaska & DiClemente, 1992). However, for certain behaviors to be considered successful, a certain level of criterion must be met. For instance, abstaining from smoking as opposed to decreasing frequency of cigarettes smoked. In this stage, there is a substantial commitment of time and energy that result in overt behavioral changes and tend to receive the most praise and reinforcement. Although, it needs to be recognized that change has occurred prior to this stage, it has just been more cognitive thus less observable. People in the action stage are primed

for action-oriented process of change (e.g., stimulus control, counterconditioning, contingency management) to provide them with skills to help them affect change.

In the last stage, Maintenance, individuals have made the appropriate changes in their problem areas and seek to consolidate the gains attained during their change process (Prochaska, 2000; Prochaska & DiClemente, 1992). Engaging in stabilizing behavior, free from the problem, for a discrete period, usually six months is a sign of movement to the Maintenance stage. This stage is a continuing stage so for some problem areas it lasts for a lifetime (i.e., alcohol recovery). A major goal of this stage is relapse prevention. Recall that some people have to repeat earlier stages to relearn or recommit to tasks of those stages. In this way, the progression of the stages of change could be thought of as a spiral, which one recycles through gaining more motivation and a greater commitment to changing their problem area(s).

Findings of the Stages of Change Scale (Valid uses of the Stages of Change Scale)

The Stages of Change Scale (SCS, McConaughy et al., 1989; McConaughy et al., 1983) was designed to be a continuous self-report measure to assess clients' readiness for change. It was designed to be used with a mental health population, first used with outpatient psychotherapy clients (McConaughy et al., 1983) and then cross validated with an in-patient psychiatric population (McConaughy et al., 1989). Each stage is broken down and represented on the SCS with the exception of the Preparation stage, which is seen as a mid-point between Precontemplative and Action.

Cluster analysis discovered that clients may have attitudes and behaviors representative of more than one stage. To more clearly explain the behaviors exhibited across all of the stages by clients, McConnaughy and his colleagues augmented the stages of change by introducing the use of stage profiles (McConnaughy et al., 1989; McConnaughy et al., 1983). This was originally done by the use cluster analytic methods with an inpatient mental health population (McConnaughy et al., 1983) and then with an out patient population (McConnaughy et al., 1989). The decision to examine stage profiles was based on analysis that indicated that it was not only possible for clients to simultaneously be engaged in attitudes and behaviors described by more than one stage at a time, but as clients progressed from stage to stage this “progression of movement involved a fluctuation in stage involvement,” reflecting a richer description of their stage of change (McConnaughy et al., 1989, p494). These nine profiles are accompanied with brief narratives describing the different attitudes towards change and motivational levels for change representative of individuals within each profile. Recently, O’Hare (O’Hare, 1996b) conducted further validation and refinement to the original profiles with an outpatient population. This study identified five profiles clusters.

The SCS has been most frequently utilized with addiction behavior (Prochaska, DiClemente et al., 1992, for review) including smoking cessation (O’Connor, Carbonari, & DiClemente, 1996) and alcoholism (DiClemente & Hughes, 1990). An additional problem area studied with SCS is health behaviors such as condom use (Grimley, Prochaska, & Prochaska, 1997) arthritis ( Keefe,

Lefebvre, Kerns, Rosenberg, Beaupre, Prochaska, & Caldwell, 2000) and weight control (Prochaska, Norcross, Fowler, Follick, & Abrams, 1992). Studies have revealed that amount of patient progress is directly related to their pre-treatment stage of change measure (Prochaska & DiClemente, 1992; Prochaska, DiClemente, Velicer, & Rossi, 1993). Moreover, if clients can progress one stage during their first month of treatment they doubled their chance of taking action during the six-month treatment program. Yet, this requires identifying patients pre-treatment stage and matching them with the appropriate therapeutic interventions. Another finding of interest comes from a study examining 12 problem behaviors in the addiction and health areas (Prochaska, Velicer, Rossi, & Goldstein, 1994). These findings indicated across these twelve different problem areas individuals used similar patterns for decision making.

Findings of the stages of change construct such as these are important but how much do they generalize to problem areas of the mental health population, the SCS original area of intent, such as depression, anxiety, adjustment, and interpersonal relationship problems. While addiction and health behaviors have been the primary areas of research to utilize the SCS, selected research has been conducted in mental health other than the validation studies (McConaughy et al., 1989; McConaughy et al., 1983). Stages of change studies in this area include, distress (DiClemente & Hughes, 1990), panic disorder (Beitman, Beck, Deuser, Carter, Davidson, & Maddock, 1994), and premature termination (Brogan et al., 1999). In a recent study using the SCS and other properties of the transtheoretical model, researchers were able to

predict 93% of the premature terminators, continuers, and appropriate terminators by their pretreatment measures (Brogan et al., 1999).

O'Hare (1996b) found that stages of change profiles were related to the degree that mental health clients would rate psychophysiological distress and family pathology. Those in the preliminary stage profiles reported psychophysiological distress and family pathology below the mean and those in the more advanced profiles reported these measures above the mean. These findings are consistent with the stages of change premise that those in the preliminary stages of change lack awareness of the seriousness of their problems or avoid addressing them. In another study, O'Hare (1996a) assessed readiness for change of court ordered psychotherapy clients versus voluntary psychotherapy clients. Results indicated that there were ten times more precontemplator profiles in the court-referred group, however 28% of the court-referred clients were in advanced profiles of stages of change. These findings suggested that stages of change is likely a better predictor of readiness for change than referral source alone.

*Stages of Change construct and hope.* To date no studies have been done examining the association of hope and stages of change. However there are some similarities between the two constructs. The stage of change construct is a measure of motivation and degree action (behavior) toward goals. Similarly, hope is goal oriented and a function of goal oriented motivation (agency) and planning strategies and identifying resourced to reach ones goal (pathways).

## Chapter III

### *Methods*

The goal of this study is to investigate relationships that the construct hope has with psychotherapy. In order to expand the research base into this area, the four research questions that have been chosen vary in form and focus. These questions call for varied methodological approaches to analysis. Broadly, questions fall into two types (a) those examining change in hope during psychotherapeutic treatment and (b) those analyzing implications of pre-treatment data. In this first category, evaluations of hope were examined during the psychotherapeutic treatment process (pretreatment and fifth session). Originally the design called for repeated measures to be taken at pre-treatment, fifth session, and tenth session. Due to attrition, 28 subjects completed this series of treatment. So, to assure adequate power and effect size, the tenth session repeated measure was eliminated to allow for a larger sample size (n=56). In the latter category, differences in hope among various stages of change profiles examine (hope/SCS) and predictions of pre-treatment individual variables are investigated (hope/premature termination).

### *Participants*

All adults (18 or older) who present for individual therapy services between November 2000 and May 2002 at a large University counseling psychology training center were participants in this study. Each participant signed an

informed consent form for treatment. The resulting sample of the aforementioned period consisted of 163 participants who are predominately female (67.5% female and 32.5% male). The mean age is 27.4 years, with ages ranging from 18 years to 61 years. The modal age is 21 years and the median age is 25 years. Approximately 81% of the participants are Caucasian and the remaining participants were distributed across African-American (9%), Asian (1%), Latino/a (6%), Middle Eastern (1%), and others (2%). Approximately 27% of the participants have undergraduate degrees, and the remaining participants were distributed across completion of advanced degree (21%), completed some college (18%), completed high school (27%), completed less than a high school degree (4%), and vocational or technical training certificate (2%). Approximately 71% of participants were not married and 29% were married.

The training center is part of a large southeastern University and provides psychotherapy service and assessment as an outpatient mental health center for individuals, couples, families, and groups. Services are available to all members of the community and fee payments are based on a sliding scale. This affordability of services draws clients from surrounding counties in the Northeastern portions of the state including rural and farming settings, mountainous regions, and urban areas. Nonetheless, as the training center is located on a large university campus, thus a portion of clients are affiliated with the university, either as students or staff while the remainder of the clinical population are members of the community. Primarily clients are self-referred or referred by others who have utilized service at the training center.



### *Instrumentation*

#### Hope Scale

The Hope Scale (HS, Snyder et al., 1991) is a self-report measure consisting of 12 items. Each item is rated on a 4-point scale (1=*definitely false*, 2=*mostly false*, 3=*mostly true*, 4=*definitely true*) for respondents to answer to the extent each item applies to them. The HS is administered under the title “Future Scale” so the construct being assessed is not made explicit. The scale is comprised of 12-item, four each loading into Agency (factor 1) and Pathways (factor 2) and four distracters. The four agency items tap the overall sense of successful goal-related determination, specifically one item reflects the past, two items reflect the present, and the last reflects the future. The four pathway items apply to individual’s cognitive assessments of their capabilities to create means to reach goals and overcome goal-related obstacles. The highest possible score is 32 (16 agency and 16 pathway). Average scores for college and no college samples of people are approximately 24, with significantly lower scores for people who are seeking psychological help and those persons who are inpatients at a psychiatric hospital.

The HS has been administered over 10,000 times but primarily to college students. The original validation study in 1991 by Snyder and his colleagues (Snyder et al., 1991) examined eight different samples ranging from 97-508 subjects and Babyak and his associates (Babyak, Snyder, & Yoshinobu, 1993) did a confirmatory analysis with four samples ranging from 472-955 subjects. All subject were college students with the exception of two samples; 97 patients of

an outpatient stress center and 109 inpatients at a state hospital. No sex difference has been found in regards to the Hope Scale. And no difference among race have been found with the Hope Scale

In the original 1991 (Snyder et al., 1991) instrument validation full-scale internal consistency reliability coefficients using Cronbach's alpha ranged from .74 to .84. For the agency subscale Cronbach's alpha ranged from .71 to .76 and for the pathway subscale Cronbach's alpha ranged from .63 to .80. Nunnally (1978; Snyder et al., 1991) indicates that for research purposes internal reliability coefficients of .70 to .80 are acceptable because they are not affected by any great degree of measurement error. The test-retest correlation was .85 over a 3-week interval and .76 and .82 over 10-week intervals in two samples. Additionally, in 1993, reliability estimates ( $R^2$ ) ranged from .26 to .86 for scale items and .96 to .99 for the agency and pathways factors (Babyak et al., 1993).

In 1991 (Snyder et al., 1991) concurrent validation was reported through positive correlations to several instruments including the Life Orientation Test (LOT) developed by Scheier and Carver (Scheier & Carver, 1985) that correlated .60 and .50 with the Hope Scale in two separate studies. The Hope Scale also correlated .58 ( $p < .005$ ) with responses to the Rosenberg Self-Esteem Scale (Rosenberg, 1965). The Hope Scale correlated negatively  $-.51$  ( $p < .005$ ) with The Hopelessness Scale. Snyder and his associates conclude that the hope scale has "good discriminant utility in the prediction of coping styles and overall psychological well-being beyond variance attributable to other related constructs" (Snyder et al., 1991).

Because the instrument is designed to reflect the two separate but related theoretical components of a greater construct of hope, a factor analysis was performed to explore the presence of agency and pathways for factor structure (Snyder et al., 1991). The four items hypothesized to tap agency demonstrated high loading on Factor 1 and not Factor 2, and the four pathway items demonstrated high loading on Factor 2 but not Factor 1. The two Factors accounted for 52% to 63% of the variance across samples. In 1993, Babyak and his associates tested the tenability of this two-factor model as compared to the one factor model. Their results suggest “that while agency and pathways are highly related they do not constitute a single factor, rather are relatively distinct entities that converge upon a broader latent construct”—hope (Babyak et al., 1993, 167). They note that this is consonant with Snyder and associates hope theory (Snyder et al., 1991).

#### Stages of Change Scale

The Stages of Change Scale (SCS, DiClemente & Prochaska, 1982; McConaughy et al., 1989; McConaughy et al., 1983) operationally defines the four theoretical stages of change (Precontemplation, Contemplation, Action, and Maintenance). This self-report measure has eight items for each scale, totaling 32 items. The questionnaire has a 5-point Likert scale from 1 = strong disagreement to 5 = strong agreement. Internal consistency through inter-item correlations was high ranging from .70 in the original study (McConaughy et al., 1983) to the high .80's (McConaughy et al., 1989) in the replication study. The four scales have shown high correlation to the adjacent subscale, but low

correlation with non-adjacent subscales that suggest clients move through the stages in sequence (McConaughy et al., 1989; McConaughy et al., 1983).

This supports the theoretical premise of stages.

The following is a description of each scale (Prochaska, DiClemente et al., 1992):

*Precontemplation.* The stage at which there is no intention to change behavior in the foreseeable future. Individuals in this stage are unaware or under-aware of their problems, while their family and friends are often well aware of their problems. They often present for psychotherapy because of pressure from others, that they experience as coercion.

*Contemplation.* The stage during which people are aware that a problem exists and are seriously thinking about overcoming it but have not yet made a commitment to take action. Individuals are weighing the pros and cons of the problem and the solution to the problem, sometimes described as ambivalence.

*Action.* The stage when individuals modify their behavior, experiences, or environment in order to overcome their problem. It requires considerable commitment and energy and involves the most overt behavior changes during which their tends to be the most external recognition.

*Maintenance.* Clients have made many changes and employ strategies to consolidate previous gains and prevent relapse.

An additional stage was included in the original conceptualization of the stages of change, called Decision-making or Preparation, but was eliminated because analysis illustrated this stage's questions loaded on the stage sub-scales both directly before and after (Prochaska, DiClemente et al., 1992). Yet, these same authors now include the Preparation stage, which is indicative of someone who scores high on both Contemplation and Action, thus it is not directly measure by the SCS as the other four stages are.

*Preparation.* Preparation indicates a willingness to change in the future. Individuals are not only poised to make priorities, set goals, and take action, but usually have begun some small change strategies.

Reflective of the re-addition of the Preparation stage, the original research (McConnaughy et al., 1989; McConnaughy et al., 1983) has shown that clients can show attitudes and behaviors that are representative of multiple stages at one time. By using cluster analysis of the Stages of Change Scale sub-scales, five to eight profile patterns have been discovered that provide richer information of the clients readiness for change (DiClemente & Hughes, 1990; McConnaughy et al., 1989; McConnaughy et al., 1983). More recently O'Hare (1996b) using a community mental health center population conducted another cluster analysis using refined criterion including, "clinical utility, theoretical parsimony, reasonable sample size, (minimum of n-30), clear differentiation in cluster profiles, and a high degree of similarity to previous cluster solutions (p. 15)." The following is a brief description of the profiles and centroids from O'Hare's (1996b) investigation.

*Pre-contemplators:* (means: precontemplation (P) = 66, contemplation (C) = 30, Action (A) = 39, Maintenance (M) = 38) are not even considering change, and many apparently disputed or denied the existence of a problem.

*Uninvolved:* (means P = 54, C = 48, A = 50, M = 49) minimize their problems somewhat and are not doing much to initiate change or maintain any gains.

*Contemplators:* (means P = 49, C = 53, A = 38, M = 52) are seriously thinking about change, perhaps are maintaining current conditions, but have not begun to take further action on their problems.

*Participators:* (means P = 40, C = 56, A = 57, M = 50) have made a decision to change but were making only modest efforts at following through on maintaining gains.

*Maintainers:* (means P = 42, C = 61, A = 63, M = 65) are clearly thinking about their problems, doing something about them, and maintaining some level of progress.

### *Procedures*

The training center that this study draws its data from is run on a three-pronged model of service, training, and research. The fundamental goal is to create an environment in which psychotherapy research informs service delivery and clinical training. As part of this research component, a longitudinal database was created to provide information needed by clinicians, supervisors, and clinic

administrators to enhance psychotherapeutic practices. In turn, clinical experience has impacted the focus and direction of the research process and procedures. Ongoing interaction between clinical and research staff has served to create a model for integrating research, service, and training. This interface contributed to the pursuit of this study as well as the infrastructure for collecting this data.

#### Data Collection

Primarily, clients' first contact occurs over the phone (occasionally in person) where pertinent information is obtained (such as primary concern, demographics, and contact information). After initial client contact, the case is assigned to a therapist who schedules a pre-treatment meeting with the client. At this meeting, either the office manager or a therapist provides informed consent and administers a comprehensive battery of self-report assessment measures (explaining the instructions and answering any question if necessary). The clinical evaluation packet (CEP) includes an informed consent form, Future Scale (Hope Scale), and Stages of Change Scale (SCS) along with four other instruments not included in this study. This packet approximately requires between one and one and one-half hours to complete.

Only after the CEP is scored and clinicians have reviewed the battery for clinical information may the intake session be conducted. During the intake session, demographic and clinical information is gathered. Through this process, clients/participants are assessed for appropriateness of treatment and referrals are made and/or treatment plans are devised. Only participants who are

assessed to be appropriate for treatment at this training center (i.e., not actively suicidal or abusing substances) are involved in this study, consequently there is no charge for the pre-treatment meeting or intake session.

Participant sessions are generally held on a weekly basis. The next session is counted as the first session, since the intake session, while therapeutic, is not considered a typical psychotherapy session. Next data was collected at the beginning of the fifth session, at which time the therapist and participant have had one intake session and four typical psychotherapy sessions together. At this point, participants were asked to complete the Hope Scale (HS). Through this process participants were tracked for attrition from treatment. The data of those participants that did not complete the treatment portion of the study were removed from the treatment pool. Further, the data of those participants who complete an intake session but failed to complete the third session were also be removed from the treatment pool but were labeled as premature terminators to later be compared to continuers of treatment (participants attending three sessions or more).

#### Treatment of Data

Pre-treatment, and repeated measures data was maintained confidentially using a coding system utilized by the larger center database. The evaluator utilized computerized scoring programs and database for all research instruments. SPSS Version 11.0 was used for scoring and analyses of the data.



## Factors of Sampling

Two of the four research questions solely address the treatment condition of this study. Ideally this research would track participants through their whole counseling process, however attrition concerns do not make this a judicious decision. Originally these questions required clients to be active participants from pre-treatment meeting through ten individual psychotherapy sessions. By examining the process through ten sessions it is possible to balance integrity of treatment and attrition concerns. However, attrition affected the sample size so the pretreatment-fifth session design was employed. This design still allows for valuable information within the psychotherapeutic process to be gathered while still reaching a reasonable sample size for substantial statistical power. Even by limiting the treatment to five sessions, for varied reasons, attrition concerns exists. Pekarik and Wierzbicki (1986) found 75% of community mental health center clients terminate therapy by the tenth session. Thus, with clinical research adequate sampling size is always a concern. Ideally, tracking clients throughout their entire psychotherapy treatment would be the preference, but in order to uniformly compare participants certain parameters of are required. Thus, the present study originally required ten session of psychotherapy to be completed to qualify as having completed the treatment portion of this study. However, to assure adequate power and effect size, the tenth session repeated measure was eliminated to allow for a larger sample size (n=56). So five sessions of psychotherapy were required to be completed to qualify as having completed the treatment portion of the present study. Much of the psychotherapy research has

shown that change occurs by five sessions, three sessions, one session, and even after intake (Howard, Kopta, Krause, & Orlinsky, 1986; Kellner & Sheffield, 1971; Lambert & Bergin, 1994). By our treatment lasting five sessions, it is reasonable to expect to see change within what can be considered a full course of treatment in this era of mental health care.

### *Research Questions*

The present study is an effort to begin to characterize hope empirically in the context of psychotherapy and inspire future lines of research in this area. For these reasons, the questions that are being investigated vary in an attempt to capture some breadth of the hope construct in the context of psychotherapy. In an effort to promote clarity the research questions are repeated in this section, and a brief description of the research design related to each question is given.

*Question 1.* Does the degree of hope of individual psychotherapy clients, as measured by Hope Scale (Snyder et al., 1991), significantly change between pre-treatment and five sessions of treatment? Questions one and two apply to the treatment portions of this investigation. Only subjects who complete the appropriate self-report assessment measure at pre-treatment and fifth sessions were included in these questions.

*Question 2.* Are the individual psychotherapy clients' degrees of agency (factor 1) and pathways (factor 2), as measured by Hope Scale (Snyder et al., 1991), significantly different between pre-treatment and five sessions of treatment?

*Question 3.* Is there a difference between pre-treatment scores of hope, agency (factor 1), and pathways (factor 2) as measured by the Hope Scale (Snyder et al., 1991) among participants' readiness for change cluster types at pre-treatment as measured by the Stages of Change Scale (SCS, McConaughy et al., 1989; McConaughy et al., 1983)?

*Question 4.* Are pre-treatment scores of hope, agency (factor 1) and pathways (factor 2) scores as measured by Hope Scale (Snyder et al., 1991) predictive of premature termination (prior to three sessions)? Question 4 does require that all participants attend the intake and then participants pre-treatment meeting data was categorized into two groups, (a) those who complete more than three sessions (continuers) and (b) those who complete three sessions or less (premature termination).

#### *Statistical Analysis*

Cronbach alphas are reported on all raw data to provide a measure of inter-item consistency and evidence for assumptions are provided for appropriate analysis.

Questions one and two are to be analyzed in a within subjects design. A related samples t-test is used to for comparisons of change in hope, agency (factor 1), and pathways (factor 2) from pre-treatment to fifth session.

Question three analyzes the relationship of hope measures and type of readiness for change profiles (SCS) at pre-treatment. An initial analysis was done using O'Hare's previously validated stages of change clusters (O'Hare, 1996b) to create an independent variable of five different readiness for change

profiles. This analysis used the stages of change profiles and mean centroids O'Hare determined. The QuickCluster feature of SPSS performed this cluster analysis. After change profiles clusters (independent variable) were determined from the sample, an analysis of variance was run for the three hope measures across change profile clusters.

Question four was first analyzed with an analysis of variance to determine if there is a relationship between hope measures (hope, agency and pathways; Snyder et. al., 1991) and premature termination. If a relationship was found, question four was examined with a direct discriminant analysis to reveal the degree to which the measure of hope can discern participant premature termination from treatment. Full scale, factor 1, and factor 2 hopes scores serve as predictors and extent (duration) of treatment participation serves as a categorical criterion. Utilizing this analysis controls for experiment-wise error and provides information on the dimensionality of group differences since the predictor variable is simultaneously examined (Betz, 1987).

## Chapter IV

### *Results*

The purpose of the present study is to empirically explore the relationships that exist between the hope construct as measured by the Hope Scale (HS, Snyder et al., 1991) and individual psychotherapy. More specifically, the present study analyzed if clients' individual level of hope (hope, agency and pathways; Snyder et. al., 1991) changed during the early course of individual psychotherapy. Additionally, this current investigation analyzed the degree to which individuals' levels of hope vary by Stages of Change Scale (SCS, McConaughy et al., 1989; McConaughy et al., 1983) scores—readiness for change profiles at pre-treatment. Finally, the relationship between individual pre-treatment level of hope and premature termination was examined. Results are reported within three different areas: (a) variance in hope during the psychotherapy process, (b) relationship of hope and readiness for change profiles, and (c) relationship of hope and premature termination.

#### Test of Assumptions

The qualitative analyses used in this study, utilized comparison of means, one-way analysis of variance, repeated measures analysis of variance, univariate measures analysis of variance, multivariate analysis of variance, independent *t*-test, paired samples *t*-test, and correlated group *t*-test. The three underlying assumptions of normality, equal variance, and independence were met for this

study. First, descriptive data revealed similar and minimal deviations from normality for the Hope Scale measures (hope: skewness  $-.123$ ; kurtosis  $-.211$ ; agency: skewness  $-.287$ ; kurtosis  $-.315$ ; pathways: skewness  $.136$ ; kurtosis  $-.192$ ) to meet the assumption of normality. Next, Levene's tests for equality of error variances were non-significant ( $p_{\text{Hope}} = .329$ ,  $p_{\text{agency}} = .229$ ,  $p_{\text{pathways}} = .930$ ) thus the variances are assumed to be homogenous for all profiles to meet the assumption of equal variance. Lastly, though this study did not use randomization, the subjects were independent volunteers and assumed to be independent of each other. No subject is represented more than once in this study. Additionally, Cronbach's alpha was run on all items that loaded onto the HS ( $\alpha = .85$ ,  $N = 167$ ).

#### *Variance in Hope During the Psychotherapy Process*

The purpose of this analysis was to explore if the clients' individual levels of hope changes as measured by HS scores (hope, agency and pathways; Snyder et. al., 1991) during the early course of psychotherapy. For the purpose of this study the pre-treatment and fifth session sample are analyzed utilizing paired samples *t*-test.

#### Representativeness of Sample

A comparison of the pretreatment HS score means between the 56 participants who completed the fifth session repeated measure and the 111 participants who did not complete the fifth session were statistically non-significant ( $t = .437$ ,  $df = 165$ ,  $p = .663$ ). This provided evidence that study participants were representative of those who originally volunteered for this study

since there seemed to be no meaningful difference between these groups (Table 1).

Table 1

Representativeness of Sample

Variable	Pretreatment Only ( <i>n</i> = 111)				Fifth Session Group ( <i>n</i> = 56)				<i>t</i>
	<i>M</i>	<i>SD</i>	Kurtosis	Skewness	<i>M</i>	<i>SD</i>	Kurtosis	Skewness	
			s	s			s	s	
Hope	22.30	4.30	-.137	-.284	22.61	4.55	-.807	-.136	.437
Agency	10.81	2.60	-.130	-.328	10.80	2.86	-.230	-.558	.016
Pathway	11.49	2.23	-.038	.005	11.81	2.22	.423	-.610	.881

Note. Maximum score = 32

Question 1

Does the degree of hope of individual psychotherapy clients, as measured by Hope Scale (HS, Snyder et al., 1991), change between pre-treatment, and five sessions of treatment? A related samples *t*-test was computed on the HS scores to evaluate changes between pretreatment and five sessions of psychotherapy in hope. Results of the *t*-test (table 2) showed significant increases from pretreatment to fifth session means for hope ( $t = 2.58$ ,  $df = 55$ ,  $p = .013$ ). On average clients' hope score increased by 1.07 points at fifth session.

Table 2

Related Samples *t*-test Results

Variables	Pretreatment	Fifth Session	<i>t</i>	Probability
	<i>M</i> ( <i>SD</i> )	<i>M</i> ( <i>SD</i> )		
Total Hope	22.61 (4.55)	23.69 (4.58)	2.58	.013
Agency	10.80 (2.86)	11.43 (2.83)	2.31	.025
Pathways	11.81 (2.22)	12.26 (2.24)	2.17	.034

## Question 2

Are the individual psychotherapy clients' degrees of agency (factor 1) and pathways (factor 2), as measured by HS scores (Snyder et al., 1991), significantly different between pre-treatment and fifth session of psychotherapy? A related samples *t*-test was computed to evaluate changes between pretreatment and five sessions of psychotherapy in HS agency and pathways scores. Results of the *t*-test (table x) showed statistically significant increases from pretreatment to fifth session on means for agency ( $t = 2.31$ ,  $df = 55$ ,  $p = .025$ ) and pathways ( $t = 2.17$ ,  $df = 55$ ,  $p = .034$ ). On average clients' agency and pathways scores increased by 0.66 and 0.45 points after five sessions of psychotherapy.

Since these findings indicate that there is a statistically significant difference in agency and pathways between pre-treatment and fifth session, analysis was conducted to determine if there was a statistically significant difference between the degree by which agency and pathways changed from



pre-treatment and fifth session. A repeated measures analysis of variance was conducted to determine if there was a statistically significant interaction of these two subscales (agency, pathways) and time (pre-treatment, fifth session). The repeated measure ANVOA interaction was statistically non-significant  $F(1, 55) = .543, p = .464$ . The interaction between agency and pathways scores across time was not significantly different. While the above comparisons of means and related samples *t*-test does suggests there is a significant increase in agency and pathways scores between pre-treatment and fifth session, the test for interaction findings suggests there is no significant difference between the rates by which agency and pathways change.

#### *Relationship of Hope and Readiness for Change Profiles*

The purpose of this question was to explore the types of relationships at pretreatment that exist between readiness for change and hope. This section presents the independent variable created by population cluster analysis as well as the test of assumptions and the results of the quantitative analyses. A one-way analysis of variance was utilized to determine the linear relationship between cluster groupings on the Stages of Change Scale (SCS, DiClemente & Prochaska, 1982; McConnaughy et al., 1983; Prochaska & DiClemente, 1992) and HS scores (hope, agency and pathways; Snyder et. al., 1991).

#### Cluster Analysis

The independent variable used in the analysis was the client's readiness for change profile as derived from the Stages of Change Scale score (DiClemente & Prochaska, 1982; McConnaughy et al., 1983; Prochaska &

DiClemente, 1992). The profiles were derived from cluster analysis using criteria based on the SCS's four factors to classify client groups. O'Hare (1996b) recently, utilizing the SCS, performed an updated cluster analysis based on original profiles by McConnaughy and others (1983) using a community mental health population. Using this new population, O'Hare (1996b) applied statistical criterion including "clinical utility and theoretical parsimony as conceptual guides" to create "clear differentiation in cluster profiles, and a high degree of similarity to previous cluster solutions found in studies conducted with similar populations including mental health" (p.15). These centriods were used as starting centriods in the current study in order to utilized similar grouping criteria for a hierarchical agglomerative method, Ward's method (Milligan & Cooper, 1987) to optimize the minimum variance within clusters. O'Hare's (1996b) centriods and this dissertation's resulting centriods are presented in overlay format for comparison in Figure 1-5. See chapter three for descriptions of these profiles.

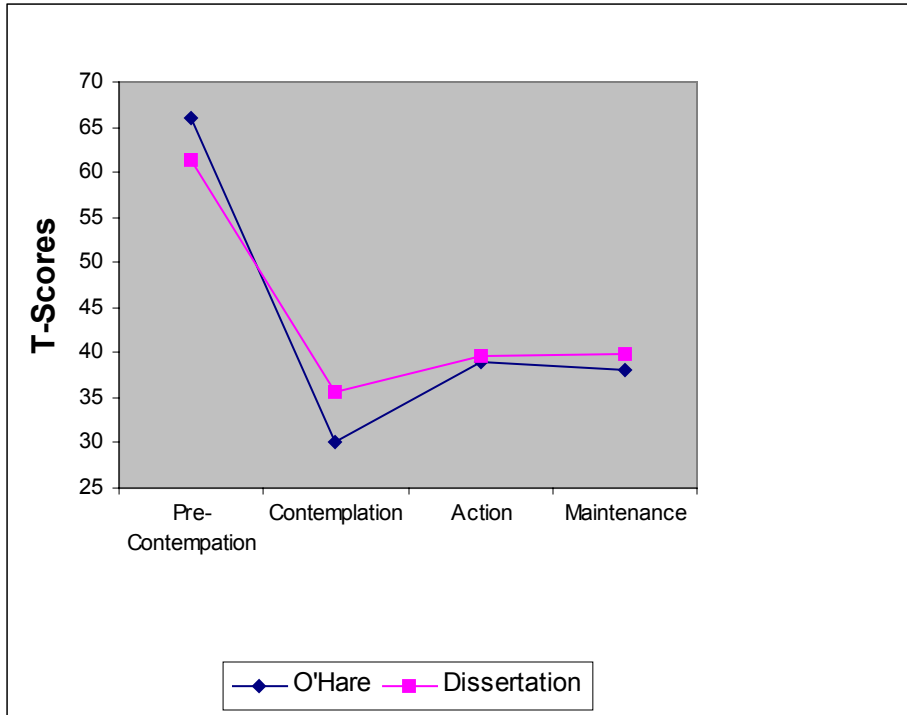


Figure 1: Mean score for Precontemplation cluster

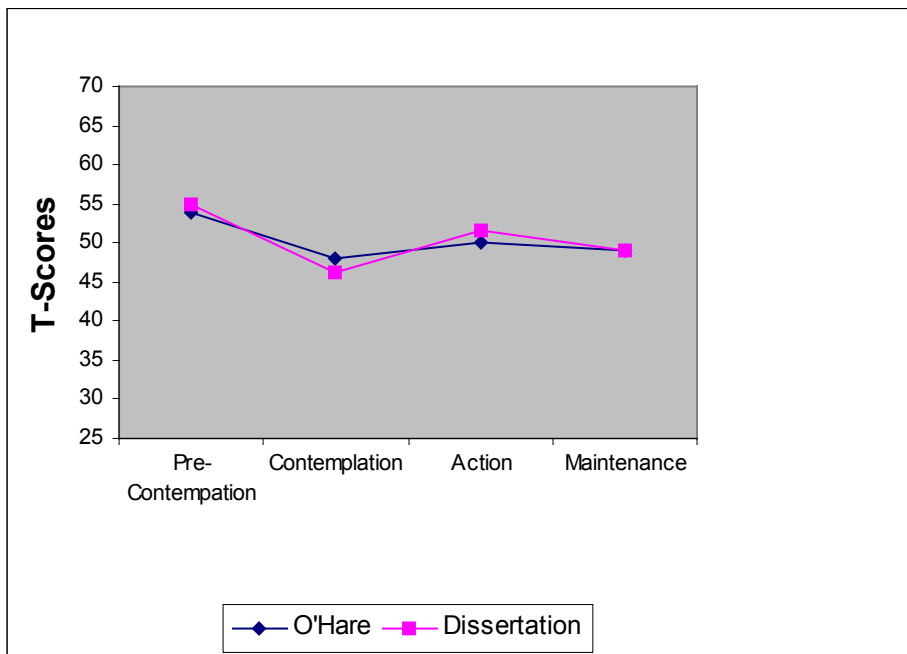


Figure 2: Mean score for Uninvolved cluster

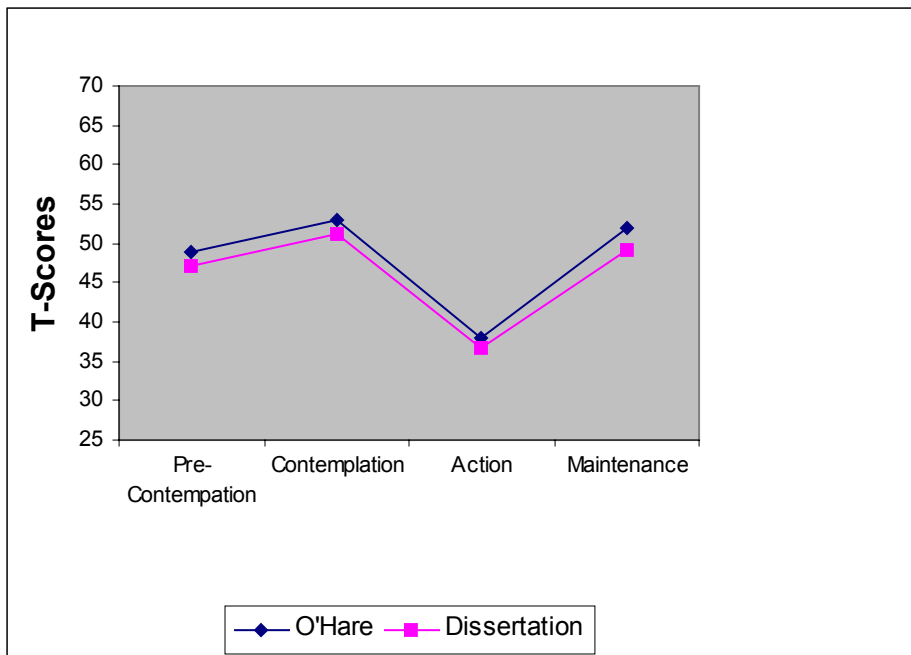


Figure 3: Mean score for Contemplation cluster

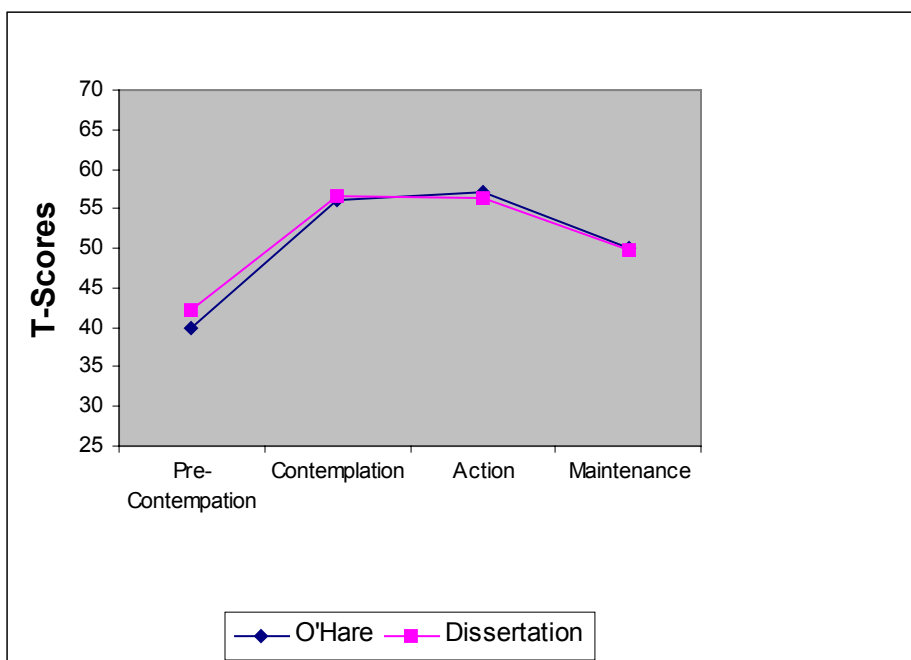


Figure 4: Mean score for Participator cluster

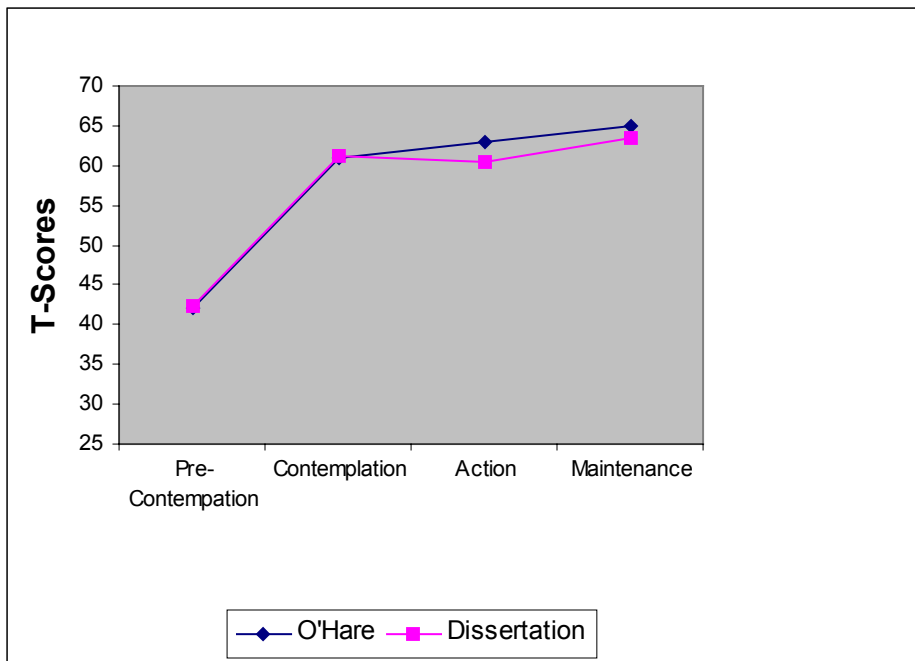


Figure 5: Mean score for Maintainer cluster

*Comparison of participants to previous studies.* A one-sample chi-square test was performed to determine if the proportions of participants in the current study were similar to the expected distribution of participants from the model study. The results of this test were statistically non-significant,  $\chi^2(4, N = 143) = 2.87$ ,  $p = .580$ . This indicates the proportion of clients per cluster type in the current study was not significantly different to the proportions expected from the model study. This provides a basis to assume that this study's clusters are representative of the model study's clusters.

For the current analysis, the Quick Cluster function of SPSS 11.0 was employed using initial cluster centroids from O'Hare (1996b). Figure 6 presents the number of clients at pre-treatment by each cluster type. The independent variable for this question was readiness for change groups as determined by the

cluster analysis. Figure 7 distinguishes between those who were part of the treatment sample and those who were not. There are various reasons why someone may not have been part of the treatment factor. The majority of this group was not included because they failed to reach the fifth session, however a smaller portion of this group reach the fifth session but was missing data so weren't able to be included. A more in-depth discussion is presented in chapter 3.

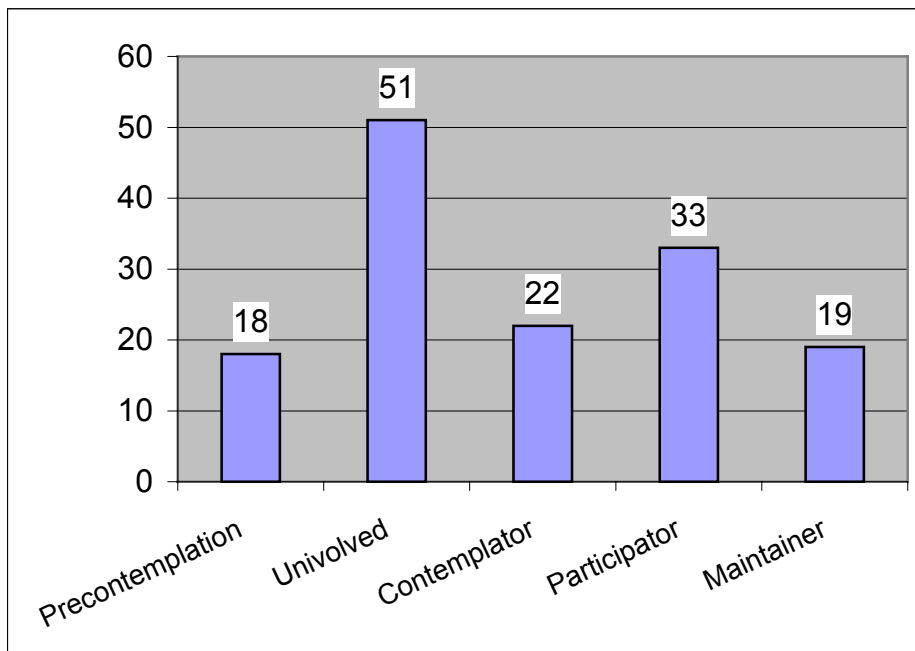
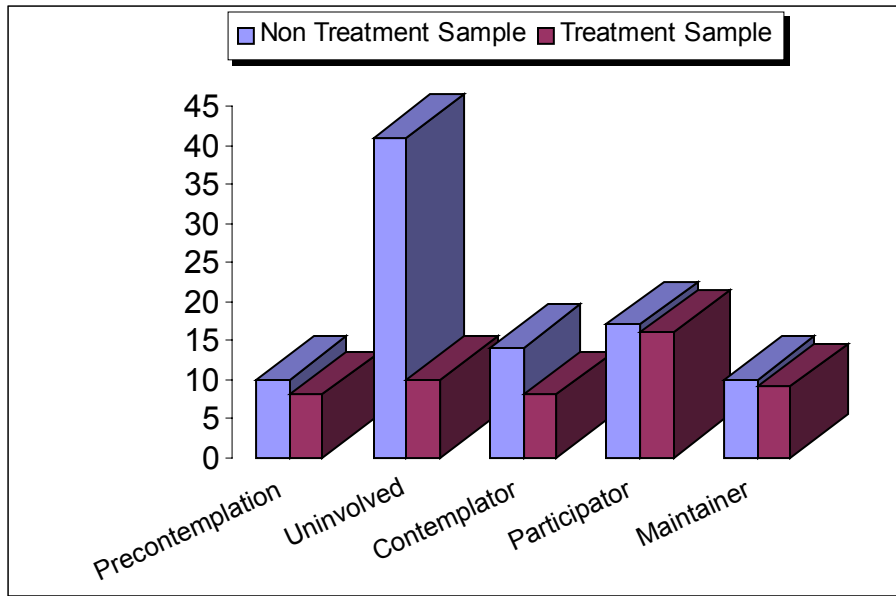


Figure 6: Number of participants within clusters



**Figure 7:** Treatment sample versus non-treatment sample by cluster membership

An additional analysis was conducted to determine if SCS cluster membership changed for clients from pretreatment to fifth session (Table 3). The sample for this analysis is a subset ( $n = 27$ ) of the treatment sample pool ( $n = 56$ ) due to missing data. The diagonal in table 3 illustrates those clients whose stage membership did not change from pretreatment to fifth session. Reading cells across the rows, provides the frequencies of group membership at pretreatment. As stated the diagonals have not changed membership. The values in cells to the right of the diagonal identify advancement in stage development (reading by columns) after five sessions of psychotherapy. The values in cells to the left of the diagonal represent regression in stage development (reading by columns) after five sessions of psychotherapy.

Table 3

Comparison of SCS Cluster Membership From Pretreatment to Fifth Session

Pretreatment	Fifth Session					Total Pretreatment Membership
	Precontemplators	Uninvolved	Contemplators	Participators	Maintainers	
Precontemplators	<b>3</b>		1*			4
Uninvolved		<b>4</b>	2*	1*		7
Contemplators		1#	<b>1</b>	1*		3
Participators		3#	1#	<b>4</b>	1*	9
Maintainers				3#	<b>1</b>	4
Total Fifth Session Membership	3	8	5	9	2	27

**Bold cells denote participants who did not change stages**

\* Denotes participants who advanced in stage development after five sessions

# Denotes participants who regressed in stage development after five sessions

Pearson Chi-Square value 30.69,  $p < .05$

## Question 3

Is there a difference between pre-treatment scores of hope, agency (factor 1), and pathways (factor 2) as measured by the HS (Snyder et al., 1991) among participants' readiness for change cluster types at pre-treatment as measured by the SCS (McConaughy et al., 1989; McConaughy et al., 1983)? The independent variable, readiness for change clusters, included five levels: Precontemplation, Uninvolved, Contemplation, Participator, Maintainer. The first dependent variable was hope. The ANOVA was statistically non-significant  $F(4, 143) = 1.748$ ,  $p = .143$ . The pattern for the hope score was not significantly different across the levels of readiness for change. This means hope scores do



not significantly vary across the different readiness for change profiles (Table 3 provides hope means for the clusters). The second dependent variable was agency. The ANOVA was statistically non-significant  $F(4, 143) = 1.916, p = .111$ . The pattern for the agency score was not significantly different across the levels of readiness for change. This means agency scores do not significantly vary across the different readiness for change profiles. The third dependent variable was pathways. The ANOVA was statistically non-significant  $F(4, 143) = 0.936, p = .445$ . The pattern for the pathways score was not significantly different across the levels of readiness for change. This means pathways scores do not significantly vary across the different readiness for change profiles.

Table 3

Hope Means Grouped by O'Hare's Clusters

Cluster	Hope		
	Mean	Std. Deviation	N
Pre-Contemplators	22.38	3.88	24
Uninvolved	24.03	4.19	31
Contemplators	21.59	3.68	23
Participators	22.66	4.89	40
Maintainers	23.31	3.96	21
Total	22.84	4.27	139

*Relationship of Hope and Premature Termination*

The purpose of this question was to explore the relationship between pre-treatment hope and client premature termination from psychotherapy. This section presents an independent variable determined by clients' premature

termination or continuing in psychotherapy treatment. Discussion of how the independent variable premature termination is derived is discussed in the Methods chapter of this dissertation. Two different analyses of variance were conducted to determine if there was a statistically significant linear relationship between HS scores (hope, agency and pathways; Snyder et. al., 1991) and premature termination.

#### Question 4

Are pre-treatment scores of hope, factor one (goal directed energy) and factor two (planning towards meeting ones goal) as measured by the hope scale (Snyder et al., 1991) predictive of pre-mature termination (prior four sessions)? For the hope measure a univariate analysis of variance was utilized and for the agency and pathways measures a multivariate analysis of variance was conducted. The univariate ANOVA for hope was statistically non-significant  $F(1, 134) = 0.011, p = .917$ . The hope measure does not significantly vary between clients who prematurely terminate psychotherapy and those who continue. Without any significant relationship between hope and premature termination, using the hope measure to predict premature termination would be baseless. Since this would be the purpose of a discriminant analysis, the non-significant univariate ANOVA findings preclude the use of this next step of analysis. The mean score for hope for premature termination group was 22.54 (n=29). The mean score for hope for continuers group was 22.44 (n=105).

For the agency and pathways measures a multivariate analysis of variance was conducted. The multivariate ANOVA for agency was statistically

non-significant  $F(1, 134) = 0.806, p = .371$ . The agency measure does not significantly vary between clients who prematurely terminate psychotherapy and those who continue. Without any significant relationship between agency and premature termination, using the agency measure to predict premature termination would be baseless. Since this would be the purpose of a discriminant analysis, the non-significant multivariate ANOVA findings preclude the use of this next step of analysis. The mean score for agency for premature termination group was 11.22 (n=29). The mean score for agency for continuers group was 10.72 (n=105).

The multivariate ANOVA for pathways was statistically non-significant  $F(1, 134) = 0.719, p = .398$ . The pathways measure does not significantly vary between clients who prematurely terminate psychotherapy and those who continue. Again, without any significant relationship between pathways and premature termination, using the pathways measure to predict premature termination would be baseless. Since this would be the purpose of a discriminant analysis, the non-significant multivariate ANOVA findings preclude the use of this next step of analysis. The mean score for pathways for premature termination group was 11.31 (n=29). The mean score for pathways for continuers group was 11.71 (n=105).

## Chapter V

### *Discussion*

In 1968, Frank stated that individuals come to psychotherapy because they are demoralized by their inability to be able to solve some problem(s) in their lives. He suggested three decades ago that effective psychotherapy would instill hope in these people so they would be more effectual in their lives. Frank and others' (Fitzgerald, 1979; Frank, 1968; Frank & Frank, 1991; Snyder, Irving, & Anderson, 1991; Stotland, 1969; Yalom, 1995) view has become an underlying assumption among psychologists. With this in mind, the purpose of this dissertation is to provide some preliminary exploration into this underlying assumption by exploring if hope does change during the early processes of psychotherapy. Overall, psychotherapy patients' level of hope showed increases among the three Hope Scale measures (HS; hope, agency and pathways; Snyder et. al., 1991). Additionally, this dissertation explored the relationship of hope with two other elements studied in psychotherapy: readiness for change and premature termination. This was done to explore the relationship of the hope construct in psychotherapy. The current chapter interprets these findings in relation to the existing theoretical and literature base. Further, the discussion includes implications of the findings for theoretical, clinical, and future research application.

### *Variance in Hope During the Psychotherapy Process*

#### Question One: Hope

The first two research questions ask if there was significant change among the three HS measures (hope, agency and pathways; Snyder et al., 1991) between pre-treatment and fifth session of psychotherapy. The first question asks if hope, as measured by HS (Snyder et al., 1991), changes significantly between pretreatment and the fifth session of psychotherapy. The findings suggest that individuals experienced an increase in hope or perception that goals can be met after five sessions of psychotherapy treatment.

One explanation for the results from question one is the parallel between the goal-based premise of Snyder and others' (Snyder et al., 1989; Snyder et al., 1991) hope theory and the goal-based process of psychotherapy. When patients seek psychotherapy, Frank (1968, 1991) would say they do so because they are demoralized. Moreover, they are seeking relief or resolution to some form of problem. An elementary part of the psychotherapeutic process is identifying these problems through various forms of assessment and devising goals to resolve them. Goals are the purpose for therapeutic interventions and the psychotherapeutic process in general. Also recall that Snyder and associates (1991) as well as others (Averill, J. R., Catlin, G., & Chon, K. K., 1990; Farran et al., 1995; Miller & Powers, 1988; Nunn & Lewin, 1996; Staats, 1987) believe that goals are the framework or endpoints upon which the operations of hope act. Thus, if Snyder and others' (1991) hope construct is defined as the perceptions that goals can be met, and psychotherapy is a goal-based process, then

suppositions can be made. Psychotherapy, in part, is a hope-based process. A byproduct of a psychotherapist successfully providing both support and learning to a patient that results in some behavioral change or goal-attainment is a positive influence on the patient's perception of his ability to obtain goals. This is Snyder and colleagues' (1991) definition of hope. Thus using this hope theory, successful psychotherapy (achieving therapeutic goals) has some relationship with strengthening one's level of hope (perception that goals can be met), as Frank (1968; 1991) and Stotland (1969) have suggested.

A correlation between hope and successful psychotherapy also suggests an interaction is present in this study. When a construct is correlated with a treatment it does present a limit to internal validity. While this will be addressed later in this paper, this interaction allows for an explanation for the findings as well as enhances these findings. The findings show that individual hope increased for the 56 clients who continued through five sessions of psychotherapy. However, many clients terminated before they reached the fifth session, why? It is possible the answer lies in the interaction between level of individual hope and psychotherapy. More specifically, if successful psychotherapy was taking place, clients stayed in therapy and their individual level of hope increased. Accordingly, clients who didn't experience successful psychotherapy, their hope remained flat or decreased, and consequently most dropped-out. So in effect the individual level of hope and success in psychotherapy may have had a selective effect on the present study's treatment sample. If this is true, while it does present limits to internal validity, it confirms a

relationship between individual level of hope and successful psychotherapy. Which also has implications for the hope construct as an outcome measure of psychotherapy.

#### Question Two: Agency and Pathways

Question two more specifically asks if HS (Snyder et al., 1991) subscales agency and pathways change significantly between pretreatment and the fifth session of psychotherapy. The findings suggest that individuals experienced an increase in agency or goal directed energy after five sessions of psychotherapy. Snyder and others (Snyder et al., 2000; Snyder, Michael et al., 1999; Snyder & Taylor, 2000) consider agency a common factor of treatment and pathways a specific treatment factor. Agency is conceptualized as the energy that drives and motivates one towards meeting their goals. An explanation for the increase in individual agency from pretreatment to fifth session is clients' perception that psychotherapy will lead to a desired outcome or positive expectancies. These positive expectancies are typically conveyed early in the psychotherapy process by both the patient's psychotherapists and by the patient's positive expectations of the institution itself (seeking professional help). This results in an increase of motivational energy towards solving their problem(s) or increase in agency. An additional contributing factor to explain this energizing effect from pretreatment to fifth session is participants doing something to reach their personal goal(s). They may, for the first time, be actively doing something about their problem. By doing so they create some motivational inertia that increases their goal-directed energy or agency.

Furthermore, findings suggest that after five sessions of psychotherapy individuals experienced an increase in pathways or ability to employ different strategies to successfully reach goals. The pathways component of hope is a measure of the ability and resourcefulness an individual uses in strategizing and devising routes to obtain goals (Snyder et al., 1991). It is also a measure of how individuals respond to barriers preventing or delaying goal attainment. The psychotherapy process, which entails exploring intra-personal and external barriers preventing clients from achieving their goals, addresses fundamental pathway issues. As psychotherapist, we help our patients consider new perspectives and encourage insights into both their chosen goals and ways they approach their goals. As well, armed with the behaviorist knowledge that success breeds confidence, psychotherapists carefully guide clients' goal choices and anticipate pitfalls in order to set their patients up for success. These are examples of high-level pathway skills that are common proficiencies of psychotherapists. Accordingly, the parallel shared between pathway processes and psychotherapist expertise functions within the psychotherapy process to increase patients' pathway component of hope.

#### Implications of Variance in Hope During the Psychotherapy Process

The finding that the three HS (Snyder et al., 1991) measures increases during the early course of psychotherapy is a step towards a greater understanding of hope's relationship within the psychotherapy process. This finding provides some empirical basis to the assumption that hope plays an innate role in this process.



Hope Scale validation studies (Snyder et al., 1991) did not find any significant change in hope among individuals not receiving treatment and supports the typical view of the hope construct as trait. While, Frank (1968) and Snyder (1995) consider hope to be a stable construct, they also view psychotherapy as a vehicle for increasing one's level of hope. The results from the treatment questions support their commonly held view by providing some empirical evidence that an increase in individual hope is attributable to psychotherapy. As well, the findings suggest hope may have outcome implication for successful psychotherapy as researchers have suggested (Fitzgerald, 1979; Frank, 1968; Frank & Frank, 1991; Snyder, Irving, & Anderson, 1991; Stotland, 1969; Yalom, 1995). If there is an interaction between level of hope and successful psychotherapy and thus a positive relationship, then level of hope has merit as an outcome measure for successful psychotherapy.

The results of the present study indicate that the hope construct does have a significant role in the psychotherapeutic process. Accordingly researchers should take heed of recent calls to shift from examining maladaptations and pathologies to investigate what works instead of what does not (Sheldon & King, 2001). The healing power of hope has been clearly shown in medical research and this study has shown that while hope is a stable trait it can increase within the psychotherapy process. Hope within the psychotherapy process represents a mental health construct worthy of utilization, especially in this new era of positive psychology. Therefore, therapist should focus on assessing and increasing individuals' level of hope. The hope theory (Snyder et

al., 1991) not only provides a means for assessing individual hope, but the agency and pathway components allows for an effective framework to apply specific interventions to increase hope.

Training programs should attend to the importance of hope in successful psychotherapy. It should be a formalized part of training. Psychologists in training should be taught to assess hope and ways in which to increase hope. However certain cautions should be made regarding hope due to the seductive nature of positive expectancies. Recall the fable of Pandora's box. When the box was opened evil forces that prey on the body and mind were released, and as Pandora rushed to close the lid on force remained—hope (Smith, 1983). Was hope an antidote for the ills unleashed on humanity or a debilitating cancer of the soul?

The present study is based on a hope theory that operationalizes hope in its positive and beneficial form yet there is another aspect that I will refer to as false hope. False hope can be defined as blindly believing the illusion some future goal can be obtained. It is a false promise not grounded by bounds of reality or past experience, yet it eagerly seduces with promise of ones fondest desires. Tillich (1965) reconciled these opposing views, which are important to consider when tapping the hope construct's healing power. "Hope is easy for the foolish, but hard for the wise. Everybody can lose himself in foolish hope, but genuine hope is something rare and great" (Tillich, 1965, p. 17). It is plausible when beginning clinicians are taught of the healing power of hope it may appear

to be a silver bullet, so they should be cautioned of the potential misuses. Only when hope is genuine does it have healing power.

Additional implications of this finding suggest that hope may be another common factor within psychotherapy. Methodology of this study allowed psychotherapists to choose their own theoretical orientations and specific treatments, thus there was no uniform treatment mandated. If one assumes that there was some variety among the specific treatments and theoretical orientations that the clinicians used, these findings imply there was a general trend of increase in hope among participants regardless of orientation or treatments utilized. Thus, hope may be viewed as a common factor to psychotherapy.

*Agency and pathways.* Results suggest that psychotherapy plays a role in stimulating agency or goal directed energy. An implication of this finding is the importance of engendering positive expectancies for clients early in treatment as a way to increase patients' hope. One way to tap this component of hope is during the informed consent process. By discussing treatment options and prognosis, clients can be given some idea of what outcomes can be expected. Not only does this normalize their current experience but also it is a vehicle to quell any cognitive distortions that may exist regarding their outcome expectancies. The HS can be used as a measure to assess motivational energy during treatment. Additionally, further results suggest during the early course of psychotherapy that clients' are able to increase their pathway thinking. This, too, is a way to increase patients' hope. Recall in Snyder and associates' (1991)

hope theory that the presence of both agency and pathways and more importantly their interaction represents what is necessary to achieve high levels of hope. Consequently, both these aspects of hope are important to assess and increase because according to Frank (1968) the higher the patient's hope the better the treatment prognosis. So if hope can be increased so can their prognosis. Furthermore if their hope increases, they have an increased perception they can achieve their goals. This has implications for increasing patients' engagement in treatment. They would likely be more willing to work on treatment goals outside of the therapy room, which is an important component of successful psychotherapy.

#### *Relationship of Hope and Readiness for Change Profiles*

Question three asks if there is a difference in individual hope measures (Snyder et al., 1991) prior to treatment across different readiness for change profiles (McConaughy et al., 1989; McConaughy et al., 1983; O'Hare, 1996a). The findings suggest there are no significant differences among hope measures across different readiness for change profiles. While there were no significant findings, there was a trend among all three HS measures. Across all measures of hope the uninvolved profile had the highest HS means and the contemplators' profile had the lowest means. There may be several explanations for this trend and the lack of significant findings. A possible reason for the latter is there may be no relationship between readiness to change profiles (individuals' willingness to both identify personal areas in need of change and pursuit of these areas) and hope measures.

An additional explanation may relate to two issues across the different profiles: problem awareness/acknowledgement and action taken to change. Precontemplation and uninvolved profiles don't acknowledge their problems or minimize them respectively. Contemplators are considering they may have problems. Participators and maintainers acknowledge their problems and are actively pursuing change to different degrees. So for the progression from precontemplation through maintainers profiles there is an increase of problem awareness/acknowledgement and in the more advanced profiles the frequency of action being taken to affect change increases. Thus, individuals in early profiles are denying their problems and hope is unaffected. Those in more advanced profiles, while aware of their problems; actions they are taking to affect change (goal movement) may be mediating their level of hope. It is the middle profile (contemplator), when there is some problem awareness but little if any action taken to solve these problems, where a difference in hope would be seen. In fact this middle profile did have the lowest HS means but this difference was not statistically significant. An explanation for no findings for this question is the interaction between problem awareness/acknowledgement and actively addressing one's problems may contribute to the findings of no significant differences in hope among these different profiles. This would also explain why those in the contemplator profile had the lowest HS means because the interaction was weakest during this readiness for change profile.

## Implication of the Relationship of Hope and Readiness to Change Profile Findings

It appears that readiness for change profiles derived from the Stages of Change Scale (SCS; McConaughy et al., 1989; McConaughy et al., 1983; O'Hare, 1996a) do not have an apparent relationship to hope. However, a more sensitive measure of hope may be able to detect a relationship between readiness for change profiles and hope. Also, an investigation exploring the possible interaction between problem recognition and problem solving behavior may have implications for the relationship between readiness for change and hope.

### *Relationship of Hope and Premature Termination*

Question four asks if pretreatment HS scores (Snyder et al., 1991) are predictive of premature termination. The findings suggest no relationship between premature termination and hope. One explanation for these findings is there is no relationship between hope and premature termination. Alternatively, there may be a relationship but none was found using the current studies' methodology. It may be that the level of hope during the first three sessions, rather than prior to treatment, is related to premature termination. For example, if a patient's level of hope decreases during early treatment they may be more likely to terminate prematurely from the psychotherapy process. As HS measures were found to increase for the participants who completed five sessions of psychotherapy treatment, it is unknown if individuals who did not complete the treatment may not have had the same experience or may have

experienced a decrease in hope. Due to the methodology of this dissertation, current findings don't address this hypothesis.

#### Implication of Hope and Premature Termination Findings

The lack of finding an empirical relationship of significance does not necessarily mean that there is no relationship between hope and premature termination. The implications of these findings do suggest that other methodological tactics should be employed to thoroughly investigate this relationship. As Frank (1968) and Stotland (1969) state, engendering hope is an important part of successful psychotherapy, so it is important to know if there is a relationship between patients level of hope and premature termination.

#### *Limitations to Construct Validity*

Because of the enigmatic nature of hope there are natural concerns regarding construct validity. As discussed in Chapter two, there are a variety of descriptions of the hope construct. However, Snyder and others' (1991) hope theory is fairly representative of the literature and is one of the most utilized instruments to study hope. One reason for this may be its clear operational definition which increases construct validity. However, the current investigation does present a mono-method bias due to only using one measure to capture the construct of hope and this limits the construct validity. Further by using a four-point Likert scale the HS (Snyder, et. al., 1991) presents some possible sensitivity issues. Snyder and colleagues (Snyder, Sympson, Ybasco, Borders, Babyak, & Higgins, 1996) are currently trying to validate the HS with an eight-point Likert scale. As the HS is a self-report measure, some measurement error

is expected and no attempt was made to follow up with clients to corroborate their responses. For these reasons there are some limits to the HS ability to actually capture the essence of the hope construct.

#### *Limitations to Internal Validity*

The research design and method of inquiry included many limitations with regard to internal validity, even though some results were found to be significant. A challenge of clinical research is to strike a balance with scientific rigor and participants' needs and welfare. Using the American Psychological Association ethical guidelines and policy of CCPE, participants were viewed as patients first and research participants second. Utilizing these guiding factors the decision to not use a wait list as a control group was made. The participants were all clients that sought treatment at an outpatient clinic during a certain time period so random assignment of participants was not possible. Thus, all participants received the treatment condition and clients were free to drop out of treatment at their discretion.

Further, due to a variety of reasons, the treatment condition had to be reduced from pretreatment, fifth, and tenth session to only pretreatment and fifth session. This decision was made to achieve a sufficient sample size and ensure adequate statistical power. A major contributor to this decision was attrition of subjects through the course of ten sessions of psychotherapy (see chapter two for a more in-depth discussion). In addition, therapists were responsible for administering the HS at incremental data points and one missed point would eliminate a participant from analysis. Moreover, possible interaction between the



treatment and hope may create limits in internal validity. That is to say if hope were to decrease during treatment, participants may be more likely to terminate treatment. Attrition for this reason would significantly impact internal validity.

The only measures that were taken to verify the treatment integrity were the normal safeguards used by the training facility (supervision and evaluation). Previous reviews of client satisfaction surveys provide a historical indication that clients are generally satisfied with their therapist and the counseling process within this training facility. In addition, the 21% premature termination rate during the current study is well below the 40% premature termination rate found among community mental health center clients within two sessions (Wierzbicki & Pekarik, 1993). Thus it is assumed that psychotherapy was taking place. Further, likely confounding variables for this population such as previous or concurrent treatment, psychotropic medication, and presenting problem were not assessed. These variables may have contributed to the observed variance during the treatment condition and could have been controlled for as a co-variant. The increase in hope was not likely due to history because hope is considered a trait and validation studies indicate no significant change in HS scores over time without treatment (Snyder et al., 1991). Finally, for the pretreatment questions random assignment of participants into groups was not possible because the independent variables (readiness for change and premature termination) were associated with the patients. This would have limited causal inferences had these findings been significant.

### *Limitations to External Validity*

The purpose of this investigation was to explore the relationship of hope and psychotherapy within a clinical population. However, there are two issues regarding the treatment setting that limit external validity and the ability to generalize across settings with this clinical population. The clinicians used to provide psychotherapy were trainees within a training clinic at a larger southeastern university counseling psychology department. Also, while this clinic most closely fits a community mental health center, the majority of clients are self-referred and all clients were members of the community, students on campus, or employees at the University.

The participant pool is a population of convenience consisting of all adult clients presenting for individual therapeutic services between November 2000 and May 2002. The racial and gender distributions were skewed with the majority being Caucasian females. Due to these limitations, these results may not be generalized to more diverse populations or to other age groups (i.e., adolescent, geriatric). Finally, this research was conducted exclusively on an outpatient population and may not be generalized to inpatient groups.

### *Future Directions*

As these findings indicate hope does increase during psychotherapy, this investigation provides some evidence for the literature (Fitzgerald, 1979; Frank, 1968; Frank & Frank, 1991; Snyder, Irving, & Anderson, 1991; Stotland, 1969; Yalom, 1995) theorizing about hope's fundamental role in the healing process of psychotherapy. While these findings have implications for a significant

relationship between hope and successful psychotherapy, further research should explore this relationship. First hope should be investigated throughout the entire psychotherapy process. A repeated measures design that will monitor hope by using the HS at set intervals during the psychotherapy process should be utilized. Secondly, the present results have direct implications for hope as an outcome measure. Accordingly, these findings suggest that further research should be conducted to investigate hope as an outcome measure for successful psychotherapy as Frank (1968) and Stotland (1969) advocate. Along with the repeated measures design just mentioned other reliable outcome indicators. I suggest using at measure of therapeutic alliance. It is well known as an excellent indicator of psychotherapy outcome and it is a construct that likely has a strong relationship with increasing the level of hope during psychotherapy.

Third, a study to investigate the relationship of hope and premature termination is suggested. A design to monitor hope from pretreatment and during each of the first three sessions would provide a greater understanding of the variability of hope has on patients decisions to quit treatment or continue. Design methods would have to control for instrument sensitization. This would also help determine if early movement in hope is necessary to continue psychotherapy treatment. This would also provide some evidence if there is an interaction between the treatment and the hope construct. Fourth, research could be conducted to investigate techniques that are effective in increasing hope, agency, and pathways.

Additionally, much can be learned from the present study to bolstered future research. Including using a control group such as a waiting list and / or a pre-post group to control for repeated measures instrument sensitization. Also, because of the difficulty in defining hope there are some limits to construct validity. While using additional instruments to measure hope is suggested, a qualitative component to explore both therapists and clients' experience would provide a greater richness to our understanding of hope in the psychotherapeutic process. Finally, conducting clinical research outside of a training facility with a more representative sample population would increase the ability to generalize findings.

### *Summary*

Many theories advocating the importance of hope in psychotherapy and mental health have been made over the past three decades. While the belief that hope plays a part in mental well-being are seemly wide held, there is a void in the literature of empirical evidence for theoretical implication made about hope's importance to the psychotherapeutic process. The purpose of this dissertation was to gain a greater knowledge of hope's role in the psychotherapeutic process by means of empirical investigation and there by contribute to the literature base. The main findings suggest that there was a significant increase among the three Hope Scale measures (Snyder, et. al., 1991) during early psychotherapy treatment. While findings were not significant regarding hope and premature termination, further research in this area is recommended. Finally, the findings

regarding readiness for change and hope suggest that there is no relationship between these two constructs.

While the results of this study support that hope does increase in the early part of the psychotherapy process, they do not entirely substantiate the many theories about hope within the psychotherapy. These findings indicate hope increases early in psychotherapy, but is this important to the success of psychotherapy outcomes? I submit that it is, but without further research this may continue to just be an assumption. In this era of positive psychology and psychotherapy research it is this authors hope that this construct will be further explored within psychotherapy. It is this author's belief that hope is a powerful construct with regards to mental health and should be further studied to tap the power hope for the benefit of those we seek to help.

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