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A content analysis of client hope in psychotherapy sessions

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Graduate School of Education and Psychology

A CONTENT ANALYSIS OF CLIENT HOPE IN PSYCHOTHERAPY SESSIONS

A clinical dissertation submitted in partial satisfaction

of the requirements for the degree of

Doctor of Psychology

by

Stacie Lyn Cooper

November, 2008

Susan Hall, J.D., Ph.D. – Dissertation Chairperson

This clinical dissertation, written by

Stacie Lyn Cooper

under the guidance of a Faculty Committee and approved by its members, has been submitted to and accepted by the Graduate Faculty in partial fulfillment of the requirements for the degree of

DOCTOR OF PSYCHOLOGY

June 27th, 2008

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DEDICATION

First and foremost, this dissertation is dedicated to Mike, for his unwavering love and encouragement through my journey in the doctoral program and for being not only my husband, but also my best friend. Thank you for reminding me how to instill hope in others and take care of myself. Second, to my amazing parents (and friends), Greg and Elaine, for their love, support, and acceptance that has been a constant throughout my life. Thank you for inspiring me to make a difference in the lives of others, and modeling what true selflessness and generosity mean. To Grandma Gloria, for her unconditional love and beautiful soul that brings out the best in all around her including myself; Jen, Mike and Connor, as well as Don and Ada, my family members-by-choice, for showing me that family and love extend beyond biological relationships; my extended family, including Aunt Jan, Jamie, Erica, and the Cooper cousins, for believing in me and supporting me through all of the milestones in my life; and my new family, Eric, Peggy, and Jaime, for their patience and acceptance of my insane life these past few years.

I want to thank my friends, old and new, for giving me perspective and reminding me to not take myself too seriously: Bessma, for exemplifying true friendship and always being there to listen when it matters most; my classmates (and friends) who supported me along the way; particularly Michele Archambeault, Katy Jakle, and Shana Spangler; and Anne, Pat, Jules, Niki, Debbie, Kathleen, Mariel, J-Lee, Jodi, Jen, Dave, and Travis for reminding me there is a light at the end of the tunnel and waiting for me to reemerge! All of you are precious to me and you will remain close to my heart regardless of the time that passes between our visits.

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I would like to acknowledge those who contributed to the development and completion of this project, all of whom inspired my interest in the topic, provided feedback, insight, support, or assistance with the research in some form. I would like to extend my sincere gratitude and appreciation to my fellow lab members, without whom I could not have completed this dissertation research; Josina Grassi Moak, my fellow "black sheep," who has been a constant source of support and encouragement during our journey in the doctoral program, and without whom I would not have "survived" graduate school; and Alexander Bacher, for continually reminding me to look at the big picture, get enough sleep, and engaging me in thought-provoking conversations.

I would like to extend a special thank you to Dr. Susan Hall, for offering research expertise and guiding me every step of the way through my graduate education and professional development. I have been moved by her passion and unwavering dedication to her students and her work, which I aspire to follow in my career. I would like to express my gratitude to Dr. David Elkins for reminding me to remain connected to my true "self" as I develop as a therapist, for being my "editor" and mentor on many occasions, and embodying what it truly means to be a humanistic psychologist; and to Dr. Tom Greening for providing me with fresh perspectives and helping me develop my skills as a qualitative researcher. I am encouraged to incorporate creative writing into my professional development because of both of you. I would also like to thank Quinn Neugebauer for her help with transcription. Finally, I would like to extend sincere thanks to Dr. Duncan Wigg, for inspiring me to think "outside the box," teaching me about narrative therapy, and always emphasizing the importance of the client's perspective.

CURRICULUM VITAE

Stacie L. Cooper

EDUCATIONAL HISTORY

Doctoral Student in Clinical Psychology, APA-accredited Psy.D. program
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Dissertation Title: *A Content Analysis of Client Hope in Psychotherapy Sessions*
Dissertation Oral Defense: June, 2008

- Psy.D. Student Government Association, Student Representative
- Glen and Gloria Holden Scholarship Recipient

Master of Arts in Clinical Psychology with an Emphasis in Marriage and Family Therapy, May 2005
Pepperdine University, Graduate School of Education and Psychology, Malibu, CA

Bachelor of Arts in Psychology with a Minor in Communications, May 2003
University of Southern California, Los Angeles, CA

- Study abroad program- Madrid, Spain
- Psi Chi & Alpha Lambda Delta Honor Societies
- National Society of Collegiate Scholars
- Achievement Scholarships

LANGUAGES

Proficient in reading and writing Spanish, basic Spanish conversational skills

PROFESSIONAL EXPERIENCE

Pre-doctoral Intern in Professional Psychology
Duke University Counseling and Psychological Services
Durham, NC
August 2008 – August 2009
Training Director: Anita-Yvonne Bryant, Ph.D.

- Provide brief, short, and long-term individual therapy, couples, and group psychotherapy, consultation, career counseling, and crisis management services to college students
- Conduct six weekly intake assessments, participate in weekly Eating Disorders Treatment Team, and coordinate care with interdisciplinary treatment team
- Apprenticeship focused on training, research, clinical work, and outreach/developmental programming for women's issues on campus
- Involved with campus outreach activities, educational and prevention programs
- Participate in weekly individual and group supervision with a psychologist and counseling professionals, and case consultation team meetings
- Attend weekly seminars and trainings on a variety of topics significant to university mental health

Outreach Intern and Individual Therapist
Mount St. Mary's College, Counseling and Psychological Services
Los Angeles, CA
October 2007 – May 2008
Supervisor: Kendra Nickerson, Ph.D.

- Provided brief individual psychotherapy, consultation, and crisis management to college students
- Conducted intake assessments, formulated diagnoses and treatment plans
- Participated in stress management presentations for freshman college students
- Partnered with residence life to provide educational seminars on mental health issues as needed throughout the fall and spring semesters
- Developed and implemented outreach projects for college students and staff throughout the year (i.e., National Depression Screening Day, Diversity Training, Project Clothesline, Take Back the Night, Body Image Awareness)
- Attended weekly case consultation meetings with the assistant director, predoctoral intern, and postdoctoral fellow to assess campus needs for specific outreach and consultation services, with special consideration given to diversity (the majority of students self-identify as Catholic, Latina females, and first in the family to attend college)
- Received individual supervision utilizing an integrative approach consistent with the university's brief therapy model, which drew from psychodynamic, humanistic, existential, multicultural, and cognitive-behavioral orientations based on client needs

Doctoral Trainee
LAC-USC Medical Center, Psychology Assessment Clerkship, Child and Adolescent Track
Los Angeles, CA
September 2007 – June 2008
Supervisor: Louise Macbeth, Ph.D.

- Assessed adolescents on an inpatient psychiatric unit utilizing brief screening assessment instruments (e.g., MMPI-A, WASI, TONI, WRAT-4, MACI), in order to determine diagnoses, treatment plans, recommendations for potential services, and to provide feedback to multidisciplinary staff
- Conducted comprehensive psychological evaluations including chart review, test administration (e.g., WISC-4, WRAT-4, WIAT, Connor's Rating Scale-Revised), scoring, and full written reports in the outpatient clinic with low-income Latino school-age children presenting with learning, developmental, mood, anxiety, behavioral, and trauma-related disorders
- Participated in weekly psychological assessment seminars on topics such as cross-cultural issues in assessment, psychopharmacology, psychological trauma, assessment of developmental and learning disorders, ADHD, and child abuse
- Attended weekly individual and group supervision meetings with clinical psychologist and fellow trainees to discuss cases, determine the appropriate tests based on referral questions and presenting issues, and review scoring, interpretation, and written reports

Doctoral Trainee
Long Beach Job Corps Health and Wellness Center
Long Beach, CA
August 2006 – September 2007
Supervisor: Joseph Grillo, Ph.D.

- Provided crisis intervention and short- and long-term individual psychotherapy in a residential/ educational setting with young adults and adolescents (ages 17 to 24) from low socioeconomic and diverse cultural backgrounds to improve psychological, interpersonal, and occupational functioning
- Developed and implemented individual psychotherapy plans with clients with a variety of presenting problems (e.g., relational issues, adjustment disorders, trauma/abuse histories, depression, anxiety, substance abuse and/or dependence) in order to increase adaptability and improve well-being
- Facilitated weekly psychoeducational groups with incoming Job Corps students to introduce available psychological services and provide information about various mental health issues
- Adapted and facilitated an empirically supported positive psychotherapy group intervention for young women suffering from mild to moderate depression in order to foster self-efficacy, and identify and nurture personal and environmental resources
- Collaborated and participated in a multidisciplinary treatment plan with on-site residential staff, educational, career, and health professionals to improve client progress and attend to multiple contextual factors
- Developed and co-led a trauma presentation to all staff members at the center as a part of a training program in order to provide information on issues relevant to the student population
- Attended weekly individual and group supervision meetings with clinical psychologist utilizing an integrative approach to conceptualization and therapy that combined humanistic, cognitive-behavioral, systemic, developmental, and multicultural perspectives
- Completed agency paperwork, updated diagnoses, weekly progress notes, and client goals for therapy in order to evaluate client improvement and the need for further services

Doctoral Trainee
Pepperdine University Counseling Center
Irvine, CA
August 2005 – July 2006
Supervisor: Duncan Wigg, Ph.D.

- Conducted intake interviews with adolescents, adults (primarily college students), and families in order to assess psychotherapy needs based on client and therapist perspectives
- Administered a battery of assessment measures pre, mid, and post intervention to monitor client progress, level of psychological adjustment, level of motivation, social support, existing coping methods and working alliance for treatment and research purposes
- Organized and implemented individual and/or family therapy plans with clients experiencing a variety of current life stressors and psychological distress in order to improve functioning
- Provided ongoing individual and family therapy utilizing therapeutic interventions informed by cognitive behavioral, family systems, and narrative therapy to increase coping skills,
  improve communication within relationships, and provide a safe, supportive environment to enhance meaning in life
- Developed and implemented a short-term women's support group with the goal of providing victims of abuse with a normalizing, empowering experience within a positive interpersonal context

- Participated in weekly group supervision meetings with clinical supervisor and fellow trainees to exchange ideas, present cases, review video and audio-taped psychotherapy sessions, and discuss legal/ethical issues and other relevant topics based on client needs
- Attended weekly training sessions to learn the theories behind social constructionism and narrative therapy and how to apply them in clinical practice

MFT Trainee
Hollywood YMCA Counseling Center
Hollywood, CA
May 2004 – May 2005
Supervisor: Larry Shaw, MFT, Ph.D.

- Scheduled appointments, provided referrals, and conducted initial intakes with adult clients over the phone and in the counseling center
- Provided individual play therapy at a local elementary school to children, of primarily Latino and Armenian ethnicities, with an array of emotional and behavioral problems exacerbated by multiple life stressors such as poverty and community violence
- Collaborated regularly with the school psychologist, teachers, and parents in order to gain multiple perspectives and ensure comprehensive assessment and intervention
- Provided individual adult, child, and family counseling services at the YMCA Counseling Center for clients who had experienced major life stressors, traumatic events, and loss in order to renew hope and access coping mechanisms
- Attended weekly group supervision meetings with staff psychologists, trainees, and intern at the counseling center to discuss reactions to therapeutic material, multicultural issues, update therapy plans, and to perform weekly case presentations with group feedback
- Participated in agency trainings on child therapy, somatic experiencing, and guided imagery

MFT Trainee
OPICA Elderly Day Care Facility
West Los Angeles, CA
January 2004 – May 2004
Supervisor: Shirley Riley, M.A.

- Co-facilitated a variety of therapy groups for clients suffering from dementia-related illnesses, which consisted of: art therapy, music therapy, cognitive stimulation exercises, physical health, gender-specific, and long-term support groups
- Provided individual therapy for older adult clients with cognitive impairment, consulted with family members, and provided informal support by taking them on walks, making home visits to assisted living facilities, and helping with art, entertainment and educational activities of the facility
- Assisted staff members with office duties, organized files, maintained progress notes, served lunch to the clients, and communicated with family members
- Participated in group supervision and didactic training on art therapy techniques

Junior Therapist
Center for Autism and Related Disorders
Torrance, CA
August 2002 – May 2003
Supervisor: Eric Maier, M.A.

- Implemented applied behavior analysis (ABA) to guide and perform therapy with mildly to severely autistic children from the ages of 3 to 11 years old

- Worked one-on-one in the home environment to foster social, motor, and cognitive skills, and to decrease self-stimulatory or injurious behaviors
- Attended bi-monthly clinic meetings with families, therapists and supervisors to discuss each client's progress and ensure collaboration, while providing parents and siblings with psychoeducation, skills, and emotional support to generalize therapeutic gains across settings

RESEARCH EXPERIENCE

Research Assistant
Children's Hospital of Los Angeles, Hematology/Oncology Unit
Los Angeles, CA
March 2006 – August 2006
Supervisors: Sandra Sherman, M. S., and Ernest Katz, Ph.D.
Worked on the "Healing Effects of the Built Environment" project to study the built environment and hospital design at CHLA as they affect pediatric oncology patients, parents, and their care staff

- Administered assessment battery to pediatric oncology patients, their parents, and nursing staff to evaluate their experiences at the hospital in relation to quality of life and physical health
- Entered participants' questionnaire data into computer research database and computed SPSS and qualitative analyses to determine the relationships between the hospital environment, quality of life, physical, social, and emotional functioning
- Collaborated with hospital staff and attended department meetings to introduce the study, recruit subjects, and maintain safety and confidentiality

Research Assistant
Pepperdine University, Graduate School of Education and Psychology
Malibu, CA
June 2004 – May 2005
Supervisor: Dennis Lowe, Ph. D.
Conducted research in conjunction with supervisor's professional workshops on key factors to establish and maintain healthy relationships

- Researched psychology databases for published journals that examined characteristics of long-term, satisfying relationships
- Compiled a summary of research findings that listed the common factors of healthy relationships

TEACHING EXPERIENCE

Teaching Assistant
Pepperdine University, Graduate School of Education and Psychology
Los Angeles, CA
August 2007 – December 2007
Professor: Carolyn Keatinge, Ph.D.

- Reviewed and edited students' psychological test scoring, analyses, and integrated reports (including WAIS-III, MMSE, Bender-2, RAVLT, TRAILS, Rorschach, and FAS for adults, and WISC-IV, WRAT-4, and VMI for children) for two doctoral level cognitive assessment courses and masters level personality assessment course

- Proctored cognitive testing labs for doctoral students focused on WAIS-III and WISC-IV test administration, scoring, and interpretation
- Created the comprehensive psychological assessment report on a college student evaluated for learning disabilities to be used as the template on the Pepperdine University website for doctoral level cognitive assessment courses

Teaching Assistant
Pepperdine University, Graduate School of Education and Psychology
June 2004 - May 2005
Malibu, CA
Professor: Dennis Lowe, Ph.D.

- Prepared quizzes, review questions, and study guides for two graduate courses, entitled "Clinical Management of Psychopathology," and "Marriage and Family Therapy," as well as an undergraduate freshman seminar, "Developing Healthy Relationships" resulting in student learning and further integration of the course material
- Aided in the grading process for all APA-style research papers and exams to enhance students' writing and formatting skills as well as to provide constructive feedback to them

OUTREACH PRESENTATIONS

Edwards, J., Cooper, S. L., & Kashani, S. (2007, November). *Body image awareness.* Leadership bootcamp training, Mount St. Mary's College, Los Angeles, CA.

Archambeault, M. E., Brown, J., & Cooper, S. L. (2007, April). *Trauma in childhood and adolescence.* Staff training, Long Beach Job Corps, CA.

Cooper, S. L., Grassi, J., & O'Dell, J. M. (2006, April). *Disordered eating, body image, and the media.* Community outreach presentations, Fountain Valley High School, CA.

PROFESSIONAL DEVELOPMENT ACTIVITIES

International Psychology: Addressing the Crisis in Darfur Presentation, Pepperdine University, Los Angeles, CA, 2008
National Eating Disorders Association (NEDA) Conference, San Diego, CA, 2007
Management of Aggressive Behavior Training, LAC-USC Medical Center, Los Angeles, CA, 2007
California Psychological Association Convention, Costa Mesa, CA, 2007
Woodcock-Johnson Cognitive and Achievement Tests Workshop, Pepperdine University, Los Angeles, CA, 2007
Child Abuse Assessment and Reporting Workshop, Pepperdine University, Irvine, CA, 2006
Visual Narrative Therapy and Domestic Violence Workshop with Art Fisher, Los Angeles, CA, 2006
Evolution of Psychotherapy Conference, Anaheim, CA, 2005
Heart and Science of Psychotherapy Conference, Brentwood, CA, 2005
Guided Imagery Training, Hollywood YMCA Counseling Center, CA, 2005
California Association of Marriage and Family Therapy Conference, Los Angeles, CA, 2004

PROFESSIONAL AFFILIATIONS

American Psychological Association, Student Affiliate
American Psychological Association, Humanistic Division, Student Member
American Psychological Association, Division of Counseling Psychology, Student Member
American Psychological Association, Positive Psychology Section-in-Formation of the Division of Counseling Psychology (17), Member
California Psychological Association, Student Member
National Eating Disorders Association, Student Member

ABSTRACT

The purpose of this study was to understand the role of hope and how it was expressed by diverse clients in the initial sessions of individual psychotherapy. Five adult clients representing a range of ages, gender, ethnicities, religious/spiritual orientations, and presenting issues were observed in archival videotapes of their 3rd or 5th psychotherapy sessions at two southern California community counseling clinics. Content analysis revealed that client expression of hopefulness during these sessions varied in quantity and quality. Using a modified version of the CHANGE (Change and Growth Experiences Scale; Hayes & Feldman, 2005), the average scores among the 5 participants were low positive hope, medium negative hope, and low pathways. Thus, higher levels of hopelessness (i.e., negative hope) were found than hopefulness (i.e., positive hope and pathways), consistent with previous writings that have viewed psychotherapy as the process of re-instillation of hope (Hubble, Duncan, & Miller, 1999; Lopez et al., 2006).

Results also supported Snyder's (2002) current hope theory, revealing 2 separate but related subcomponents of hopefulness: agency and pathways. Specific themes that emerged for client expressions of positive hope, negative hope, and pathways were similar to those found in Snyder's conceptualization of hope because they involved statements of motivation, commitment, belief in one's capacity (or lack thereof for negative hope), desire to attain goals, and identification of specific ways to move toward those goals. But coders also observed specific differences from existing hope constructs, including frequent pathways or agency expressions in reference to the past (in contrast to current present and future-focused definitions), and pathways statements involving cognitive or meaning making strategies (rather than Snyder's definition that is primarily

behavioral/action focused). Further, an examination of relationships between hope codes and other CHANGE codes found that positive hope frequently co-occurred with a measure of meaning-making, negative hope was rated with protection/avoidance and unproductive processing, and higher levels of pathways were found with higher perceived relationship quality.

The present study, therefore, highlighted the need to expand the conceptualization of hope to include references to the past cognitive expressions of pathways, and the context of its expression in order to attend to various aspects of hope varying across domains of diverse individuals' lives. By eliciting and bolstering clients' expressions of past hope and cognitive or meaning making types of pathways, therapists may enhance clients' agency and ability to identify new strategies or routes to attain their goals. Further, a complex and multifaceted understanding of hope may remind therapists to value and attend to a client's diverse experiences and manner of responding to those experiences, fostering increased understanding and integration of various aspects of the self.

Introduction

History of Clinical Psychology

Since its inception in 1896, the field of clinical psychology has predominantly focused on the negative aspects of human personality and functioning (Abi-Hashem, 2001; Lopez et al., 2006; Maddux, 2002). This focus has been influenced by a number of factors, including: Freud's popularization of the medical model of psychopathology; the founding of the Veteran's Administration in 1946, which created a plethora of jobs for psychologists trained to assess and treat psychiatric "illness" in returning veterans; and the birth of the National Institute of Mental Health (NIMH) in 1947, which led to the funding of research on "mental illness" (Lopez et al; Maddux). Primarily receiving their training in psychiatric hospitals and clinics emphasizing medicine and psychoanalysis, clinical psychologists and other mental health professionals were, therefore, educated in the assessment and remediation of what was labeled as mental illness (Keyes & Lopez, 2002; Seligman & Csikszentmihalyi, 2000).

As a result of these efforts, psychology has made groundbreaking progress in the classification and treatment of "mental illness," personality disorders, and relationship issues (Duckworth, Steen, & Seligman, 2005; Keyes & Lopez, 2002). However, the emphasis on pathology has resulted in a paucity of research and interventions dealing with the other side of human functioning: strengths and resources (Gable & Haidt, 2005; Keyes, 2005; Shogren, Lopez, Wehmeyer, Little, & Pressgrove, 2006; Tedeschi & Kilmer, 2005).

Historically, there have been many significant attempts to study the human condition and clinically intervene with clients from a more positive framework. For example, William James emphasized the study of subjective feelings, life satisfaction, and meaning beginning in 1902, and Gordon Allport focused his research on positive human characteristics and healthy

personality development starting in 1958 (Duckworth et al., 2005; Gable & Haidt, 2005; Lopez et al., 2006; Pawelski, 2003; Schneider & May, 1995). The field of developmental psychology has studied resiliency and fostered prevention work (Baltes, Ebner, & Freund, 2006). Humanistic psychology, counseling psychology, and social constructionist theoretical models have all devoted their energy to looking beyond the cure of "mental illness" toward enhancing meaning in life and optimal psychological functioning with a more balanced approach emphasizing the full range of human experiences (refer to full literature review in Appendix A) (Bohart & Greening, 2001; Kirschenbaum, 2004; Rogers, 1961; Simonton & Baumeister, 2005; Snyder, Rand, & Sigmon, 2002).

Unfortunately, many of these efforts toward prevention or enhancement of functioning and well-being have been largely overlooked or criticized by the mainstream scientific community for lack of empirical evidence, or have failed to garner more support due to the pressure from academic, financial, and medical institutions (Duckworth et al., 2005; Lopez et al., 2006). However, in the domain of humanistic psychology, criticism of a lack of empirical evidence is not supported. Both humanistic and counseling psychologies have historically espoused a holistic and strengths-based perspective toward research and practice (Mollen, Ethington, & Ridley, 2006). It can be argued that positive psychology is merely a continuation of earlier work applied more to clinical psychology, and credit should be given to these long-standing efforts and accomplishments in the field (Bohart & Greening, 2001; Giorgi & Giorgi, 2003; Rogers, 1961).

Positive Psychology Movement

In response to a call by some for a more balanced approach to psychology that attends to the positive as well as the negative to adjoin a more empowering, hopeful perspective of human

functioning, positive psychology has emerged as yet another catalyst for the empirical study of positive psychological processes, resources, and strengths within the psychological community as a whole (Duckworth et al., 2005; Frederickson, 2000; Lopez et al., 2006; Seligman & Csikszentmihalyi, 2000; Simonton & Baumeister, 2005; Snyder, 2002; Wong, 2006). It has brought increased attention to positive historical concepts and processes and is incorporating them into current psychological research and practice to balance the traditional deficit-based model of "mental illness" prevalent in clinical psychology (Duckworth et al.; Handler, 2006; Pawelski, 2003; Snyder, Ritschel, Rand, & Berg, 2006).

Positive psychology has been defined as the "scientific pursuit of optimal human functioning" (Lopez et al., 2006, p. 210), in three primary domains or pillars: (a) positive subjective experience, (b) positive individual or character traits, and (c) positive institutions (Seligman & Csikszentmihalyi, 2000). The present study examined the first pillar that concerns positive thoughts and emotions about the past, present, and future, and more specifically, the emotive/cognitive experience of hope (Duckworth et al., 2005; Lopez, Ciarlelli, Coffman, Stone, & Wyatt, 2000). Because positive emotions have the potential to reverse the effects of negative emotions, enhance an individual's cognitive and behavioral capabilities, build upon enduring personal resources, and have been linked to better mental and physical health (Frederickson, 2000), they deserve further attention and research.

A criticism of the nascent field of positive psychology and the study of positive emotions is the lack of congruence among researchers and practitioners when defining and measuring these constructs (Mollen et al., 2006; Shogren et al., 2006). For instance, hope and optimism have frequently been described interchangeably in the positive psychology literature and elsewhere due to their conceptual overlap and the difficulty in operationally defining complex

psychological processes in general (Bryant & Cvengros, 2004). Researchers assert that global descriptions of such constructs and measurement tools must be developed to allow communication and sharing among professionals (Lampropoulos, 2001; Lopez & Magyar-Moe, 2006; Shogren et al.). The dilemma with global positive constructs is that they may not be temporally, environmentally, developmentally, or culturally consistent (Flores & Obasi, 2003; Lopez et al., 2002; Lopez, Snyder, & Pedrotti, 2003; Mollen et al.; Sagy & Adway, 2006). The development of positive psychology constructs and measures are still in their infancy and need more attention due to the importance of incorporating strengths into culturally and developmentally appropriate psychotherapy assessment and treatment (Lopez & Snyder, 2003; Maddi, 2006).

Of particular relevance to the proposed dissertation is the study and clinical application of strength-based assessment in the context of psychotherapy (Snyder et al., 2003; Walrath, Mandell, Holden, & Santiago, 2004). Strengths-based assessment has been defined by Epstein and Sharma (1998, as cited in Cox, 2006) as:

> The measurement of those emotional and behavioral skills, competencies and characteristics that create a personal sense of accomplishment; contribute to satisfying relationships with family members, peers, and adults; enhance one's ability to deal with adversity and stress; and promote one's personal, social and academic development. (p. 288)

Humanistic psychologists and other professionals have been advocating for an emphasis on client strengths and resources for decades with the rationale that psychological strengths can be accessed to empower clients, increase hope, improve the therapeutic alliance, and enhance psychological well-being (Ahmed & Boisvert, 2006; Bohart & Greening, 2001; Lopez, Snyder,

& Rasmussen, 2003; Peterson, Park, & Seligman, 2006; Rogers, 1961). Abraham Maslow first used the term "positive psychology" decades ago, and Carl Rogers' positive view of human nature influenced the client-centered approach to therapy that aims to facilitate clients' natural tendencies toward growth and development (Mollen et al., 2006; Rogers; Schneider, Bugental, & Pierson, 2001). The research outcomes in humanistic psychology in particular have provided support for the positive impact of fostering client potentials above and beyond alleviating acute emotional distress (Bohart & Greening; Rogers). Recent researchers have also suggested that extra-therapeutic factors (such as clients' personal strengths and social/environmental resources) account for approximately 40 % of variance in psychotherapy outcomes (Bohart & Greening; Hubble, Duncan, & Miller, 1999; Wampold, 2001). As such, the balanced assessment of strengths and weaknesses in psychotherapy may provide a more holistic view of the client as a person in context and a more comprehensive conceptualization of the client's issues that guides the treatment plan (Richman et al., 2005; Seligman, Steen, Park, & Peterson, 2005; Tedeschi & Kilmer, 2005; Walrath et al., 2004).

Assessing Hope: Ingredient for Psychotherapeutic Success

In the 1950's, Karl Menninger first introduced hope as an integral asset to the therapeutic relationship and outcome of psychotherapy (Irving et al., 2004). Menninger and other early proponents of hope theories asserted that psychopathology is a sign of a lack of hope, or despair, and therapists' goals should involve reinvigorating a sense of hope in clients (Irving et al.; Tedeschi & Kilmer, 2005; Tyler, 1973). Jerome Frank pioneered a theory that hope was one of the common factors across numerous psychotherapeutic modalities that contributed to positive therapeutic experiences and outcomes (Hubble et al., 1999; Snyder et al., 2002). These early theorists all agreed that positive expectancies are essential to mental health and well-being. There

has also been agreement in the field of psychology that the client's experience or development of hope is related to the process of therapy, therapeutic relationship, and a positive outcome (Irving et al.; Snyder et al., 1991, 2002). Recent research has provided further support for the previous assertions, suggesting that hope may be one of the most important constructs to assess in psychotherapy clients given its relationship to psychological well-being and therapy outcome (Bergin & Walsh, 2005; Hubble et al.; Isaacowitz, Vaillant, & Seligman, 2003; Snyder, Michael, & Cheavins, 1999).

Hope has been defined in a number of ways, which has been one of the limitations of its clinical and scientific applications in the past (Bergin & Walsh, 2005; Feldman & Snyder, 2005; Snyder, 2002). Hope has been characterized as a belief in one's own efforts, an affect related construct, a personality trait, a coping mechanism for stressful events, a spiritual process, an interpersonal process, and an expectation for specific positive outcomes (Bergin & Walsh; Feldman & Snyder; Snyder et al., 2002; Wallace & Shapiro, 2006). C. R. Snyder's emotive/cognitive hope theory has integrated and expanded upon previous researchers' notions of the concept, and it is currently the most widely used and researched model in clinical psychology (Lopez & Kerr, 2006; Snyder). Snyder has conceptualized hope as a combination of an individual's personal goals, motivation (agency), and his or her perceived pathways to achieve those goals (Shogren et al., 2006; Steed, 2002).

Recent research has supported Snyder's hope theory. Not only has Snyder's self-report measure of hope been validated across cultures (within the United States among Caucasians, African-Americans, Native Americans, Hispanics, and Asian-Americans), and translated in China, Russia, France, Germany, Italy, Spain, Japan, Israel, Norway, and Kuwait (Abdel-Khalek & Snyder, 2007; Snyder, 2002), but it also has been correlated with a number of positive

psychological processes and outcomes (Abi-Hashem, 2001; Horton & Wallander, 2001; Hubble et al., 1999; Snyder et al., 2006). Some positive processes include making meaning in life, psychological well-being, motivation, and social connectedness (Feldman & Snyder, 2005; Snyder, 2002; Wallace & Shapiro, 2006). A review of psychotherapy outcome research by Hubble et al. in 1999 evidenced four major factors that contribute to positive psychotherapeutic outcome, all of which include some aspect of the client's hope: (a) intrinsic hope or faith, (b) hope or belief in the therapeutic process, (c) rationale for therapy, including approach and techniques used, or (d) the therapist. More recently, numerous studies have found relationships between client hope and perceived social support, therapeutic alliance, satisfaction with life, recovery from illness, pain tolerance, and psychotherapeutic improvement (Horton & Wallander; Irving et al., 2004; Snyder et al., 2006; Wallace & Shapiro). However, these studies have relied primarily on self-report measures, and there is a paucity of research using more in-depth qualitative methods to study the processes and relationships among these constructs (Irving et al.; Lopez, Snyder, & Pedrotti, 2003; Snyder et al., 2003; Wampold, 2001).

Purpose and Scope of Study

In a content analysis of the counseling psychology research literature, Lopez et al. (2006) found that positive psychological constructs/processes have rarely been operationalized and measured. Specifically, hope was the topic of only 5 of 1,135 selected articles in the major counseling psychology scientific journals. This result may be explained in part because of the difficulty in operationalizing constructs such as hope, love, courage, and well-being, which are relatively complex and obscure when compared to more familiar and researched concepts such as anxiety that can be measured through objective behavioral and physiological descriptions. The lack of attention to positive constructs regarding a range of human experiences in the scientific

literature may also continue to perpetuate the assumption that they are irrelevant, unimportant, or unworthy of publication (Joseph & Linley, 2006; Lopez et al., 2006). "By directing more resources to basic research on positive psychological constructs, counseling psychologists could generate a better understanding of motivational forces that may be associated with psychological change and growth" (Lopez et al., 2006, p. 221). This is an assertion that may be even more applicable to the area of clinical psychology with its traditional emphasis on pathology.

Although previous research indicates that hope seems to play an important role in psychotherapy and the psychotherapeutic relationship, there is still a lack of knowledge about how hope is expressed by clients during psychotherapy sessions. Hope has primarily been measured using self-report questionnaires, which provide limited information regarding the complex processes involved (Flores & Obasi, 2003; Lopez et al., 2000; Lopez, Snyder, & Pedrotti, 2003; Maoine & Chenail, 1999; Steed, 2002). Researchers have called for qualitative examination to develop a more comprehensive understanding of positive psychological constructs such as hope (Flores & Obasi, 2003; Lopez et al., 2006). Unfortunately, the qualitative studies that have examined hope through content analysis of verbal or written language have defined and measured hope in quite discrepant manners as well, limiting research replicability (Gottschalk, 1974, 2000; Hayes, Beevers, Feldman, Laurenceau, & Perlman, 2005; Snyder, 2002). For example, Gottschalk developed a scale to measure hopeful language from written or oral communication, but the construct is defined more broadly and subjectively than Snyder's definition of hope, including optimism and wishful thinking as part of hopefulness (Gottschalk, 1974). Hayes and colleagues (2005) have created and utilized a coding system from a positive psychology perspective to rate psychological processes including the category of hope more similar to Snyder's conception of hope, which will be discussed in detail below.

The purpose of the present study was to qualitatively examine the role of hope in the intake experiences of clients seeking psychotherapy at a university's community counseling clinics in order to gain a deeper understanding of how hope is expressed within the context of therapy. It is anticipated that the study will contribute to the field's knowledge of ways to enhance the assessment and use of strengths in the practice of psychotherapy. Thus, the research question for the proposed study is: how, and to what extent, do clients express hope during the initial sessions of therapy?

Method

The purpose of this chapter is to provide an overview of the methods used during the course of this study. It begins with a description of the participants and instruments. Next, there is a discussion of the study's design, sampling and data collection procedures, data coding using a previously established coding system, human subjects considerations, and analysis procedures.

Participants

Based on the general suggested guidelines of qualitative and observational research and what was feasible for this particular study (Creswell, 1998; Denzin & Lincoln, 1998, Mertens, 2005), purposeful random sampling was used to access five psychotherapy cases with sufficient data from an archival research database of a southern California university's community counseling centers and clinics. Database materials and procedures were developed with Institutional Review Board (IRB) consultation, and IRB approval was obtained prior to accessing archival client data. At the time of intake for psychotherapy, participants consented to have their written records and audio/videotaped sessions included in the research database; therapists also consented to have their written data about their clients and taped sessions included in the research database. In order to maintain participant confidentiality, all names were removed from

videotapes and replaced with research codes, and steps were taken to ensure that research coders did not know the clients or therapists on the videotapes.

In order to be included in the current study, clients had to be at least 18 years of age at the time of intake, fluent in English, and to have given written consent for written records and either audio or videotaping to be included in the research database (Appendix B). In addition, their therapists had to provide written consent for inclusion of these records as well (Appendix C). Inclusion criteria for "cases with sufficient data" consisted of audible audio and/or videotaped sessions from the entire first, second, or third session, and completed measures at intake. Individuals coming to the clinics seeking couples, family, or child/adolescent therapy were excluded from the sample.

The sample included adult clients who sought individual counseling between the years of 2004 and 2007 at two of the university community counseling clinics. In an attempt to be representative of the diversity of the clinics and surrounding communities, the sample included three female and two male participants, ranging from age 21 to 36 (M = 27.8), self-identifying as Asian-American, Polish-American, African-American, or Mexican-American, and as Catholic, Pentacostal, Unitarian, or not religious or spiritual. Important participant demographic characteristics are summarized in Table 1.

Instrumentation

This section will describe the instruments used in this study. The demographic information and psychotherapy sessions that were examined were obtained from an archival research database at the clinics and counseling centers. The database contains materials completed by therapists, and measures completed by all clients at the clinics at the intake session

and five session intervals to assess client needs and strengths as well as monitor client progress and satisfaction.

Table 1

Participant Demographic Information

Participant	Age	Gender	Ethnicity	Religion
P1	21	Female	Mexican-American	Pentacostal Christian
P2	28	Male	African-American	None indicated
P3	25	Female	Polish-American	Catholic
P4	36	Female	Mexican-American	Unitarian
P5	29	Male	Korean-American	Non-religious

Client Demographics

To determine whether the sample used in this study was representative of the population normatively serviced by the clinics and counseling centers, demographic information gathered from the research database was used. Information on gender, ethnicity, age, marital status, religious/spiritual beliefs, presenting problems, and psychological history was gathered from an adult demographic form completed by the clients at the first session. This information was utilized to attempt to include a diverse sample of participants in the present study.

Change and Growth Experiences Scale

Hope. The hope subscale of the Change and Growth Experiences Scale (CHANGE; Hayes, Feldman, & Goldfried, 2007) was used to code the verbal content of hope expressed by clients in the initial psychotherapy session. The CHANGE is used to code the content of essays or of psychotherapy sessions, and has been used in qualitative research on the process of

psychotherapy (Hayes, Beevers et al., 2005; Hayes et al.). The CHANGE was selected because it allows coders to be trained in a brief time period, has demonstrated adequate psychometric properties (e.g., inter-rater agreement on all coding categories = .73-.84), was developed within a positive psychology framework given its focus on symptom change as well as health promotion, and has a specific category for the measure of hopeful language that is relatively consistent with C. R. Snyder's definition of hope that involves goals, agency and pathways to attain those goals (Hayes, Beevers et al.; Hayes et al.). The authors have described hope as an individual's motivation and belief in his/her future goals, as well as his/her ability to consider realistic routes to achieve those desired goals (Hayes, Beevers et al.). More specifically, hope is coded in the CHANGE manual as "the person's capacity to see the possibility of change in the future, to recognize recent positive changes, and to express a commitment or determination to make changes (Hayes & Feldman, in press, p. 7). The hope scale includes both positive and negative hope content variables that were both coded for the purposes of this study based on positive psychology research advocating a balanced approach that examines all aspects of a given construct (Lopez et al., 2003). Variables are not mutually exclusive, and are coded on a scale from 0 to 3 (0 = *not present or very low,* 1 = *low,* 2 = *medium,* 3 = *high*). The negative hope variable is described as "a feeling of being stuck, trapped, having no way out, sinking, feeling tired of trying, or a lack of commitment" (Hayes & Feldman, p. 7). The positive hope variable is described as "a feeling of movement or possibility, a commitment or determination to change."

Snyder's (2002) definition of hopeful language was utilized to further inform the coding process to ensure that the component of pathways (identification of specific routes, actions, behaviors to be taken to achieve goals) was also identified in the transcripts. This was done through the process of developing and refining the coding manual as the researchers practiced

with training tapes and transcriptions to achieve inter-rater reliability. In addition to coding for positive and negative hope (since the CHANGE codes capture mainly the agency subcomponent of hope), an additional code for pathways thinking was created for the coding manual based on Snyder's definition and examples (see Appendix D for full coding and transcription training manual). The coding manual defines pathways as goal-directed thinking in which the individual perceives that he or she can produce desirable, realistic, and manageable routes or strategies to move toward the direction of present or future goals. This involves brainstorming options, planning ways to meet goals, and describing specific behaviors to perform. Pathways thinking was coded on a scale from 0 to 3 to maintain consistency with the CHANGE variables.

Coping and meaning making. Certain codes from the Change and Growth Experiences Scale (CHANGE; Hayes, Feldman, & Goldfried, 2007) were used as measures of coping and meaning making and coded by the four researchers as part of two related research studies. Since these CHANGE variables were all coded for the same five psychotherapy sessions simultaneously, the discussion section will discuss comparisons made between these codes and the hope codes as they were observed by researchers during the coding process and research lab meeting discussions. The CHANGE codes that represented aspects of coping were the content variable of relationship quality (positive and negative) and the process variable of protection/avoidance. Relationship quality is defined as how clients express their perceptions of interactions and relationships to individuals in their social encounters. Protection/avoidance measures avoidance coping clients exhibit when having difficulty facing disturbing thoughts, emotions, or experiences (e.g., drinking to numb oneself; avoiding therapeutic tasks; laughing inappropriately in session; isolating oneself). The CHANGE codes that represented aspects of meaning making most relevant to hope were the process variables of unproductive processing

and cognitive emotional processing. Unproductive processing captures the extent to which the client approaches a problem and tries to explore or understand it but repetitively gets stuck trying to analyze it without significant insight. Conversely, cognitive emotional processing captures the extent to which a client approaches a problem, tries to make meaning out of it, and then experiences insight or a shift in perspective or meaning.

Design

Grounded in a pragmatic paradigm, the present study employed a combination of qualitative and quantitative content analyses of client expressions of hope in the initial stages of the psychotherapeutic process, utilizing taped therapy sessions from an archival research database at a university's community counseling centers and clinics (Denzin & Lincoln, 1998; Mertens, 2005). The content analytic methods used were informed by the work of Schilling (2006), Smith (2000), and Haverkamp and Young (2007), as well as the methodology used by the researchers who developed and utilized the CHANGE coding system (Hayes et al., 2007). As previously noted, part of the CHANGE scale (Hayes et al.), an empirically validated form of content analysis applicable to verbal and written samples to evaluate the process of psychotherapy, was used to assess the amount and intensity of clients' verbal expressions of hope during psychotherapy in an attempt to identify and quantify client hopeful statements (Haverkamp & Young; Smith). In addition, Snyder's hope theory and examples of hopeful statements taken from his empirically supported Hope Scale (Snyder, 2002) were also used to inform the coding process utilizing an a priori approach in conjunction with the CHANGE scale (Smith). In other words, as noted above, an additional pathways content analysis code was added and researchers were trained and practiced coding with the pathways code as well as the CHANGE codes.

Several reasons exist for the decision to utilize a content analysis approach for this particular study (Mertens, 2005). Content analysis is pan theoretical in that it is a method of analyzing language expression above and beyond theoretical assumptions of the various schools of psychotherapeutic orientation (Viney, 1983). This method of analysis can be applied to archival or live data, provides a rich, complex perspective of the construct of interest (i.e., hope), and can be implemented unobtrusively (Gottschalk, 1974; Schilling, 2006; Viney). A number of researchers have argued that methods such as qualitative and quantitative content analyses of written and verbal material should be used in the study of psychotherapy, especially in the relatively new area of positive psychology that has primarily relied on paper-and-pencil self-report questionnaires (Creswell, 1998; Flores & Obasi, 2003; Hubble, Duncan, & Miller, 1999; Lopez & Snyder, 2003; Schilling, 2006; Viney).

As outlined by Creswell (1998) and Smith (2000), content analysis allows researchers to study individuals in depth and to reduce a large amount of information into smaller meaningful units of representation. The goal was to address the research objectives through the noninvasive exploration of client hope to provide a more accurate, in-depth examination of the construct (Denzin & Lincoln, 1998; Giorgi & Giorgi, 2003). Coding and content analysis of taped psychotherapy sessions and examination of written materials from an archival research database thus have the advantage of being non-reactive and unobtrusive (Smith, 2000). By using a "nonparticipation" form of qualitative observation of client hope in psychotherapy, it was possible to observe the unique process and qualities of hopeful language as they meaningfully appeared in this naturalistic setting (Mertens, p. 382). Additionally, the paucity of literature regarding an in-depth analysis of clients' positive psychological processes such as hope

highlighted the need to supplement our existing literature with an understanding of how these processes can be accessed and enhanced by practitioners in therapy (Mertens).

Procedures

Sample Selection/Data Collection

A purposeful sampling procedure was utilized to target the very specific population of clients in a university's counseling centers and clinics (Creswell, 1998; Mertens, 2005). Specifically, five individual adult psychotherapy cases that met the inclusion and exclusion criteria were selected from the confidential research database at a university's community counseling centers and clinics. Specific client characteristics and demographic variables were considered during the sampling procedure to ensure that a representative sample of the population was obtained (Kazdin, 2003). A purposeful sampling approach was taken to make an effort to accurately represent a diversity of gender, ethnicities, religious affiliations, and presenting issues. A list of research record numbers was obtained, and adults above 18 years of age were purposefully selected based on inclusion criteria, exclusion criteria, and representation of diverse populations.

Purposeful random sampling was the method of choice due to the fact that an archival database already existed with a complete de-identified list of the client population that agreed to be included in the research database. An advantage of using a purposeful random sample of multiple cases for this study was the increased likelihood of generalizability in spite of the fact that the clients to be included may or may not have been representative of all clients who go to therapy as a whole (Mertens). However, Creswell (1998) asserts that generalizability is not of critical importance when conducting qualitative research; rather, in-depth analysis and use of

extensive data collection methods for no more than four or five cases is suggested to optimize transferability.

Transcription

Two master-level psychology graduate students were recruited to transcribe therapy sessions on a volunteer basis. The transcribers were trained to criterion of the established transcription system, and practiced transcription utilizing a 15-minute segment of a psychotherapy session on a professional psychotherapy training tape (the transcription system was adapted from Baylor University's Institute for Oral History; see Appendix D) (Baylor University, 1997).

Data Coding

The coders used for the content analysis utilizing the CHANGE were three doctoral-level clinical psychology graduate students, and the supervising researcher/psychologist. Coders were trained for approximately 4 weeks with 4 more weeks of practice coding to ensure criterion agreement (percentage agreement ≥.75; Hayes et al., 2005). Specifically, the researchers attained percentage agreement of .84 prior to examining the actual psychotherapy sessions. Based on the methods employed by Hayes et al. (2005), the specific ratings of the hope variable obtained by coders for each session as a whole were averaged (once they reached .75 correlation after discussion) to be used in the analyses.

Training consisted of: (a) education about the hope construct (as defined by Snyder and Hayes, as well as the other researchers' coping and meaning-making constructs); (b) development of the coding manual (based on the CHANGE manual and Snyder's hope construct, as well as the other researchers' coping and meaning-making constructs); (c) creation of and modifications to the Change and Growth Experiences Coding Worksheet (for recording

frequencies, types of pathways expressed by each client, and types of relationships for the relationship quality code measuring coping, specific client statements coded as hope, coping, or meaning-making, and overall codes; see Appendix E); (d) practice sessions involving coding of sample tapes and transcripts; (e) group discussions to compare codes obtained and to discuss differences to achieve understanding of the constructs and attain inter-rater reliability; and (f) ongoing meetings to control for coding drift. After the initial education about the constructs behind the codes (e.g., hope), the researchers discussed their process of coding, including comparing how they were reaching decisions on which individual meaning units or statements constituted a code (e.g., hopefulness or pathways) and to what intensity level they should be coded (none, low, medium, or high). Specific rules to be used in cases of speculation were clarified (e.g., when only two examples of medium pathways were noted throughout the entire session, it was to be assigned an overall code of low).

Throughout the training and coding process, the researchers developed a more in-depth and comprehensive understanding of the content analysis method. The coders gained insight firsthand into the high level of inference inherent in the CHANGE content analytic method, even though it is structured and has empirical support. Coders attempted to account for researcher bias and subjectivity through continued research meeting discussions and comparisons of specific codes for meaning units when there were differences among coders.

Human Subjects Considerations

Confidentiality was ensured in a number of ways prior to review of the participants' data. First, all participants included in the study had consented to have their records included in the research database upon commencing therapy at the community clinic. The limits of confidentiality were discussed by respective therapists, and they gave verbal and written

agreement to allow the review of their records for clinical and research purposes at a later date (see Appendix B for sample client informed consent form). Second, all therapists included in the study had consented to have their therapy tapes and client forms in the research database (see Appendix C for sample therapist informed consent form). Approval was sought and obtained from the Institutional Review Board prior to data access as well. Third, all identifying information was removed from the clients' research files and replaced with a research number to ensure anonymity and protect the clients' identities throughout coding and data analysis (Mertens, 2002; Ray, 2003). Fourth, prior to accessing any written, audio, or video records, each researcher completed an IRB certification course to ensure understanding and adherence to ethical human subject research. Researchers also completed online training on the Health Insurance Portability & Accountability Act of 1996 (HIPAA), and signed a confidentiality agreement to use the research database. Fifth, a list of all therapists' identification numbers and a pre-screening of each tape were used during tape selection to ensure that the coders did not know the therapist to preserve anonymity and reduce bias. Finally, the benefit of the content analysis methodology of choice is that it was noninvasive, in that it did not require participants to answer questions or be coerced in any way, but rather involved coding previously recorded psychotherapy sessions and examining written documents from the archival database (Denzin & Lincoln, 1998).

Data Analysis

Subsequent to collecting the study data, all tapes were transcribed verbatim and reviewed for accuracy by the researchers (see Appendix D for full Change and Growth Experiences Scale Training Manual). In order to protect anonymity of the participants, written transcriptions omitted names of people and institutions. The unit of analysis for the coding of tapes using the

CHANGE was a full therapy session for each client included in the study, and the specific coding units were defined as themes or categories (Hayes et al., 2007). As noted by Smith (2000), categories specify the variables to be assessed; in this case, the category of hope, defined in the CHANGE manual as "the extent to which the person expects that the future will be better and that progress can be made on problem areas" (Hayes et al., p. 238), and pathways, defined by Snyder as "perceived capacity to generate strategies for attaining goals" (Irving et al., 2004, p. 420). As noted above, categories of coping and meaning making were also assessed; the procedures that follow regarding hope and pathways also pertain to coping and meaning making.

After coders were trained to achieve percentage agreement of at least .75 on the hope and pathways categories (.84, as described above), they began the process of coding following the procedures used by previous researchers for the CHANGE (Hayes et al., 2007). The authors suggested reading the transcript or listening to the session while taking notes prior to coding the material (Hayes & Feldman, in press). This is also a general guideline for conducting research using qualitative and quantitative methods of content analysis of language (Denzin & Lincoln, 1998; Schilling, 2006). Coders, therefore, listened to each session while watching the videotape, and read the transcript one time through while taking notes independently and trying to listen for the theme of hope prior to coding and analysis. The coders then read the transcript a second time and recorded their general impressions of the entire session based on the definition and method outlined by Hayes and Feldman in the CHANGE manual.

In addition, coders examined the transcript in detail at least two more times to look for specific meaning units, or client statements, to be coded for pathways, positive hope or negative hope within the session, while attending to the context and overall session. Meaning units consisted of one sentence at a minimum to as long as a paragraph, depending on the context of

the verbalization (Schilling, 2006). When a hope or pathways code was found to apply to a meaning unit, it was rated on an intensity scale of 0 (not present or extremely low) to 3 (high). This additional qualitative step was employed to gain a more detailed and descriptive understanding of what types of statements seemed to constitute the participants' expressions of hope. During group meetings, coders would review each meaning unit they had coded as negative hope, positive hope, or pathways and discuss each one in depth until all four coders reached agreement on whether or not it should be coded and to what intensity. This additional step assisted the coders by allowing for detailed documentation of each coder's content analytic process and preventing progressive subjectivity during coding of each session (Creswell, 1998; Mertens, 2005).

Based on the methods employed by Hayes et al. (2005), the final ratings of the positive hope, negative hope and pathways variables obtained by coders for each session as a whole were averaged (once they reached .75 percentage agreement after discussion) to be used in the analyses. This rigorous coding process was employed to improve credibility, which is the qualitative researcher's equivalent to internal validity (Mertens, 2005). Coders also discussed their areas of agreement and disagreement, specific rules from the manual informing coding decisions for each meaning unit and for the overall session code, and observations noted from the session (e.g., client nonverbal behavior, client tone of voice during statements, therapist attitude toward the client, interactions between client and therapist).

After this, based on the qualitative content analytic methods outlined by Denzin and Lincoln (1998), Schilling (2006), and Smith (2000), the primary researcher read through each transcript and the notes and reliability worksheet (from the final version that coders reached inter-coder percentage agreement of .75 or 1.0 after group discussion) to examine the client hopeful

statements within and across each unit of analysis (session). This was done to gain a more detailed and descriptive understanding of the nature and types of hopeful language utilized by psychotherapy clients in the study. Findings are included in the results and discussion sections through the use of examples of common themes or hopeful expressions in client statements.

Results

This section will provide results of the inter-rater reliability analyses followed by the findings from the qualitative and quantitative content analysis. The content analysis consists of positive and negative hope CHANGE codes, the pathways CHANGE code developed by the researcher, and examples of participant expressions of hope constructs as coded by participant. This section concludes with results of a qualitative analysis of the positive hope, negative hope, pathways, and other CHANGE codes related to coping and meaning making (i.e., positive and negative relationship quality, protection/avoidance, unproductive processing, and cognitive emotional processing).

Inter-rater Reliability

Table 2 outlines the percentage agreement among all four coders before and after group discussion meetings. As shown below, coders had an average pre-group discussion agreement of .75 for positive hope, .60 for negative hope, and .90 for pathways, and an average post-group discussion agreement of 1.0 for positive hope, .95 for negative hope, and 1.0 for pathways.

Table 3 includes the multiple-rater Cohen's Kappa coefficient (K) based on the codes obtained among all four coders pre- and post-group discussion. This coefficient was computed in order to test whether the agreement exceeds chance. Kappa is commonly as a measure of inter-rater reliability among coders in content analysis when categories are few in number and there is a small sample size (Lonborg, Daniels, Hammond, Houghton-Wenger, & Brace, 1991; Uebersax,

2007). A Kappa (K) of > .70 is considered acceptable inter-rater reliability, a K of 0.40 to 0.59 is moderate inter-rater reliability, a K of 0.60 to 0.79 substantial, and a K of 0.80 outstanding (Landis & Koch, 1977). For inter-rater reliability of a set of items, such as a scale, one would report mean Kappa. The average K obtained for the hope codes used in the present study was .513 pre-discussion, and .948 post-discussion, which suggests moderate pre-discussion and excellent post-discussion inter-rater reliability. Table 3 outlines the Kappa scores obtained for each code as well as the average across codes.

Table 2

Inter-rater Percentage Agreement Pre- and Post-Group Discussions Among 4 Coders

	Positive Hope		Negative Hope		Pathways	
Participant	Pre	Post	Pre	Post	Pre	Post
1	.50 N/A	1.0 Low	.50 Low	1.0 Low	.75 Low	1.0 Low
2	1.0 N/A	1.0 N/A	1.0 N/A	1.0 N/A	1.0 N/A	1.0 N/A
3	.75 Med	1.0 Med	.50 Med	1.0 Med	.75 Med	1.0 Med
4	.50 Low	1.0 Low	.50 Low	.75 Med	1.0 Med	1.0 Med
5	1.0 Low	1.0 Low	.50 Med	1.0 Med	1.0 Low	1.0 Low
Average	.75 Low	1.0 Low	.60 Low	.95 Med	.90 Low	1.0 Low

Note. Med is an abbreviation for medium, and N/A represents none.

Table 3

Inter-rater Cohen's Kappa

CHANGE Code	Pre-Discussion	Post-Discussion
Positive Hope	.404	1.0
Negative Hope	.428	.844
Pathways	.706	1.0
Overall	.513	.948

Researcher Bias

The primary researcher observed her own bias resulting in a tendency to view more statements than the other coders as representative of positive hopefulness and pathways in the first few coding sessions. Upon reflection, this may have been due to her expectations and desire to see clients as hopeful during the initial therapy sessions and confirm her hypothesis. Thus, through group discussions and reliability checks, it was important to have four different perspectives to maintain a more balanced and diverse view of the construct. Group discussions also revealed biases for the other coders to identify and code more statements that represented specific constructs applying to their own areas of research, and continual discussions and comparisons attempted to best redress the potential for biases in coding. Coders discussed their reasons for deciding upon meaning units as representative of various aspects of hope, why each meaning statement received a certain intensity code, and referred back to the manual at each disagreement or uncertainty. This process led to a refinement of the coding manual as noted above (e.g., making frequency counts of client coded statements within a given session rather

than merely providing one code for the entire session as a whole) to provide more detailed rules when specific coding uncertainties arose throughout the coding process.

Content Analysis

As outlined above in Table 2, the content analysis of adult clients' language in transcribed psychotherapy sessions yielded no clients given high positive codes, one client with medium positive hope, three clients with low positive hope, and one client with a "none" positive hope code. The average positive hope rating among all 5 participants was of low intensity. Regarding negative hope, the analysis yielded no clients given overall high scores, three clients with overall medium negative hope scores, one client with a low intensity score, and one client with a "none" negative hope code. This resulted in an average negative hope rating of medium intensity among all 5 participants. No clients obtained overall scores of high pathways; two clients were rated as showing medium pathways; two clients were coded as low pathways; and one client was rated as having no expressions of pathways. The average pathways score was low overall. Table 4 details the specific number and intensity of coded statements for each participant to demonstrate how each participant's overall code was decided upon.

In addition to the quantitative summary of results across participants summarized above and detailed in Table 4, this section will provide a qualitative description of participant statements that were coded as low, medium, and high positive hope, negative hope, and pathways. To enrich this description, each participant's demographic information and presenting issues for psychotherapy will be outlined along with examples from specific quotes from each participant's session.

Table 4

Number and Intensity of Participant Hopeful Statements

Positive Hope	Participant 1	Participant 2	Participant 3	Participant 4	Participant 5
High	0	1	1	1	0
Medium	3	0	13	6	0
Low	3	3	8	8	15
Overall Code	Low	None	Medium	Low	Low
Negative Hope					
High	0	0	2	1	0
Medium	3	0	4	3	6
Low	0	0	1	1	5
Overall Code	Low	None	Medium	Medium	Medium
Pathways					
High	0	0	2	2	0
Medium	2	0	2	12	1
Low	2	0	7	6	5
Overall Code	Low	None	Medium	Medium	Low

Participant 1

The first client, a 21-year-old, divorced, Mexican-American, Pentacostal Christian female was observed in the third session of therapy. On the intake demographic questionnaire, she indicated 33 primary presenting issues for psychotherapy, namely: feeling nervous or anxious, under pressure/feeling stressed, needing to learn to relax, feeling angry much of the time,

difficulty expressing emotions, feeling inferior to others, lacking self-confidence, feeling unhappy, feeling lonely, feeling down on herself, experiencing guilty feelings, concerns about emotional stability, feeling cut-off from her emotions, wondering "Who am I?," having difficulty being honest/open, difficulty making decisions, feeling confused much of the time, difficulty controlling her thoughts, being suspicious of others, difficulty with school or work, trouble communicating, concerns with weight or body image, feeling pressured by others, marital problems, family difficulties, difficulty making or keeping friends, break-up of relationship, difficulties in sexual relationships, feeling guilty about sexual activity, feeling conflicted about attraction to members of same sex, feelings related to having been abused, concerns about physical health, and difficulties with weight control.

Participant 1 obtained an overall score of low for positive hope, negative hope, and pathways, as listed in Table 4. During this session, the client expressed six positive hopeful statements focused on the topics of physical health, fitness, succeeding academically, and working hard in school. When specific client statements were examined, this particular client made three medium intensity positive hopeful statements: (a) "I want to because I want to get ahead. I know that I don't want to stay. I want something good out of it. I don't just want to settle for less" (referring to academic success at college); (b) "I started taking vitamins so I think I'm going to take vitamins and then start going again. I just don't want to get as sick as I was last week"; and (c) "No, because I try to be on top of things" (in response to therapist inquiry about other areas she may be absentminded). She made three low positive hope statements: (a) "I do miss going and I do want to go, I just haven't really planned for it or prepared myself for it"; (b) "I try not to pay attention to that. I don't really care what size I am, I just want to be fit"; and (c)

"I don't, I'm not looking to be a size zero, I just want to be fit" (referring to her desire to be healthy and fit, as well as her goal to get back to the gym).

This client made three medium negative hopeful statements reflecting a sense of feeling stuck, lack of motivation, or hopelessness around topics of her physical abilities and interpersonal/religious issues. Specific statements included: (a) "I have kind of gotten to the point where I…I was just tired of living my life according what was politically correct according to the church. And so, I just got tired of it (shrugging)"; (b) "I haven't looked for it. I haven't really, really looked for it 'cause I'm scared I'm not going to find it, then I'm going to have to tell 'T' and he's going to be upset because he bought it for me"; and (c) "I don't try to be clumsy. It's just like I can't control it. It drives me nuts."

When examining specific expressions of pathways (routes toward desired goals) that reached inter-rater agreement, this female client was able to articulate and identify pathways related to her goals of "getting fit," coping with stress/anxiety, and interpersonal issues, as evidenced by two low and two medium pathways statements. The low statements agreed upon by all four coders were: (a) "I'm just starting to let go of things, but I think his parents are easing up a lot"; and (b) "Well, talking myself through it I guess, I don't know" (when asked how she has been coping with her stress and relationship concerns). Her medium pathways statements were: (a) "I started taking vitamins, so I think I'm going to take vitamins again and then start going again (to the gym). I just don't want to get as sick as I was last week cuz' I was miserable"; and (b) "Just the English writer's block, so I'm going to sit and talk with him on Thursday" (referring to getting help from her professor at school).

Participant 2

The second client, a 28-year-old, single African American male client with no expressed religious or spiritual orientation was observed in the fifth session of therapy. On the intake demographic questionnaire he indicated that his primary presenting issues for psychotherapy were family difficulties, relationship problems, and pressure and stress. He also noted a family history of abuse, substance use, involvement in the legal system, and a recent gun shot wound to the head. He left many of the questions blank, so it is unclear whether this information is a true representation of his history, presenting issues, or level of distress.

After coding and discussion among coders to compare impressions, Participant 2 was given codes of "N/A" for positive hope, negative hope, and pathways for the session overall. There were no specific negative hope or pathways statements found in his session. Although he received a 0 intensity positive hope code, four positive hope meaning units were identified, three at a low level, and one at a high level (but in reference to past agency). The three low positive hope statements included: (a) "Ya, but it's probably worth it in the long run" (when discussing his long hours at work); (b) Therapist: "So you and your friends tried to play it straight," Client: "Uh huh," (when discussing his commitment to staying out of gangs despite family history and gang activity in his neighborhood); and (c) "It was more like, okay, I can go back to school and catch up or I can get a job, so I went and got a job." The high hope statement in reference to past agency that coders agreed upon was: "Once I heard it I was like, okay, well, I can make it happen. I can make it work. And then my whole attitude changed" (upon finding out he was having a child). Coders all agreed that these four meaning units were representative of hopefulness, but did not meet criteria for a code because two (statement c noted above and the high hope code) were in reference to past agency and his belief in his capacity to overcome

obstacles. Another meaning unit (statement b above) was therapist elicited, making the statement not as strong as it could have been coming directly from the client. Statement a qualified as a low hope code, but there was an absence of any other client-initiated, present-focused positive hope statements. Thus, it was determined that these statements did not represent enough present hopefulness to increase his overall code to a low.

Participant 3

The third client, a single, 25-year-old Polish-American, heterosexual Catholic female was observed in the third session of therapy. She indicated her primary presenting issues for therapy were: nervousness and anxiety, concern about finances, concern about weight/body image, premarital counseling, and under pressure and feeling stressed. On the intake demographic questionnaire, she also noted problems related to extended unemployment, unsure about adoption, inadequate health care, and currently in a romantic relationship.

Participant 3 expressed 22 positive hopeful statements with an overall score of medium intensity positive hope, medium negative hope, and medium pathways, as listed in Table 4. When specific positive hopeful statements were examined, this particular client made one high, thirteen medium, and eight low positive hope statements that all coders agreed upon. The high hope statement was in reference to the past, but coders agreed it should be included due to its connection with her current goals and motivation:

> I don't wanna be financially unstable, like, financial stability was my number one goal. Just at least get there. So I did everything I could to do that, you know, I put myself through college and did well and was able to pay all my bills and never had a problem.

Examples of medium intensity positive hopeful statements from her session related to her career and educational goals included: (a) "I think I really wanna probably leave" (in

reference to her job dissatisfaction); (b) “I think I’ve kinda grown out of it. A lot of people I worked with have left. The projects coming in are just not as great so I think I’m ready for something else”; (c) “Um, I think I’ve just meant to be here, like to do big things”; (d) “I kinda feel like right now I’m in a place where I can choose a lot of different things”; and (e)

> Well, right now, at this point, I’m really thinking about just getting as much knowledge and education as I possibly can. You know, now that school is finished now it’s like work experiences and seeing exactly what I want to do so that one day when I guess, I want to do something significant and feel accomplished.

She also expressed a medium intensity positive hopeful statement related to her current romantic relationship: “I think that I’d be okay if I had to, if I wasn’t with him for the rest of my life. I know that eventually I’d get over it, move on…so part, so then I know that, you know, I want to stay with him.”

Participant 3 expressed low positive hope statements connected to her belief in therapy as potentially helpful, motivation to move on from the past, educational and career goals, and her romantic relationship. An example of a low positive hope statement connected to career and educational goals was: “I took a lot of classes on it when I was in school and I haven’t had the chance to work on any project yet, so I’d like to do that.” Examples of low hopeful statements connected to her motivation to deal with her past and move forward included, but were not limited to: (a) “I’m thinking that it’s almost time to deal with it or get, not deal with it but get over it almost?”; and (b) “I’m now thinking, well, I’ve just kinda gotten used to being in this thought process, and I guess I kinda want to get over some of these things, or I don’t know.”

All coders agreed that this client was coded as expressing two high negative hopeful statements, four of medium intensity, and one of low intensity. Her two high negative hopeful

statements were: (a) “Right now, it just feels like there’s only circumstances that I can’t control. They’re out of my hands”; and (b) “It kinda sucks because I feel like I’m in a no win situation.” Examples of this client’s medium statements included: (a) “So, but this time it just feels kind of like it’s really long and I can’t like break out of that” (feeling confused about her romantic relationship); and (b) “Just vulnerable and frustrated, and like, that’s how I used to feel as a child when I couldn’t do anything about it.” Her low negative hopeful statement was “Until you know, I got into this relationship and now, like, I am in this financial mess and I’ve paid all this money for his things and (shrugs).”

Participant 3 identified and elaborated upon pathways related to her goal of financial stability, reframing how she perceives and handles situations, and improving her interpersonal relationships. Specifically, this client had two high pathways statements, two medium, and seven low statements in this particular session. Her high pathway statements were: (a) “I found a position but haven’t applied for it yet. I’m working on my resume”; and (b) “Well right now at this point, I’m really thinking about just getting as much knowledge and education as I possibly can.” Her medium pathways statements were: (a) “Well, now that school’s finished now it’s like about work experience and seeing exactly what I want to do so that I, one day when I guess, I want to do something significant and feel accomplished”; and (b) “I sent my resume and then tried to go to as many functions or events that they put on so that I can try to make some sort of connection, have some kind of foot in the door.” Examples of her low pathways statements include, but are not limited to: (a) “I took a lot of classes when I was in school and I haven’t had the chance to work on any project yet, so I’d like to do that”; (b) “Well, the couples counseling is great and D—is great” (when asked about her belief that therapy has been/will be helpful); (c)

"Um, I dunno" (when asked if she believes coming to individual therapy will help solve her problems); and (d) "Like, I've kinda like re-evaluated, I kinda re-evaluate in a sense."

Participant 4

The fourth client, a divorced, 36-year-old Mexican-American, Unitarian female was observed in the third session of therapy. At the time of therapy she was seeing a psychiatrist and taking prescription medications for depression. She indicated that her primary presenting issues for therapy included difficulty making and keeping friends, and the break-up of her relationship. On the intake demographic questionnaire, she also indicated a significant history of family drug and alcohol abuse (her father was described as a "homeless junkie," and her mother was described as "Bipolar"). She noted a number of secondary presenting issues, including: feeling nervous/anxious, need to learn to relax, feeling angry, down on self, difficulty expressing emotions, lack self-confidence, feeling lonely, concerned about emotional stability, difficulty being honest, making decisions, controlling thoughts, financial concerns, communication troubles, weight/body image concerns, marital/family difficulties, and physical health concerns.

Participant 4 obtained an overall score of low positive hope, medium negative hope, and medium pathways. When specific positive hopeful statements were examined, this particular client was given one high, six medium, and eight low hope statements that reached full inter-coder agreement. Her high positive hope statement was: "I was very proud of myself. I asked a coworker to go to a Dodger game with me Friday." Examples of her medium hopeful statements included: (a) "I, I am. I want to change. I want to work on it"; (b) "Yeah, I'm trying to allow mistakes, and whatever I do, I have a sense of humor"; and (c) "So I'm trying to teach myself to initiate invitations for things, and that's hard for me. I don't know if it's rejection or, or what it is, but it's, it's uh, a real struggle for me." She expressed more low hope statements (eight) than

medium (six) or high (one) positive hope statements that involved expressions of ambivalence, a tentative commitment and belief in herself, and struggle to move herself forward. Coders discussed her tendency to use "I need to," and "I want to" statements, and it was agreed upon that statements including "want" would receive a low positive hope code, but statements including "need" did not represent any true motivation, belief in her capabilities, or commitment. Examples include: (a) "My supervisor recommended a book called 'Meditation Made Easy,' so I want to pick that up"; (b) "I just want to put it behind me," "And then I have to adjust my work schedule again. I want to get there earlier in the day"; and (c) "I think I'd like to give Al-Anon another try."

All coders agreed upon giving this client (P4) one low, three medium, and one high intensity negative hope statement codes. However, it is important to note that even after discussion, coders did not reach full agreement on the negative hope score (.75 inter-coder percentage agreement as noted in Table 2), as one coder believed that the negative hope score should be low rather than medium. The discussion centered on the large number of positive hopeful statements that were made by this client in comparison to very few negative hope statements. The other three coders who agreed on negative medium hope felt that within the context of her presentation and overall sense of "stuckness" in the session, as well as the more intense quality of negative hope statements versus weaker positive hope statements, a higher level of negative hope should be representative of her expression. This also led to the question of how pathways can be present without positive hope, or agency. There was also discussion about the possibility of qualifying her "need to" statements as reflecting a sense of hopelessness and feeling stuck, but these were not added into the total due to the high level of inference. Her high intensity negative hope statement, in reference to her continual focus on her parents' substance

abuse and neglect of her growing up, was: “And I’m stuck here, I’m stuck, yeah.” Her medium intensity hope statements included: (a) “Yeah, I just don’t know if it will happen in three years” (referring to working through the same issues with her past); (b) “I was really terrified and now I still don’t understand if what I felt, if that’s a permanent, uh, chemical imbalance” (fear she will develop a lifelong psychiatric condition); and (c) “I don’t understand what, what exactly is wrong with me. If I have a chemical imbalance and the depression is going to be there forever, or if the anxiety is going to be there forever.” Her low negative hope statement was “And then it just goes around to, well, if I did it, why can’t they do it? You know? It just, it just goes round and round.”

Expressing 20 pathways statements throughout the session, P4’s overall pathways score was determined by all coders to be higher than her level of positive hope, which was the first time this pattern (higher pathways than positive hope, or agency) had been observed in a session. Specifically, coders reached full agreement to give this client two high, twelve medium, and six low intensity pathways statement codes. One of her high pathways statements identified multiple strategies and specific routes to move toward her goal of taking care of herself:

> I think I will. I’ve taken some steps to look at my schedule and actually include eating and working out in there. And um, also um, being proactive about scheduling those chiropractic appointments ahead of time, um, trying to schedule some massage appointments.

Examples of her medium pathways statements included: (a) “And so, I read the literature you know, Al-Anon, I’m going to try to go back”; (b) “The next thing will be to, to kind of schedule my weekends, uh, cause I do have an assignment due every Sunday at noon so it’s really scheduling time for my readings and my homework”; and (c)

> Those are the meetings I need to attend. I need to get to the counseling center because they have all these workshops that uh, might be helpful for me on uh, self-esteem, depression, so I'll see if anything will fit into my schedule.

The final statement was an example of one of her expressions identifying pathways, or a potential route toward her goals, without the agency component due to her phrasing of "need to" rather than expressing belief in her capacity, motivation, or commitment. Examples of her low pathways statements included: (a) "I have been um, I have been doing that cognitive stuff, um, you know, trying to say that, you know, they, they don't know how to take care of themselves, they don't know how to take care of me"; and (b) "I don't know, I think I'd like to give Al-Anon another try."

Participant 5

The fifth client, a 29-year-old, single Korean male with no religious or spiritual orientation was observed in the third session of psychotherapy. He self-referred for therapy after the death of a close friend, and indicated 23 primary presenting issues on the intake demographic questionnaire, including: feeling nervous/anxious, need to learn to relax, afraid of being on his own, feeling inferior to others, feeling down/unhappy, lonely, experiencing guilty feelings, feeling down on himself, concerns about emotional stability, wondering "Who am I?," difficulty making decisions, feeling confused much of the time, difficulty controlling thoughts, being suspicious of others, concerns with weight or body image, feeling pressured by others, feeling controlled or manipulated, family difficulties, difficulty making or keeping friends, difficulty in sexual relationships, guilt about sexual activity, use or abuse of drugs or alcohol, and problems associated with sexual orientation. On the intake demographic questionnaire, he also noted

financial problems, discriminatory experiences, death and loss, inadequate access to health care, physical and emotional abuse in history, and possible trouble due to alcohol or drug use.

Participant 5 was given an overall code of low for positive hope, medium for negative hope, and low for pathways. When specific positive hopeful statements were examined, this particular client made no high or medium intensity hopeful statements in the session, and 15 low intensity positive hopeful statements. His low level positive hope statements were focused on topics of interpersonal relationships, his tentative positive expectations for psychotherapy, and his capacity to change and succeed in his professional and personal life. Examples of low positive hope statements related to his interpersonal goals (i.e., dating women; seeking new friends) included: (a) "Now that the 20's is kind of you know, winding down, I'm starting to kind of start thinking about what I need to do in the next ten years. You know, I mean, put that down" (referring to his desire to make new friends and get back into dating); and (b)

> It's not necessarily, you know, I just want to go and 'screw' a bunch of girls or whatever, but you know, that's not true necessarily. I do want some sort of a meaningful relationship or something. That's preferable.

Examples of his low positive hopeful statements related to hope and expectations for therapy included: (a) "I'm trying to get as much out of this as possible, right. Within my comfort zone and at my own pace, right?"; (b) "Uh, I do, ya I do, actually. I see it as a courageous thing" (response to therapist's inquiry regarding coming to therapy); and (c) "Well, I mean, it's a sense of accomplishment" (referring to the decision to come to therapy and his perception of his progress in the first few sessions thus far). The preceding examples illustrated the process of clarifying goals, and his explication of a desire and commitment to begin to make some changes

in his life. Coders discussed these statements as indicators of readiness to change and motivation for therapy, but without the expressed belief in his capacity to move in a preferred direction.

When negative hopeful statements were examined, all coders agreed upon giving this client (P5) no high, six medium, and five low intensity negative hopeful statement codes relating to his fear of rejection, feeling undesirable, self-doubt, and sense of feeling stuck and giving up trying to pursue women. Examples of his medium intensity hopeful statements included: (a) "No, not really. Well, you see, it's that, you know, I've been discouraged by the fact that, you know" (referring to his lack of attempt to try other online dating services after one bad experience); (b) "I did a little bit of both. Not really trying because of fear of rejection, trying and then getting rejected, then saying f--- it, I'll just get out of here"; (c) "But that's getting old. And that's my problem" (after stating that he has been "getting high" for three years and avoiding relationships or intimacy); and (d)

> And that also adds to the neurosis and makes it even more difficult I would say, you know? And everything I have to try now, ah, do I, what am I supposed to do? Am I supposed to go online? And that's kind of a blow to the self-esteem there too.

Examples of low intensity negative hope statements were: (a) "It seems like a concession, right, you know? It's like, okay, I have to resort to this?" (regarding the attempt to meet women online); and, in reference to his sense of hopelessness with pursuing women and lack of confidence in his capabilities to attract women; (b)

> I don't know. It's just not easy. You've just got to, you've got to kind of look for it, you know. I guess if you're Brad Pitt you don't have to look for it, you know. Girls come up to you and whatever, right?

This client also expressed a total of five low and one medium intensity pathways

statements, with an overall code of low pathways for the session. The coders felt that P5 was able to consider possible cognitive strategies to reach his goals and make positive improvements in his life, but his descriptions were tentative, uncertain, and often vague. Specifically, his medium intensity pathway statement was:

> I mean it, it, uh, it makes sense in uh, uh, in uh, in a cognitive, no, it makes sense in a theoretical point of view, right? But when I'm not sure, I guess, uh, So I have to somehow get, change beliefs, thoughts, and maybe some memories and some stuff like that to get things framed in a, in a more, framed in a way that would ultimately help me as opposed to hurt me.

Examples of low intensity pathways statements that coders agreed upon included: (a) "I suppose I could, you know?" (after the therapist asked if he will look into online dating as an option to meet women in the future); (b) "And I'm sure the therapy, I'm sure it just, thinking, talking about your problems, just kind of analyzing them helps get your mood up a bit in general"; and (c) "Maybe uh, let's see, try to make some new friends and stuff like that. You know, I've had the same friends my whole life and stuff, right? That's all it's really been, you know?"

Themes

Although a systematic qualitative analysis was not formally utilized to identify themes within and across participants, a brief description of themes noted by the researcher is summarized in this section. Results of this analysis are followed by results of analysis across CHANGE codes.

Themes Across Participants

The researcher reviewed the meaning units identified for each participant that were representative of positive hope, negative hope, and pathways, and created a summary listing of

themes for each transcript, outlined in Table 5. Then, themes were examined across participants to identify any thematic patterns for each of the three codes.

For positive hope, two themes that appeared to be present for all 5 participants as evidenced through specific statements involved (a) identification of recent positive changes, and (b) the belief in his or her capability to overcome obstacles and work toward desired goals. The areas in which participants were able to express recognition of recent positive changes included: self-care activities, seeking new relationships, working on current friendships or romantic relationships, ability to reframe, academic or career success, beginning therapy and/or self-exploration, and noticing positive changes from initial therapy sessions. In terms of the second theme, types of statements involving participants' commitment to work toward desired goals or belief in their capabilities included: (a) positive expectations and commitment toward therapy, motivation and commitment to improve physical health, emotional well-being, and enhance interpersonal connections; (b) desire to make meaningful life changes through career, academics, or relationships; and (c) recognition of past obstacles overcome (community violence, immigration, poverty, neglectful parents, unexpected pregnancy, loss, substance use). The recognition of these past obstacles participants had been able to overcome was often connected to statements of belief in current capabilities or agency.

Table 5

Common Themes Observed Across Participants (N = total)

Positive Hope	Specific Types Expressed by Participants	N
Identifying Recent Positive Changes	Reframing, self-care activities, seeking new relationships, working on current friendships or romantic relationships, academic or career success, beginning therapy and/or self-exploration, noticing positive changes from therapy	5
Belief in Capability to Overcome Obstacles and Desire to Work Toward Goals	Positive expectations toward therapy; motivation and commitment to improve physical health, emotional well-being, and enhance interpersonal connections; desire to make meaningful life changes through career, academics, or relationships, recognition of past obstacles overcome (community violence, immigration, poverty, neglectful parents, unexpected pregnancy, loss, substance use)	5
Negative Hope		
Feeling "Stuck" or Out of Control	Tired of judgment from others; fear of being "crazy" or unable to "resolve past issues"; belief that things will not change or improve (financially, interpersonally, emotionally, career); feeling that things need to change but not knowing how it is possible	4

(table continues)

Sense of Frustration and Thinking of Giving Up	Relationship problems; changing a specific behavior, thought, or feeling; or trying to make positive changes after repeated failures; result in fear of rejection, low self-esteem, and sense of self as a failure; questioning own abilities; lack of direction or goal-directed energy	4
Pathways		
Reframing the Problem	Alternative ways of thinking; attempts to make meaning out of experiences; self-talk to improve confidence and self-esteem	4
Relationships	Initiating invitations; seeking out friendships or romantic relationships; joining support groups; letting go of resentment; trying online dating	4
Psychotherapy	Individual or couples' therapy	3
Career and Academics	Look for new jobs; changing schedule, asking for assistance at school, better time management, obtain new experiences to discover career path	3
Physical Health	Exercise; diet and nutrition; meditation; massage therapy; chiropractic treatment	2

After examining all 5 participants' transcripts and positive hope statements, additional observations were made by the primary researcher. For one, it also appeared common for participants to express variability in their levels of positive hope when discussing different domains of their lives. For example, Participant 4 expressed higher levels of positive hope related to her belief in her own capacity to move forward, commitment and motivation to grow and heal, but expressed low levels of positive hope (and significant amounts of negative hope) related to specific interpersonal relationships (i.e., her parents). Similarly, Participant 2 expressed higher levels of positive hope related to his past agency and ability to change perspective or overcome obstacles, but expressed low levels (or no) positive hope related to present circumstances or belief in his capacity to change. Further, although the present study focused on client language, therapist questions and statements preceding hope codes were examined to determine if any additional patterns emerged. Higher levels of positive hope were often directly following the therapist's empathetic reflections or open-ended questions regarding client personal strengths, interpersonal relationships, other external resources, or eliciting client agency. For example, Participant 2's medium and high level positive hope statements followed questions about his decision to nurture friendships to stay out of gang life, how he felt and reacted when he discovered his girlfriend was pregnant, and an empathetic reflection. Similarly, Participant 1 expressed a high intensity positive hope statement after the therapist inquired about the client's goals and her intrinsic reasons for the motivation to do well academically.

When negative hope was examined across participants, the primary researcher noted two themes. For one, a sense of feeling "stuck" or out of control was expressed by 4 participants (Participant 2 did not express any negative hope statements, so themes were not observed in his session to compare with the other 4 participants). Specific types of statements included: feeling

tired of judgment from others, fear of being "crazy" or unable to "resolve past issues," the belief that things will not change or improve (financially, interpersonally, emotionally, career-related), and a common feeling that things need to change but not knowing how it is possible. The second pattern that emerged for 4 participants was a sense of frustration and a consideration of giving up that occurred in the following areas: relationships; changing a specific behavior, thought, or feeling; or trying to make positive changes after repeated failures. The theme of frustration/giving up was accompanied by fear of failure or rejection, and centered on a discussion of one of the presenting problems for psychotherapy. The statements also did not co-occur with pathways statements involving participants' brainstorming and expression of realistic routes that they believe may help them achieve their goals.

Similar to the observations made for positive hope, there was also variability in levels of negative hope, or hopelessness, when participants discussed different domains of their lives (as noted above in the example from Participant 4). Often, higher levels of negative hope involved the participants' discussion and recall of past failures or interpersonal rejections (11 out of the 16 total medium negative hope statements were counted for all 5 participants across each full session, and 2 out of the 3 high negative hope statements across all 5 participants). For example, Participant 3 expressed medium negative hope after recounting her feelings of isolation and feeling disconnected from "the big group" after immigrating from another country. Another observation noted by the primary researcher was that higher levels of negative hope often followed therapist's incorrect interpretations of client experiences or feelings, close-ended questions, advice-giving or psycho-education regarding the client's problems, or directive questions eliciting client discussion or exploration of intrapersonal or interpersonal problems. This final type of therapist question was followed by a client negative hope statement

specifically when the therapist inquired about the client's problem in a manner that assumed client responsibility for his or her predicament (i.e., blaming, labeling). One example from Participant 5 was a medium negative hope statement following the therapist's inquiry regarding his fear of rejection and "inability" to seek out relationships. The client then agreed that his fear of rejection had resulted in his inability to seek out relationships, thus expressing negative hope and a sense of personal inadequacy and failure.

There were five apparent themes that emerged when pathways statements across all 5 participants were examined by the researcher. Four of the 5 participants identified pathways related to alternative ways of thinking about a problem, or reframing their perspective to create a sense of meaning. Three of 5 participants explicitly noted psychotherapy (individual or couples) as a potential pathway to move in a desired direction toward expressed goals (including self esteem and confidence, as noted below). These statements were accompanied by positive hope codes as well, given that these statements included the expectation of therapy as being helpful, and a belief in a capacity in the self to utilize therapy in productive ways. For example, when the therapist assessed goals and expectations for therapy, Participant 3 expressed a desire to utilize therapy to work on her current relationship and "deal with" her past. She explained that couples therapy had been extremely helpful, and was beginning to believe that individual therapy may be another necessary (and beneficial) component for her. The three other common themes involved participants' identification of pathways related to interpersonal relationships (e.g., initiating invitations, seeking out friendships or romantic relationships, joining groups, letting go of resentment), career or educational goals (e.g., looking for a new job, changing schedule, asking for assistance at school, better time management, obtain new experiences to discover career path), and physical health (e.g., working out, healthy diet, massage therapy, meditation).

There was only one consistent observation regarding pathways statements and their relationship to either therapist questions or variability across domains. Therapists' open-ended questions about clients' past, current, and possible future coping methods elicited pathways language among all 4 participants who expressed pathways. However, there was also considerable variability in therapist questions or statements that led to pathways statements across participants as well. Some participants were able to articulate pathways after the therapist provided reflections or tracking statements, while others articulated pathways following praise or supportive comments, and still others made pathways statements after therapist directive suggestions for possible routes or strategies. However, these final pathways statements related to therapist suggestions were primarily low level pathways and often existed in isolation without the co-occurrence of the positive hope code.

Themes Across Other CHANGE Codes

The most pronounced overlap observed by all coders across participants was between positive hope and cognitive emotional processing (an aspect of meaning making). Codes for positive hope and cognitive emotional processing frequently occurred within the same meaning units. When this pattern occurred, positive hope codes co-occurred within the same statement, directly followed cognitive emotional processing in the clients' verbalizations, or vice versa. An example of cognitive emotional processing (CEM) preceding a positive hope statement from Participant 1 follows the therapist's question about what would have happened if she did not finish college: "Everyone would be really disappointed and upset" (medium CEM). The therapist then asks if she is doing it for them or herself, and she responds with a medium intensity positive hopeful statement: "I want to because I want to get ahead. I know that I don't want to stay, I want something good out of it." Even within the very few positive hope statements expressed by

Participant 2, there was an example of cognitive emotional processing co-occurring with positive hope (medium intensity CEM and high past positive hope): "So once I heard it, I was like, ok, well, I can make it happen. I can make it work. And then my whole attitude changed." Participant 4 expressed another example of the co-occurrence of positive hope and cognitive emotional processing within one client statement: "Yeah, I'm trying to allow the mistakes and, whatever I do, I do have a sense of humor."

Alternatively, a positive hopeful statement preceded cognitive emotional processing. For example, when Participant 3 expressed: "I'm thinking that it's kinda time to either deal with it or get over it almost" (medium positive hope), it was followed by:

> Yeah, like, um, like I think I've, like I wonder, have I forgiven my parents for all the things that I think they kinda messed up on? And I think one of the really big issues for me was um, financial. Like we never had enough money, was getting kicked out, it was never stable, like that. So I know that still really affects me today.

This statement was immediately followed by another positive medium intensity hopeful statement: "I guess I want to kinda get over some of these things." As such, hopefulness, or the process of becoming hopeful, may be related to client meaning making in the early phase of psychotherapy. The relationship between the two should be further explored in qualitative research.

Another pattern noted by all coders was the overlap between negative hope (or hopelessness, feeling stuck, lack of commitment or motivation) and the coping code of protection/avoidance and the meaning making code of unproductive processing. It seemed that clients tended to express hopelessness when simultaneously engaging in protective or avoidant coping behaviors or exploring problem areas without significant insight or change. One example

of a statement made by Participant 1 that was coded as low negative hope and protection/avoidance was: “I just didn’t know how to deal with it so I just kind of pushed it to the side because I didn’t know which way I wanted to go with it.” An example of a statement made by Participant 4 exemplifying negative hope in conjunction with protection/avoidance was:

> I, (sighs), yeah, and it’s difficult. I don’t want to do it because, I, I think its just easy to sit around and bitch about things that used to happen. And why you think, you know, you have problems.

Participant 3 expressed an example of the co-occurrence of unproductive processing with the negative hope code (both of medium intensity):

> And that lasts like, I dunno, like a month I’m upset about it, whatever, and then I think about it and I say, ‘Yeah, okay, this is where I’m supposed to be,’ or, or ‘I can make a change or something.’ And so, but this time it just feels kind of, like it’s really long and like I can’t break out of that.

Another example of unproductive processing co-occurring with negative hope was a statement made by Participant 5: “But I haven’t really been dating in around three years. I’ve been getting high for three years. That’s just not working anymore, dude.” What was interesting about this statement was the expression of cognitive emotional processing and positive hope immediately following Participant 5’s admission that his behaviors were not suiting his lifestyle and goals anymore. It appeared that once he articulated his current low level of hopelessness (feeling stuck, giving up old ways before change), he was then able to clarify why he suddenly had these feelings and what he might view as a goal for the future.

One final pattern that was noted was that the participants with the highest intensity overall pathways code, and the most specific pathways statements within the session, also had

the highest intensity positive relationship quality code and the most positive relationship quality statements within the session. Participants 3 and 4 were the only two clients given medium pathways codes, and their sessions were also the only two coded as demonstrating medium positive relationship quality. When the transcripts were examined to glean additional insight into the nature of this relationship, there did not appear to be any connections among specific client statements. These participants were also the only two with medium and high levels of unproductive processing, however, which suggested that they might have been able to perceive available social support and pathways to achieve goals or move in a desired direction but were lacking the agency component of hope (i.e., feeling stuck, lacking motivation, belief in own capacity, or commitment to act).

Discussion

The current study examined statements of hope among adult clients at a university's community counseling clinics within the initial sessions (third to fifth, specifically) of individual psychotherapy. Few studies have employed qualitative methods when researching the construct of hope; thus, this study attempted to advance the positive psychological, humanistic, and strengths-based literature by integrating qualitative examination of actual client language in therapy sessions. The researcher aimed to examine both components of hope supported by current literature, pathways and agency (Snyder, 2002), as well as hope versus hopelessness through use of the Change and Growth Experiences Scale (CHANGE; Hayes et al., 2007) positive and negative hope codes.

This section provides a summary and discussion of codes and themes observed across participants and codes. First, there is a discussion of the CHANGE coding system (i.e., refinement and modifications prior to coding, results for positive hope, negative hope and

pathways for participants, and proposed modifications for future measurement of hope). Second, there is a summary and discussion of the common themes observed across participants among hope codes and the other relevant codes (i.e., coping and meaning making codes). Third, methodological limitations are discussed. Finally, implications and possible directions for future research are explored.

Codes and Themes

Content analysis of the 5 participants' psychotherapy sessions revealed no overall codes of high intensity for positive hope, negative hope, or pathways. The average scores across participants were found to be low positive hope, medium negative hope, and low pathways, which appears consistent with the literature and expectations of a client's level of hope in early psychotherapy sessions (Feldman & Snyder, 2005; Frederickson, 2000; Hubble et al., 1999; Irving et al., 2004; Rogers, 1961). Because previous research has asserted that clients may have higher levels of hopelessness than either component of hopefulness (agency and pathways thinking) in the beginning sessions, psychotherapy has thus been conceptualized as the process of re-instilling a sense of hope (Hubble et al.; Lopez et al., 2006).

At the same time, the presence of hopefulness in the present study (i.e., overall low positive hope code averaged across participants) suggests that even in the initial sessions of psychotherapy, clients begin therapy with a level of hope. As previous researchers have opined, some of the early expressions of agency and hopefulness in psychotherapy are the decision to enter therapy, and the expectancy for positive change (Flaskas, McCarthy, & Sheehan, 2007; Hubble et al.; Irving et al., 2004; Wampold, 2001). When specific meaning units were examined within each session and across participants, the researcher gained additional insight into how

these participants expressed agency or pathways throughout the course of the session, which will be described in the following sections.

CHANGE Codes

Prior to data analysis, the researcher wanted to ensure that the present study captured client expressions of hopefulness in accordance with C.R. Snyder's widely accepted and commonly utilized hope construct involving perceived capacity to achieve goals (agency) and perceived routes or strategies to achieve goals (pathways) (Feldman & Snyder, 2005; Irving et al., 2004; Snyder, 2002). Coders agreed that the present CHANGE coding system defined positive hope in a manner that captured the agency component of hope, as client expressions coded for positive hope exemplified agency thinking. For example, Participant 3 made the statement: "The projects that are coming in are just not as great so I think I'm ready for something else" (referring to her motivation to begin a new job search). Statements such as this represented client expressions of motivation, commitment, or belief in his or her capability to move toward goals or make desired changes in his or her life, which captured agency thinking as defined by Snyder (Irving et al.).

However, the researchers found that the CHANGE did not fully capture the second component of pathways thinking. Thus, pathways was included and coded in the same manner as the other CHANGE codes for consistency, and adapted to model Snyder's examples of pathways from the published self-report measures of hope that have been validated across diverse samples in a number of countries (Abdel-Khalek & Snyder, 2007; Snyder, 2002). As noted previously, pathways was coded as goal-directed thinking in which the individual perceives that he or she can produce routes or strategies to move toward the direction of desired goals, or planning ways to meet goals (Irving et al., 2004; Snyder). An example of a client statement that received a

pathways code but would not have been captured by the positive hope code from the CHANGE coding system's definition was made by Participant 4: "It's really now, uh, scheduling time for my readings and my homework" (referring to her goal of reducing anxiety and stress from school and work commitments). This statement exemplified Participant 4's ability to perceive a strategy to move toward her desired goal, but without the explicit expression of agency thinking (i.e., belief in her capacity to accomplish this, motivation to take these specific steps she described).

Further, the present researchers adapted the CHANGE coding system after they were unable to reach inter-rater reliability through Hayes' method of merely coding the overall session as one global code. Following qualitative content analytic methods described by Haverkamp and Young (2007), Schilling (2006), and Smith (2000), the researchers coded and analyzed specific meaning units within each session (refer to Appendix E for detailed coding worksheet). Detailed information regarding patterns, themes, and specific types of client verbalizations expressing hope was gleaned from this adapted method of utilizing the CHANGE coding system that otherwise would have been missed. For example, Participant 4 expressed positive hope and negative hope statements that varied in amount and intensity across different domains of her life that would not have been discriminated with a general code for the overall session. The expressions of positive and negative hope statements existed simultaneously and to varying degrees depending on the topic or context among clients, and the analysis of specific meaning units allowed for deeper exploration of the full range of client hopeful/hopeless experiences. Thus, future coders using the content analysis method to code client language in psychotherapy sessions should consider coding specific meaning units and categorizing codes by domain rather than merely assigning a global code for the entire sessions in order to capture nuanced language and experiences of clients within the sessions.

An unexpected finding from the adapted CHANGE coding system (Hayes et al., 2007) involved the presence of hopeful language in reference to the past among the adult psychotherapy clients included in the study, which was not captured by the present coding system but noted by the primary researcher. Throughout the coding process and group discussions, coders agreed that many client statements would have qualified as hopeful (expressing agency and/or pathways thinking) if present connections to past motivation, capacity to move forward, and recognition of previous successful strategies were included in the coding system and conceptualization of hope, as they are included in Snyder's Trait Hope Scale. Because hopefulness in reference to the past was a consistent theme across all participants, it may have resulted in overall codes for no positive hope, negative hope, or pathways for Participant 2. More specifically, Participant 2 discussed his past motivation and belief in his capabilities to overcome hardships, as well as instances that he was able to identify alternative routes to make positive changes. Specifically, he described how he was able to make up for falling one year behind in school and even surpass his peers, his past decision to actively take steps to avoid gang involvement, and his ability to radically alter his priorities and sense of meaning once he became a father. These are significant statements that coders agreed represented agency (belief in his capacity to adapt to difficult circumstances, in his case), and pathways (e.g., reframing, choosing friends who were uninvolved in gang life, working harder in school). On a related note, it is unclear whether this client would have expressed higher levels of present or future-focused hopefulness if the therapist had attended to his past agency expressions in the session and continued to build upon his narrative of resiliency by connecting it to the present.

Another example of past agency was expressed in Participant 3's statements related to her immigration history. She recounted aspects of her family's immigration to the United States, and connected that experience with examples of personal agency and the belief that she was capable and "strong." This participant's reference to her family's immigration narrative involved her expression of courage, a description of how her family had remained hopeful, and a cultural legacy of overcoming financial hardships and social isolation.

In sum, clients' past stories of success and recognition of their ability to overcome obstacles may not be captured by the present coding system, leading to lower hope scores than diverse clients' actual subjective levels of hope. As McGoldrick and Hines (2007) poignantly expressed, "We can nourish our own hope and that of our clients by attending to our connection with our ancestors and to our descendants, tapping into our cultural legacies" (p. 61). Client hope must include consideration of past agency, stories of courage and strength, and cultural or family stories of resilience.

As such, it appears that the current hope construct, as measured by the CHANGE coding system (Hayes et al., 2007), Gottschalk's hope scale applicable to verbal samples (1974), and Snyder's widely used self-report measure, the State Hope Scale (Snyder, 2002), may not capture the nuances of hopefulness experienced by a diverse sample of psychotherapy clients. In addition to including references to the past, it may be important to assess hope in various domains in addition to global hope to determine which specific areas clients may benefit from re-instillation of hope. For example, Snyder and colleagues (Lopez et al., 2000) recently developed the Adult Domain Specific Hope Scale, a self-report measure that has expanded upon the construct of hope to measure various domains of clients' lives, such as romantic relationships, family life, and work. This approach is consistent with Wong and other proponents of integrative strengths-

centered approaches to psychotherapy who assert that character strengths and positive psychological constructs should be perceived as context-dependent and co-created through social relationships and environmental interactions (Lopez & Kerr, 2006; Wong, 2006). Thus, an examination of the temporal, thematic, and contextual variability in hope expressions across clients is supported by recent social constructionist literature that conceptualizes positive psychological constructs from a more contextual perspective (Wong, 2006). Similarly, Flaskas, McCarthy, and Sheehan (2007) discussed hope as primarily relational, defining hope as "something we do with others" (p. 28). One way to further this work is to utilize Snyder's Domain Specific Hope Scale in adapting qualitative measures of hope like the CHANGE to encourage a contextual analysis of hope with consideration for levels of hope variability across domains of diverse clients' lives.

Modifications to the CHANGE coding system and the definition of positive hope may assist researchers and clinicians to identify client expressions of agency in the past that can be further built upon in the present. One specific way this could be done is by expanding the definition of hope utilized by the CHANGE system from the person's capacity to see the possibility of change in the future, to recognize recent positive changes, and to express a commitment or determination to make changes (Hayes & Feldman, in press), to the person's capacity to see the possibility of change in the future, to recognize positive changes in the past, to express a commitment or determination to make changes, or *the recognition of these abilities at some point in the past*. Similarly, the pathways code that was created for this content analysis based on Snyder's definition (2002) (i.e., "goal-directed thinking in which the individual perceives that he or she can produce routes, strategies to move toward the direction of desired goals, or planning ways to meet goal," p. 252) could be expanded for qualitative research and

coding of psychotherapy sessions to include goal-directed thinking in which the individual perceives that he or she can produce routes, strategies to move toward the direction of desired goals, or planning ways to meet goals, or *the recognition of these pathways at some point in the past*. Questions based on these definitions could also be utilized in the assessment phase of therapy by clinicians to elicit client agency and pathways thinking. Research shows that eliciting such thinking can help the client increase hopefulness and move toward positive change in psychotherapy (Feldman & Snyder, 2005; Flaskas et al., 2007; Frederickson, 2000; Hubble et al., 1999; Snyder; Wampold, 2001).

One implication of our findings for the early phase of therapy would be to attend to clients' past hopeful statements and utilize these to elicit connections to the present. In this way, clients may move from a discussion centered on past motivation, capabilities, and successful pathways toward a present and future-focused sense of hopefulness and feeling of empowerment. By eliciting and bolstering clients' expressions of past hope, therapists may enhance their agency and ability to identify new strategies or routes to attain their goals.

Themes Across Participants

There were a number of common themes observed across participants in their expressions of hope during the sessions. An overarching theme among participants (4 out of 5) was the co-occurrence of hopeful statements, hopeless (negative hope) statements, and pathways thinking at various points within the same session and in reference to different topics or life domains. The coexistence of hope and hopelessness in the present study is analogous to recent positive psychology, humanistic/existential, postmodern, and family therapy literature that challenges dichotomous thinking of human experiences (e.g., loss, trauma, abuse) and their responses (e.g., hope, despair, courage, resilience) (Flaskas et al., 2007; Flores & Obasi, 2003; Keyes, 2005;

Lopez et al., 2000). Flaskas and colleagues argue that it is important to value and attend to a client's diverse experiences and manners of responding to those experiences, while remaining cognizant that hope and hopelessness are fluid processes. This is congruent with Carl Rogers' theory of psychotherapy emphasizing the importance of clients developing increased openness to a range of emotions, thoughts, and experiences, leading to acceptance and integration of multiple aspects of the self (Brodley, 2006; Rogers, 1961). Thus, by conceptualizing client hope as complex and multifaceted, it may invite the therapist to begin conversations that strengthen hope while validating and attending to client's simultaneous hopelessness. In a similar vein, Wade (2007) proposed that understanding what a client is despairing *against*, or what the client is hopeless about, can illuminate what he or she may then be hopeful *for*, leading to an empowering conversation that enlists the client's active engagement.

Two themes that emerged among all 5 participants specifically for positive hope statements involved: (a) identification of recent positive changes, and (b) belief in capacity to overcome obstacles and desire to work toward goals. Positive hope statements often followed therapist empathetic reflections, or open-ended questions inquiring about client personal or environmental strengths and resources, or eliciting personal agency. This finding is supported by previous literature in humanistic and existential psychology, which has emphasized the importance of viewing the client as the expert of his or her phenomenological experience, as well as the therapeutic relationship as a critical ingredient for positive therapeutic outcome (Bohart & Greening, 2001; Brodley, 2006; Rogers, 1961; Schneider et al., 2001; Schneider & May, 1995). Brodley's recent article on contemporary client-centered psychotherapy highlights how being fully present, accepting, and attempting to fully understand the client's world from his or her perspective leads to increased client self-determination and empowerment. Moreover, current

research across theoretical orientations in psychotherapy has supported empathy as the most important interpersonal variable related to the client-therapist relationship as well as improved psychological functioning (Hubble et al., 1999; Norcross, 2007).

Two themes that emerged in all 4 participants who expressed negative hope statements were: (a) feeling "stuck," or out of control, and (b) sense of frustration and considering giving up, which usually involved a discussion of experiences of rejection, isolation, or failure. Negative hope statements often followed therapists' incorrect interpretations of client experiences or feelings; close-ended questions, advice-giving or psycho-education regarding the client's problems, or questions eliciting client discussion or exploration of intrapersonal or interpersonal problems. This final type of therapist question was followed by a client negative hope statement specifically when the therapist inquired about the client's problem in a manner that assumed client responsibility for his or her predicament (i.e., blaming, labeling). Clients then agreed that their present situations or experiences were due to internal deficiencies and thus, expressed negative hope. Consistent with psychotherapy literature across therapeutic modalities, therapists have been trained to convey acceptance, while attempting to normalize and de-pathologize the client's experience in order to empower the client and encourage belief in his or her intrapersonal capacities (Hubble et al., 1999; Norcross, 2007; Wampold, 2001). Thus, disempowering and blaming language can serve to foster a sense of hopelessness and a belief that the client is to blame for his or her current circumstances. The present findings provide further evidence for the importance of empowering clients and utilizing non-pathologizing or non-blaming language in psychotherapy.

Five themes that emerged among the 4 participants who expressed pathways statements involved: (a) reframing, (b) interpersonal relationships, (c) psychotherapy, (d) career and

academics, and (e) physical health. Pathways statements often followed therapists' inquiries regarding client past, present, or possible future coping strategies. Consistent with this observed connection, Irving and colleagues (2004) found that pathways thinking was related to clients' existing coping mechanisms, but had predictive power in client's functioning beyond coping skills clients brought to therapy. In other words, clients' pathways thinking is conceptualized as going beyond existing coping skills to perceiving new possible ways of coping or moving forward in the future.

Previous research has highlighted the connection with pathways thinking and the middle and later stages of therapy, rather than the initial sessions, proposing that clients are "taught strategies in therapy" (Irving et al., 2004, p. 439). Thus, the present findings suggest that clients may already have existing pathways thinking that can be bolstered throughout the course of therapy. Consistent with humanistic and postmodern approaches to psychotherapy, it seems important to consider the strengths and resources clients bring in to the initial sessions of psychotherapy, rather than perceiving the therapist as an expert who imparts all knowledge and skills upon the client (Bohart & Greening, 2001; Norcross, 2007; Rogers, 1961; Wong, 2006). Further, lower levels of pathways statements without co-occurring codes of positive hope often followed therapist-elicited routes, directives, or suggestions for actions to take. The pattern may imply that therapist elicited pathways that do not align with client needs or preferences may be superficial and lack the personal agency or motivation to increase overall hopefulness.

Based on the therapy sessions coded in this particular analysis, significant overlap was found between client pathways and agency, but there were examples in isolation of one another as well, as mentioned previously. This relationship between pathways and agency is consistent with results from previous studies supporting C. R. Snyder's hope theory, which defines

pathways and agency as two separate but related sub-components of hope (Feldman & Snyder, 2005; Irving et al., 2004; Lopez et al., 2000; Snyder, 2002). According to Snyder's (2002) empirically supported hope construct, agency involves motivation, commitment, and the belief in one's capacity to move toward realistic, desired goals (the will); while pathways involves the ability to perceive routes or strategies to attain those goals (the way). Thus, goals, agency, and pathways together comprise the process of hopefulness, but an individual is conceptualized as having the capacity to express one component in isolation of the other. Namely, one can be motivated or committed to make positive changes in one's life (agency), but lack specific ideas of how these changes can be realistically made. Conversely, one can articulate routes or strategies that exist to achieve goals, but lack either the belief in his or her personal capabilities to attain them, or the commitment to take action.

It was more common to find client agency in the sessions than pathways, which is supported by recent literature on hope suggesting that agency is related to the early phase of therapy, while more pathways are developed in the middle and end phases through therapeutic interventions or approaches (Hubble et al., 1999; Irving et al., 2004; Snyder, 2007). Researchers have compared the process of re-instilling hope in psychotherapy to Prochaska and DiClemente's Stages of Change model, with agency directly related to the Contemplation stage, and pathways (envisioning and elaborating upon routes to reach goals) correlating closely with the subsequent Action stage of change among clients in psychotherapy (Irving et al., 2004; McConnaughy, Prochaska, & Velicer, 1983; Wallace & Shapiro, 2006). However, the findings of our present study do not appear to support the notion of hope developing sequentially in line with the client's progression through motivational stages in therapy; rather hope expressions of agency and

pathways were present to varying degrees within these initial therapy sessions among participants.

The levels and types of hopefulness expressed in the present study were more complex than what would be captured by a measure of hope as a global construct; expressions varied among the participants, especially across different domains of their lives (as they described in session). Although all 5 participants identified goals for therapy, each varied in their individual levels of positive and negative hope and ability to articulate various pathways to achieve those goals. Thus, therapists might be encouraged to match their approach to specific client variables that include hopefulness (Hubble et al., 1999; Rochlen, Rude, & Baron, 2001; Wampold, 2001). When low levels of agency are present, eliciting client agency early in therapy may result in quicker improvements and the client's ability to formulate realistic strategies or routes toward goals for therapy, reducing the number of sessions necessary for positive change.

However, it is also important to point out that Snyder perceived agency and pathways thoughts to be reciprocally and causally related to one another, explaining that psychotherapeutic increases in one component should enhance the other component (Snyder & Taylor, 2000). He further described their additive nature, noting that agency and pathways thinking combined lead to successful goal attainment and together represent high hope (Snyder & Taylor). In a recent article, Snyder himself expressed the belief that a client may begin focused primarily on goal development, agency thinking, or pathways thinking, but any one of these can be expanded upon to build a "positive, workable life story line" (Lopez & Kerr, 2006, p. 149). As such, it may be more common for clients to begin with a goal, develop agency thinking, and then come up with potential routes to achieve these goals. But the process of hope development is multifaceted and differs from client to client. Therapists should attend to the client's language to determine which

aspect of hope the client initiates discussion around and utilize this information to elicit thinking about the other components in order to instill hope and assist in co-creating meaningful change.

Also as expected, when pathways statements were present, they often accompanied statements of agency. There are a number of possible explanations for this finding, including the previous assertion that agency is an important part of the early phase of psychotherapy; thus explaining the common presence of agency along with pathways thinking when expressed (Irving et al., 2004; Lopez et al., 2006; Snyder, 2002). However, 1 out of the 5 participants (P4) received a higher intensity code for pathways than positive hope. One possibility is that P4 was capable of identifying a variety of realistic routes or strategies that could be enlisted to achieve her goals while lacking the agency to either believe in her capacity or motivation to make improvements. She also expressed a significant amount of negative hope throughout the session, which provides further support for her ability to articulate potential pathways without the sense of agency or hopefulness related to her ability to move forward or make desired changes. Based on Snyder's conceptualization described previously (Snyder & Taylor, 2000), this particular client may benefit from therapeutic focus on enhancing her motivation, goal-directed energy, and belief in her capacity to make meaningful life changes (agency component).

Finally, a theme emerged across participants that may expand on the current understanding of Snyder's (2002) pathways component of hope. Four of the 5 participants identified pathways related to alternative ways of thinking about a problem, or reframing their perspective to create a sense of meaning. This was an interesting finding since pathways as defined traditionally by C. R. Snyder (2002) seemed to depict behavioral pathways rather than cognitive pathways, and after a lengthy group discussion all coders agreed that these statements should qualify as pathways. Thus, the process of reframing, benefit-finding, brainstorming

alternative ways of thinking about a problem, and trying to make meaning out of one's experiences may be one common type of cognitive, or perhaps even existential, pathway that clients utilize during the course of therapy that can be incorporated to the construct of hope in qualitative measures such as the CHANGE coding system. Future development of this construct may involve additional clarification regarding pathways, to be explicitly defined as not only changing behaviors or actions, but also altering cognitions.

Themes Across Codes

The overlap between the agency component of hope (CHANGE positive hope code), pathways, and meaning making (CHANGE cognitive emotional processing code) is supported by previous findings (Irving et al., 2004; Wallace & Shapiro, 2006). Irving and colleagues described pathways as an individual's attempts to plan ways to cope with stressful events, and agency thinking as re-interpretation and motivating positive self-talk that one engages in during stressful times. In their research of hope's relationship to psychotherapy outcome, the researchers concluded that client agency was significantly and uniquely correlated with positive outcome, greater well-being, and part of the meaning making process. An example that illustrates the connection of the present study with these previous findings was Participant 3's frequent co-occurrence of cognitive emotional processing (part of meaning making) and positive hope (agency), supporting the notion that higher agency may be related to increased ability to make meaning. Specifically, Participant 3 had 10 out of her total 22 positive hope statements co-occurring with cognitive emotional processing. Conversely, Participant 2 had the lowest level of cognitive emotional processing (low intensity overall), while also receiving the lowest positive hope code (none, or "N/A"), suggesting that lack of agency may be connected to less meaning making early in therapy. It would be interesting to explore which specific types of hopeful

statements (e.g., agency related to commitment to therapy, agency expressed through belief in one's capacity to make changes based on past obstacles one has overcome) are most closely related to meaning making.

Similarly, Wallace and Shapiro (2006) described a model of well-being that integrates Western psychology with Buddhist tradition whereby "conative balance" is the cornerstone to achieving balance in one's life, creation of meaning, and a sense of well-being (p. 693). The authors identify conative balance, which is equivalent to hope by their definition, as the first of four components necessary for the development of well-being and a meaningful life. Intention, volition, and motivation to set goals and priorities are viewed as essential developments prior to an individual's cultivation of attentional capacities, cognitive, and affective/emotional balance (Wallace & Shapiro). Their model supports the current findings involving significant overlap between meaning-making and positive hope. All 5 participants received co-occurring codes for cognitive emotional processing and positive hope, and during group discussions, coders observed that the two codes were present within the same meaning units more often than they occurred in isolation of one another.

Likewise, Snyder (2002) proposed a relationship between hope and meaning, stating: "It is through self-reflections about personal goals and the perceived progress in reaching those goals that meaning is constructed in a person's life" (p. 262). In one of his recent studies, Snyder found hope to be an integral component to perceiving one's life as meaningful (Feldman & Snyder, 2005). Thus, the present study supports the relationship between hope and meaning making suggested by recent literature (Feldman & Snyder; Snyder, 2002; Wallace & Shapiro, 2006).

Another pattern noted by the researcher was that higher levels of pathways appeared to be related to higher perceived positive relationship quality among participants, which is similar to the observed common theme of pathways and positive hope statements that involved specific interpersonal relationships. The connection between hope and interpersonal relationships is supported by contemporary humanistic theory (Schneider et al., 2001), as well as Snyder's understanding of hope, evidenced by his statement, "hoping always involves other people" (Lopez & Kerr, 2006, p. 149). The participants with the highest pathways scores also had the highest positive relationship quality scores, suggesting that individuals who perceive more social support are also able to identify more strategies or routes to make desired changes in their lives. The literature provides evidence of the relationship between social support, positive life changes, and hope (Horton & Wallander, 2001; Lopez & Magyar-Moe, 2006); however, the present findings suggest a specific relationship between perceived social support and one component of hope: pathways. The potential relationship between pathways and perceived social support should be further explored in qualitative and quantitative research.

Methodological Limitations

Content analysis of verbal language in the psychotherapeutic context can provide rich information, but it can be time consuming and difficult to analyze and compare (Creswell, 1998; Denzin & Lincoln, 1998; Mertens, 2005). A period of 4 months was spent training coders to reach adequate inter-rater agreement, continually monitoring the coding process, as well as transcribing, analyzing, and re-analyzing spoken language. There was an increased threat of researcher bias due to the time-intensive, subjective nature of data collection and analysis involved in content analytic methodologies (Ray, 2003). "Progressive subjectivity" is one way to prevent researcher bias that is a threat in any in-depth examination of processes, and thereby

enhance credibility (Mertens, 2005, p. 255). This strategy involves the researchers monitoring and documenting the process throughout the study to maintain a flexible, open-minded perspective. The researchers attempted to use this strategy by engaging in persistent, repeated observations of the psychotherapy sessions, re-reading transcribed psychotherapy sessions at different time periods, keeping and reviewing notes taken throughout observation, coding, and analysis, peer debriefing, and member checks among coders, primary researchers and committee members throughout data collection, coding and analysis stages (Mertens; Smith, 2000).

Furthermore, the use of an existing coding measure rather than open coding increased credibility by reducing the degree of researcher subjectivity and interpretation. Qualitative researchers commonly support the use of this variety of proposed strategies to enhance credibility (Creswell, 1998; Mertens, 2005). However, it is important to note that there was still a moderate degree of inference among the coders since the CHANGE coding system, as with any content analytic approach, allows for subjective judgment and interpretation (Viney, 1983). It was designed as an inferential system given that the codes are not mutually exclusive and that the ratings are subjective. Qualitative research methodologists have emphasized the inherent subjectivity in the descriptive and phenomenological studies of human experiences; however, many researchers argue that these approaches provide a richer understanding of what Rollo May called "the ontological characteristics of human existence" (Krippner, 2001, p. 296).

Unlike traditional positivistic research, there are no standard guidelines in qualitative research regarding sample size, and there was a low degree of control over the environment in contrast to traditional experimental designs (Creswell, 1998; Ray, 2003). However, the nature of qualitative methods that do not employ experimental control conditions naturally lend themselves to practical, generalizable results (looking at how a complex process works) rather

than determining what causes the phenomenon of interest (Kazdin, 2003). Furthermore, qualitative studies attempt to gain a more comprehensive understanding of a specific, unique system or process through "extensive descriptions and analysis" (Mertens, 2005, p. 235). Transferability (equivalent to external validity in traditional quantitative research) was strengthened by detailed attention to the verbal content of therapy sessions, the use of multiple participants within the site, and an effort to ensure a diverse, representative sample (Mertens, p. 256). However, although the purposeful sampling method resulted in a diverse group of individuals, the sample size was small and a number of ethnic, religious, and age groups were not represented in the present study (e.g., Arab-Americans, Pacific Islanders, adolescents, elderly individuals, Jewish individuals). Due to the exclusion of "at risk" clients admitting to suicidal thoughts or recent suicide attempts, moderate and severe depression may also be underrepresented and result in a lower level of hopelessness than would be expected with clients reporting depression as the primary presenting issue.

Potential Implications of the Current Study

Despite the limitations of the present study, the researcher believes that the current findings have potential implications for two research areas. First, the study may have the ability to contribute to the operational definition and understanding of the process of hope in the field of psychology. As noted in Chapter 1, there has been a re-emergence in psychology on the study of positive psychological processes, but there is still a lack of agreement among researchers regarding how constructs such as hope are defined and measured. C. R. Snyder's (2002) conceptualization of hope involving goals, agency, and pathways thinking is currently the most widely used and researched hope construct, but most recent studies of hope in psychotherapy have utilized Snyder's self-report measures of hope. The studies that have utilized qualitative

measures of the process of hope within psychotherapy sessions have defined hope in broad, quite discrepant manners. The current study was an attempt to add to the in-depth, qualitative research on hope in psychotherapy while also utilizing C. R. Snyder's definition of hope. Findings of the current study indicate that definitions and assessment of hope may need to include reference to the past, consideration of cognitive or existential pathways in addition to behavioral/action pathways, and a contextual, domain-specific perspective on hopefulness as proposed by C. R. Snyder's recent Adult Domain Specific Hope Scale (2002).

Another potential benefit of this particular study is that contributes to the growing body of literature that emphasizes the client's contribution to psychotherapeutic change by attending to client strengths. There has been a plethora of research investigating the therapist's impact on the client in psychotherapy; some focused on common interpersonal variables exhibited by successful therapists, while others focused on the specific techniques employed by therapists to enhance client psychological functioning and outcome (Bohart & Greening, 2001; Horvath & Symonds, 1991; Hubble et al., 1999; Tedeschi & Kilmer, 2005). The present study identified a variety of client expressions of hopefulness within the initial three to five sessions of therapy, as well as evidence that hopefulness may be related to meaning making, positive relationships, and coping. Mindful of the present study's limitations, this insight into the complexity of hopefulness and the presence of client hopeful language within the early sessions of therapy may lead to future emphasis on client strengths in psychotherapy. Hopefully, these psychological and interpersonal strengths (expressed within client hopeful statements) will be accessed early in the assessment process of therapy, incorporated into therapy plans, and utilized as resources to empower clients.

Directions for Future Research

Follow up investigations should increase sample size and age distribution to include child, adolescent, and older adult participants as well as the diversity of the sample by including other ethnicities, religions, socioeconomic status, and various locations not limited to southern California. One type of research study that may be indicated involves interviewing a diverse sample of individuals and/or conducting focus groups to inquire about how they perceive the construct of hope to determine whether or not the present construct accurately represents various cultural groups' experiences.

Additionally, it would be important to conduct a study similar to the present one but extend the design to include pre- and post-measurement to compare each client's level and quality of hope across the course of therapy. Recent research findings suggest that client hopefulness increases over time in therapy, and is related to working alliance, level of social support, pre-treatment levels of hope, and client spiritual/religious beliefs; but studies have primarily utilized self-report measures of hope to assess outcome (Bergin & Walsh, 2005; Horton & Wallander, 2001; Lopez et al., 2000; Snyder et al., 2002). Thus, future studies could extend the current design to include assessment of the same clients at the end of therapy to examine outcome, as well as a comparison of hope to self-report measures of working alliance, social support, spiritual/religious beliefs, and level of distress. Self-report measures of client hope (such as Snyder's State Hope Scale or Domain Specific Hope Scale) could also be included for comparison with qualitative measures of hopeful statements within the psychotherapy sessions (i.e., CHANGE codes) to examine how these hope measures correlate.

Another area of future research that might be indicated is a systematic examination of therapist and client verbalizations to understand how the therapist impacts the client's level of

hope. One example of a system that may be used to code thematic content of client and therapist discussions in psychotherapy sessions is the Counseling Topic Classification System, which includes 55 topics and 8 emotional categories for client and therapist topics (Richards & Lonborg, 1996). During the process of data analysis and coding in the present study, the researchers noticed how the individual therapist's style, personality, and questions appeared to impact the client's process in important ways. For example, Participant 2 frequently changed the topic, shrugged or laughed off difficult emotions, and provided mainly superficial descriptive and historical information in response to the therapist's line of questions and demeanor. All coders reviewed the videotape and the transcript, and discussed how the client appeared to become increasingly protective, defensive, and avoidant of serious topics when the therapist would laugh or ask matter-of-factly for historical information without responding empathetically to the client's expression of feelings or highly personal sharing. The coders wondered whether this absence of reflection of feelings or empathetic responding might have hindered the client's level of processing, comfort in therapy, and the eliciting of hopefulness. Alternatively, Participant 3 expressed hopefulness throughout the session, as evidenced through 22 positive hope (agency) statements and 11 pathways statements, which often followed specific types of questions or responses from the therapist. More specifically, this client appeared to express hopefulness in response to the therapists' expression of acceptance, genuine interest, empathy, and inquiries about the client's role in recent positive experiences or events. Future studies should therefore examine psychotherapy sessions to gain more in-depth understanding about the interactional process between therapist and client, and how the therapist's demeanor, questions, and the interplay between therapist and client affect the client's discussion of hope versus hopelessness.

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APPENDIX A

Literature Review

Clinical psychology has historically dealt with the assessment and amelioration of "mental illness." The positive psychology movement is attempting to correct this imbalance and renew an interest in assessment and psychotherapy emphasizing strengths and mental health that has been familiar to counseling psychology. The role of hope in psychotherapy is one avenue of positive human functioning that has been researched through the development of positive psychology. In this chapter, literature will be reviewed in four major areas: (a) the historical background of clinical psychology and development of positive psychology, (b) a general overview of positive psychology, (c) positive assessment, and (d) the role of hope in psychotherapy.

Historical Background of Positive Psychology

History of Clinical Psychology

Up until the late 1800s, "mental illness" was viewed as a manifestation of evil, feared by the majority, and treated either through mystical/religious practices or a lifetime asylum sentence (Lopez et al., 2006). The field of clinical psychology was founded in 1896 with the first psychological clinic, in which the first clinical psychologists worked with children who had learning problems. It was relatively soon after when Freud's influence spread from psychiatry to clinical psychology and the field began to use a medical model of psychopathology (Maddux, 2002). The ancient roots of the term *clinical psychology* come from the Greek words meaning "medical practice at the sickbed" and "soul or mind" (Maddux, p.13). Given these roots, the field of clinical psychology has mainly been concerned with identifying, healing and repairing damage or what has been labeled disease.

Primarily receiving their training in psychiatric hospitals and clinics emphasizing medicine and psychoanalysis, clinical psychologists and other mental health professionals were educated in assessment and remediation of illness rather than prevention or enhancement of functioning and well-being (Keyes & Lopez, 2002). With the focus of attention on psychological problems from a medical model, psychological theories supported the view that humans were driven by external reinforcements, drives, and had chemical imbalances which needed to be corrected (Seligman & Csikszentmihalyi, 2000). Empirical research increasingly focused on psychological disorders, negative outcomes and effects, and curing individuals' "mental diseases." Research tended to give emphasis to the characteristics and prevention of problem behaviors, rather than on characteristics and promotion of optimal functioning (Shogren, Lopez, Wehmeyer, Little, & Pressgrove, 2006).

Another reason that psychology has been so focused on the negative may be due to the fact that human beings inherently attend to the negative more readily than the positive (Gable & Haidt, 2005; Seligman & Csikszentmihalyi, 2000). Negative emotions and experiences are more urgent from an evolutionary perspective. Human beings are designed to attend to the threatening, negative stimuli in the environment for survival, and have a capacity for attending to the pain and suffering of fellow human beings (Frederickson, 2000). An evolutionary rationale may be supported by the priority given in crisis interventions to alleviating immediate pain and suffering before concentrating on other issues. Abraham Maslow conceptualized this as the hierarchy of needs, which posited that basic needs are attended to first (i.e. hunger, safety), and as these are met, individuals are then able to attend to psychological growth and transcendence (Bohart & Greening, 2001).

As will be explained in the next section, there was a period during the early 20th century when the fields of psychiatry and psychology began to focus more on human strengths, but two significant developments shortly after World War II have been described as stifling the movement. First, after the founding of the Veteran's Administration in 1946, psychologists began to build careers treating pathology and "mental illness" of returning veterans (Gable & Haidt, 2005). The second development was the founding of the National Institute of Mental Health (NIMH) the following year. Because NIMH provided grant funding for the research of pathology, the treatment and research of "mental illness" logically became psychology's primary investment (Lopez et al., 2006).

During the second half of the 20th century, therefore, the field of psychology attended mainly to the negative, dysfunctional side of human experience, and on identifying ways to cure those already suffering from what was termed "psychopathology" (Gable & Haidt, 2005; Tedeschi & Kilmer, 2005). Researchers were primarily studying issues such as abnormality, depression, schizophrenia, racism, and that which had already gone wrong with individuals or communities (Shogren et al., 2006). Psychology has made revolutionary progress in the classification and remediation of cognitive and emotional difficulties, personality disorders, and relationship issues. Researchers have identified many specific genes they believe may be linked to mental disorders, environmental stressors related to psychopathology, and empirically validated treatments for a number of common disorders (Duckworth, Steen, & Seligman, 2005). Without these accomplishments, the field would not have its current understanding of the relationship between environmental stressors and psychological functioning, predictors and mediators of severe emotional issues, or a variety of other major problems.

Unfortunately, this focus of attention on pathology and "mental illness" has resulted in a neglect of research and treatment concerning human strengths and resources as well as preventative efforts (Gable & Haidt; Keyes, 2005). As Keyes has asserted, "the burden of mental illness" has overshadowed the study of mental health (p. 540). Treatment has been concerned with fixing what is broken instead of recognizing and enhancing personal, social, and cultural competencies.

History of the Focus on Client Strengths

The recent development of positive psychology has brought recognition and scientific attention to the study of positive psychological processes, but these have been present throughout the history of psychology and psychiatry. This section will provide a historical account of some of the earlier theorists, disciplines and movements that have examined what makes life worth living.

Early theorists in psychology and psychiatry. Throughout the early 1900s, psychology began learning about optimal human functioning. Heralded as America's foremost psychologist, William James emphasized the holistic, multifaceted nature of people with his multidisciplinary outlook (Schneider & May, 1995). James was one of the first psychologists to stress the importance of studying subjective feelings, values, and life satisfaction/meaning. He wrote on "healthy mindedness" in 1902, which clearly supports the early devotion to studying optimal human functioning (Lopez et al., 2006; Pawelski, 2003). In addition to James, Alfred Jung hypothesized about spirituality in 1955, Gordon Allport studied positive human characteristics and the development of the healthy, mature personality in 1958, Terman studied marital satisfaction and giftedness, and Watson focused on parenting skills (Duckworth et al., 2005; Gable & Haidt, 2005; Lopez et al., 2006; Schneider & May). In 1959, Karl Menninger

emphasized that professionals in psychiatry should look beyond curing psychological, cognitive, and emotional problems toward prevention and provide interventions to assist individuals in developing their true potential (Lopez et al., 2006; Snyder, Rand, & Sigmon, 2002).

Counseling psychology. Paralleling the early attempts in clinical psychology to improve people's lives (Seligman & Csikszentmihalyi, 2000), the field of counseling psychology has been concerned with human strengths (Lopez et al., 2006; Mollen, Ethington, & Ridley, 2006). Since the period of World War II, counseling psychology has focused on enhancing individuals' personal and social resources in areas like vocational counseling and student counseling.

Humanistic movement. Humanistic psychology has been the most publicly connected with the study of positive human traits and experiences (Duckworth et al., 2005; Kirschenbaum, 2004). The humanistic movement began with Abraham Maslow's belief that health is more than the absence of disease, and with his assertion that human beings could become "self-actualized" with access to their strengths and talents (Duckworth et al.). This focus on personal growth then was fueled by the work and research of Carl Rogers (Simonton & Baumeister, 2005). Carl Rogers developed the phenomenological, client-centered approach to psychotherapy, research, and assessment that emphasized human potential (Lopez et al., 2006; Rogers, 1961), in stark contrast to the philosophy of clinical psychology at the time which was more preoccupied with individual deficits and pathologies. Humanistic psychology stressed the individual's phenomenological world, focusing more on psychological health, wellness, and self-actualization than the remediation of psychological dysfunction (Kirschenbaum). Rogers' central assumption was based on humankind's natural tendency toward growth: "If I can provide a certain type of relationship, the other will discover within himself the capacity to use that relationship for growth, and change and personal development will occur" (Rogers, p. ix).

The humanistic movement and Rogers' assertions received a significant amount of criticism from the scientific community for lacking sufficient empirical support and for being unrealistically optimistic (Kirschenbaum, 2004; Lopez et al., 2006). The humanistic, client-centered approach was soon disregarded by the scientific community due to the rejection of empirical research by many countercultural practitioners who advocated a completely different approach to science (Simonton & Baumeister, 2005). It is important to note that these criticisms were unfounded, and Carl Rogers not only pioneered the scientific study of psychological processes and psychotherapy, but he was also instrumental in revitalizing the field's interest in human potentiality and strengths. Ironically, current psychotherapy research is empirically validating Rogers' core conditions for therapeutic change as important for positive outcomes (Hubble, Duncan, & Miller, 1999; Kirschenbaum; Wampold, 2001). Furthermore, the humanistic movement offers an alternative to the medical model in the adoption of a broader vision of psychotherapy as relief from suffering as well as promotion of well-being (Joseph & Linley, 2006).

Social constructionist theory. One area that has been greatly overlooked in many of the academic and scientific journals as a contributor to the positive psychology movement is social constructionist theory (Wong, 2006). Ten years prior to the positive psychology movement, a number of social constructionist therapies existed that had quite complementary interests in human resources, strengths, and values. Solution-focused therapy emphasized future hopes, expectations, and goals while building upon the client's past successes. Postmodern therapies such as narrative and collaborative systems stress the client as expert, and work with the client to build upon his or her internal and community resources (Lopez & Kerr, 2006; Wong).

Prevention. The American Psychological Association meeting of 1998 emphasized the need to research the area of prevention (Seligman & Csikszentmihalyi, 2000). The field of prevention focused on strengths, development, and coping long before the positive psychology movement began. Researchers such as Paul Baltes have been studying the life span developmental theory to ascertain what people want in life, and how they go about achieving these goals at various phases of their lives (Baltes, Ebner, & Freund, 2006). Baltes and colleagues developed the selection, optimization, and compensation (SOC) model in 1990 which examines how shifts in people's goal orientation across the lifespan adapt to changing biological, social and environmental opportunities. Through the study of prevention, researchers and practitioners have developed a more empowering and hopeful perspective of human functioning. "No longer do the dominant theories view the individual as a passive vessel 'responding' to 'stimuli,' rather individuals are now seen as decision makers, with choices, preferences and the possibility of becoming masterful, efficacious" (Seligman & Csikszentmihalyi, p. 10).

Positive psychology movement. Recently, there has been a movement on the rise called positive psychology or the "scientific pursuit of optimal human functioning" (Lopez et al., 2006, p. 210) that emerged due to the recognition that clinical psychology was grossly imbalanced and preoccupied with psychopathology. Former president of the American Psychological Association (APA) Martin Seligman has been instrumental in fueling this positive psychology movement, which earned public attention in 1999 with the First Positive Psychological Summit (Simonton & Baumeister, 2005). In the January 2000 special issue of *American Psychologist,* Seligman and Csikszentmihalyi outlined the emerging field of positive psychology and accentuated the need for a shift in psychology away from the traditional deficit-based model (Gable & Haidt, 2005; Seligman & Csikszentmihalyi).

Since then, the positive psychology movement has been gaining momentum. By the first International Positive Psychology Summit in 2002, the field had extended across clinical psychology, educational settings, social work, health, and personality studies (Lopez & Kerr, 2006; Simonton & Baumeister, 2005). A number of handbooks have been published, grants for research have been awarded, and a range of studies have been done on the classification of positive psychological constructs, treatment, and outcomes of positive psychological interventions (Gable & Haidt, 2005; Keyes & Lopez, 2002; Seligman & Csikszentmihalyi, 2000; Snyder, 2002; Tedeschi & Kilmer, 2005). As a result, the field of mental health (more specifically, clinical psychology) has experienced a shift away from traditional deficit-oriented approaches toward increasing emphasis on resilience, strengths, psychological growth, and adjustment that previous movements initiated (Tedeschi & Kilmer, 2005).

Summary. Many psychologists and researchers believe that positive psychology has emerged as a complement to the humanistic movement due to its empowering approach focused on human potential and strengths (Bohart & Greening, 2001; Handler, 2006; Lampropoulos, 2001; Lopez et al., 2006). Positive psychology may also be a movement in support of the same ideals as postmodern therapeutic approaches, prevention research and interventions. Linley and Joseph (2003) acknowledge this complementary relationship in their recent positive psychology textbook:

> We are aware that the relationship between positive psychology and humanistic psychology has been a subject of debate. To be sure, there are differences between positive psychology and humanistic psychology, but we believe that these differences are far outweighed by their similarities. Hence, we have worked hard in this volume to speak to readers from the traditions of both positive psychology and humanistic psychology.

> Our knowledge will advance all the more quickly if we are able to acknowledge similarities, constructively explore our differences, and work together in the joint pursuit of our common goals (p. xvi).

Highlighting the need for more prevention work, Keyes and Lopez (2002) stated, "In our opinion, the science of mental illness has produced effective treatments for more 'broken down' people; it remains ineffective for preventing more people from 'breaking down'" (p. 46). Although prevention efforts have increased, many studies only focus on "at risk" populations; thus, it is argued that mental health *promotion* must be augmented (Duckworth et al., 2005; Keyes & Lopez; Lopez & Snyder, 2003; Seligman & Csikszentmihalyi, 2000).

General Overview of Positive Psychology

Definition

Positive Psychology has been defined as the "scientific pursuit of optimal human functioning" (Lopez et al., 2006, p. 210) in three primary domains or pillars: "a science of positive subjective experience, of positive individual traits, and of positive institutions" (Seligman & Csikszentmihalyi, 2000, p. 5). It is an emergent movement that aims to reorient mainstream psychology's fixation on dysfunction, pathology, and human weaknesses toward mental health and human strengths (Wong, 2006).

Positive psychology did not originate the concept of positive emotions, optimal functioning, or character strengths (Kirschenbaum, 2004; Lopez et al., 2006; Pawelski, 2003; Rogers, 1961). As highlighted earlier, these concepts and processes have been a significant part of psychology's history. Positive psychology has been influential by reinvigorating the scientific interest in mental health and well-being and providing additional support for the need to attend to more than client problems to effect meaningful therapeutic change (Duckworth et al., 2005).

One of positive psychology's main tenets is that even individuals suffering from severe psychological distress can benefit from more than just the alleviation of their suffering (Shogren et al., 2006). As Duckworth et al. (2005) point out, "troubled persons want more satisfaction, contentment, and joy, not just less sadness and worry" (p. 630). The most distressed persons are viewed as encompassing more than their presenting problems, abusive family histories, or imbalanced neurotransmitter activity, but as also possessing a number of strengths (Duckworth et al.). Furthermore, an individual's current suffering may in fact be diminished by nourishing these positive emotions and building client's strengths.

Three Pillars of Positive Psychology

Positive subjective emotions. The first pillar concerns positive emotions about the past, present, and future, also termed "the pleasant life" (Duckworth et al., 2005, p. 635). Positive emotions about the past include contentment and satisfaction, while the present includes somatic and complex emotions such as joy, flow, and interest. Positive emotions about the future include hope, faith, and optimism. An underlying assumption of positive psychology is that positive and negative emotions are not merely on opposite ends of the continuum. If they were, there would be no need to study and implement interventions to foster positive emotions given the means to relieve the negative (Duckworth et al.). A number of recent studies have supported this notion that positive emotion represents a separate psychological process than negative emotion (Frederickson, 2000; Keyes, 2005; Lopez, Snyder, & Rasmussen, 2003). Well-being, for example, would be argued in positive psychology to be a process "over and above the absence of depression, anxiety and anger" (Duckworth et al., p. 634).

Frederikson (2000) has studied positive emotions extensively in recent years and has developed the "broaden and build model of positive emotions" (p. 10). According to this model,

positive emotions like joy and contentment enhance an individual's cognitive and behavioral capabilities, and build upon enduring personal resources. This model asserts that positive emotions can reverse the effects of negative emotions and have been linked to better mental and physical health, as well as life satisfaction. Studies have demonstrated this undoing effect of positive emotions by reversing cardiovascular problems, and reducing the amount of negative emotions experienced (Duckworth et al., 2005; Frederikson).

Positive characteristics. The second pillar consists of positive individual traits or characteristics that are considered virtuous across cultures, also termed "the engaged life" (Duckworth et al., 2005, p. 635). Positive psychologists have been working to create a resource manual categorizing human strengths that is comparable to the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)*. Seligman and Peterson developed the *Values in Action (VIA) Classification of Strengths Manual* comprised of 24 strengths that are clustered around six major virtues: courage, humanity, justice, wisdom, temperance, and transcendence (Pawelski, 2003). The VIA was developed from a worldwide, cross-cultural examination of human strengths and virtues, and was based on the earlier *Wellsprings Questionnaire* developed by the Gallup Organization that measured 16 strengths: capacity for love and intimacy, satisfying work, helping others/altruism, being a good citizen, spirituality, leadership, aesthetic appreciation/pleasures of the mind, knowledge and understanding of areas of life larger than one's self, integrity, creativity/originality, play, courage, purposive future-mindedness, individuality, self-regulation, and wisdom (Issacowitz, Vaillant, & Seligman, 2003). These are considered to be positive traits or character strengths that can be shaped by genetics, early experiences and environmental influences as well.

Positive institutions. The third pillar consists of belonging to and serving positive institutions, also termed "the meaningful life" (Duckworth et al., 2005, p. 636). These institutions are believed to cultivate positive traits and emotions, and include strong families, cultural, political, educational, and religious communities. The idea is that people are embedded in a social context, and psychology needs to take interpersonal relationships, community, and positive institutions into account. This is currently the area with the least amount of research devoted to its contributions (Seligman & Cziksentmihalyi, 2000). Seligman and Cziksentmihalyi summarized a few of the recent studies in this area, such as the findings by Myers (cited in Seligman & Cziksentmihalyi, 2000) concluding that there is an association between religious faith (and affiliation with some religious institution), close personal relationships, and happiness. However, this finding is correlational in nature and is the result of a specific sample of individuals from a relatively homogenous group that may not generalize to other cultures.

Criticisms of Positive Psychology

The positive psychology movement has received a number of legitimate criticisms since its inception. One major criticism has been that positive psychology is unrealistic, ignoring the negative realities of life (Gable & Haidt, 2005; Joseph & Linley, 2006). This "Pollyanna fallacy" has been corrected by a number of positive psychology proponents who explain that the comprehensive vision of positive psychology is not to ignore prior research on dysfunction and psychological difficulties, but to supplement it with a balance of research on human growth and resilience (Gable & Haidt; Keyes & Lopez, 2002). For example, Ahmed and Boisvert (2006) advocated the use of positive psychology with individuals suffering from severe psychopathology, emphasizing how attention to positive traits and values can improve coping with emotional problems. They cited the resilience literature and argued that negative

experiences and suffering can actually enhance ability to handle stress and cope with difficult situations. As Gable and Haidt pointed out:

> Those who study topics in positive psychology fully acknowledge the existence of human suffering, selfishness, dysfunctional family systems, and ineffective institutions. But the aim of positive psychology is to study the other side of the coin- the ways that people feel joy, show altruism, and create healthy families and institutions- thereby addressing the full spectrum of human experience. (p. 105)

Positive psychology has also been criticized for focusing on Western ideals of optimal functioning, and not taking into account multicultural notions of strengths (Wong, 2006). Labeling something as "optimal" or "good" involves making a subjective value judgment, and personal and cultural experiences play a role in what is considered positive (Gable & Haidt, 2005; Wong). A one size fits all model does not work. There are many circumstances where a positive label may not be acceptable, desirable, or functional for an individual. The study of positive psychological processes, like that of negative processes, should always take individual beliefs, values, and experiences into account and recognize the complexity of positive constructs. More research is needed to examine positive psychological constructs and their application to diverse ethnic, socioeconomic, regional, and age groups (Ahmed & Boisvert, 2006; Flores & Obasi, 2003; Lopez, Prosser, et al., 2002; 2003; Shogren et al., 2006). However, it is important to note that positive psychological researchers have made attempts to redress this notion of cultural bias. For example, Seligman has attempted to include a diversity of beliefs, perspectives and values in the development of positive psychological constructs (Seligman, Steen, Park, & Peterson, 2005). As mentioned previously, *Values In Action*, which defines a number of adaptive personality traits, or strengths, was constructed through an extensive review of religious,

philosophical and social texts around the world to attempt to create a multicultural conceptualization (Keyes & Lopez, 2002). Furthermore, research has begun to extend the examination of positive psychological constructs across cultures in the areas of assessment of hope, well-being, and problem solving (Flores & Obasi).

An additional issue associated with positive psychology has been the lack of attention given to positive institutions, communities, and social networks in psychotherapy (Gable & Haidt, 2005). Much of the research has focused primarily on studying individual character traits and positive emotions with a lack of incorporation of interpersonal and social influences (Duckworth et al., 2005; Frederickson, 2000; Lopez et al., 2006). As Keyes (2005) argued in his review of the clinical literature, interpersonal relationships and supportive communities have been found to be major contributors to mental health and well being. Similarly, Simonton and Baumeister (2005) supported this argument with their assertion that physical and psychological well being are both embedded in the context of interpersonal relationships and communities. This is a common criticism in the field of psychology in general, and something that positive psychology has recognized as an area to develop through future investigation.

A final criticism within the domain of positive psychology research is that it is still relatively new, and congruence needs to be established among researchers and practitioners. In addition, many of the constructs that are being examined are somewhat amorphous and often have considerable overlap with one another (Mollen et al., 2006; Shogren et al., 2006). For instance, hope and optimism have frequently been described interchangeably in the positive psychology literature and elsewhere (Bryant & Cvengros, 2004). Researchers assert that global descriptions of such constructs, as well as measurement tools, must be developed to allow communication and sharing among professionals (Lopez & Magyar-Moe, 2006; Shogren et al.).

The dilemma with global positive constructs is that these may not be temporally, environmentally, developmentally, or culturally consistent (Flores & Obasi, 2003; Mollen et al.; Sagy & Adway, 2006). For example, Isaacowitz et al. (2003) found that older adults had higher levels of differing strengths than younger adults (primarily from Caucasian samples), and these strengths contributed to life satisfaction to varying degrees across the lifespan. The development of positive psychology constructs and measures are still in their infancy and need more attention due to the importance of incorporating strengths into culturally and developmentally appropriate psychotherapy assessment and treatment.

Positive Assessment

A major shortcoming of traditional psychological assessment procedures in the medical model of psychopathology has been the concentration on negative aspects of functioning, with limited consideration given to the assessment of a client's personal or environmental strengths. A major reason for the historical focus on problem-based measures is the assumption that "strength" is merely the absence of impairment and pathology (Maddux, 2002; Walrath, Mandell, Holden, & Santiago, 2004). This perspective assumes that individuals who have been diagnosed with a psychological condition cannot exhibit emotional, interpersonal, behavioral, or cognitive strengths simultaneously.

Recent studies support the hypothesis that strengths and risks/pathologies are separate but related constructs that should both be included in assessment (Keyes, 2005; Lopez et al., 2003). First, a study done by Richman and colleagues (2005) with 1,041 adult patients from urban and suburban multispeciality practices found that higher levels of self reported hope and curiosity were associated with decreased likelihood of having or developing hypertension, diabetes mellitus and respiratory tract infections two years later. The researchers found that the positive

emotions studied were associated with health outcomes beyond the effects of negative emotions (anxiety and anger). Second, Keyes (2005) measured mental health and "mental illness" as separate constructs in a national study using survey data from the Midlife in the United States dataset (MIDUS). The findings suggested that adults found to possess mental health in addition to the absence of "mental illness" exhibited the highest levels of psychosocial functioning and the fewest health problems.

Accordingly, strengths-based assessment should be developed and utilized in mental health assessment, treatment, and research (Cox, 2006; Snyder, Lopez, Edwards, Pedrotti, Prosser, Walton, et al., 2003; Walrath, Mandell, Holden, & Santiago, 2004). Strengths-based assessment has been defined by Epstein and Sharma (1998; as cited in Cox, 2006) as:

> The measurement of those emotional and behavioral skills, competencies and characteristics that create a personal sense of accomplishment; contribute to satisfying relationships with family members, peers, and adults; enhance one's ability to deal with adversity and stress; and promote one's personal, social and academic development. (p. 288)

The clinical implications and benefits of utilizing strengths in assessment are numerous. One rationale for including competencies and resources into the clinical assessment is the expectation that clients are more likely to become empowered, motivated, and develop a positive therapeutic connection with the therapist (Snyder, Ritschel, Rand, & Berg, 2006; Tedeschi & Kilmer, 2005). The client may be reminded of positive aspects of his or her circumstances and past coping successes, thereby increasing the client's level of hope (Snyder et al., 2006), life satisfaction and well-being. Another potential benefit is that the balanced assessment of strengths as well as weaknesses provides a more holistic view of the client as a person in context

(Tedeschi & Kilmer). Assessing strengths also provides a more comprehensive perception and conceptualization of the client which can help to guide the therapy plan by including personal and social resources.

A number of agencies have already been incorporating the measurement of and attention to social, emotional, behavioral, and community strengths with a variety of clinical populations (Cox, 2006; Lopez, Snyder, & Rasmussen, 2003; Seligman, Steen, Park, & Peterson, 2005; Walrath et al., 2004). For example, Cox (2006) found that the inclusion of a strengths-based assessment for youth in a mental health clinic led to statistically significant psychotherapeutic gains, higher rates of parental involvement, and lower drop-out rates as compared to those youths who were simply given the traditional deficit-based assessment protocol. Irving et al. (2004) found that clients at a community mental health center who received a pre-therapy orientation to positive, hopeful thinking and motivational concepts had greater symptom reduction, better functioning, coping, and subjective well-being post-therapy than those who did not received the orientation. In a similar study, Peterson, Park, and Seligman (2006) argued that people benefit from finding or building upon strengths after a traumatic experience. Their research findings suggested that adults who had recovered from either a physical illness or psychological disorder had higher scores on measures of strengths such as bravery, curiosity, love of learning, spirituality, gratitude, kindness, and most importantly, higher self-reported life satisfaction than those who had not recovered (Peterson et al.). As a result of these findings, among others, the authors recommended assessment and interventions targeting the increase of these strengths to help people increase their satisfaction with life and well-being.

Although incorporating positive assessment into psychotherapy appears warranted, efforts may be limited due to amorphous and overlapping constructs. In a content analysis of the

counseling psychology research literature, Lopez et al. (2006) found that positive psychological constructs/processes have rarely been operationalized and measured. Specifically, hope was the topic of only 5 of 1,135 selected articles in the major counseling psychology scientific journals. This result may be explained in part because of the difficulty in operationalizing constructs such as hope, love, courage, and well-being, which are relatively complex and obscure when compared to more familiar and easily measurable concepts such as anxiety. The lack of attention to positive constructs in the scientific literature may also continue to perpetuate the assumption that they are irrelevant, unimportant, or unworthy of publication (Lopez et al.). "By directing more resources to basic research on positive psychological constructs, counseling psychologists could generate a better understanding of motivational forces that may be associated with psychological change and growth" (Lopez et al., p. 221). An increased emphasis on positive growth, psychological adaptivity, and change may in turn enhance current graduate training programs by providing a balanced viewpoint.

Hope: Ingredient for Psychotherapeutic Success

Hope was first introduced to the field of psychology as an integral asset to the therapeutic relationship and outcome of psychotherapy by Karl Menninger in the 1950s (Irving et al., 2004). Menninger and other early proponents of hope theories asserted that psychopathology is a sign of a lack of hope, and a therapist's goals should involve reinvigorating a sense of hope in clients (Irving et al.; Tedeschi & Kilmer, 2005). In addition, Jerome Frank pioneered a theory that hope was one of the common factors across numerous psychotherapeutic modalities that contributed to positive therapeutic experiences and outcomes (Snyder et al., 2002). These early theorists all agreed that positive expectancies are essential to mental health and well-being, and that the

development of a trusting, successful therapeutic relationship is crucial (Irving et al.; Snyder et al., 2002).

Hope Defined

Hope has been defined in a number of ways, which has been one of the limitations of its clinical and scientific applications in the past (Bergin & Walsh, 2005; Feldman & Snyder, 2005; Snyder, 2002). The concept was first defined as a belief in one's own efforts, or the perception that one's personal goals can be realistically attained (Snyder et al., 2002). Hope has since been characterized as an affect related construct, a personality trait, a coping mechanism for stressful events, a spiritual process, an interpersonal process, and an expectation for specific positive outcomes (Bergin & Walsh). C. R. Snyder developed a hope theory that expanded upon previous researchers' notions of the concept, and it is currently the most widely used and researched model. Snyder (2002) developed his theory of hope after years of literature research and extensive interviews with individuals about their goals. From these qualitative interviews, he postulated that hope was more complex than thought processes surrounding specific events.

Snyder defined hope as "a cognitive set that is based on a reciprocally derived sense of successful (a) agency (goal-directed determination) and (b) pathways (planning ways to meet goals)" (Steed, 2002, p. 470). Thus, Snyder's hope theory assumes that an individual's actions are goal directed, and involves two components: (a) pathways thinking, and (b) agentic thinking (Shogren et al., 2003). Pathway thinking is defined as "goal-directed thinking in which people perceive that they can produce routes to desired goals," and agency thinking is the motivation, or goal directed energy, to use those perceived pathways (Shogren et al., p. 38). The key to this theory is that the goals, pathways, and agency are perceived by the individual to be possible, if necessary and desirable (Feldman & Snyder, 2005). Therefore, the present model of hope can be

distinguished from unrealistic or wishful thinking, in that it involves manageable goals that can realistically be achieved (Bergin & Walsh, 2005; Snyder, 2002).

Snyder's theory proposes that goal-pursuit cognitions cause emotions; when a goal is blocked, negative emotions arise (Snyder et al., 1991; Snyder et al., 2002). Thus, individuals who perceive unsuccessful attempts toward goals, impeded actions, or demonstrate an inability to generate possible pathways to attain a goal, are more likely to experience subsequent psychological distress or reduced well-being (Bergin & Walsh, 2005; Snyder et al., 2002). If psychological distress is associated with a lack of hope, or lack of "goal directed expectations" (Irving et al., 2004, p. 422), successful psychotherapy should, therefore, involve the reinstallation of hope through the therapeutic alliance and process.

Related Positive Psychology Constructs

Optimism. Optimism has recently been operationalized in two major theories. The first was developed by Martin Seligman, and reflected the attributional explanatory process (Snyder, 2002). This theory defines optimism as an explanatory style based on external, variable, and specific attributions for negative outcomes (Bryant & Cvengros, 2004). Optimistic thinking is meant to distance the individual from negative outcomes s/he experiences (Snyder et al., 2002). One major difference between this theory of optimism and Snyder's hope theory is that hope theory emphasizes reaching future, positive goal-related outcomes, while explanatory style focuses on the attempt to distance oneself from negative outcomes. In addition, hope theory places emphasis on both agency and pathways thinking, and the etiology of both positive and negative emotions (Snyder et al., 1991).

The second theory of optimism, proposed by Scheier and Carver (Bryant & Cvengros, 2004; Snyder, 2002), emphasizes generalized outcome expectancies. According to their theory,

optimism is a "goal-based cognitive process" in which people perceive themselves as being capable of moving toward a desired goal (Snyder, p. 257). This theory is similar to hope theory, but focuses primarily on agency-thinking, with less emphasis on pathways. Whereas Scheier and Carver's conceptualization of optimism focuses on the importance of outcome expectancies, Snyder's hope theory argues that motivation/intention and pathways to achieve goals are equally important predictors of goal-directed behavior (Steed, 2002). Both theories are cognitive in nature, future oriented, and explain behaviors across situations. Hope theory provides an explanation of the etiology of positive and negative emotions that is not mentioned in either of these optimism theories (Snyder et al., 2002).

Self-efficacy. Self-efficacy, according to Bandura (Snyder, 2002), is based on situation-specific goals, as opposed to hope theory's generalized expectancies of goal outcomes. Self-efficacy is determined by a person's perceived capacity to perform an action, similar to the agency component of Snyder's hope theory. In comparison to hope theory, self-efficacy is focused on an individual's perceived expectation that action will be effective, while hope emphasizes the intention or will to perform (Snyder; Snyder et al., 2002). Self-efficacy can be thought of as the individual's self-perceived ability to perform a specific behavior based on his/her perceived capability or capacity. Hope can be thought of as reciprocal action between efficacy expectancy (perceived ability), along with the motivation (agency), and an outcome expectancy reflecting the perception of available means (pathways) to achieve a goal (Snyder et al., 1991).

Meaning. A number of theorists have hypothesized that hope is an important component of meaning in life (Feldman & Snyder, 2005; Snyder, 2002; Wallace & Shapiro, 2006). One study found a strong correlation between meaning measures and hope, concluding that hopeful

thought may be a crucial part of an individual's perception of his/her life as meaningful (Feldman & Snyder). Snyder argued that "hope and meaning should be companions because it is through the self-reflections about personal goals, and the perceived progress in reaching those goals, that meaning is constructed in a person's life" (p. 262). When defined in this manner, it seems that hope is a necessary psychological process for meaning construction in an individual's life.

In support of the relationship of hope and meaning in life, Wallace and Shapiro (2006) proposed a four factor model of well-being based on Buddhist philosophy, whereby the primary, essential factor is "conative balance" (p. 693). Conative balance allows individuals to set goals, intentions, and motivations, much like the current conceptualizations of hope in psychology as related to meaning in life. The authors cite numerous studies to support the assertion that conative balance, or hope, must be achieved first in order for attentional, cognitive, and affective balance to be achieved in therapy.

Role of Hope in Psychotherapy

As described in the previous section, current work in the field of positive psychology, including discussions by proponents of the hope theory, as well as psychotherapy outcome studies not conducted by positive psychologists, support the findings of the early hope theorists (Snyder, Michael, & Cheavins, 1999; Irving et al., 2004; Snyder et al., 2006). The leader of positive psychology, Seligman, supported the notion that hope is a key ingredient to positive psychotherapeutic outcome and believed it may possibly be the most important strength-building strategy (Lopez & Kerr, 2006). C. R. Snyder explained his positive approach to therapy using his hope theory in this way, "we use the weakness, if you will, to get to the strengths in people…we share the quest for the best in people…my client and I use some of the basic tenets of hope

theory to build a positive, workable life story line" (as cited in Lopez & Kerr, 2006, p. 148). Hope theorists find that irrespective of specific psychotherapy techniques, psychotherapeutic change reflects the client's development of effective goal directed thinking (pathways), and the motivation (agency) to use those routes (Snyder, 2002).

Hope theory has been supported by research, which makes the case that client and therapist expectancies, motivations, and goals play a crucial role in psychotherapeutic success (Hubble et al., 1999). Likely to be equally crucial for the development of a successful therapeutic relationship and outcome of psychotherapy are the client's hope in him or herself, the therapist, and the healing possibilities of the therapeutic process (Abi-Hashem, 2001; Snyder et al., 2006), as well as the therapist's hope, positive expectations, and belief in him or herself and the client. A review of psychotherapy outcome research evidenced four major factors that contribute to effective psychotherapy: (a) client extra therapeutic factors (40% of outcome variance), such as personal strengths, faith, supportive family members, and persistence; (b) therapeutic relationship factors (30% of outcome variance), such as encouragement, empathy, acceptance, and trust; (c) "placebo," or hope and expectancy (15%), such as the client's belief in the therapist's credibility, or expectancy of therapeutic improvement; and (d) model/technique factors (15%), including therapist and/or client beliefs or procedures unique to specific treatments, preparation for the client to take action to help themselves (Snyder et al., 1999). Each of these factors involves some aspect of hope, and provides further support for the assertion that hope is an integral part of the therapeutic relationship and the client's psychological well-being.

Another source of support for the claim that hope is an important component of psychotherapeutic process and outcome is the research done by Wallace and Shapiro (2006). Wallace and Shapiro relate conative process (hope) to Prochaska and DiClemente's stages of

change research on motivational level in therapy. The stages of change model of addictive behavior developed by Prochaska, DiClemente and Norcross in 1992 supports the proposition that clients progress in therapy as motivation level increases. Wallace and Shapiro pointed out that research done on stages of change matching therapists' interventions to clients' level of hope and motivation have been found highly effective.

Hope has been found to be related to a number of positive outcomes in psychotherapy research. First, hope has been connected with life satisfaction in adolescents and adults. Shogren et al. (2003) implemented positive psychology interventions to adolescents with and without cognitive impairments and found that hope and optimism were highly correlated with general life satisfaction. Another study measuring strengths across the lifespan found hope to be the only significant predictor of life satisfaction among young adults and community-dwelling older adults (Isaacowitz et al., 2003). A study by Irving et al. (2004) at a community counseling center found that higher levels of self-reported hope were associated with greater client well-being, better functioning, coping, and fewer reported symptoms in adult clients.

A second outcome is the relationships found between hope, social support and psychological distress. Horton and Wallander (2001) surveyed mothers of children with chronic health conditions to determine the role of social support and hope as resilience factors. They found that higher levels of hope and perceived social support among the mothers related to lower levels of psychological distress. Hope theory has also been implemented as a framework for pretreatment preparation at counseling clinics with results indicating significantly greater client well-being, functioning, coping, regulation of emotional distress, and fewer symptoms, especially with those initially lower in hope (Irving et al., 2004; Snyder, 2002). In addition, hope-based group interventions for older adults resulted in improved activity level and

significantly lower levels of depression than the current treatment of preference for older adult groups (Snyder).

The helping relationship should be one of the focal areas of future research in hope, according to C. R. Snyder (2002). He makes the argument that empirical findings have already suggested a strong relationship between therapeutic or working alliance, and hope. Snyder (2002) referred to a study by Magyar-Moe, Edwards and Lopez in 2001, which found a strong positive correlation between the therapeutic alliance and clients' levels of hope. In support of this finding, recent empirical research on contextual factors in therapy has reinforced the importance of the therapeutic relationship, instillation of hope, and psychotherapeutic success (Hubble, Duncan, & Miller, 1999).

Assessment of Hope

According to Snyder and colleagues, using hope theory in the assessment and early intervention phases of therapy can also play an important role in the therapy process and therapeutic relationship (Lopez, Snyder, & Pedrotti, 2003; Snyder et al., 2006). As reviewed above, research has shown that positive expectations (hope) in psychotherapy both from therapists and clients contribute to the quality of the therapeutic relationship (Snyder et al., 2002; Snyder et al., 2006). Positive expectations that therapists have of their clients' capabilities and prognosis, and clients' expectations of therapy as well as hope from within have been found to enhance positive therapeutic outcomes (Hubble et al., 1999; Snyder et al., 1999). Furthermore, focusing on a client's resourcefulness makes the job of the clinician easier, providing direction to therapy based on what internal and external resources to which the client already has access.

As Duckworth et al. (2005) have recently pointed out, positive psychology is still in its infancy in terms of empirical support of its constructs and interventions: "For many constructs of

interest to positive psychologists, assessment tools are still in development" (p. 634). Maddi (2006) supported this contention that positive psychology needs to begin to define how variables fit together, their nature, etiology, and how this would lead to accurate conceptualizations in various cultures. He suggested qualitative research (i.e., interviews, examination of documents and therapy sessions) to examine positive psychology constructs and how they are being measured. To date, most measures of positive constructs, hope in this particular case, have used individual self-report measures. Snyder has developed a self-report measure for dispositional hope in adults, state hope (their level of hope at present time) and a children's hope scale (which will not be reviewed here since the study's focus is with adults). Observational and narrative procedures are also alternatives to self-report methods for assessing hope (Lopez, Ciarlelli, Coffman, Stone, & Wyatt, 2000; Hayes, Beevers, Feldman et al., 2005).

Adult dispositional hope scale. Because Snyder argued that hope is conceptualized in terms of agency and pathways, his Hope Scale (HS) is comprised of 12 items to measure dispositional hope: four measure agency, four measure pathways, and the final four are intended to disguise the nature of the scale. Respondents rate the extent to which statements apply to them on a 4-point Likert-type scale. The scale provides a total hope score or two separate subscale scores of agency and pathways (Irving et al., 2004; Steed, 2002).

Test-retest reliability of the HS has been examined in various college and non-college samples and found to be above .82 up to a 10-week period (Lopez, Ciarlelli, et al., 2000; Steed, 2002). Internal consistency has been reported by numerous authors at .74 to .84 (total and subscale scores) for samples of undergraduate college students and individuals in psychotherapy (Irving et al., 2004; Lopez, Ciarlelli, et al., 2000). A number of structural analyses have been performed which support the two-factor model (agency and pathways). HS scores have

correlated highly with scales measuring optimism, self-esteem, expectancy for attaining goals, and inversely with depression and hopelessness (Snyder et al., 2006). The HS has been found to predict health and achievement in a variety of studies, as well as demonstrate that agency is distinct from self-efficacy and the pathways subscale is distinct from optimism (Steed). The Hope Scale has been administered to a variety of cultural groups, and translations have been made in China, France, Germany, Italy, Norway, Israel, Spain, Russia, and Japan (Lopez, Gariglietti, et al., 2000). Since such results have yet to be published, the authors call for additional cross-cultural research regarding the construct's applicability and appropriateness to diverse populations.

Adult state hope scale. The State Hope Scale is a six-item self-report scale measuring goal-directed thinking in a particular point in time (Lopez, Ciarlelli, et al., 2000; Lopez et al., 2003). The respondent is instructed to answer the questions in the present moment, has three items assessing agency, and three items measuring pathways thinking. Test-retest correlations vary significantly due to the fact that it is a time-sensitive measure. There is strong support for internal reliability of the agency and pathways subscales (Cronbach's alphas ranged from .63 to .80), as well as the total scale (Cronbach's alpha ranged from .74 to .84) (Snyder et al., 1991). The State Hope Scale score has been found to fluctuate, but vary around the mean of the HS (dispositional) with a correlation of .79 (Lopez, Ciarlelli, et al.). Predictive utility and construct validity have been supported by a number of studies demonstrating significant increases or decreases in State Hope Scale scores related to goal pursuit activity, independent of measures of self-esteem and various emotions (Lopez, Ciarlelli, et al.).

In sum, the self-report measures of hope have a number of strengths, including meeting psychometric standards, quick administration and scoring, and applicability to a variety of

settings. Limitations include potential overlap among related concepts like optimism and self efficacy, as well as subjective, biased nature of self-report measures in general (Lopez, Ciarlelli et al., 2000; Steed, 2002).

Observational and narrative measures of hope. Although self-report measures such as the Hope Scale and State Hope Scale have been relevant to a variety of settings and useful for numerous purposes, other forms of assessment can provide a different, arguably more in-depth perspective of the hope construct. Qualitative methods of measurement can explore the variations, associated perceptions and meanings of a phenomena of interest, thus providing a rich, more naturalistic depiction of hope (Maione & Chenail, 1999). As Lopez, Snyder, and Teramoto-Pedrotti (2003) asserted, "observing hope in action may be one of the most meaningful ways to determine if individuals have the intangible qualities that connect them to their goals, and this can be accomplished with some reliability" (p. 99).

Observational versions of the Adult Hope Scale and Child Hope Scale have been developed and found to have moderate correlation with self-report (Lopez, Gariglietti, et al., 2000). However, these scales have not been published, were not made available when requested by this writer, and are in need of further validation. No observational versions of the State Hope Scale have been reported to date.

Regarding narrative approaches, Lopez, Ciarlelli and colleagues (2000) provided guidelines for interviewing clients to measure levels and components of hope. They suggested lists of questions to assess general levels of hope, including: specific goals clients have made and pursued, motivation towards goals, strategies to achieve goals, and barriers encountered. At the time of this review, no published research using this interviewing method has been published in a peer-reviewed journal.

Some researchers have developed and implemented techniques to assess levels of hope from clients' writings (in the form of letters, stories, poems, and journal entries), daily conversation, and therapeutic exchanges; many of which need further research and validation (Lopez et al., 2003). These forms of content analysis/measurement are indicated for use when direct questioning is not feasible, and when researchers want to observe hopeful behavior, and/or review written or spoken language. Two such measures were located in the published literature.

In 1974, Louis Gottschalk developed a hope scale applicable to the content analysis of verbal samples taken from people in a variety of settings. The Gottschalk Hope scale was normed and validated on a sample of children, adults, and a group of psychiatric outpatients soon after its construction as a component of the Gottschalk and Gleser Content Analysis Method (Gottschalk, 1974, 2000). By analyzing five-minute speech samples, trained researchers have obtained interscorer reliability of at least .85 when scoring the content items of the Hope Scale. The scale is meant to be a measure of hope as a psychological state, assessing speech references to aspects of hope in conversation such as: references to feelings of optimism about the present or future, self or other receiving support, advice, confidence, and hope leading to interpersonal relationships, growth, or constructive outcomes (Gottschalk, 1974). Gottschalk's Hope Scale has been used as a predictor of outcome at a mental health crisis intervention clinic in Orange, CA, and at Cincinatti General Hospital where higher hope was related to longer survival and quicker return home among cancer patients (Gottschalk). According to Gottschalk and colleagues (2000), this content analysis methodology has been applied to psychotherapy intervention effectiveness research, understanding of psychotherapy processes, and can be an effective method to analyze therapy sessions in depth. However, their definition of hope is much broader than that of Snyder, and coding can be somewhat subjective as the scale leaves room for interpretation.

More recently, Hayes and colleagues (2005) developed a coding system of change processes; the Change and Growth Experiences Scale (CHANGE). The CHANGE is a rating system that can be used to rate session tapes and transcripts to analyze client emotional and insight-related processes (Hayes et al., 2005). The scale was developed and normed on a university-based community mental health center sample of adult participants (ranging from 16 to 58 years old) from various cultural backgrounds (Hayes et al.) One of the categories from the CHANGE scale includes the measurement of positive and negative hope. Hope is defined by the authors as "the extent to which the person describes an expectation that the future will be better and progress can be made on problem areas, as well as a commitment to change" (Hayes et al., p. 117). The authors proposed that the CHANGE might be a useful instrument to study therapy sessions qualitatively. Findings from three recent studies suggest that that researchers can be trained in coding in a relatively short period of time and attain high (.80 or above) interrater agreement (Hayes et al.; Hayes et al., 2007; Hayes, Feldman & Goldfried, 2007). Furthermore the scale was developed within the positive psychology framework with the goal of allowing for more in-depth examination of the process and qualities of positive change in the therapeutic context. However, there are potential limitations of the measure. The CHANGE scale has been developed and implemented by the primary researchers in a limited number of published studies to date, which have established preliminary interrater agreement and predictive validity. Hayes et al. recommended future research to include other samples, in a variety of contexts, and comparison with other measures to examine concurrent and discriminant validity. There is a need for the establishment of empirical validity through further research applications.

APPENDIX B

Client Consent Form

Pepperdine University
Counseling and Educational Clinics
Consent for Services

INITIALS

Welcome to Pepperdine University's Counseling and Educational clinics. Please read this document carefully because it will help you make an informed decision about whether to seek services here. This form explains the kinds of services our clinic provides and the terms and conditions under which services are offered. Because our clinic complies with the Health Insurance Portability and Accountability Act (HIPAA), be sure to review the Privacy Rights pamphlet that was also given to you today. It is important that you understand the information presented in this form. If you have any questions, our staff will be happy to discuss them with you.

Who We Are: Because the clinic is a teaching facility, graduate students in either the Clinical Psychology Doctorate Program or the Masters in Marriage and Family Therapy Program provide the majority of services. Our graduate student therapists are placed in the clinic for a time-limited training position, which typically lasts 8-12 months. In all cases, all therapists are supervised by a licensed clinical psychologist or a team that includes a licensed mental health professional. The clinic is housed in Pepperdine University and follows the University calendar. As a general rule, the clinic will be closed when the University is not in session. No psychological services will be provided at those times.

- I understand and agree that my services will be provided by an unlicensed graduate student therapist who will be working under the direct supervision of a licensed mental health professional.
- I understand and agree that, as required by law, my therapist may disclose any medical, psychological or personal information concerning me to his/her supervisor(s).
- I confirm that I have been provided with information on how to contact my therapist's supervisor(s) should I wish to discuss any aspects of my treatment.

I understand and agree with the above three statements. _____

Services: Based on the information you provided in your initial telephone interview, you have been referred to the professional service in our clinic appropriate to your concern. The clinic provides the following professional psychological services:

Psychotherapy: The first few sessions of therapy involve an evaluation of your needs. At the end of the evaluation phase, a determination will be made regarding whether our services appropriately match your mental health needs. A determination will also be

made regarding whether to continue with services at our clinic, or to provide you with a referral to another treatment facility more appropriate to your needs. As part of your services, you will be asked to complete questionnaires during your intake session, at periodic intervals (e.g., every fifth session), and after you have completed treatment. Psychotherapy has both benefits and risks. Risks sometimes include being asked to discuss unpleasant aspects of your life and experiencing uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. Sometimes decisions are made in therapy that are positive for one family member and can be viewed negatively by another family member. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reduction in feelings of distress. But there are no guarantees of what you will experience. In order for therapy to be effective, a commitment to regular attendance is necessary. Frequent cancellations or missed therapy appointments may result in termination of services or a referral to an alternative treatment setting. Unless otherwise arranged, therapy sessions are scheduled once a week for 50 minutes. Educational Therapy is also offered in some of our clinics. This is an intervention that focuses on learning difficulties by addressing how circumstances in a person's life contribute to these difficulties. Educational therapy combines tutoring as well as attention to socio-emotional issues that affect learning.

Psychological Assessment: The clinic provides psychological and psychoeducational assessments. These assessments may be initiated by you, your therapist or a third party. Assessment sessions are longer than therapy sessions and can take several hours to complete. The number of sessions required for conducting the assessment will be determined based on the nature and number of tests administered. You have the right to request a copy of your assessment report and test data. You also have the right to receive feedback regarding your assessment results. However, there are some situations in which we may not be able to release test results, including test data, to you: a) When such a disclosure may cause substantial harm or misuse of the test results and test data, and/or b) When you were notified and agreed in advance and in writing that the assessment was ordered and/or paid for by a third party and that we would release your results only to that third party. The benefits of psychological assessment include a clearer understanding of your cognitive and emotional functioning. Although the risks of participating in a psychological assessment are generally no greater than the risks of counseling, test results may reveal information that may be painful and/or difficult to accept. If that is the case, we recommend that you review with the examiner options for addressing your concerns.

Consent to Video/audiotaping and Observations: It is standard procedure at our clinic for sessions to be audiotaped and videotaped for training/teaching and/or research purposes. **It should be noted that videotaping for teaching/training purposes is a prerequisite for receiving services at our clinic**. In addition, sessions may be observed by other therapists and/or supervisors at the clinic through the use of a one-way mirror or direct in-session observation.

- For Teaching/Training purposes, check all that apply:

I understand and agree to _____

_____ Video/audiotaping
_____ Direct Observation

Psychological Research: As a university based clinic, we engage in research activities in order to determine the effectiveness of our services, including client satisfaction, as well as to better understand assessment and therapy practices. Participation in research is totally voluntary and means that the forms you complete as a part of your treatment will be placed in a secure research database. Clinic staff will remove any of your identifying information (e.g., name, address, date of birth) from the written materials before they are placed in the database. You may also consent to have your taped sessions included in the research database, and if so these tapes will be used and stored in a confidential manner. Only those professors and graduate students who have received approval from the Clinic Research Committee, and who have signed confidentiality agreements, will be granted access to the database in order to conduct scholarly research. If any information from the database is involved in a published study, results will be discussed in reference to participant groups only, with no personally identifying information released. Your services do not depend on your willingness to have your written and/or taped materials included in our research database. You may also change your mind about participation in the research database at any time. While there is no direct benefit to you to have your materials placed in the database, your participation may provide valuable information to the field of psychology and psychotherapy.

Please choose from the following options (confirm your choice by initialing in the margin).

- I understand and agree that information from my services will be included in the Research Database (check all that apply).

_____

_____ Written Data
_____ Videotaped Data
_____ Audiotaped Data

OR

- I do not wish to have my information included in the Research Database. _____

- I understand and agree that I may be contacted in the future about the opportunity to participate in other specific research programs. _____

OR

- I do not wish to be contacted in the future about the opportunity to participate in other specific research programs. _____

Fees: The fee for the initial intake is nonrefundable. Payment for services is due at the time the services are rendered. Your ongoing fee will be based on your income (for minors: the income of your parents) or upon your ability to pay. Once an appointment is

scheduled, you will be expected to pay for it unless you provide 24-hour notice of cancellation prior to the appointment time. Please notify us of your cancellation via phone. Please do not use E-mail since we cannot guarantee a secure and confidential correspondence. Failure to pay for services may result in the termination of treatment and/or the use of an outside collection agency to collect fees. In most collection situations, the only information released is your name, the nature of services provided and amount due.

Payment for psychological assessment services: The intake fee is due at the time of the first appointment. Following this appointment, the full cost of the psychological testing will be determined. Payment in full for the psychological testing is required prior to the completion of the testing. Feedback from the testing as well as a test report will be provided after payment has been made in full. Fees for psychological testing cover: initial interview, test administration, scoring and interpretation, oral feedback of test results, and a written test report. Any additional services requested will be billed separately.

After Hours and Emergency Contact: Should you need to reach your therapist during or after business hours you may leave a message on the clinic's voice-mail. The therapist will most likely return your call by the next day. Should you need to contact your therapist for an urgent matter, you may use the clinic's pager number, provided to you, to get in touch with the on-call therapist. Please be aware that the clinic is not equipped to provide emergency psychiatric services. Should you need such services, during and/or after business hours, you will be referred to more comprehensive care centers in the community.

Confidentiality & Records: All communications between you and your therapist are strictly confidential and may not be disclosed to anyone outside the clinic staff without your written authorization. However, there are some situations in which disclosure is permitted or required by law, without your consent or authorization:

- Your therapist may consult with other mental health professionals regarding your case. The consultants are usually affiliated with Pepperdine University. Your therapist may also discuss your case in other teaching activities at Pepperdine, such as class discussions, presentations and exams. Every effort is made to avoid revealing your identity during such teaching activities.
- If the situation involves a serious threat of physical violence against an identifiable victim, your therapist must take protective action, including notifying the potential victim and contacting the police.
- If your therapist suspects the situation presents a substantial risk of physical harm to yourself, others, or property he/she may be obligated to seek hospitalization for you or to contact family members or others who can help.
- If your therapist suspects that a child under the age of 18, an elder, or a dependent adult has been a victim of abuse or neglect, the law requires that he/she file a report with the appropriate protective and/or law enforcement agency.
- If you are involved in a court proceeding and a request is made for information about the services provided to you, the clinic cannot provide any information,

including release of your clinical records, without your written authorization, a court order, or a subpoena.
- If you file a complaint or lawsuit against your therapist and/or the clinic, disclosure of relevant information may be necessary as part of a defense strategy.
- If a government agency is requesting the information pursuant to their legal authority (e.g., for health oversight activities), the clinic may be required to provide it for them.
- If the clinic has formal business associates who have signed a contract in which they promise to maintain the confidentiality of your information except as specifically allowed in the contract or otherwise required by law.

If such a situation arises, your therapist will make every effort to fully discuss it with you before taking any action. Disclosure will be limited to what is necessary for each situation.

Your Records: The clinic keeps your Protected Health Information in your clinical records. You may examine and/or receive a copy of your records, if you request it in writing, except when: (1) the disclosure would physically or psychologically endanger you and/or others who may or may not be referenced in the records, and/or (2) the disclosure includes confidential information supplied to the clinic by others.

HIPAA provides you with the following rights with regard to your clinical records:
- You can request to amend your records.
- You can request to restrict from your clinical records the information that we can disclose to others.
- You can request an accounting of authorized and unauthorized disclosures we have made of your clinical records.
- You can request that any complaints you make about our policies and procedures be recorded in your records.
- You have the right to a paper copy of this form, the HIPAA notice form, and the clinic's privacy policies and procedures statement.

The clinic staff is happy to discuss your rights with you.

Treatment & Evaluation of Minors:

As an unemancipated minor (under the age of 18) you can consent to services subject to the involvement of your parents or guardians.
- Over the age of 12, you can consent to services if you are mature enough to participate in services and you present a serious danger to yourself and/or others or you are the alleged victim of child physical and/or sexual abuse. In some circumstances, you may consent to alcohol and drug treatment.
- Your parents or guardians may, by law, have access to your records, unless it is determined by the child's therapist that such access would have a detrimental effect on the therapist's professional relationship with the minor or if it jeopardizes the minor's physical and/or psychological well-being.
- Parents or guardians will be provided with general information about treatment progress (e.g., attendance) and they will be notified if there is any concern that the

minor is dangerous to himself and/or others. For minors over the age of 12, other communication will require the minor's authorization.

- All disclosures to parents or guardians will be discussed with minors, and efforts will be made to discuss such information in advance.

My signature or, if applicable, my parent(s) or guardian's signature below certifies that I have read, understood, accepted, and received a copy of this document for my records. This contract covers the length of time the below named is a client of the clinic.

_____ and/or _____

Signature of client, 18 or older (Or name of client, if a minor)

Signature of parent or guardian

_____

Relationship to client

_____

Signature of parent or guardian

_____

Relationship to client

_____ please check here if client is a minor. The minor's parent or guardian must sign unless the minor can legally consent on his/her own behalf.

_____ _____

Clinic/Counseling Center Representative/Witness

Translator

_____

Date of signing

APPENDIX C

Therapist Consent Form

INFORMED CONSENT FOR THERAPIST PARTICIPATION IN PEPPERDINE CLINICS RESEARCH DATABASE PROJECT

1. I, _____ , agree to participate in the research database project being conducted under the direction of Drs. Eldridge, Ellis, and Hall, in collaboration with the clinic directors. I understand that while the study will be under the supervision of these Pepperdine GSEP faculty members, other personnel who work with them may be designated to assist or act in their behalf. I understand that my participation in this research database is strictly voluntary.

2. One purpose of research at the Pepperdine University GSEP Clinics and Counseling Centers is to examine the effectiveness of new clinic policies and procedures that are being implemented. This is being done through standard internal clinic practices (headed by the clinic directors and the Clinic Advancement and Research Committee) as well as through the construction of a separate research database (headed by Drs. Eldridge, Ellis, and Hall). Another purpose of this research project is to create a secure database from which to conduct research projects by the faculty members and their students on other topics relevant to clinical practice.

3. I have been asked to participate in the research database project because I am a student therapist or intern at a GSEP Clinic or Counseling Center. Because I will be implementing the new clinic policies and procedures with my clients, my input (or participation) will provide valuable data for the research database.

My participation in the research database project can involve two different options at this point. I can choose to participate in any or neither of these options by initialing my consent below each description of the options.

First, my participation in the research database project will involve being asked, from time to time, to fill out questionnaires about my knowledge, perceptions and reactions to clinic trainings, policies and procedures. In addition, my participation involves allowing questionnaires that I complete about my clients (e.g., treatment alliance) and/or tapes from my sessions with clients to be placed into the database.

<u>Please choose from the following options by placing your initials on the lines.</u>

- I understand and agree that the following information will be included in the Research Database (check all that apply).

  _____ Written questionnaires about my knowledge, perceptions and reactions to clinic trainings, policies and procedures

_____ Written Data about My Clients (e.g., Therapist Working Alliance Form)

_____ Video Data of sessions with my clients (i.e., DVD of sessions)

_____ Audio Data of sessions with my clients (i.e., CD or cassette tapes of sessions)

OR

- I do not wish to have any/all of the above information included in the Research Database.

_____

Please choose from the following options by placing your initials on the lines.

- I understand and agree that I may be contacted in the future about the opportunity to participate in other specific research programs at the GSEP Clinic or Counseling Center.

_____

OR

- I do not wish to be contacted in the future about the opportunity to participate in other specific research programs at the GSEP Clinic or Counseling Center.

_____

4. My participation in the study will last until I leave my position at the GSEP Clinic or Counseling Center.

5. I understand that there is no direct benefit from participation in this project, however, the benefits to the profession of psychology and marriage and family therapy may include improving knowledge about effective ways of training therapists and implementing policies and procedures as well as informing the field about how therapy and assessments are conducted in university training clinics.

6. I understand that there are certain risks and discomforts that might be associated with this research. These risks include potential embarrassment or discomfort at having faculty review materials about my clinic practices, which may be similar to feelings about supervisors reviewing my work ; however this risk is unlikely to occur since the written materials will be coded to protect your identity. Sensitive video data will be also coded to protect confidentiality, tightly secured (as explained below), and reviewed only by those researchers who sign strict confidentiality agreements.

7. I understand that I may choose not to participate in the research database project.

8. I understand that my participation is voluntary and that I may refuse to participate and/or withdraw my consent and discontinue participation in the research project at any time without prejudice to my employment in the GSEP Clinics and Counseling Centers. I also understand that there might be times that the investigators may find it necessary to end my

study participation (e.g., if my client withdraws consent for participation in the research study).

9. I understand that the investigators will take all reasonable measures to protect the confidentiality of my records and my identity will not be revealed in any publication that may result from this project.

10. The confidentiality of my records will be maintained in accordance with applicable state and federal laws. Under California law, there are exceptions to confidentiality, including suspicion that a child, elder, or dependent adult is being abused, or if an individual discloses an intent to harm him/herself or others. I understand there is a possibility that information I have provided regarding provision of clinical services to my clients, including identifying information, may be inspected and/or photocopied by officials of the Food and Drug Administration or other federal or state government agencies during the ordinary course of carrying out their functions. If I participate in a sponsored research project, a representative of the sponsor may inspect my research records.

11. The data placed in the database will be stored in locked file cabinets and password-protected computers to which only the investigators, research team members and clinic directors will have access. In addition, the information gathered may be made available to other investigators with whom the investigator collaborates in future research and who agree to sign a confidentiality agreement. If such collaboration occurs, the data will be released without any personally identifying information so that I cannot be identified, and the use of the data will be supervised by the investigators. The data will be maintained in a secure manner for an indefinite period of time for research purposes. After the completion of the project, the data will be destroyed.

12. I understand I will receive no compensation, financial or otherwise, for participating in study.

13. I understand that the investigators are willing to answer any inquiries I may have concerning the research herein described. I understand that I may contact Dr. Kathleen Eldridge at (310) 506-8559, Dr. Mesha Ellis at (310) 568-5768, or Dr. Susan Hall at (310) 506-8556 if I have other questions or concerns about this research. If I have questions about my rights as a research participant, I understand that I can contact the Chairperson of the Graduate and Professional Schools IRB, Pepperdine University at (310) 568-5600.

14. I will be informed of any significant new findings developed during the course of my participation in this research which may have a bearing on my willingness to continue in the study.

15. I understand to my satisfaction the information regarding participation in the research project. All my questions have been answered to my satisfaction. I have received a copy of this informed consent form which I have read and understand. I hereby consent to participate in the research described above.

_____ _____

Participant's signature Date

Participant's name (printed)

I have explained and defined in detail the research procedure in which the participant has consented to participate. Having explained this and answered any questions, I am cosigning this form and accepting this person's consent.

Researcher/Assistant signature Date

Researcher/Assistant name (printed)

APPENDIX D

Change and Growth Experiences Scale Training Manual

CHANGE AND GROWTH EXPERIENCES SCALE TRAINING MANUAL
(adapted from CHANGE, Hayes & Feldman, 2005)

This training manual is intended to help orient you to the methods of transcription and coding that will be utilized for the research projects. The specific therapy tapes will be clients and therapists at the Pepperdine University clinics that have been selected by Dr. Hall based on inclusion/exclusion criteria (e.g., individual adult clients representing diverse ethnicities, genders, religions, and presenting issues). Josina Grassi Moak, Stacie Cooper, and Alexander Bacher will be utilizing this for their respective dissertations to gain a more in-depth understanding of how clients talk about coping, hope, and meaning-making early in therapy (first few sessions). Your role as research assistants will be to transcribe the sessions in great detail and help with the preliminary coding phase for each of the constructs measured by CHANGE (see below).

I. TRANSCRIPTION INSTRUCTIONS

(adapted from Baylor University's Institute for Oral History - http://www3.baylor.edu/Oral_History/Styleguiderev.htm)

The first step will be to transcribe verbatim each therapy session to be included in the research to provide a format for more in-depth analysis of client statements to then be coded using the CHANGE codes listed below (for meaning-making, hope, and coping). Attached at the end of this section is a template that you will use for your transcriptions. After reading this manual and discussing questions during training, you will be asked to practice transcribing an excerpt from a Motivational Interviewing tape by William Miller. At the end of the manual, you will find a completed transcript to use to check your work.

A good transcription should reflect as closely as possible the actual words, speech patterns, and thought patterns of the speakers. The speakers' word choice, including his/her grammar and speech patterns should be accurately represented. The transcriber's most important task is to render as close a replica to the actual event as possible. Accuracy, not speed, is the transcriber's goal.

When identifying who is speaking, us a "T" to indicate the therapist is speaking and a "C" to indicate the client is speaking. In addition, please use numbers to indicate how many times each person is speaking. For example, the first the therapist speaks represent it as T1: and the second time as T2, T3, etc., and vice versa for the client (C1, C2, C3, etc.)

Long passages should be broken into new paragraphs to enhance readability. If one of the speakers speaks for a long time, or includes multiple different ideas/thoughts in a given response, please break the long response up into shorter segments by topic/idea and represent each different topic/idea by starting new paragraph, indenting two spaces, and using the following numbering system:

C12: ……..
  C12.1: ……
  C12.2: ……..
  C12.3: ……..
T13: …….
C14: ……..

In addition to capturing the actual words, speech patterns and thought patterns of the speakers, we would like to try and capture some of the more important non-verbal behaviors/communication taking place between the therapist and client. In order to do so, please use parentheses with numbers inside of them to indicate pauses in a speaker's response. For example, use (3) to represent a three second pause or (10) for

a ten second pause. Use this whenever there are significant pauses or moments of silence between the speakers.

When attempting to capture non-verbal behaviors/movements that are significant to the therapeutic interaction taking place, use brackets [ ] to indicate these movements and clearly state which person—the therapist or client—is performing the movement and what specifically he/she does. For example, [Client turned away from the therapist and looked down at the ground] or [Client laughs] or [Therapist sighed deeply and looked away briefly]. Also use brackets to indicate the inability to hear/understand a word or sentence: [Unintelligible] or [Inaudible]. Please make every effort to hear and understand what is said. Sometimes you can figure out a word by the context of what the speaker is saying. If you can make an educated guess, type the closest possible approximation of what you hear, underline the questionable portion, and add two question marks in parentheses.

Example: I went to school in Maryville (??) or Maryfield (??).

If you and those you consult cannot make a guess as to what is said, leave a blank line and two question marks in parentheses.

Example: We'd take our cotton to Mr. _____(??)'s gin in Cameron.

If a speaker lowers his/her voice, turns away from the microphone, or speaks over another person, it may be necessary to declare that portion of tape unintelligible.

Example: When he'd say that, we'd— [unintelligible].

While there is some merit in having an absolutely verbatim tape, which includes all the feedbacks (such as Um-hm and Yeah), too many interruptions in the flow of the interviewer's remarks make for tedious transcribing now and exhaustive reading later. Knowing when to include feedback sounds and when to omit them calls for very careful judgment. Usually the interviewer's noises are intended to encourage the interviewee to keep talking. Look at your transcript. If every other line or so is an interviewer's feedback, go back and carefully evaluate the merit of each feedback. Don't include every feedback, especially if it interrupts the interviewee's comments in midstream. Only if the feedback is a definite response to a point being made by the interviewee should you include it. When in doubt, ask.

Type no more than two crutch words per occurrence. Crutch words are words, syllables, or phrases of interjection designating hesitation and characteristically used instead of pauses to allow thinking time from the speaker. They also may be used to elicit supportive feedback or simple response from the listener, such as: you know, see?, or understand?

Use of *Uh*: The most common word used as a crutch word is *uh*. When *uh* is used by the narrator as a stalling device or a significant pause, then type *uh*. But sometimes a person will repeatedly enunciate words ending with the hard consonants with an added "uh," as in and-uh, at-uh, did-uh, that-uh, in-uh. Other examples are to-uh, of-uh, they-uh. In these instances, do not type *uh*.

Guggles are words or syllables used to interrupt, foreshorten, or end responses, and also as sounds of encouragement. Guggles are short sounds, often staccato, uttered by the interviewer to signal his desire to communicate. They may be initial syllables of words or merely *oh, uh, ah*, or *er*. Spelling of specific guggles: Agreement or affirmation: uh-huh, um-hm; Disagreement: unh-uh.

For consistency, use only the following for exclamations:

- Uh
- Um
- Uh-huh
- Mm-hmm
- Unh-uh

Do not use ah, oh, er, and so forth. Pick from the list above and use what seems closest to what is being uttered.

Incomplete sentences are familiar occurrences in oral history because of its conversational nature. They are best ended with an em dash (—).

Quotation Marks:

1. When a direct expression is spoken by one person (I, he, she), set apart the expression with commas, use opening and closing quotation marks, and capitalize the first letter of the first word quoted. Example: She said, "I am going to graduate in May."
2. When a direct expression is spoken by more than one person (we, they), do not use quotation marks, but do set apart the expression with commas and do capitalize the first letter of the first word quoted. Example: They said, What are you doing here?
3. When a thought is quoted, do not use quotation marks, but do set the thought apart by commas and capitalize the first letter of the first word quoted. Example: I thought, Where am I?

When finished transcribing, please go through the session one last time to make sure you have captured all the spoken data and as many of the important non-verbal behaviors as possible.

TRANSCRIPTION TEMPLATE

CONFIDENTIAL VERBATIM TRANSCRIPT

Confidentiality: The following is a confidential document, which may contain information that could be detrimental if used by untrained individuals. Nonconsensual disclosure by individuals not associated with Pepperdine University and the Positive Psychology PARC lab is prohibited.

Session Number: Coder:
Client #: Date of Session:

C = Client
T = Therapist

Verbatim Transcript of Session	**Initial Coding Impressions**
T1:	
C1:	
T2 :	
C2:	
T3:	

C3:	
T4:	
C4:	
T5:	
C5:	

II. CODING OVERVIEW

This coding system is designed to study the variables associated with change in therapy or in adaptation to life events. There are two parts to the CHANGE, a measure of client or participant variables and a measure of therapist interventions. We will focus on the client variables in our study.

CHANGE Client Variables can be used to code essays or therapy sessions. We will be using it to code transcripts of therapy sessions that clients and therapists have consented to place in a confidential research database. The coding system assesses seven content areas and three client processes. For the purposes of our studies, these areas will be covered in the manual:

1) Sense of hope
2) Historical antecedents
3) Relationship Quality
4) Protection/avoidance
5) Cognitive/emotional processing
6) Unproductive processing

1. Coding Steps:

1. **Read this manual and learn the CHANGE codes**

2. **Watch the video tape of session all of the way through, take notes in the right hand column of the transcript to get a general gist of possible applicable codes, impressions of client (non-verbals versus language, tone, affect, etc.)**

3. **Read the transcript all the way through to gain an overall sense of the client in this session. Again, take notes.**

   The notes will help you to remember the reasons for your coding decisions and will help you in the discussions in the consensus meetings.

4. **Read the transcript again in detail by looking at each statement (C1, C2, etc.) and write your coding impressions on the code sheet.**

5. **Review your code sheet and give your final ratings.**

When coding, you want to **try to balance attention to details with an ability to think abstractly** and see the bigger picture. It is also important to maintain focus by pacing yourself carefully. It is difficult to code accurately when you are rushed or code in binges. In the discussion meetings, it helps to present your questions and confusions and to agree with others only when the consensus makes sense. Coding requires an **openness and flexibility but not acquiescence**.

Record each instance in the transcript that you believe a code is present on the code sheet (record "C1," "C2" etc. and the phrase you believe matches the code). Then, tally the frequency count on the code sheet. This will help to verify your overall score and will be used during group meetings to discuss and compare scores for the sessions. Refer to training materials when guidance is needed.

Next, rate each category using the appropriate scale. Some ask you to rate intensity during the session. This is done by giving a rating from **0** to **3:**

INTENSITY
0 = NONE (0-1 ratings for session)
1 = LOW (2 or more; rarely, a bit, minimal, infrequently, now and then)
2 = MEDIUM (sometimes, kind of, variable, reflecting ambivalence)
3 = HIGH (almost always, very much, all of the time, really, incredibly)

Other categories ask you to rate valence (**positive or negative**) or ("**absent**" or "**present**"). For example, if you believe that a client statement depicts perceived POSITIVE RELATIONSHIP QUALITY, you would mark "positive relationship quality."

Please make sure that all of the categories for each essay or session are completed. Note that the **coding categories are not mutually exclusive**, which means that categories overlap and can co-occur. For instance, there can be both positive and negative emotion in the same essay or session. The categories of emotion and somatic functioning often overlap.

When coding a therapy session, **consider the context** provided by the therapist and client. At times, the person will refer loosely to previous content. For instance, a person might talk about past failures and feelings of incompetence and then in subsequent essays or sessions say, "I screwed up again. Here we go again, I feel horrible." The terms, "screwed up again" and "here we go again" refer back to the more explicitly articulated negative view of the self and cycle of self-criticism from previous essays or sessions.

In using context, consider the person's baseline but also use a standard scale so that comparisons can be made across individuals. For instance, when coding the material from someone who is depressed, the emotional tone is often consistently negative. In this context, a glimmer of positive emotion can appear to warrant a high rating, when it should actually be coded as low. Similarly, in the context of a destructive relationship, a mildly positive event can seem to warrant a high positive emotion rating because the baseline is so low. Be careful of this **baseline bias**.

Mark each phrase or verbalization for which you are unsure of the coding to bring up in the next team meeting for review. If you find a given section or category particularly difficult to code, make note of the issues and what went into your decision. The coding meeting might be a week after you've coded the passage, and this will help you to remember your thought process.

2. SPECIFIC CODES USED FOR THIS STUDY:

A. CONTENT CODES

1) SENSE OF HOPE (AGENCY) (CHANGE SCALE)

This code captures the person's capacity to see the possibility of ***change in the future, to recognize recent positive changes (1month in past at most)***, and to express a commitment or determination to make changes. You will be coding the intensity (0-3) of negative and positive hope.

* Client has to verbally express feelings of agency, motivation, commitment, determination and their role in it.

Negative: a feeling of being stuck, trapped, having no way out, sinking, feeling tired of trying, or a lack of commitment. Sometimes one can experience a giving up of old ways before change.
Although this is **hopelessness** before change, it is still coded as negative hope

Examples:

- "I hate my life. I feel stuck. I can't see a way out." (NEGATIVE, HIGH)
- "**Sometimes** (or often) I feel stuck or get tired of the games" (NEGATIVE, MEDIUM)

- "**Every once in a while** I just get tired of the games." (NEGATIVE, LOW)

Positive: a feeling of movement and possibility, a motivation, commitment or determination to change
Examples:

- "I am realizing that **I do have some control** over my mood and fate." (POSITIVE, HIGH)
- "I have got to stop beating myself up. I must stop." (POSITIVE, HIGH)
- "At present time, I am energetically pursuing my goals." (POSITIVE HIGH)
- "Right now, I see myself as being pretty successful." = (POSITIVE HIGH)
- "At this time, I am meeting goals I have set for myself." = (POSITIVE HIGH)
- "Currently, I believe I MAY be able to change my problems." = (POSITIVE MEDIUM)
- "I kind of feel ready for a fresh new start." = (POSITIVE, MEDIUM)
- "I **sometime**s feel like I am **capable** of changing." (POSITIVE, MEDIUM)
- "I sometimes think I can get out of my depression but I am not sure today." = (POSITIVE LOW)
- "I am **beginning to think** that there **might** be a way out of this mess." (POSITIVE, LOW)

ALTERNATE HOPE CODE:
SNYDER'S HOPE CONSTRUCT (*PATHWAYS)*

Brief overview: C.R. Snyder's emotive/cognitive hope theory is currently the most widely used and researched model of the hope construct in clinical psychology. Snyder conceptualized hope as a combination of an individual's personal goals, motivation (agency) and his or her perceived pathways to achieve those goals. He has developed measures that look at current hopeful thinking about general life goals including agency and pathways items, which have been modified and included to compare this definition of hope to the CHANGE construct above.

PATHWAYS

This involves goal-directed thinking (cognitive process of brainstorming options for self) in which the individual perceives that he or she can produce ROUTES, STRATEGIES, to move toward the direction of desired goals, or **planning ways to meet goals, and specific behaviors to perform toward the goal; steps in the right direction.**

In other words: brainstorming options, possible routes toward goals: "Here is how I can do it"

For PATHWAYS, the PRESENT OR FUTURE goals must be perceived by the person to be **possible,** and **desirable- manageable goals that can be realistically achieved.**

Pathways is only marked on *intensity,* not positive or negative **(note or check specific examples of each and rate overall code based on specific examples and number of statements made- e.g., if the session contains 5 high pathways statements and 2 medium, it would be high pathways overall).**

Examples:

- "If I should find myself stuck or in a jam, I could think of many ways to get out of it." = HIGH PATHWAYS (multiple and/or specific ways – one is okay with elaboration and certainty)
- "There are lots of ways around any problem I am facing right now." = HIGH PATHWAYS
- "I can think of ways to meet my current goals." = HIGH PATHWAYS
- "I could look for other jobs, or maybe I will tell my boss how I feel and that will make things better at work." = HIGH PATHWAYS
- "Couples therapy is a way for me to figure out if this relationship is worth saving." =HIGH PATHWAYS
- "There might be some ways out of my abusive relationship that I can try." = MEDIUM PATHWAYS (one specific, or multiple uncertainty)
- "I think that going to couples therapy might be a way that I can figure out if this relationship is worth saving." = MEDIUM PATHWAYS
- "I can maybe see a realistic way to improve my mood but I am not sure." = LOW PATHWAYS (non-specific and uncertainty)

Coders may also be asked to indicate on the coding sheet the types of pathways they noticed during the session.

2) HISTORICAL ANTECENDENTS (EARLY CAREGIVERS)

This category captures the extent to which the person focuses on early experiences with parents or early caretakers *when identifying, exploring, or examining issues related to current problems*. Higher scores reflect a) a more elaborated discussion of historical antecedents, and b) a discussion that integrates past experiences with current problems or with positive changes.

Examples:

Negative	High Negative: • "My mother taught us that it was best to 'never air dirty laundry.' It was forbidden to go outside the family when there was a problem. No wonder it is so hard for me to ask for help when I need it."
	Medium Negative:
	Low Negative: • "My parents were cold and critical." (The client does not elaborate on this comment or connect it with current issues. This has the potential to be rated as high, but there is not enough content provided.)
Positive	High Positive: • "You know, my father always believed in me. Although I have periods of self-doubt, his words always come through when I am down. He used to tell me that I was a strong character and that I could get through most of what life has to give me. I try to remember that when I feel anxious." • "I am starting to realize how important my grandmother was. When my parents were drinking and having all kinds of problems, she was a stable force. She keeps me from getting really depressed at times."
	Medium Positive:
	Low Positive: • "As I think about why I am so nervous around people, I am puzzled because I never had anything horrible happen, and my parents were supportive." (This is a low positive because it is not elaborated on)

ADDITIONAL CODE: ALL HISTORICAL ANTECEDENTS (not limited to caregivers):

This is an additional code to account for the limitations of CHANGE that only measures the individual's mention of experiences with early caregivers or parents and how those affect their experiences, problems, etc. This additional code will function exactly the same way as the other Historical Antecedents code, but also take into account important/significant experiences with people other than parents/caregivers in the individual's life. E.g. Friends, partners, relatives, etc. In addition, any significant past precipitating events related to current problems or positive changes that has had some definitive ending point in the past (at least a month ago, and not ongoing. **Past events** or experiences. "It reminds me of…" OR "that relates kind of to when…"

Examples:

Negative	High Negative: • "I started feeling anxious when I moved to LA because there is so much pressure to conform and fit in, which made me focus on my flaws and feel anxious."
	Medium Negative: • "I started feeling anxious when I moved to LA."
	Low Negative: • "LA is a harsh place to grow up."

Positive	High Positive: • "I always had a strong connection to my church growing up, which helped provide a strong support system and foundation for belief in myself and I try to turn to god when I am feeling down and believe things happen for a reason."
	Medium Positive: • "I always had a lot of support growing up in New York with my friends and these friends help me get through ups and downs."
	Low Positive: • "It was easy to make friends growing up in New York."

Coders may also be asked to indicate on the coding sheet the types of historical antecedents they noticed during the session.

3) FEELINGS TOWARD RELATIONSHIP QUALITY

This category captures the perceived quality of the person's interactions with others that week or in general. This can involve immediate family, romantic partners, friends, co-workers, or people in general. This is not a frequency count like the behavior category, but rather how positive or negative the person *perceives* the interactions to be (as interpreted by overall session statements). This can include memories about past relationships or fears about future relationships, if the memories or fears are tied to current functioning. This **does not need to include direct *feeling* statements. The words chosen assumed to reflect feeling- attend to the STRENGTH of positive or negative descriptive words when coding.**

Negative: Encounters that involve distress or dissatisfaction, such as feeling slighted, ignored, alienated, humiliated, controlled, manipulated, betrayed, or engaging in conflict. Feelings of alienation, isolation, and loneliness can also be activated in the absence of encounters.

Positive: Encounters that involve enjoyment or satisfaction, such as feeling part of a group, cared for, loved, connected, or stimulated.

Examples:

- "I went to see my family for my father's birthday, but the criticism began in the first hour. I felt myself shut down, just like I did when I was a child." (NEGATIVE, HIGH)
- "I felt left out of a party at work last weekend. Roberto slipped and mentioned the party. When he realized that I hadn't been invited, he stuttered and tried to make excuses. Why did they exclude me? Why doesn't anyone want to be with me? I don't understand." (NEGATIVE, HIGH)

* "She was so bitchy to me and she and the girls at work are always catty and talk shit." (NEGATIVE, HIGH)

- "Sometimes I think I will never have a good relationship, so why bother. A lot of times I wonder if the person I am dating now will leave me…" (NEGATIVE, MEDIUM; This is an example of a fear or hypothetical outcome.)
- "I have had a couple of days where I feel alone, but then I call my friends and feel more connected." (NEGATIVE, LOW)

Examples:

- "I went home and had a heart-to-heart talk with my husband about wanting to spend more time together. He suggested that we take a vacation together, and I felt like he cared. It really felt good." (POSITIVE, HIGH)
- "And I think my supervisors were trying to make me feel comfortable and let me know I had their undying support and this created a welcoming atmosphere to transition back to work." (POSITIVE, MEDIUM) – some positive statements said with less certainty, or coder not able to distinguish certainty
- "Things are on and off with my mother, sometimes I think she is helpful and supportive and sometimes I feel like she doesn't get me." (POSITVE, MEDIUM)

- "I made myself go to an ALANON meeting. It was OK, I guess. I hope it helps." (POSITIVE, LOW)

Coders may also be asked to indicate on the coding sheet the types of relationships they noticed during the session.

B. PROCESS CODES

INSTRUCTIONS

Rate the extent to which the person reports the following reactions in the essay or session. The categories in this section are not coded for valence (positive, negative) but are coded as low, medium, or high.
Attend to entire session when coding process codes-

1) COGNITIVE/EMOTIONAL PROCESSING

This category captures the extent to which the person approaches a problem and explores, tries to understand, challenge, and make meaning of it. It can begin as thinking about and questioning a problem area or exposing oneself to new information, and then is followed by insight or shift in perspective or meaning. The ratings of low, medium and high reflect **level** of processing, rather than frequency or intensity. **NOTE: Coders should attend to the context of the entire session**, noting patterns of approaching a problem or pattern of processing. If pattern is repetitive or there seems to be no resolution by end of session, consider repetitive processing code. At medium and high levels, there are often emotional or behavioral manifestations of this shift in perspective/meaning.

Inquisitive, wondering rather than describing.

Cognitive/emotional processing usually takes place in narrative form, in which people use reappraisal, reattribution, and other revaluing techniques in order to better understand/make sense of some experience/aspect of their lives which is presently causing them distress. This in done in order to help realign their situational meaning (problematic experience/feelings) with their global meaning (people's enduring beliefs, values, goals, assumptions and expectations about the world) and relieve any anxiety/despair associated with the incongruence.
Examples:

0 = N/A	No processing is apparent or slight movement toward thinking about or approaching a problem
1 = Low	Exploring and questioning a problem area, but without a significant insight and uncertainty: • "Looking back now, I think maybe my co-workers were so unpleasant toward me because they were envious of me…?" • "I began to wonder why I had stayed so long in this unhealthy relationship. What kept me there? What was I getting out of it?" • "I think some of it might be due to my fear of intimacy, but I'm not sure." • " I wonder why I am so scared of succeeding. Why do I avoid the spotlight?"
2 = Medium	Exploring and questioning a problem area with some new connections and insights and more certainty, but no substantial perspective shifts: • " I realized that I am afraid to succeed. I have been holding myself back because I am afraid to move too fast and then to fail." • " I made myself go to three meetings this week, and my anxiety decreased a little bit. I'll keep working on my exposure exercises." • "After talking about his death over and over with my therapist, it is beginning to be less painful."
3 = High	Engaged and exploring or confronting a problem area with substantial insight and perspective shifts—an "Ah-ha" like experience-physiological affective

	reaction. This can include making new meaning of experience, **integrating past experience with current functioning**, benefit finding, reframing, reaching a higher level of abstraction, and resolutions/acceptance: • "Then it hit me, I must stop running. I run and run so that I won't get hurt, but then I can't feel at all, and I am alone. I am exhausted. I want to feel again, connect with other people, and live again." • "I feel more solid. Bad things still come my way, but somehow I don't let things devastate me as I did before. I am starting to see that the bad things are not personal; they are part of being alive." • "My mother was a jerk to me when I was younger, but I realize that she thought she was protecting me from living a life that she did. In doing so, she killed my spirit and made me afraid of my own shadow. Somehow by pushing it this far, something in me snapped. I finally protected and took care of myself."

2) UNPRODUCTIVE (REPETITIVE) PROCESSING

This category captures the extent to which the person approaches a problem, explores, tries to understand, and make meaning of it, BUT gets stuck **repetitively** thinking about or analyzing a problem without significant insight. Unproductive processing can occur not only in a session or essay, but also across time; therefore it is important to consider the context.

Examples:

0 = N/A	No or little evidence of being stuck
1 = Low	Exploring and questioning a problem with **some** evidence of repetitive or intrusive thoughts or repetitive venting of emotion with little or no insight: • " I began to wonder why I had stayed so long in this unhealthy relationship. I think about him a lot, and I get mad at myself. I feel like I'm not getting anywhere."
2 = Medium	Exploring and questioning a problem area with **clear** evidence of repetitive thoughts and emotions with little or no insight. The repetition is not as frequent or as elaborated as at the high level: • "I realized that I am afraid to succeed. Why am I so afraid? What is wrong with me? Why can't I be normal? I'm so sick of myself."
3 = High	Strong evidence of repetitive thoughts and emotions. These can involve rumination, perseveration, obsessions, repetitive intrusive thoughts, and difficulty disengaging from emotions. There is usually evidence of vicious cycles and of being caught in a cognitive/emotional loop: • "I can't stop thinking about everything that I did to hurt him and how I have failed in relationships. I've failed at everything. I am haunted by a list of failures." • "I have to quit putting these sad records on. I hear the sad music and start the pity party. On and on it goes…"

3) PROTECTION/AVOIDANCE

This category captures attempts to protect or defend oneself by pulling away from rather than moving toward problems or issues. Pulling away can take many forms, such as social withdrawal, staying in bed, numbing, mentally avoiding certain topics, substance use for coping, distraction, difficulty concentrating and focusing, wandering off topic/topic change, using humor to avoid the topic, minimizing, blaming

others or external circumstances. Some other words associated with this category are "disengaged, disconnected, unplugged, sleepwalking through life, numbed or tranced out."

Externalization of problems, and in session behaviors: lots of shrugging, "I don't knows," not answering, or "I don't want to talk about that."

Examples:

HIGH PROTECTION/ AVOIDANCE

- "I can't believe she did this to me. It's all her fault. She keeps trying to pull me into this, but our relationship could have worked, if she weren't so difficult."(Person blames the other and spends all of the time focusing on her problems)
- After a difficult session or essay, the person reports, "I have been out of it this week. I'm in a fog and feel totally numb and shut down." (Person shuts down after an intense session)
- Above-mentioned behaviors/statements exhibited for at least two thirds of the session or for most of the period of time discussed in the session.

MEDIUM PROTECTION/ AVOIDANCE

- "He never helps me like he doesn't care. I know that I also have a part in it but I just didn't want to bring it up with him. (Blames others and focuses on others problems, but can elaborate some of own avoidance)
- Moderate amount of minimizing in session, discounting statements changing topics or discussing avoidance behaviors such as substance use or withdrawal behaviors for at least half of the session.

LOW PROTECTION/ AVOIDANCE

- "I was feeling kind of anxious, so I didn't feel like going out this week." (Person mentions some avoidance, but it is not elaborated enough to score medium or high).
- Some behaviors or topics mentioned above, but occur in less than one third of session.

Finally, when you have finished tallying your best guesses for frequencies and overall scores, make sure you put your name, session number, client ID number, and bring for team meetings to discuss/compare findings. Good luck and have fun!

VERBATIM TRANSCRIPT FOR CODING TRAINING
William Miller Therapy Session from APA Series III-Behavioral Health and Counseling

Therapist: Dr. William Richard Miller Session Number: 1
Client: Ms. S Date of Session: xx/xx/xxxx

Introduction: This session was included in a training video for APA, entitled, "Behavioral Health and Health Counseling: William Richard Miller, PhD, Drug and Alcohol Abuse," and was hosted by Jon Carlson, PsyD, EdD. The session that follows was transcribed verbatim, for the purposes of coder training for Pepperdine University as a part of the Positive Psychology PARC Lab supervised by Susan Hall, JD, PhD. This format will be followed for future transcribed sessions to be utilized in the actual research.

T = Therapist; C = Client

Verbatim Transcript of Session	
T1: Ok, Well now that were settled in just a little bit, um, I understand that what you wanted to talk about was alcohol and perhaps some other drugs and how that fits into some of the other things that you are dealing with in your life, so fill me in a little, what's happening?	
C1: Well, as far as the alcohol and drugs I've been in and out of recovery since 1995. I used to be basically a social drinker. I lived in Chicago 32 years and moved to California and that's when the heavy use started.	
T2: Uh-huh. [Head nodding]	
C2: A lot of that had to do with, I think, the change in lifestyle. Out there, especially where I lived, it was the Palm Springs area. A lot of people, a lot of partying, a lot of drugs. And I just kind of got into it because the people were in the environment where I was living, it—um, that's what everybody did. C2.1: I actually started cuz I was going to college, and I wanted, a girl who I was a neighbor suggested I try speed to keep me awake. She used it as a waitress and it helped her and I thought, well, and that's how I got started into that part of it. C2.2: I had been smoking marijuana for the longest time, since the eighties, but I had done nothing else. And then when I moved to California, I started drinking because I hung out with younger people, and we would drink, I don't mean just beers, we'd drink hard liquor.	
T3: Yeah, you get thrown along with the lifestyle	
C3: Exactly, and that was also a problem because I have an addictive personality and it's, I believe it's hereditary and it's part of other problems that I have. C3.1: It just manifested itself very quickly. I did in perhaps one year, what some people would do 3, 4,	

5 years. I just crammed it all together. I got started with the speed, and then I switched to cocaine. Now, people call it crack or rock, whatever you want to call it. Free, the freebasing. You buy the, buy it in the rock form or in the powdered form, and I spent, I spend $7000 in 3 months on that.	
T4: So you're very efficient about the drug use, packing it into a short period of time.	
C4: Well I packed it in, unfortunately, I don't know if it's good or it's bad, I went from buying it from people I didn't really, trying to get what I could from wherever, to climbing up the ladder to finding the main source, so to speak. C4.1: And I was one of those people, who I'm always proud to say, I never did any sex or anything for drugs or anything like that. Now, I didn't do any, anything… prostitution, or there was a lot of girls that would, a lot of women that would do that.	
T5: [Head nodding] So it was very common.	
C5: And, I was the kind of person, I got my nose broken because I wouldn't sleep with somebody's; this one fella wanted me to sleep with him when his girlfriend was at work and I wouldn't do it so he busted my nose. That's the kind of person I am. I don't believe in, that the two have to meet. My love was drugs. I didn't need a man, I didn't need relationships. If I had the money, if I didn't have the money, I had a way to get, you know, get it through people. I had, I didn't just party you know. I partied with uh--	
T6: Contacts.	
C6: Yeah, people who used to be in the show business industry, so to speak. You know, or who were related, A girl that was related to a guitarist in a famous rock star's band, and I'm not gonna name names, and she unfortunately—she died of AIDS but she had the money and she had, always, there was always partying going on with her. We'd go to the hotel and party, party, party.	
T7: And you got caught up in that very quickly.	
C7: Oh, very quickly, and it's easy to I guess, if you have the personality for it, you know. And I didn't have any, and I was at a point in my life where I didn't really care about anything. And I wasn't young either. I was 32.	
T8: So it sort of felt natural to you.	
C8: It felt fun, it felt, actually, it felt good, you know. I was trying to, as they say, chase that next high. It got fun, but when I started running out of the money and I don't know how I had the stamina for it because I actually still worked, paid rent, kept a job, I did everything, well, which a lot of people can do, but for the amount of drugs and drinking I did--	
T9: Pretty remarkable--	
C9: Some people would probably not even be able to get out of bed. I'm not bragging about it. C9.1: Now, ten years later, I feel like I'm physically,	

I'm just kind of burnt out, you know, C9.2: I stopped doing cocaine in '95, and then I admitted myself into rehab in California that same year, and I've done it still on occasion, but I'm on medication which, thank goodness, doesn't make it where the drug has addictive properties.	
T10: Really?	
C10: Ya, I found it very interesting. I could do cocaine and put it down and not go back to it.	
T11: Which was new?	
C11: Which is something new to me, I mean, this is as recent as moving back to Chicago. [Therapist's head nodding] You know, I haven't been able, I've struggled in and out of sobriety, you know, I feel like Robert Downey, Jr. sometimes. [Therapist laughs] C11.1: It's like okay, but I've not, I've never gotten arrested for drugs, or for selling, you know, one of those people who was too smart to keep it in the house and you know, I even though I never had money I had the common sense of well, you don't keep it in the house, don't drive around with it, you don't drink and drive, you don't drink and use. You know, why ask yourself for trouble? C11.2: One time I had drank and drove, and that was because I was at my boyfriend's, we were out, I had an argument, and we both went our separate ways. So, I ended up having to go home inebriated. And, um, fortunately nothing happened so I was pretty lucky. C11.3: And um, I've been in and out of recovery with AA and NA and, although I love the program and I espouse to do it, they say anonymity in AA, but I think that the condition in a situation like this, it's…well, it's part of talking about recovery and addiction. And, I've worked in and out of the program, I was clean, and sober for 3 years until I moved back to Chicago. Because I had gotten myself surrounded by people in recovery. Yet, when I moved back here, I was not surrounded by people in recovery and I discovered that I was staying clean and sober for the wrong reasons. I was doing it for other people, not for myself. I was doing it to help my mother, because my mother was dying of cancer, so I tried to, I wanted to…	
T12: So the change again of, of moving--	
C12: Right, they say geographics, you are running away from yourself. But I left California for many reasons. And uh.	
T13: And coming back here in a way set off--	
C13: It set off, right. It set off everything because I felt like I had the freedom. There was nobody there, I had no sponsor, no clean and sober neighbor, nobody checking up on me so to speak to make sure I was still, I was still smoking pot. I hadn't quit marijuana and, but the alcohol was the one that really got to me. I had been, I had quit marijuana for about a 7-8 months after I got out of recovery,	

but ended up getting back into that situation when I moved in, uh, out of sober living and I ended up eventually moving in keeping a roommate who was a friend of mine from my drinking and using days who was dying of AIDS. But he needed someone to take care of him. And I was going back to school at night plus working, so basically, my drug use was limited to marijuana and alcohol, sometimes doing coke or whatever. I never liked speed really because I saw people, the more they did that their teeth would rot out and, you know, it's Drain-o or rat poison, it comes in so many different colors. I've noticed it's not that big here in Illinois, in Chicago.	
T14: So when you say your in and out of recovery now, its alcohol and marijuana your talking about—and every now and then cocaine.	
C14: Right, ya, well the cocaine, basically I've stopped, ah, pretty much avoided that because the individual who introduced me to that again, I avoid seeing him at all costs…which I do for my own well being. I don't want to ride the dragon again. I don't want to go there, even though I know that if I do, I'm not going to be going there again every day. I won't be getting loaded every day because of the medication I take. But, and, he was paying for it, but I realized it was just something that I wasn't even enjoying.	
T15: So why do it?	
C15: Right, you know, to me, everybody, I believe has an addiction. We all have addictions be it food, sex, drugs, alcohol, gambling, family life, work. You know, whatever it may be, I think everybody has one, one thing at least that they crave and that in the back of their mind that they focus on and they really desire.	
T16: And you said you think you have an addictive personality--someone who easily gets drawn into things	
C16: Yeah, well right, I have been. I'm an artist, freelance artist as well, and my addiction used to just be drawing. As a child, I would just come home and draw, you know.	
T17: So whatever you do like that you do it intensely	
C17: Yeah, I wish I could do it to make money and do it, you know. [Therapist laughs] Get a money making idea and do like that, I'd probably be rich, it's just um, but not able to find a proper substitute, you know. At this time, I'm trying to get back into drawing and being more creative, and my personal life, though I feel so mentally, emotionally, and physically exhausted after all I've been through in my life, that all I want to do is almost not do anything. I'm trying not to focus on any addictions. I'm at the point where I'm getting tired. You almost get tired of it physically. Like, if I drink I feel, I don't get the hangovers cuz I won't even allow myself to drink enough, but physically the next day, I feel, I	

ache, you know I feel the hangover with the headache would manifest itself with my body aches, and I don't want to, want to get up on the…you feel as vital and I've just done so much that I'm burning out.	
T18: And you've used up your chances, huh?	
C18: Yeah, pretty much. And being single all my, which, since 1990 and not having…being blessed without having children, which I never wanted, thank God, I'm not a kid lover. I chose not to have kids also because of my husband and that was one of the reasons we also parted ways. I was happy. I'm lucky enough to where I've had my own life and I've not had to drag anybody, drag anybody down with me, you know. It did affect family members. Anytime you're, you have an addiction, people who care about you, it will, but eventually they turn you away too.	
T19: Now what is recovery for you besides not using alcohol or marijuana?	
C19: To me recovery would be going to meetings, having a sponsor, working a twelve step program, um, I still try to incorporate 12 step beliefs and behaviors in my life as far as, "Let go, Let God," the use the steps, resentment, a lot of people say if you're drinking and using you cannot work the steps, but I think you can use them in a behavior, method of behavior modification if you're, instead of turning to getting loaded or anger or what have you, when you have a problem in life, try to do something positive, call somebody, read if you have an AA Big Book or an NA Big Book, pick something up in there and try to read it. Try to keep yourself as close to the, that behavior as you can because it helps you to get…the closer I try to stay to meetings, even if I'm drinking, if I go to meetings it helps me from not wandering too far off track to where I'll say drink more, or just stop totally leaving in that whole lifestyle or that whole belief process.	
T20: There's a piece here which were missing before we go, which is what are you wanting to move toward? What do you--	
C20: What I want to move toward is to just be able to totally not have to drink or use. And at this point--	
T21: Which is doing nothing.	
C21: Right. Well, at this point I still enjoy my pot. I'll be the old person sitting out there smoking a joint on the steps with all my cats around me, you know, and that's okay with me, but I don't want to drink. That's what I'm trying to avoid, and I'll be, I'll go a couple weeks without drinking and then maybe I'll drink again. But it's getting to where I want it less and less again.	

APPENDIX E
Change and Growth Experiences Scale Coding Worksheet

Record intensity next to each specific statement (L, M. or H; and P or N)
Example: C2.1: "Client paraphrased statement"- L P Hope would be low positive hope for client statement 2.1 from transcript

INTENSITY: 0 = NONE (0-1 ratings for session)
1=LOW (2 + ratings for session: rarely, a bit, minimal, infrequently, now and then)
2 = MEDIUM (sometimes, kind of, variable, reflecting ambivalence)
3 = HIGH (almost always, very much, all of the time, really, incredibly)

	Examples from each session (notes and line number from transcript)	***Frequency of occurrence***	***Intensity = None (0), Low (1), Med (2), High (3) Total session score = overall code***
	Sense of Hope		**Overall Code:**
Positive "I can do it"		Low: Medium: High:	Feeling of movement, expectancy and possibility that one can make improvements in one's life in recent past (within 1 month or less), present, or future. Perception of one's capacity to initiate and sustain movement towards very recent, present or future goals. Commitment, motivation, belief in ability, determination to change.
Negative			**Overall Code:**
		Low: Medium: High:	Feeling of being stuck, trapped, having no way out, sinking, hopeless. Feeling tired of trying or lack of commitment.
Pathways "Here is how I can do it"	**Snyder's Additional Hope Code**		**Overall Code:**
		Low: Medium: High:	Cognitive processes involving brainstorming, specific ways to achieve or move toward goals, looking for, finding, exploring ways to move forward. Specific behaviors or steps in the right direction, identifying or planning actions to meet goals
	Relationship Quality (Perceptions Expressed)		**Overall Code:**
Positive		Low: Medium:	Perceived quality of interactions with others that week or in general. Encounters that involve enjoyment or satisfaction,

		High:	such as feeling part of a group, cared for, loved, connected, stimulated
Negative		Low: Medium: High:	Encounters that involve distress or dissatisfaction, such as feeling slighted, ignored, alienated, humiliated, controlled, manipulated, betrayed, or engaging in conflict. Feelings of alienation, isolation, and loneliness can also be activated in the absence of encounters
	Cognitive Emotional Processing		**Overall Code:**
		Low: Medium: High:	Engaged, exploring, or confronting problem areas, making new meaning out of experiences, integrating past experiences with current functioning in a new way. Reframing, benefit-finding, acceptance, resolutions- present "Ah-hah" moments of new insight. It can begin as thinking about and questioning a problem area or exposing oneself to new information.
	Unproductive (Repetitive) Processing		**Overall Code:**
			Explores problems, tries to understand, make meaning, but keeps getting stuck. Repetitive thinking about problem without insight, perseveration, obsessions, rumination, repetitive emotions surrounding problem. Analyzing a problem without significant insight.
	Protection/Avoidance		**Overall Code:**
		Low: Medium: High:	Moving away from problems, protecting, defending oneself through avoiding topics, numbing, substance use for coping, using humor to avoid topics. Minimizing or blaming others or external circumstances, disconnected, in a trance, disengaged. Distraction, difficulty concentrating and focusing, wandering off topic, changing topic, silence, "I don't know" statements… Pulling away can also take many forms, such as social withdrawal, staying in bed, and numbing.