George Fox University

Digital Commons @ George Fox University

Doctor of Psychology (PsyD)

Theses and Dissertations

11-1992

The Problems of Assessing Change in Hopelessness Among Employees in Employee Assistance Programs

James Paul Porowski

Follow this and additional works at: https://digitalcommons.georgefox.edu/psyd

Part of the Psychology Commons

Order Number 9311581

The problems of assessing change in hopelessness among employees in employee assistance programs

Porowski, James Paul, Psy.D.

George Fox College, 1992

U·M·I
300 N. Zeeb Rd.
Ann Arbor, MI 48106

The Problems of Assessing Change in Hopelessness Among Employees in Employee Assistance Programs

by

James Paul Porowski

Presented to the Faculty of

George Fox College

in partial fulfillment

of the requirements for the degree of

Doctor of Psychology

in Clinical Psychology

Newberg, Oregon

November 22, 1992

APPROVAL

The Problems of Assessing Change in Hopelessness Among Employees in Employee Assistance Programs

by

James Paul Porowski

Signatures:

Committee Chairman

Vice president for

Academic Affairs

Date: 12-18-92

Members

Date:

The Problems of Assessing Change in Hopelessness Among Employees in Employee Assistance Programs

George Fox College
Newberg, Oregon

Abstract

Hope has been designated by many theorists as playing an important part in both psychological and physical healing. However, to this point, whether or not time-limited psychotherapy can increase the level of hope in clients has not been adequately investigated. This study sought to measure the level of hope in participants pre-therapy and post-therapy by the Beck Hopelessness Scale (BHS). It also sought to explore the special problems that are encountered when conducting research within an Employee Assistance Program.

Three hypotheses were proposed. The first stated that groups would differ in pretest hopelessness levels according to type of presenting problem. The second stated that groups would differ in post-treatment mean level of hopelessness, according to type of

presenting problem. The third stated that time-limited therapy would increase the post-treatment mean level of hope in participants, when compared with pre-treatment measurement of hope. The level of hopelessness would decrease following time-limited therapy.

The collection of data was hindered by several problems that are faced in EAP outcome studies: Initiating research, facilitating cooperation, and overcoming economically motivated concerns. Twenty-six participants were recruited to participate from an employee assistance program located in Portland, Oregon. No significant differences were found among the groups according to type of presenting problem. The fact that no posttest could be performed on the sample highlighted the difficulties that one encounters when conducting EAP outcome research. Attention was also focused on the paucity of available outcome studies utilizing psychological variables within the EAP movement, and some possible reasons for this lack of data.

Acknowledgments

A work of this size could not have been accomplished without the help of others. It was through the kind efforts of many people that I was enabled to complete this project. I want to take this opportunity to thank the following individuals who contributed their expertise to this paper:

My committee members, Dr. Rodger Bufford, Dr. Mark McMinn, and, especially, the committee chairman, Dr. Clark Campbell, who spent a great deal of time reading and rereading manuscripts and offering helpful comments.

The faculty within the Graduate School of Clinical Psychology at George Fox College for the provision of an excellent academic foundation.

Tim Perkins for his extensive help in statistical analysis.

The individuals who agreed to participate in the study.

Dedication

This dissertation is dedicated to the five most wonderful women I know: my wife, Ginny, and our children, Stephanie, Jody, Corinne, and Bridget.

Table of Contents

Page

Approval.................................... ii

Abstract.................................... iii

Acknowledgments............................. v

Dedication.................................. vi

Table of Contents........................... vii

List of Tables.............................. xi

CHAPTER 1: INTRODUCTION..................... 1

Statement of the Problem................ 3

Related Literature...................... 3

Psychological Perspectives on Hope........................ 4

Previous Research on Hope.......... 6

Hope as a Key Element in Psychotherapy.................. 9

Measuring Hope as a Theoretical Construct...................... 11

Hopelessness.................. 11

Hope......................... 13

The Hopelessness Scale in This Study.............. 14
Time-Limited Therapy............... 18
Employee Assistance Programs....... 21
Recent Studies of EAP Evaluation and Outcome Research............ 22
Empirical Research............ 23
Reporting Data................ 24
Subjective Criteria........... 25
Rationale for the Study................. 26
Hypotheses............................. 27
Research Questions..................... 28
Summary................................ 29
CHAPTER 2: METHODS........................ 32
Participants........................... 32
Instruments............................ 34
The Hopelessness Scale............. 34
Reliability.................. 34
Validity..................... 35
Demographic Questionnaires......... 36
Procedure.............................. 37
Research Design........................ 38
CHAPTER 3: RESULTS........................ 42

Description of the Sample.............. 43

Participants...................... 43

Counselors........................ 49

Termination Data.................. 50

Descriptive Statistics................. 54

Hopelessness Effects................... 57

Research Questions..................... 61

Hopelessness and Client Sex........ 62

Hopelessness and Client Age........ 63

Hopelessness and Marital Status.... 64

Hopelessness and Education......... 65

Hopelessness and Previous Counseling..................... 66

Summary................................ 71

CHAPTER 4: DISCUSSION...................... 73

Participants........................... 74

Implications From the Hopelessness Scores................................ 77

Implications From the Hypotheses........ 79

Implications From the Research Questions 80

Problems in Doing Research Within an EAP 82

Initiating Research................ 83

Facilitating Cooperation........... 84

Competition........................ 87

Economic Concerns.................. 88

Who Is The Client?................. 89

Recommendations for Future Research..... 91

Summary.................................. 94

REFERENCES................................. 96

APPENDICES................................. 109

Appendix A: General Information......... 110

Appendix B: Counselor Questionnaire..... 113

Appendix C: Proposal Letter............. 115

Appendix D: Raw Data.................... 117

Appendix E: Theological Perspectives on Hope.................. 122

Appendix F: Vita........................ 125

List of Tables

Table 1 Correlations of Hope Scales with the Beck Hopelessness Scale................ 17
Table 2 Schematic Representation of the Research Design 40
Table 3 Marital Status....................... 44
Table 4 Education............................ 45
Table 5 Previous Counseling.................. 46
Table 6 Length of Previous Counseling......... 47
Table 7 Reason for Seeking Counseling at This Time................................ 48
Table 8 Referral Source...................... 49
Table 9 Counselor Statistical Information..... 50
Table 10 Severity of Symptoms at Termination... 51
Table 11 Participants Referred Elsewhere....... 52
Table 12 Type of Referral.................... 53
Table 13 Total Number of Sessions............. 54
Table 14 Beck Hopelessness Scale Score......... 56
Table 15 Level of Hopelessness................ 57
Table 16 Results of ANOVA Comparing Pretest Hopelessness Scores According To Reason For Seeking Counseling.................... 58

Table 17 Reason For Seeking Counseling - Group Means, Standard Deviations, and Standard Errors of Hopelessness Scores.............. 60

Table 18 Reason For Seeking Counseling - Group Ranges of Hopelessness Scores.............. 61

Table 19 Results of ANOVA Comparing Pretest Scores By Groups According to Participants' Sex.......................... 63

Table 20 Results of ANOVA Comparing Pretest Scores By Groups According to Participants' Marital Status............... 64

Table 21 Results of ANOVA Comparing Pretest Scores By Groups According to Participants' Level of Education........... 65

Table 22 Hopelessness Scores According to Participants' Level of Education - Means and Standard Deviations.................... 66

Table 23 Results of ANOVA Comparing Pretest Scores By Groups According to Participants' Previous Counseling Experience............. 67

Table 24 Results of ANOVA Comparing Pretest Scores By Groups According to Whether the Participant was Referred Elsewhere for Counseling................................ 68

CHAPTER 1

INTRODUCTION

"Hopelessness can retard recovery or even hasten death, while mobilization of hope plays an important part in many forms of healing. . ." (Frank, 1974, p. 329). Frank wrote these words in his review of twenty five years of experiments conducted at the Johns Hopkins Psychotherapy Research Unit on brief psychotherapy. He believed that the level of discomfort that clients felt was relieved by increasing their level of hope and by teaching them social skills. However, none of the experiments conducted at that time actually measured the construct of hope prior to and after therapy. It was simply believed that these two elements were critical and accounted for the decreased level of discomfort experienced by clients.

Menninger stated in 1959 that the literature concerning hope was sparse.

> Our shelves hold many books now on the place of _faith_ in science and psychiatry, and on the

> vicissitudes of man's efforts to <u>love</u> and be loved. But when it comes to hope, our shelves are bare. The journals are silent. The Encyclopedia Britannica devotes many columns to the topic of love, and many more to faith. But hope . . . is not even listed. (p. 481)

Since 1959, interest and discussion regarding hope have increased. In 1962, Goldstein found that high expectation of help before therapy was significantly correlated with positive therapy outcome (Goldstein, 1962), and as noted above, in 1974 Frank summarized twenty five years of research at Johns Hopkins by pointing to hope as one of two significant factors that decreased client discomfort.

In the last fifteen years, the role of hope has been explored in both the medical (Dufrane and Leclair, 1984; Levine, 1989; Pommer, Diedrichs, Hummel, Kratzer, Offerman, and Molzahn, 1985; Scheier and Carver, 1987) and the psychological literature (Carson, Soeken, and Grimm, 1988; Mercier, Fawcett, and Clark, 1984; Miller and Powers, 1988; Staats, 1987, 1989; Taylor and Brown, 1988; Yalom, 1985). The purpose of this study was to explore the role of psychotherapy in increasing hope in clients who seek therapy through employee assistance programs (EAPs). It also assessed

the problems that are encountered when doing research within the context of EAPs.

Statement of the Problem

This study explored the concept of fostering hope through psychotherapy. It asked the question, "What effect does time-limited therapy have on the level of hope in subjects seeking employee assistance counseling in general; and, in particular, for substance abuse, marriage and family issues, emotional, or work related problems?" It also explored the special problems that are encountered when conducting research within an employee assistance program.

Related Literature

The literature related to this study comes from seven areas: (a) psychological perspectives on "hope", (b) previous research on hope, (c) hope as a key element in psychotherapy, (d) measuring hope as a theoretical construct, (e) time-limited therapy, (f) employee assistance programs, and (g) recent studies on EAP evaluation and outcome research.

Psychological Perspectives on Hope

The psychological literature of the last three decades contains a fair amount of discussion on the subject of hope, incorporating a broad array of perspectives. Yet, the key term in most definitions appears to be the word "expectation". Frank (1968) described hope as a shorthand term for desire accompanied by expectation. Stotland (1969) defined hope as, "an expectation greater than zero of achieving a goal." In his theory he maintained that hope had cognitive, affective, and behavioral aspects. Beck, Weissman, Lester, and Trexler (1974) highlighted the cognitive aspect. They defined hopelessness as a system of cognitive schemas whose common denomination is negative expectations about the future. The inverse provides a succinct definition of hope, a system of cognitive schemas whose common denomination is positive expectations about the future. Rosenthal and Bandura (1978) also focus on expectations. In Bandura's theory of self-efficacy, hope is a matter of increasing expectations of self-efficacy.

Erikson's (1964) psychosocial theory views hope as a product of the first stage of development. The

individual's foundation of hope is rooted in his or her first relations with trustworthy maternal parents. "Hope is both the earliest and the most indispensable virtue inherent in the state of being alive. . . . Hope is the enduring belief in the attainability of fervent wishes, in spite of the dark urges and rages which mark the beginning of existence" (Erikson, 1964, p. 115, 118).

Miller and Powers (1988) offer an expanded conceptualization of hope by reviewing its etymology as well as the theologic, philosophic, psychologic, socioanthropologic, and nursing perspectives of hope. They conclude the following:

> Hope is a state of being characterized by an anticipation for a continued good state, an improved state, or a release from a perceived entrapment. The anticipation may or may not be founded on concrete, real world evidence. Hope is an anticipation of a future which is good, based on mutuality (relationships with others), a sense of personal competence, coping ability, psychological well-being, purpose and meaning in life, and a sense of "the possible." (p. 6)

This section has sought to explore various definitions for hope from a broad range of psychological perspectives. (A brief look at some theological perspectives on hope may be found in Appendix E). The importance of the term "expectation" was highlighted, and for the purpose of this study, it was adopted as the central theme in the author's definition of the construct. "Hope is both the belief that one's expectations can be fulfilled, and the desire to see them accomplished."

Previous Research on Hope

In the medical literature the role of hope, or optimism, in the successful outcome of medical procedures is strongly supported (Scheier and Carver, 1987). Bodily states are affected by one's view of the future. Dufrane and Leclair (1984) conclude that any efforts to improve the individual's mental or physical functioning should include an attempt at mobilizing the person's expectations.

Studies conducted in an attempt to assess the impact of hope on outcome generally point to the same conclusion: hope plays a key role both in physical health and in physical recovery. This is true concerning a broad spectrum of diseases.

Pommer, Diederichs, Hummel, Kratzer, Offermann, and Molzahn (1985) studied patients' expectations as a factor in kidney transplant outcome. They found an inverse relationship between optimism toward kidney transplantation and rate of failure or death. Among those recovering from coronary artery bypass surgery, optimism is positively related to rate of recovery. Optimists recover six to eight days sooner than pessimists and are more likely to begin walking around their rooms for an extended period of time (Scheier and Carver, 1987).

Hope has also been found to be a significant factor in the treatment of alcoholism. Strack, Carver, and Blaney (1987) found that optimism was the greatest predictor of successful outcome in an aftercare program following treatment for alcoholism.

The level of hope was assessed in persons with Multiple Sclerosis (Foote, Piazza, Holcombe, Paul, and Daffin, 1990). It was found that those with a high level of hope were also characterized by both high levels of self-esteem and social support. The authors concluded that these factors ought to be considered when evaluating the client's level of hope.

Herth (1990) found a significant positive relationship between a high hope level and effective grief resolution in elderly widow(er)s. Positive outcome in grief resolution and a high hope level were aided by a supportive hospice setting and the effective utilization of coping skills.

Drawing on results from clinical experience, Levine (1989) concludes that hope plays an important role in both maintaining physical health and in the recovery from illness. Health care professionals need to be sensitive to the effect of their words, stating the facts regarding an illness in such a way that all possibility of hope is not taken away from the patient.

A survey of the medical literature concerning the role of hope in the successful outcome of medical procedures strongly supports the conclusion that hope is positively related to outcome. The words spoken by physicians to patients are reported to be critical (Levine, 1988). Together these findings suggest the great importance of seeking to foster hope in individuals through psychotherapy, and that time-limited therapy may increase the level of hope in clients.

Hope as a Key Element in Psychotherapy

Summarizing 25 years of research at Johns Hopkins Psychotherapy Research Unit on brief psychotherapy, Frank (1974) found two major components of the benefits of psychotherapy: the activation of patients' expectations and the learning of social skills.

> Hopelessness can retard recovery or even hasten death, while mobilization of hope plays an important part in many forms of healing . . . Unless the patient hopes that the therapist can heal him, he will not come to therapy in the first place or, if he does, will not stay long. (Frank, 1974, p. 329)

The average drop in uncomfortable symptoms following either psychotherapy, in one experiment, or a placebo pill in another, resulted in very similar curves. Frank interpreted these findings as support for the assumption that "the short term symptomatic effects of both psychotherapy and placebo depend on their mobilization of the patient's hopes for relief" (1974, p. 329).

Reich and Neenan (1986), assessing principles common to various forms of short-term psychotherapies,

list the restoration of hope or morale as a primary requisite. In fact it is the client's initial state of hopelessness that brings him or her into therapy in the first place.

In the area of group psychotherapy, Yalom (1985) has identified the instillation of hope as one of 11 therapeutic factors operating within the group therapy experience. Couch and Childers (1987) maintain that group leaders can improve therapeutic outcomes by understanding the importance of hope as a curative factor and by learning specific strategies for its instillation in counseling groups. Taylor and Brown (1988) find hope to be a characteristic of normal (healthy) human thought.

> . . . considerable research evidence suggests that overly positive self-evaluations, exaggerated perceptions of control or mastery, and unrealistic optimism are characteristic of normal human thought. Moreover, these illusions appear to promote other criteria of mental health, including the ability to care about others, the ability to be happy or contented, and the ability to engage in productive and creative work. (p. 193)

Within the literature, the instillation of hope is regarded as a key element in both individual and group psychotherapy. This study examines the effect of time-limited therapy on the level of hope among participants. It explores the concept of instilling hope in clients by asking whether this form of therapy significantly increases hope.

Measuring Hope as a Theoretical Construct

Several instruments have been developed to measure the construct of hope.

Hopelessness

Initial efforts to measure the construct of hope were conducted by Beck, Weissman, Lester, and Trexler (1974). This followed Beck's conclusion that hopelessness was a core characteristic of depression (Beck, 1967). Later Beck reported that the Hopelessness Scale was an effective predictor of eventual suicide (Beck, 1986). The mean hopelessness rating for psychiatric inpatients who eventually committed suicide was significantly higher than for those who did not. This was based on a follow up study, 5 to 10 years later, of 141 inpatients (Beck and Steer, 1989). The same results were replicated with a study of 1,958

psychiatric outpatients. Those patients who eventually committed suicide were predicted by the Hopelessness Scale in 16 out of 17 cases (Beck, Brown, Berchick, Stewart, and Steer, 1990). The percentage of false positives in Beck's (1986) sample of 165 patients hsopitalized with suicidal ideation was 54.2%. The percentage of false negatives, on the other hand, was 9.1%.

Beck objectified hopelessness as a system of negative expectancies concerning oneself and one's future life, and designed his instrument to reflect this definition. Three factors were extracted from the twenty true/false items on the scale: (a) an affective, (b) a motivational, and (c) a cognitive factor. Factor a, revolves around affectively toned associations such as hope and enthusiasm, happiness, faith, and good times. This factor is labeled Feelings about the Future. Factor b, labeled Loss of Motivation, is concerned with giving up: deciding not to want anything, and not trying to get something that is wanted. Factor c, labeled Future Expectations, includes anticipations about what life will be like: a dark future, getting good or bad things, things not working out, and the future being vague and uncertain.

Hope

Mercier, Fawcett, and Clark (1984) modified the Beck Hopelessness Scale and developed the Hopefulness Scale. Their work was in response to a claim that the Hopelessness Scale did not yield much variance in a community based, nonpsychiatric, older population. They retained the content on each item on the Hopelessness Scale, but added a 5-point Likert-type scale for responding to each item. The scale asked persons to respond to the questions by indicating how frequently during the past two weeks they had felt a particular way.

The Stoner Hope Scale (Farran, Salloway, and Clark, 1990) is composed of three subscales measuring Interpersonal Hope, Intrapersonal Hope, and Global Hope.

The Expected Balance Scale (EBS) (Staats, 1987) operationalizes hope as the difference between expected positive and expected negative affect. Because the scale has a distinct focus on feelings rather than on cognition, Staats (1989) coupled the EBS with the Hope Index (Staats and Stassen, 1986) which defines hope as the interaction between wishes and expectation and is theoretically based on the self-other-world depressive triad (Beck, 1967).

The State-Trait Hope Scale (Grimm, 1984) represents both the individual's personality and current situation. State hope reflects a dynamic and changeable response to specific situations at a given time, while trait hope, in contrast, is considered to be a relatively stable personality characteristic (Carson, Soeken, and Grimm, 1988).

The Miller Hope Scale (Miller and Powers, 1988) had a very broad base, reflecting theology, philosophy, psychology, anthropology, biology, sociology, and nursing perspectives. It was developed on the critical elements of hope revealed in the literature and on an exploratory study of hope among those who survived a critical illness. The critical elements of hope included: (a) mutuality-affiliation, (b) sense of the possible, (c) avoidance of absolutizing, (d) anticipation, (e) achieving goals, (f) psychological well-being and coping, (g) purpose and meaning in life, (h) freedom, (i) reality surveillance-optimism, and (j) mental and physical activation.

<u>The Hopelessness Scale in This Study</u>

The Beck Hopelessness Scale was selected for use in this study for two reasons. First, the instrument

has produced strong reliability scores and validity correlations (Beck, Weissman, Lester, and Trexler, 1974; Holden and Fekken, 1988). Second, of all the instruments currently in clinical use, it is the most well-known and the most widely used.

In order to use the Hopelessness Scale to measure the level of hope in subjects, it was necessary to show the relatedness of the scale to the hope literature. This relationship was demonstrated both theoretically and empirically.

Theoretically, Beck et al. (1974) formulated their definition of hopelessness from one put forth by Stotland (1969) in The Psychology of Hope. Stotland spoke of hopelessness as a system of negative expectancies concerning oneself and one's future life. Hope, on the other hand, was an expectation greater than zero of achieving a goal. Consequently, hope was a system of positive expectancies concerning the future, or the inverse of hopelessness. Bear in mind that Stotland's prime objective was a discussion of hope. The use of the word "expectancy" places Beck well within the hope literature, since Frank (1968), Stotland (1969), Rosenthal and Bandura (1978), and Erikson (1964) all place significant weight on the

term from a psychological perspective, while Murray (1979) and Morris (1979) do the same from a theological perspective.

The construction of the various hope scales mentioned above followed the Beck Hopelessness Scale and did not appear until the 1980's. They bear a strong relationship to the Hopelessness Scale, by virtue of their theoretical base, or, in some cases, by their similarity in construction. For example, Mercier, Faucett, and Clark's (1984) Hopefulness Scale is essentially a modified Hopelessness Scale, utilizing a 5 point likert-type scale, rather than Beck's true/false format. The Hope Index (Staats and Stassen, 1986) is theoretically based on Beck's self, world, future depressive triad, and related to Beck's conclusion that hopelessness is a core characteristic of depression (Beck, 1967).

Several hope scales have reported negative correlations with the Hopelessness Scale, a finding that would be expected if the construct of hope was the inverse of the construct of hopelessness. These correlations are presented in Table 1.

Table 1

Correlations of Hope Scales with the Beck Hopelessness Scale

Scale	*r*
The Expected Balance Scale (Staats, 1987)	-.49
The Miller Hope Scale (Miller and Powers, 1988)	-.54
The Hope Index (Staats and Stassen, 1986)	-.30
The Stoner Hope Scale (Farran, Salloway, and Clark, 1990)	-.47
The Hopefulness Scale (Mercier, Fawcett, and Clark, 1984)	-.74

In relation to the popularity of the Beck Hopelessness Scale among clinicians, during the last decade, seventy-six dissertations and masters level theses have utilized the Hopelessness Scale. Five utilized a pretest post-test design. Three were conducted in an inpatient and two in an outpatient

setting (Bowers, 1987; Burns, 1981; Hamilton, 1982; McGovern, 1983; Schmidt, 1980). This present study is unique in that it focuses not only on the change in reported hopelessness levels, but also on the differences among groups, according to their reason for seeking counseling.

Time-Limited Therapy

Time limited therapy is any therapy that rations the amount of time in therapy and uses this rationing as an integral part of the treatment (Reich and Neenan, 1986). Support for this form of therapy is based on the following: (a) Clients generally anticipate that their program of treatment will be short. (b) Brief methods have generally produced the same success rates as longer term treatment. (c) Most insurance companies limit the liability of payment to a set number of sessions (Koss and Butcher, 1986).

Historically, time-limited therapy is not a new concept. Ferenczi attempted to shorten psychoanalysis by what he referred to as "active therapy." At a time when psychoanalysis was more focused on symptom relief, he urged analysts to take a more active role in therapy (Koss and Butcher, 1986; Malan, 1973; Reich and Neenan, 1986).

The psychological crises of World War II added impetus to a briefer therapy. The number of stress-related symptoms developed by soldiers increased, while the personnel required to handle such problems was in limited supply.

Over the past two decades brief therapy has found representatives within most theories of psychotherapy. Representing the psychodynamically oriented approaches, Strupp has formed his time-limited dynamic psychotherapy (Strupp and Binder, 1984). The cognitive-behavioral school is represented by Beck's cognitive therapy, which employs a goal directed, time-limited format (Beck, 1976), and the rational-emotive therapy of Ellis, which is naturally designed for brief therapy (Ellis, 1980).

Koss and Butcher (1986) summarize the literature identifying nine common characteristics of brief therapies.

(1) The client is informed of the time limitations in advance and it is expected that the focused and limited goals will be achieved in that period.

(2) Therapeutic goals are limited within attainable reach.

(3) The development of a therapeutic relationship is an important element in brief therapy.

(4) Brief therapy sessions are centered on the concrete content of the "here and now" instead of early life events.

(5) Therapists tend to be active and directive in relating to the client in order to maintain direction and organization of the sessions.

(6) Most therapists believe that effective brief therapy requires an experienced therapist with assessment skills and the ability to stay on track with agreed-upon goals.

(7) Most approaches consider flexibility in the therapist's role an essential element in abbreviating therapy.

(8) Approaches are aimed at prompt early intervention at the onset of symptoms or during crisis.

(9) Regardless of symptom severity, patients who have a good ability to relate are considered to be better candidates for brief therapy than those who have difficulty forming relationships.

This brief overview of time-limited therapy has been included to describe the mode of therapy employed in this study. Research in this general area of therapy is important, as the expectations of both clients and insurance companies continue to move the practice of psychotherapy toward briefer frameworks.

Employee Assistance Programs

Employee Assistance Programs (EAP's) had their historical initiative in the drug and alcohol programs that were established in corporations two decades ago. The recent growth that EAP's have experienced can be traced to several factors: (a) the employer's desire to contain rising health costs, (b) the need for effective supervisory systems for managing troubled employees, (c) the awareness that EAP's may enhance productivity, (d) the genuine concern of companies for the welfare of their employees (Dixon, 1988; Goldman, 1983).

EAP's provide various services to employees, including information, assessment, advice, counseling and referral. They are generally open to all employees on a self- or supervisor-referred basis, but EAP services are most often made known by word of mouth among employees themselves (Basso, 1989).

Counseling is an important feature of most employee assistance programs. Problems that are frequently addressed in counseling include substance abuse (Molloy, 1989; Sholette, 1986), marriage and family issues (Larson, Wilson, and Beley, 1988), smoking cessation (Jason, Lasowitz, Michaels, and Blitz, 1989), emotional

problems (Madonia, 1985), and work related problems, including termination and early retirement, as well as conflict in relationships within the corporation (Balk, 1988; Burdett, 1988). Benfield (1985) maintains that the employee assistance program, which involves third party counseling, enables management to solve personnel problems in a relatively short time, with a minimum of tension and disruption to the organization.

Webb (1990) has argued that the cognitive behavior therapy approach is particularly suited for employee assistance counseling. Several reasons are offered, including time limitation, problem-specificity, and the use of a teaching model.

Recent Studies of EAP Evaluation and Outcome Research

Klarreich, DiGiuseppe, and Dimattia (1987) state that, while it was estimated that 5,000 EAPs existed as far back as 1981 and 10,000 by 1987, to this date few experimental studies related to psychological constructs within the EAPs have been undertaken. For the most part, evaluations are discussed in the literature, but not undertaken. Furthermore, the few studies conducted largely center around the areas of program use and exonomics. The authors report

that the lack of good research or program evaluation data is one of the major ethical issues facing the EAPs. Claims for the effectiveness of programs are marketed, while empirical evidence is sparse. They state that, "Discussions concerning evaluations of EAPs appear to focus less on traditional dependent measures such as trait or state measures of psychological constructs or psychopathology, but on factors concerning program use . . . or economic and health use measures" (1987, p. 140). Consequently, this study sought to measure change in a psychological construct, "hopelessness". It also reports the problems that are encountered in doing research such as this within an EAP.

Empirical Research

"EAPs have received great exposure but what evidence exists about the effectiveness of EAPs?" (Battle, 1988, p. 83). Colantonio (1989) reviewed all studies evaluating EAPs that were published since 1975 in peer-reviewed journals by means of "Index Medicus," "Psychological Abstracts," and "Work Related Index." She found thirteen studies and stated that, "even though it appears that the presence of EAPs is on the rise, research in this area does not seem to be

growing at the same pace, as only one study was published after 1983" (1988, p. 20). All the programs were unanimous in reporting positive results, but only three of the thirteen studies used statistical tests to verify differences.

Two dissertations have been written concerning EAP evaluation since 1980 (Hoffman, 1989; Plavan, 1989). Hoffman's work was a financial analysis of in-house EAPs. Plavan's work had relevance to the discussion here. She conducted a descriptive study of Fortune 500 Industrial and Service companies and concluded that,

> Evaluation procedures are not a common characteristic of EAPs. In large part this reflects the lack of need to justify their existence or operation.
>
> . . . (EAP administrators) and their companies saw them providing a positive return on investment for the money spent on operating them. (1989, p. 3855)

Reporting Data

The accurate and adequate reporting of data appears to be a problem in EAP outcome research. Trice and Sonnenstuhl (1988) state that supervisors generally

report a 70-80% improvement rate on employees who return from EAP substance abuse intervention, yet no sources of their figures are given. Pointing to reports such as this, Balgopal and Patchner (1988) conclude that,

> Due to confidentiality and privacy issues, systematic collection of qualitative data regarding clients' perceptions of services and the impact of the program on their personal situations and work are seldom collected. The only sources for such data have been generally through testimonials and anecdotal writings. (p. 102)

Balgopal and Patchner (1988) further conclude that collaboration among EAPs in developing data bases is nonexistent.

Subjective Criteria

Outcome evaluation related to symptom improvement within EAPs tends to be based upon subjective appraisal. This is true whether the evaluation assesses existing or collected data (Kim, 1988), supervisor's assessment of improvement (Trice and Sunnenstuhl, 1988) or the assessment of professional mental health care workers (Colantonio, 1988). Colantonio found that of the thirteen EAP evaluations published since 1975, only

one used a standardized test as a means of assessing change.

The use of objective criteria is more common in EAP cost-benefit or cost-effectiveness analysis. EAP administrators use this analysis to answer the question of whether the cost of the program produces a satisfactory return in worker productivity and well-being (Cayer and Perry, 1988; Hoffman, 1989; Kim, 1988; Nadolski and Sandonato, 1987). This type of analysis is more limited in scope than the program evaluation studies reviewed by Colantino (1988).

Rationale for the Study

This study explores the concept of fostering hope through psychotherapy, and asks the question, "What effect does time-limited therapy have on the level of hope in persons seeking employee assistance counseling in general; and, in particular, for substance abuse, marriage and family issues, emotional, or work related problems?" Although the level of hope in participants has been previously measured by various instruments, pre-therapy/post-therapy measures of hope have been studied in a limited manner, and have

not evaluated the differences among groups, according to their reason for seeking counseling. The literature further reveals that psychological constructs have been only minimally addressed within EAP research. This study seeks to fill that void and to assess the problems that are encountered in doing research such as this within the EAP context.

Hypotheses

The literature review above provides the basis for the following three hypotheses.

H_1. Groups will differ in pretest hopelessness as measured by BHS scores, according to type of presenting problem: substance abuse, marriage and family, emotional, or work-related.

H_2. Groups will differ in post-treatment mean level of hope, according to type of presenting problem: substance abuse, marriage and family, emotional, or work-related.

H_3. Time-limited therapy will increase the post-treatment mean level of hope, as measured by the Hopelessness Scale, in participants seeking employee assistance counseling, when compared with pre-treatment

measurement of hope. The level of hopelessness will decrease following time-limited therapy.

Research Questions

The following questions were also considered. Questions 1-4 are further related to client level of hopelessness and arose both out of curiosity on the part of the researcher, and to assess ideas for future research. Question 5 is related to the problems that are encountered when doing research within an EAP.

1) What is the correlation between hopelessness and the various demographic variables that were obtained from the client (sex, age, marital status, education, and whether the individual had been in counseling before)?

2) What is the relationship between pre-treatment level of hopelessness and counselor-rated severity of symptoms at termination?

3) What is the relationship between pre-treatment level of hopelessness and whether the individual was referred elsewhere for treatment?

4) What is the relationship between pre-treatment level of hopelessness and total number of sessions completed?

5) What problems are encountered when doing research within an EAP context?

Summary

Hope is a key element in the psychotherapeutic process. Yet whether time-limited therapy can increase the level of hope in clients has not been adequately examined, nor have psychological constructs been explored within the EAP context. This study measures the participants' pre-therapy and post-therapy level of hope by the Beck Hopelessness Scale, which measures the absence of hope. The Hopelessness Scale originated in the hope literature opposite of hope, and has become one of the primary standards by which hope scales have been validated. A literature review examined hope, first, from a psychological perspective, and second, in the light of previous research. It also overviewed time-limited therapy and employee assistance programs, the context in which data were collected. Special attention was given to the EAP evaluation and outcome literature.

The importance of the term "expectation" was highlighted, since it appears as the central theme in definitions of hope put forth by the major theorists. Strong support was found in the medical literature for the role of hope in the successful outcome of medical procedures.

Time-limited therapy was defined as any therapy that rations the amount of time in therapy and uses that rationing as an integral part of the treatment. Support for it was found in both client and insurance company expectations for length of treatment, and in success rates comparable to longer term therapies.

EAPs were described in relation to their rapid growth over the last two decades. The empirical evidence for program effectiveness was highlighted as a major weakness within the EAP movement.

It was hypothesized that there would be an increase in post-therapy mean level of hope, as demonstrated by a decrease in scores on the Hopelessness Scale, when compared with pre-therapy levels. Two additional hypotheses stated that groups would differ in both pre-treatment levels of hope and post-treatment levels of hope according to type of presenting problem. Finally, five research questions were asked to shed further light on levels of hopelessness within EAP

clients and to explore the anticipated problems that might be encountered when attempting to do research of this type within an EAP.

CHAPTER 2

METHODS

This study was designed to explore the concept of fostering hope through psychotherapy, and asks the question, "What effect does time-limited therapy have on the level of hope in subjects seeking employee assistance counseling?" In addition to this the study also was designed to assess the problems that are encountered when doing research within an EAP setting. The methods that have been used for this study are set forth in this chapter. They are discussed in four sections: (a) subjects, (b) instruments, (c) procedure, and (d) research design.

Participants

Five Employee Assistance Programs were contacted for participation in this study. Programs were selected from listings in the Portland, Oregon, Yellow Pages. One program agreed to participate in the study. This

agency had contracted to provide time-limited counseling to the employees of health care agencies and various other corporations in the Portland area. Data was provided by three counselors, all of whom were females. The mean age for the counselors was 35.3. Each of these held Masters degrees (two with M.A.'s and one with an M.S.W.). The mean years of experience was 6.7 years.

Twenty-six clients were recruited to participate in the study. All new clients entering counseling during the data collection period (September 3, 1991 to October 15, 1991) were given the client questionnaire by the receptionist of the EAP (Appendix A). The questionnaire asked them to voluntarily participate in this study; 26 clients either did not finish the course of therapy or declined to complete the post-test measure. This left 26 total for an analysis of the pretest only. Of these, 19 were females and 6 were males, while one participant did not indicate gender. The mean age of the clients was 33.17 years.

Clients reported seeking counseling for the following reasons: 1 for substance abuse, 13 for marriage and family issues, 9 for emotional problems, 1 for work related problems, and 1 for some problem

other than those that were listed. Twenty one of the clients were self referred or voluntarily seeking counseling, 1 was referred by their employer to enter counseling, and 3 by another source.

Instruments

The Hopelessness Scale

Hope was measured using the Hopelessness Scale (Beck, Weissman, Lester, and Trexler, 1974). The Hopelessness Scale (HS) is a 20-item, true/false, self-report inventory that assesses pessimistic cognitions. Scores range from 0-20, with 0-3 indicating no or minimal hopelessness; 4-8 mild; 9-14 moderate; and 15-20 severe hopelessness.

Reliability

A population of 294 hospitalized patients who had made recent suicide attempts provided the original data for determining the internal consistency of the HS. The internal consistency of the scale was analyzed by means of KR-20, which yielded a reliability coefficient of .93 (Beck, Weissman, Lester, and Trexler, 1974). Holden and Fekken (1988) demonstrated high test-retest reliability over a three week period.

Test-retest reliability was .85 for their entire sample, .94 for males, and .67 for females. The lower value for females reflected a greater restriction of range in that sample.

Validity

The concurrent validity was determined by comparing HS scores with clinical ratings of hopelessness and with other tests designed to measure negative attitudes about the future (Beck et al., 1974). Strong correlations were found with the clinical ratings of hopelessness (.74), and hospitalized patients with previous suicide attempts (.62). The correlation with the pessimism item of the Depression Scale (Beck, 1967) was .63.

The construct validity was provided by the use of the HS as a measure in testing various hypotheses relevant to the construct of hopelessness. Beck et al. (1974) found that in each case the hypothesis was confirmed by the Hopelessness Scale.

Factorial validity was established when the data obtained from the 294 suicide attempters were subjected to factor analysis. The three factors, which made sense clinically, tapped affective, motivational, and cognitive aspects (Beck et al., 1974).

The HS has also demonstrated impressive ability to predict eventual suicide. A scale cutoff score of 9 or above identified a high percentage of those who later committed suicide: 90.6% (Beck, 1986), 90% (Beck, Brown, and Steer, 1989), and 94.2% (Beck, Brown, Berchick, Stewart, and Steer, 1990). In his 1986 sample, Beck reported a false positive rate of 54.2% and a false negative rate of 9.1%.

Demographic Questionnaires

Two questionnaires were designed by the author, according to Dillman's (1978) model for self-administered surveys. These were designed to collect demographic information from both the clients and the counselors.

Client questionnaires included a brief explanation of the study, informed consent information, and an explanation of confidentiality. Demographic information gathered included age, sex, marital status, education, occupational title, counseling history, referral source, and some specific questions regarding the nature of the current problem (see Appendix A).

Counselor questionnaires included instructions and counselor demographic questions (sex, age, education, and experience). Some specific questions regarding each client were also included (see Appendix B).

Procedure

Potential agencies were contacted by phone, and the nature and purpose of the study was briefly explained. Those which showed interest in participating were sent a proposal letter containing an explanation of the requirements of the study and examples of the measures to be used (see Appendix C). Letters were followed up with phone calls one week later to solicit participation. Instructions and questionnaires were delivered to the agency which agreed to participate. Other agencies gave various reasons for deciding not to participate, including: (a) hiring new counselors, (b) a lack of available time, and (c) a lack of interest in the study.

Each counselor was given one packet containing: two envelopes, two Hopelessness Scales, a client questionnaire, and a counselor questionnaire. Client questionnaires and pretest Hopelessness Scales were administered and collected prior to the first counseling session. Post-test Hopelessness Scales and counselor questionnaires were administered and collected at the end of the last session. All client measures

were sealed in the enclosed envelopes before being returned to the counselor. Data was collected by the author on November 14 and 22, 1991.

Research Design

The purpose of this study was to measure the level of hope in subjects prior to therapy and after therapy. This was done to discover whether time-limited therapy is effective in increasing hope within subjects. The study also assessed the problems that are encountered in doing research such as this within an EAP. The design employed in the study was a within subjects pretest-posttest design (Campbell and Stanley, 1966).

The first hypothesis was statistically analyzed by a Oneway ANOVA along with a Post Hoc test (TUKEY) to examine any significant main effect. The original plan was to statistically analyze the second and third hypotheses by a Split Plot ANOVA to find any differences among groups by presenting problem: substance abuse, marriage and family, emotional, or work-related. This plan was not carried out, since no posttest could be obtained on the sample population. An alpha level of .05 was used for determining significance in the

tests that were actually performed. A schematic representation of the research design is displayed in Table 2. The difficulties in obtaining posttests will be discussed fully in chapter four.

Table 2

Schematic Representation of the Research Design

	Pretest		Posttest
Total Group	O_1	X_1	O_2
Substance Abuse	O_1	X_1	O_2
Marriage and Family	O_1	X_1	O_2
Emotional	O_1	X_1	O_2
Work-related	O_1	X_1	O_2

Note: The O's stand for the respective administration of the Beck Hopelessness Scale (observations) and the X represents the treatment of therapy. Participants were not randomly assigned.

The design utilized the statistical technique of analysis of variance (ANOVA) with repeated measures to analyze the data. In this design the independent variable was the treatment of therapy given to the group. The dependent variables were the scores obtained on the Beck Hopelessness Scale administered pre-therapy and post-therapy.

CHAPTER 3

RESULTS

The purpose of this study was to explore the concept of fostering hope through psychotherapy. It sought to measure the effect of time-limited therapy on the level of hope in participants seeking employee assistance counseling. It also sought to assess the problems that are encountered in doing research such as this within an EAP. Chapter 1 presented the background for the study, while Chapter 2 presented the method used to complete it. Chapter 3 now describes the results of the study.

The results are presented as follows: (a) further statistical descriptions of the participants (clients and counselors); (b) the descriptive statistics, the mean and standard deviation; (c) the hypotheses set forth in chapter one will be dealt with respectively; and (d) the research questions.

Description of the Sample

Participants

The sample was verbally described in Chapter 2 as to its composition. Here descriptive statistics of the sample will be provided.

The sample consisted of adult outpatients at an employee assistance program in Portland, Oregon. Participants included 6 males and 19 females. The mean age of the sample was 33.17 years, with a range of 21 to 55 years. Other descriptive information about the sample follows in Tables 3-12.

Table 3 summarizes the marital status for the sample. In the group, 15.4% were never married, 46.2% were married, 15.4% were divorced, 7.7% were separated, 7.7% were living together, and 7.7% of the cases did not report marital status.

Table 3

Marital Status

	n	%
Never Married	4	15.4
Married	12	46.2
Divorced	4	15.4
Separated	2	7.7
Living Together	2	7.7
Missing Cases	2	7.7

N = 26.

The percentage breakdown of education completed by the participants is found in Table 4. The sample included 26.9% who completed high school, 26.9% who attended college, 23.1% with an associates degree, and 19.2% with a bachelors degree. One participant did not report educational level.

Table 4

Education

	n	%
High School	7	26.9
Attended College	7	26.9
Associates Degree	6	23.1
Bachelors Degree	5	19.2
Missing Case	1	3.8

N = 26.

Table 5 presents the percentage breakdown for previous counseling. The percentage of participants who had been in counseling previously was 50%, while for 46.2% of the participants this was a first-time experience. One participant did not report previous counseling history.

Table 5

Previous Counseling

	n	%
Yes	13	50.0
No	12	46.2
Missing Case	1	3.8

N = 26.

Table 6 presents the length of previous counseling for the participants. Of this group, 50% had never been in counseling before, 11.5% had 1-4 weeks, 11.5% had 5-8 weeks, 7.7% had 9-12 weeks, 0% had 13-16 weeks, 3.8% had 17-20 weeks, 3.8% had 21-24 weeks, and 11.5% had greater than 24 weeks.

Table 6

Length of Previous Counseling

	n	*%*
None	13	50.0
1-4 weeks	3	11.5
5-8 weeks	3	11.5
9-12 weeks	2	7.7
13-16 weeks	0	0
17-20 weeks	1	3.8
21-24 weeks	1	3.8
25 + weeks	3	11.5

N = 26.

The reasons indicated by participants for seeking counseling at this present time are found in Table 7. Both the participant and the counselor answered this question, with slight differences noted in three of the categories. Participant's self-report found 34.6% seeking counseling for emotional problems, (counselors answered the same), 3.8% for substance abuse problems (counselors noted 7.7), 3.8% for work

related problems (counselors noted 7.7), 53.8% for family or marriage problems (counselors noted 46.2), and finally, 3.8% sought counseling for other problems.

Table 7

Reason for Seeking Counseling at This Time

	Participant Self-Report		Counselor Report	
	n	%	n	%
Emotional Problems	9	34.6	9	34.6
Substance Abuse Problems	1	3.8	2	7.7
Work Related Problems	1	3.8	2	7.7
Family/Marriage Problems	14	53.8	12	46.2
Other	1	3.8	1	3.8

N = 26.

Referral source percentages are found in Table 8. Participants who listed themselves as voluntary or self referred comprised 80.8% of the sample, 3.8% were required by their employer, and 11.5% stated the referral source as "other".

Table 8

Referral Source

	n	%
Voluntary or Self-Referred	21	80.8
Required by Employer	1	3.8
Other	3	11.5
Missing Case	1	3.8

N = 26.

Counselors

The following demographic information pertains to the counselors from the employee assistance program who participated. Demographic information for the counselors is provided in Table 9. Three female counselors participated in the study. Two held M.A. degrees and one held and M.S.W. degree. Experience ranged from 4 to 10 years.

Table 9

Counselor Statistical Information

	Gender	Age	Education	Experience
Counselor 1	F	35	MA	6 years
Counselor 2	F	31	MSW	10 years
Counselor 3	F	40	MA	4 years

Termination Data

The Counselor ratings of the participants at termination produced the following descriptive statistics. The severity of symptoms at termination are presented in Table 10. The mean level of severity for the participants at termination was 4.31, the standard deviation was 1.67.

Table 10

Severity of Symptoms at Termination

Severity	n	%
1	0	0
2	5	19.2
3	4	15.4
4	5	19.2
5	5	19.2
6	4	15.4
7	3	11.5
8	0	0
9	0	0
10	0	0

Note: 1 = Mild, 5 = Moderate, 10 = Severe

N = 26.

The referral percentages are found in Table 11 and Table 12. Table 11 presents the percentage of participants who were referred elsewhere for treatment, 30.8% were and 69.2% were not.

Table 11

Participants Referred Elsewhere

	n	%
Yes	8	30.8
No	18	69.2

N = 26.

Table 12 presents the type of treatment to which the participants were referred. Roughly two thirds (69.2%) were not referred, 0% were referred to an inpatient facility, 0% to outpatient long-term, 19.2% to group treatment, and 11.5% were referred to other sources.

Table 12

Type of Referral

	n	%
None	18	69.2
Inpatient	0	0
Outpatient Long-Term	0	0
Group Treatment	5	19.2
Other	3	11.5

N = 26.

The percentages for the total number of sessions by the participants at the employee assistance program are presented in Table 13. Those who attended one session comprised 19.2% of the sample, 23% attended two sessions, 42.3% attended 3 sessions, 7.7% attended 4 sessions, 3.8% attended 5 sessions, and 3.8% attended 6 sessions. The mean number of total sessions for the sample was 2.65.

Table 13

Total Number of Sessions

Session	*n*	*%*
1	5	19.2
2	6	23.0
3	11	42.3
4	2	7.7
5	1	3.8
6	1	3.8

N = 26

Mean = 2.65.

Descriptive Statistics

The Beck Hopelessness Scale was used to measure hope (hopelessness) in this study. The mean and standard deviation for the pretest were computed. The mean level of hopelessness was 4.04, the standard deviation was 3.55.

Table 14 presents score percentages and levels of severity, where 7.7% were 0, 23.1% were 1, 15.4% were 2, 3.8% were 3, 11.5% were 4, 11.5% were 5, 3.8% were 6, 15.4% were 10, and 3.8% were 11. Thirteen participants were rated as having none or minimal hopelessness, Seven were rated as having mild hopelessness, and five were rated as having moderate hopelessness. Table 15 presents the percentages for Beck's descriptions for level of hopelessness, where 50% had none or minimal hopelessness, 26.9% had mild hopelessness, and 19.2% had moderate hopelessness.

Table 14

Beck Hopelessness Scale Score

Score	n	%	Level of Severity
0	2	7.7	
1	6	23.1	None or Minimal
2	4	15.4	
3	1	3.8	
4	3	11.5	
5	3	11.5	
6	1	3.8	Mild
7	0	0	
8	0	0	
9	0	0	
10	4	15.4	
11	1	3.8	Moderate
12-14	0	0	
15 +	0	0	Severe
Missing	1	3.8	

N = 26.

Table 15

Level of Hopelessness

Severity	n	%
None or Minimal	13	50.0
Mild	7	26.9
Moderate	5	19.2
Missing Case	1	3.8

N = 26.

Hopelessness Effects

The first hypothesis presented in Chapter 1 stated that groups would differ in pretest hopelessness scores, according to type of presenting problem: substance abuse, marriage and family, emotional, or work-related.

Table 16 demonstrates that there was no significant difference between the groups in HS pretest hopelessness based on a Oneway ANOVA $F(2,22) = 2.21$; NS.

The counselor reported reason for seeking counseling was used for analysis, since all participants were included in their report, and the two reports differed

only slightly. For the purpose of analysis, three of the problems were collapsed into one group, as there were not enough participants in those three to stand as individual cells. Thus the three groups were emotional problems, marriage or family problems, and other problems.

Table 16

Results of ANOVA Comparing Pretest Hopelessness Scores According To Reason For Seeking Counseling

	SS	MS	df	F	p
Between Groups	50.60	25.30	2	2.21	.13
Within Groups	252.36	11.47	22		
Total	302.96		24		

Note: SS = Sum of Squares; MS = Mean Square.
N = 25.

Table 17 presents information on the means, and standard deviations of the three groups. Those with emotional problems consisted of 9 participants, with a mean hopelessness score of 3.78, and a standard deviation of 4.09. Those with marriage or family problems consisted of 11 participants, with a mean hopelessness score of 3, and a standard deviation of 2.83. Those with other problems consisted of 5 participants, with a mean hopelessness score of 6.8 and a standard deviation of 3.12.

Table 18 presents the ranges of mean hopelessness scores for the three groups. Participants with emotional problems ranged from 0 to 11, those with marriage or family problems from 1 to 10, and those with other problems from 3 to 10. Thus, no significant difference was found in pretest hopelessness scores according to type of presenting problem.

Table 17

Reason For Seeking Counseling - Group Means, Standard Deviations, and Standard Errors of Hopelessness Scores

Group	n	Mean	SD
Emotional	9	3.78	4.09
Marriage/Family	11	3.00	2.83
Other	5	6.80	3.12
Total	25	4.04	3.55

Note: SD = Standard Deviation.

n = 25.

Table 18

Reason For Seeking Counseling - Group Ranges of Hopelessness Scores

Group	n	Minimum	Maximum
Emotional	9	0	11
Marriage/Family	11	1	10
Other	5	3	10
Total	25	0	11

n = 25.

The second and third hypotheses presented in Chapter 1 were not analyzed as no posttest data was obtained on the sample population. Reasons for this problem will be discussed in Chapter 4.

Research Questions

Five additional research questions were also asked. These will be covered in consecutive order. First, what is the relationship between hopelessness and the various demographic variables that were obtained

from the client (sex, age, marital status, education, and whether the individual had been in counseling before)?

Hopelessness and Client Sex

Table 19 demonstrates that no significant difference was found between client groups based upon participant's sex in HS pretest hopelessness scores based on a Oneway ANOVA $F(1,23) = .01$; NS.

Table 19

Results of ANOVA Comparing Pretest Scores

By Groups According to Participants' Sex

	SS	MS	df	F	p
Between Groups	.13	.13	1	.01	.92
Within Groups	302.83	13.17	23		
Total	302.96				

Note: SS = Sum of Squares; MS = Mean Square.

n = 25.

Hopelessness and Client Age

A negative correlation of $r = -.28$ was found between Hopelessness and client age (n = 25), indicating that as age decreased hopelessness tended to increase. Thus, the younger clients were found to be more hopeless. However, the correlation was not significant at either the .05 or the .01 level.

Hopelessness and Marital Status

Table 20 demonstrates that there was no significant difference between those married and not married in HS hopelessness scores based on a Oneway ANOVA $F(1,23) = .25$; NS. Those clients who were married constituted 50% of the group, while the other cells were not large enough to stand alone, and had to be collapsed to form one group designated, "not married".

Table 20

Results of ANOVA Comparing Pretest Scores By Groups According to Participants' Marital Status

	SS	MS	df	F	p
Between Groups	17.60	17.60	1	1.42	.25
Within Groups	285.36	12.41	23		
Total	302.96		24		

Note: SS = Sum of Squares; MS = Mean Square.
n = 24.

Hopelessness and Education

Table 21 demonstrates that there was no significant difference between the groups in HS hopelessness scores according to educational attainment based on a Oneway ANOVA $F(1,23) = .06$; NS.

Table 21

Results of ANOVA Comparing Pretest Scores By Groups According to Participant's Level of Education

	SS	MS	df	F	p
Between Groups	1.14	1.14	1	.06	.82
Within Groups	249.71	20.81	23		
Total	250.85		24		

Note: SS = Sum of Squares; MS = Mean Square.
$n = 25$.

Table 22 presents the means and standard deviations for the four groups of participants according to level of education.

Table 22

Hopelessness Scores According to Participants' Level of Education - Means and Standard Deviations

Group	n	Mean	Standard Deviation
High School	7	4.43	4.43
Attended College	7	5.00	4.69
Associates Degree	6	3.00	2.19
Bachelors Degree	5	3.40	1.82

n = 25.

Hopelessness and Previous Counseling

Similar to the other demographic variables, Table 23 demonstrates that there was no significant relationship between the mean level of HS hopelessness and whether the client had previous counseling based on a Oneway ANOVA $F(1,23) = .08$; NS.

Table 23

Results of ANOVA Comparing Pretest Scores By Groups According to Participants' Previous Counseling Experience

	SS	*MS*	*df*	*F*	*p*
Between Groups	1.02	1.02	1	.08	.78
Within Groups	301.94	13.13	23		
Total	302.96		24		

Note SS = Sum of Squares; MS = Mean Square.

n = 25.

A second research question asked what the relationship was between pretest level of hopelessness and counselor-rated severity of symptoms at termination. Only a very slight positive correlation of $r = .06$ was found, but was not significant at either the .05 or the .01 level of significance.

The third research question concerned the relationship between pretest level of hopelessness and whether the individual was referred elsewhere for treatment. Table 24 demonstrates that again,

no significant difference was found between pretest HS hopelessness scores and whether or not the individual had been referred elsewhere for treatment based on a Oneway ANOVA $F(1,23) = .03$; NS.

Table 24

Results of ANOVA Comparing Pretest Scores by Groups According to Whether the Participant was Referred Elsewhere for Counseling

	SS	MS	df	F	p
Between Groups	.33	.33	1	.03	.88
Within Groups	302.64	13.16	23		
Total	302.96		24		

Note SS = Sum of Squares; MS = Mean Square. $n = 25$.

The fourth research question sought to determine if there was any relationship between pretest level of HS hopelessness and the total number of sessions that were completed by the client. A negative correlation of -.20 was found, indicating that as

hopelessness went up, the number of sessions declined. This means that those participants who had higher hopelessness scores tended to stay for fewer sessions. However, the correlation was not significant at either the .05 or the .01 level.

The fifth research question asked, "What problems are encountered in doing research within an EAP?" This question actually highlights a major finding of this study. It is essentially a process question and will be presented here as a result of the research and discussed in Chapter 4 in light of the literature.

Expectations were initially high as preliminary contacts were made with Portland, Oregon area EAPs. Three programs showed positive interest, while one agreed to implement the study at their facility and assured the researcher that obtaining data from 100 clients would not be a problem. Contact with this EAP took place over a five month period from July to November of 1991.

On August 30, a meeting was scheduled with the program coordinator and the counselors working at the EAP. When the actual meeting took place only the program coordinator and one counselor attended. In retrospect, personal accountability was minimized

with the other counselors at this point. In fact, the counselor who attended this meeting returned the most data to the researcher (approximately 40%). Initial data from pre and posttests was promised "in a few weeks."

On October 3, five weeks later, the program coordinator was contacted. He stated at that time that, "No data was available."

On November 1, the coordinator reported that only pretests were available (n = 54). He also reported for the first time that difficulties were being experienced in obtaining posttests.

On November 14, the researcher determined along with the EAP coordinator to pick up only the pretests and the counselor questionnaires. However, the coordinator's general mood revealed that he would have liked to have canceled the project at this point. Only $\underline{n}$ = 7 pretests were available (while he had stated two weeks earlier that 54 were available)?!

On November 22, the final pick-up of pretests was arranged. An additional 19 were received for a total of $\underline{n}$ = 26.

In reference to economic concerns, the coordinator of the EAP had hoped to gain program effectiveness

information to be used in marketing the program. The individual counselors did not appear to share this perspective, and were thus detached from the importance of the research. This was a serious procedural flaw, since their willing participation was crucial to the success of the study. Obtaining posttests became difficult, first by the unanticipated sporadic nature of the sample, and second, by a sensitivity to economic interests on the part of the EAP. The individuals who came for counseling represented various corporations that the EAP was in contract with, and their satisfaction was crucial. It was felt by the EAP coordinator that a second plan of mailing a posttest to these clients would be too intrusive.

Summary

The results of the statistical analyses failed to support the first hypothesis stated in Chapter 1. There was no significant difference in pretest hopelessness scores, according to type of presenting problem: substance abuse, marriage and family, emotional, or work-related.

Other statistical tests found no significant relationships between pretest hopelessness scores and client demographic variables, counselor-rated severity of symptoms at termination, whether the individual was referred elsewhere for treatment, or the total number of sessions that were completed.

The problems that were encountered while conducting research within an EAP were highlighted. The particular significance of these findings will be expanded on in relation to the EAP outcome literature in Chapter 4.

Chapter 4 will include a discussion of the results found in Chapter 3. There will also be a section dealing with suggestions for future research.

CHAPTER 4

DISCUSSION

This study sought to measure the effect of time-limited therapy on the level of hope in participants seeking employee assistance counseling. Particular attention was also paid to the problems that are encountered when conducting research within an EAP context. Chapter 1 presented the background for the study within the psychological and EAP literature. Chapter 2 presented the method used to complete the study. Chapter 3 described the results of the study, and Chapter 4 interprets those results, discusses limitations, and provides recommendations for future research.

This discussion will include: (a) information concerning the participants (clients and counselors), (b) implications from the hopelessness scores, (c) implications from the hypotheses, (d) implications from the research questions, and (e) problems in doing research within an EAP. The implications that are

drawn will be applied toward recommendations for future research.

Participants

The participants consisted of adult outpatients at an employee assistance program in Portland, Oregon. Twenty-six participants were involved in the study, 6 males and 19 females, and one individual who failed to provide information on his or her gender. The sample size was small for a study that sought to analyze group differences within the sample. Two major obstacles were encountered that restricted the size of the available sample. First, while 7 counselors were originally intending to provide pre and posttests to 10 clients each, only 3 of the counselors completed the study. Second, the participants were essentially receiving "free" counseling (paid for by their employer), and terminated their counseling either by calling to say they were finished or by failing to show for their appointments. This second problem made the collection of a posttest an impossibility.

However, in regard to the sample, there are several things that are worth noting. First, the sample was

quite diverse. Ages ranged from 21 to 55 years, and they did not tend to cluster around any particular age. Half of the participants were married, and the rest were spread over several categories of being single (never married, divorced, separated, living together). In the area of education, the sample was spread nearly equally among four categories, ranging from high school to a bachelors degree from college. Half of the participants had previous counseling, and half had not. Thus the sample was heterogeneous in nature, and not clustered around a single group of individual characteristics.

Second, it was originally thought that the sample would be clustered around substance abuse and work-related problems, but these two categories represented only a small portion of the sample. Marriage and family, and emotional problems were more common than substance abuse and work-related problems. Approximately 80% claimed emotional, or marriage and family problems as their reason for seeking counseling. It was also found that approximately 80% of the individuals were listed as self-referred as opposed to employer-referred. Interestingly, these two findings coupled together fit a pattern (Miller, 1986). There

are distinct "life-cycles" within EAPs. In the beginning they tend to be all supervisory referrals, as the employees with more difficult problems are seen first. Later, the EAP becomes more accepted among employees and becomes a more trusted resource. It is at this point that the EAP begins to receive more self-referred cases and begins to handle more emotional and marriage/family problems. It is possible that this study approached the EAP at this point in its "life-cycle." Future research should take into account program age, lest interpretations be falsely skewed in any one direction.

The counselors were similar in gender, age, education, and experience. All three were females, with a mean age of 35.3 (range = 31-40). All three had Masters degrees with between 4 and 10 years of counseling experience. So the counselors were also suited for a study that was not focusing on counselor variables, but rather was enhanced by similarities among counselors.

Implications From the Hopelessness Scores

There are two points that merit discussion from the pretest hopelessness scores themselves. First, the mean level of hopelessness for the sample was 4.04 with a standard deviation of 3.55. This result brings up the question, "How does this sample relate to other samples?"

In a normal, non-clinical population, Holden and Fekken (1988) tested 149 university undergraduates and found a mean of 2.67 and a standard deviation of 2.58. Three weeks later the results remained stable, with a mean of 2.52 and a standard deviation of 2.66. In clinical populations, higher scores have been found. Beck et al. (1990) report in a study of 165 patients hospitalized with suicidal ideation, that those who eventually committed suicide had a mean score of 13.27 and a standard deviation of 4.43, while those who did not had a mean of 8.94 and a standard deviation of 6.05.

The samples of Holden and Fekken (1988) and Beck et al. (1990) were compared with the EAP sample in this study by means of the independent-measures *t* test. Compared with Holden and Fekken's non-clinical

sample of university undergraduates, the EAP sample was significantly more hopeless $t(172) = 2.30$; $p \leq .05$. On the other hand, when compared with Beck's sample of patients hospitalized with suicidal ideation, the hospitalized patients were significantly more hopeless than the EAP sample. Those inpatients who did not eventually commit suicide were significantly more hopeless $t(171) = 3.92$; $p \leq .05$, as were the inpatients who eventually did commit suicide $t(40) = 7.29$; $p \leq .05$. Thus the EAP sample is positioned where an outpatient sample would perhaps be expected. They are significantly more hopeless than a non-clinical college sample, but significantly less hopeless than an inpatient sample hospitalized with suicidal ideation.

Secondly, the participants in this study, according to Beck's levels of severity, were grouped with 13 in the "none or minimal hopelessness" (0-3) category, 7 in the "mild hopelessness" (4-8) category, and 5 in the "moderate hopelessness" (9-14) category. This second point deals with levels of severity, and is related to the issue of clinical diagnosis. Beck (1986), Beck et al. (1989), and Beck et al. (1990) have reported a cutoff score of 9 or above to denote individuals who are at high-risk for eventual suicide. This group was 11 times more likely to commit suicide

than the rest of the outpatients who were studied (Beck et al., 1990). This present study found 5 out of the 26 participants to be above the cutoff score of 9, including four with a score of 10 and one with a score of 11. Thus, while the study found the sample as a whole to be in the "mild hopelessness" (the 4-8 range in Beck's scoring) category (mean = 4.04), approximately 20% of the participants should be seriously evaluated for potential suicide.

Implications From the Hypotheses

All but one of the three hypotheses required a posttest for evaluation. The first hypothesis did not, and will be discussed first. The second and third hypotheses required a posttest, and will be discussed together, with a look at the literature for outcome studies within employee assistance programs.

The first hypothesis stated that groups will differ in pretest hopelessness scores, according to type of presenting problem: substance abuse, marriage and family, emotional, or work-related. However, there was no statistically significant difference among the groups, and the hypothesis was not supported by this sample. Essentially, hopelessness test scores

varied more within groups than between them, and within group ranges were similar for each group.

Low sample size was a major factor in the insignificant results of the study. Thus the size of the sample proved to be a major limitation. At the onset of data collection, it was anticipated that a sample of at least 100 would be available for analysis, but problems arose at the employee assistance program where data was collected, and this number was not attained.

The second and third hypotheses were not analyzed due to the fact that the posttest could not be administered. Most participants terminated their counseling by phone, or simply did not show up for their next appointment. This turn of events was not anticipated when data collection was initiated at the employee assistance program.

Implications From the Research Questions

Implications from the five additional research questions asked will be assessed in consecutive order. The first question involved the relationship between hopelessness and the various demographic variables that were obtained from the client (sex, age, marital

status, education, and whether the individual had been in counseling before). It was stated in Chapter 3 that no statistically significant relationships were found. In part this was due to the size of the sample obtained. A sample closer to 100 may have yielded clearer results. However, as was noted above under "discussion of the participants," the sample was diverse, and other than sharing the same EAP they were well distributed in age, marital status, education, and previous counseling experience. The actual relationships between these variables and level of hopelessness were small and not significant.

The second research question asked what the relationship was between pretest level of hopelessness and counselor rated severity of symptoms at termination. Again, no statistically significant relationship was found. This was in effect a counselor-rated posttest. It might have been expected that termination severity would be elevated for clients with higher pretest levels of hopelessness. However this result was not found. The availability of posttest BHS scores would have made an assessment of this factor more complete.

The third and fourth research questions asked what the relationship was between pretest level of

hopelessness and whether the individual was referred elsewhere for treatment, and the total number of sessions attended. Whereas it might have been expected that those with the highest level of hopelessness would be most likely to be referred, no significant relationship was found. These results were again limited by sample size, and the low degree of severity within the sample.

The fifth research question involves problems in conducting research in an EAP setting and comprises an important finding within this study. For this reason it will be discussed under its own heading.

Problems in Doing Research Within an EAP

The fifth research question sought to assess the problems that are encountered in doing research within an EAP. This question will be discussed under five headings: (a) initiating research, (b) facilitating cooperation, (c) competition, (d) economic concerns, and (e) the problem of client identification "Who is the client: employer or employee?"

Initiating Research

The fact that the EAP phenomenon has not come to the interest of the behavioral scientists is regarded by Miller as the "Achilles heel" of the EAP movement. "This is a dramatic problem for the field because if we do not have a research base, our Core Technology will be largely hypothetical" (Miller, 1986, p. 79). Not surprisingly, he concludes that the lack of scientific interest stems from the extreme difficulty encountered when one attempts to secure sites in which to perform research.

Walsh and Hingson (1985) report that, despite an eight-year collaborative relationship with 68 companies, only one agreed to participate in a randomized study. They noted that willingness to collaborate with outside researchers was a rare occurrence within the EAP field.

The EAP that agreed to take part in the present study was one of five programs that were contacted in the Portland, Oregon area. The program coordinator was initially quite positive, but as the study progressed the effort became progressively more cumbersome for him. Perhaps one major result is that, at least in the case of this particular EAP, it will be much more difficult to collaborate on future research.

Facilitating Cooperation

The EAP's lack of perserverance with the study may have been influenced by a failure to perceive it as relevant to program goals. Kim (1988, p. 179) reports that "EAPs usually have specific treatment goals with measureable criteria." These generally include reductions in absent days, medical claims, number of accidents, and disciplinary measures (Nadolski and Sandonato (1987). Consequently, the significance of reducing hopelessness may have been hard for the individual counselor to relate to behaviorally specific EAP treatment goals. Had the researcher used a broader and more common term such as "depression" the study might have taken on a more relevant appearance. Employers are interested in improving work performance (Cayer and Perry, 1988; Kim, 1988; Nadolski and Sandonato, 1987). Consequently, EAPs must also be interested in work performance. Issues of well-being must be related to the employee's job performance. It likely would have helped if the researcher had taken greater care to show how the study was related to the accomplishment of specific EAP treatment goals.

The problem of facilitating the cooperation of EAPs is described by Balgopal and Patchner (1988, p. 101).

> There is no guarantee that the EAP staff will fully cooperate with the external researchers in facilitating the data collection process because their commitment to the research may be lacking. On the other hand, if the data collection activity is implemented by the EAP staff themselves, their general lack of research skills . . . further complicates the evaluation process due to time limitations and staff needs for training. EAP staff may be hesitant about evaluation outcome and concerned that the results may not positively reflect on their programs. Thus, these dynamics may not only bias the research, but may also impede this endeavor.

They further conclude that the benefits of research must be conveyed as providing "payoffs" for everyone involved. This includes the company, their employees, and the EAP being studied. "EAP evaluation should be seen as a team effort. This effort should first and foremost define the purpose of the evaluation and what its payoffs are" (Balgopal and Patchner, 1988, p. 104).

Facilitating cooperation can be further hindered by the threat that program managers may feel when

considering the assessment of their own organization (Battle, 1988). The counselors and program director involved in this study felt some uneasiness at the prospect of published results despite the careful measures that were taken to insure confidentiality. This further substantiates the need to carefully develop a working relationship that is perceived as mutually beneficial.

Two follow-up studies in the literature demonstrate the importance of establishing a working relationship. Fiedler, Bowden, Kelly-McNeil, Steinberg, and Gochfeld (1991) studied compliance rates of EAP clients who were referred to outpatient services for treatment. Little difficulty was experienced in completing the study, as it was the EAP itself that had initiated and conducted it. Foote and Erfurt (1991) studied the effects of EAP follow-up on preventing relapse among substance abuse clients. They experienced great difficulty: 63% refused help or dropped out of follow-up, and intervention was incompletely implemented due to a variety of "organizational problems." The authors concluded that the EAP was simply not set up to handle the type of research that was conducted. Poor communication proved to be a major problem.

These two examples are not exhaustive, but they do illustrate the importance of taking great care to develop a working relationship prior to beginning a study. The need for cooperation with both the program coordinator and program counselors cannot be underestimated.

Competition

EAPs operate within a competitive market. Battle (1988, p. 102) concludes that "EAPs have yet to collaborate with each other in developing data bases for their activities such as utilization rates, treatment results, and cost-benefit issues." This point is illustrated in an article by Wright (1988) published in the Employee Assistance Quarterly. He developed and used a client feedback questionnaire for evaluating the program he directs. However, in describing his data collection he states,

> From a collegial point of view, we would very much like to provide the actual one page questionnaire as an appendix item for all to see and copy but, alas, it is a competitive world we live in. We consider this tool very important in the maintenance of what the marketeers call 'our edge' (1988, p. 212).

This competitive framework, while understandable from a business perspective, does not lend itself to cooperative research. Miller (1988, p. 71) concludes that

> to sustain an experimental design in the workplace is almost impossible. . . . My knowledge of whether or not others are attempting to test EAP effectiveness is, I suspect quite low for the simple reason that there is little, if any, communications between persons engaged in such efforts.

Economic Concerns

A fourth problem encountered in conducting EAP outcome research centers around economic factors. There has been a marked escalation of health care costs borne by employers. EAPs attempt to provide early interventions "before (problems) become too costly for the employer . . . and channel the employee to a source of assistance . . . which will presumably provide the most cost-effective help for the employee's problem" (Roman and Blum, 1988, p. 504). However, this focus on economics can provide a difficult framework for the EAP researcher.

Roman (Miller, 1986) found that most companies stress "management efficiency" (i.e., the efficient use of resources), as opposed to the "cost/benefit" ratio (i.e., do the benefits obtained from the program justify costs?) that is generally used to express their economic concerns. Still, it appears that either designation has the idea of cost effectiveness at heart. Consequently, when a researcher places him or herself within the EAP context, studies must demonstrate relevance to economic concerns (Battle, 1988; Miller, 1986). Thus, as with the conclusion of Klarreich, DiGiuseppe, and DiMattia (1987), experimental studies related to psychological constructs have not been attempted within the EAPs. The study under discussion here was an attempt at evaluating a psychological construct within an EAP. This discussion of economic concerns bears a relationship to the problem of perceived relevancy that was discussed above under "facilitating cooperation."

Who is the Client

A fifth problem that makes EAP research difficult involves identifying who the client is: the company that the EAP serves, or the employees of that company?

In this particular study, the EAP owed allegiance to both, but the researcher was primarily concerned with the employees. Roman and Blum (1987) argue that the employer that utilizes the EAP's services is the client of the EAP.

It was noted in Chapter 3 that the program director was unwilling to mail out the post-test to the clients. This would have been very helpful from the standpoint of the study, but may have jeopardized his relationship with the "client" in the broader sense. Thus while the researcher was focused on the individual employees, the focus of the coordinator was on both employee and employer. In fact, one of the coordinator's responsibilities involved marketing the program to corporations in the Portland, Oregon area. The economic success of his program was primarily a reflection of how corporate "clients" (the employers) viewed the EAP. Consequently, for research efforts to succeed their scope must extend beyond corporation employees. This study may have been accomplished more effectively if it had subsumed itself into a broader study that fit more easily into a marketing profile. In other words, the researcher should have approached the coordinator first as an asset to his marketing efforts.

At the point where the coordinator faced the greatest amount of pressure to succeed, and the place of greatest felt need. Change in hopelessness might then have been listed as part of the data base.

Five problem areas that are encountered when one attempts research within an EAP have been examined in relation to this study. They incorporate the major areas covered in the literature. Recommendations for future research are now addressed with these problems in mind.

Recommendations for Future Research

The site that was chosen for this study, the method used to collect data, the actual data obtained, and the problems encountered give rise to a discussion of recommendations for future research.

1. Ideally, though beyond the scope of this present study, the researcher should not have plunged in cold with his own ideas. Rather, rapport should have been established first by assisting with research that the company was already doing, or by suggesting research that would help the company meet program objectives. The literature puts this forth as an

ideal (Miller, 1988), although the limitations involved in the case of a dissertation are obvious.

2. This study needs to be replicated in a different setting in order to successfully assess change in hopelessness. The sporadic nature of the participants, and the fact that the EAP's "client" was actually the corporation from which the participant came, made data collection difficult. The study could be undertaken at a variety of locations, as long as they utilize a form of time-limited therapy. It would also be beneficial to conduct the research where the researcher could have more control over administering data collection.

3. The method used to collect the data could be improved upon. First, it has been noted above that only three out of the seven counselors who were initially scheduled to take part actually followed through. The researcher met with the director and one of the counselors to answer questions and to pass out and explain the materials used. On hindsight, it would have been helpful to cultivate a working relationship with each counselor, by meeting with them separately or in a group. This would have provided face-to-face contact, and would perhaps have increased personal accountability and follow through.

4. The data obtained and the analyses completed highlight the need for a larger sample. Replication of this study needs to be performed in a setting where a sample size of approximately 100 is obtainable. Available samples of clinical populations could possibly be obtained in a community mental health setting, or in a private practice where time-limited therapy is performed.

5. The fact that 50% of the sample sought counseling based on marriage and family problems is of interest. The study hypothesized that there would be different groups of participants according to type of problem, while the prevalence of any one type of problem could have been a hypothesis on its own. The area of frequency of presenting problem type was happened upon unexpectedly in this study. However, as was discussed above, this could simply be a reflection of this particular EAPs "life-cycle." Information of this type could be used in demonstrating to an EAP the importance of actively conducting research, in order to guarantee a better understanding of the nature of their clientele.

Summary

The hypotheses presented in Chapter 1 of this study were not supported. The first hypothesis concerning group differences in pretest hopelessness scores did not find statistical support. The second and third hypotheses were not examined, as a posttest was not obtained. It was concluded that the literature supports the difficulty one faces when conducting research within the EAP context.

The research questions revealed some interesting information concerning the population at the EAP where the study was conducted. It appears that the population was diverse, with no overrepresentation of any single group based on age, marital status, education, or previous counseling history. Problems encountered with this study were not unique. They perhaps serve to highlight the need for EAP providers to be held accountable to scientific investigation.

Future research in EAP settings should be initiated with careful planning. Care must be taken to establish rapport and to facilitate EAP program objectives. However, in order to reach the goal of evaluating

the effect of time-limited therapy on the level of hopelessness in clients, the study ought to be replicated in a different setting.

References

Balgopal, P. R., & Patchner, M. A. (1988). Evaluating employee assistance programs: Obstacles, issues and strategies. _Employee Assistance Quarterly_, _3_(3-4), 95-105.

Balk, U. J. (1988). Retiring early. _Personnel Administrator_, _33_(6), 81-83.

Basso, R. (1989). A consumer's grapevine in an employee assistance program. _Employee Assistance Quarterly_, _4_(3), 1-10.

Battle, S. F. (1988). Issues to consider in planning employee assistance program evaluations. _Employee Assistance Quarterly_, _3_(3-4), 79-93.

Beck, A. T. (1967). _Depression: Causes and treatment_. Philadelphia: University of Pennsylvania Press.

Beck, A. T. (1976). _Cognitive therapy and the emotional disorders_. New York: International University Press.

Beck, A. T. (1986). Hopelessness as a predictor of eventual suicide. _Annals of the New York Academy of Sciences_, _487_, 90-96.

Beck, A. T., Brown, G., Berchick, R. J., Stewart, B. L., & Steer, R. A. (1990). Relationship between hopelessness and ultimate suicide: A replication with psychiatric outpatients. American Journal of Psychiatry, 147(2), 190-195.

Beck, A. T., & Steer, R. A. (1989). Prediction of eventual suicide in psychiatric inpatients by clinical ratings of hopelessness. Journal of Consulting and Clinical Psychology, 57(2), 309-310.

Beck, A. T., Weissman, A., Lester, D., and Trexler, L. (1974). The measurement of pessimism: The Hopelessness Scale. Journal of Consulting and Clinical Psychology, 42(6), 861-865.

Benfield, C. J. (1985). Problem performers: The third-party solution. Personnel Journal, 64(8), 96-101.

Bowers, W. A. (1987). A comparison of three therapeutic approaches to the treatment of depression with inpatients: Cognitive therapy plus medication, relaxation therapy plus medication, medication alone. Dissertation Abstracts Online, 0994978. (University Microfilms No. AAD88-10124)

Burdett, J. O. (1988). Easing the way out. Personnel Administrator, 33(6), 157-166.

Burns, N. A. B. (1981). Evaluation of a supportive-expressive group for families of cancer patients. Dissertation Abstracts Online, 757762. (University Microfilms No. AAD81-21332)

Campbell, D. T., & Stanley, J. C. (1966). Experimental and quasi-experimental designs for research. Chicago: Rand McNally and Company.

Carson, V., Soeken, K. L., & Grimm, P. M. (1988). Hope and its relationship to spiritual well-being. Journal of Psychology and Theology, 16(2), 159-167.

Cayer, N. J., & Perry, R. W. (1988). A framework for evaluating employee assistance programs. Employee Assistance Quarterly, 3(3-4), 151-168.

Colantonio, A. (1989). Assessing the effects of employee assistance programs: A review of employee assistance program evaluations. Yale Journal of Biology and Medicine, 62(1), 13-22.

Couch, R. D., & Childers, J. H. (1987). Leadership strategies for instilling and maintaining hope in group counseling. Journal for Specialists in Group Work, 12(4), 138-143.

Dillman, D. R. (1978). Mail and telephone surveys. New York: John Wiley & Sons.

Dixon, K. (1988). Employee assistance programs: A primer for buyer and seller. Hospital and Community Psychiatry, 39(6), 623-627.

Dufrane, K., & Leclair, S. W. (1984). Using hope in the counseling process. Counseling and Values, 29(1), 32-41.

Ellis, A. (1980). Rational-emotive therapy and cognitive behavior therapy: Similarities and differences. Cognitive Therapy and Research, 4, 325-340.

Ellison, C. W. (1983). Spiritual well-being: Conceptualization and measurement. Journal of Psychology and Theology, 11(4), 330-340.

Erikson, E. H. (1964). Insight and responsibility. New York: Norton.

Farran, C. J., Salloway, J. C., & Clark, D. C. (1990). Measurement of hope in a community-based older population. Western Journal of Nursing Research, 12(1), 42-59.

Fiedler, N., Bowden, J., Kelly-McNeil, K., Steinberg, M., & Gochfeld, M. (1991). Employee assistance program compliance: Impact of contrasting insurance coverage. Journal of Occupational Medicine, 33(8), 862-867.

Foote, A., & Erfurt, J. C. (1991). Effects of EAP follow-up on prevention of relapse among substance abuse clients. Journal of Studies on Alcohol, 52(3), 241-248.

Foote, A. W., Piazza, D., Holcombe, J., Paul, P., & Daffin, P. (1990). Hope, self-esteem and social support in persons with multiple sclerosis. Journal of Neuroscience Nursing, 22(3), 155-159.

Frank, J. D. (1968). The role of hope in psychotherapy. International Journal of Psychiatry, 5, 383-395.

Frank, J. D. (1974). Therapeutic components of psychotherapy. The Journal of Nervous and Mental Disease, 159(9), 325-342.

Goldman, R. L. (1983). Marketing employee assistance programs to industry. Health Marketing Quarterly, 1(2-3), 91-98.

Goldstein, A. P. (1962). Therapist-patient expectancies in psychotherapy. New York: Pergamon Press.

Grimm, P. M. (1984) The State-Trait Hope Inventory: The empirical evaluation of an instrument. Unpublished Manuscript, University of Maryland School of Nursing, Baltimore.

Hamilton, E. W. (1982). A longitudinal study of attributional style and dysfunctional attitudes in a clinical population. Dissertation Abstracts Online, 806992. (University Microfilms No. AAD83-07397).

Herth, K. (1990). The relationship of hope, coping styles, concurrent losses, and setting to grief resolution in the elderly widow(er). Research in Nursing and Health, 13(2), 109-117.

Hoffman, M. A. (1989). An analysis of characteristics and financial evaluation for established in-house corporate Employee Assistance Programs. Dissertation Abstracts International, 50(7-A), 2135.

Holden, R. R., & Fekken, G. C. (1988). Test-retest reliability of the Hopelessness Scale and its items in a university population. Journal of Clinical Psychology, 44(1), 40-43.

Jason, L. A., Lasowitz, T., Michaels, M., & Blitz, C. (1989). A worksite smoking cessation intervention involving the media and incentives. American Journal of Community Psychology, 17(6),785-799.

Kim, D. S. (1988). Assessing employment assistance programs: Evaluation typology and models. Employee Assistance Quarterly, 3(3-4), 169-188.

Klarreich, S. H., DiGiuseppe, R., & DiMattia, D. J. (1987). Cost effectiveness of an employee assistance program with rational-emotive therapy. Professional Psychology: Research and Practice, 18, 140-144.

Koss, M. P., & Butcher, J.N. (1986). Research on brief psychotherapy. In S. L. Garfield & Bergin (Eds.), Handbook of psychotherapy and behavior change. New York: John Wiley & Sons.

Larson, J. H., Wilson, S. M., & Beley, R. (1988). The assessment of family wellness. American Journal of Health Promotion, 2(3), 20-30.

Levine, A. M. (1989). The importance of hope. Western Journal of Medicine, 150(5), 609.

Madonia, J. F. (1985). Handling emotional problems in business and industry. Social Casework, 66(10), 587-593.

Malan, D. H. (1973). The outcome problem in psychotherapy research. Archives of General Psychiatry, 29, 719-729.

McGovern, T. F. (1983). The effects of an inpatient alcoholism treatment program, with two variations, on measurements of depression, hopelessness, loss and grief. Dissertation Abstracts Online, 814935. (University Microfilms No. Not available from University Microfilms)

Menninger, K. (1959). Hope. The American Journal of Psychiatry, 116, 481-491.

Mercier, M. A., Fawcett, J. A., & Clark, D. C. (1984). Hopefulness: A preliminary examination. Unpublished manuscript, Rush-Presbyterian-St. Luke's Medical Center, Chicago.

Miller, J. F., & Powers, M. J. (1988). Development of an instrument to measure hope. Nursing Research, 37(1), 6-10.

Miller, R. E. (1986). EAP research then and now. Employee Assistance Quarterly, 2(1), 49-86.

Molloy, D. J. (1989). Peer intervention: An exploratory study. Journal of Drug Issues, 19(3), 319-336.

Monsma, P. H. (1976). Hope. In M.C. Tenney (Ed.), The Zondervan pictorial encyclopedia of the Bible. Grand Rapids, Michigan: Zondervan.

Morris, L. (1979). The first epistle of Paul to the Corinthians. Grand Rapids, Michigan: Wm. B. Eerdmans.

Murray, J. (1979). Epistle to the Romans. Grand Rapids, Michigan: Wm. B. Eerdmans.

Nadolski, J. N., & Sandonato, C. E. (1987). Evaluation of an employee assistance program. Journal of Occupational Medicine, 29(1), 32-37.

Plavan, K. A. (1989). A descriptive study of significant characteristics and evaluation activities of Employee Assistance Programs. Dissertation Abstracts, 50(12-A), 3855.

Pommer, W., Diederichs, P., Hummel, M., Kratzer, P., Offermann, G., & Molzahn, M. (1985). Patient's expectations from renal grafting and transplantation outcome. Psychotherapy and Psychosomatics, 44, 95-102.

Reich, J., & Neenan, P. (1986). Principles common to different short-term psychotherapies. American Journal of Psychotherapy, 40(10), 62-69.

Roman, P. M., & Blum, T. C. (1987). Ethics in worksite health programing: Who is served? Health Education Quarterly, 14(1), 57-70.

Roman, P. M., & Blum, T. C. (1988). Formal intervention in employee health: Comparisons of the nature and structure of employee assistance programs and health promotion programs. Social Science and Medicine, 26(5), 503-514.

Rosenthal, T. L., & Bandura, A. (1978). Psychological modeling: Theory and practice. In S. L. Garfield and A. Bergin (Eds.), Handbook of Psychotherapy and Behavior Change (2nd ed., pp. 621-658). New York: Wiley.

Scheier, M. F., & Carver, C. S. (1987). Dispositional optimism and physical well-being: The influence of generalized outcome expectancies on health. Journal of Personality, 55(2), 169-210.

Schmidt, M. M. (1980). Amount of therapist contact and outcome in a multimodal depression treatment program. Dissertation Abstracts Online, 769078. (University Microfilms No. AAD82-01952)

Sholette, R. L. (1986). The alcoholic and responsibility: A reconsideration of the moral model. Employee Assistance Quarterly, 2(1), 103-110.

Staats, S. (1987). Hope: Expected positive affect in an adult sample. Journal of Genetic Psychology, 148, 357-364.

Staats, S. (1989). Hope: A comparison of two self-report measures for adults. Journal of Personality Assessment, 53(2), 366-375.

Staats, S., & Stassen, M. A. (1986). The Hope Index: A measure of self-other-world expectations for adults. Paper Presented at the 94th Annual Convention of the American Psychological Association, Washington, DC.

Stotland, E. (1969). The psychology of Hope. San Francisco: Josey-Bass Inc., Publishers.

Strack, S., Carver, C. S., & Blaney, P.H. (1987). Predicting successful completion of an aftercare program following treatment for alcoholism: The role of dispositional optimism. Journal of Personality and Social Psychology, 53(3), 579-584.

Strupp, H. H., & Binder, J. L. (1984). Psychotherapy in a new key: A guide to time-limited dynamic psychotherapy. New York: Basic Books.

Taylor, S. E., & Brown, J. D. (1988). Illusion and well-being: A social psychological perspective on mental health. Psychological Bulletin, 103(2), 193-210.

Trice, H. M., & Sonnenstuhl, W. J. (1988). Constructive confrontation and other referral processes. Recent Developments in Alcohol, 6, 159-170.

Vande Kemp, H. (1984). Hope in psychotherapy. Journal of Psychology and Christianity, 3(1), 27-35.

Walsh, D. C., & Hingson, R. W. (1985). Where to refer employees for treatment of drinking problems. Journal of Occupational Medicine, 27(10), 745-752.

Webb, W. (1990). Cognitive behavior therapy for employee assistance counselors. Employee Assistance Quarterly, 5(3), 55-65.

Wright, D. A. (1988). A brief overview of research techniques used to evaluate three employee assistance programs through the family service association of metropolitan Toronto experience. Employee Assistance Quarterly, 3(3-4), 205-214.

Yalom, I. D. (1985). The theory and practice of group psychotherapy. New York: Basic Books.

APPENDICES

Appendix A

General Information

T#_____ C#_____

General Information

Explanation of the Study - My Colleague and I are conducting research as part of our graduate studies at George Fox College. We are investigating brief therapy among clients using employee assistence counseling.

Participation - If you choose to participate in this study, you will be asked to answer the questions on the next page and two other brief questionnaires: one now and one after your last session. Altogether this will take no more than 5 minutes of your time and will be of great assistance to us. In addition your counselor will be asked to identify your problem type and rank the severity of your situation. We will also be asking if you were recommended for other types of treatment. At any point if you should decide to withdraw from this study you will be allowed to do so and your questionnaires will be destroyed.

Confidentiality- All information gathered will be strictly confidential. All questionnaires will be given an identification number to assure your anonymity and coordinate data collection.

If you are willing to participate in our study please answer each of the questions on the following page.

Thank you,

Jim Porowski, M.A.

T# _____ C# _____

General Information

Please answer the following questions as accurately as possible.

Q0 Your sex. (check one)
- ☐ FEMALE
- ☐ MALE

Q1 Your present age. _____ YEARS.

Q2 Current Marital Status. (check one)
- ☐ NEVER MARRIED
- ☐ MARRIED
- ☐ DIVORCED
- ☐ SEPARATED
- ☐ WIDOWED
- ☐ LIVING TOGETHER

Q3 Education (check the highest appropriate box).
- ☐ HIGHSCHOOL OR _____ HIGHEST GRADE COMPLETED.
- ☐ ATTENDED COLLEGE.
- ☐ ASSOCIATES DEGREE OR TRADE SCHOOL.
- ☐ BACHELORS DEGREE.
- ☐ ATTENDED GRADUATE SCHOOL.
- ☐ GRADUATE DEGREE.

Q4 Occupational Title. ______________________________

Q5 Have you ever been in counseling before?
- ☐ YES
- ☐ NO

Q6 If YES, how long? _____ WEEKS _____ MONTHS _____ YEARS.

Q7 Reason for seeking counseling now. (check one)
- ☐ EMOTIONAL PROBLEMS.
- ☐ SUBSTANCE ABUSE PROBLEMS.
- ☐ WORK RELATED PROBLEMS.
- ☐ FAMILY OR MARRIAGE PROBLEMS.
- ☐ OTHER (please specify) ______________________________

Q8 Referral source (check one).
- ☐ VOLUNTARY OR SELF-REFERRED.
- ☐ REQUIRED BY EMPLOYER.
- ☐ OTHER (please specify) ______________________________

Appendix B

Counselor Questionnaire

T#____ C#____

Counselor Questionnaire

Instructions - Part I. of this questionnaire is to be filled out once by each counselor. On each successive questionnaire you may indicate that Part I. has already been completed by marking the appropriate box below Part II. needs to be filled out for each of the clients upon completion of the last session. Please be as accurate and complete as possible. Thank you.

Part I. Counselor Information

☐ THIS SECTION COMPLETED ONCE.

Q9 Your Sex. (check one)

☐ MALE
☐ FEMALE

Q10 Your Present Age. ____ YEARS.

Q11 Your highest earned degree. ________

Q12 Counseling experience. ____ YEARS (round to the nearest full year).

Part II. Client Information

Q13 Reason for counseling. (check one)

☐ EMOTIONAL PROBLEMS
☐ SUBSTANCE ABUSE
☐ FAMILY OR MARRIAGE
☐ WORK RELATED
☐ OTHER (please specify) ____________

Q14 Rate the severity of symptoms at termination. (circle the most appropriate number)

1-----2-----3-----4-----5-----6-----7-----8-----9-----10
MILD MODERATE SEVERE

Q15 Was this person referred elsewhere for treatment.

☐ YES
☐ NO

Q16 If YES, what type of treatment

☐ INPATIENT
☐ OUTPATIENT LONG-TERM
☐ GROUP TREATMENT
☐ OTHER (specify) ____________

Q17 Total number of sessions ____

Appendix C

Proposal Letter

George Fox College
Newberg, OR

Box 351
George Fox College
414 N. Meridian St.
Newberg, OR 97132
Thu, Aug 29, 1991

Bob Hulsey
Sisters of Providence E.A.P.
1235 NE 47th, #297
Portland, Oregon 97213

Dear Mr Hulsey,
Jim Porowski and I are graduate students in the George Fox College Clinical Psychology Program, under the supervision of Clark Campbell, Ph.D.. We are interested in examining the effect of brief therapy on increasing hope among clients using Employee Assistance Programs. The restoration of hope is believed to be a primary requisite of the counseling experience. In fact it is the client's initial state of hopelessness that brings him or her into therapy in the first place. At this point we are attempting to solicit the participation of at least two Employee Assistance Programs.

Data collection will involve a brief demographic questionnaire, a pretest Hopelessness Scale (Beck, et al; 1974), a posttest Hopelessness Scale, and a brief questionnaire to be filled out by the therapist/counselor. Clients should be able to complete both tests and the questionnaire in no more than 5 minutes. Therapist questionnaires should take 2 minutes for the first questionnaire and 3-5 for each of the rest. All questionnaires and tests have been included for your inspection.

The procedure for data collection is fairly simple. Each therapist will be given a packet containing 1 therapist questionnaire (to be filled out some time before the end of the study), and 20 client questionnaires. Clients (if willing to participate) will fill out the demographic questionnaire and the pretest Hopelessness Scale prior to the first session. The posttest Hopelessness Scale will be administered after the last session. At this time the therapist will also answer some brief questions about the client.

All scales and questionnaires will be numerically coded in order to maintain confidentiality. This study will adhere to American Psychological Association guidelines for research with human participants and has been approved by the Human Participants Research Committee at George Fox College. Results and a summary of our conclusions will be provided to the agency upon completion of this project. Clients may request the summary information by mail.

If you have any questions I can be reached at (503)231-2938. My colleague and I would greatly appreciate your consideration and participation.

Sincerely,

Tim Perkins, M.A. Jim Porowski, M.A.

Appendix D

Raw Data

Explanation of Raw Data

Columns 1-2:	Client Number
Column 4:	Counselor Number
Column 5:	Client Sex
	1 = Female
	2 = Male
Columns 6-7:	Client Age
Column 8:	Client Marital Status
	1 = Never Married
	2 = Married
	3 = Divorced
	4 = Separated
	5 = Widowed
	6 = Living Together
Column 9:	Client Education
	1 = High School
	2 = Attended College
	3 = Associates Degree
	4 = Bachelors Degree
	5 = Attended Graduate School
	6 = Graduate Degree

Column 10: Previous Counseling

1 = Yes

2 = No

Columns 11-12: If Yes, How Long?

Column 13: Reason For Counseling

1 = Emotional Problems

2 = Substance Abuse

3 = Work Related

4 = Marriage and Family

5 = Other

Column 14: Referal Source

1 = Voluntary/Self

2 = Employer

3 = Other

Column 15: Counselor Sex

1 = Male

2 = Female

Columns 16-17 Counselor Age

Column 18 Highest Earned Degree

1 = Less Than BA

2 = BA

3 = MA

4 = PhD

Columns 19-20 Counselor Experience

Column 21	Counselor - Reason For Counseling
	1 = Emotional Problems
	2 = Substance Abuse
	3 = Work Related
	4 = Marriage and Family
	5 = Other
Columns 22-23	Counselor-Rated Severity
Column 24	Counselor Referal?
	1 = Yes
	2 = No
Column 25	If Yes, What Type
	1 = Inpatient
	2 = Outpatient Long-Term
	3 = Group Treatment
	4 = Other
Column 25	Total Number of Sessions
Columns 26-46	Answers to the Beck Hopelessness Scale

```
THE VARIABLES ARE LISTED IN THE FOLLOWING ORDER:

LINE   1: CLIENT COUNSEL Q0 Q1 Q2 Q3 Q4 Q5 Q6 Q7 Q8 Q9 Q10 Q11 Q12 Q13 Q14 Q15
          Q16 Q17 TF1 TF2 TF3 TF4 TF5 TF6 TF7 TF8 TF9 TF10 TF11

LINE   2: TF12 TF13 TF14 TF15 TF16 TF17 TF18 TF19 TF20 BHSS1 BHSCAT Q13A Q7A

 1 113821 .124112353 61 42.312122121222212122212 2.001.001.001.00
 2 114222 .1 8412353 64 5142121211222122121222 12 1.001.002.002.00
 3 113323 .11841235 3 61 22.5121211212122121222 12  .001.001.002.00
 4 114334 .1 4412353 64 62.2121221212122121222 12 1.001.002.002.00
 5 112313 .2 .112353 61 42.2121121212122111221 12 4.002.001.001.00
 6 113221 .2 .412353 64 7141121111222122121222 12 2.001.002.002.00
 7 122621 .2 .132353 61 52.2121211212122121222 12  .001.001.001.00
11 2122.1 .178412313104 42.312121122212212122212 1.001.002.002.00
12 22 .43 .2 .212313102 313312112121212222122212 3.001.003.003.00
13 213734 .2 .432313104 32.612122121212211122212 2.001.002.002.00
14 213922 .2 .112313104 22.312121121222212122212 1.001.002.001.00
15 212524 .1 2412313104 22.312221121212122120102 4.002.002.002.00
16 2. ... .. .4.2313104 6143....................  .  .  2.002.00
18 223424 .1 8412313104 42.312121112212211222112 5.002.002.002.00
19 214621 .1 8412313102 713312112122222211122212 5.002.003.002.00
20 212562 .2 .512313105 22.12211122112212122211210.003.003.003.00
21 323322 .2 .112403 41 22.412122121212222122212 2.001.001.001.00
22 313412 .2 .112403 41 713312111121212212122212 1.001.001.001.00
23 322412 .112132403 43 32.32211212212111112211210.003.003.001.00
24 312112 .2 .112403 41 62.11211211222111112212210.003.001.001.00
25 323524 .2 .412403 44 62.112122111222212222112 5.002.002.002.00
26 312641 .1 4412403 44 52.32211211212210112210210.003.002.002.00
27 312363 .112412403 41 513212111122012002022122 4.002.001.002.00
28 314533 .199412403 44 32.212122121212212122212 1.001.002.002.00
29 313521 .2 .122403 41 51342211222222211122212211.003.001.001.00
30 315533 .199312403 43 42.122121112212111122112 6.002.003.003.00
```

APPENDIX E

Theological Perspectives on Hope

Theological Perspectives on Hope

In Ellison's (1983) initial conceptualization of spiritual well-being, he states that both faith and hope appear to be an integral part of spiritual well-being. Carson, Soeken, and Grimm (1988) later examined the relationship between hope and spiritual well-being, and found a positive relationship between the two.

Vande Kemp (1984) points out that many who come for therapy or healing do _not_ have hope. Accordingly, the important element of interpersonal relationship inherent in the Scriptural words for hope adds credence to the therapeutic relationship.

The Biblical concept of hope has been defined by Monsma (1976) as, "an interest or desire whose fulfillment is cherished" (p. 198). He draws a distinction between faith and hope; while they supplement each other, they are hardly identical. Hope is based on desire, facts, and rational considerations as well as, in its higher form, on faith. Faith is based not only on facts and rational considerations, but on a sense of God's presence in one's own life and

in the life of God's community. It is in faith that Christ Himself becomes one's hope.

Objects of hope in the Bible include: (a) earthly blessings, (b) God, and (c) a new world. The Biblical concept of hope transcends earthly blessings, and, along with faith, rests ultimately on the promises of God. So, according to Murray (1979), hope is "the outreach of expectation in reference to fulfillment" (p. 147). Morris (1979) addresses the anticipated fulfillment of hope as directed toward God and a new world. "In the first centuries Christianity made a habit of taking people from the depressed classes, slaves, women, outcasts, and giving them a living hope" (p. 189).

Hope has been found to be positively related to spiritual well-being, and is an important term in the Bible. Thus the theological perspectives on hope have significance in a study which seeks to explore the effect of time-limited therapy on the level of hope among participants.

APPENDIX F

Vita

James Porowski
117 Trailing Oak
Cary, North Carolina 27513
919-481-4203

Education:

Psy.D	(Doctor of Psychology, in Clinical Psychology Candidate) George Fox College, Newberg, Oregon. Anticipated date of graduation, December 19, 1992
Intern	Internship (1992): Johnston County Mental Health Center, Smithfield, North Carolina.
Practicum	Practicum (1990-1991): William Temple House, Portland, Oregon (275 hours). Practicum (1991): Pacific Gateway Hospital, Portland, Oregon (300 hours).
M.A.	Master of Arts in Clinical Psychology, George Fox College, Newberg, Oregon. April 1991
Th.M.	Master of Theology, Dallas Theological Seminary, Dallas, Texas. June 1981
B.A.	Bachelor of Arts, Sociology, Texas Christian University, Fort Worth, Texas. June 1977

Work Experience:

Mental Health Therapist, Pacific Gateway Hospital, Portland, Oregon. July 1991-December 1991

Dissertation Title

The Problems of Assessing Change in Hopelessness Among Employees in Employee Assistance Programs