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AN ANALYSIS OF CLIENT LIFE EXPERIENCES AND RELATIONSHIPS
WITH COUNSELING OUTCOME

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By

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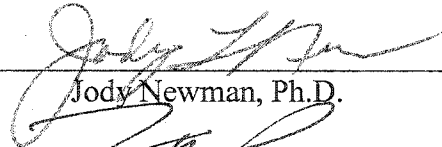
AN ANALYSIS OF CLIENT LIFE EXPERIENCES AND RELATIONSHIPS
WITH COUNSELING OUTCOME

A Dissertation APPROVED FOR THE
DEPARTMENT OF EDUCATIONAL PSYCHOLOGY

BY



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ABSTRACT

In research conducted with ninety clinical outpatient clients, significant variance in counseling outcome as assessed by clients and counselors was attributed to life experience (20% to 30%), religious constructs (9.8 % to 13.2 %) including spiritual well-being and religious orientation, and social support (4.1%). The life experiences construct included normative weightings scaled by the client's perspective and measured over time. This conceptualization of life experience allows monitoring related targets of therapeutic intervention, changing life circumstances, and the client's perception of these that may be related to counseling outcome. This study provides empirical support and offers suggestions recognizing the salience of religion and spirituality in the lives of many clients.

An Analysis of Client Life Experiences and Relationships With Counseling Outcome

Introduction

Research suggests there are relationships between psychological health and (1) life experiences (Chiriboga & Catron, 1991, Miller & Rahe, 1997), (2) social support (Komproe, et al., 1997; Thevos, Thomas, & Randall, 2001), (3) religious orientation (Gartner, 1996; Richards & Bergin, 1997), and (4) spiritual well-being (Lazarus, 2000; Pargament, 1997). Most research that addresses life experiences has not considered the person's perception of life events (Miller & Rahe, 1997; Sarason, Johnson, & Siegel, 1978), treats events as a single circumstance rather than considering the constellation of factors surrounding the life event (Parkes & Weiss, 1983), and has not considered how life events and one's perception of them change over time (Lambert, 1992). Survey research has consistently shown the importance of religion in the lives of Americans. Gallup polls of 1997 indicated that 95% of the American public believes in God or a "higher power" which is consistent with beliefs expressed over the past 50 years where the percentage of Americans who believe in God has never dropped below 90% (Gallup & Lindsay, 1999). Gallup polls of 1998 indicated that 65% of the people in the nation believe religion can answer all or most of today's problems with 20% indicating that religion is largely old-fashioned and out-of date (Gallup & Lindsay, 1999). Although previous ethical codes addressed religion in the context of non-discrimination among

employees and by employers, it did not address religion in the context of competence until the revision of 1992 (APA Ethics Code, 1981; APA Ethics Code, 1992).

Historically, spirituality and religion have been viewed both negatively and positively by many prominent in psychology (Genia, 1994; Meyer, 1988; Warmock, 1989); likewise, some religious leaders have viewed psychology positively while others have viewed it negatively (Meyer, 1988). Recently, there has been an increasing interest in performing empirical research related to religious and spiritual constructs (Francis & Kaldor, 2002; Pargament, 1997; Siegel & Schrimshaw, 2002).

Most of the research has evaluated these constructs at one point in time and individually in relationship with psychological health rather than monitoring the interrelationships among these constructs over time as they may be related to counseling outcome. The primary focus of this study is to provide empirical data to clarify the relationships among the changing dynamics of life experiences and religious/spiritual constructs in relationship to counseling outcome. Using a clinical population in an outpatient setting, these constructs were measured along with social support and the counseling relationship which have been shown to be related to counseling outcome (Baumeister, Faber, & Wallace, 1999; Hatcher & Barends, 1996). Results of this study provide empirical support that might suggest the importance of recognizing a person's religious/spiritual experience in relationship to their attention to psychological issues addressed in counseling.

Operational Definition of Terms

Life Experiences

Life experiences are circumstances or events experienced by an individual which require adaptation or social readjustment (Holmes & Rahe, 1967). The measurement of life experiences recognizes (1) the magnitude of adjustment associated with life experiences varies according to the significance of the stressor (Holmes & Rahe, 1967; Miller & Rahe, 1997), (2) the necessary adjustment or perception of life stressors may vary by each individual's perception (Mueller, Edwards, & Yarvis, 1977; Sarason, Johnson, & Siegel, 1978), and (3) life experiences and one's perception of them may change over time (Lambert, 1992; Orlinsky, Grawe, & Parks, 1994).

Social Support

House (1981) proposed that social support is "an interpersonal transaction involving one or more of the following: (1) emotional concern (liking, love, empathy), (2) instrumental aid (goods and services), (3) information (about the environment), or (4) appraisal (information relevant to self-evaluation)" (p. 30). If networks provide support, information, and feedback (Caplan, 1974), then perceived social support can be defined as the extent to which an individual believes that his/her needs for support, information, and feedback are fulfilled (Procidano & Heller, 1983).

Spirituality

Spirituality is “the feelings, thoughts, experiences, and behaviors that arise from a search for the sacred. The term “search” refers to attempts to identify, to articulate, to maintain, or to transform. The term “sacred” refers to a divine being, divine object, Ultimate Reality, or Ultimate Truth as perceived by the individual” (p. 66; Hill, Pargament, Sawyers, Gorsuch, McCullough, Hood, & Baumeister, 1998).

Religion

“Religion is a search for non-sacred goals (such as identity, belongingness, meaning, health, or wellness) in a context that has as its primary goal the facilitation of spirituality as previously defined. Furthermore, *it is* [italics added] the means and methods (e.g., rituals or prescribed behaviors) of the search that receive validation and support from within an identifiable group of people.” (p. 66; Hill, Pargament, Sawyers, Gorsuch, McCullough, Hood, & Baumeister, 1998).

Extrinsic Religiosity

In describing extrinsic religiosity, Allport and Ross (1967) stated, “The embraced creed is lightly held or else selectively shaped to fit more primary needs. *An extrinsic person* turns to God, but without turning away from self” (p. 434, italics added). Extrinsic religiosity is the dimension of religion in which the individual uses religion for self-serving purposes such as for comfort from sorrows or misfortunes, for socializing, and for establishment in the community. Persons whose religion is

characterized as extrinsic are more inclined to compromise beliefs to protect their social and economic well-being.

Intrinsic Religiosity

The intrinsically religious individual's "other needs ... are regarded as of less ultimate significance, and they are ... brought into harmony with the religious beliefs and prescriptions" (Allport & Ross, 1967, p. 434). Intrinsic religiosity is the dimension of religion which provides a sense of meaning in life. The person is motivated by their intrinsic religiosity and desires to spend time in religious thought and meditation to feel the presence of God or the divine being, to want to learn about their religion, and to participate in prayer or meditation and religious affiliations. An intrinsically religious person finds his/her master motive in religion.

Spiritual Well-Being

Spiritual well-being is the affirmation of life in a relationship with God, self, community, and environment that nurtures and celebrates wholeness (National Interfaith Coalition on Aging, 1975). Moberg and Brusek (1978) suggested that spiritual well-being is best conceived as having two dimensions. The vertical dimension connotes one's sense of well-being in relationship to the divine (i.e., religious). The horizontal dimension connotes one's perception of life's purpose and satisfaction (i.e., existential) without conferring any specifically religious reference.

Review of the Literature

This study will build on the literature associated with life experiences, social support, religious and spiritual relationships, and the counseling relationship with counseling outcome.

Life Experiences

There is a correlation between life experiences such as illnesses (Miller & Rahe, 1997; Rahe, Meyer, Smith, Kjaer, Holmes, 1964), divorce (Chiriboga & Catron, 1991), stressful events (Dunkel-Schetter & Bennett, 1990; Siegel & Schrimshaw, 2002), and psychological well-being.

Three dimensions supported by the literature can be considered in the conceptualization of life experiences. First, the magnitude of adjustment associated with life experiences varies according to the significance of the stressor (Holmes & Rahe, 1967; Miller & Rahe, 1997). For example, more stress would generally be associated with the death of a child as compared to a voluntary move within the same city. Second, the necessary adjustment or perception of life stressors may vary by each individual's perception (Mueller, Edwards, & Yarvis, 1977; Sarason, Johnson, & Siegel, 1978). For example, one individual may view a job promotion as a positive experience that provides opportunities and relief from financial stressors while another individual may view the promotion as very stressful because it creates other concerns in their life such as less time for their family. Third, life experiences and one's perception of them may change over time while in therapy (Lambert, 1992; Orlinsky, Grawe, &

Parks, 1994). For example, a client may be experiencing stress due to the loss of a job but will likely feel some relief if another job is found during the course of therapy. Also, a person may be feeling alienated or in conflict with other family members but during the course of therapy may learn to more constructively interact with family members which could facilitate improved relationships.

Rahe has conducted several classic studies to consider the effects on health associated with the clustering of stress events. Holmes and Rahe (1967) brought greater precision to life stress and illness studies by scaling 43 representative life change events to arrive at estimates of their social readjustment or stress magnitudes as perceived by the participants. Recent research has rescaled and increased the original 43 items to 74 items according to the Recent Life Changes Questionnaire (RLCQ) that address events associated with an individual's work, educational situation, family and romantic relationships, personal and social, and financial aspects of life experiences (Miller and Rahe, 1997).

Typically, there are several concurrent life experiences that affect psychological well-being in adjusting to a life stressor (Parkes & Weiss, 1983). For example, in a London study of depression, events were rated as more or less stressful on the basis of "the configuration of factors surrounding a life event" (Parkes & Weiss, 1983). Two women may learn that their husbands are terminally ill. One may be socially isolated except for the contact with her husband, may have no assurance of remaining in her home once he dies, and may have had no warning of his illness; whereas for the second

woman, the concurrent stressors may be absent. The threat of the illness would likely be much greater for the first woman.

New measures were constructed in an effort to increase life-events measures' predictive validity. For instance, the prevailing approach of life-events measurement itself shifted, from gauging life-change impact via previously established normative weightings, which assumed a given event's impact to be constant across persons and which did not differentiate between desirable and undesirable events (Holmes & Rahe, 1967; Miller & Rahe, 1997; Rahe, 1975), to measuring each event's impact by self-reported, subjective weightings, thereby incorporating each individual's appraisal of the event's intensity and desirability (Sarason, Johnson, & Siegel, 1978).

Social Support

Investigators of perceived social support have been guided by Cobb's (1976) early description of social support as information that leads a person to believe that he or she "is cared for and loved ... esteemed and valued ... and belongs to a network of communication and mutual obligations" (p. 300). Support perception is generally viewed as synonymous with support appraisal (Barrera, 1986; Cohen & Wills, 1985). Sarason, Pierce, and Sarason (1990) added conceptual enrichment by defining perceived support as a sense of acceptance. Perceived support most consistently contributes to well-being and distress and buffers, or moderates, the impact of life stress (Cohen & Wills, 1985; Procidano, 1992a).

Several researchers have reported a relationship between social support and physical and psychological well-being (Cohen & Wills, 1985; Komproe, et al., 1997; Thevos, Thomas, & Randall, 2001). Individuals who have a strong social support system can recover from stress and trauma better than people who do not (Baumeister, Faber, & Wallace, 1999; Berkman & Syme, 1979). Social support has been shown to aid people in adjusting to stressful life events (Berkman & Syme, 1979).

Social support sometimes mediates stressful relationships determined in studies of chronically stressed groups such as families in poverty, persons with chronic illness, or their caregivers (Gersten, 1992; Procidano, 1992b). There has been evidence for social support's direct positive relationship to well-being and inverse relationship to symptomatology/distress (Cohen & Wills, 1985; Procidano, 1992a; Procidano & Smith, 1997).

Women report higher perceived support, have more effective support-seeking skills, are more likely to seek support openly, and tend to establish more functional support networks (Olson & Schultz, 1994). Bansal, Monnier, Hobfoll, and Stone's (2000) research suggests that emotions are more closely linked with perceptions of social support and workplace resources for women than for men. Conversely, negative emotions have been reported to disrupt social interactions (Patterson & Forgatch, 1990). Second, people's emotional distress can burden their support providers, resulting in potential loss of both support and the other resources that supporters might contribute (Kaniasty & Norris, 1993).

Religion and Spirituality

Survey research has consistently shown the importance of religion in the lives of Americans. In Gallup Polls during 1998, 87% of the nation ranked religion as very important (60%) or fairly important (27%), mirroring similar public opinion polls conducted for the past three decades (Gallup & Lindsay, 1999). A review of the demographics of religiosity consistently portrays America throughout its history and into the present as a nation of religious believers. Religiosity appears to be a distinctive feature that requires consideration in all aspects of applied psychology, including the psychology of coping and psychological treatment (Kosmin and Lachman, 1993).

Historically, spirituality and religion have often been viewed dichotomously by those prominent in psychology. While William James, Viktor Frankl, and Carl Jung have seen the value in spirituality, other prominent psychologists have viewed spirituality as irrational and destructive (Meyer, 1988; Warnock, 1989). In a survey, Genia (1994) noted that “compared with the public at large, secular psychotherapists are less likely to affiliate or participate in organized religion and are more likely to express their spiritual interests in nontraditional ways” (p. 395).

The antagonism is not one-sided; many religions reject psychology and the human sciences just as avidly. Many within the religious community believe that religion is the domain of chaplains, pastors, priests, rabbis, shamans, and so on, not psychologists (Meyer, 1988).

In psychological well-being and recovery from illness, illness prevention and health enhancement, suicide prevention, substance abuse prevention, preventing heart disease and high blood pressure, and negotiating with pain, the clinical evidence for the impact of religious beliefs is increasingly strong (Francis & Kaldor, 2002; Larson & Milano, 1995; Pargament, 1997; Siegel & Schrimshaw, 2002).

Religious Orientation

Allport and Ross (1967) were the first to characterize a person's religious characteristics into two categories, intrinsic and extrinsic religiosity. During the past two decades, numerous studies have shown that people who are religiously devout or intrinsic in their religious orientation tend to enjoy better physical and mental health (Gartner, 1996; Richards & Bergin, 1997). In a study conducted by Park, Meyers, and Czar (1998), they reported that individuals who were more self-realized possessed greater spiritual well-being and tended to have more intrinsic, committed, and consensual religious orientations as well as stronger religious commitment and more frequent spiritual experiences.

Nelson (1990) concluded in a study of 68 community-based elderly persons that subjects with high self-esteem had more intrinsic religious orientation and were less depressed. On the other hand, a study performed by Commerford and Reznikoff (1996) of 83 nursing home residents indicated that intrinsic religiosity and the subjects perceived social support from friends were not significantly related to depression or self-esteem.

Death concern or anxiety has been found to be negatively related to an intrinsic religious orientation (Kahoe & Dunn, 1976; Maltby & Day, 2000; Thorson, 2000).

Baker and Gorsuch (1982) found that persons who had an intrinsic religious orientation were less anxious than persons who were not intrinsic, and extrinsic persons were more anxious than persons who were not extrinsic on some components of trait anxiety.

Spiritual Well-being

Spiritual well-being is the affirmation of life in a relationship with God, self, community, and environment that nurtures and celebrates wholeness (National Interfaith Coalition on Aging, 1975). Moberg (1978) believes that spirituality is not synonymous with religion and refers to the overall “wellness” of the “inner resources” of people. Moberg and Brusek (1978) suggested in their pioneering work that spiritual well-being is best conceived as having two dimensions. A vertical dimension refers to one’s sense of well-being in relationship to God. A horizontal dimension connotes one’s perception of life’s purpose and satisfaction apart from any specifically religious reference.

Ellison (1983) suggested that the spiritual dimension is not isolated from the psyche and it affects and is affected by our physical state, feelings, thoughts, and relationships. “It is the spirit of human beings, which enables and motivates us to search for meaning and purpose in life, to seek the supernatural or some meaning that transcends us, to wonder about our origins and our identities, to require morality and equity.” (Ellison, 1983, p. 331). Ellison (1983) believed that the spirit synthesizes the

total personality and provides some sense of energizing direction and order in a person's life.

Graham et. al. (2001) performed a study with a sample of 115 graduate students in counseling to investigate the relationship among religion, spirituality, and the ability to cope with stress. In their study, religion and spirituality positively correlated with coping with stress. Counseling students who expressed spirituality through religious beliefs had greater spiritual health and immunity to stressful situations than counseling students who identified themselves as spiritual but not religious. Counseling students with a religious/spiritual affiliation indicated more discomfort counseling clients hostile to religion compared with counseling students with a spiritual-only affiliation.

Pargament (1997) reviewed over 30 studies where religious/spiritual coping was commonly used. Pargament's research team identified varieties of religious/spiritual coping and specific conditions associated with good and poor outcomes, and developed a theoretical framework for the search for significance. There is no simple answer regarding whether or not religion is effective in coping with life events or stress. Pargament (1997) determined that it depends on the kind of religion, who is doing the religious coping, and the situation with which the person is coping. Depending on the interaction among variables, religion can be helpful, harmful, or irrelevant to the coping process (Pargament, 1997). Pargament (1997) concluded that (1) religious coping seems especially helpful to more religious people, (2) religion can moderate or deter the effects of life stress, or both, and (3) religious coping adds a unique dimension to the coping process.

Counseling Relationship and Counseling Outcome

There is also a growing body of research linking positive counseling outcome to therapist empathy (Bohart & Greenberg, 1997; Hill & Nakayama, 2000), therapist facilitative skills such as acceptance, warmth, empathy, and genuineness (Greenberg, Elliott, and Lietaer, 1994; Lambert and Bergin, 1994), and the ability to form a meaningful, collaborative working relationship between client and the counselor (Hatcher & Barends, 1996).

The Patterson (1984) review of studies had shown that client perceived relationship factors, rather than objective raters' perceptions of the relationship, more consistently represented positive results. Furthermore, the larger correlations with outcome are often between client process ratings and clients' self-report of outcome.

In their exhaustive review of over 2,000 process-outcome studies since 1950, Orlinsky, Grawe, and Parks (1994) identified therapist variables that have consistently been shown to have a positive impact on treatment outcome: therapist credibility, skill, collaborativeness, empathic understanding, and affirmation of the client, along with the ability to engage with the client, invest in the treatment process, facilitate a strong therapeutic bond, focus on the patient's problems, and direct attention to the client's affective experience.

Summarizing fifteen years of research, Horvath (2000) concluded that the quality of the alliance is a robust predictor of therapy outcome. They contended that the relationship between the alliance and eventual therapeutic outcome is apparent as early

as the third session in therapy, and the correlation between alliance and the results of treatment seem to hold reasonably constant across various treatments, clinical diagnoses, and client populations (Horvath, 2000). Horvath (2000) later found that it was not the objectively measured level of therapist's behavior that had the most powerful impact on the therapy outcome; rather, it was the client's perception of these qualities that foretold the success of counseling (Horvath, 2000).

There is a general consensus that outcome assessment needs to be multifaceted, involving different perspectives such as those from clients and counselors (Bergin & Garfield, 1994). Research suggests that five sessions are sufficient for significant measurable change (Howard, Kopta, Krause, & Orlinsky, 1986).

Research Questions

The proposed study will address the following questions:

1. Will independent variables (life experiences, social support, religious orientation, spiritual well-being, and the client-counselor relationship) be related to client counseling outcome as reported by the client?
2. Will independent variables (life experiences, social support, religious orientation, spiritual well-being, and the client-counselor relationship) be related to client counseling outcome as reported by the counselor (using items consistent with those rated by the client)?

3. Will independent variables (life experiences, social support, religious orientation, spiritual well-being, and the client-counselor relationship) be related to client counseling outcome (according to counselor's GAF scores)?
4. Will there be a statistically significant difference between the client's rating of counseling outcome (as determined in research question 1) and the counselor's rating of counseling outcome (as determined in research question 2)?

Method

Participants

Participants included adult clients who presented for individual counseling at the University of Oklahoma Counseling Psychology Clinic. Ninety clients, 60% female and 40% male, participated in the study. Overall, the number of counseling sessions attended ranged from 1 to 59 ($M = 10.98$, $SD = 10.16$, $Median = 7.5$). Seventy clients attended at least 5 counseling sessions, and 41 of these clients attended at least 10 sessions, while 20 of the 90 participants attended fewer than 5 sessions. Clients were 83.3 % Caucasian, 5.6% Native American, and 3.3% represented all other ethnicities. All ethnic minorities attended at least 5 counseling sessions with the exception of one Native American client who attended 2 sessions. Clients who were Protestants represented the largest group at 54.4%, Catholics 6.7%, other 7.8%, Jehovah's Witness 2.2%, Agnostic/Atheist 3.3%, those stating "none" represented 10%, and 15.6% did not specify a religious preference. Most participants were single at 52.2%, married 35.6%, divorced 8.9%, and 3.3% did not specify their partner status.

General demographic information includes age ranging from 18 to 54 years-old ($M = 28.81$, $SD = 9.59$), number of years of education ranging from 5 to 18 where 12 years represents a high school education ($M = 13.52$, $SD = 2.15$), number of children ranging from 0 to 4 ($M = .83$, $SD = 1.22$), and income ranging from 1,100 to 60,000 dollars ($M = 18,998$, $SD = 14,039$). The importance of religion as rated by the clients ranged from 1 (Unimportant) to 7 (Important) with a mean of 4.75 and standard deviation of 2.09.

Measures

Demographic Information. Demographic information was acquired from the application for services form routinely completed by clients at the counseling clinic. Demographic information included ethnicity, sex, age, education, religious preference, and family income. Included on the application is a question for the client to rate the importance of his or her religion or spiritual belief. This rating is based on a 7-point Likert scale ranging from 1, unimportant to 7, important.

Life Experiences. Three dimensions supported by the literature are incorporated in the measurement of life experiences. First, the magnitude of adjustment associated with life experiences varies according to the significance of the stressor (Holmes & Rahe, 1967; Miller & Rahe, 1997). Second, the necessary adjustment or perception of life stressors may vary by each individual's perception (Mueller, Edwards, & Yarvis, 1977; Sarason, Johnson, & Siegel, 1978). Third, life experiences and one's perception

of them may change over time while in therapy (Lambert, 1992; Orlinsky, Grawe, & Parks, 1994).

First, specific life experiences information was collected from the application for services, routinely completed by clients at the counseling clinic; therefore, a separate instrument was not administered to participants to identify life stressors. Using life experiences reported by the client on the application form, a total score for Life Change Units (LCU) was calculated consistent with the method used by the Recent Life Changes Questionnaire (RLCQ) developed by Miller and Rahe (1997). Test-retest coefficients ranged from .87 to .90 with a one week interval between testing (Miller & Rahe, 1997) and .70 with a six month interval between test and retest. Higher scores indicate greater stress.

Second, consistent with the dimensions forming the LCU measurement, each individual client's rating of satisfaction with (1) work or employment, (2) educational situation, (3) family relationships, (4) romantic, marital or intimate relationships, (5) social and recreational, and (6) physical health were measured by items 1 through 6, respectively on the Adult's Counseling Form (ACF). The average of items 1 through 6 represents the client's rating of stress or satisfaction (Ross, 2004). Higher values represent greater stress or greater dissatisfaction.

Third, client's adjustment to stressors or life circumstances are measured after counseling sessions 1, 5, and optionally for session 10 using the Adult's Counseling Form. Thus, these repeated measures with their associated life experiences scores (e.g., Life Experience for session 1 is designated Life Experience 1) indicate changes over

time during therapy. This provides information regarding the extent to which changing events or client's perceptions of stressors have occurred during therapy. These changes may be a consequence of therapy or client extratherapeutic changes (Lambert, 1992).

Life Experiences are calculated for each client by multiplying the LCU score (calculated using the RLCQ scoring method) by the client's rating of stress (average of items 1 – 6 of the ACF; Ross, 2004). Using the repeated measures of client's rating of stress, a separate life experience score is determined for session 1, 5, and 10. Higher values of life experiences represent greater stress. To determine how life experiences change over time during therapy, difference scores are calculated. Specifically, the life experience score used in the study (Life Experience) is the life experience score calculated for session 5 subtracted from the life experience score calculated at session 1. Positive scores indicate that the stress has decreased over time while negative scores indicate that stress has increased over time. The magnitudes of the scores indicate the extent of the change whether positive (stress reduced) or negative (stress increased). Life Experience Cronbach alpha for the current sample was .82.

Perceived Social Support Family and Friends. Social support for this study will be measured by the Perceived Social Support – Family (Family Support) a 20 item instrument and Perceived Social Support – Friends (Friend Support) which is also a 20 item instrument (Procidano & Heller, 1983). Subjects are asked to respond to each statement by choosing one response from three possible responses: “Yes,” “No,” or “Don't know.” Higher scores indicate a greater level of perceived social support from either family (Family Support) or friends (Friends Support).

Four samples of subjects (college students, adolescents, adolescents with alcoholic fathers, and high school girls) were used to assess test-retest reliabilities and internal consistency of Family Support and Friend Support. Test-retest reliabilities over a one-month period ranged from .80 to .86 for Family Support and from .75 to .81 for Friend Support (Procidano, 1992). Internal consistency reliabilities ranged from .88 to .91 for Family Support and from .84 to .90 for Friend Support. Cronbach's alpha for this current study was .93 for family support and .92 for friend support. Good evidence of construct validity was demonstrated in research comparing perceived social support measures (Procidano, 1992) to the Family Environment Scale (FES; Moos, 1974), the Social Network Questionnaire (Liem & Liem, 1977), and Social Support Questionnaire (Sarason et al., 1987).

Religious/Spiritual Orientation – Revised. This 14 item instrument provides an extrinsic score (Extrinsic) and an intrinsic score (Intrinsic) for religious orientation (Allport & Ross, 1967). Items are presented on a 5-point Likert scale ranging from "Strongly Agree" to "Strongly Disagree." Higher scores on the extrinsic scale (Extrinsic) indicate a higher level of extrinsic orientation. Higher scores on the intrinsic scale (Intrinsic) indicate a higher level of intrinsic orientation.

The revised 14 item scale was derived by performing a factor analysis of the 20 item Age Universal I-E Scale (Gorsuch & McPherson, 1989; Gorsuch & Venable, 1983). Internal consistency coefficients of .82 for the intrinsic scale and .65 for the extrinsic scale have been reported. Cronbach's alpha for the current study were .80 for Intrinsic and .78 for Extrinsic.

Spiritual Well-Being Scale (SWBS) – Belief Survey. The 20 item Spiritual Well-Being Scale (SWBS) was developed as a general indicator of subjective state of well-being. It provides an overall measure of the perceived spiritual quality of life as conceived in two dimensions: a religious dimension and an existential dimension (Moberg & Brusek, 1978; Paloutzian & Ellison, 1982). In order to distinguish religious and existential items, all 10 of the Religious Well-Being items contain a reference to God. The 10 Existential Well-Being items contain no such reference. The 20 items of the SWBS yields three scores: (1) a total score (Spiritual WB); (2) a summed score for religious well-being (Religious WB) items; and (3) a summed score for existential well-being (Existential WB) items.

For this study, the Spiritual Well-Being Scale (SWBS; Paloutzian & Ellison, 1982) is used as originally developed by the authors, except the name was changed to Belief Survey so the client would not perceive the projection of the value for spirituality. Consistent with the authors' suggestion to make the instrument more universally acceptable, instructions have been added to the instrument indicating that "Higher Power" or some other appropriate term may be substituted for the word "God" when completing the instrument (Paloutzian & Ellison, 1982).

The instrument has a six-point response format ranging from strongly agree to strongly disagree. Nine of the 20 items are negatively worded to avoid the possibility of a patterned response set. After accounting for negatively worded items, higher scores reflect a higher level of well-being for total spiritual well-being (Spiritual WB), the

existential well-being subscale (Existential WB), and the religious well-being subscale (Religious WB).

In four studies with 1 to 10 week intervals between testing, the religious well-being (Religious WB) test-retest reliability coefficients were .96, .99, .96, and .88 (Bufford, Paloutzian, & Ellison, 1991). For the existential well-being (Existential WB), the coefficients were .86, .98, .98, and .73. For the total spiritual well-being (Spiritual WB), the coefficients were .93, .99, .99, and .82 (Bufford, Paloutzian, & Ellison, 1991). Across seven samples, the internal consistency coefficients ranged from .94 to .82 (Religious WB), .86 to .78 (Existential WB), and .94 to .89 (Spiritual WB; Bufford, Paloutzian, & Ellison, 1991). Cronbach's alpha for the current study was .91 for spiritual well-being total (Spiritual WB), .85 for existential well-being (Existential WB), and .96 for religious well-being (Religious WB).

The SWBS has good face validity as is evident by the content of the items, and research has revealed that the items cluster as expected onto the subscales (Bufford, Paloutzian, & Ellison, 1991). Validity studies of the Spiritual Well-Being Scale have revealed positive correlations with a number of psychological variables, supporting the conceptualization of the scale as an integrative measure of health and well-being (Ellison, 1983; Miller, 1990; Paloutzian & Ellison, 1982). The SWBS and subscales are negatively correlated with ill health, emotional maladjustment, and lack of purpose in life (Bufford, Paloutzian, & Ellison, 1991).

Adult's Counseling Form (ACF) Overview. This 25 item questionnaire was developed by Terry M. Pace, Ph.D. (2000) and is a revision of the Client's Evaluation

of Counseling Form. It is used to determine the client's assessment of the counseling relationship, of emotional health, of quality of life roles, of motivation and belief about counseling, and of results and satisfaction with counseling. One of the 25 items asks the client to write the most important problem he or she is working on or wanting to work on in counseling. One item is reversed scored relative to the others and asks the client to rate how distressing this most important problem is according to a 7 point Likert scale ranging from 1, "very distressing" to 7, "not at all," where the least favorable response is 1 and the most favorable response is 7. The remaining 23 items use a 7 point Likert scale ranging from 1 most favorable to 7 least favorable response for the dimensions being assessed.

Face validity of the instrument appears to be good after reviewing the instrument items and constructs used for assessing counseling outcome (Bergin & Garfield, 1994; Lambert & Bergin, 1994; Pace, 2002). Preliminary results of a validity and reliability study for the ACF confirm good reliability for a 3 factor model (Frey, Beesley, Ross, Conger, Liang, Abanishe, & Miller, 2004). The overall Cronbach alpha is .88 for the instrument administered after the fifth counseling session ($N = 160$). The Cronbach alpha for factor 1 is .87, factor 2 is .89, and factor 3 is .75 ($N = 160$). Constructs used in this study are consistent with the conceptualization of outcome assessment and factor loadings confirmed in previous research using the Adult's Counseling Form (Frey, Beesley, Ross, Conger, Liang, Abanishe, & Miler, 2004; Pace, 2002; Ross, 2004).

Counseling relationship. The counseling relationship as rated by the client is addressed by ACF items 19 – 25. The counseling relationship (Counseling Rel) is the average of ACF items 19 – 25 completed by the client at session 5. A lower score indicates that the client's rating of the counseling relationship is good with a higher score indicating a less satisfactory relationship. Cronbach alpha of counseling relationship for this study is .95.

Emotional Health and Counseling Outcome. The client's rating of emotional health (Emotional Health) is the average of ACF items 9 – 11 and is used in determining counseling outcome as rated by the client (Client Outcome; Ross, 2004). This rating is calculated each time the client completes the ACF form at sessions 1, 5, and 10. Lower scores indicate better emotional health while higher scores indicate worse emotional health. The client's rating of counseling outcome is calculated by determining the difference between emotional health scores at sessions 1 and 5 for this study. Counseling outcome could also be calculated by determining the difference between scores at session 1 and session 10. Specifically, client's rating of emotional health at session 5 (average of ACF items 9 – 11) is subtracted from the session 1 rating (average of ACF items 9-11) resulting in the client's rating of counseling outcome (Client Outcome). Positive scores indicate an improvement of emotional health while negative scores indicate a worsening of emotional health as rated by the client between sessions. The score indicates the extent of improvement (if positive) or worsening (if negative) between the sessions. The Cronbach alpha of the client's rating of outcome (Client Outcome) is .81 for this study.

Counselor Rating of Client Counseling Outcome Form (CRCCOF) Overview.

The current study uses this instrument to determine the counselor's assessment of the client's emotional health which is used to calculate counseling outcome (Research question 2), and Global Assessment of Functioning (GAF) scores which are used to calculate the GAF Outcome score (Research question 3). Two items of the instrument ask the counselor to rate how distressing the client's main problem is to them and how much improvement the client has experienced with this problem during counseling.

Counselor Rating of Counseling Outcome (Cnslr Outcome). The Counselor Rating of Client Counseling Outcome (CRCCOF) is based on items from the ACF. Using the (CRCCOF) form, the counselor makes assessments similar to those determined by the client.

The counselor's rating of emotional health is the average of CRCCOF items 2 – 4 which is similar to the client's rating of emotional health using ACF items 9 – 11 (Ross, 2004). This rating is calculated for sessions 1, 5, and 10 when the ACF is routinely administered with the client. The counselor's assessment of counseling outcome is determined by the differences of emotional health between sessions 1 and 5. Thus, the counselor's rating of counseling outcome (Cnslr Outcome) is determined by subtracting the counselor's rating of emotional health at session 5 from the rating of emotional health at session 1. Positive scores indicate an improvement of emotional health while negative scores indicate a worsening of emotional health as rated by the counselor between sessions. The score indicates the extent of improvement (if positive)

or worsening (if negative) between the sessions. Cronbach alpha of counselor's rating of outcome (Cnslr Outcome) is .85.

Counselor's GAF rating of outcome (GAF Outcome). The counselor's rating of counseling outcome based on the Global Assessment of Functioning (GAF; American Psychiatric Association, 1994) score is determined by subtracting the counselor's GAF rating for session 1 from the counselor's assessment of session 5 (GAF Outcome). Positive scores indicate an improvement of global assessment of functioning and negative scores indicate a worsening as rated by the counselor between sessions. The score indicates the extent of improvement (if positive) or worsening (if negative) between the sessions.

Procedure

Information about the research was provided to graduate counseling students (masters and doctoral) who were asked to volunteer for the study. Those who volunteered reviewed and signed an informed consent form. They received training to elicit participation by their adult clients, how to properly administer the consent form and instruments, and to respond to questions asked by client participants. Clients who volunteered to participate in this study completed an informed consent form and pencil-and-paper instruments. The experimental packet included an informed consent form, an Adult's Counseling Form, Perceived Social Support – Family form (PSS-Fa), Perceived Social Support – Friends form (PSS-Fr), Belief Survey (renamed: Spiritual Well-Being instrument), and a Religious/Spiritual Orientation – Revised form. The order of

presentation of the instruments within the packets was randomly varied. Participating clients completed the instrument packet after the first counseling session. About 20-30 minutes were required to complete the instrument packet. Consistent with clinic procedures, in addition to completing the Adult's Counseling Form after the first session, each client was asked to complete one after the 5th, 10th, 20th, and final counseling sessions. The principal investigator provided reminder notes to facilitate the counselors' consistent compliance for the administration of instruments. Each counselor completed a Counselor Rating of Client Counseling Outcome Form (CRCCOF) after each participant's 1st, 5th, 10th, 20th, and final counseling sessions without referring to the client's completion of the ACF. Demographic and life experiences information was acquired from the application for services form routinely completed by clients of the clinic prior to their intake session. Although the paper instruments had client identification information, the final database created for statistical analysis does not have any client identification information associated with it.

Results

Zero-order correlations for independent and dependent variables are shown in Table 1. Life experience (Life Experience) is significantly and negatively correlated with spiritual well-being total (Spiritual WB: $r = -.273$, $p < .05$), and the existential well-being subscale (Existential WB: $r = -.388$, $p < .01$). Thus, a client's perception for the reduction in stress associated with life experiences is related to higher levels of existential well-being and consequently higher levels of total spiritual well-being. The

Existential Well-being subscale (Existential WB) is significantly and positively correlated to perceived social support for family (Family Support: $r = .291, p < .01$) and friends (Friend Support: $r = .466, p < .01$) indicating greater perceptions of social support are related to higher existential well-being. The spiritual well-being total (Spiritual WB) is likewise correlated with perceived social support for family and friends as shown in Table 1. The religious well-being subscale (Religious WB) is significantly and positively correlated with intrinsic religiosity (Intrinsic: $r = .712, p < .01$) and extrinsic religiosity (Extrinsic: $r = .543, p < .01$). The total spiritual well-being (Spiritual WB) is also significantly and positively correlated with intrinsic and extrinsic scores as shown in Table 1. Subscales for spiritual well-being and religious orientation are correlated with each other as shown in Table 1.

For research questions 1 through 3, forward selection multiple regression was used to identify the specific independent variables that would best support the dependent variables. The entry of variables was determined based upon statistical criteria (probability of F to enter $< .20$). All data was included in the analyses, as there were no outliers affecting the normality, linearity, or homoscedasticity of the residuals.

Research Question 1

Will independent variables (life experiences, social support, religious orientation, spiritual well-being, and the client-counselor relationship) be related to client counseling outcome as reported by the client? Multiple regression analysis was used to determine the independent variables that would best support the dependent

variable (Client Outcome) as summarized in Table 2. Life Experience accounted for 30.2% of the variance in estimating Client Outcome (Client Outcome: Adj. $R^2 = .302$, $F = 29.018$, $p < .001$), intrinsic religiosity (Intrinsic) accounted for an additional 9.8% of variance (Adj. $R^2 = .400$, $F = 23.699$, $p < .001$) for a total variance of 40 % as shown in Table 2. Persons who experienced a reduction in stress due to changes in life experiences or their perception of these had better outcome. Persons with higher intrinsic religiosity were related to lower outcome.

Research Question 2

Will independent variables (life experiences, social support, religious orientation, spiritual well-being, and the client-counselor relationship) be related to client counseling outcome as reported by the counselor (using items consistent with those rated by the client)? Multiple regression analysis was used to determine the independent variables that would best support the dependent variable counselor rating of outcome (Cnslr Outcome) as summarized in Table 3. Life Experience accounted for 28.6% of the variance in estimating counselor outcome (Cnslr Outcome: Adj. $R^2 = .286$, $F = 27.861$, $p < .001$) as shown in Table 3. Persons who experienced a reduction in stress due to changes in life experiences or their perception of these had better outcome.

Research Question 3

Will independent variables (life experiences, social support, religious orientation, spiritual well-being, and the client-counselor relationship) be related to client counseling outcome (according to counselor's GAF scores)? Multiple regression

analysis was used to determine the independent variables that would best support the dependent variable counselor GAF rating of outcome (GAF Outcome) as summarized in Table 4. Life Experience accounted for 20.6% of the variance in estimating counselor GAF rating of outcome (GAF Outcome: $\text{Adj. } R^2 = .206$, $F = 18.365$, $p < .001$), extrinsic religiosity accounted for an additional 7.7 % of variance ($\text{Adj. } R^2 = .283$, $F = 14.217$, $p < .001$), religious well-being (Religious WB: $\text{Adj. } R^2 = .338$, $F = 12.403$, $p < .001$) accounted for an additional 5.5 % of variance, and Friend Support accounted for an additional 4.1 % variance ($\text{Adj. } R^2 = .379$, $F = 11.237$, $p < .001$), for a total variance of 37.9 % as shown in Table 4. Life experiences and friend support accounted for 24.7 % of the variance. Spiritual variables accounted for 13.2 % of variance with Extrinsic and Religious WB accounting for 7.7% and 5.5%, respectively. Persons who experienced a reduction in stress due to changes in life experiences or their perception of these had better outcome. Persons with higher religious well-being had better outcome. Persons with higher extrinsic religiosity and friend support had lower outcome.

Research Question 4

Will there be a statistically significant difference between the client's rating of counseling outcome (as determined in research question 1) and the counselor's rating of counseling outcome (as determined in research question 2)? The paired sample t-test was used so that comparisons would be made on a pair-by-pair basis rather than on an aggregate of mean data for each group. The paired sample t-test indicated that there is

not a statistically significant difference ($t = -1.248$, $df = 68$, $p = .216$) between the client's rating of counseling outcome (Client Outcome) and counselor's rating of outcome (Cnslr Outcome).

Analyses to Supplement Interpretation of Results

In research questions 1 through 3, life experiences accounted for the greatest variance in each of the models for counseling outcome. Perceived social support from friends (Friends Support) was only incorporated directly in the model based on the counselor's GAF rating of outcome (Research question 3). Although, perceived social support for friends when assessed at session one was not otherwise directly reflected in the models, the effects of social support were incorporated in the life experiences construct and accounted for variance associated with counseling outcome. Three of the 6 items that comprise the client's rating of life experiences are associated with relationships with others (item 3 – family; item 4 – romantic, marital or intimate relationship; item 5 – social and recreational). The clients' ratings associated with life experiences at session 1 are significantly correlated with perceived social support from family (Family Support: $r = -.220$, $p < .05$) and perceived social support from friends (Friend Support: $r = -.384$, $p < .01$). These negative correlations indicate that higher perceived social support is related to less stress experienced by the client. When considering all six items that comprise the client's rating of life experiences, the three related to the social dimension had the greatest changes accounting for the greatest variance associated with counseling outcome. This is exemplified by reviewing the

means of the client's changes in ratings between session 1 and 5 where the greatest change is in the social dimension (Means: family = .714, romantic or other intimate relationship = .529, and social = .286) compared with other dimensions (Means: work = .171, education = .171, and health = .214). Positive values are related to a reduction in stress or increase in satisfaction.

The client's rating for the single item on the application form for importance of religion was significantly correlated with spiritual well-being ($r = .523, p < .01$), religious well-being ($r = .640, p < .01$), intrinsic religiosity ($r = .692, p < .01$), and extrinsic religiosity ($r = .483, p < .01$). This suggests that those who express high importance of religion are related to higher scores for the spiritual and religious constructs measured.

After counseling session one, client's reported motivation to make changes in their life was significantly correlated with spiritual well-being (Spiritual WB: $r = -.265, p < .05$; Existential WB: $r = -.212, p < .05$; Religious WB: $r = -.247, p < .05$). Also, after session one, client's reported belief that counseling can help to make the changes necessary to improve their life was significantly correlated with spiritual well-being (Spiritual WB: $r = -.300, p < .01$; Religious WB: $r = -.290, p < .01$). The negative correlations indicate that persons with high spiritual well-being were more motivated and had higher belief that counseling could be beneficial. By the fifth counseling session, clients' reported motivation or belief in counseling were no longer significantly correlated with spiritual well-being. Intrinsic and extrinsic scores were not significantly correlated with motivation or belief in counseling after session one or session five.

The relationship between the counseling relationship and counseling outcome was not statistically significant. The absence of a correlation may be due to the distribution of the data as measured using the ACF form. Clients rate the relationship on 7 items using a Likert 7 point scale where 1 is the most favorable response and 7 is the least favorable response. The counseling relationship is the average of the client's responses to these 7 items. Clients' ratings indicate a very favorable counseling relationship as indicated by the data with a mean of 1.68 and standard deviation of 0.86. The data is skewed toward lower values the most favorable response where 75.7 % of the responses are 2 or lower on the 7 point Likert scale.

Although 70 of the 90 participants attended at least five sessions, 20 of the 90 participants attended fewer than five sessions. Statistical analyses confirmed that there were no statistically significant differences ($p > .05$) for any of the nine independent variables when comparing these two groups.

Discussion

Life experience, spiritual and religious constructs, and social support explained significant variance associated with clients' and counselors' assessment of counseling outcome. Life experiences explained most of the variance at about 20 – 30 percent related to counseling outcome. Spiritual and religious constructs explained 13.2 %, and 9.8% of counseling outcome associated with the counselor's GAF rating and client's rating, respectively. Friend's support accounted for 4.1 % of the variance related to the counselor's GAF rating of outcome. Although a relatively small portion of variance is

attributed to friend support when rated at the beginning of therapy, the potential impact of the changing dynamics associated with family and friends support is captured within the life experiences construct.

Lambert (1992) suggested that extratherapeutic change accounts for the greatest portion of variance attributed to improvement in psychotherapy patients. Life experiences capture aspects of Lambert's extratherapeutic construct indicating that a positive improvement in the client's experience or perception of life experiences during the course of therapy may be related to improvement in outcome. Within the conceptualization of counseling outcome determined from emotional health, it seems reasonable that this should be related to the client's ratings of factors associated with the conceptualization of life experience such as work or employment, educational situation, family relationships, romantic, marital or intimate relationships, social and recreational, and physical health. Also, addressing client concerns in these areas may become targets of intervention and thus should contribute to changes in life experiences and consequently counseling outcome. Thus, changes in life experiences are related to counseling outcome regardless of how they occur whether as a consequence of therapy, the client's extratherapeutic resources, changes in events or the client's perception of these.

When compared to other constructs, perceived social support from family and friends assessed at the beginning of counseling accounted for the least variance in explaining counseling outcome. However, clients' ratings of family and friends relationships were an important aspect of the life experiences construct. According to

clients' ratings at the first counseling session, higher perceived support from family and friends was related to clients' experiencing less distress from life experiences. Three of the six items rated by clients for life experiences are related to their relationship with others. During the course of therapy, the items related to the client's social perspective changed most in comparison to the other dimensions considered. These changes may have occurred because they were the target of therapeutic intervention. Since this study is correlational, one cannot determine whether there is a causal relationship between better social relationships contributing to improvements in mental health or vice versa.

When considering religious and spiritual constructs, religious well-being is positively related to outcome while both intrinsic and extrinsic religiosity are negatively related to counseling outcome. This suggests that persons with higher religious well-being improve more during therapy while persons with higher intrinsic religiosity and higher extrinsic religiosity improve less during therapy. This latter outcome may appear counter-intuitive to many people.

Some may assume that intrinsic persons, who experience a sense of God's presence, find meaning and purpose in their spiritual beliefs, seek God for comfort, find peace through prayer and meditation, and base their approach to life on their religious or spiritual beliefs, might work through psychological discomfort in counseling at a quicker rate. The data in this study does not suggest this. One can only speculate about the reasons. Could working through psychological discomfort involve a more complex process of integration for highly intrinsic persons? Could they view the psychological turmoil as more significant than non-intrinsic people? They may feel that everything

matters, especially experiences that disrupt their daily living. It may take more time to fully accept these unsettling experiences in a way that is meaningful (Frankl, 1963). A highly religious person may not be seeking quicker symptom or emotional relief; instead, they may want to pursue further spiritual searching. A highly religious client may feel defensive in a secular counseling setting and this may effect change in therapy. Overall, counseling outcome may be impacted by the expectations and the dynamics of the counseling relationship related to spiritual and religious issues of the client and counselor.

An intrinsic person may experience a buffering effect against life stressors through their participation in religious or spiritual rituals or symbolism; however, this buffering effect may complicate healthy integration of meaning of life's experiences during times of conflict. Could highly intrinsic persons be more rigid and have more discomfort if what they are experiencing seems to be in conflict with their belief system? For example, they may wonder why God allowed something bad to happen to them; they may be experiencing an event such as a divorce which is in conflict with their belief system; or they may feel guilty in regard to negative feelings (e.g., anger) they are experiencing. A person who is more highly intrinsic is more likely to be affected by psychological distress that is in conflict with their belief system since the salience of their belief system is more important to their approach toward life. In comparison, a person who is less intrinsically oriented is likely to be less affected by psychological distress that is in conflict with their belief system. For example, in reviewing specific results of this study, it was determined that several clients who were

Catholic and had a high intrinsic orientation were experiencing a divorce which was in conflict with their religious belief system. In this study, these individuals experienced less improvement in counseling outcome as compared to others less intrinsically oriented.

In summary, it is not just the strength of one's intrinsic orientation but the specifics of their religious belief system and how psychological issues might be integrated within their belief system. Other psychological issues (e.g., depression, anger, anxiety, sexual issues, and abuse) can have significant meaning, proscriptions, and engender strong feelings associated with a person's spiritual belief system as they relate to psychological health and adjustment (Acklin, Brow, and Mauger 1983; Kosmin and Lachman, 1993; Maltby, 2000; Thorson, 2000). A client experiencing these issues or possible feelings of stigma may be reluctant to bring them up in counseling; however, a counselor who is sensitive to the possibility of these issues may be able to help a client to constructively address them.

Research has shown that a person's motivation, high expectation, belief in the counseling process and in the credibility of the counselor are related to positive counseling outcome. Recognizing this, one might hypothesize that highly religious or intrinsically oriented persons have predisposed negative views toward these factors. The evidence of this study does not support this hypothesis. Study results indicate that a person with a high intrinsic orientation or high spiritual well-being is not less motivated nor has lower expectation that counseling can be helpful. According to the client's rating after the first session, there is a significant positive correlation between religious

well-being and a client's motivation and belief that counseling can help. Study results indicate that there is not a significant relationship between motivation and belief in counseling related to a person's intrinsic or extrinsic belief. Thus, a person with high intrinsic orientation is not predisposed to low motivation or a belief that counseling will not be helpful. Furthermore, there is not a statistically significant relationship between religious or spiritual constructs and counseling relationship including counselor credibility as measured in this study.

Study results suggest that persons who are highly extrinsic improve less than those who are less extrinsic. Extrinsic persons seek social contact through their religious affiliations and may seek protection and comfort through prayer; however, they may lack an internal belief system which establishes a sense of meaning and purpose in relationship to their spirituality. When disturbing circumstances arise, they may lack a coherent belief system which may give significance, meaning, and hope in addressing these issues. Although they may seek comfort from God through prayer, they may feel abandoned or feel guilty at these times.

Pargament (1997) concluded that (1) religious coping seems especially helpful to more religious people, (2) religion can moderate or deter the effects of life stress, or both, and (3) religious coping adds a unique dimension to the coping process. It is possible that a more religious or spiritual person could be relying so much upon their faith that God will take care of their problems that they are slower to engage in dealing directly with problems themselves (Richmond & Christensen, 2000). Coping strategies used by individuals range from avoidant behaviors, maladaptive behaviors, seeking

emotional or material support from their social and religious/spiritual networks, and the use of approach coping strategies to directly address their concerns (Pargament, 1997; Procidano & Smith, 1997; Vaux, 1988). Lazarus (2000) has tried to explain the impact of spirituality by describing it as an orienting system that determines, in part, an individual's method of coping.

Clinical implications

A clinician needs to be mindful that different coping strategies may be helpful or harmful depending on when and how they are applied during the coping process (Richmond & Christensen, 2000; Wallace, Bisconti, Bergeman, 2001). A clinician who is sensitive to the possible interactions between a client's religious/spiritual beliefs and their counseling issues (e.g., life experiences, feelings of stigma, anger, or guilt) may be able to help the client to constructively address these during counseling.

Results of this study suggest significant variance in outcome is explained through constructs of religious orientation and spiritual well-being. Gallup polls of 1997 indicated that 95% of the American public believes in God or a "higher power" which is consistent with beliefs expressed over the past 50 years where the percentage of Americans who believe in God has never dropped below 90% (Gallup & Lindsay, 1999). Several studies have offered evidence showing that religious individuals who receive support for their sense of worth and spiritual identity heal at a faster rate and are able to establish healthier lifestyles (Bergin et al., 1994; Richards & Potts, 1995; Graham, Furr, Flowers, & Burke, 2001). Austad and Morgan (1998) conclude that by

the 5th or 6th sessions, only 10-15% of patients continue in counseling. The National average or mean number of sessions attended is 5 to 6 (Austad & Morgan, 1998). Given these factors, it may be prudent for practitioners to consider addressing spiritual and religious issues within a brief timeframe during the course of therapy. Given the APA mandate related to competency in addressing religious as well as other cultural issues and the salience of these in the lives of clients, it seems that counselors in training could benefit from more proactive treatment of religious/spiritual issues through coursework and supervised practicum experience as these factors interact with a counselor's personal perspective (Graham, Furr, Flowers, & Burke, 2001).

Obtaining feedback from clients during the course of counseling may provide important insight for therapy. Since life experiences accounted for the greatest variance related to outcome, it may be helpful to monitor this construct during the course of therapy as done in this study with only six items.

A single item on an application asking the client to rate the importance of religion or spirituality may provide a reasonable screening to indicate the possible positive correlation between high importance of religious beliefs and high intrinsic or religious well-being. Results of this study indicate moderately high significant correlations between the client's rating for the importance of their religious and spiritual beliefs and the religious constructs.

Given the contribution of the religious and spiritual dimensions related to outcome, items assessing this construct in regard to the counseling relationship might be insightful in practice and in research. A body of research supports the importance of

the counseling relationship related to outcome (Hatcher & Barends, 1996; Horvath, 2000; Orlinsky, Grawe, and Parks, 1994); however, this research does not address issues associated with religion and spirituality during the course of therapy.

Limitations of the Study

Due to its correlational nature, this study can only describe the relative strengths of relationships among the variables being examined and cannot posit causality. This study does not attempt to delineate the exact way in which life experiences, social support, spiritual well-being, religious orientation, or counseling relationship are interrelated with counseling outcome.

Results associated with counseling relationship are inconclusive. Since clients generally rated their counselors very highly, there was not significant variance in results to obtain a meaningful correlation with counseling outcome. The setting and the procedure for administering the instrument to measure the counseling relationship may contribute to more favorable ratings. Since the setting is a training clinic for graduate level counselors (i.e., masters and doctoral level students), it could be hypothesized that client's want their counselors to be highly viewed by their professors so they may be inclined to rate them higher. The procedure may contribute to slightly higher ratings. Specifically, the counselor gives the form to the client to complete after the end of the appropriate session, the client then completes the form in the waiting room, and gives the completed form to a staff person adjacent to the waiting room. Although the form states that the counselor will not have access to their ratings until after the client is no

longer receiving services at the clinic, the client may be concerned that this confidentiality may not be kept and consequently may rate their counselors more highly. Also, when measuring the counseling relationship, not all aspects of therapeutic alliance which has been shown to be related to counseling outcome were included in the measure (Hatcher & Barends, 1996; Martin, Garske, and Davis, 2000).

The study is further limited by its population sample which was comprised of individuals presenting to the University of Oklahoma Counseling Psychology Clinic. The generalizability of the study's results will be limited by the particular demographics and clinical issues that emerged in the sample of volunteer participants.

Future Research Directions

During the past four decades, most emphasis for outcome studies has focused on the issues related to demonstrating the efficacy of psychotherapy (Bergin & Garfield, 1994) with more recent emphasis being placed on the processes of therapy (Elliott & James, 1989). Thus, more insight may be gained by addressing process in relationship to religious and spiritual issues and interventions in the counseling setting. Qualitative or a mixed method studies could be used to better understand the process or interaction of client's religious/spiritual beliefs and their counseling outcome. These studies could provide useful insights leading to better interventions and outcomes for these clients. Research that addresses counselor and counselors in training attitudes toward religion and spirituality may provide insights regarding the integration of these in the counseling relationship. Research to determine the extent that religious/spirituality issues are

incorporated in training programs' coursework and practicum experience may provide insights into successes, limitations, and opportunities for improvement in this area.

A general measure of emotional health as assessed by clients and counselors was used in this research so that results might be generalizable to a clinical outpatient population addressing multiple disorders. Future research could evaluate these constructs (e.g., religious/spiritual, life experiences) for specific disorders such as depression or anxiety using objective measures to monitor counseling outcome.

Concluding Remarks

The primary focus of this study is to provide empirical data indicating the correlations and amount of variance accounted for in considering the changing dynamics of life experiences and religious/spiritual constructs in relationship to counseling outcome. Using a clinical population in an outpatient setting, these constructs were measured along with social support and the counseling relationship which have been shown to be related to counseling outcome.

This study provides empirical support indicating that significant correlations and variance are associated with religious/spiritual constructs related to counseling outcome. Although, this study does not show causal relationships or definitive answers into the specifics associated with these, it does indicate that attention should be given to spiritual issues during therapy. A single item on an application asking the client to rate the importance of their religious/spiritual beliefs can provide a simple screening for the counselor in considering interactions during the counseling process.

This research also provides empirical support relating counseling outcome to life experiences using a threefold conceptualization: (1) normative weighting depending on the magnitude of the stress; (2) scaling of these based on the client's perception; and (3) recognizing and monitoring changes in client's perception of life experiences that may be due to changing events, improving circumstances, or client's adjustment.

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Tables

Table 1

Zero-order correlations for independent and dependent variables

	1	2	3	4	5	6	7	8	9	10	11
1 – Life Experience											
2 – Family Support	-.124										
3 – Friend Support	-.161	.206									
4 – Intrinsic	-.197	.055	.119								
5 – Extrinsic	-.115	.026	.105	.532**							
6 – Spiritual WB	-.273*	.238*	.348**	.648**	.481**						
7 – Existential WB	-.388**	.291**	.466**	.195	.089	.678**					
8 – Religious WB	-.159	.149	.200	.712**	.543**	.888**	.304**				
9 – Counseling Rel	-.162	-.015	.008	.072	.007	-.070	-.013	-.060			
10 – Client Outcome ¹	.553**	-.079	-.139	-.423**	-.225	-.251*	-.105	-.301*	-.129		
11 – Cnslr Outcome ¹	.531**	.082	-.034	-.275*	-.191	-.119	-.149	-.038	-.223	.653**	
12 – GAF Outcome ¹	.463**	-.086	-.271*	-.219	-.347**	-.139	-.276*	-.012	-.226	.452**	.680**

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

** Correlation is significant at the 0.01 level (2-tailed)

¹ Dependent Variables: Client Outcome is counseling outcome as assessed by client; Cnslr Outcome is counseling outcome as assessed by counselor; GAF Outcome is counseling outcome based on counselor's GAF rating

Table 2

Multiple linear regression analysis for client rating of counseling outcome

Model	Adj. R ²	Change R ²	F Chng.	Sig. F chng.	F	Sig. F	DF
1	.302	.302	29.018	.001	29.018	.001	1
2	.400	.098	13.127	.001	23.699	.001	2
3	.419	.019	3.178	.079	17.379	.001	3

Model	Variable	B	Beta	t	Sig.
1	Constant	.671		1.597	.115
	Life Experience	.00831	.550	5.387	.001
2	Constant	5.809		3.952	.001
	Life Experience	.00711	.470	4.876	.001
	Intrinsic	-.195	-.349	-3.623	.001
3	Constant	3.154		1.519	.134
	Life Experience	.00808	.534	5.266	.001
	Intrinsic	-.207	-.371	-3.877	.001
	Existential WB	.0769	.180	1.783	.079

Note: N=69

Table 3

Multiple linear regression analysis for counselor rating of counseling outcome

Model	Adj. R ²	Change R ²	F Chng.	Sig. F chng.	F	Sig. F	DF
1	.286	.286	27.861	.001	27.861	.001	1
2	.299	.013	2.239	.139	15.311	.001	2
3	.309	.010	1.894	.174	10.979	.001	3
4	.326	.017	2.624	.110	9.099	.001	4

Model	Variable	B	Beta	t	Sig.
1	Constant	1.120		2.638	.010
	Life Experience	.00838	.545	5.278	.001
4	Constant	2.263		1.302	.198
	Life Experience	.00811	.528	5.074	.001
	Family Support	.06875	.108	1.030	.307
	Intrinsic	-.170	-.305	-2.128	.037
	Religious WB	.06229	.234	1.620	.110

NOTE: N = 68; Variables added to each model (1 – 4): 1- Life Experience,

2- Family Support, 3-Intrinsic, 4- Religious WB

Table 4

Multiple linear regression analysis for counselor GAF rating of outcome

Model	Adj. R ²	Change R ²	F Chng.	Sig. F chng.	F	Sig. F	DF
1	.206	.206	18.365	.001	18.365	.001	1
2	.283	.077	8.095	.006	14.217	.001	2
3	.338	.055	6.409	.014	12.403	.001	3
4	.379	.041	5.260	.025	11.237	.001	4
5	.391	.012	2.195	.143	9.599	.001	5

Model	Variable	B	Beta	t	Sig.
1	Constant	2.837		3.293	.002
	Life Experience	.01380	.467	4.285	.001
4	Constant	10.583		3.577	.001
	Life Experience	.01247	.422	4.286	.001
	Extrinsic	-.700	-.451	-3.964	.001
	Religious WB	.164	.320	2.794	.007
	Friend Support	-.289	-.224	-2.293	.025

NOTE: N = 68; Variables added to each model (1 – 5): 1- Life Experience,

2- Extrinsic, 3-Religious WB, 4- Friend Support, 5 - Intrinsic

Appendix A: Prospectus

**The Relationships of Client's Life Experiences, Social Support,
Religious Orientation, Spiritual Well-Being, and the Client-Counselor
Relationship with Counseling Outcome**

Introduction

Research suggests there are relationships between psychological health and adjustment to adversity or life stressors and (1) life experiences, (2) social support, (3) religious orientation, and (4) spiritual well-being. Furthermore, research demonstrates that the client-counselor relationship is an important component contributing to counseling outcome.

Life Experiences

There is a correlation between life experiences and psychological well-being (Chiriboga & Catron, 1991; Jacobson, 1983). Typically, there are several concurrent life experiences that effect psychological well-being in adjusting to a life stressor (Parkes & Weiss, 1983). For example, in a London study of depression, events were rated as more or less stressful on the basis of "the configuration of factors surrounding a life event" (Parkes & Weiss, 1983). Two women may learn that their husbands are terminally ill. One may be socially isolated except for the contact with her husband, may have no assurance of remaining in her home once he dies, and may have had no warning of his illness; whereas for the second woman, the concurrent stressors may be absent. The threat of the illness would likely be much greater for the first woman.

Holmes and Rahe (1967) have conducted several classic studies to consider the effects on health associated with the clustering of stress events. Holmes and Rahe (1967), hoping to bring greater precision to such life stress and illness studies, scaled 43 representative life change events (e.g., divorce, changes in health, income, employment) to arrive at estimates of their social readjustment (e.g., one aspect is stress) magnitudes as perceived by the participants. Rahe (1975) revised, rescaled, and expanded the Schedule of Recent Experience SRE and most recently during a 1995 study revised his instrument to become the Recent Life Changes Questionnaire (RLCQ; Miller & Rahe, 1997). The RLCQ inquires about 74 potential recent life change events in a person's life.

Social Support

House (1981) proposed that social support is "an interpersonal transaction involving one or more of the following: (1) emotional concern (liking, love, empathy), (2) instrumental aid (goods and services), (3) information (about the environment), or (4) appraisal (information relevant to self-evaluation)" (p. 30). This list establishes the "what"; the "whom" might include a spouse, relatives, friends, neighbors, work supervisors, coworkers, caregiver, and professionals. In short, House sees support in terms of problem-related social interactions with a broad range of people.

Lin (1986) suggested that a person's linkage to the social environment can be represented at three distinct levels: the community, the social network, and intimate and confiding relationships. Cobb (1976) emphasized that social support provides meaningful attachments to others, integration in a network of shared relationships,

opportunity for nurturing others and being nurtured by them, reassurance of an individual's worth through performance of valued social roles, a sense of reliable alliance with kin, and access to guidance in times of stress (Cobb, 1976).

Kaplan et al. (1977) defined social support as "the relative presence or absence of psychosocial support resources from significant others" (p. 109). Thoits (1982) defined it as "the degree to which a person's basic social needs are gratified through interaction with others" (p. 147). These needs were identified as including affection, esteem or approval, belonging, identity, and security (p. 147). Turner, Frankel, and Levin (1983) suggested "social support and social support resources should be viewed as related but distinct concepts" (p. 74). The former is seen as "a personal experience rather than a set of objective circumstances or even a set of interactional processes" (p. 74). Shumaker and Brownell (1984) defined social support as "an exchange of resources between at least two individuals perceived by the provider or the recipient to be intended to enhance the well-being of the recipient" (p. 17). In their model, support is not limited to a stress reduction but includes a broader outcome. They also tie positive, negative, and neutral outcomes to intentions. Lin (1986) proposed a definition of social support as "the perceived or actual instrumental and/or expressive provisions supplied by the community, social networks, and confiding partners" (p. 18). He distinguished two broad categories of support. First, the "instrumental dimension involves the use of the relationship as a means to achieve a goal" (p. 20) whereas the second expressive dimension "involves the use of the relationship as an end as well as a means" (p. 20).

All of the above definitions highlight social ties, exchanges, and subjective appraisal. They focus on support in the context of problems, explicitly avoiding this constraint or emphasize functions related to ongoing social needs. Most recognize several sources of support but distinguish these differently. Social support researchers continue to wrestle with conceptual and methodological issues.

Another source of diversity and confusion in social support thought and research concerns the varied forms and functions of social support. People assist one another in a variety of ways, and relationships serve many functions. In delineating the topic, early writers sketched out the kinds of activities that constituted support. Vaux's (1988) model has been frequently cited possibly because of its simplicity and depth. He contends that supportive activities are often very subtle social behaviors such as listening, expressing concern, showing affection, sharing a task, caretaking, loaning money, giving advice, making suggestions, and socializing. These activities function to elicit feeling of love, belonging, intimacy, and integration. Evidence of support function can be obtained only by an examination of subjective appraisals; that is, the person's cognitive-affective condition of his or her sense of being loved, of belonging, or of feeling attached (Vaux, 1988). Vaux (1988) also proposes three social support constructs: support network resources, supportive behavior, and subjective appraisals of support. These constructs refer to, respectively, features of the network of individuals who routinely provide assistance, specific acts of assistance, and the person's evaluation of such resources and assistance. In short, social support is now viewed as a metaconstruct comprising several conceptual components. Rather than using the term in

a general way, theorists and researchers can be more specific by focusing on the above constructs within the context of social support. These three conceptual elements are linked in a dynamic process of transactions between the individual and his or her social environment. Further, the sources, forms and functions of support are recognized as multidimensional.

Support appraisals are subjective, evaluative assessments of a person's supportive relationships and the supportive behavior that occurs within them (Vaux, 1988). Appraisals may take many forms including satisfaction, feeling cared for, respected, or involved, and having a sense of attachment, belonging, or reliable alliance. Appraisals also may be global, reflecting an evaluative synthesis of a person's relationships with the network as a whole, or focused, reflecting a particular domain of network relationships (for example, spouse, workmates, or friends), or a particular mode of support (for example, emotional or practical).

One way of measuring social support is by examining the size and density of a person's social network (Hirsch, 1980; House & Kahn, 1985). Another way in which social support has been characterized is by measuring the actual enacted support a person receives (Cohen & Hoberman, 1983; Schaefer, Coyne, & Lazarus, 1981). A third way that social support has been categorized is by the perception of social support available to or received by the recipient (Sarason, Pierce, & Sarason, 1990).

Perceived social support refers to the impact networks have on the individual. If networks provide support, information, and feedback (Caplan, 1974), then perceived social support (PSS) can be defined as the extent to which an individual believes that

his/her needs for support, information, and feedback are fulfilled (Procidano & Heller, 1983). Lazarus, Averill, and Opton (1974) suggest that the perception of social support is one element in an individual's appraisal of and subsequent coping with stress. While the perception of support depends upon the availability of supportive structures in the environment, perceived support and support provided by networks are not identical. PSS probably is influenced by within-person factors, including both long-standing traits on the one hand, and temporal changes in attitude or mood on the other. Both of these may influence the perception of whether support is available or has been provided. Procidano and Heller's (1983) PSS measures were designed to measure the extent to which an individual perceives that his/her needs for support, information, and feedback are fulfilled by friends (PSS-Fr) and by family (PSS-Fa).

During the mid 1980s, Barrera proposed the "buffering hypothesis." The buffering hypothesis is the expectation that social support (or some other psychosocial assets, such as coping style or coping skills) might buffer, or moderate, the impact of stressful events. Chronic stress can isolate its victims, alienate them from persons with whom they might otherwise enjoy mutually supportive relationships, and erode their perception of being accepted and valued by others. Social support sometimes mediates stressful relationships determined in studies of chronically stressed groups such as families in poverty, or persons with chronic illness, or their caregivers (Gersten, 1992; Procidano, 1992b). There has been evidence for social support's direct positive relationship to well-being and inverse relationship to symptomatology/distress (Cohen & Wills, 1985; Procidano, 1992a; Procidano & Smith, 1997).

Cobb (1976) reported that an individual's sense of being loved and cared for, respected and esteemed, and involved or on his or her sense of attachment, reliable alliance, reassurance of worth, or other provisions of social relationships were related to well-being. Pearlin (1985), making similar points, has referred to "latent social ingredients" of support. He writes, "Much support is sought, recognized, and contracted for in response to concrete problems. But much of it has a general presence, is beyond the level of awareness, and is embedded in the everyday transactions that take place between people in their prosaic pursuits" (p. 52).

Recent investigations have demonstrated that general, support-related cognitive schemas predict more specific support perceptions (Lakey & Cassady, 1990; Lakey & Dickinson, 1994). Beck originally defined a schema as "a (cognitive) structure for screening, coding, and evaluating the stimuli that impinge on the organism ... On the basis of this matrix of schemas, the individual is able to orient himself [sic] in relation to time and space and to categorize and interpret experiences in a meaningful way" (1967, p. 283, as cited by Young, Beck, & Weinberger, 1993). Procidano and Smith (1997) suggested that cognitive and cognitive-behavioral conceptions apply directly to perceived support and its assessment. Like self-schemas, people simultaneously carry both positive and negative support schemas (e.g., "I am accepted and considered worthy" vs. "I am considered incompetent and am rejected"). A particular schema's salience, relative to that of other schemas depends on the individual's learning history. People's behavior can be seen as efforts to confirm positive or negative schemas (e.g., through striving for success or for rewarding relationships vs. through procrastination

or becoming involved in abusive relationships). A particular schema can be elicited and strengthened by life events with which it is consistent (e.g., experiencing success vs. being devalued). Similarly, people spontaneously make both positive and negative support statements. Thus, support schemas influence the emergence of support statements, which in turn, as they accumulate over time, influence both support schemas and self-schemas (consistent with the main-effect model, which posits that social support enhances self-esteem).

Several researchers have reported a relationship between social support and physical and psychological well-being (Cohen & Wills, 1985; Komproe, et al., 1997; Thevos, Thomas, & Randall, 2001). Individuals who have a strong social support system can recover from stress and trauma better than people who do not (Berkman & Syme, 1979; LaRocca, House, & Kahn, 1985; Baumeister, Faber, & Wallace, 1999). Social support has been shown to aid people in adjusting to stressful life events (Berkman & Syme, 1979, LaRocca, House, & Kahn, 1985).

Religion and Spirituality

Survey research has consistently shown the importance of religion in the lives of Americans. Throughout the 1980's a little over half of the nation consistently ranked religion as very important (Gallup & Lindsay, 1999). In Gallup Polls during 1998, 87% of the nation ranked religion as very important (60%) or fairly important (27%), mirroring similar public opinion polls conducted for the past 3 decades (Gallup & Lindsay, 1999). Gallup polls of 1997 indicated that 95% of the American public believes in God or a "higher power," which is consistent with beliefs expressed over the

past 50 years where the percentage of Americans who believe in God has never dropped below 90% (Gallup & Lindsay, 1999). A review of the demographics of religiosity consistently portrays America throughout its history and into the present as a nation of religious believers. Religiosity appears to be a distinctive feature that requires consideration in all aspects of applied psychology, including the psychology of coping and psychological treatment (Kosmin and Lachman, 1993).

Historically, spirituality and religion have often been viewed dichotomously by those prominent in psychology. While William James, Viktor Frankl, and Carl Jung have seen the value in spirituality, other prominent psychologists have viewed spirituality as irrational and destructive (Meyer, 1988). Meyer (1988) cited that more recently, Ellis (1980) stated “the elegant therapeutic solution to emotional problems is to be quite unreligious and have no degree of dogmatic faith that is unfounded or unfoundable in fact ... The less religious they are, the more emotionally healthy they will tend to be” (p. 637). Warmock (1989) offers the following synopsis of psychological theorists on religion, “Through the years, religion has been viewed by psychologists and those in related professions in many ways: by Freud as an illusion, an obsession and a fulfillment of infantile wishes; by Jung as an Archetype; by Fromm as human love; by Erikson as an epigenetic virtue; by James as an intensely personal experience; by Sargant as a matter of classical conditioning; by Skinner as a matter of operant conditioning; by Allport as a matter of personal becoming; and by Maslow as a quest for man’s higher nature ...” (p. 263).

The antagonism is not one-sided; many religions reject psychology and the human sciences just as avidly. Many within the religious community believe that religion is the domain of chaplains, pastors, priests, rabbis, shamans, and so on, not psychologists (Meyer, 1988). During the past two decades, political and religious fundamentalists have launched a vigorous campaign against humanism (Gould, 1990). Some charge that humanism is immoral and anti-God, and that it has taken over the government, education, the United Nations, and is attempting to control the world (Lahaye, 1980). Robinson and Wilson (1982) compare the attacks to the McCarthy era tactics of the 1950s, only now humanists instead of communists are the scapegoats.

However persons choose to describe their religious and spiritual experiences, as reported above, they view them as very important aspects of their lives. Mounting empirical studies demonstrate that for many Americans, spirituality and/or religion are very important means of coping with major illness (Koenig, 1998). In psychological well-being and recovery from illness, illness prevention and health enhancement, suicide prevention, substance abuse prevention, preventing heart disease and high blood pressure, and negotiating with pain, the clinical evidence for the impact of religious beliefs is increasingly strong (Francis & Kaldor, 2002; Larson & Milano, 1995; Pargament, 1997; Siegel & Schrimshaw, 2002).

Allport and Ross (1967) were the first to characterize a person's religious dimension into two categories, intrinsic and extrinsic religiosity. Their study was intended to determine whether churchgoers are more prejudiced against ethnic minorities than non church attenders. Instead of finding a linear relationship where low

attenders had low prejudice scores and high attenders had high prejudice scores, Allport and Ross found a curvilinear relationship. To explain this, a person's religious motivation was called into question. In essence, they found that an extrinsically religious person is motivated to use religion for personal gain. The religious beliefs are shaped into whatever form to meet the person's primary needs. In contrast, an intrinsically religious person finds their "master motive in religion" (Allport & Ross, 1967, p. 434). They internalize the rules, laws, and beliefs of their religion. Allport and Ross (1967) developed the Religious Orientation Scale (ROS) to measure intrinsic and extrinsic religiosity.

Additional instruments based on the ROS developed by Allport and Ross were developed over the next several decades. Gorsuch and Venable (1983) developed an age universal version of the religious orientation scale. Gorsuch and McPherson (1989) determined by confirmatory multiple group factor analyses that extrinsic items could be identified as those concerned with social relationships ("Es") and with personal benefits ("Ep"). Maltby (1999) incorporated changes suggested during 30 years of investigation to develop the 'Age-Universal' I-E Scale – 12. This instrument is slightly shorter with only 12 items and retains items for the Es and Ep proposed by Gorsuch.

During the past two decades, numerous studies have shown that people who are religiously devout or intrinsic in their religious orientation tend to enjoy better physical and mental health (Gartner, 1996; Richards & Bergin, 1997). The evidence suggests that intrinsic religiousness is a healthy and mature way of being and is a resource in many peoples' lives (Richards & Bergin, 1997; Park & Cohen, 1992).

Spiritual well-being is the affirmation of life in a relationship with God, self, community, and environment that nurtures and celebrates wholeness (National Interfaith Coalition on Aging, 1975). Moberg (1978) believes that spirituality is not synonymous with religion and refers to the overall “wellness” of the “inner resources” of people.

Many measures that were developed to assess quality of life involved objective indicators and did not assess the internal feelings or perceptions of respondents and very few mentioned the role of religion or spirituality in perceived well-being (Paloutzian & Ellison, 1982). Moberg and Brusek (1978) suggested in their pioneering work that spiritual well-being is best conceived as having two dimensions. A vertical dimension refers to one’s sense of well-being in relationship to God. A horizontal dimension connotes one’s perception of life’s purpose and satisfaction apart from any specifically religious reference.

The Spiritual Well-Being Scale (SWBS) was developed to measure these two dimensions, Religious Well-Being (RWB) and Existential Well-Being (EWB), respectively (Paloutzian & Ellison, 1982). The SWBS is viewed as an expression of spiritual health or maturity and with the need for transcendence, which refers to a sense of well-being that comes from purposes involving ultimate meaning in life (Paloutzian & Ellison, 1982). The RWB scale measures the sense of well-being in relationship to God. The EWB scale measures one’s well-being related to their sense of purpose and satisfaction apart from any specifically religious belief system. Thus, the SWBS is a) the subjective, cognitive/affective evaluation (i.e., satisfaction) of the purpose and

ultimate meaning of one's life; and b) an expression of spiritual health or maturity. To have a sense of existential well-being is "to know what to do and why, who (we) are, and where (we) belong" (p. 137; Blaikie & Kelsen, 1979) in relation to ultimate concerns. Both dimensions involve transcendence, or a stepping back from and moving beyond what is.

Ellison (1983) suggested that the spiritual dimension is not isolated from the psyche and it affects and is affected by our physical state, feelings, thoughts, and relationships. "It is the spirit of human beings, which enables and motivates us to search for meaning and purpose in life, to seek the supernatural or some meaning that transcends us, to wonder about our origins and our identities, to require morality and equity." (Ellison, 1983, p. 331). Ellison (1983) believed that the spirit synthesizes the total personality and provides some sense of energizing direction and order in a person's life. If one is spiritually healthy they will generally feel alive, purposeful, and fulfilled to the extent that they are psychologically healthy as well (Ellison, 1983). The relationship is bidirectional. Ellison (1983) suggested that to a lesser extent the spiritual well-being of a person is affected by physical well-being. There are numerous cases of courage (or faith) which has allowed people to transcend physical handicaps and suffering, and to experience spiritual and emotional health and growth (Ellison, 1983). The key seems to be holding on to one's deepest spiritual commitments and being able to interpret the suffering within the context of deeper positive meaning (Frankl, 1963).

Pargament (1997) reviewed over 30 studies where religious/spiritual coping was commonly used. Pargament's research team identified varieties of religious/spiritual

coping and specific conditions associated with good and poor outcomes, and developed a theoretical framework to the search for significance. There is no simple answer regarding whether or not religion is effective in coping with life events or stress. Pargament (1997) determined that it depends on the kind of religion, who is doing the religious coping, and the situation the person is coping with. Depending on the interaction among variables, religion can be helpful, harmful, or irrelevant to the coping process (Pargament, 1997). Pargament (1997) concluded that (1) religious coping seems especially helpful to more religious people, (2) religion can moderate or deter the effects of life stress, or both, and (3) religious coping adds a unique dimension to the coping process.

In addition to the role of religion in the psychology of coping, there is accumulating empirical evidence identifying religion to be an important variable in health. Systematic reviews of empirical research and survey data suggest a positive correlation between religious commitment and participation and health status (Ellison & Levin, 1998; Levin & Chatters, 1998; Matthews, Larson, & Barry, 1993).

Client-Counselor Relationship and Counseling Outcome

Truax and Mitchell (1971) carried out the most complete and comprehensive review of studies of client-counselor relationship and counseling outcome up until 1971 and were optimistic in their conclusions about the strong relationship between therapist interpersonal skills and client improvement. They concluded that warmth, empathy, and genuineness contributed to positive change with a wide variety of clients across a variety of therapy modalities and theories.

Lambert et al. (1978) reviewed what they described as 17 well-designed and executed studies of facilitative conditions and outcome. They concluded that these studies present “only modest evidence in favor of the hypothesis that such factors as accurate empathy, warmth and genuineness relate to measures of outcome” (p. 472). These researchers indicated further that there were other unaccounted-for variables contributing to client change and that there was little evidence showing a cause-effect relationship between the facilitative conditions and outcome.

The Patterson (1984) review of studies pointed out that, while client-therapist relationship may be seen as critical to successful psychotherapy, the relationship between therapist attitudes and interpersonal skills and outcome is more ambiguous than was once thought. Much of the uncertainty about this stems from how relationship factors are measured. Specifically, research findings have shown that client perceived relationship factors, rather than objective raters’ perceptions of the relationship, compare more consistently to positive results. Furthermore, the larger correlations with outcome are often between client process ratings and clients’ self-report of outcome. One explanation for this may be that clients as a whole perceive the therapeutic relationship as more positive than observers and clients are more accurate in their perceptions of the quality of the therapeutic relationship.

Gatson (1990) suggested the following components of the therapeutic alliance: (a) the client’s affective relationship to the therapist, (b) the client’s capacity to purposefully work in therapy, (c) the therapist’s empathic understanding and involvement, and (d) patient-therapist agreement on the goals and tasks of therapy. The

goals of therapy are the agreed-upon objectives of the therapy process that both parties must endorse and value. Tasks involve the behaviors and processes within the therapy session that constitute the actual work of therapy. Both therapist and client must view these tasks as important and relevant for a strong therapeutic alliance to exist.

Reviews of process-outcome studies have identified specific therapist qualities, skills, and responses that are related to outcome. In their exhaustive review of over 2,000 process-outcome studies since 1950, Orlinsky, Grawe, and Parks (1994) identified several therapist variables that have consistently been shown to have a positive impact on treatment outcome: therapist credibility, skill, collaborativeness, empathic understanding, and affirmation of the client, along with the ability to engage with the client, invest in the treatment process, facilitate a strong therapeutic bond, focus on the patient's problems, and direct attention to the client's affective experience.

Therapist empathy continues to resurface as a central element in treatment success. Studies have strongly supported the importance of therapist-offered empathy in all forms of treatment with many types of clients. There is also a growing body of research linking therapist empathy with positive treatment outcomes (Bohart & Greenberg, 1997; Hill & Nakayama, 2000).

The ability to form a meaningful, collaborative working relationship between client and therapist has also been reported to promote effective therapeutic alliances and positive treatment outcome (Hatcher & Barends, 1996). This collaboration not only appears to involve the therapist's ability to communicate acceptance, warmth, and empathy but also requires the client and therapist to come to a mutual agreement on the

goals of treatment and how those goals will be accomplished (Hatcher & Barends, 1996). Thus, collaboration between therapist and client begins with the client's experiencing security in the therapeutic relationship and further develops as the therapist and client exhibit a willingness to negotiate the goals and tasks of therapy (Hatcher & Barends, 1996).

The Lambert and Bergin (1994) review of the literature suggest there is an abundance of empirical data, spanning five decades, indicating that therapist facilitative behaviors such as acceptance, warmth, empathy, and genuineness are fundamental in establishing a good therapist-client relationship and are related to positive outcomes.

Definition of Terms

Life Experiences

Life experiences are circumstances or events experienced by an individual, which require adaptation or social readjustment (Holmes & Rahe, 1967).

Social Support

House (1981) proposed that social support is "an interpersonal transaction involving one or more of the following: (1) emotional concern (liking, love, empathy), (2) instrumental aid (goods and services), (3) information (about the environment), or (4) appraisal (information relevant to self-evaluation)" (p. 30).

Spirituality

Spirituality is "the feelings, thoughts, experiences, and behaviors that arise from a search for the sacred. The term "search" refers to attempts to identify, to articulate, to maintain, or to transform. The term "sacred" refers to a divine being, divine object,

Ultimate Reality, or Ultimate Truth as perceived by the individual” (p. 66; Hill, Pargament, Hood, McCullough, Swyers, Larson, & Zinnbauer, 1998). Pargament (1999) sees potentially important (and measurable) consequences to “sanctify” or spiritualize what are otherwise secular objects, roles, or responsibilities. “A job is likely to be approached differently when it becomes vocation. For example, a marriage likely takes on special power when it receives divine sanction. The search for meaning, community, self, or a better world are likely to be transformed when they are invested with sacred character (e.g., God or a higher power, an inner light, or awakening from within). Even if beliefs in a personal God fade, other objects of significance may remain sanctified” (p.12).

Religion

“Religion is a search for non-sacred goals (such as identity, belongingness, meaning, health, or wellness) in a context that has as its primary goal the facilitation of spirituality as previously defined. Furthermore, *it is* the means and methods (e.g., rituals or prescribed behaviors) of the search that receive validation and support from within an identifiable group of people.” (p. 66; Hill, et al., 1998, italics added).

Extrinsic religiosity

In describing extrinsic religiosity, Allport and Ross (1967) stated, “The embraced creed is lightly held or else selectively shaped to fit more primary needs. *An extrinsic person* turns to God, but without turning away from self” (p. 434, italics added). Extrinsic religiosity is the dimension of religion in which the individual uses religion for self-serving purposes such as for comfort from sorrows or misfortunes,

socializing, and establishment in the community. Persons whose religion is characterized as extrinsic are more inclined to compromise beliefs to protect their social and economic well-being.

Intrinsic religiosity

The intrinsically religious individual's "other needs ... are regarded as of less ultimate significance, and they are ... brought into harmony with the religious beliefs and prescriptions" (Allport and Ross, 1967, p. 434). Intrinsic religiosity is the dimension of religion which provides a sense of meaning in life. The person is motivated by their intrinsic religiosity and desires to spend time in religious thought and meditation to feel the presence of God or the divine being, want to learn about their religion, and participate in prayer or meditation and religious affiliations. An intrinsically religious person finds their master motive in religion.

Spiritual Well-Being

Spiritual well-being is the affirmation of life in a relationship with God, self, community, and environment that nurtures and celebrates wholeness (National Interfaith Coalition on Aging, 1975). Moberg and Brusek (1978) suggested that spiritual well-being is best conceived as having two dimensions. The vertical dimension connotes one's sense of well-being in relationship to the divine. The horizontal dimension connotes one's perception of life's purpose and satisfaction (i.e., existential) without conferring any specifically religious reference.

Statement of the Problem

Research suggests there are relationships between psychological health and adjustment to adversity or life stressors and (1) life experiences, (2) social support, (3) religious orientation, and (4) spiritual well-being. Most of this research has investigated these variables at a snapshot in time (i.e., not over time and not in the context of counseling outcome) and individually related to psychological health and adjustment to adversity or life stressors. This study will build on previous research recognizing the importance of the client-counselor relationship and the potential that other variables, previously cited, will contribute to counseling outcome. More specifically, this study will investigate the relationships of (1) life experiences, (2) social support, (3) religious orientation, (4) spiritual well-being, and (5) the client-counselor relationship on the counseling outcome of adult clients in a clinical setting. The study will also serve to generate new hypotheses regarding the interrelationships among these independent variables (i.e., life experiences, social support, religious orientation, spiritual well-being, and the client-counselor relationship) and dependent variable, counseling outcome.

Significance of the Study

This study will clarify the relationship among client's life experiences, social support, religious and spiritual relationships, and the client-counselor relationship with counseling outcome. It will build on literature that suggests psychological well-being and adjustment to adversity are individually related to (1) life experiences, (2) social support, (3) religious orientation, and (4) spiritual well-being. Previous research

evaluated the relationship of these variables at one point in time, did not evaluate these variables together, or did not monitor change over time relative to these variables. Therefore, counseling outcome (i.e., change over time) will be monitored while concurrently measuring and analyzing all of these variables in a clinical client-counselor relationship. The information resulting from this research may help therapists in their understanding of the interrelationships of these variables relative to counseling outcome which may lead to more efficacious work with clients.

Limitations of the Study

The proposed study does not attempt to identify all aspects of the client-counselor relationship. For instance, theoretical orientation, interventions used, or client-counselor match are not identified nor does the study attempt to delineate the exact way in which the client-counselor relationship, social support or religious/spiritual dimensions may affect counseling outcome. Due to its correlational nature, it can only describe the relative strengths of relationships among the variables being examined and cannot posit causality. The outcome measure will be evaluated after five counseling sessions. Certainly greater effects could be expected if the study were extended to more sessions, but research suggests that five sessions are sufficient for significant measurable change (Howard, Kopta, Krause, & Orlinsky, 1986).

The study is further limited by its population sample which will be comprised of individuals presenting to the University of Oklahoma Counseling Psychology Clinic. The generalizability of the study's results will be limited by the particular demographics and clinical issues that emerge in the sample of volunteer participants.

Specifically, it is anticipated that the vast majority of clients will be Christian and Euro-American.

Review of the Literature

This study will clarify the relationship among client's life experiences, social support, religious and spiritual relationships, and the client-counselor relationship with counseling outcome. It will build on the following literature addressing significant components of this study: (1) life experiences, (2) social support, (3) religious orientation, (4) spiritual well-being, and (5) the client-counselor relationship.

Life Experiences

There is a correlation between life experiences and psychological well-being (Chiriboga & Catron, 1991; Jacobson, 1983). Typically, there are several concurrent life experiences that effect psychological well-being in adjusting to a life stressor (Parkes & Weiss, 1983). For example, in a London study of depression, events were rated as more or less stressful on the basis of "the configuration of factors surrounding a life event" (Parkes & Weiss, 1983). Two women may learn that their husbands are terminally ill. One may be socially isolated except for the contact with her husband, may have no assurance of remaining in her home once he dies, and may have had no warning of his illness; whereas for the second woman, the concurrent stressors may be absent. The threat of the illness would likely be much greater for the first woman.

Rahe has conducted several classic studies to consider the effects on health associated with the clustering of stress events. Rahe reviewed work done at the University of Washington School of Medicine demonstrating a clustering of life change

events frequently occurring in the year or two prior to clinical onset of a variety of illnesses (Rahe, Meyer, Smith, Kjaer, Holmes, 1964). This clustering was not standardized; however, and most investigators simply counted the number of events reported by subjects over arbitrarily defined periods of time (Rahe, Meyer, Smith, Kjaer, Holmes, 1964). Holmes and Rahe (1967), hoping to bring greater precision to such life stress and illness studies, scaled 43 representative life change events (i.e., divorce, changes in health, income, employment) to arrive at estimates of their social readjustment (i.e., one aspect is stress) magnitudes as perceived by the participants. Studies that began at the University of Washington in Seattle continued at the U.S. Navy Neuropsychiatric Research Unit in San Diego and utilized the epidemiologic method in evaluating another psychosocial factor thought to be important in disease etiology – subjects' recent life change (Rahe, 1975). These scaling studies became well known and the resultant magnitude estimations, later termed life change units (LCU), were used in several epidemiological studies of persons' stressful life events and their subsequent illness experiences (Miller & Rahe, 1997). Although 42 of these 43 events were rescaled in the mid 1970s, this second scaling study was required after Rahe revised and expanded the Schedule of Recent Experience (SRE; Rahe, 1975). The revised and expanded SRE is called the Recent Life Changes Questionnaire (RLCQ) and was most recently updated in a 1995 study (Miller & Rahe, 1997). The RLCQ inquires about 74 potential recent life change events in a person's life. The events are summed over four 6-month intervals across the past 2 years. Scaling data derived from this study serve to bring the RLCQ up to date in terms of applicable LCU magnitudes

for these events. Six month totals equal to or greater than 300 LCU, or 1-year totals equal to or greater than 500 LCU, are considered indicative of high recent life stress (Miller & Rahe, 1997). Serving as a partial, but measurable aspect of recent life “stress,” subjects’ recent life change experiences have been correlated with their subsequent illness reports. Statistically significant, but generally low-order, correlations have been repeatedly found (Miller & Rahe, 1997).

New measures were constructed in an effort to increase life-events measures’ predictive validity. For instance, the prevailing approach of life-events measurement itself shifted, from gauging life-change impact via previously established normative weightings, which assumed a given event’s impact to be constant across persons, and which did not differentiate between desirable and undesirable events (Holmes & Rahe, 1967; Rahe, 1975; Miller & Rahe, 1997), to measuring each event’s impact by self-reported, subjective weightings, thereby incorporating each individual’s appraisal of the event’s intensity and desirability (Sarason, Johnson, & Siegel, 1978).

Social Support

Conceptualization of social support. Theorists have debated its components of the second independent variable of this study, social support. House (1981) proposed that social support is “an interpersonal transaction involving one or more of the following: (1) emotional concern (liking, love, empathy), (2) instrumental aid (goods and services), (3) information (about the environment), or (4) appraisal (information relevant to self-evaluation)” (p. 30). This list establishes the “what”; the “whom” might include a spouse, relatives, friends, neighbors, work supervisors, coworkers, caregiver,

and professionals. In short, House sees support in terms of problem-related social interactions with a broad range of people.

Lin (1986) suggested that a person's linkage to the social environment can be represented at three distinct levels: the community, the social network, and intimate and confiding relationships. Support springs from the bonds and obligations of relationships with family, friends, and acquaintances (at work, at school, and in organizations), as well as from contacts with helping professionals (Lin, Simeone, Ensel, & Kuo, 1979). Cobb (1976) emphasized that social support provides meaningful attachments to others, integration in a network of shared relationships, opportunity for nurturing others and being nurtured by them, reassurance of an individual's worth through performance of valued social roles, a sense of reliable alliance with kin, and access to guidance in times of stress (Cobb, 1976).

Kaplan et al. (1977) defined social support as "the relative presence or absence of psychosocial support resources from significant others" (p. 109). Thoits (1982) defined it as "the degree to which a person's basic social needs are gratified through interaction with others" (p. 147). These needs were identified as including affection, esteem or approval, belonging, identity, and security (p. 147). Turner, Frankel, and Levin (1983) suggested "social support and social support resources should be viewed as related but distinct concepts" (p. 74). The former is seen as "a personal experience rather than a set of objective circumstances or even a set of interactional processes" (p. 74). Shumaker and Brownell (1984) defined social support as "an exchange of resources between at least two individuals perceived by the provider or the recipient to

be intended to enhance the well-being of the recipient” (p. 17). In their model, support is not limited to a stress reduction but includes a broader outcome. They also tie positive, negative, and neutral outcomes to intentions. Lin (1986) proposed a definition of social support as “the perceived or actual instrumental and/or expressive provisions supplied by the community, social networks, and confiding partners” (p. 18). He distinguished two broad categories of support. First, the “instrumental dimension involves the use of the relationship as a means to achieve a goal” (p. 20) whereas the second expressive dimension “involves the use of the relationship as an end as well as a means” (p. 20).

All of the above definitions highlight social ties, exchanges, and subjective appraisal. They focus on support in the context of problems, explicitly avoiding this constraint or emphasize functions related to ongoing social needs. Most recognize several sources of support but distinguish these differently. Social support researchers continue to wrestle with conceptual and methodological issues. They are still arguing about the degree to which they should focus on events and activities or on individual perceptions of these. Should social support researchers count the number of friends that a person has or how often they are visited? Is a person’s membership in informal organizations the proper object of study? Should intimate relationships be observed to assess the frequency of carefully defined activities, such as expressing empathy, making suggestions, or sharing tasks? Or should the spotlight be turned on the individual’s perception of these events and activities – his sense of belonging to a

church congregation, her feelings of being bonded with friends, or his conception of the support provided or available within a close relationship?

Another source of diversity and confusion in social support thought and research concerns the varied forms and functions of social support. People assist one another in a variety of ways, and relationships serve many functions. In delineating the topic, early writers sketched out the kinds of activities that constituted support. For example, Caplan (1974) noted three broad categories of activity: (1) helping to mobilize resources and manage emotional problems, (2) sharing tasks, and (3) providing material and cognitive assistance to help deal with a particular stressful situation. Cobb (1976) distinguished information leading to beliefs of being cared for, esteemed, and involved. Weiss (1974) distinguished six provisions of social relationships, including attachment, social integration, reassurance of worth, reliable alliance, guidance, and opportunity for nurturance. Weiss view of social provisions is relational, that is, feeling support arises from relationships, not from particular activities. Numerous other researchers have distinguished modes and functions of social support. The terminology and distinctions made are varied and confusing. For instance, consider key terms for support by major theorists: instrumental and affective (Pattison, 1977); tangible, intangible, advice, and feedback (Tolsdorf, 1976); concern, assistance, valued similarity, positive interaction, and trust (Brim, 1974); emotional support, cognitive guidance, tangible assistance, social reinforcement, and socializing (Hirsch, 1980); self-esteem, appraisal, belonging, and tangible support (Cohen and Hoberman, 1983); emotional support, socializing, practical assistance, financial assistance, advice/guidance (Vaux, 1988); emotional,

appraisal, informational, and instrumental (House, 1981); esteem, informational, instrumental, social companionship, motivational (Wills, 1985); and instrumental and expressive (Lin, Dean, and Ensel, 1986).

Vaux's (1988) model has been frequently cited possibly because of its simplicity and depth. He contends that supportive activities are often very subtle social behaviors such as listening, expressing concern, showing affection, sharing a task, caretaking, loaning money, giving advice, making suggestions, and socializing. These activities function to elicit feeling of love, belonging, intimacy, and integration. Evidence of support function can be obtained only by an examination of subjective appraisals; that is, the person's cognitive-affective condition of his or her sense of being loved, of belonging, or of feeling attached (Vaux, 1988).

Vaux (1988) also proposes three social support constructs: support network resources, supportive behavior, and subjective appraisals of support. These constructs refer to, respectively, features of the network of individuals who routinely provide assistance, specific acts of assistance, and the person's evaluation of such resources and assistance. In addition, support may be derived through diverse social ties, ranging from the strong ties of intimate confidant relationships to the weak ties of social acquaintanceship. Support serves different functions and takes different forms. Vaux (1988) reports that a consensus is emerging regarding the importance of six modes of support: emotional, advice/guidance, feedback, practical, financial/material, and socializing. In short, social support is now viewed as a metaconstruct comprising several conceptual components. Rather than using the term in a general way, theorists

and researchers can be more specific by focusing on the above constructs within the context of social support. These three conceptual elements are linked in a dynamic process of transactions between the individual and his or her social environment. Further, the sources, forms and functions of support are recognized as multidimensional.

Vaux (1988) suggested the support network as a concept to help clarify support systems. A support network is that subset of the larger social network to which a person routinely turns or could turn for assistance (or which spontaneously provides such assistance) in managing demands and achieving goals (Vaux, 1988). Overlapping networks may provide specific kinds of support such as emotional, practical, financial, advice/guidance, appraisal, and socializing. Support networks are assumed to show stability both in size and composition except during periods of developmental transition (for example, going to high school, getting married) or nonnormative life change (for example, divorce, disabling accident).

Friendship networks, interest groups, religious groups, and human service agencies may partially substitute for or supplement help from the family if it alone cannot provide enough or appropriate support (Vaux, 1988). This is more likely when the family cannot adequately respond, such as situations in which the performance of routine tasks is thrown into disarray, patterns of exchange and reciprocity are disrupted, or family members do not have the skills needed to provide appropriate assistance.

The availability of supports depends in part on a person's position in a network of persons willing and able to provide support (McLanahan, Wedemeyer, & Adelberg,

1981). Members of primary groups are not always able or willing to help. For example, a divorce upsets the pattern of exchange in a family and kin network. Family members may not approve of the decision to divorce. There may be strained relationships with in-laws. Some friends become defined as “his” or “hers,” thereby further cutting potential support (Miller, 1970). In situations such as divorce, the source and type of support available to a person may be more problematic, and help may be needed from outside one’s circle of family and friends. It is also the case that the help offered may not actually be helpful. “Help” may include bad advice, actions that restrict a person’s options, or advice that leads to anger and frustration (“I’m telling you this for your own good.” “What you need to do is ...”).

Vaux (1988) distinguishes diverse supportive behaviors as being intentional efforts to help a person, either spontaneously or upon request. These include both providing tangible goods and services and expressing affection and evaluation. Six modes of supportive behavior reflect an emerging consensus: emotional, feedback, advice/guidance, practical, financial/material, and socializing (Vaux, 1988). Despite good intentions, supportive behavior is not necessarily helpful; the outcome will depend on the amount, timing, and mode of supportive behavior that occurs, as well as on the relationship with the provider and other aspects of the context.

Support appraisals are subjective, evaluative assessments of a person’s supportive relationships and the supportive behavior that occurs within them (Vaux, 1988). Appraisals may take many forms including satisfaction, feeling cared for, respected, or involved, and having a sense of attachment, belonging, or reliable

alliance. Appraisals also may be global, reflecting an evaluative synthesis of a person's relationships with the network as a whole, or focused, reflecting a particular domain of network relationships (for example, spouse, workmates, or friends), or a particular mode of support (for example, emotional or practical).

One way of measuring social support is by examining the size and density of a person's social network (Hirsch, 1980; House & Kahn, 1985). Another way in which social support has been characterized is by measuring the actual enacted support a person receives (Cohen & Hoberman, 1983; Schaefer, Coyne, & Lazarus, 1981). A third way that social support has been categorized is by the perception of social support available to or received by the recipient (Sarason, Pierce, & Sarason, 1990).

Perceived social support. For decades, psychological research has recognized the importance of participant perception of experience. Clarifying the distinctions between social network characteristics and perceived social support is one way of refining the social support construct (Procidano & Heller, 1983). Social networks refer to the social connections provided by the environment and can be assessed in terms of structural and functional dimensions (Marsella & Snyder, 1981). For example, size, density, multiplexity, etc., refer to structural network characteristics while network functions include the provision of information, comfort, emotional support, material aid, etc. On the other hand, perceived social support refers to the impact networks have on the individual. If networks provide support, information, and feedback (Caplan, 1974), then perceived social support (PSS) can be defined as the extent to which an individual believes that his/her needs for support, information, and feedback are

fulfilled (Procidano & Heller, 1983). Lazarus, Averill, and Opton (1974) suggest that the perception of social support is one element in an individual's appraisal of and subsequent coping with stress. While the perception of support depends upon the availability of supportive structures in the environment, perceived support and support provided by networks are not identical. PSS probably is influenced by within-person factors, including both long-standing traits on the one hand, and temporal changes in attitude or mood on the other. Both of these may influence the perception of whether support is available or has been provided.

Procidano and Heller (1983) PSS measures were designed to measure the extent to which an individual perceives that his/her needs for support, information, and feedback are fulfilled by friends (PSS-Fr) and by family (PSS-Fa). The distinction between friend support and family support is considered important. Different populations (e.g., different age cohorts) may rely on or benefit from friend or family support to different extents. At a given time, there might be more change in an individual's friend network (e.g., through moving for education or employment) or family network (e.g., through death). Friend relationships are often of relatively shorter duration than family relationships.

During the mid 1980s, Barrera proposed the "buffering hypothesis." The buffering hypothesis is the expectation that social support (or some other psychosocial assets, such as coping style or coping skills) might buffer, or moderate, the impact of stressful events. Chronic stress can isolate its victims, alienate them from persons with whom they might otherwise enjoy mutually supportive relationships, and erode their

perception of being accepted and valued by others. Social support sometimes mediates stressful relationships determined in studies of chronically stressed groups such as families in poverty, or persons with chronic illness, or their caregivers (Gersten, 1992; Procidano, 1992b). There has been evidence for social support's direct positive relationship to well-being and inverse relationship to symptomatology/distress (Cohen & Wills, 1985; Procidano, 1992a; Procidano & Smith, 1997).

Cobb (1976) reported that an individual's sense of being loved and cared for, respected and esteemed, and involved or on his or her sense of attachment, reliable alliance, reassurance of worth, or other provisions of social relationships were related to well-being. Pearlin (1985), making similar points, has referred to "latent social ingredients" of support. He writes, "Much support is sought, recognized, and contracted for in response to concrete problems. But much of it has a general presence, is beyond the level of awareness, and is embedded in the everyday transactions that take place between people in their prosaic pursuits" (p. 52).

In general, social embeddedness, as inferred from structural characteristics of peoples' social networks (e.g., number and type of relationships), generally predicts well-being but not distress and does not buffer stress; whereas, enacted support sometimes correlates with the incidence of stress but does not predict well-being or distress. Of the three approaches, perceived support most consistently contributes to well-being and distress and buffers, or moderates, the impact of life stress (Cohen & Wills, 1985; Procidano, 1992a).

Investigators of perceived social support have been guided by Cobb's (1976) early description of social support as information that leads a person to believe that he or she "is cared for and loved ... esteemed and valued ... and belongs to a network of communication and mutual obligations" (p. 300). Support perception is generally viewed as synonymous with support appraisal (Barrera, 1986; Cohen & Wills, 1985). Sarason, Pierce, and Sarason (1990) added conceptual enrichment by defining perceived support as a sense of acceptance.

Recent investigations have demonstrated that general, support-related cognitive schemas predict more specific support perceptions (Lakey & Cassady, 1990; Lakey & Dickinson, 1994). Beck originally defined a schema as "a (cognitive) structure for screening, coding, and evaluating the stimuli that impinge on the organism ... On the basis of this matrix of schemas, the individual is able to orient himself [sic] in relation to time and space and to categorize and interpret experiences in a meaningful way" (1967, p. 283, as cited by Young, Beck, & Weinberger, 1993). Procidano and Smith (1997) suggested that cognitive and cognitive-behavioral conceptions apply directly to perceived support and its assessment. Like self-schemas, people simultaneously carry both positive and negative support schemas (e.g., "I am accepted and considered worthy" vs. "I am considered incompetent and am rejected"). A particular schema's salience, relative to that of other schemas depends on the individual's learning history. People's behavior can be seen as efforts to confirm positive or negative schemas (e.g., through striving for success or for rewarding relationships vs. through procrastination or becoming involved in abusive relationships). A particular schema can be elicited and

strengthened by life events with which it is consistent (e.g., experiencing success vs. being devalued). Similarly, people spontaneously make both positive and negative support statements. Thus, support schemas influence the emergence of support statements, which in turn, as they accumulate over time, influence both support schemas and self-schemas (consistent with the main-effect model, which posits that social support enhances self-esteem).

Several studies have reported relationships between attachment to parents and self-models on the one hand, and perceived support on the other potentially explain perceived support's origins (Blain, Thompson, & Whiffen, 1993; Lakey & Dickinson, 1994; Sarason et al., 1991; Procidano & Smith, 1997; Asendorpf & Wilpers, 2000). Attachment theory can add validity to perceived support research through its consideration of the importance of emotional bonds (Procidano & Smith, 1997). Perceived support is more than cognition, as the Sarason et al. (1990) "sense of acceptance" definition suggests. More enduring support schemas, and more spontaneous support statements, are interwoven with positive emotions such as contentment and warmth, happiness and joy, as opposed to negative emotions such as anxiety, depression, and anger. In many different non-clinical and clinical groups, for instance, perceived family and friend support are interrelated, suggesting a continuity from the quality of people's early relationships to that of subsequent ones (Procidano, 1992a).

Personality traits also are related to perceived social support. Most empirical attention for their relevance to social support include gender-related characteristics,

such as instrumentality, expressiveness, androgyny, introversion-extroversion, and hostility. Women report higher perceived support, have more effective support-seeking skills, are more likely to seek support openly, and tend to establish more functional support networks (Olson & Schultz, 1994). Extraversion also has been linked to support receipt and perception, since extraverts are likely to be less aroused and more comfortable in interpersonal situations in general (Lakey & Dickinson, 1994; Procidano, 1992a; Zellars & Perrewe, 2001). Hostility has been associated consistently with fewer positive support experiences (Raikkonen, Keskivaara, & Keltikangas-Jarvinen, 1992). Hostile individuals are likely to behave in ways that alienate others from providing support and also to construe a wider variety of transactions as nonsupportive, based on their support-related schemas.

Other areas researchers have examined are global perceptions of support and reports of the support received after a stressful event (Barrera, 1986; Dunkel-Schetter & Bennett, 1990). Although both inevitably reflect an individual's perceptions of support, the former may be better seen as reflecting a stable personality characteristic in its own right (Lakey & Cassaday, 1990), while the second is more functional, and attuned to a particular event or domain (Sarason et al., 1997). These two types of support might be only weakly correlated (Barrera, 1986). Second, we can distinguish between different sources of support, which may operate differently under different circumstances (Sarason et al., 1997). Some individuals may receive little support from friends, but this may be compensated for by support from their family (Hobfoll, 1988).

This “balancing out” of needed support may also be highly culture dependent, given that family integration is more highly valued in collectivist, familial cultures (Fukayama, 1995). Research on the personality correlates of culture has suggested that individuals high on collectivism enjoy higher life satisfaction. Goodwin and Plaza (2000) found that their support networks are a critical factor in their life satisfaction.

Social support studies. Rook and Dooley (1985) reported that the variance in psychological functioning accounted for by social support ranged from 2 percent to 17 percent in eighteen studies reviewed. Higher figures are sometimes reported and, in general, support appraisals show a stronger association with well-being than do support resources or behaviors (Vaux, 1988).

Weiss (1974) proposed differentiated links between support and affective problems. He distinguishes social and emotional loneliness, forms of distress that not only have different origins with respect to social support but different affective sequela. According to this view, social loneliness results from the lack of a network of social relationships and is associated with boredom and depression. In contrast, emotional loneliness results from the absence of a close and intimate attachment to another person and is associated with a sense of isolation and anxiety. Pearlin, Lieberman, Menaghan, & Mullan, (1981) have suggested that depression may be a probable outcome of the stress process under certain conditions, specifically, when life events exacerbate chronic strains that undermine a person’s self-esteem and sense of mastery. They argue and present evidence that emotional support, specifically, averts this process by bolstering self-esteem and mastery.

Bansal, Monnier, Hobfoll, & Stone (2000) explored the influence of anger and depressive mood on the receipt of perceived workplace social support and perceived workplace resources among 121 postal workers over a period of 3 months. They theorized that emotional distress would result in perceptions of decreased social support and workplace resources for women, but not men. The hypothesis was partially supported. Interaction effects revealed that, whereas women perceived losing support and resources when experiencing depression and anger, respectively, these emotions had only limited negative consequences for men. The findings suggest that emotions are more closely linked with perceptions of social support and workplace resources for women than for men. Conversely, negative emotions have been reported to disrupt social interactions (Patterson & Forgatch, 1990). Second, people's emotional distress can burden their support providers, resulting in potential loss of both support and the other resources that supporters might contribute (Kaniasty & Norris, 1993).

The mediational effect of hardiness (hardiness – commitment, control, and challenge that function as a resistance resource) on social support relative to health and well-being was investigated using 443 elderly subjects (Wallace, Bisconti, Bergeman, 2001). Results revealed that across types of support (i.e., quantity of family and friend support) and outcomes (i.e., depression, life satisfaction, and self-reported health), there is consistent evidence for the mediation role of hardiness. Additionally, the study provided consistent evidence for the mediating role of hardiness in the relation between social support and outcome. One possible interpretation is that social support may influence self-esteem, foster (or inhibit) the sense of being cared for, and encourage (or

limit) community involvement. This type of influence, in turn, may affect one's attitudes and perceptions of the self and of the larger community, thus promoting the subcomponents of hardiness. For instance, the level of one's social support network might contribute to one's feelings of control, openness to new experiences, and beliefs about oneself and one's activities. In turn, it is this internal psychological significance of the external event that actually promotes health and well-being outcomes. In contrast, a second possible interpretation of the mediational model suggests that hardiness may help individuals mobilize their social support resources. In particular, one's level of hardiness may relate to seeking out support, as well as the effective utilization of that support. The way in which social support is used, in turn, may contribute to psychological well-being and physical health outcomes. Thus, the external event (social support) is transformed in some way by the properties of the person (hardiness).

Several researchers have reported a relationship between social support and physical and psychological well-being (Cohen & Wills, 1985; Komproe, et al., 1997; Thevos, Thomas, & Randall, 2001). Individuals who have a strong social support system can recover from stress and trauma better than people who do not (Berkman & Syme, 1979; LaRocca, House, & Kahn, 1985; Baumeister, Faber, & Wallace, 1999). Social support has been shown to aid people in adjusting to stressful life events (Berkman & Syme, 1979, LaRocca, House, & Kahn, 1985). Loss of or changes in possessions, position, or relationships with others disrupts accustomed ways of thinking, perceptions of the self, the performance of tasks, and interactions with others

(Parkes, 1971). Parkes (1971) speculates that in such situations, a person's assumptions need to be examined and retested, and habits need to be modified. Supportive persons may reduce the feeling of being in a strange, ambiguous, or unexpected situation. Support brings assurance that although some of a person's life has been modified, much of it remains the same. This continuity helps people to re-establish their equilibrium and routines more rapidly (Parkes, 1972). Primary groups such as families or friendship networks may provide support for an individual by taking over or assisting in the performance of instrumental tasks by providing a setting for expressing emotions and testing coping strategies, and by maintaining continuity in other aspects of a person's life (Litwak, 1985). Relationships thus serve to buffer or mediate some of the stress-producing aspects of life changes (Dean & Lin, 1977). They do so, in part, by providing feedback or evidence from others that actions are leading to the desired outcome in the new situation and by providing opportunities to express pent-up emotions during conditions of uncertainty and indecision (Cassel, 1976).

Religion and Spirituality

Survey research has consistently shown the importance of religion in the lives of Americans. Throughout the 1980's a little over half of the nation consistently ranked religion as very important (Gallup & Lindsay, 1999). In Gallup Polls during 1998, 87% of the nation ranked religion as very important (60%) or fairly important (27%), mirroring similar public opinion polls conducted for the past 3 decades (Gallup & Lindsay, 1999). Gallup polls of 1998 indicated that 65% in the nation believe religion can answer all or most of today's problems with 20% indicating that religion is largely

old-fashioned and out-of date (Gallup & Lindsay, 1999). Gallup polls of 1997 indicated that 95% of the American public believes in God or a "higher power," which is consistent with beliefs expressed over the past 50 years where the percentage of Americans who believe in God has never dropped below 90% (Gallup & Lindsay, 1999). A review of the demographics of religiosity consistently portrays America throughout its history and into the present as a nation of religious believers. Religiosity appears to be a distinctive feature that requires consideration in all aspects of applied psychology, including the psychology of coping and psychological treatment (Kosmin and Lachman, 1993).

Historically, spirituality and religion have often been viewed dichotomously by those prominent in psychology. While William James, Viktor Frankl, and Carl Jung have seen the value in spirituality, other prominent psychologists have viewed spirituality as irrational and destructive (Meyer, 1988). Meyer (1988) cited that more recently, Ellis (1980) stated "the elegant therapeutic solution to emotional problems is to be quite unreligious and have no degree of dogmatic faith that is unfounded or ungroundable in fact ... The less religious they are, the more emotionally healthy they will tend to be" (p. 637). Warmock (1989) offers the following synopsis of psychological theorists on religion, "Through the years, religion has been viewed by psychologists and those in related professions in many ways: by Freud as an illusion, an obsession and a fulfillment of infantile wishes; by Jung as an Archetype; by Fromm as human love; by Erikson as an epigenetic virtue; by James as an intensely personal experience; by Sargant as a matter of classical conditioning; by Skinner as a matter of

operant conditioning; by Allport as a matter of personal becoming; and by Maslow as a quest for man's higher nature ..." (p. 263).

In a survey, Genia (1994) noted that "compared with the public at large, secular psychotherapists are less likely to affiliate or participate in organized religion and are more likely to express their spiritual interests in nontraditional ways" (p. 395). Lovinger (1984) posited that "training in the sciences (such as psychology, psychiatry and nursing) is at odds with the religious orientation and background of many Americans." He also stated that "the humanist orientation and liberal political outlook of training institutions tends to complement a worldview which is essentially nonreligious, if not anti-religious" (p. 2).

The antagonism is not one-sided; many religions reject psychology and the human sciences just as avidly. Many within the religious community believe that religion is the domain of chaplains, pastors, priests, rabbis, shamans, and so on, not psychologists (Meyer, 1988). During the past two decades, political and religious fundamentalists have launched a vigorous campaign against humanism (Gould, 1990). Some charge that humanism is immoral and anti-God, and that it has taken over the government, education, the United Nations, and is attempting to control the world (Lahaye, 1980). Robinson and Wilson (1982) compare the attacks to the McCarthy era tactics of the 1950s, only now humanists instead of communists are the scapegoats.

Research performed by Gould (1990) exploring the ethical, religious, and spiritual beliefs of humanists suggests these allegations may be unfounded. Specifically, a clear majority of participants in Gould's research (59%) believed in the

Judaic-Christian God. Although 72% disagreed that humanism is a religion, 83% believed that there are more similarities than differences among humanist and religious values, and 83% agreed that, if freely chosen, religion is consistent with humanistic beliefs. It was also found that 79% believed in a universal spiritual force that can manifest itself in ways other than the Judaic-Christian God. Gould (1990) posited the results of his study “suggest that a large majority of these humanists demonstrate a high compatibility with traditional religious beliefs and values. The supposed humanist aversion to religion is not supported by these findings.”

However persons chose to describe their religious and spiritual experiences, as reported above, they view them as very important aspects of their lives. Mounting empirical studies demonstrate that for many Americans, spirituality and/or religion are very important means of coping with major illness (Koenig, 1998). In psychological well-being and recovery from illness, illness prevention and health enhancement, suicide prevention, substance abuse prevention, preventing heart disease and high blood pressure, negotiating with pain, and good dying, the clinical evidence for the impact of religious beliefs is increasingly strong (Francis & Kaldor, 2002; Larson & Milano, 1995; Pargament, 1997; Siegel & Schrimshaw, 2002).

Although the APA, 1981 ethical code addressed religion in the context of non-discrimination among employees and by employers, it did not address religion in the context of competence until the revision of 1992 (APA Ethics Code, 1981; APA Ethics Code, 1992). Principle D of the ethics code states, “Where differences of age, gender, race, ethnicity, national origin, *religion*, sexual orientation, disability, language, or

socioeconomic status significantly affect psychologists' work concerning particular individuals or groups, psychologists obtain the training, experience, consultation, or supervision necessary to ensure the competence of their services, or they make appropriate referrals" (APA Ethics Code, 1992; italics added). Principle B adds that "Psychologists strive to be aware of their own belief systems, values, needs, and limitations and the effect of these on their work." (APA Ethics code, 1992). Thus, to remain true to the ethical guidelines of professional psychology, religion should be at least considered within the context of a cultural framework, lest religious clients be denied the same understanding afforded to those more overtly culturally distinct.

Spirituality and religiosity and how these may relate to mental health is receiving increasing attention in the field of psychology. "Scientists and philosophers have often viewed religious belief as little more than magical thinking employed in the pathetic attempt to understand nature and to influence natural forces that are otherwise beyond our control" (p. 122; Alcock, 1992). As a result, some view religion as irrational and mentally unhealthy. Likewise, some religious leaders have often viewed mental health professionals as charlatans who meddle in matters that should be left to religious leaders (Meyer, 1988). Many in the mental health field have been wary of religion's effect on mental health while many active in religion have been wary of the mental health field's effect on the perception of religion (Bergin, 1983). This type of stand-off has been in effect without any empirical data to support either position for many years (Meyer, 1988).

Religious orientation. Allport and Ross (1967) were the first to characterize a person's religious dimension into two categories, intrinsic and extrinsic religiosity. Their study was intended to determine whether churchgoers are more prejudiced against ethnic minorities than non church attenders. Instead of finding a linear relationship where low attenders had low prejudice scores and high attenders had high prejudice scores, Allport and Ross found a curvilinear relationship. To explain this, a person's religious motivation was called into question. In essence, they found that an extrinsically religious person is motivated to use religion for personal gain. The religious beliefs are shaped into whatever form to meet the person's primary needs. In contrast, an intrinsically religious person finds their "master motive in religion" (Allport & Ross, 1967, p. 434). They internalize the rules, laws, and beliefs of their religion. Allport and Ross (1967) developed the Religious Orientation Scale (ROS) to measure intrinsic and extrinsic religiosity.

Additional instruments based on the ROS developed by Allport and Ross were developed over the next several decades. Gorsuch and Venable (1983) developed an age universal version of the religious orientation scale. Gorsuch and McPherson (1989) determined by confirmatory multiple group factor analyses that extrinsic items could be identified as those concerned with social relationships ("Es") and with personal benefits ("Ep"). Maltby (1999) incorporated changes suggested during 30 years of investigation to develop the 'Age-Universal' I-E Scale – 12. This instrument is slightly shorter with only 12 items and retains items for the Es and Ep proposed by Gorsuch.

During the past two decades, numerous studies have shown that people who are religiously devout or intrinsic in their religious orientation tend to enjoy better physical and mental health (Gartner, 1996; Richards & Bergin, 1997). The evidence suggests that intrinsic religiousness is a healthy and mature way of being and is a resource in many peoples' lives (Richards & Bergin, 1997; Park & Cohen, 1992).

Park, Meyers, and Czar (1998) performed a study to explore the relationship of the California Psychological Inventory (CPI) 3-vector model of personality and various aspects of religiosity and spirituality. Their study supported the notion that a link exists between self-realization and religiosity/spirituality. Individuals who were more self-realized possessed greater spiritual well-being and tended to have more intrinsic, committed, and consensual religious orientations as well as stronger religious commitment and more frequent spiritual experiences.

Acklin, Brow, and Mauger (1983) conducted a study concerning anger and intrinsic religiosity measured by the Religious Orientation Scale (Allport & Ross, 1967). Subjects for their study were adult cancer patients at a Baptist medical center. The authors found intrinsic religiosity and church attendance to be inversely related to anger and hostility in cancer patients.

Several studies examine relationships between religiosity and depression. Nelson (1989) studied the religious behaviors of 68 elderly persons consisting of 47 % Whites, 50% Blacks, and 3% Mexican Americans. Findings indicated that Blacks were more intrinsically oriented toward religion than were Whites, but Blacks were more

depressed than Whites. There was a significant negative relationship between intrinsic orientation and depression for whites, blacks, and Mexican Americans.

Nelson (1990) performed a study of 68 community-based elderly persons. Her study concluded that subjects with high self-esteem had more intrinsic religious orientation and were less depressed. On the other hand, a study performed by Commerford and Reznikoff (1996) of 83 nursing home residents indicated that intrinsic religiosity and the subjects perceived social support from friends were not significantly related to depression or self-esteem. Perceived social support from family, public religious activity, and length of stay in the home were related to self-esteem and to depression. Health status and having a choice in selecting the nursing home were negatively related to depression.

Horton (1999) investigated the role of religion in the adjustment process of mothers raising children with chronic physical conditions (either spina bifida or cerebral palsy). She found that mothers who endorsed a high intrinsic religious orientation exhibited more positive adjustment and those with high extrinsic orientations were associated with poorer adjustment during times of high perceived disability-related stress.

Ekemo (1996) examined adjustment to widowhood by 168 participants from local organizations. She found that internal locus of control and intrinsic religious motivation were significantly associated with self-reported adjustment to widowhood, as was collaborative problem solving.

Other researchers have found relationships between intrinsic religiosity and purpose in life and death concern or anxiety. Bolt (1975) examined purpose in life and religious orientation. His study supported the hypothesis that the people who are intrinsic and indiscriminately proreligious have a significantly greater sense of purpose in life than the extrinsic person. Death concern or anxiety has been found to be negatively related to an intrinsic religious orientation (Kahoe, Dunn, 1976; Thorson, 2000; Maltby, 2000).

Two studies indicate that anxiety and worry are inversely related to an intrinsic religious orientation. Baker and Gorsuch (1982) studied the relationship of intrinsic and extrinsic among participants in a religious camping organization. They found that persons who were intrinsic were less anxious than persons who were not intrinsic, and extrinsic persons were more anxious than persons who were not extrinsic on some components of trait anxiety. Tapanya, Nicki, and Jarusawad (1997) studied 104 non-institutionalized, middle class, and generally healthy elderly adults (aged 65 – 90 yrs). Multiple regression analysis revealed that overall for both Buddhists and Christians, an intrinsic orientation toward religion was associated with less worry. An extrinsic orientation among Buddhists, in contrast to Christians, was linked to greater worry.

While reviewing psychological literature related to intrinsic and extrinsic motivation, Batson, Schoenrade, and Ventis (1993) identified seven different conceptions of mental health. These seven conceptions are absence of mental illness, appropriate social behavior, freedom from worry and guilt, personal competence and control, self-acceptance or self-actualization, personality unification and organization,

and open-mindedness and flexibility. For the extrinsically motivated individual, a negative relationship was found between extrinsic scores and good mental health in the majority of the eighty studies. For the intrinsically motivated individual, the results were not as clearly delineated. Just over half of the studies showed a positive relationship between intrinsic scores and good mental health while approximately fifteen percent showed a negative relationship between intrinsic scores and good mental health. The remainder showed no clear relationship with good mental health.

Spiritual well-being. Spiritual well-being is the affirmation of life in a relationship with God, self, community, and environment that nurtures and celebrates wholeness (National Interfaith Coalition on Aging, 1975). Moberg (1978) believes that spirituality is not synonymous with religion and refers to the overall “wellness” of the “inner resources” of people.

Many measures that were developed to assess quality of life involved objective indicators and did not assess the internal feelings or perceptions of respondents and very few mentioned the role of religion or spirituality in perceived well-being (Paloutzian & Ellison, 1982). Moberg and Brusek (1978) suggested in their pioneering work that spiritual well-being is best conceived as having two dimensions. A vertical dimension refers to one’s sense of well-being in relationship to God. A horizontal dimension connotes one’s perception of life’s purpose and satisfaction apart from any specifically religious reference.

The Spiritual Well-Being Scale (SWBS) was developed to measure these two dimensions Religious Well-Being (RWB) and Existential Well-Being (EWB),

respectively (Paloutzian & Ellison, 1982). SWBS is viewed as an expression of spiritual health or maturity and with the need for transcendence, which refers to a sense of well-being that comes from purposes involving ultimate meaning in life (Paloutzian & Ellison, 1982). The RWB scale measures the sense of well-being in relationship to God. The EWB scale measures one's well-being related to their sense of purpose and satisfaction apart from any specifically religious belief system. Thus, SWBS is a) the subjective, cognitive/affective evaluation (i.e., satisfaction) of the purpose and ultimate meaning of one's life; and b) an expression of spiritual health or maturity. To have a sense of existential well-being is "to know what to do and why, who (we) are, and where (we) belong" (p. 137; Blaikie & Kelsen, 1979) in relation to ultimate concerns. Both dimensions involve transcendence, or a stepping back from and moving beyond what is.

A 1998 Gallup Poll indicated that 69% of Americans have thought a lot about the basic meaning and value of their life during the past two years with 20% indicating thinking a fair amount (Gallup & Lindsay, 1999). A 1998 Gallup Poll indicated how much Americans thought about their relationship with God. Poll results indicated that 58% thought a lot, 21% a fair amount, 14% only a little, and 7% not at all or had no opinion related to how much they have thought about their relationship with God during the past two years (Gallup & Lindsay, 1999).

Ellison (1983) suggested that the spiritual dimension is not isolated from the psyche and it affects and is affected by our physical state, feelings, thoughts, and relationships. "It is the spirit of human beings, which enables and motivates us to search

for meaning and purpose in life, to seek the supernatural or some meaning that transcends us, to wonder about our origins and our identities, to require morality and equity.” (Ellison, 1983, p. 331). Ellison (1983) believed that the spirit synthesizes the total personality and provides some sense of energizing direction and order in a person’s life. If one is spiritually healthy they will generally feel alive, purposeful, and fulfilled to the extent that they are psychologically healthy as well (Ellison, 1983). The relationship is bidirectional. Ellison (1983) suggested that to a lesser extent the spiritual well-being of a person is affected by physical well-being. There are numerous cases of courage (or faith) which has allowed people to transcend physical handicaps and suffering, and to experience spiritual and emotional health and growth (Ellison, 1983). The key seems to be holding on to one’s deepest spiritual commitments and being able to interpret the suffering within the context of deeper positive meaning (Frankl, 1963).

Paloutzian and Ellison (1982) studied quality of life as reflected in loneliness considering social context variables, developmental background variables, and values. Subjects included 115 middle-aged women who resided in a dense urban center, a medium sized city and a small farm town, and 206 subjects from college students. Lower loneliness was associated with higher SWBS, RWB, EWB, purpose in life scores, and intrinsic religious orientation. In nearly all cases, the strength of the relationships obtained with the nonreligious population was comparable to those obtained with the religious population.

Two studies identified a significant high correlation relationship between the Religious Well-Being (RWB) subscale of the Spiritual Well-Being Scale (SWBS)

instrument and the Intrinsic subscale of the Religious Orientation Scale (ROS) instrument (Ellison, 1983; Allport & Ross, 1967). The first study of 500 participants including men, women, housewives, college students, young adults and senior citizens, high school students, married and single persons, religious and non-religious people from large cities, small cities, and rural areas reported a Pearson correlation coefficient of .79, ($p < .001$) between the SWBS - RWB and ROS Intrinsic Scale (Ellison, 1983). The second study of 401 college students from three Western universities reported a correlation of .74 ($p < .01$) between the SWBS - RWB and ROS Intrinsic Scale (Park, Meyers, & Czar, 1998). This second study included 256 females, 144 males and one participant who did not report his or her sex. The students ranged in age from 17 – 58 years of age ($M = 23.53$, $SD = 7.26$) and were 50.1% Caucasian, 20.0% Asian, 10.5% Hispanic, 8.5% African-American, 1.7% Native American, and 7.7% other, with 1.5% not reporting their ethnicity. In total, 32.2% identified themselves as Christians, 30.9% were Catholics, 6.5% were Buddhists, 11.2% were of some other faith, 16.5% reported that they had no religious denomination, and 2.7% did not answer the question (Park, Meyers, & Czar, 1998).

Graham, et. al. (2001) performed a study with a sample of 115 graduate students in counseling to investigate the relationship among religion, spirituality, and the ability to cope with stress. In their study, religion and spirituality positively correlated with coping with stress. Counseling students who expressed spirituality through religious beliefs had greater spiritual health and immunity to stressful situations than counseling

students who identified themselves as spiritual but not religious. Counseling students with a religious/spiritual affiliation indicated more discomfort counseling clients hostile to religion compared with counseling students with a spiritual-only affiliation.

Hathaway and Pargament (1992) reported that when faced with a problem, religious individuals use a variety of religious coping resources which they draw from spiritual, cognitive, behavioral, and social aspects of their faith. Individuals who have a positive spiritual identity feel connected to God's love, feel self-worth, have meaning and purpose in life, and are better able to fulfill their greatest potential (Richards & Bergin, 1997). Several studies have offered evidence showing that religious individuals who receive support for their sense of worth and spiritual identity heal at a faster rate and are able to establish healthier lifestyles (Bergin et al., 1994; Richards & Potts, 1995; Graham, Furr, Flowers, & Burke, 2001).

Lazarus (2000) has tried to explain the impact of spirituality by describing it as an orienting system that determines, in part, an individual's method of coping. An orienting system can be seen as the sum of influences, individual and collective, conscious and unconscious, located within the individual and positioned outside as social forces that shape personal meaning and behavior. Lazarus (2000) wrote, "The conceptual bottom line ... is the relational meaning that an individual constructs from the person-environment relationship ... is the result of appraisal of the confluence of the social and physical environment and personal goals, beliefs about the self and world, and resources" (p. 665). The religious dimension within an orienting system shapes perspectives, attributions, and affects in its construction a subjective experience

which produces a world view where the secular and sacred perspectives are woven to provide broad categories of meaning. Pargament (1997) added that religion and coping converge because religion is a relatively available part of the orienting system and because it is a relatively compelling way of coping. The salience of religion within an orienting system varies among individuals.

Pargament (1997) reviewed over 30 studies where religious/spiritual coping was commonly used. Pargament's research team identified varieties of religious/spiritual coping and specific conditions associated with good and poor outcomes, and developed a theoretical framework to the search for significance. There is no simple answer regarding whether or not religion is effective in coping with life events or stress. Pargament (1997) determined that it depends on the kind of religion, who is doing the religious coping, and the situation the person is coping with. Depending on the interaction among variables, religion can be helpful, harmful, or irrelevant to the coping process (Pargament, 1997). Pargament (1997) concluded that (1) religious coping seems especially helpful to more religious people, (2) religion can moderate or deter the effects of life stress, or both, and (3) religious coping adds a unique dimension to the coping process.

In addition to the role of religion in the psychology of coping, there is accumulating empirical evidence identifying religion to be an important variable in health. Systematic reviews of empirical research and survey data suggest a positive correlation between religious commitment and participation and health status (Ellison & Levin, 1998; Levin & Chatters, 1998; Matthews, Larson, & Barry, 1993).

Kirkpatrick and Shaver (1992) showed that, among participants who believed in God, those describing their relationship with God as a 'secure attachment' were less lonely and depressed than those describing insecure attachment to God.

Client-Counselor Relationship and Counseling Outcome

Truax and Mitchell (1971) carried out the most complete and comprehensive review of studies of client-counselor relationship and counseling outcome up until 1971 and were optimistic in their conclusions about the strong relationship between therapist interpersonal skills and client improvement. They concluded that warmth, empathy, and genuineness contributed to positive change with a wide variety of clients across a variety of therapy modalities and theories.

Lambert et al. (1978) reviewed what they described as 17 well-designed and executed studies of facilitative conditions and outcome. They concluded that these studies present "only modest evidence in favor of the hypothesis that such factors as accurate empathy, warmth and genuineness relate to measures of outcome" (p. 472). These researchers indicated further that there were other unaccounted-for variables contributing to client change and that there was little evidence showing a cause-effect relationship between the facilitative conditions and outcome.

The Patterson (1984) review of studies pointed out that, while client-therapist relationship may be seen as critical to successful psychotherapy, the relationship between therapist attitudes and interpersonal skills and outcome is more ambiguous than was once thought. Much of the uncertainty about this stems from how relationship factors are measured. Specifically, research findings have shown that client perceived

relationship factors, rather than objective raters' perceptions of the relationship, obtain consistently more positive results. Furthermore, the larger correlations with outcome are often between client process ratings and clients' self-report of outcome. One explanation for this may be that clients as a whole perceive the therapeutic relationship as more positive than observers and clients are more accurate in their perceptions of the quality of the therapeutic relationship.

Gatson (1990) suggested the following components of the therapeutic alliance: (a) the client's effective relationship to the therapist, (b) the client's capacity to purposefully work in therapy, (c) the therapist's empathic understanding and involvement, and (d) patient-therapist agreement on the goals and tasks of therapy. The goals of therapy are the agreed-upon objectives of the therapy process that both parties must endorse and value. Tasks involve the behaviors and processes within the therapy session that constitute the actual work of therapy. Both therapist and client must view these tasks as important and relevant for a strong therapeutic alliance to exist.

Najavits and Strupp (1994) conducted a study in which 16 practicing therapists were identified as more effective or less effective using time-limited dynamic psychotherapy with outpatient cases. Therapist effectiveness was determined by clients' outcome scores and length of stay in treatment. Multiple measures of outcome were used and completed by clients, therapists, independent observers, and therapist supervisors. Results revealed that more effective therapists showed more positive behavior and fewer negative behaviors than less effective therapists. Positive behaviors included warmth, understanding, and affirmation. Negative behaviors included

belittling and blaming, ignoring and negating, and attacking or rejecting. Therapists were differentiated almost entirely by nonspecific (relationship) factors rather than specific (technical) factors. On the basis of these findings, Najavts and Strupp (1994) commented: "Thus, basic capacities of human relating – warmth, affirmation, and minimum of blame – may be at the center of effective psychotherapeutic intervention. Theoretically based technical interventions were not nearly as often significant in this study" (p. 121).

Reviews of process-outcome studies have identified specific therapist qualities, skills, and responses that are related to outcome. In their exhaustive review of over 2,000 process-outcome studies since 1950, Orlinsky, Grawe, and Parks (1994) identified several therapist variables that have consistently been shown to have a positive impact on treatment outcome: therapist credibility, skill, collaborativeness, empathic understanding, and affirmation of the client, along with the ability to engage with the client, invest in the treatment process, facilitate a strong therapeutic bond, focus on the patient's problems, and direct attention to the client's affective experience.

Using meta-analysis, Greenberg, Elliott, and Lietaer (1994) examined 19 process-outcome studies of client-centered and experiential therapies. Their results revealed a consistent, reasonably strong relationship between facilitativeness and outcome ($r = .43$). In studies reviewed, Greenberg et al. found improvement was positively correlated with therapist warmth, concreteness, and activeness (mean $r = .34$), with facilitative interventions ($r = .25$), and the strongest correlation with therapist self-relatedness (i.e., genuineness; $r = .61$).

Therapist empathy continues to resurface as a central element in treatment success. The above studies have strongly supported the importance of therapist-offered empathy in all forms of treatment with many types of clients. There is also a growing body of research linking therapist empathy with positive treatment outcomes (Bohart & Greenberg, 1997; Hill & Nakayama, 2000).

The ability to form a meaningful, collaborative working relationship between client and therapist has also been reported to promote effective therapeutic alliances and positive treatment outcome (Hatcher & Barends, 1996). This collaboration not only appears to involve the therapist's ability to communicate acceptance, warmth, and empathy but also requires the client and therapist to come to a mutual agreement on the goals of treatment and how those goals will be accomplished (Hatcher & Barends, 1996). Thus, collaboration between therapist and client begins with the client's experiencing security in the therapeutic relationship and further develops as the therapist and client exhibit a willingness to negotiate the goals and tasks of therapy (Hatcher & Barends, 1996).

The Lambert and Bergin (1994) review of the literature suggest there is an abundance of empirical data, spanning five decades, indicating that therapist facilitative skills such as acceptance, warmth, empathy, and genuineness are fundamental in establishing a good therapist-client relationship and are related to positive outcomes.

Martin, Garske, and Davis (2000) performed a meta-analysis of 79 studies relating the therapeutic alliance to outcome and found a moderate ($r = .22$) relationship of therapeutic alliance with outcome. Their findings further indicated that the alliance-

outcome relation was consistent regardless of the many variables that have been thought to influence this relationship.

Using meta-analytic techniques, Horvath and Symonds (1991) summarized the results of 15 years of therapeutic alliance research. They concluded that the quality of the alliance is a robust predictor of therapy outcome. The relationship between the alliance and eventual therapeutic outcome is apparent as early as the third session in therapy, and the correlation between alliance and the results of treatment seem to hold reasonably constant across various treatments, clinical diagnoses, and client populations (Horvath & Symonds, 1991). Horvath (2000) later found that it was not the objectively measured level of therapist's behavior that had the most powerful impact on the therapy outcome, rather, it was the client's perception of these qualities that foretold the success of counseling (Horvath, 2000). Furthermore, Horvath & Symonds (1991) concluded that research on the therapist-offered relationship conditions indicated that the client's perception was more predictive of the results of treatment than the therapist's report or third-party evaluations of the relationship quality. If the relation between alliance quality and outcome is accepted as a measure of validity, then the research literature indicates that the most trustworthy estimates of alliance quality are based on client reports, followed by outside raters, regardless of who evaluates outcome and therapists appear to be less astute judges of the level of alliance between themselves and their clients (Horvath & Symonds, 1991). The results of these studies also suggested that the relations among alliance and various outcomes were generally stronger than relations

found among other relationship constructs (such as empathy, transference, etc.) and outcome (Horvath & Symonds, 1991).

Summary of Literature Review

A review of the literature indicates there are relationships between psychological health and adjustment to adversity or life stressors and (1) life experiences, (2) social support, (3) religious orientation, and (4) spiritual well-being. This review shows the importance of the client-counselor relationship as one aspect in the therapeutic setting that may contribute to counseling outcome.

There is a correlation between life experiences and psychological well-being (Chiriboga & Catron, 1991; Jacobson, 1983). Typically, there are several concurrent life experiences that effect psychological well-being in adjusting to a life stressor (Parkes & Weiss, 1983). Holmes and Rahe (1967) have conducted several classic studies in the area of clustering stress events effects on health. Rahe (1975) revised, rescaled, and expanded the Schedule of Recent Experience SRE and most recently, during a 1995 study, revised his instrument to become the Recent Life Changes Questionnaire (RLCQ; Miller & Rahe, 1997). The RLCQ inquires about 74 potential recent life change events in a person's life.

House (1981) proposed that social support is "an interpersonal transaction involving one or more of the following: (1) emotional concern (liking, love, empathy), (2) instrumental aid (goods and services), (3) information (about the environment), or (4) appraisal (information relevant to self-evaluation)" (p. 30).

A source of diversity and confusion in social support thought and research concerns the varied forms and functions of social support. People assist one another in a variety of ways, and relationships serve many functions. In delineating the topic, early writers sketched out the kinds of activities that constituted support. Vaux's (1988) model has been frequently cited possibly because of its simplicity and depth. He contends that supportive activities are often very subtle social behaviors such as listening, expressing concern, showing affection, sharing a task, caretaking, loaning money, giving advice, making suggestions, and socializing. These activities function to elicit feeling of love, belonging, intimacy, and integration. Evidence of support function can be obtained only by an examination of subjective appraisals; that is, the person's cognitive-affective condition of his or her sense of being loved, of belonging, or of feeling attached (Vaux, 1988). Vaux (1988) also proposes three social support constructs: support network resources, supportive behavior, and subjective appraisals of support. These constructs refer to, respectively, features of the network of individuals who routinely provide assistance, specific acts of assistance, and the person's evaluation of such resources and assistance. In short, social support is now viewed as a metaconstruct comprising several conceptual components. Rather than using the term in a general way, theorists and researchers can be more specific by focusing on the above constructs within the context of social support. These three conceptual elements are linked in a dynamic process of transactions between the individual and his or her social environment. Further, the sources, forms and functions of support are recognized as multidimensional.

One way of measuring social support is by examining the size and density of a person's social network (Hirsch, 1980; House & Kahn, 1985). Another way in which social support has been characterized is by measuring the actual enacted support a person receives (Cohen & Hoberman, 1983; Schaefer, Coyne, & Lazarus, 1981). A third way that social support has been categorized is by the perception of social support available to or received by the recipient (Sarason, Pierce, & Sarason, 1990).

Perceived social support refers to the impact networks have on the individual. If networks provide support, information, and feedback (Caplan, 1974), then perceived social support (PSS) can be defined as the extent to which an individual believes that his/her needs for support, information, and feedback are fulfilled (Procidano & Heller, 1983). Lazarus, Averill, and Opton (1974) suggest that the perception of social support is one element in an individual's appraisal of and subsequent coping with stress. While the perception of support depends upon the availability of supportive structures in the environment, perceived support and support provided by networks are not identical. PSS probably is influenced by within-person factors, including both long-standing traits on the one hand, and temporal changes in attitude or mood on the other. Both of these may influence the perception of whether support is available or has been provided. Procidano and Heller (1983) PSS measures were designed to measure the extent to which an individual perceives that his/her needs for support, information, and feedback are fulfilled by friends (PSS-Fr) and by family (PSS-Fa).

Several researchers have reported a relationship between social support and physical and psychological well-being (Cohen & Wills, 1985; Komproe, et al., 1997;

Thevos, Thomas, & Randall, 2001). Individuals who have a strong social support system can recover from stress and trauma better than people who do not (Berkman & Syme, 1979; LaRocca, House, & Kahn, 1985; Baumeister, Faber, & Wallace, 1999). Social support has been shown to aid people in adjusting to stressful life events (Berkman & Syme, 1979, LaRocca, House, & Kahn, 1985).

Survey research has consistently shown the importance of religion in the lives of Americans. Throughout the 1980's a little over half of the nation consistently ranked religion as very important (Gallup & Lindsay, 1999). In Gallup Polls during 1998, 87% of the nation ranked religion as very important (60%) or fairly important (27%), mirroring similar public opinion polls conducted for the past 3 decades (Gallup & Lindsay, 1999). Religiosity appears to be a distinctive feature that requires consideration in all aspects of applied psychology, including the psychology of coping and psychological treatment (Kosmin and Lachman, 1993).

However persons chose to describe their religious and spiritual experiences, as reported above, they view them as very important aspects of their lives. Mounting empirical studies demonstrate that for many Americans, spirituality and/or religion are very important means of coping with major illness (Koenig, 1998). In psychological well-being and recovery from illness, illness prevention and health enhancement, suicide prevention, substance abuse prevention, preventing heart disease and high blood pressure, negotiating with pain, and good dying, the clinical evidence for the impact of religious beliefs is increasingly strong (Francis & Kaldor, 2002; Larson & Milano, 1995; Pargament, 1997; Siegel & Schrimshaw, 2002).

Allport and Ross (1967) were the first to characterize a person's religious dimension into two categories, intrinsic and extrinsic religiosity. To explain unexpected results in their research, a person's religious motivation was called into question. In essence, they found that an extrinsically religious person is motivated to use religion for personal gain. The religious beliefs are shaped into whatever form to meet the person's primary needs. In contrast, an intrinsically religious person finds their "master motive in religion" (Allport & Ross, 1967, p. 434). They internalize the rules, laws, and beliefs of their religion. Allport and Ross (1967) developed the Religious Orientation Scale (ROS) to measure intrinsic and extrinsic religiosity.

Additional instruments based on the ROS developed by Allport and Ross were developed over the next several decades. Gorsuch and Venable (1983) developed an age universal version of the religious orientation scale.

During the past two decades, numerous studies have shown that people who are religiously devout or intrinsic in their religious orientation tend to enjoy better physical and mental health (Gartner, 1996; Richards & Bergin, 1997). The evidence suggests that intrinsic religiousness is a healthy and mature way of being and is a resource in many peoples' lives (Richards & Bergin, 1997; Park & Cohen, 1992).

Moberg and Brusek (1978) suggested in their pioneering work that spiritual well-being is best conceived as having two dimensions. A vertical dimension refers to one's sense of well-being in relationship to God. A horizontal dimension connotes one's perception of life's purpose and satisfaction apart from any specifically religious reference.

The Spiritual Well-Being Scale (SWBS) was developed to measure these two dimensions, Religious Well-Being (RWB) and Existential Well-Being (EWB), respectively (Paloutzian & Ellison, 1982). SWBS is viewed as an expression of spiritual health or maturity and with the need for transcendence, which refers to a sense of well-being that comes from purposes involving ultimate meaning in life (Paloutzian & Ellison, 1982). The RWB scale measures the sense of well-being in relationship to God. The EWB scale measures one's well-being related to their sense of purpose and satisfaction apart from any specifically religious belief system.

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The Patterson (1984) review of studies pointed out that, while client-therapist relationship may be seen as critical to successful psychotherapy, the relationship between therapist attitudes and interpersonal skills and outcome is more ambiguous than was once thought. Much of the uncertainty about this stems from how relationship factors are measured. Specifically, research findings have shown that client perceived relationship factors, rather than objective raters' perceptions of the relationship, obtain consistently more positive results. Furthermore, the larger correlations with outcome are often between client process ratings and clients' self-report of outcome. One explanation for this may be that clients as a whole perceive the therapeutic relationship

as more positive than observers and clients are more accurate in their perceptions of the quality of the therapeutic relationship.

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(a) the client's effective relationship to the therapist, (b) the client's capacity to purposefully work in therapy, (c) the therapist's empathic understanding and involvement, and (d) patient-therapist agreement on the goals and tasks of therapy.

Reviews of process-outcome studies have identified specific therapist qualities, skills, and responses that are related to outcome. In their exhaustive review of over 2,000 process-outcome studies since 1950, Orlinsky, Grawe, and Parks (1994) identified several therapist variables that have consistently been shown to have a positive impact on treatment outcome: therapist credibility, skill, collaborativeness, empathic understanding, and affirmation of the client, along with the ability to engage with the client, invest in the treatment process, facilitate a strong therapeutic bond, focus on the patient's problems, and direct attention to the client's affective experience.

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Research Questions

The proposed study will address the following questions:

1. Will independent variables (life experiences, social support, religious orientation, spiritual well-being, and the client-counselor relationship) be related to client counseling outcome as reported by the client?
2. Will independent variables (life experiences, social support, religious orientation, spiritual well-being, and the client-counselor relationship) be related to client counseling outcome as reported by the counselor (using items consistent with those rated by the client)?
3. Will independent variables (life experiences, social support, religious orientation, spiritual well-being, and the client-counselor relationship) be related to client counseling outcome (according to counselor's GAF scores)?
4. Will there be a statistically significant difference between the client's rating of counseling outcome (as determined in research question 1) and the counselor's rating of counseling outcome (as determined in research question 2)?

Method

Participants

Participants will include adult clients who present for individual counseling or who transfer from one counselor to another at the University of Oklahoma Counseling Psychology Clinic. Subjects will include both males and females, aged 18 and over, from cultural, spiritual, religious, and ethnic backgrounds consistent with the clientele

of the counseling clinic. A total sample size of at least 50 will be needed in order to interpret the appropriate statistical analyses.

Measures

Demographic Information. Demographic information will be acquired from the application for services routinely completed by clients at the counseling clinic.

Demographic information will include: ethnicity, sex, age, education, religious preference, and family income. Included on the application is a question for the client to rate the importance of his or her religion or spiritual belief. This rating is based on a 7-point Likert scale ranging from 1, unimportant to 7 important.

Life Experiences. Life experiences information will be collected from the application for services routinely completed by clients at the counseling clinic; therefore, a separate instrument will not be administered to participants. Using life experiences reported by the client on the application form, a total score for life experience (e.g., or anticipated stress) will be determined consistent with the method used by the Recent Life Changes Questionnaire (RLCQ) developed by Miller and Rahe (1997).

The RLCQ (Miller & Rahe, 1997) includes 74 life experiences and is the latest instrument building on research previously reported by Holmes and Rahe (1967) and Rahe (1975). The RLCQ assigns Life Change Units (LCU) values for each of the 74 life experiences depending on the amount of social readjustment, adaptation or perceived stress level that would be associated with each event. These LCU values are added together to determine a total score. The higher the total score the greater the level

of stress or social readjustment that would be expected. The 74 items of the RLCQ address events associated with an individual's health, work, home and family, personal and social, and financial aspects of life experiences. Life experiences identified on the application form will be assigned LCU values consistent with the RLCQ such as, divorce - 96 units, marriage - 50, death of a close friend - 70, decreased income - 60, hospitalization - 74, and being fired from work - 79.

Three reliability studies of the RLCQ indicate mixed results. Using a sample of college students with a one week interval between testing, test-retest coefficients ranging from .87 - .90 were reported (Miller & Rahe, 1997). When the interval between testings was extended to six months for a sample of resident physicians, a correlation of .70 was reported (Rahe, 1975). When the interval between testings was nine months for U. S. Navy enlisted men a correlation of .55 was obtained. These results indicate that test-retest scores are quite stable over a short period of time but become less reliable as time between testing is extended. In validity studies, spouses independently agree with their mates' scoring of their recent life changes, with correlation ranging between .5 and .75 (Rahe, 1975; Miller & Rahe, 1997). Correlations between Norwegian Navy subjects' RLCQ scores and frequency of illness episodes ranged from .12 to .50 ($p < 0.01$; Holmes & Rahe, 1967; Rahe, 1975). Illness episodes are those reported by participants of the study to medical personnel during the follow-up year.

Perceived Social Support Family and Friends. Social support for this study will be measured by the Perceived Social Support – Family (PSS-Fa) a 20 item instrument and Perceived Social Support – Friends (PSS-Fr) which is also a 20 item instrument

(Procidano & Heller, 1983). Subjects are asked to respond to each statement by choosing one response from three possible responses: "Yes," "No," or "Don't know." Higher scores indicate a greater level of perceived social support from either family (PSS-Fa) or friends (PSS-Fr).

Four samples of subjects (college students, adolescents, adolescents with alcoholic fathers, and high school girls) were used to assess test-retest reliabilities and internal consistency of PSS-Fa and PSS-Fr. Test-retest reliabilities over a 1-month period ranged from .80 to .86 for PSS-Fa and from .75 to .81 for PSS-Fr (Procidano, 1992). Internal consistency reliabilities ranged from .88 to .91 for PSS-Fa and from .84 to .90 for PSS-Fr.

As evidence of construct validity, studies examined the correlation between the PSS-Fa and PSS-Fr and other social support instruments. The relationships of PSS-Fa to family environment characteristics as measured by subscales of the Family Environment Scale (FES; Moos, 1974 in Procidano, 1992), were fairly high: ($r = .67$) for Cohesion, ($r = .51$) for Expressiveness, and ($r = -.44$) for Conflict. The relationship between PSS-Fr and FES were moderate for Cohesion ($r = .29$), and Expressiveness ($r = .27$), and low for Conflict ($r = -.14$). The relationships of PSS-Fa network characteristics as measured by subscales of the Social Network Questionnaire (Liem & Liem, 1977) were moderately related to the number of family members reported to provide intangible support ($r = .30$) and more modestly to the number of tangible-support providers in the family ($r = .22$). Similarly, PSS-Fr was related moderately to the number of friend intangible-support providers ($r = .31$) and more weakly ($r = .16$) to

friend tangible-support providers. The Social Support Questionnaire (Sarason et al., 1987) Satisfaction scale was related to PSS-Fa ($r = .56$) and PSS-Fr ($r = .57$).

Relationships between symptomatology and PSS-Fa and PSS-Fr were evaluated by comparing the PSS-Fa and PSS-Fr scales with MMPI subscales (MMPI – D, depression; MMPI – Pt, psychasthenia; and MMPI – Sc, schizophrenia) and the Brief Symptom Inventory (BSI; Derogatis, 1993). The BSI is a short-self-report, multiphasic, 53 item symptom inventory used to assess nine areas (Somatic, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideations, and psychoticism) of psychological interest. The PSS-Fa was significantly related to MMPI – D ($r = -.43$), MMPI – Pt ($r = -.33$), and MMPI Sc ($r = -.33$), and the BSI ($r = -.50$; Louis, 1986 in Procidano, 1992; Procidano, 1992). The PSS-Fr was significantly related to MMPI – D ($r = -.12$), MMPI – Pt ($r = -.23$), and MMPI - Sc, ($r = -.20$), BSI ($r = -.32$; Louis, 1986 in Procidano, 1992; Procidano, 1992).

The PSS-Fr and PSS-Fa scales were better predictors of symptomatology than life events or social network characteristics (Procidano & Heller, 1983). Obviously, causality cannot be determined by these data. While it is possible that perceived support “buffers” or protects an individual from the adverse effects of stress, equally plausible is the possibility that symptomatic individuals simply perceive less support, or because of their pathology, actually receive less support from others (Procidano & Heller, 1983).

Religious/Spiritual Orientation – Revised. This 14 item instrument provides an extrinsic score and an intrinsic score for religious orientation. Allport and Ross (1967)

suggested two dimensions (i.e., intrinsic and extrinsic) to describe a person's religious orientation. Extrinsic religiosity is the dimension of religion in which the individual uses religion for self-serving purposes such as for comfort from sorrows or misfortunes, socializing, and establishment in the community. Intrinsic religiosity is the dimension of religion where a person's behavior is guided by their religious/spiritual beliefs a desire to spend time in religious thought, meditation, and learning about their religion. Items are presented on a 5-point Likert scale ranging from "Strongly Agree" to "Strongly Disagree." Higher scores on the extrinsic scale indicate a higher level of extrinsic orientation. Higher scores on the intrinsic scale indicate a higher level of intrinsic orientation.

The revised 14 item scale was derived by performing a factor analysis of the 20 item Age Universal I-E Scale (Gorsuch & Venable, 1983; Gorsuch & McPherson, 1989). The Age Universal I-E Scale is a modification of the Religious Orientation Scale (ROS) which reduces the level of reading comprehension so that extrinsic and intrinsic religious orientation can be measured for both children and adults. Individual intrinsic item factor loadings ranged from .63 to .75, while the individual extrinsic item factor loadings ranged from .45 to .73. Internal consistency coefficients of .82 for the intrinsic scale and .65 for the extrinsic scale have been reported.

The Religious/Spiritual Orientation -- Revised Scale (Gorsuch & Venable, 1983) builds on the original instrument Religious Orientation Scale (Allport & Ross, 1967) with both scales measuring extrinsic and intrinsic religious orientation. A correlation of .79 was determined for the extrinsic subscales and .90 for the intrinsic subscales

which is as high as possible given the alpha reliabilities (Gorsuch & McPherson, 1989). Results of a study of 500 diverse participants (i.e., men and women, young and old, college and high school students, married and single, religious and non-religious) from large cities, small cities, and rural areas revealed a Pearson correlation coefficient of .79, ($p < .001$) between the Religious Well-Being subscale of Spiritual Well-Being scale (SWBS – RWB) and ROS Intrinsic Scale (Ellison, 1983). During the past two decades, numerous studies have shown that people who are religiously devout or intrinsic in their religious orientation tend to enjoy better physical and mental health (Gartner, 1996; Richards & Bergin, 1997).

Spiritual Well-Being Scale (SWBS) – Belief Survey. The 20 item Spiritual Well-Being Scale (SWBS) was developed as a general indicator of subjective state of well-being. It provides an overall measure of the perceived spiritual quality of life, as conceived in two dimensions: a religious dimension and an existential dimension (Moberg & Brusek, 1978; Paloutzian & Ellison, 1982). The religious dimension refers to one's sense of well-being in relationship to God or a higher power. The existential dimension connotes one's perception of life's purpose and satisfaction apart from any specifically religious reference. The SWBS is nonsectarian and composed of two subscales: the Religious Well-Being Scale (RWBS) and the Existential Well-Being Scale (EWBS). In order to distinguish religious and existential items, all 10 of the Religious Well-Being (RWBS) items contain a reference to God (NOTE: Form instructions suggest that participants may substitute "Higher Power" or some other appropriate term for the word "God"). The 10 Existential Well-Being (EWBS) items

contain no such reference. The 20 items of the SWBS yields three scores: (1) a total SWBS score; (2) a summed score for religious well-being (RWBS) items; and (3) a summed score for existential well-being (EWBS) items.

For this study, the Spiritual Well-Being Scale (SWBS; Paloutzian & Ellison, 1982) is used as originally developed by the authors, except the name was changed to Belief Survey so the client would not perceive the projection for the value of spirituality. Consistent with the authors' suggestion to make the instrument more universally acceptable, instructions have been added to the instrument indicating that "Higher Power" or some other appropriate term may be substituted for the word "God" when completing the instrument (Paloutzian & Ellison, 1982).

The instrument has a six-point response format ranging from strongly agree to strongly disagree. Nine of the 20 items are negatively worded to avoid the possibility of a patterned response set. After accounting for negatively worded items, higher scores reflect a higher level of well-being which is consistent with the scales two dimensions and a total (existential - EWB, religious - RWB, and spiritual – SWBS).

In four studies with 1 to 10 week intervals between testing, the RWBS test-retest reliability coefficients were .96, .99, .96, and .88 (Bufford, Paloutzian, & Ellison, 1991). For the EWBS, the coefficients were .86, .98, .98, and .73. For the total SWBS, the coefficients were .93, .99, .99, and .82 (Bufford, Paloutzian, & Ellison, 1991). Across 7 samples, the internal consistency coefficients ranged from .94 to .82 (RWBS), .86 to .78 (EWBS), and .94 to .89 (SWBS; Bufford, Paloutzian, & Ellison, 1991).

The SWBS has good face validity as is evident by the content of the items and research has revealed that the items cluster as expected, into the RWBS and EWBS subscales (Bufford, Paloutzian, & Ellison, 1991). Research has indicated that the SWBS is a good general indicator of well-being, and is especially sensitive to lack of well-being. SWBS, RWBS, and EWBS are correlated positively with a sense of purpose in life, physical health, emotional adjustment, and a positive self concept (Bufford, Paloutzian, & Ellison, 1991). People who scored high on SWBS tended to be less lonely, more socially skilled, higher in self-esteem, and more intrinsic in their religious commitment (Paloutzian & Ellison, 1982). Validity studies of the Spiritual Well-Being Scale have revealed positive correlations with a number of psychological variables, supporting the conceptualization of the scale as an integrative measure of health and well-being (Ellison, 1983; Miller, 1990; Paloutzian & Ellison, 1982). The SWBS and subscales are negatively correlated with ill health, emotional maladjustment, and lack of purpose in life (Bufford, Paloutzian, & Ellison, 1991).

Adult's Counseling Form. This 25 item questionnaire was developed by Pace (2000) and is a revision of the Client's Evaluation of Counseling Form. It is intended to assess client's perceptions for their quality of life roles (i.e., work/employment, family, social recreational, physical health), emotional health (i.e., depression, anxiety, anger), most important problem for counseling, motivation and belief about counseling, overall results and satisfaction with counseling, and feelings about their counselor and counseling experience (i.e., rating for counselor's caring, understanding, professional knowledge, and motivation). One of the 25 items asks the client to write the most

important problem he or she is working on or wanting to work on in counseling. The client is asked to rate how distressing this problem is according to a 7 point Likert scale ranging from 1, "very distressing" to 7, "not at all." The remaining 23 items use a 7 point Likert scale ranging from 1, most favorable to 7, least favorable response for the dimensions being assessed.

Face validity of the instrument appears to be good after reviewing the instrument items and constructs addressed for assessing counseling outcome (Bergin & Garfield, 1994; Lambert & Bergin, 1994; Pace, 2002). A confirming reliability or validity study has not been performed for the Adult's Counseling Form. A validity study of the Adult's Counseling Form is currently in process at the University of Oklahoma. Reliability data is not available for the current revision of Adult's Counseling Form. However, data for an earlier version of the instrument, the Client's Evaluation of Counseling Form may provide some indications for instrument reliability. In a study conducted with a one week interval between testing, test-retest coefficients ranged from .36 to .97 for the subscales of the instrument (Jerez, 1999). The alpha coefficient for the instrument was .91 (Jerez, 1999).

Counselor Rating of Client Counseling Outcome Form. The instrument consists of 5 items for the counselor to rate their client's functioning and satisfaction with life. For one of the items, the counselor provides a Global Assessment of Functioning (GAF) Scale rating consistent with criteria established by the DSM-IV (American Psychiatric Association, 1994). For the other 4 items, the counselor provides a rating based on a Likert 7 point scale to indicate the client's overall satisfaction with life,

overall rating of the client's emotional state (i.e., depression, anxiety, anger), how much improvement the client has experienced since beginning counseling, and how distressing the client's main problem is to him or her. For the first 3 items, previously cited, a low number (e.g., 1) indicates the best response (e.g., highest satisfaction, best emotional state) for each of the dimensions assessed, while for the latter item a lower number indicates that the problem is "very distressing." The counselor is to provide these ratings after the 1st, 5th, 10th, 20th, and final session. It is anticipated that ratings after the 1st and 5th sessions will be used to address the hypotheses for this research. Data available after the 5th session may be available for possible post-hoc analyses.

Procedure

Information about the research will be provided to graduate counseling students (masters and doctoral) who will be asked to volunteer for the study. Those who volunteer will be asked to review and sign an informed consent form. They will then receive training about how to elicit participation by their adult clients, how to properly administer the consent form and instruments, and to respond to questions asked by client participants. Clients who volunteer to participate in this study will complete an informed consent form and pencil-and-paper instruments. The experimental packet will include an informed consent form, an Adult's Counseling Form, Perceived Social Support – Family form (PSS-Fa), Perceived Social Support – Friends form (PSS-Fr), Belief Survey, and a Religious/Spiritual Orientation – Revised form. The order of presentation of the instruments within the packets will be randomly varied. Participating clients will complete the instrument packet after the first counseling

session. It is anticipated that 20-30 minutes will be required to complete the instrument packet. Consistent with clinic procedures, in addition to completing the Adult's Counseling Form after the 1st session, each client will be asked to complete one after the 5th, 10th, 20th, and final counseling sessions. Each counselor will be asked to complete a Counselor Rating of Client Counseling Outcome Form after each participant's 1st, 5th, 10th, 20th, and final counseling sessions. For this study the data collected at the 5th session will be used for the client-counselor relationship and for determining counseling outcome relative to the 1st session. Demographic and life experiences information will be acquired from the Application for Services Counseling Psychology Clinic University of Oklahoma which is routinely completed by clients of the clinic before their first session.

Instruments completed by the clients and their counselors will be stored in a designated location and maintained in a locked file cabinet consistent with other client confidential records. Participants' responses will remain confidential. Although the paper instruments will have client identification information, the final database created for statistical analysis will not have any client identification information associated with it. This client identification information is required so that appropriate information from the client's application and instruments completed after future counseling sessions can be associated with the correct client.

Data Analysis

A database will be created to address the research questions posed previously through multiple regression and a t-test. Multiple regression is a multivariate technique

for studying the relation between a dependent variable and two or more independent variables (Shavelson, 1996).

Three regression analyses will be performed using the same independent variables for each analysis but different dependent variables. The independent variables are scores for life experiences (from the application completed by the client and scored according to the method used for the RLCQ), social support (PSS-Fa and PSS-Fr), religious orientation (the intrinsic scale of the Religious/Spiritual Orientation – Revised instrument), spiritual well-being (total SWBS, RWB subscale of the SWBS, and EWB subscale of the SWBS), and the client-counselor relationship (the average of items 19 to 24 on the Adult's Counseling Form completed by the client after the 5th counseling session).

All three regression analyses will use the same independent variables and a pilot study is planned to better identify which specific factors to consider for measuring the dependent variables, counseling outcomes. In general, the dependent variable, counseling outcome, is the difference between the value determined after the 1st and the 5th counseling sessions. For research question 1, the dependent variable is the client's perspective of counseling outcome determined from the clients' response on the Adult's Counseling Form. It may be an average of the client's rating for: the quality of life roles, emotional health, the most important problem or issue for counseling, and belief about counseling. For research question 2, the dependent variable is the counselor's perspective of counseling outcome determined by the counselors' response on the Counselor Rating of Client Counseling Outcome Form to statements similar to those

used in research question 1 for the clients' rating. For research question 3, the dependent variable is determined from the counselors' Global Assessment of Functioning (GAF) scores.

Research question 4 will use a two-dependent-sample t-test to determine if there is a statistical difference between the client and counselor rating of the clients' counseling outcome. Client rating of counseling outcome will be as previously described for the dependent variable associated with research question 1. Counselor rating of clients' counseling outcome will be as previously described for the dependent variable associated with research question 2.

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Appendix B: IRB Approval Letters and Consent Forms



The University of Oklahoma

OFFICE OF RESEARCH ADMINISTRATION

May 22, 2002

Mr. J. Mike Ross
117 Monticello Rd.
Norman, OK 73072

Dear Mr. Ross:

The Institutional Review Board-Norman Campus, has reviewed your proposal, "Client Relationships and Counseling Outcomes" at the convened meeting on May 15, 2002. The Board found that this research would not constitute a risk to participants beyond those of normal, everyday life except in the area of privacy which is adequately protected by the confidentiality procedures. Therefore, the Board has approved the use of human subjects in this research.

This approval is for a period of 12 months from May 15, 2002, provided that the research procedures are not changed from those described in your approved protocol and attachments. Should you wish to deviate from the described subject procedures, you must notify this office, in writing, noting any changes or revisions in the protocol and/or informed consent document and obtain prior approval from the Board for the changes. A copy of the approved informed consent document is attached.

At the end of the research, you must submit a short report describing your use of human subjects in the research and the results obtained. Should the research extend beyond 12 months, a progress report must be submitted with the request for continuation, and a final report must be submitted at the end of the research.

If data are still being collected after three years, resubmission of the protocol is required.

Should you have any questions, please contact me.

Sincerely yours,

A handwritten signature in cursive script that reads "Susan Wyatt Sedwick".

Susan Wyatt Sedwick, Ph.D.
Director of the Office of Research Administration and
Administrative Officer for the
Institutional Review Board - Norman Campus (MPA #1146)

SWS/lk
FY2002-402

cc: Dr. E. Laurette Taylor, Chair, Institutional Review Board
Dr. Rocky Robbins, Educational Psychology

Informed Consent Form – Counselor

For research being conducted under the auspices of the University of Oklahoma – Norman Campus

Introduction: This study entitled “Client Relationships and Counseling Outcomes” is being conducted by principal investigator J. Mike Ross at 405-325-2914 whose advisor is Rockey Robbins, Ph.D., Assistant Professor, Department of Educational Psychology, University of Oklahoma, 405-325-8442.

Purpose, description, and participants of the study: The purpose of this study is to evaluate client relationships relative to their counseling progress. Clients will be asked to complete four one page instruments and information from the Adult’s Counseling Form will be used for this study. This information will provide research data to better understand the importance of client relationships with family, friends, spirituality and/or religion, life experiences and their counseling relationship relative to counseling outcome. Additionally, information from the client’s file as stated on the Informed Consent Form – Client form, to be signed by the client, will be used in this study. Information that the client shares with their counselor during counseling sessions WILL NOT be used in this research. Counselors whose clients participate in this study will be asked to complete a “Counselor Rating of Client Counseling Outcome Form” after session numbers 1, 5, 10, 20, and after their client’s final session. Completing this Counselor’s form should require less than five minutes. About 110 clients will take part in this study with 90 of these individuals from this location.

Confidentiality: The research database used for analysis WILL NOT INCLUDE THE NAMES OF PARTICIPANTS FOR THIS STUDY. Information collected for this research will remain confidential and will only be seen by the investigators, research assistants, and the proper clinic staff. Results of these forms and client’s feelings about their counselor and counseling experience will not be shared with their counselor or other counselors. However, clients are free to discuss them at their discretion. This information will be treated as confidential and protected in a manner consistent with other files stored (i.e., in locked file cabinets, inside a locked room, inside a locked building protected by a security system) within the OU Counseling Psychology Clinic. Dissertations, theses, and other publications that use these data will not include the names of any participants or counselors of this study.

Risks of participation: The confidentiality of records associated with this research is protected to the same standards as other documents used in the counseling process; therefore, the risk is no greater than that of a typical counseling relationship and that associated with completing associated objective psychological instruments. The results of the completed counselor form will not be shared with the client; however, the counselor is free to discuss these with the client at the counselor’s discretion.

Benefits of participation: You will not receive direct benefit from participating in this study. However, several indirect benefits may be available if you participate in this study. Answering the evaluation questions may enable you and the client to reflect on their needs, sources of support, progress, and feelings about counseling. This may help identify issues that they may want to discuss with their counselor. Furthermore, participating in this study may provide valuable research information helpful in working with other clients and benefit society at large.

Conditions of participation: Your participation is voluntary, refusal to participate will involve no penalty or loss of benefits to which you are otherwise entitled, and you may discontinue participation at any time without penalty or loss of benefits to which you are otherwise entitled. To participate, you must be 18 years of age or older.

Contacts for Questions: I understand that if I have any questions about this research or need to report any adverse effects from the research, I may contact J. Mike Ross or Dr. Rockey Robbins at the University of Oklahoma, Department of Educational Psychology, 820 Van Vleet Oval, Norman, OK 73019. I may call J. Mike Ross or Dr. Rockey Robbins at 405-325-2914 or 405-325-8442. I also understand that this research has been authorized by the appropriate overseeing board at the University of Oklahoma. Inquiries about your rights, as a research participant, may be directed to the Office of Research Administration at 405-325-8110.

By signing this form, you are agreeing to participate in this research study under the conditions described. You have not given up your legal rights or released any individual or institution from liability for negligence. You have been given an opportunity to ask questions. You will be given a copy of this consent document.

_____ Research Subject’s Signature	_____ Date	_____ Subject’s Printed Name
_____ Person Obtaining Informed Consent	_____ Date	_____ Principal Investigator
		_____ Date

Informed Consent Form – Client

For research being conducted under the auspices of the University of Oklahoma – Norman Campus

Introduction: This study entitled “Client Relationships and Counseling Outcomes” is being conducted by principal investigator J. Mike Ross at 405-325-2914 whose advisor is Rockey Robbins, Ph.D., Assistant Professor, Department of Educational Psychology, University of Oklahoma, 405-325-8442.

Purpose, description, and participants of the study: The purpose of the study is to evaluate client relationships and life experiences relative to their counseling progress. Participants will be asked to complete four one-page forms which should take about 10 to 20 minutes to complete after your first counseling session. Additionally, participants will be asked to complete an Adult’s Counseling Form after the 1st, 5th, 10th, 20th, and final counseling session and a similar form will be completed by your counselor (Counselor Rating of Client Counseling Outcome Form). These forms typically take about 5 minutes to complete independently by you and your counselor. Information from these forms will provide research data to better understand client relationships with family, friends, counselor, spirituality and/or religion, life experiences and counseling outcome. Additional information from your file will be used for this research including your diagnosis, information from the application form, in sections A, C, D, F, and H including demographic information (e.g., gender, age, race/ethnicity, education level); items that you have checked (i.e., placed a check mark beside) such as divorce, separation/break-up, moves, work problems; reasons for seeking counseling; and household income. Information that you share with your counselor during counseling sessions WILL NOT be used in this research. About 110 people will take part in this study with 90 of these individuals from this location.

Confidentiality: The research database used for analysis WILL NOT INCLUDE THE NAMES OF PARTICIPANTS FOR THIS STUDY. Information collected for this research will remain confidential and will only be seen by the investigators, the proper clinic staff, and research assistants. This information will be treated as confidential and protected in a manner consistent with other files stored (i.e., in locked file cabinets, inside a locked room, inside a locked building) within the University of Oklahoma Counseling and Testing Services. Results of these forms and your feelings about your counselor and counseling experience will not be shared with your counselor or other counselors. However, you are free to discuss them at your discretion. Dissertations, theses, and other publications that use these data will not include the names of any participants of this study.

Risks of participation: The confidentiality of records associated with this research are protected to the same standards as other documents used in the counseling process; therefore, the risk is no greater than that of a typical counseling relationship and that associated with completing associated objective psychological instruments. To minimize potential risk, these files will be kept in locked file cabinets and only accessible by authorized personnel.

Benefits and costs of participation: You will not receive direct benefit from participating in this study and there are no additional costs to you for participating in this study. Several indirect benefits may be available if you participate in this study. Answering the evaluation questions may enable you to reflect on your needs, sources of support, progress, and feelings about counseling. This may help identify issues that you may want to discuss with your counselor. Furthermore, participating in this study may provide valuable research information helpful in working with other clients and benefit society at large.

Conditions of participation: Your participation is voluntary, refusal to participate will involve no penalty or loss of benefits to which you are otherwise entitled, and you may discontinue participation at any time without penalty or loss of benefits to which you are otherwise entitled. To participate, you must be 18 years of age or older.

Contacts for Questions: I understand that if I have any questions about this research or need to report any adverse effects from the research, I may contact J. Mike Ross or Dr. Rockey Robbins at the University of Oklahoma, Department of Educational Psychology, 820 Van Vleet Oval, Norman, OK 73019. I may call J. Mike Ross or Dr. Rockey Robbins at 405-325-2914 or 405-325-8442. I also understand that this research has been authorized by the appropriate overseeing board at the University of Oklahoma. Inquiries about your rights, as a research participant, may be directed to the Office of Research Administration at 405-325-8110.

By signing this form, you are agreeing to participate in this research study under the conditions described. You have not given up your legal rights or released any individual or institution from liability for negligence. You have been given an opportunity to ask questions. You will be given a copy of this consent document.

_____ Research Subject’s Signature	_____ Date	_____ Subject’s Printed Name
_____ Person Obtaining Informed Consent	_____ Date	_____ Principal Investigator
		_____ Date

University of Oklahoma Research Privacy Form 1

PHI Research Authorization

IRB No.:FY2002-402

**AUTHORIZATION TO USE or DISCLOSE
PROTECTED HEALTH INFORMATION FOR RESEARCH**Title of Research Project: **Client Relationships and Counseling Outcomes**Leader of Research Team: **James Mike Ross**Address: **University of Oklahoma Counseling Psychology Clinic; 2709 Lawrence Ave.;
Norman, OK 73019**Phone Number: **405-325-2914**

If you decide to join this research project, University of Oklahoma (OU) researchers may use or share (disclose) information about you that is considered to be protected health information for their research. Protected health information will be called private information in this Authorization.

Private Information To Be Used or Shared. Federal law requires that researchers get your permission (authorization) to use or share your private information. If you give permission, the researchers may use or share with the people identified in this Authorization any private information related to this research from your medical records and from any test results. Information, used or shared, may include all information relating to any tests, procedures, surveys, or interviews as outlined in the consent form, medical records and charts, name, address, telephone number, date of birth, race.

Purposes for Using or Sharing Private Information. If you give permission, the researchers may use your private information to evaluate your relationships with others and life experiences relative to counseling outcome. For this research, you will be asked to complete forms to provide information about your relationships among your family, friends, spirituality and/or religion, and your counseling relationship relative to your counseling outcome as reported by you and your counselor.

Other Use and Sharing of Private Information. If you give permission, the researchers may also use your private information to develop new procedures or commercial products. They may share your private information with the research sponsor, the OU Institutional Review Board, auditors and inspectors who check the research, and government agencies such as the Food and Drug Administration (FDA) and the Department of Health and Human Services (HHS). The researchers may also share your private information with research assistants and members of the Leader of the Research Team's dissertation committee (i.e., Dr. Rocky Robbins, Dr. Terry Pace, Dr. Cal Stoltzenberg, Dr. Jody Newman, and Dr. Larry Toothaker).

Confidentiality. Although the researchers may report their findings in scientific journals or meetings, they will not identify you in their reports. The researchers will try to keep your information confidential, but confidentiality is not guaranteed. The research database used for analysis **WILL NOT** include your name. Any person or organization receiving the information based on this authorization could re-release the information to others and federal law would no longer protect it.

University of Oklahoma Research Privacy Form 1

PHI Research Authorization

Voluntary Choice. The choice to give OU researchers permission to use or share your private information for their research is voluntary. It is completely up to you. No one can force you to give permission. However, you must give permission for OU researchers to use or share your private health information if you want to participate in the research and if you revoke your authorization, you can no longer participate in this study.

Refusing to give permission will not affect your ability to get routine treatment or health care from OU.

Revoking Permission. If you give the OU researchers permission to use or share your private information, you have a right to revoke your permission whenever you want. However, revoking your permission will not apply to information that the researchers have already used, relied on, or shared.

End of Permission. Unless you revoke it, permission for OU researchers to use or share your private information for their research will never end. You may revoke your permission at any time by writing to:

Privacy Official
University of Oklahoma
660 Parrington Oval, Room 318 Evans Hall, Norman, OK 73019
If you have questions call: (405) 271-2511 or e-mail: ou-privacy@ouhsc.edu

Giving Permission. By signing this form, you give OU and OU's researchers led by James Mike Ross, permission to share your private information for the research project called Client Relationships and Counseling Outcomes.

Subject Name (Please Print): _____

Signature of Subject

Date

IRB No.: FY2002-402

Appendix C: Supplemental Tables

Table C-1

Number and percent for sex, ethnicity, marital status, and religious preference

Category	Number	Percent
Sex		
Female	54	60
Male	36	40
Missing Data	0	0
Ethnicity		
Caucasian	75	83.3
Native American	5	5.6
Hispanic/Latino	0	0
African American	1	1.1
Asian	1	1.1
Multicultural	1	1.1
Other	0	0
Missing	7	7.8

Table Continued

Table C-1 Continued

Category	Number	Percent
Marital Status		
Married	32	35.6
Single	47	52.2
Divorced	8	8.9
Missing	3	3.3
Religious Preference		
Protestant	49	54.4
Catholic	6	6.7
Jehovah's Witness	2	2.2
None	9	10.0
Agnostic/Atheist	3	3.3
Other	7	7.8
Missing	14	15.6

Table C-2

Number, minimum, maximum, means, standard deviations, for age, years of education
number of children, importance of religion, income, and number of counseling sessions

Category	N	Min.	Max.	Mean	Std. Dev.
Age	90	18	54	28.81	9.59
Education (yrs.)	89	5	18	13.52	2.15
Children	90	0	4	.83	1.22
Importance of religion	83	1	7	4.75	2.09
Income	70	1100	60000	18998.30	14039.93
Number of sessions	90	1	59	10.98	10.16

Table C-3

Descriptive statistics and Cronbach alphas for independent and dependent variables

Category	N	Min.	Max.	Mean	Std. Dev.	Cronbach Alpha
Independent Variables						
Life Experience	70	-549	1330	85.53	258.92	.8196
Family Support	90	0	20	11.27	6.40	.9273
Friend Support	90	0	20	11.86	5.99	.9171
Intrinsic	90	6	40	25.39	6.94	.8012
Extrinsic	90	3	28	15.44	5.17	.7820
Spiritual WB	90	30	119	76.56	19.20	.9066
Existential WB	90	15	60	37.18	9.17	.8486
Religious WB	89	4	60	39.82	14.08	.9573
Counseling Rel	70	1.00	5.43	1.68	.86	.9446
Dependent Variables						
Client Outcome (Q1)	70	-11	12	1.37	3.91	.8126
Cnslr Outcome (Q2)	69	-10	10	1.86	3.93	.8513
GAF outcome (Q3)	69	-18	30	3.99	7.53	--