

ABSTRACT

Title of Dissertation: THERAPIST WORK WITH CLIENT STRENGTHS: DEVELOPMENT AND VALIDATION OF A MEASURE.

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Drawing from the positive psychology literature, the Inventory of Therapist Work with Strengths and Assets (IT-WAS) was constructed to measure the degree to which clinicians incorporate strength-based approaches in their therapy work. Two different samples were gathered in the current study; a professional sample ($n = 128$) and a university sample ($n = 97$). The professional sample was randomly selected from the 2005 membership directory of Divisions 17 (Counseling Psychology), 29 (Psychotherapy), and 42 (Independent Practice) of the American Psychological Association (APA), and resulted in a 51% return rate. The university sample consisted of graduate students in counseling related fields as well as faculty and counseling center staff at a large Mid-Atlantic university; the return rate for this sample was 62%. T-test results found no significant differences between samples on IT-WAS scores, and thus samples were combined for analyses.

Three factors (Theory of Intervention, Strength Assessment, & Supporting Progress) were extracted by factor analysis, accounting for 52% of the total variance.

The IT-WAS demonstrated very good internal consistency ($\alpha = .96$) and test-retest reliability ($r = .83$). Scale validity was supported by positive associations between the IT-WAS and measures of favorable attitudes toward human nature, benevolent world assumptions, as well as therapist work with the strengths of a most recent client. Most therapists generally conducted strength-based clinical work to a high degree, supporting propositions made by Seligman (2002; Seligman & Peterson, 2003). Cognitive-behavioral, humanistic, multicultural, and feminist theoretical orientations were positively related to the IT-WAS, while psychodynamic and psychoanalytic theoretical orientations were negatively correlated to the IT-WAS. No differences between clinical and counseling psychologists were found on IT-WAS scores. Implications of therapist work with client strengths are discussed and areas for future research are provided.

THERAPIST WORK WITH CLIENT STRENGTHS: DEVELOPMENT AND
VALIDATION OF A MEASURE

By

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Chapter 1: Introduction and Literature Review

Positive psychology has been theorized to not only improve and build on people's strengths but also to boost resilience, increase quality of life, and buffer against symptom relapse (Keyes & Lopez, 2002; Lampropoulos, 2001; Seligman, 2002). Nurturing the strengths of people is an important aspect of healing that may be seen as complementary to symptom reduction (Keyes & Lopez, 2002). Furthermore, fostering human strengths may actually be a crucial component of effective symptom reduction in and of itself (Lampropoulos, 2001). For instance, positive emotion has been shown in laboratory research to undo negative emotion (Fredrickson, 1998). Thus, increasing client strengths and well-being may facilitate the decline of negative symptoms. Overall, research conducted within positive psychology thus far has shown great potential to enrich the lives of people (Peterson & Seligman, 2004; Seligman & Csikszentmihalyi, 2000; Tennen & Affleck, 2002).

Despite the promises of positive psychology, the field of psychology in general has been dominated by the medical model, which focuses entirely on reducing symptoms and healing deficits (Bohart & Talman, 1999). Consequently, more is known about the processes of negative emotion than positive emotion (Salovey, Rothman, Detweiler, & Stewart, 2000). Additionally, most theoretical orientations are bent toward the healing deficits and few take into account improving strengths. A major outcome of the dominance of the disease model in mental health is that psychologists have discovered treatments for the majority of psychological problems (Seligman, 1994; Seligman & Csikszentmihalyi, 2000). However, a fundamental mission of psychology, to further enhance the lives of all people, has been neglected as a result of such a prevalent focus on

pathology (Seligman & Csikszentmihalyi, 2000). Thus, psychologists should begin to shift their focus away from treating deficits and towards studying how to make people's lives even better by using similar research methods previously used to examine deficits.

In recent years, the movement of positive psychology has gained momentum. For example, entire journal issues have recently been devoted to the topic of positive psychology (*American Psychologist*, Vol. 55, 2000; *American Psychologist*, Vol. 56, 2001; *Journal of Social and Clinical Psychology*, Vol. 19, 2000) as well as several positive psychology books and handbooks (*Counseling Psychology and Optimal Human Functioning*; *Handbook of Positive Psychology*; *Positive Psychology Assessment*). Research has shown that positive psychology can improve quality of life and prevent illness (Seligman & Csikszentmihalyi, 2000). For instance, fostering an attitude of optimism has been found to essentially inoculate people against physical illness as well as prevent depression (Seligman et al., 1999; Taylor et al., 2000). Additionally, people who found benefits from their experience after a traumatic event (e.g., tornado, mass cafeteria shooting, first heart attack) have been shown to not only have a decline in post-traumatic stress symptoms but also reduced morbidity (Affleck, Tennen, Croog, and Levine, 1987; McMillen, Fisher, & Smith, 1997).

Although positive psychology research has expanded overall, how positive psychology plays out in psychotherapy remains largely unstudied. Very few studies have been conducted on human strength, positive psychology, and optimal functioning variables in the context of counseling. Specifically, one area left essentially uninvestigated is therapist work with client strengths. Despite rarely being trained to work with strengths (Gelso & Woodhouse, 2003), therapists are thought to intuitively

build on the strengths of their clients in actual practice (Seligman, 2002; Seligman & Peterson, 2003).

The purpose of the present study is to develop and validate a measure of such therapist work with client strengths. This measure may allow researchers to investigate therapist work with client assets through their strength-based interventions, theory, assessment, and focus on client progress. Additionally, the development and validation of this measure may allow for the beginning of empirical investigation on the process and outcome of positive therapy.

In the following literature review, I will first provide a summary of the philosophy of positive psychology within psychotherapy. Then, I will explore the historical background and context of positive psychology, including a general overview of the medical model, the history of positive psychology within counseling psychology, and the history of positive psychology within psychology in general. Next, I will examine the beginning of a renaissance in the positive psychology movement. Finally, I will investigate theories of using strengths in therapy in addition to the few empirical studies that have been conducted in the area of client strengths.

The Philosophy of Positive Psychology within Psychotherapy

Within the context of psychotherapy, the name “positive psychology” may be misinterpreted to mean an exclusive focus on the positive. Unlike the medical model, which concentrates solely on the negative, positive psychology incorporates a positive perspective in addition to a negative perspective. The primary reason clients enter therapy is to heal what is wrong rather than build what is right. To only pay attention to strengths of these clients would neglect the very reason they entered therapy in the first

place! Thus, a narrow focus on the positive is considered by positive psychologists to be overly optimistic or even “Pollyanna” (Gelso & Woodhouse, 2003; Lopez, Snyder, & Rasmussen, 2003; Sheldon & King, 2001). Hence, this positive perspective recognizes the utility of symptom reduction in addition to the importance of focusing on positives. Martin Seligman (2002) supported this idea when he stated,

“Psychology is not just the study of disease, weakness, and damage; it is also the study of strength and virtue. Treatment is not just fixing what is wrong; it is also building what is right. Psychology is not just about illness or health; it is also about work, education, insight, love, growth, and play. And in this quest for what is best, positive psychology does not rely on wishful thinking, self-deception, or hand waving; instead, it tries to adapt what is best in the scientific method to the unique problems that human behavior presents in all its complexity” (p. 4).

The position of balancing negative views with positive ones has been supported by a multitude of theorists who have emphasized that a model of positive psychotherapy needs to focus on client strengths as well as weakness, in contrast to the traditional model of pathology that focuses entirely on deficits (Gelso & Woodhouse, 2003; Ivey & Ivey, 1998; Keyes & Lopez, 2002; Lampropoulos, 2001; Lopez & Snyder, 2003b; Sandron, 1970; Seligman, 2002; Witryol & Boly, 1954). Lampropoulos (2001) suggests that the best way to accomplish a major shift in the field of psychology toward positive psychology is by gradually integrating positive psychology with current models of psychopathology and treatment through programmatic research. Lampropoulos offered

three specific areas of research in which strength-oriented approaches may be integrated with pathology-oriented approaches. First, client strengths need to be incorporated into the examination of pathology and therapy outcome research. Lampropoulos next noted that self-help and self-change treatments should be studied as a way to compliment more disease-oriented treatment. Finally, current psychotherapy treatments need to be tailored to include key factors related to positive psychology, such as improving client expectation of change (e.g., Hubble, Duncan, & Miller, 1999), self-efficacy (e.g., Lent, Brown, Hackett, 1994), and adaptive coping strategies (e.g., McWilliams, Cox, & Enns, 2003). Furthermore, research in positive psychology should be used on clinical samples as well as with healthy populations. However, before models of positive psychology can be integrated with models of pathology in treatment and research, psychologists must first be able to effectively measure aspects of positive psychology within psychotherapy (Lopez, Snyder, & Rasmussen, 2003).

Positive psychology has historically been missing from most research, theory, and clinical practice in psychology (Seligman & Csikszentmihalyi, 2000). For example, very little research has been conducted on therapist work with client strengths, and therapists are rarely trained to incorporate strength-based approaches in their interventions and conceptualizations (Gelso & Woodhouse, 2003). Nonetheless, though rarely investigated, it seems that effective therapists may commonly build on the strengths of their clients in actual practice (Seligman, 2002). If these processes are examined and researched more closely, therapists may eventually be trained to work with the strengths of their clients to become more successful therapists. Working with client strengths may

enable therapists to harness the power of positive psychology to help clients in ways such as buffering against symptom relapse (Keyes & Lopez, 2002).

The purpose of the present study is to take a step toward generating more research on positive psychology within the context of therapy by creating an instrument that measures therapist work with client strengths. Such a measure may be used in future research to examine whether positive interventions truly bring about constructive client change in hypothesized ways (e.g., increase well-being, buffer against relapse). Even so, prior research on positive psychotherapy has rarely been conducted as a result of the domination of the medical model within psychology.

The History of the Positive Psychology Movement: Background and Context

The Lens of Pathology: Recent History and Influence of the Medical Model

“The illness ideology emphasizes abnormality over normality, poor adjustment over healthy adjustment, and sickness over health. It promotes dichotomies between normal and nonclinical populations. It locates human adjustment and maladjustment inside the person rather than in the person’s interactions with the environment and encounters with sociocultural values and societal institutions. Finally, this ideology and its language portray people who seek help as passive victims of intrapsychic and biological forces beyond their direct control. As a result, they are relegated to the passive reception of an expert’s care” (Maddux, Snyder, & Lopez, 2004, p.322).

In the beginning, the field of psychology was established in the context of the medical model (Bohart & Talman, 1999). Psychotherapy continues to be impacted by the roots of the medical field from which therapy was created. Consequently, the dominant

model in psychotherapy remains the medical model and is thus more oriented toward the treatment of pathology. Using an illness metaphor to understand psychological problems (Maddux et al., 2004), the medical model adopts the perspective of a physician who diagnoses the disorder within the patient and applies an intervention appropriate to that disorder (Orlinsky, 1989). While the treatment may simply be a verbal attempt to educate or persuade the patient, it is viewed as being very different from attempts to educate or persuade done by friends, relatives, preachers, and teachers (Maddux et al., 2004; Szasz, 1978). As the medical model's sole attention to psychopathology has overshadowed more positive approaches in research and training, many researchers and theoreticians within positive psychology believe that this disease-orientation "narrows our focus on what is weak and defective about people to the exclusion of what is strong and healthy" (Maddux et al., 2004, p. 322).

The medical model has greatly expanded over time, especially within the last 50 years (Barone, Maddux, & Snyder, 1997; Albee, 2000). The growth of the medical model is perhaps best represented by the expansion of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM; APA, 2000). The DSM has had a tremendous influence on therapy training, research, and practice. The first DSM was published in 1952 and is currently in its fourth edition (not including revisions of the third and fourth editions). In the last 50 years, the DSM has increased over ten times in size from 96 pages to over 900 pages (Maddux et al., 2004). Additionally, the number of mental disorders jumped from 106 to 297 during this time. As the DSM has grown, the pathologizing of clients with problems of living has also increased. Furthermore, the expansion of the medical model in therapy, research, and

training has been reinforced by dollars provided from grants and HMOs that are frequently only given for the treatment of disorders diagnosed using the DSM (Peterson & Seligman, 2004). Thus, both the medical model and the DSM continue to have a powerful influence on psychotherapy.

As a result of the historical dominance of the medical model, most previous research in psychology has been based on viewing people through the lens of pathology. For example, much less is known about the influence of positive affect on health than the influence of negative affect on illness (Salovey et al., 2000). The model of psychopathology has also had an immense influence on clinical practice and research, especially in areas such as assessment and diagnosis (Sandron, 1970; Witryol & Boly, 1954; Chazin et al., 2000; Gelso & Woodhouse, 2003). The majority of psychological tests assess weaknesses more than strengths as a result. For example, the widely used Outcome Questionnaire (Lambert, Burlingame, Umphress, Hansen, Vermeersch, Clouse, & Yanchar, 1996) assesses therapy outcome based solely on symptom reduction. Even so, client diagnoses and treatment based solely on pathology has been postulated to actually distort reality by not taking into account a more complete model of mental health (Lopez & Snyder, 2002; Wright & Fletcher, 1982).

In contrast to the medical model, the human potential movement that began in the early 1960s took into account positives aspects of therapy. However, while there was great interest in optimal functioning and human potential at that time, this movement had a relatively short-lived impact on the practice of therapy in general (Wachtel, 1993). Hence, presently there is a growing concern about the pathologizing nature of the medical model and tendency to classify every problem as a psychological disorder (Joseph &

Linley, 2004; Hubble & Miller, 2004; Maddux, 2002; Maddux et al., 2004). Designating DSM diagnoses to clients may have negative self-fulfilling consequences as a result of pejorative labeling (Snyder et al., 2003). For instance, clients diagnosed from the perspective of pathology may internalize such diagnoses and define themselves in terms of mental illness, thus creating a self-fulfilling prophecy (Sandron, 1970). Other problems may also emerge when clients' diagnoses and treatment are based entirely on the model of pathology. The pathologizing nature of treatments may contribute to keeping people away from helping services by exacerbating the social stigma associated with therapy (Lampropoulos, 2001).

In contrast to the medical model's unilateral concentration on pathology, positive psychology integrates both client strengths and weaknesses into diagnosis, treatment, and conceptualization (Gelso & Woodhouse, 2003; Lampropoulos, 2001; Witryol & Boly, 1954). Seligman (2002) points out that "by embracing the disease model of psychotherapy, we have lost our birthright as psychologists, a birthright that embraces both healing what is weak and nurturing what is strong" (p. 6). Hence, psychologists need to attain more desirable self-fulfilling prophecies through adherence to a strength-based approach and move away from a disproportionate focus on the illness (Sandron, 1970; Snyder et al., 2003). Nonetheless, positive psychology, while explicitly asserting that a positive focus is an extremely effective way to help those in trouble, continues to take into account the disease-oriented model (Seligman & Peterson, 2003).

The Human Potential Movement in Therapy

Perspectives on human nature in general may be thought of as falling into two categories: negative and thus more destructive or positive and thus more constructive

(Joseph & Linley, 2004). The positive psychology movement has explicitly pointed out that mainstream psychology has traditionally adhered to the medical model and thus held the fundamental assumption that human nature is predominantly negative (Hubble & Miller, 2004; Maddux, 2002; Maddux et al., 2004). In contrast to more negative views of human nature, positive psychology maintains that human nature needs to be thought of as being motivated toward developing its potential (Seligman & Csikszentmihalyi, 2000). This perspective on human nature has been a consistent cornerstone of the positive mental health movement that has slowly developed over the last few decades.

Psychologists began theorizing and investigating human thriving and high level functioning in the 1960s. For example, Allport (1963) discussed the mature personality, Heath (1964) wrote about the reasonable adventurer, Foreman (1966) studied optimal psychologically healthy people described as “zestfuls”, and Maslow (1970) examined the self-actualized person. These psychologists’ ideas helped to establish the human potential movement that eventually formed the groundwork for the present day positive mental health movement. While the original human potential movement had substantial influence on practices related to positive psychology, such as the encounter and growth groups of the 1960s and 1970s (e.g., Jones & Medvene, 1975; Kimball & Gelso, 1974), it had a relatively short-lived effect on psychotherapy practice in general (Wachtel, 1993). One major exception was Carl Rogers, a leading psychologist in both psychotherapy and the human potential movement.

One of the first psychologists to explicitly incorporate a positive perspective into his therapy practice was Carl Rogers. While no leading figures in psychotherapy have specifically discussed the process of building on the positives within clients, Rogers came

closest to describing this process (Wachtel, 1993). In addition, the concept of a human drive toward fulfilling its potential held by the positive psychology movement is at the heart of Rogers' (1963) self-actualizing tendency (Jorgensen & Nafstad, 2004).

Furthermore, Lampropoulos (2001) noted that the positive psychology movement appears to be a renewal of the Rogerian focus on human's potential for happiness, except the present movement is being buttressed by more stringent empirical investigation and research methodology. Hence, many of the ideas originally set forth by Carl Rogers are central to the present positive psychology movement.

Rogers proposed that human nature is in fact positive and that people are motivated toward fulfilling their potential (Joseph & Linley, 2004). This actualizing tendency, while being a pillar of person-centered therapy and philosophy (Bozarth, 1997), has been a controversial idea within mainstream psychology (Ryan, 1995). In response to mainstream psychology's view of human nature, Rogers (1969) stated,

“I have little sympathy with the rather prevalent concept that man is basically irrational, and thus his impulses, if not controlled, would lead to the destruction of others and self. Man's behavior is exquisitely rational, moving with subtle and ordered complexity toward the goals his organism is endeavoring to achieve (p. 29)

As person-centered therapists believe in the innate goodness of all people, the underlying goal of their therapy is to get clients in touch with such inborn strengths. Hence, humanistic therapy is largely based on unveiling clients' organismic valuing process

(OVP), or the innate ability to know what is needed for a fulfilling life, which may be viewed as an internal strength all clients possess (Joseph & Linley, 2004).

The positive nature of Roger's person-centered therapy is reflected within its deep nondirectiveness (Bozarth, 1997; Gelso & Woodhouse, 2003). The humanistic view asserts that it is not what therapists *do* in therapy (i.e., strength-based interventions and techniques) that is relevant to positive therapy but instead how therapists *think* that is of key importance (i.e., therapist attitudes and fundamental assumptions; Joseph & Linley, 2004). In order to fully facilitate the expression of client's actualizing tendency, therapists must hold a profound trust in the inner strengths of their clients (Gelso & Woodhouse, 2003). Hence, an underlying assumption of person-centered therapy is that people can be trusted to know their own best directions in life (Joseph, 2003). Additionally, Rogers believed in "prizing" clients and affirmatively viewing their experience without questioning or diagnosing (Wachtel, 1993). However, the specific manner in which strengths are conceptualized and fostered is not discussed in humanistic theory (Gelso & Woodhouse, 2003).

The movement toward positive psychology within psychotherapy may be understood in terms of therapist work with client strengths. Recently, clinical literature has begun examine how to build on the strengths of people in the context of therapy (Chazin, Kaplan, & Terio, 2000; Gelso & Woodhouse, 2003). In the past several years, various theoretical orientations have examined and reexamined how they incorporate client strengths into their conceptualizations and treatment. Examples include Adlerian therapy (Slavik, Sperry, & Carlson, 2000), Humanistic therapy (Sheldon & Kasser, 2001), Behavioral therapy (Follette & Linnerooth, 2001), the Satir system (McLendon,

1999), and Hope therapy (Lopez, Floyd, Ulven, & Snyder, 2000). These theoretical orientations have begun to consider how therapists may effectively work with client strengths.

A theoretical approach that has perhaps paid the greatest attention to working with client strengths is solution focused therapy. Coming from the social constructionist school of thought, solution focused therapy seeks to discover positive exceptions to clients' problematic patterns and magnify solutions that have worked for them in the past (Sharry, Darmody, & Madden, 2002). Additionally, solution focused therapy views client strengths as more useful than deficits in determining the focus of the therapeutic work (DeShazer, 1988, 1991). Nonetheless, solution focused therapy and previously mentioned theoretical orientations that have incorporated strength-oriented approaches lack both empirical and theoretical scrutiny from psychologists outside these theories' inner circles (Gelso & Woodhouse, 2003). Pathology continues to be typical focus of actual practice, despite the clinical interest in client strengths (Chazin et al., 2000). In addition, strengths are rarely incorporated in meaningful ways in client conceptualizations, even in university counseling centers (Gelso & Woodhouse, 2003). It is important that theories of therapist work with client strengths gain further empirical validation in order to supply a solid empirical foundation for the strengths model.

The History of Counseling Psychology and Positive Psychology

The field of counseling psychology has been interested in positive psychology and human strengths since its inception. Super (1955) declared that counseling psychology distinguishes itself from clinical psychology through its attention to "hygiology" compared to the disease-oriented approach of clinical psychology. Super

pointed out that counseling psychology's focus on hygiene emphasizes "the normalities of even of abnormal persons, with locating and developing personal and social resources and adaptive tendencies so that the individual can be assisted in making more effective use of them" (1955, p. 19). Hence, attention to hygiene encourages client strengths and resources, while attention to psychopathology works to reduce weaknesses and maladjustment. Describing it another way, Super (1977) acknowledged oversimplifying counseling psychology's distinction from clinical psychology when he stated that clinical psychologists search for what is wrong and treat it while counseling psychologists search for what is right and help clients use it. Gelso and Fretz (2001) have since supported this concept when they branded one of counseling psychology's unifying themes as its "focus on people's assets and strengths, and on positive mental health, regardless of the degree of disturbance," and indicated that this focus is "an assumption and attitude we carry with us and convey to our clientele" (p.6-7). As a result of this focus, counseling psychologists tend to be optimistic and hopeful regarding people's abilities to direct themselves effectively and discover ways to use their own resources (Jordaan, Myers, Layton, & Morgan, 1968; Lopez, Edwards, Magyar-Moe, Pedrotti, & Ryder, 2003).

In addition to the focus on human strengths in counseling psychology, the field's training in the scientist-practitioner model further undergirds our potential to provide special contributions to the research and practice of positive psychology (Lopez, Edwards, et al., 2003). The fact that counseling psychologists develop and test hypotheses helps prevent theories on positive psychology from being based entirely on our own biases. Thus, counseling psychologists are equipped to incorporate their

experiences using positive psychotherapy from practice into their research as well as to apply research findings into their clinical practice.

Gelso & Fassinger (1992) described investigation on healthy personalities and human strengths as counseling psychology's "unfulfilled promise" and called for more research in this area. However, a decade later, the field has still largely neglected to empirically validate the hygiology philosophy originally set forth by Super (1955; Gelso & Woodhouse, 2003). For instance, counseling psychologists have done little to examine the specific processes by which therapist work with client strengths. However, in the context of burgeoning psychological research in the area of positive psychology, the field counseling psychology finally appears poised to fulfill this promise (Lopez, Edwards, et al., 2003; Walsh, 2003).

The Genesis of a Renaissance within the Positive Psychology Movement

Current Research in Positive Psychology

In 1998, Martin Seligman called for greater theory and research in the area of positive psychology and optimal functioning in his presidential address to the American Psychological Association (Seligman, 1998). Since then, his call has finally begun to be answered as the movement has achieved momentum (Seligman & Csikszentmihalyi, 2000). For example, the *American Psychologist* recently had two full issues dedicated to the topic (i.e., "Special Issue on Happiness, Excellence, and Optimal Functioning," 2000; "Positive Psychology," 2001), and the *Journal of Social and Clinical Psychology* (Vol. 19, 2000) had an entire issue dedicated human strengths and virtues. *Counseling Psychology and Optimal Human Functioning*, a collection of chapters on positive psychology written by counseling psychologists, was also recently published (Walsh,

2004). Furthermore, several handbooks have been published on positive psychology such as *Positive Psychology Assessment* (Lopez & Snyder, 2003a) and the *Handbook of Positive Psychology* (Snyder & Lopez, 2002).

Research has shown that positive psychology promises to improve quality of life and prevent illness (Seligman & Csikszentmihalyi, 2000). It seems that symptom reduction often depends on the enhancement of positive affect, well-being, and human strengths (Seligman & Peterson, 2003). For instance, results of laboratory research have shown that negative emotions dissipate rapidly when positive emotions are induced (Fredrickson, 1998). Additional research has shown emotional well-being to buffer older adults from the onset of disability and the deterioration of physical health (Ostir, Markides, Black, & Woodwin, 2000). Hence, therapy techniques that attend to promoting positive affect and well-being have been theorized to facilitate more complete client mental health when used to complement pathology-focused approaches (Keyes & Lopes, 2002).

In addition, fostering well-being may be related to a reduction in depression, its relapse, as well as a reduction in other mental disorders. For example, research has shown higher levels of well-being to be associated with a diminished risk for depression in adults (Lewinsohn, Rehner, & Seeler, 1991). Thus, the elevation of well-being has been postulated to prevent the onset of certain mental disorders (Keyes & Waterman, 2003). Furthermore, therapy that promotes well-being has been hypothesized to delay the reoccurrence of disorders such as depression or prevent it all together (Keyes & Lopes, 2002). Since treatments that focus solely on symptom reduction do not necessarily lead to improved client well-being (Riskind, Sarampote, & Mercier, 1996; Snyder &

McCullough, 2000), positive treatments need to be developed to promote well-being and build on client strengths (Kaplan, 2000; Keyes & Lopez, 2002). These positive treatments may serve the valuable purpose of inoculating clients against the relapse of negative symptoms.

As an alternative to the DSM's classification of psychological disorders, Peterson and Seligman (2004) recently created a scientific classification of human strengths they described as a "manual of the sanities." To be classified as a strength, an asset must to satisfy certain criteria such as contributing to "various fulfillments that constitute the good life, for oneself and for others" (p. 17). Peterson and Seligman identified a total of 24 primary strengths, and these human strengths may be measured by the 240 item Values in Action Inventory of Strengths (VIA-IS). Future research may use the VIA-IS as an outcome measure to determine whether positive interventions actually build on client assets as hypothesized by theoreticians (e.g., Lopez & Snyder, 2002).

Additional research has shown that the fostering positive traits further helps to buffer against negative health outcomes. For instance, building the human strength of optimism has been shown to prevent depression and protect people against physical illness (Seligman et al., 1999; Taylor et al., 2000). Furthermore, enhancing well-being and human strengths not only appears to buffer against psychological disorders but also has been found to be essential to building resilience (Scales, Benson, Leffert, & Blyth, 2000). Hence, it seems that the healing of deficits often depends on the fostering of strengths (Seligman & Peterson, 2003).

An Example of Research on Human Strengths: Benefit Finding

The developing research on benefit finding provides a good example of the mounting literature within positive psychology. Snyder and McCullough (2000) described benefit finding as a human strength and have encouraged its inclusion into positive psychology. People who experience difficult circumstances, traumatic events, and debilitating diseases often report benefits from their experiences (Affleck & Tennen, 1996; McMillen et al., 1997; Katz, Flasher, Cacciapaglia, & Nelson, 2001). For example, people who have been lost a loved one have reported a new appreciation for life or closer relationships with others as a result of the loss (Park, Cohen, & Murch, 1996; Tedeschi & Calhoun, 1995). Such a discovery of the “silver lining” in adverse circumstances is known as benefit finding.

One construct related to benefit finding is optimism, and it is important to point out distinctions between these variables. Optimism is an attitude of having more favorable expectations for the future (Carver & Scheier, 2003) and is a broader construct than benefit finding. In contrast, benefit finding is the perception of positive changes in one’s life as a result of difficult circumstances. Dispositional optimism has been found to be positively and moderately correlated to benefit finding (Affleck & Tennen, 1996; Tedeschi & Calhoun, 1995). Hence, it appears that optimism and benefit finding are two distinct yet related constructs.

Finding benefit from loss or trauma may be an important means for people to create positive meaning from the adverse situation. Such positive meaning may help people to have greater purpose in life. Theorists have suggested that having purpose in life is essential to positive adjustment (Frankl, 1955/1986; Thompson & Janigian, 1988); thus, benefit finding may also be associated with positive adjustment. Although

researchers have been interested in the relationship between benefit finding and adjustment, the lack of solid conceptual definition and theory on benefit finding has made clear hypotheses difficult. However, most research and theory agrees that benefit finding is a “good thing.”

A review was conducted by the present author on all 12 studies investigating the relationship between benefit finding and adjustment after the occurrence of adverse events in non-laboratory settings. Studies revealed that most people did in fact find benefits after adverse events. Several studies reported over 80% of participants reported at least one benefit (Fromm, Adrykowski, & Hunt, 1996; Sears, Stanton, & Danoff-Burg, 2003; McMillen et al., 1997), while only one study showed less than half of participants to have found benefits (Bower, Kemeny, Taylor, & Fahey, 1998). Moreover, research indicates that in general benefit finding appears to be related to healthy adjustment. Of the 12 studies reviewed, 8 studies found benefit finding to be positively related to adjustment (Affleck et al., 1987; Bower et al., 1998; Davis et al., 1998; Katz et al., 2001; McMillen et al., 1997; Tennen, Affleck, Urrows, Higgins, & Mendola, 1992; Thompson, 1985; Updegraff, Taylor, Kemeny, & Wyatt, 2002), 2 studies found a negative relationship (Tomich & Helgeson, 2004; Mohr et al., 1999), 2 studies found no relationship (Sears et al., 2003; Fromm et al., 1996). Furthermore, three quarters of the longitudinal studies on benefit finding found it to be positively associated to adjustment (Affleck et al., 1987; Bower et al., 1998; Davis et al., 1998; McMillen et al., 1997; Tennen et al., 1992; Thompson, 1985). Hence, research indicates that benefit finding shows great promise as a valuable human asset.

Studies on benefit finding and adjustment contained several strengths. First, adjustment was investigated by a range of different constructs (e.g., diminished risk of PTSD diagnosis, reduced morbidity, reduction in pain) in a range of different adverse situations (e.g., mass shooting in a cafeteria, HIV positive men who lost a loved one to AIDS). For example, Davis et al. (1998) discovered that those who found benefits from the loss of a loved one in hospice care were less likely to be distressed 13 months after the loss. Thus, benefit finding seems to predict improvement in a variety of types of adjustment across various adverse events and diseases. Another strength of these studies is that samples were collected outside of a laboratory in the “real world” with people experiencing serious difficult circumstances, contributing to the external validity of this body of research. Thus, it appears that the benefit finding- adjustment relationship generalizes across a wide range of settings.

Despite the strengths of this body of research, there are a several limitations that need to be addressed. Benefit finding was assessed in a variety of ways. In fact, very few studies used the same method to measure benefit finding, making it difficult to directly compare findings across studies. The most common method was to ask participants a single question on benefit finding such as, “Have you found anything positive about this experience?” (Davis et al., 1998). Using a single question to assess a complicated construct such as benefit finding brings up concerns as to the validity of the measure. Another limitation is the lack of validity information on the scales developed to assess benefit finding. Most measures were used once and were not validated and/or developed across several studies. This lack of valid measures within the benefit finding literature is consistent with research on human strengths in psychotherapy. In other

words, research on client strengths, like benefit finding research, has been plagued by a lack of valid and reliable measures making empirical support for this area of positive psychology difficult to do (Lopez, Snyder, & Rasmussen, 2003).

Results of these studies on benefit finding and adjustment are important to positive psychology as such research provides a deeper perspective on the influence of positive functioning, coping, and human strengths on health outcomes. Future investigations may examine how benefit finding may be used to inform therapy process and outcome. For instance, in addition to a helping clients deal with negative consequences of difficult circumstances, therapists may also encourage benefit finding. Perhaps if therapists can effectively incorporate strength-based interventions to help clients to find more benefits in concert with commonly used deficit-based interventions, clients may adjust better as a result. One study found that women who wrote positive thoughts and feelings toward their struggle with breast cancer were likely to have fewer medical appointments for cancer-related morbidities than those who did not do such writing (Stanton, Danoff-Burg, Sworowski, & Collins, 2001). However, no research has examined how therapist interventions directly aimed at increasing benefit finding might influence client adjustment. Future studies will need to test the effectiveness of interventions aimed at increasing benefit finding before recommendations can be made to practitioners.

The Movement within Positive Psychology toward Human Strengths

Human strengths have been described as the building blocks of the positive psychology movement (Lopez, Snyder, & Rasmussen, 2003). All people are thought to have psychological strengths (Lopez & Snyder, 2003b) and these strengths may help to

facilitate healthy processes such as coping. Hence, building on human strengths has been posted to be an important aspect of improving well-being and adjustment (Lopez & Snyder, 2002; Tennen & Affleck, 2002).

Gelso and Fassinger (1992) suggested research on human strengths, healthy personality, and qualities that are part of positive functioning can be understood in terms of two different levels. On one level is a constellation of traits that constitute a healthy personality, and these traits may be either domain-specific (e.g., work, relationships, health) or trans-situational. An example of a healthy personality on this level is reflected in Kobasa's (1982) theory of the hardy personality. Another level of research on human strengths is comprised of more specific traits considered to be positive and healthy. Counseling psychologists in particular have conducted research on this level, including work on effective problem solving (Heppner & Krauskopf, 1987; Heppner, Witty, & Dixon, 2004) and self-efficacy (Betz & Hackett, 1981; Lent et al., 1994).

Since the possession of human strengths have been shown to improve the quality of life (Peterson & Seligman, 2004), Snyder and Lopez (2003) proposed an omnibus hypothesis that measuring, identifying, and enhancing human strengths make a difference in people's lives. More specifically, these authors have hypothesized that working with strengths should improve achievement in students, create more production in the workplace, enhance mental health, and improve clinical training. However, such hypotheses on the impact of human strengths in general largely remain untested. Additionally, while there has been an increase in research on human strengths and healthy personalities overall in the past several years, research on how these qualities are used and play out within psychotherapy has lagged far behind. For instance, very few

published empirical studies have examined variables related to the strengths of clients or therapist's work with those strengths, as will be later discussed. Furthermore, research investigating human strengths within a cultural context has also been lacking.

Human Strengths in the Context of Multiculturalism

Some clinicians contend that treatment approaches based on psychopathology can have particularly detrimental affects when applied to clients of other cultures or races (Chazin et al., 2000). Cowger (1994) points out that disease-oriented clinical practice “reinforces those social structures that generate and regulate unequal power relationships that victimize clients,” (p.206) and this negative consequence is believed to be amplified with marginalized populations (Chazin et al., 2000). Thus, such pathology-focused approaches are inconsistent with the purpose of multiculturalism to “enhance the dignity, rights, and recognized worth of marginalized groups” (Fowers & Richardson, 1996, p.609).

The multiculturalism movement affirms that diversity should be celebrated and that the strengths linked to diversity demand attention (Sue & Sue, 2003). An important aspect of understanding human strengths within a cultural context is respecting all types of development, strengths, and optimal functioning (Jorgensen & Nafstad, 2004). Nonetheless, the ideals of healthy functioning are inherently influenced by the dominant cultural and social values of the time. For example, Seligman (2002) points out that the idea of “fully-functioning” in and of itself is a culture-bound concept. Additionally, characteristics seen as benefits in one cultural context may be pathologized in another cultural context (Lopez, Edwards, et al., 2003). Hence, it is essential that psychologists

seek to understand the predominant values of the culture on which we prioritize strengths (Bruner, 1986; Gergen, 1991; Jorgensen & Nafstad, 2004).

Interestingly, Sue and Constantine (2003) pointed out that of the 34 authors who wrote articles in the two special issues of the *American Psychologist* focusing entirely on positive psychology and optimal functioning, not a single person of color was represented. This fact has raised questions as to whether the positive psychology movement is actually only interested in the strengths and effective functioning of white people (Bacigalupe, 2001). While some people of color, such as Edward Chang (2001), have been involved in the positive psychology movement, clearly psychologists need to be mindful of the ways in which strengths and optimal functioning may be ingrained in European American norms (Sue & Constantine, 2003). Positive psychologists must constantly ask themselves questions such as, “What is optimal within the cultural context?” to attempt to take into account potential cultural biases. Furthermore, the meaning and expression of human strengths that are mediated by culture also need to be considered by theorists, researchers, and practitioners within positive psychology (Gelso & Fassinger, 1992; Gelso & Woodhouse, 2003).

Counseling psychology has emerged as the leader in all of psychology in multicultural research and practice due to the field’s emphasis on human strengths as well as person-environment interactions (Gelso & Fretz, 2001; Lopez, Edwards, et al., 2003). Nonetheless, the absence of theoretical and empirical investigation on the cultural context of human strengths and optimal functioning is another unfulfilled promise of counseling psychology (Gelso & Fassinger, 1992). Counseling psychologists should be investigating the degree to which healthy personalities, optimal functioning, and human strengths

differ according to cultural factors. Gelso and Fassinger suggest that some manifestations of optimal functioning are universal and others seem to differ among cultures. However, more theory and research are needed to understand the degree to which concepts of psychological health are culturally bound. Future research may examine the effectiveness of therapists' focus on the strengths of minority as well as majority clients in psychotherapy.

Theoretical and Empirical Examinations of Client Strengths in Therapy

Theories on Therapist Work with Client Strengths

Seligman (2002; Seligman & Peterson, 2003) proposed that currently positive psychology is intuitively incorporated into psychotherapy practice on a regular basis and is a "major effective ingredient" in therapy (Seligman, 2002, p.6). Although therapists may be integrating positive psychology into their therapy practice unaware, they are rarely or never trained to utilize client strengths into their conceptualizations and interventions (Gelso & Woodhouse, 2003). However, until the use of positive psychology in therapy is recognized, measured, and honed, it cannot fulfill its potential to become an even more effective component of psychotherapy (Seligman, 2002; Seligman & Peterson, 2003).

In an attempt to account for the fact that large and specific effects are hardly ever found when comparing differences between psychotherapy techniques, Seligman (2002; Seligman & Peterson, 2003) identified two classes of "nonspecifics" within therapy: tactics and deep strategies. Tactics are aspects of therapy that have more often been studied and are well known. Examples of tactics include the therapist attention, development of rapport, and naming the problem. In contrast to tactics, deep strategies

are often used in therapy yet do not have names and are rarely investigated. Describing deep strategies, Seligman (2002) stated the following,

“The deep strategies are not mysteries. Good therapists almost always use them, but they do not have names, they are not studied, and, locked in the disease model, we do not train our students to use them to better advantage. I believe that the deep strategies are all techniques of positive psychology and that they can be the subject of large scale science and of the invention of new techniques to maximize them” (p. 6)

Examples of deep strategies include instilling hope (Snyder, Ilardi, Michael, & Cheavens, 2000) as well as the building or buffering strengths (Seligman, 2002). Most competent therapists are thought to not exclusively attend to healing pathology but in fact regularly identify and build on the strengths of their clients. For instance, therapists likely foster client strengths such as insight, interpersonal skill, realism, optimism, honesty, perseverance, and courage. More specifically, building the strength of courage has been posited to buffer clients against social phobia (Seligman & Peterson, 2003).

Wachtel (1993) offered specific ways in which therapists may explicitly attend to clients' strengths and build on them. He noted, for instance, that therapists may call attention to client strengths in such a way as to enhance therapeutic progress. Therapists may also point out when clients take small steps in the right direction in order to build on their clients' strengths by being attentive to small variations that exist in a pattern. Additionally, therapists may comment on a nascent strength as though it were fully present as a way of enabling clients to take ownership of their strength and explore what

it feels like (Gelso & Woodhouse, 2003). Alternatively, therapists can challenge apparent client strengths that may not be true strengths in order to determine the strengths clients actually possess.

Keyes and Lopez (2002) theorized that strengths are just as important as weaknesses when considering therapeutic interventions and client diagnoses. They have recently promoted the idea that “the study of mental health is distinct from and complementary to the long-standing interest in mental illness, its prevalence, and its remedies” (p. 45). Hence, by this view, mental health is seen as both the absence of mental illness (e.g., symptoms) and the presence of well being (i.e., both psychological wellbeing and social wellbeing). Based on this idea, Keyes and Lopez have created a complete mental health model in which clients may be viewed as having high or low mental illness symptoms and having high or low subjective well-being. Thus, there are four “types” of clients: 1) struggling clients (i.e., those with high mental illness symptoms and high subjective wellbeing), 2) flourishing clients (i.e., those with low mental illness symptoms and high subjective wellbeing), 3) floundering clients (i.e., those with high mental illness symptoms and low subjective wellbeing), and finally 4) languishing clients (i.e., those with low mental illness symptoms and low subjective wellbeing).

As a means of explaining the importance of taking into account well-being in clinical diagnoses and interventions, Keyes and Lopez (2002) focus on the languishing clients. Considered from one standpoint, languishing clients represent the hypothetical client whose deficits have been healed according to the disease-oriented model yet have not received the positive interventions that might increase their well-being and life satisfaction. Clients who are languishing with life may be at a “way station” where they

exist before the onset of depression or after the termination of therapy. Without the presence of positive coping mechanisms, these clients may lack the tools necessary to prevent relapse on their own. Consequently, interventions need to be designed to not only reduce symptoms but also improve well-being in order to prevent slipping into negative symptoms and prevent relapse. These positive interventions should “build upon or draw out a person’s existing strengths” (p.50). Similarly, Lampropoulos (2001) underscored the importance of interventions that build on assets when he wrote, “Interventions that enhance people’s strengths and positive traits should be components of every treatment, because they can reduce symptoms, prevent relapses, increase quality of life, and bring positive psychology qualities into therapeutic psychology” (p.88). Such interventions may promote the goal of helping clients to flourish in life. However, most interventions are geared towards symptom reduction. Newer interventions based on the promotion of well-being need to be studied to determine whether they can truly enhance the lives of people as conceived by such theoreticians.

Additionally, it is important for clinicians to assess client strengths in addition to deficits, given that theoreticians have posited beneficial consequences to be associated with assessing client assets (Snyder et al., 2003). For instance, asking clients about their strengths may invoke several positive reactions from clients. First, clients may feel as though the clinician is trying to understand them as a whole person rather than their deficits alone. Second, asking clients about their assets demonstrates that client is not being equated with the problem. Third, clients are not being reinforced for only “having a problem.” Fourth, assessing strengths may facilitate clients to regain some sense of personal worth that had been dissipated prior to coming to therapy. Finally, respecting

client assets may foster an alliance of trust and mutuality, thus helping the client to be more open in providing information. Hence, directly asking clients about their strengths has been posited to act as a positive intervention that may help clients to evoke their strengths and be more resilient when they encounter future challenges.

Empirical Investigation on Client Strengths

In spite of the fact that there has been a great amount of clinical interest on the topic (Gelso & Woodhouse, 2003; Ivey & Ivey, 1998; Keyes & Lopez, 2002; Lampropoulos, 2001; Lopez & Snyder, 2003b; Sandron, 1970; Seligman, 2002; Smith, 2006; Witryol & Boly, 1954; Wong, in press), very little research has investigated variables broadly related to client strengths. Additionally, only two published empirical studies have specifically investigated constructs related to therapeutic interventions based on client strengths (Conoley, Padula, Payton, & Daniels, 1994; Mitchell & Berenson, 1970). Given the overall lack of research on client strengths, those studies that have explored client assets will be reviewed in detail in the present section. Hopefully, through this detailed review, future researchers may be able to build upon these previous studies by learning from their limitations.

One such study examined the effects of therapist confrontations based on either client strength or weakness (Mitchell & Berenson, 1970). Therapists (n=56) conducting intake interviews were divided ex-post facto into high and low facilitative, where facilitative was operationalized as the therapists conveying empathy, positive regard, and genuineness. High facilitative therapists were found to give significantly more confrontations based on the clients' strengths or resources than low facilitative therapists. Conversely, low facilitative therapists gave significantly more confrontations based on

the clients' weaknesses or pathology. Thus, it appears that therapists who are perceived as more empathic by third-party raters are more likely to use confrontations based on client strengths.

The authors noted that it is especially important for therapists to focus on strengths in an intake interview in order to prepare clients for the challenges of psychotherapy (Mitchell & Berenson, 1970). Relatedly, researchers have found that a confrontational style tends to make clients more resistant and defensive (Miller, Benefield, & Tonigan, 1993; Salerno, Farber, McCullough, Winston, & Trujillo, 1992). Perhaps if therapists explicitly focus more on client strengths, clients will feel less defensive and be more receptive to interventions such as challenges.

While Mitchell and Berenson's (1970) investigation provided a good initial examination into the utility of focusing interventions based on client strengths, there are several flaws in the design. For instance, therapists were divided *after the fact* into high and low facilitative conditions. Facilitative conditions were based on Roger's (1957) necessary and sufficient conditions for change to occur. One possibility is that humanistic therapists may use confrontations based on the clients' strengths more than nonhumanistic therapists. Hence the study may have been measuring factors associated with theoretical orientation rather than the impact of empathy

Another more recent study examined the role of client strengths in therapist recommendations. Specifically, Conoley et al. (1994) investigated the degree to which clients implemented counselor recommendations based on whether or not the recommendations were based on client strengths. In addition to examining if the recommendations were built on client strengths, the investigators also examined the

recommendations' level of difficulty as well as the degree of match between the recommendations and client problem. Whether or not a therapist recommendation has built on client strengths was hypothesized to predict the implementation of the recommendation. Examples of client strengths given by the researchers included past successes, knowledge of the recommendation, and specific interest in the recommendation.

The data for this study was collected from 37 archived videotaped cases of client-counselor dyads (Conoley et al., 1994). The extent to which the recommendation was based on client strength was nominally categorized as either yes or no based on whether the clients verbalized that they had history with the behavior, interest in the behavior, or belief that they could perform the behavior recommended. Judges showed unanimous agreement on the implementation of counselor recommendation ($kappa = 1$) as well as unanimous agreement on the match between client problem and the recommendation ($kappa = 1$) and whether or not the recommendation was built on the client's strengths ($kappa = 1$). A simultaneous multiple regression performed to test the impact of the predictors on the criterion variable found all three predictors to be significant. However, the highest Pearson correlation coefficient between predictor and criterion variables was on implementation of the recommendation and whether or not it was based on client strengths ($r = .71$). It seems that clients were significantly more likely to follow therapist recommendations when they were based on client strengths, less difficult, and match with the problem.

There were several flaws in the methodology of this study, including the rating of whether or not the therapist recommendation built on client strengths. This rating was

categorized nominally indicating “yes” or “no,” thus not representing the wide variability in the degree to which therapist recommendations could build on client strengths (Conoley et al., 1994). For instance, it seems likely that some recommendations may be more strongly based on client strengths than others. Furthermore, the categorization of whether a recommendation was based on client strengths was determined by client verbalizations in the session in which the recommendation was given. It seems plausible that clients may have possessed strengths in some cases and simply not overtly verbalized them at all or just not in the one session which was rated for the analyses. Without client perceptions of the recommendations, it becomes impossible to know whether some recommendations were based on non-verbalized client strengths.

Overall, the study seems to have used very simplified scales to measure complicated constructs. For example, one of the predictor variables (i.e., strength) as well as the criterion variable (i.e., implementation) both used 2 point scales asking “yes” or “no” (Conoley et al., 1994). Interestingly, the raters showed unanimous agreement on ratings of both these variables. It seems that the simplicity and lack of variability of the study resulted in 100% agreement among the raters for most of the constructs. While unanimous agreement is usually good, it may be an indication of oversimplification. Future research should utilize validated measures examining client strengths so that greater variability may be obtained to better understand the range in which recommendations were based on client strengths.

In addition to exploring therapist interventions based on client strengths, studies have also examined the role of strengths in terms of more specific constructs. Researchers have operationalized strengths as hope (Lopez et al., 2000), intrinsic

motivation (Sheldon & Kasser, 2001), hardiness (Kobasa, 1982), self-efficacy (Bandura, 1986), “virtues” such as forgiveness and humility (McCullough & Snyder, 2000), and spirituality (Avants, Warburton, & Margolin, 2001). Spirituality may be an especially important external source of strength, and such an asset is often connected to cultural values (Gelso & Woodhouse, 2003; Lopez, Prosser, Edwards, Magyar-Moe, Neufeld, & Rasmussen, 2002).

One study investigated the utility of spirituality in improving abstinence among drug users (Avants et al., 2001). Participants were 43 HIV-positive injection drug users in an outpatient methadone clinic. In addition to recording drug usage, participants were asked to rate a single item 5-point scale on how much their religion or spirituality acts as a source of support and comfort for them. The item showed good reliability when participants were asked to rate it again 6 months later. Researchers split the participants based on their response to the single spirituality item into High Spiritual Support (n=22) and Low Spiritual Support (n=21). These ratings of spiritual support did not significantly change when tested 6 months later.

Researchers found that participants with high perceived spiritual support were abstinent significantly longer during the first 6-months of treatment than those with low perceived religious support (Avants et al., 2001). While religious support and optimism were significantly correlated ($r = .41$), religious support was a unique predictor of abstinence while optimism was not. One limitation to this study was its use of a single item to assess spiritual support, though the item showed good reliability across time. Future studies may need to assess the impact of spiritual support using more validated

multi-item measures. Nonetheless, human strengths, such as spirituality, appear to benefit people in difficult circumstances.

In addition, other client strengths such as psychological mindedness have been studied in the context of therapy. One study looked at the impact of client psychological mindedness and alexithymia on psychotherapy outcome (McCallum, Piper, Ogradniczuk, & Joyce, 2003). Psychological mindedness was defined as “the ability to identify dynamic (intrapsychic) components and to relate them to a person’s difficulties” (p.137). Psychological mindedness was measured according to the Psychological Mindedness Assessment Procedure (PMAP), in which client participants were shown videotape vignettes of patient-therapist interactions and asked what seems to be troubling the patient in the scenario. Responses were coded as more psychologically minded when participants were able to identify the patient’s internal experience, conflicted feelings, and ways they defend against these conflicted feelings. Therapy outcome was measured as a reduction in symptomatology.

Researchers found psychological mindedness to be significantly and positively associated with therapy outcomes (McCallum et al., 2003). Additionally, they found alexithymia to be significantly and negatively related to therapy outcome. There was no relationship between alexithymia and psychological mindedness as well as no interaction between these two variables on outcome. However, the investigation showed that clients able to cognitively explore the nature of their problems are more likely to show greater symptom reduction in therapy. The authors suggest that perhaps clients who enter therapy with lower levels of psychological mindedness may see improvements on this variable during treatment and experience more positive therapy outcomes as a result.

Hence, future studies may examine the moderating role of psychological mindedness on therapy outcome. Studies may also investigate the process by which therapists build on the client strength of psychological mindedness. In general, more empirical study needs to be done on numerous ways in which therapists can work with the strengths of their clients.

Conclusions

Overall, a review of the clinical literature and empirical research on client strengths indicates that valid and reliable measurement of client strengths is sorely needed (Seligman, 2002). Among research conducted on client strengths to date, nearly all of the reviewed studies had problems related to the measurement of strengths. For example, two studies used a single item scale to rate strengths (Avants et al., 2001; Conoley et al., 1994). In addition, most studies investigating the human strength of benefit finding also used a single item measure. It appears that little investment has been made into developing and validating quality measures examining client strengths, especially in therapy, thus resulting in the use of less valid single item measures in research. The present study aims to develop a measure looking at how positive psychology plays out in therapy, specifically the degree to which therapists work with client assets through strength-based interventions and conceptualizations.

It is essential that therapists assess and evaluate the strengths of their clients as a part of their conceptualizations (Keyes & Lopez, 2002; Lopez, Snyder, & Rasmussen, 2003; Wright & Lopez, 2002). In order to assess and evaluate client assets, therapist need to first explicitly name the strengths of their clients in their case conceptualization (Gelso & Woodhouse, 2003). Therapists may consciously spell out these strengths by

asking themselves questions such as, “In what areas of life does the client do well?” Strategies for such strength-based conceptualizations will most likely borrow from strategies that have been shown to be useful in conceptualizations based on client deficits (Lopez, Snyder, & Rasmussen, 2003; Maddux et al., 2004). Future research should study helpful processes by which therapists use client positives in their conceptualizations.

Strength-based therapeutic interventions can build on client strengths (Keyes & Lopez, 2002) and are posited to be an important component in all treatments (Lampropoulos, 2001; Seligman, 2002). For example, a therapist can positively reframe an apparent client deficit as a once appropriate strength that made sense earlier in life (Gelso & Woodhouse, 2003). Such strength-based interventions are thought to have the potential to enhance client well-being as well as buffer against symptom relapse (Keyes & Lopez, 2002). As with strength-based conceptualizations, strategies for interventions based on client strengths will most likely borrow from strategies that have been shown to be useful in deficit-based interventions (Lopez, Snyder, & Rasmussen, 2003; Maddux et al., 2004). Furthermore, such strength-based interventions need to grow out of conceptualizations of client assets (Snyder et al., 2003).

It is hoped that the positive psychology measure developed in the present study will allow researchers to begin to answer questions regarding the process and outcome related to therapist work with client strengths. For example, measuring therapist use of client strengths may finally enable researchers to investigate threshold and exponential effects (Lopez, Snyder, & Rasmussen, 2003). Threshold effects examine the amount of strength-based interventions that are needed to produce client benefits. Exponential effects look at effects such as whether two strength-based interventions yields double the

benefits of one intervention. Such future research questions may be explored upon the validation of the present measure of therapist work with client strengths.

Chapter 2: Statement of the Problem

The previous review has revealed the developing theoretical and empirical literature within the movement of positive psychology and human strengths. The philosophy of positive psychology generally contends that work with both deficits and assets is essential in the context of psychotherapy. Therefore, Wachtel concluded that such as movement,

“In no way implies ignoring the difficulties, the weaknesses, the inhibitions, or the self-defeating and self-limiting character traits that are likely to play a central role in the problems that have brought the patient to therapy; only a clear-eyed confrontation with the realities of the patient’s life can yield deep and lasting change. But it does imply that the overall vision of most psychotherapy is too one-sidedly focused on the negative. Effective psychotherapeutic effort must have an equally clear vision of the patient’s strengths. It is on those strengths that change is built, and failure to see them clearly can make change extremely unlikely” (1993, p. 111).

Hence, therapists who focus solely on client strengths could easily miss their presenting problems and ignore client deficits that may be contributing to such problems.

Alternatively, too little focus on client strengths may lead clients to feel overwhelmed and as though they lack the resources to effectively deal with their presenting problems.

Thus, therapists must balance working with clients’ strengths and weaknesses to both empower the client and improve their deficits.

Empirical studies have investigated human strengths in terms of specific constructs such as psychological mindedness (McCallum et al., 2003), spirituality (Avants et al., 2001), and benefit finding (Tennen & Affleck, 2002). In addition, Peterson and Seligman (2004) created an empirical classification of human strengths as well as a measure to assess the presence of such strengths. However, theory and research conducted within the Peterson and Seligman's Values in Action initiative has not investigated how therapists may work with client assets. Furthermore, only two known studies have examined therapist interventions based on client strengths (Conoley et al., 1994; Mitchell & Berenson, 1970) and no published studies have looked at the strength-based theory, assessment, or focus on client progress.

Since little research has been conducted on therapist work with client strengths, it is essential that future research draw heavily from theoretical and clinical pieces on this construct. Some authors have suggested that effective therapists, though unaware and untrained, intuitively work with the strengths of their clients (Gelso & Woodhouse, 2003; Seligman, 2002). Additionally, explicitly assessing client strengths is thought to facilitate a strong working alliance, help clients to feel that their therapist is trying to understand them as a complete person, and assist clients in regaining a sense of personal worth (Snyder et al., 2003). Moreover, therapist work with client assets has been hypothesized to buffer against symptom relapse, enhance well-being, and improve quality of life (Keyes & Lopez, 2002; Lampropoulos, 2001).

Therapists are believed to have a general style, or "trait," of working with their clients' strengths in therapy. Preliminary examination indicates that some therapists appear to have such a general tendency toward focusing on client assets (Harbin, 2004).

Hence, the overarching purpose of the present study was to develop a measure examining the degree to which therapists possess such a tendency to work with client strengths.

Since the primary focus of the current study was instrument development, and given the lack of previous research on therapist work with client strengths, exploratory factor analysis was used. Thus, another purpose of this study was to explore the factor structure of the Inventory of Therapist Work with Assets and Strengths (IT-WAS). However, it is important to note that item generation for this new measure was guided by a four factor solution (i.e., interventions, theory, assessment, and focus on client progress) offered by clinicians and theoreticians within positive psychology (Gelso & Woodhouse, 2003; Wachtel, 1993).

In the present study, therapist work with client strengths was posited to consist of four major parts, interventions, theory, assessment, and focus on client progress. Interventions refer to the part of working with client strengths that reflect the degree to which therapists actually use interventions connected to strengths and assets. This component includes the degree to which therapists use strength-based interventions such as explicitly directing clients' attention to their strengths or reframing negative perceptions in a more positive light. Theory refers to the part of working with client strengths that reflect the degree to which therapists think about and understand the ideas and philosophy behind working with client strengths. This component includes the degree to which therapists use strength-based conceptualizations such as understanding the rationale behind positive interventions and utilize a theory of working with client assets. Assessment refers to the part of working with strengths that includes assessing strengths clients presently have, using asset-based assessment tools, and incorporating

strengths into written client reports. Finally, focus on client progress reflects the degree to which clinicians may utilize interventions that highlight the progress made by clients in therapy.

Essential to all four components is the degree of appropriateness. Therapists need to understand the client context to be able to know when it is appropriate and most effective to use strength-based interventions. Working with client strengths appropriately means actually using such interventions at a time when they effectively facilitate the therapeutic process. For example, some clients may unconsciously “fish” for compliments by denigrating themselves. Thus, this would not be an ideal moment in therapy to point out client strengths. However, other clients may assume that others view them extremely negatively and hearing that their therapist views them very differently can lead to profound corrective emotional experiences.

Such appropriate strength-based work may be as simple as considering and working with the areas of life a client does well. When therapists work with strengths, clients may begin to feel that they are able to solve their problems on their own. They may feel that they have the resources and skills to deal directly with their issues. Nonetheless, further research is needed to understand if such a focus truly does bring about constructive client change.

The utility of the current measure was based on its having adequate reliability and validity estimates. Reliability was determined by internal consistency and 2 week test-retest reliability, which have been shown to be an appropriate means of estimating reliability (Dawis, 1987). Initial support for the construct validity of the Inventory of Therapist Work with Assets and Strengths was attained through correlations with

measures of favorable attitudes toward human nature, benevolent world assumptions, cynical attitudes, optimism, and therapist work with the strengths of their most recent client. If hypothesized correlations exist between the IT-WAS and these measures, this would establish initial support for the construct validity of the IT-WAS. In addition, favorability toward human nature was postulated as most fundamental to the present construct of therapist work with client assets. Hence, a significant relationship between this measures in particular was deemed integral to the validity of the IT-WAS. Other measures were expected to be related to the IT-WAS, but their relationship to the current measure was less fundamental to the construct validity of the IT-WAS.

For effective validation of a new instrument, one should compare the scale with the closest matching scale designed to assess the same construct (Dawis, 1987). This author was unable to locate a scale that corresponded with this recommendation. So, the Philosophies of Human Nature Scale was used in this study. The Philosophies of Human Nature Scale assessed the construct of favorability toward human nature, or the degree to which people view human nature as being predominantly positive or negative (Wrightsmann, 1964). While the Philosophies of Human Nature Scale was not designed to measure the same construct as the IT-WAS, it seemed to follow the theory that if a therapist believes humankind is good and can be trusted, she is more likely to work with the assets of her clients than a therapist with a more negative view of human nature.

The construct of favorability toward human nature has 4 components (Wrightsmann, 1964). The first component is trustworthiness, which includes viewing others as completely good, honest, and dependable. The next component is altruism, which includes viewing others as unselfish and thoughtful. The third component is

strength of will and rationality, which includes viewing others as being able to understand themselves and believing that in general people are the master of their own fate. Finally, the last component is independence, which includes viewing others as courageous, capable of making their own decisions, and not always following the crowd.

Research on favorability toward human nature has shown it to be negatively related to having an external locus of control, expressions of suspicion toward others, as well as beliefs that others are generally deceitful and may be easily manipulated (for a review, see Wrightsman, 1992). Additionally, those with more favorable attitudes toward human nature have been found to have greater faith in people and exhibit greater congruence between actual and ideal self-concepts. Such research lent support to Hypothesis #1: There will be a positive correlation between therapist work with client strengths and favorable attitudes toward human nature. Additionally, the relationship the Philosophies of Human Nature Scale and the IT-WAS was deemed essential to the validity the current measure, while relationships with other measures were hypothesized to be less critical to its validity.

Another possible construct to investigate when trying to understand therapist work with client strengths was people's benevolent assumptions about the world. People vary in the extent to which they view the world as a good place, expect more good events in the world than bad, and see people in general as caring and kind (Janoff-Bulman, 1989). Studies have shown such benevolent world assumptions to be negatively associated with cynical attitudes toward people and viewing people as generally immoral and easily manipulated (Gurtman, 1992). Furthermore, those with greater benevolent assumptions about the world were found to demonstrate greater interpersonal trust.

Therapists who see the world as a good place where good things happen would be expected to work more with the positives within their clients than therapists who see the world as a bad place. Hence, Hypothesis #2: There will be a positive correlation between therapist work with client strengths and benevolent world assumptions.

The next two constructs of interest were the attitudes of cynicism and optimism. People tend to differ in the extent to which they perceive people as dishonest, selfish, and disingenuous (Kanter & Mirvis, 1989). Such cynical attitudes have been found to be negatively related to interpersonal trust and benevolent world assumptions (Gurtman, 1992). If therapists believe that people are generally insincere and deceitful, they are not likely to trust clients enough to use their strengths as part of the therapeutic work. Thus, Hypothesis #3: There will be a negative correlation between therapist work with client strengths and cynical attitudes toward people.

In addition, people differ in the degree to which they expect good things to happen to them in the future (Scheier, Carver, & Bridges, 1994). Optimism has been found to buffer people from distress and depression after the occurrence of adverse events (for a review, see Carver & Scheier, 2002). People with greater optimistic attitudes have been shown to exhibit active and planful coping strategies. Furthermore, optimists are less likely to focus on negative aspects of their experience and are more likely to reframe bad situations in a positive light. Therapists who expect good things to happen to them and see the world through a positive lens would be expected to be more likely to work with the positives in their clients as well. Hence, Hypothesis #4: There will be a positive correlation between therapist work with client strengths and optimistic attitudes.

Discriminant validity was determined using the construct of public self-consciousness. Public self-consciousness is the degree to which people tend to be concerned about the way in which they present themselves to others (Fenigstein, Scheier, & Buss, 1975). A previous scale development study found public self-consciousness to be unrelated, as hypothesized, to the construct of hope (Syder, Harris, et al., 1991). It seems that therapists concern about their public presentation should also be unrelated to the degree to which therapists work or do not work with their client's strengths. Hence, Hypothesis #5: There will be no relationship between therapist work with client strengths and public self-consciousness.

Dawis (1987) indicated that the utility of a measure can be seen as its ability to predict some practical criterion. In the present study, therapists who generally worked with client assets would be expected to use strength-based conceptualizations and interventions to varying degrees depending on the specific clients they are working with. Nonetheless, it seemed likely that therapists who tended to work with client strengths in general would have worked more with assets in their most recent therapy session than therapists who tended to not incorporate strengths. This led me to Hypothesis # 6: There will be a positive correlation between therapist work with client strengths and the degree to which therapists have worked with the strengths of their most recent client.

Finally, demographic variables were also correlated with the IT-WAS. In particular, differences between clinical and counseling psychologists in their work with client strengths were explored. Relationships between the various theoretical orientations and work with client strengths were also examined. Given that no prior research has been conducted examining such associations, no specific hypotheses were formed.

Chapter 3: Methods

Participants

Two different samples were gathered in the current study; a professional sample ($n = 128$) and a university sample ($n = 97$). The professional sample was randomly selected from the 2005 membership directory of Divisions 17 (Counseling Psychology), 29 (Psychotherapy), and 42 (Independent Practice) of the American Psychological Association (APA). The university sample consisted of graduate students in counseling related fields as well as faculty and counseling center staff at a large Mid-Atlantic university. In order to qualify for the present study, participants must have conducted at least one hour of clinical intervention in the past year.

In the professional sample, 112 participants had a PhD, 11 had an EdD, 2 had a PsyD, and 3 had master's degrees. Sixty-nine (54%) participants were male and 59 (46%) were female. With respect to race/ethnicity, 118 (92%) were White/Caucasian, 3 were African American, 3 were Asian American, 3 were Latino/a, 1 was Middle Eastern, and 1 was bi-racial. Participants averaged 22.6 years ($SD = 9.7$) of experience since completing their last degree. The mean age was 55.57 ($SD = 9.4$). Additionally, clinicians were asked to rate their belief in and adherence to four theoretical orientation clusters on a 5 point scale (1 = *low* and 5 = *high*). The following mean ratings emerged: cognitive-behavioral 3.7 ($SD = 1.2$), humanistic-existential 3.6 ($SD = 1.2$), psychodynamic-psychoanalytic 3.1 ($SD = 1.5$), and multicultural-feminist 2.7 ($SD = 1.5$).

In the university sample, 81 participants were graduate students, 12 participants were counseling center staff, and 4 were tenured faculty (3 were counseling psychology and 1 was clinical psychology). Of the graduate student participants, 44 were in a

counseling psychology doctoral program, 18 were in a clinical psychology doctoral program, 14 were in a school psychology doctoral program, 6 were in a counselor education doctoral program, and 16 were counseling masters' programs. The 16 tenured faculty and counseling center staff had a PhD, while 48 of the graduate students had a masters' degree, 32 had a bachelors' degree, and 1 already had a doctorate degree. Seventy-two (74%) participants were female and 25 (26%) were male. With regard to race/ethnicity, 61 (63%) were White/Caucasian, 16 (17%) were African American, 13 (13%) were Asian American, 4 were bi-racial, 2 was Latino/a, and 1 was Middle Eastern. Using the same measure of theoretical orientation, the following mean ratings emerged: cognitive-behavioral 3.6 (SD = 1.1), humanistic-existential 3.6 (SD = 1.1), multicultural-feminist 3.2 (SD = 1.3), and psychodynamic-psychoanalytic 2.7 (SD = 1.4).

Measures

The measures used in this study were the Inventory of Therapist Work with Client Assets and Strengths (IT-WAS), the Philosophies of Human Nature Scale (PHN; Wrightsman, 1964), the World Assumptions Scale (WAS; Janoff-Bulman, 1989), the Survey of Cynicism (Kanter & Mirvis, 1989), the Life Orientation Test-Revised (LOT-R; Scheier, Carver, & Bridges, 1994), the Self-Consciousness Scale (SCS; Fenigstein et al., 1975), and a demographic measure. Additionally, two measures of therapist work with the strengths of their most recent client (Work with Strengths of Most Recent Client Likert Scale, WSMRC-S; Strengths vs. Weaknesses with Most Recent Client Continuum Scale, SvW-S) were used.

The *Inventory of Therapist Work with Client Strengths and Assets* was designed to assess the construct of therapist work with their clients' assets. It is an inventory

composed of 50 items (prior to factor analysis) to which participants indicated how important strength-based approaches were in their clinical work on a scale from one to seven (1 = *a little important*, 4 = *moderately important*, 7 = *extremely important*). Results from this measure may be used to provide clinicians with feedback with the degree to which they perceive themselves as incorporating client strengths in their therapeutic work. It was hoped that this measure can be used to determine if such work with client strengths may influence therapy process and perhaps even facilitate positive therapy outcomes. Items were generated based to four themes: (a) strength-based interventions, (b) strength-based theory, (c) strength-based assessment, and (d) focus on client progress. These themes were derived from theoretical and clinical work on therapist strengths (e.g., Gelso & Woodhouse, 2003; Wachtel, 1993) and were specified in greater detail in the subsequent section of the chapter.

The *Philosophies of Human Nature Scale* (Wrightsmann, 1964) was created to measure attitudes toward human nature, conceptualized as people's expectancies for the ways in which others generally behave. The PHN uses a 6 point Likert format where participants rate their attitudes toward human nature from -3 (*strongly disagree*) to +3 (*strongly agree*). The PHN is an 84 item measure consisting of the following six subscales: Trustworthiness, Altruism, Independence, Strength of Will and Rationality, Complexity of Human Nature, and Variability in Human Nature. The later two subscales, Complexity of Human Nature and Variability in Human Nature, have been shown to be theoretically and empirically distinct from the other subscales (Wrightsmann, 1991). Furthermore, these two subscales appear to be unrelated to the constructs currently under investigation and thus will not be included in the present study. The

remaining four subscales contain a total of 56 items and combine to form a Favorability toward Human Nature scale. The present research utilized this Favorability toward Human Nature scale, and this scale was used as the closest matching measure for the purposes of establishing initial construct validity (Dawis, 1987).

The Favorability toward Human Nature scale has been shown to be highly reliable with rating of internal consistency of .95 (Wexley & Youtz, 1985) and a test-retest reliability of .90 (Wrightsman, 1991). The validity of the scale has been well documented through its association with theoretically similar constructs. For example, favorability toward human nature was strongly and positively correlated with a scale designed to assess attitudes of faith-in-people ($r = .77$) and strongly and negatively associated a scale designed to assess beliefs that others are deceitful and easily manipulated ($r = -.68$; Wrightsman, 1964). In addition, negative attitudes toward human nature have been found to be correlated with dissatisfaction with one's self-concept ($r = .65$; Wrightsman, 1991). Hence, previous research has provided support for the construct validity of this scale.

The *World Assumptions Scale* (Janoff-Bulman, 1989) was designed to assess people's basic views or assumptions about the world. The complete 32 item scale contains 3 subscales that correspond to assumptions of the world's benevolence and meaningfulness and about the worthiness of the self. Items for this measure are rated on a 6 point Likert type scale (1 = *strongly disagree*, 6 = *strongly agree*). For the purposes of this study, the 8 item subscale pertaining to the benevolence of the world was administered. This subscale has been shown to have good reliability with an internal consistency coefficient alpha of .87. The validity for this subscale has been demonstrated

though its positive relationship with interpersonal trust and negative associations with cynical attitudes toward people as well as beliefs that others are deceitful and easily manipulated (Gurtman, 1992).

The *Survey of Cynicism* (Kanter & Mirvis, 1989) is a 7 item scale that measures cynical attitudes toward others, including beliefs that people are disingenuous, selfish, and dishonest. Items for this scale are rated on a 4 point Likert format (1 = *strongly disagree*, 4 = *strongly agree*). The scale has shown adequate reliability with an internal consistency rating of .78. Additionally, the validity for this measure has been supported through its negative relationships with interpersonal trust and benevolent world assumptions (Gurtman, 1992).

The *Life Orientation Test-Revised* (Scheier, Carver, & Bridges, 1994) is a 6 item measure designed to assess positive expectations for the future. Items are rated on a 5 point Likert scale (1 = *strongly disagree*, 5 = *strongly agree*). The LOT-R has been found to have good internal consistency ranging from the high .70s to the low .80s (Carver & Scheier, 2003). In addition, the scale also has demonstrated good construct validity through its association with similar constructs (Carver & Scheier, 2002).

The *Self-Consciousness Scale* (Fenigstein et al., 1975) will be used to determine the discriminant validity of the IT-WAS. The SCS is a 23 item measure based on a 5 point Likert format (0 = *extremely uncharacteristic*, 4 = *extremely characteristic*). The SCS contains three subscales that measure different kinds of self-consciousness: private self-consciousness, public self-consciousness, and social anxiety. For the purposes of the present study, the 7 item Public Self-Consciousness scale was used. The Public Self-Consciousness scale assesses people's awareness and concern about aspects of the self

that others can perceive and has been found to show good reliability with a two week test-retest reliability of .84.

Two measures of therapist work with the strengths of their most recent client were created for this study as a means of assessing the criterion-related validity of the IT-WAS. Prior to taking these measures, participants were asked (a) to take a moment to think about their most recent session with their most recent client and (b) to write down the first name or initials of this client to help jog their memory. The *Work with Strengths of Most Recent Client Likert Scale* is a 4 item measure designed to assess the degree to which therapists utilized strength-based interventions and conceptualizations with their most recent client. Items are rated on a 9 point Likert scale (1 = *strongly disagree*, 9 = *strongly agree*). This measure showed good reliability with an internal consistency of .81.

The *Strengths vs. Weaknesses with Most Recent Client Continuum Scale* is a 2 item inventory designed to measure the degree to which clinicians utilized strength-based interventions and assessments in contrast to weakness-based interventions and assessments. For each item, participants first marked an X on a continuum scale from 0 (*only interventions/assessments related to client weaknesses*) to 100 (*only interventions/assessments related to client strengths*) and then wrote the exact percentage. This measure also showed good reliability with an internal consistency of .76. In addition, the WSMRC-S and SvW-S were found to be positively and significantly correlated with each other ($r = .48, p < .001$).

Development of the Inventory of Therapist Work with Client Strengths and Assets

The method of item generation and scale construction used for this study was based on recent scale development research (e.g., Schlosser & Gelso, 2001, 2005) as well as Dawis' (1987) recommendations. There were four themes that were posited to characterize the items of the Inventory of Therapist Work with Client Strengths and Assets. The first theme is *strength-based interventions*, which refers to the degree to which therapists truly employ interventions related to strengths and assets. The second theme is *strength-based theory*, which reflects the degree to which therapist utilize knowledge and theory related to their work with such assets. The third theme is *strength-based assessment*, which relates to the degree to which clinicians assess the strengths of their clients and use asset-based assessment tools in their work. Finally, the fourth theme is *focus on client progress*, which refers to the degree to which clinicians support and encourage progress clients make in therapy. These four themes supply the underlying premise behind the Inventory of Therapist Work with Client Strengths and Assets. The initial pool of items was generated on the basis of a thorough review of the existing empirical, theoretical, and clinical literature on therapist work with client strengths. In addition, preliminary to item writing, semi-structured interviews were conducted with a total of two full professors and nine doctoral graduate students in counseling psychology. These interviews were structured to ask interviewees open-ended questions related to their own personal work with client assets. For example, questions were posed regarding strength-based interventions they found most helpful and most hindering in their work. Additionally, questions were asked about the specific manner in which they think about and understand their work with client strengths. After these interviews and a thorough

review of the literature, items were created by the current author to measure therapist asset-based interventions, theory, assessment, as well as items related to therapist focus on client progress. At this time, 36 items were included in the measure.

**Initial Content Validity of the Inventory of Therapist Work with
Client Strengths and Assets**

One full professor and six graduate students in counseling psychology were asked to review all of the 36 items. Based on their feedback, 11 original items were reworded, 5 items were eliminated (due to redundancy), and 19 items were added. Rewording was used to enhance clarity and reduce overlap between hypothesized factors. Items were eliminated if they were determined to be redundant with existing items or because agreement was attained among the reviewers and this author that the item did not achieve its intended function. Items were added based on the recommendations of the reviewers, given that those recommendations corresponded to the underlying theory of the Inventory of Therapist Work with Client Strengths and Assets. This author took their recommendations and included them in the development of new items. Thus, 14 of the 19 added items were partially composed by the reviewers. Additionally, this author wrote the 5 other items. Hence, this process produced a total number of 50 items.

Next, the measure was reviewed by three tenured counseling psychology faculty members (including the first author's advisor), one tenured clinical psychology faculty member, and one counseling center staff psychologist. These reviewers determined that the initially used Likert rating scale format (i.e., *strongly agree* to *strongly disagree*) was confusing and seemed to result in a longer administration time. After reviewing different rating scale formats, the first author and 5 reviewers all determined that importance

anchors were clearer and resulted in a quicker administration time. Hence, the scale rating format was then changed to the following 7 point rating scale: 1 = *not important*, 4 = *moderately important*, and 7 = *extremely important*.

Finally, a pilot study was conducted in which 15 doctoral graduate students (11 in counseling psychology and 4 in clinical psychology) were asked to fill out the measure, compare the current rating scale (i.e., importance) to the Likert format, and provide overall feedback on the IT-WAS. Participants noted preferring the importance rating scale over the Likert format due to its clarity and ease of administration. In addition, item means and standard deviations were examined for all 50 items of the IT-WAS. It was noted that the overall item mean for the IT-WAS was 5.0, and 9 items had an item mean of 6.0 or greater on the 7 point rating scale. These 9 items were reworded (e.g. adding the word *always*) to reduce the skew of the distribution. The rating scale was also altered to reduce the overall skew; in particular, the lowest anchor on the rating scale was changed from *not important* to *a little important*. Five additional doctoral students in counseling psychology were given the updated scale, which resulted in an overall item mean of 4.8 for the IT-WAS and a mean of 5.0 or less for the 9 reworded items. Hence, the above changes appeared to have the desired effect of reducing the skew of the specific items and the IT-WAS total score.

Procedures

The current study followed mail survey methods detailed in previous studies of this type (e.g., Gelso et al., 2005, Schlosser & Gelso, 2001, 2005) and followed many of the guidelines given by Weathers, Furlong, and Solórzano (1993). As previously described, the study used both a professional sample and a university sample. The

procedure for the professional sample will be first described, followed by the university sample.

To reduce the time required for completion of the survey, and thus enhance return rate, participants in both samples were not given all the measures. Two versions of the surveys were used, and both versions contained the IT-WAS and a demographics measure. It should be noted that the number of items administered from the PHN (i.e., 56) was approximately equal to the total number of items administered from all the other scales combined. Hence, one version contained the PHN whereas the second version contained the WAS, the Survey of Cynicism, the LOT-R, the SCS, the WSMRC-S and the SvW-S.

Using the 2005 membership directory of the APA, 100 names from Division 17 (Counseling Psychology), 100 from Division 29 (Psychotherapy), and 100 from Division 42 (Independent Practice) were randomly selected. Each prospective participant was assigned a number for the purpose of maintaining confidentiality. These 300 participants were mailed a packet that included a cover letter, the measures, and a self-addressed stamped envelope.

The letter cover letter used in this study emphasized the significance of the research, as well as the short length of the measures (less than 15 minutes to complete). In addition to being personally addressed to the participant, each letter was hand signed by the current author and his dissertation advisor. Participants were told that the current study is interested in examining how practitioners incorporate aspects of positive psychology in their work with clients. Furthermore, participants were asked to return the survey in the provided envelope and will be notified that by completing the survey, they

will be eligible for a \$100 prize. Additionally, follow-up reminder postcards were mailed 2 weeks after the initial mailing to participants who had not returned the packet. One month after the initial mailing, a total of 88 surveys had been received. In addition, 27 participants returned the surveys as ineligible since they had not completed one hour of clinical intervention in the past year, and 22 surveys were received that were undeliverable.

A second mailing of all materials was then sent to the remaining 163 participants who had not yet responded one month after the initial mailing. Two weeks after the second mailing, follow-up postcard reminders were mailed once again. Therefore, two rounds of mailing were interspersed with two rounds of follow-up postcards in order to maximize the return rate and external validity. This second round of surveys and postcard reminders yielded a return of 40 surveys, for a total of 128 completed surveys. Hence, the return rate for this sample was 51% (128 of 251).

For the university sample, 173 surveys were delivered to graduate students of master's and doctoral counseling related programs (e.g., counseling psychology, clinical psychology, school psychology, counselor education), faculty members of clinical and counseling psychology doctoral programs, and counseling center staff at a large Mid-Atlantic university. Surveys were collected over a one month period. As with the professional sample, participants were informed of the inclusion requirements for the study (i.e., one hour of clinical intervention in the past year) and were given the packet of measures along with a self-address, stamped envelope to return the measures. Doctoral level graduate students in clinical and counseling psychology were also informed that they may have the opportunity to complete a second, 5 minute survey for the test-rest

reliability of the measure. Two weeks after the initial mailing, follow-up reminder postcards were mailed to participants who had not returned the packet. Of the 173 mailed surveys, 97 participants completed the survey and 14 participants returned the surveys as ineligible. Thus, the total return rate for this sample was 62% (97 of 157).

Test-Retest Reliability

For the test-retest reliability, a sample of 31 doctoral students in counseling and clinical psychology programs was gathered. Twenty-three participants (74%) were female and 8 (26%) were male. In regard to race/ethnicity, 19 were Caucasian (61%), 6 were Asian American (19%), 3 were African American (10%), 1 was Latino/a, 1 was Middle Eastern, and 1 was bi-racial. Sixteen (52%) had a master's degree, 14 (45%) had a bachelor's degree, and 1 already had a doctoral degree. Twenty two (71%) were in a counseling psychology doctoral program and 9 (29%) were in a clinical psychology doctoral program. The mean age of participants was 22 years old ($SD = 7.4$). The following mean ratings emerged regarding theoretical orientation: humanistic-existential 3.5 ($SD = 1.2$), cognitive-behavioral 3.1 ($SD = 1.4$), multicultural-feminist 2.9 ($SD = 1.4$), and psychodynamic-psychoanalytic 2.8 ($SD = 1.5$).

After completing the initial survey, 56 counseling and clinical psychology doctoral students were emailed in advance to let them know they would be receiving a time sensitive survey that would only take 5 minutes to complete. Participants were then asked to complete the IT-WAS as well as a few demographic items after a 2-week interval. Thirty two participants returned the test-retest survey, though one survey was incomplete. Thus, the usable return rate for this sample was 55% (31 of 56).

Chapter 4: Results

The purpose of the current study was to determine the factor structure, initial validity, and reliability estimates of a measure assessing therapist work with client strengths. Items were generated to represent four hypothesized components of therapist work with client assets (i.e., strength-based interventions, focus on client change, theory of working with client strengths, and assessment of client strengths). Given that the notion of strengths within the context of psychotherapy is an up-and-coming area of theory and research within positive psychology (Peterson & Seligman, 2004), few empirical studies have been conducted and a consistent theory on the topic has not yet been established (Gelso & Woodhouse, 2003). Hence, due to the newness of the construct and lack of solid theory and research, an exploratory factor analysis (as opposed to confirmatory) was conducted. Initial validity for the Inventory of Therapist Work with Assets and Strengths (IT-WAS) was assessed by correlations with constructs of favorability toward human nature, benevolent world assumptions, cynical attitudes toward others, optimism, public self-consciousness, and work with the strengths of a most recent client. Additionally, reliability was obtained by using estimates of internal consistency and test-retest reliability over a two week period.

Exploratory Factor Analysis

Before testing the appropriateness of factor analysis, an independent sample t-test was conducted to determine whether the two samples (i.e., the professional sample and the university sample) used in the present study could be combined. T-test results found no significant differences between samples on clinician scores of the IT-WAS, $t(223) = .061, p > .05$. Hence, both samples were combined for subsequent analyses.

Bartlett's (1950) test of sphericity and the Kaiser-Meyer-Okin (KMO) test of sampling adequacy were both used to ascertain the appropriateness of factor analysis for the present investigation. More specifically, Bartlett's (1950) test was used to determine whether the acquired data is a representative sample of the normal population. According to Bartlett's test, a significant chi-square test indicates that the correlations of the matrix are different from zero and thus, a factor analysis would be appropriate for the data (Tinsley & Tinsley, 1987). This test was significant, $\chi^2(1225, N = 225) = 7089.84, p < .001$, indicating the data is indeed appropriate for a factor analysis. In addition, the KMO test was conducted with KMO statistic scores above .50 considered to be acceptable and scores above .90 to be exceptional (Kaiser, 1974). In the present study, the KMO statistic was found to be exceptional at .94. Based on the results of the KMO and Bartlett tests, factor analysis was judged to be appropriate for the present data set.

A principal components (rather than principal axis) factor analysis was conducted to explore the factor structure of the IT-WAS. Principal components analysis is appropriate when the investigator judges that the items drive the factors rather than the factors driving the items. Essentially, in a principal components analysis the items form, as opposed to reflect, the nature of the emerging construct (such as Theory of Intervention). Furthermore, the outcome of the principal component and principal axis analyses are virtually the same when there are a large number of variables relative to a small number of factors and 50 or so items are being analyzed (Gorsuch, 1997). Since both criteria were met in the present investigation, principal components analysis was chosen. It was also hypothesized that subscales would represent distinct aspects of

therapist work with client strengths. Hence, a varimax rotation of the extracted principal components was used.

Several criteria were utilized to determine the extracting factors: inspection of Cattell's scree plot, application of the Kaiser-Guttman rule, the proportion of variance accounted for by the factor solution, and the proportion of variance accounted for within that solution. Exploration of potential factor structures began with the examination of the scree plot while applying the Kaiser-Guttman rule (i.e., retaining only factors with eigenvalues above 1.0; Loehlin, 1998). Furthermore, in order to select and anchor items on a given factor, only items that loaded at least .40 on one factor were retained. Additionally, items that loaded greater than .40 on more than one factor were eliminated in order to prevent cross loading issues. These loading and cross-loading criteria are consistent with previous scale development research (Gelso et al., 2005; Schlosser & Gelso, 2001, 2005) and were used to clean up the factor structure of the IT-WAS. Also consistent with previous scale development research, the criteria was not chosen in which items would be eliminated if their loadings showed a difference of $<.10$ between the highest loading factor and the next highest loading factor. This particular criteria was not selected in order to allow relevant but slightly overlapping items to remain a part of the previously unresearched construct of therapist work with client strengths.

Before conducting the factor analysis, all 50 items were examined and deemed appropriate for factor analysis on the basis of means, standard deviations, kurtosis, and skewness. Additionally, eigenvalues for each item were greater than one. The initial factor analysis results suggested 9 possible factors with eigenvalues greater than 1.0, which collectively accounted for 65% of the total variance. Further inspection of the

scree plot indicated that a one, two, three, or four factor solution may be the most appropriate description of the data.

After close examination of the potential factor structures, the three factor solution was judged to be the most parsimonious and expedient description of the data set by the author, one full professor (the author's research advisor), and one counseling psychology pre-doctoral intern with a master's degree in psychometrics. The one factor structure was not selected because the factor was deemed too global, while the two factor structure was not selected as items within each factor did not clearly represent a single construct. Additionally, the four factor structure was very difficult to interpret. In contrast, the three factor structure appeared to represent distinct aspects of therapist work with client strengths.

On purely statistical grounds (e.g., examination of the scree plot, total variance accounted for by both solutions, etc.), it was difficult to determine whether the three factor structure was a better fit for the data set than the one factor structure. However, the three factor structure was chosen in part because it was deemed more theoretically meaningful and held greater heuristic value than the one factor structure. Additionally, the three factor structure was hypothesized to generate more interesting and fruitful research in the area of therapist work with client strengths.

The three factor solution accounted for 52% percent of the variance and retained 37 items. The IT-WAS factor were labeled: (a) Theory of Intervention (16 items, accounted for 21% of the variance), (b) Assessment of Strengths (11 items, accounted for 16% of the variance), and (c) Supporting Progress (10 items, accounted for 15% of the

variance). The factor loadings for the 37 items are included in Table 1. Item means, standard deviations, kurtosis, and skewness are included in Table 2.

The first subscale is composed of 16 items that reflect therapist understanding of the rationale behind positive interventions and use of strengths theory in clinical work. These items (e.g., “Working with the strengths of clients as a way to increase their sense of personal worth”; “Making special effort to build on clients’ healthy coping mechanisms”) appear best summarized by the label Theory of Intervention. Higher scores indicate therapists’ greater utilization of theory and knowledge of the avenues by which client strengths may be incorporated into their individual clinical work. Factor loadings ranged from .72 to .49.

The second subscale is composed of 11 items which involve therapists’ explicit assessment of client strengths. These items (e.g., “Selecting assessment tools that take into account clients’ strengths”; “Questioning clients about their strengths during a mental status examination”) appear best represented by the label Assessment of Strengths. Higher scores indicate greater information gathering around client strengths and use of strength-based assessment tools in clinical work. Factor loadings ranged from .73 to .49.

The third subscale is composed of 10 items related to therapist use of interventions that highlight progress made by clients in the therapeutic work. These items (e.g., “Consistently pointing clients’ attention to their therapeutic progress”; “Letting clients know how they have changed for the better”) appear best exemplified by the label Supporting Progress. Higher scores indicate greater explicit focus on positive changes clients have made in therapy. Factor loadings ranged from .80 to .42. More

Table 1

Items and Factor Loadings of the Inventory of Therapist Work with Assets and Strengths

Item	Factor		
	1	2	3
<i>1. Theory of Intervention</i>			
Working with client strengths as a way to increase their sense of personal worth.	.72	.24	.25
Working with client strengths to improve their sense of well-being.	.68	.32	.22
Working with clients' strengths to help them view themselves as the agent of change.	.68	.33	.19
Encouraging realistic optimism in clients.	.67	.09	.20
Making special effort to build on clients' healthy coping mechanisms.	.65	.36	.14
Focusing on clients' strengths to help them view their problems as more solvable.	.63	.22	.30
Reframing the experiences of clients in a positive light.	.62	.17	.24
Helping clients to see that they have the power to change things they do not like in their lives.	.61	.12	.30
Working with the strengths of clients as a primary way to help prevent them from slipping into relapse.	.60	.38	.20
Helping to build clients' resiliency.	.60	.39	.08
Focusing on clients' strengths as a way to help them be more resilient in dealing with future challenges.	.59	.37	.30
Helping clients to see themselves in a positive light.	.59	.02	.25
Focusing on clients' strengths as a primary way to help them become more confident that they can make changes.	.56	.20	.38
Helping all my clients understand their emerging strengths.	.55	.35	.32
Helping clients to see the good already within them.	.54	.05	.25
Viewing all my clients as striving to improve their lives.	.49	.10	.22
<i>2. Assessing Strengths</i>			
Questioning clients about their strengths during a mental status examination.	.08	.73	.23
Interpreting standardized tests (e.g., MMPI-2, Strong Interest Inventory) in the context of clients' strengths.	.08	.72	.08

Table 1 continued.

Item	Factor		
	1	2	3
Giving equal emphasis to clients' strengths and weaknesses in written reports.	.17	.68	.00
Discussing clients' views of their psychological assets as a way to lead to new material.	.29	.67	.23
Asking clients about all of the domains in their lives in which they excel.	.29	.66	.31
Asking my clients about their strengths in the area of work and/or school.	.28	.65	.32
Selecting assessment tools that take into account clients' strengths.	.03	.61	.27
Asking about clients' strengths that may be related to their psychopathology or conflicted feelings.	.19	.55	.30
Making an effort to build on clients' strengths in the area of work and/or school.	.35	.53	.30
Assessing the resiliency of clients.	.33	.50	.04
Also drawing attention to clients' strengths whenever I point out deficits or problems.	.37	.49	.34
<i>3. Supporting Progress</i>			
Consistently pointing clients' attention to their therapeutic progress.	.23	.10	.80
Focusing with clients on the gains they have made in our therapeutic work together.	.22	.28	.79
Shifting clients' attention toward the progress they are currently making in therapy.	.23	.17	.78
Using interventions that point out clients' progress in therapy.	.22	.29	.70
Letting clients know how they have changed for the better.	.37	.18	.63
Making special effort to notice even the smallest steps of progress clients make.	.30	.30	.59
Reminding clients of the insights they have developed as a result of the work in therapy.	.24	.27	.57
Being sure to praise clients when they do good work in the session.	.36	.26	.50
Explicitly commenting when my clients take steps in the right direction	.37	.17	.44
Instilling hope in all my clients that they can change.	.37	.03	.42

Note. $N = 225$. Kaiser-Meyer-Olkin index = .94. The Theory of Intervention, Assessment of Strengths, and Supporting Progress accounted for 21%, 16%, and 15%, respectively, of the total variance. Factor loadings were obtained with the rotated factor matrix of the varimax solution.

Table 2

Item Means, Standard Deviations, Kurtosis, and Skewness Statistics of the Inventory of Therapist Work with Assets and Strengths

Item				
	M	SD	Sk	K
<i>1. Theory of Intervention</i>				
Working with client strengths as a way to increase their sense of personal worth.	5.67	1.93	-1.04	1.15
Working with client strengths to improve their sense of well-being.	5.74	1.04	-.81	.43
Working with clients' strengths to help them view themselves as the agent of change.	5.71	1.14	-.95	.94
Encouraging realistic optimism in clients.	5.81	1.16	-1.30	2.39
Making special effort to build on clients' healthy coping mechanisms.	5.94	.96	-.85	.66
Focusing on clients' strengths to help them view their problems as more solvable.	5.67	1.14	-1.10	1.64
Reframing the experiences of clients in a positive light.	5.40	1.36	-.99	.83
Helping clients to see that they have the power to change things they do not like in their lives.	5.99	1.14	-1.30	1.88
Working with the strengths of clients as a primary way to help prevent them from slipping into relapse.	5.50	1.21	-1.00	1.31
Helping to build clients' resiliency.	5.76	1.07	-.61	-.26
Focusing on clients' strengths as a way to help them be more resilient in dealing with future challenges.	5.68	1.18	-.89	.98
Helping clients to see themselves in a positive light.	5.99	1.00	-1.25	2.57
Focusing on clients' strengths as a primary way to help them become more confident that they can make changes.	5.57	1.23	-.91	.72
Helping all my clients understand their emerging strengths.	5.68	1.00	-.46	-.29
Helping clients to see the good already within them.	6.19	1.00	-1.44	2.56
Viewing all my clients as striving to improve their lives.	5.48	1.36	-.76	.11
<i>2. Assessing Strengths</i>				
Questioning clients about their strengths during a mental status examination.	4.26	1.77	-.26	-.81

Table 2 continued.

Item				
	M	SD	K	Sk
Interpreting standardized tests (e.g., MMPI-2, Strong Interest Inventory) in the context of clients' strengths.	4.57	1.77	-.43	-.72
Giving equal emphasis to clients' strengths and weaknesses in written reports.	5.03	1.50	-.65	-.02
Discussing clients' views of their psychological assets as a way to lead to new material.	4.71	1.49	-.38	-.45
Asking clients about all of the domains in their lives in which they excel.	4.95	1.43	-.48	-.39
Asking my clients about their strengths in the area of work and/or school.	5.18	1.33	-.58	-.01
Selecting assessment tools that take into account clients' strengths.	4.64	1.76	-.29	-.84
Asking about clients' strengths that may be related to their psychopathology or conflicted feelings.	4.68	1.50	-.44	-.35
Making an effort to build on clients' strengths in the area of work and/or school.	5.52	1.24	-.75	.11
Assessing the resiliency of clients.	5.37	1.35	-.73	.23
Also drawing attention to clients' strengths whenever I point out deficits or problems.	4.92	1.67	-.73	-.23
<i>3. Supporting Progress</i>				
Consistently pointing clients' attention to their therapeutic progress.	5.30	1.37	-.76	.24
Focusing with clients on the gains they have made in our therapeutic work together.	5.52	1.25	-.82	.62
Shifting clients' attention toward the progress they are currently making in therapy.	5.27	1.40	-.79	.29
Using interventions that point out clients' progress in therapy.	5.08	1.37	-.63	.12
Letting clients know how they have changed for the better.	5.54	1.27	-.87	.71
Making special effort to notice even the smallest steps of progress clients make.	5.48	1.39	-.82	.02
Reminding clients of the insights they have developed as a result of the work in therapy.	5.33	1.42	-.84	.31
Being sure to praise clients when they do good work in the session.	5.33	1.54	-.86	.17
Explicitly commenting when my clients take steps in the right direction	5.95	1.13	-1.13	1.47
Instilling hope in all my clients that they can change.	6.42	.89	-1.93	4.54

Note. $N = 225$. M = Mean. SD = Standard Deviation. K = Kurtosis Statistic. Sk = Skewness Statistic.

detailed descriptions of all three subscales are provided in the following discussion chapter.

Reliability Estimates, Scale Intercorrelations, and Construct Validity Estimates

Table 3 displays the IT-WAS reliability estimates, including internal consistencies by means of Cronbach's α and 2-week test-retest reliabilities by means of Pearson correlation coefficients. Table 3 also displays scale intercorrelations and descriptive data (i.e., item means, scale means, item standard deviations, and scale standard deviations). Internal consistency reliabilities of the IT-WAS subscale scores ranged from .90 (Assessment of Strengths and Supporting Progress) to .93 (Theory of Intervention), and the reliability of the IT-WAS total score was .96. Two week test-retest reliabilities of the IT-WAS subscale scores ranged from .63(Assessment of Strengths) to .91 (Theory of Intervention). Additionally, the test-retest reliability of the IT-WAS total score was .81. The IT-WAS subscale item means ranged 4.91 (Assessment of Strengths) to 5.74 (Theory of Intervention), whereas the IT-WAS total item mean was 5.46. The three subscale scores correlated significantly and highly with each other. All three subscale scores were also highly and significantly correlated with the IT-WAS total score.

Evidence of construct validity of the IT-WAS was examined through bivariate correlations between the new measure and theoretically relevant constructs. Correlations between the IT-WAS, its subscales, and other validity measures are displayed in Table 4. A priori, the Philosophies of Human Nature Scale (PHN) was determined to be the closest matching scale to the IT-WAS designed to assess a similar construct (Dawis, 1987). Hence, a significant correlation between the PHN and the IT-WAS was deemed to be essential to the validity of the current measure; in contrast, significant correlations

Table 3

Correlations, Means, Standard Deviations, Internal Consistency Estimates, and Test-Retest Reliabilities for the Inventory of Therapist Work with Assets and Strengths

Scale	1	2	3	4
1. Theory	1.00			
2. Assessment	.66	1.00		
3. Progress	.70	.62	1.00	
4. IT-WAS Total	.91	.87	.86	1.00
Mean – Scale	91.96	54.00	55.31	201.90
Mean – Item	5.74	4.91	5.53	5.46
SD – Scale	12.77	11.83	9.60	30.70
SD – Item	1.14	1.55	1.32	1.33
Range – Low	46.00	22.00	20.00	94.00
Range – High	112.00	77.00	70.00	259.00
Cronbach's α	.93	.90	.90	.96
Test-Retest r^a	.91	.63	.72	.81

Note. $N = 225$. All correlations were significant ($p < .001$). Theory = Theory of Intervention; Assessment = Assessment of Strengths; Progress = Supporting Progress; IT-WAS Total = Inventory of Therapist Work with Assets and Strengths Total Score.

^a Two-week test-retest reliability ($N = 31$).

Table 4

Correlations of the Inventory of Therapist Work with Assets and Strengths to the Criterion Variables (PHN, WAS, LOT-R, SCS, WSMRC-S, SvW-S, SOC)

	IT-WAS scale			
	Theory	Assessment	Progress	Total Score
PHN scale ^a	.28**	.27**	.28**	.32***
WAS scale ^b	.24*	.13	.14	.19*
LOT-R scale ^b	.04	.08	.02	.05
SOC scale ^b	-.14	-.02	-.03	-.07
WSMRC-S scale ^b	.38***	.48***	.43***	.48***
SvW-S scale ^b	.39***	.29**	.24*	.35***
SCS scale ^b	.00	.05	.15	.07

Note. Theory = Theory of Intervention; Assessment = Assessment of Strengths; Progress = Supporting Progress. PHN = Philosophies of Human Nature Scale. WAS = World Assumptions Scale. LOT-R = Life Orientation Test – Revised. SCS = Social Consciousness Scale. WSMRC-S = Work with Strengths of Most Recent Client Likert Scale. SvW-S = Strengths vs. Weaknesses with Most Recent Client Continuum Scale. SOC = Survey of Cynicism Scale.

*** = $p < .001$. ** = $p < .01$. * = $p < .05$.

^a $N = 112$. ^b $N = 113$

with other measures were hypothesized as less crucial to its validity. The hypothesis, that there would be a positive correlation between the IT-WAS total score and the degree to which people view human nature as being predominantly positive or negative, was supported. The correlation between the IT-WAS and the PHN was .32 ($p < .001$). In addition, all three IT-WAS subscales were significantly correlated with the PHN (Theory of Intervention, $r = .28, p < .01$; Assessment of Strengths, $r = .27, p < .01$; Supporting Progress, $r = .28, p < .01$).

The second hypothesis, that the IT-WAS total score would be positively correlated with World Assumptions Scale (WAS), was supported. The correlation between the IT-WAS and the WAS was .19 ($p < .05$). Additionally, one of the IT-WAS subscales was found to be significantly correlated with benevolent world assumptions (Theory of Intervention, $r = .24, p < .05$).

The third hypotheses, that the IT-WAS would be positively correlated with optimistic attitudes, was not supported ($r = .05, p > .05$). Additionally, the fourth hypothesis that the IT-WAS would be negatively correlated with cynical attitudes toward others was also not supported ($r = -.07, p > .05$). Furthermore, to examine the discriminant validity of the new measure, the IT-WAS was correlated with public self-consciousness subscale of the Self-Consciousness Scale (SCS). As hypothesized, there was no significant relationship between the IT-WAS and public self-consciousness ($r = .07, p > .05$).

According to Dawis (1987), the usefulness of a scale may be viewed as its ability to predict some practical criterion. In the present study, the IT-WAS hypothesized to be positively correlated with two measures of therapist work with the strengths of their most

recent client. Both measures of work with most recent client strengths were significantly correlated with the IT-WAS, thus supporting the criterion validity hypothesis. The correlation between the IT-WAS and the Work with Strengths of Most Recent Client Likert Scale (WSMRC-S) was .48 ($p < .001$). In addition, all three IT-WAS subscales were significantly and positively correlated with the WSMRC-S (Theory of Intervention, $r = .38, p < .001$; Assessment of Strengths, $r = .48, p < .001$; Supporting Progress, $r = .43, p < .001$). The correlation between the IT-WAS and the Strengths vs. Weaknesses with Most Recent Client Continuum Scale (SvW-S) was .35 ($p < .001$). All the IT-WAS subscales were also significantly correlated with the SvW-S (Theory of Intervention, $r = .39, p < .001$; Assessment of Strengths, $r = .29, p < .01$; Supporting Progress, $r = .24, p < .05$).

IT-WAS Scores and Demographic Variables

Next, relationships between the IT-WAS and demographic variables were investigated. To examine differences between counseling psychology clinicians and clinical psychology clinicians on IT-WAS total scores, an independent samples t-test was conducted. Counseling psychology clinicians ($N = 109, M = 199.39, SD = 31.98$) were not found to be significantly different from clinical psychology clinicians ($N = 64, M = 196.88, SD = 31.02$), $t(171) = .57, p > .05$. In addition, correlations between the IT-WAS and gender, age, ethnicity, and highest degree held were all found to not be significant. The IT-WAS total and subscale scores were also correlated with therapist theoretical orientation (see Table 5). The correlation between the IT-WAS and the degree to which therapists rated themselves as believing in and adhering to the techniques of experiential, humanistic, or existential therapy was significant ($r = .18, p < .01$). The IT-WAS

Table 5

Correlations between the Inventory of Therapist Work with Assets and Strengths and Theoretical Orientation

	IT-WAS scale			
	Theory	Assessment	Progress	Total Score
Humanistic Rating	.25***	.08	.12	.18**
Psychodynamic Rating	-.09	-.01	-.22***	-.11
CBT Rating	.24***	.22***	.30***	.28***
Multicultural / Feminist Rating	.26***	.25***	.24***	.29***

Note. $N = 225$. Theory = Theory of Intervention; Assessment = Assessment of Strengths;

Progress = Supporting Progress. Humanistic Rating = Self-rating of Adherence to Experiential,

Humanistic, or Existential Theoretical Orientation. Psychodynamic Rating = Self-rating of

Adherence to Psychodynamic or Psychoanalytic Theoretical Orientation. CBT Rating = Self-

rating of Adherence to Cognitive, Behavioral, or Cognitive Behavioral Theoretical Orientation.

Multicultural / Feminist Rating = Self-rating of Adherence to Multicultural or Feminist

Theoretical Orientation.

*** = $p < .001$. ** = $p < .01$.

subscale, Theory of Intervention, was also significantly correlated with the humanistic self-rating ($r = .25, p < .001$). The correlation between therapist rated belief and adherence to the techniques of psychoanalytic or psychodynamic therapy and the IT-WAS total score was not significant ($r = -.11, p > .05$). However, the psychodynamic self-rating was found to be significantly and negatively correlated with the IT-WAS subscale Supporting Progress ($r = -.22, p < .001$). In addition, the correlation between therapist rated belief and adherence to the techniques of behavioral, cognitive, or cognitive behavioral therapy and IT-WAS total score was found to be significant ($r = .28, p > .001$). All three IT-WAS subscales were also significantly and positively correlated with the CBT self-rating (Theory of Intervention, $r = .24, p < .001$; Assessment of Strengths, $r = .22, p < .001$; Supporting Progress, $r = .30, p < .001$). Finally, the correlation between therapist rated belief and adherence to the techniques of multicultural or feminist therapy and the IT-WAS total score was found to be significant ($r = .29, p > .001$). All IT-WAS subscales were significantly correlated with the multicultural/feminist self-rating (Theory of Intervention, $r = .26, p < .001$; Assessment of Strengths, $r = .25, p < .001$; Supporting Progress, $r = .24, p < .001$).

In the free response theoretical orientation write-in section, responses that included only a single theoretical orientation were coded into one of four categories: Psychodynamic (e.g., object relations, self-psychology, psychoanalytic), Cognitive Behavioral, Humanistic (e.g., experiential, humanistic, existential), and Multicultural/Feminist. There were insufficient numbers of therapists who wrote in Multicultural/Feminist and Humanistic theoretical orientations ($N < 10$ for both categories); hence, both categories were not included in the analyses. Two one-way MANOVAs were

conducted to determine whether self-identified Psychodynamic and Cognitive Behavioral therapists differed from therapists of other theoretical orientations on the IT-WAS total and three subscale scores. Means and standard deviations of psychodynamic and cognitive behavioral therapists' scores on the IT-WAS compared to other theoretical orientations are presented in Table 6.

Results showed that self-identified Psychodynamic therapists were found to have significantly lower IT-WAS total scores than other therapists, $F(1, 223) = 22.27, p < .001$. Moreover, Psychodynamic therapists had significantly lower scores than other therapists on the Theory of Intervention subscale, $F(1, 223) = 30.8, p < .001$, the Assessment of Strengths subscale, $F(1, 223) = 4.03, p < .05$, and the Supporting Progress subscale, $F(1, 223) = 24.71, p < .001$. Self-identified cognitive behavioral therapists did not have significantly different IT-WAS total scores than therapists of other theoretical orientations $F(1, 223) = 1.51, p > .05$. However, the Cognitive Behavioral therapists were found to have significantly higher scores on the Supporting Progress subscale than other therapists, $F(1, 223) = 4.96, p < .05$. Additionally, Cognitive Behavioral therapists did not significantly differ from other therapists on Theory of Intervention subscale, $F(1, 223) = .06, p > .05$, and the Assessment of Strengths subscale, $F(1, 223) = 1.16, p > .05$.

Table 6

Scale Means and Standard Deviations of IT-WAS scores of Self-Identified Cognitive Behavioral and Psychodynamic Therapists Compared to Other Theoretical Orientations

	IT-WAS scale			
	Theory	Assessment	Progress	Total Score
<i>Psychodynamic vs. Other</i>				
Psychodynamic ^a	77.57 (17.93)	48.62 (14.81)	45.48 (12.87)	171.67 (41.29)
Other ^b	92.85 (11.27)	54.00 (11.34)	55.94 (8.74)	202.79 (27.24)
<i>CBT vs. Other</i>				
CBT ^c	91.84 (11.34)	55.23 (12.00)	57.88 (7.48)	204.95 (23.16)
Other ^d	91.84 (14.18)	53.09 (10.72)	54.27 (10.00)	198.67 (31.47)

Note. Standard deviations are listed in parentheses.

Theory = Theory of Intervention; Assessment = Assessment of Strengths; Progress =

Supporting Progress. Psychodynamic = Self-identified Psychodynamic Theoretical Orientation

by Free Response Method. CBT = Self-identified Cognitive Behavioral Theoretical Orientation

by Free Response Method. Other = All Other Self-identified Theoretical Orientations by Free

Response Method (i.e., theoretical orientations other than psychodynamic or CBT)

^a $N = 21$. ^b $N = 204$. ^c $N = 43$. ^d $N = 182$.

Chapter 5: Discussion

Relatively few clinicians have received direct training in working with strength-based therapeutic approaches (Gelso & Woodhouse, 2003). Yet, according to Seligman (2002; Seligman & Peterson, 2003), positive psychology may be naturally woven into psychotherapy by effective therapists who adhere to a wide range of theoretical orientations. Seligman furthermore posited that positive psychology falls into the category of deep strategies within psychotherapy. Deep strategies are techniques that are commonly utilized by successful clinicians yet do not have names and have not been investigated. Despite the great clinical interest in the topic of client strengths (Gelso & Woodhouse, 2003; Ivey & Ivey, 1998; Keyes & Lopez, 2002; Lampropoulos, 2001; Lopez & Snyder, 2003b; Sandron, 1970; Seligman, 2002; Smith, 2006; Witryol & Boly, 1954; Wong, in press), minimal research has been conducted on how client strengths may be incorporated into psychotherapy. For example, the degree to which clients' strengths can be harnessed and used to create better therapy outcomes has yet to be studied. The present study involves the creation of a new measure that may begin to shed light on the role positive psychology currently plays within psychotherapy. The IT-WAS was created to explore how therapists use strength-based approaches in their therapeutic work.

Factor Structure

Factor analyses revealed the existence of three subscales: Theory of Intervention, Assessment of Strengths, and Supporting Progress. A fourth posited theme (i.e., Strength Interventions) did not emerge from the factor analyses but shared similarities with the Theory of Intervention factor. Initially, the Theory of Intervention subscale was named the Theory of Strengths subscale, but the subscale was renamed as the construct that

resulted from factor analysis seemed more specifically related the theory behind positive interventions rather than more general positive conceptualizations. A discussion of each subscale follows.

The first subscale, Theory of Intervention, is composed of 16 items that encompass therapists' use of theory to explain how and why they utilize client strengths in their therapeutic work. Higher scores on this subscale indicate that clinicians are more likely to incorporate positive psychology theory in psychotherapy. Such a theory consists of appreciating how working with assets may be used as a means of improving clients' sense of worth about themselves, preventing relapse into negative symptoms, and helping increase client resilience. Additionally, higher scores indicate therapists' are more likely to understand the rationale behind such positive interventions as cognitive reframing, building healthy coping mechanisms, and increasing clients' awareness of their own strengths. For example, therapists who score higher on this subscale may be more likely to recognize how helping clients label their desired strengths may be used as a goal setting strategy (e.g., a depressed person may have the goal to become more courageous; Wong, in press). These clinicians are also more likely to mold treatments to take into account a range of theories linked to positive psychology such as the incorporation of self-efficacy theory into career counseling (i.e., Betz, 2004). Lower scores indicate that such theories and interventions connected with client strengths are less likely to be important to the therapists' clinical work.

The second subscale, Assessment of Strengths, is composed of 11 items that comprise therapist explicit and implicit evaluation of client strengths. Higher scores on this subscale indicate that therapists are more likely to ask clients direct questions about

their strengths, give equal attention to strengths as well as weaknesses when writing reports, and interpret psychological tests in the context of strengths. Furthermore, higher scores indicate therapists are more likely to assess clients' resiliency, strengths related to work and/or school, and the domains in which clients' do exceptionally well. For instance, therapists high on this subscale would be more likely to make implicit client strengths more explicit by asking clients to identify their strengths. These therapists would also be expected to involve clients in envisioning strengths they would like to develop which are consistent with their therapeutic goals. Wong (in press) identified these two processes of positive therapy as "explicitizing" and "envisioning," respectively. Such strategies of incorporating asset-based assessments may make evaluations more consumer-friendly by helping clients identify the good in themselves rather than simply reinforcing them for only "having a problem" (Brenner, 2003; Snyder et al. 2003). Lower scores on this subscale indicate that therapists place a lower value on strength-based assessments in their clinical work.

The third subscale, Supporting Progress, contains 10 items that cover the degree to which therapists openly focus on the gains clients make in therapy. Higher scores on this subscale indicate that therapists are more likely to point clients' attention toward the advances they have made in therapy and clearly communicating client changes noticed by the therapist. In addition, therapists who score high on this subscale are likely to spend more time concentrating on smaller gains toward therapeutic goals and outwardly praise clients for the headway they have made in psychotherapy. These therapists would also conceivably reflect back on and celebrate the improvements made by clients in therapy, especially during termination. Wong (in press) identified this process of reflecting back

on developed strengths as “evolving.” Supporting therapeutic achievements may serve to reinforce beneficial changes while also reducing clients’ view of themselves as being “stuck” in their problems (Wachtel, 1993). Moreover, such interventions can be conceptualized as encouragement and are based on the behavioral principal of positive reinforcement (Smith, 2006). Lower scores on this subscale indicate that clinicians are less likely to expressly encourage advancements that clients make in therapy.

One interesting finding in the present investigation was that most therapists generally conducted strength-based clinical work to a high degree. Extensive efforts were made in the development of the scale to avoid positively skewed items on the IT-WAS. Nevertheless, therapists across all theoretical orientations and training programs scored an average item mean of 5.5 out of a possible 7 points, indicating that they felt working with strengths was of greater than moderate importance in their therapeutic work. Hence, it appears that working with client assets has an important place in the work of the average therapist. This finding supports the proposition made by Seligman (2002; Seligman & Peterson, 2003) that most therapists do in fact work with strengths even though such work is very rarely trained or openly discussed in clinical settings. Since therapists have not been trained to work with client assets (Gelso & Woodhouse, 2003), the process is thought to often be “intuitive and inchoate” in its formulation and expression (Seligman, 2002, p. 6). Hence, concepts related to strengths may sometimes be unorganized and unformed in the minds of therapists. Nonetheless, it has been proposed to be a major effective ingredient as to why psychotherapy works as well as it does (Keyes & Lopez, 2002; Seligman, 2002; Seligman & Peterson, 2003; Smith, 2006).

Reliability and Validity Estimates

Results of the present investigation provide evidence supporting the initial reliability and validity and for the IT-WAS. The current study provided validity through correlations with theoretically relevant measures. Additionally, reliability was established through estimates of internal consistency and test-retest reliability across a two week period.

To determine the initial validity of the IT-WAS, several hypotheses were examined. The first hypothesis was that there would be a positive relationship between therapist work with client strengths and favorable attitudes toward human nature. This hypothesis was supported in the current study. Namely, the IT-WAS total scale and each subscale was positively correlated with a measure of favorable beliefs about human nature. Hence, it appears that therapists who work with the assets of their clients may be more likely to view their clients as honest, reliable, and trustworthy. Additionally, such clinicians appear may also see their clients as being more fundamentally unselfish, altruistic, and concerned for others. This finding makes intuitive sense, since clinicians who believe that people are generally good seem more likely to work with the good in their clients (i.e., strengths). It seems that perhaps therapists' favorable beliefs about human nature undergird their assumption that all people have capacity for strengths development and for growth and change (Rogers, 1961; 1964; Smith, 2006). Thus, therapists who view their clients as generally good people who can be trusted are more likely to use their own personal theory related to positive interventions, assess more strengths, and are more likely to reinforce client growth.

The second hypothesis postulated that there would be a positive relationship between therapist incorporation of strength-based approaches and benevolent assumptions about the world. This hypothesis was supported in the present investigation. Specifically, the IT-WAS total scale as well as the Theory of Intervention subscale were positively correlated with a measure of positive world assumptions. The two other subscales, Assessment of Strengths and Supporting Progress, were not correlated with the measure of benevolent world assumptions. Hence, it appears that therapists who work with the assets of their clients are more likely to believe that the world is a good place where positive events tend to occur more often than negative events. Additionally, therapists who utilize more strength-based approaches are more likely to generally view people to be kind, helpful, and caring. This finding was very similar to the first hypothesis in that both appear to indicate that therapists who work with client strengths are more likely to have positive attitudes toward human nature and the world. It is important to note that strong relationships between personality characteristics and therapeutic approaches are generally not to be expected, since therapists often use approaches they deem most effective independent of their personality traits. Consistent with such an expectation, associations between the IT-WAS and both favorable attitudes toward human nature and benevolent world assumptions ranged from moderate to small.

Hypotheses three and four were related to optimistic and cynical viewpoints held by therapists. Specifically, hypothesis three stated that there would be a positive relationship between the IT-WAS and a measure of optimistic attitudes, and hypothesis four stated that there would be a negative relationship between the IT-WAS and a measure of cynical attitudes toward others. Both hypotheses three and four were not

supported in the current investigation. There may be several reasons why significant relationships were not found between such attitudes and therapist work with strengths. In general, optimists are more likely to focus on the positive aspects of their experience than the negative aspects (Carver & Scheier, 2002). Optimists are also more likely to reframe negative events in a positive light by viewing the best in bad situations. However, therapists who work with client strengths are just as likely to take into account the negatives of clients as the positives, since developing a clear understanding of client problems is essential to strength-based approaches (Keyes & Lopez, 2002; Smith, 2006). Hence, therapists do not necessarily need to hold optimistic attitudes in order to work with client assets. Furthermore, the construct of optimism relates to people's positive expectations for *themselves* rather than others, and does not predict whether they would project such expectations on to others (i.e., clients). Additionally, independent of therapists' positive attitudes they have about themselves, they may find it to be "practical" to work with strengths. For instance, many therapists may hold negative expectancies about their own future yet perceive benefits to be associated with working with strengths. Thus, therapists may use asset-based approaches in their clinical work despite a positive attitude.

Hypothesis four posited that therapists who work with client strengths would have fewer cynical attitudes toward others, and this hypothesis was not supported. It is possible that therapists may embrace their own cynical attitudes toward others yet understand that allowing such a view to inform their work could impede therapeutic progress. Hence, these therapists may simply keep these countertransferential attitudes "in check" and alternately work with client assets as a result of observing the benefits of

strength-based approaches through their own clinical work. In addition, it is important to note that the scale used to measure cynical attitudes has shown only limited validity.

While the instrument was the only existing scale that could be used to assess the desired construct, the scale has not been examined through the use of factor analysis and only minimal validity information was available through a small handful of studies. Hence, it is possible that the measure may not have adequately assessed its intended construct. As new measures are created, future research may investigate the relationship between the IT-WAS and more valid measures of cynical attitudes.

Hypothesis five proposed that a positive relationship exists between the IT-WAS and clinicians' work with the assets of their most recent therapy client. This hypothesis was supported for the full scale IT-WAS and all three subscales. Hence, consistent with Dawes' (1987) standard, it appears that the IT-WAS has the ability to predict some practical criterion. Overall, therapists would be expected to work with client positives to varying degrees depending on factors such as the clients' personality dynamics, presenting concerns, and degree of psychopathology. Nonetheless, in accordance with the basic principals of probability, it makes sense that therapists who generally use strength-based approaches were more likely to have worked with the strengths in their most recent clinical session. Since therapists' most recent client was random across all subjects in the present study, this relationship is likely to generalize to therapist work with client assets not only in their most recent session but also in *most* sessions. Hence, it appears that therapists who use more strength based approaches would actually be likely to put their positive psychology theory, assessment, and reinforcement of client progress into practice with most of their therapy clients.

Hypothesis five stated that there would be no relationship between the degree to which therapists work with strengths and their general concern about how they are perceived by others. This discriminant validity hypothesis was supported. Such a finding provides initial evidence that the IT-WAS seems to not correlate with unrelated constructs. Hence, the present investigation demonstrates initial support for the idea that the IT-WAS not only correlates with measures as expected (e.g., favorable attitudes toward human nature) but also does not correlate with measure it would not be expected to be related to (e.g., public self-consciousness).

Furthermore, no relationship was found between clinical and counseling psychologists' scores on the IT-WAS. Hence, the current study supports the idea that differences do not exist in the degree to which clinical and counseling psychologists work with client assets. It should be noted that hypotheses about differences between these groups were not developed, since previous theory and research was insufficient to support such hypotheses. Attention to client strengths has been an integral part of counseling psychology since its origin, which it first described as "hygiology" (Gelso & Fretz, 2001; Super, 1955, 1977). However, the current psychology movement initiated by Seligman in 1998 has disseminated the concepts of positive psychology to a broader audience. As a result, positive psychology theory and research has become more popular in numerous psychology disciplines other than counseling, including clinical psychology. Indeed, Martin Seligman himself is a clinical psychologist! Thus, while focus on client strengths has been a part of counseling psychology since its inception, it appears that such concepts related to positive psychology have expanded to clinicians from other disciplines as well.

The Relationship between Theoretical Orientation and Work with Client Strengths

In addition, the therapist work with client strengths was found to be related to various theoretical orientations. While many authors discussed how diverse theoretical orientations have incorporated positive psychology concepts into therapy practice (e.g., Chazin, Kaplan, & Terio, 2000; Gelso & Woodhouse, 2003), no previous studies have investigated the relationship between strength-based clinical work and different theoretical orientations. Therapists generally worked with client strengths to a high degree (i.e., high item mean for the IT-WAS) and asset-based approaches were positively correlated with several primary theoretical orientations. Hence it seems that the vast majority of therapists work with client strengths, regardless of theoretical orientation. Nonetheless, several important differences in theoretical orientations' work with client strengths were discovered.

In the current study, theoretical orientation was measured in two ways. In the first measurement, therapists were asked to rate how much they believed in and adhered to the techniques of four different theoretical orientations (i.e., humanistic, psychodynamic, cognitive behavioral, and multicultural/feminist). Hence, this measure allowed therapists to indicate the degree to which they incorporate and integrate multiple theoretical orientations in their clinical work, as opposed to adhering to a single orientation. The second measure was a free response question in which therapists wrote in their self-described orientation. To examine therapists who were less likely to integrate various theoretical orientations in their work, only therapists who wrote a single orientation were examined on this second measure. Thus, this measure assessed more purist therapists

who adhered most strongly with a single orientation. In the discussion below, the first measure will be initially explored, after which the second measure will be examined.

Therapist self-rating of adherence to a humanistic theoretical orientation was found to be positively related to the IT-WAS total score. Additionally, the Theory of Intervention subscale was positively correlated with humanistic orientation. However, humanistic orientation was not related to the Assessment of Strengths and Supporting Progress subscales. Understanding similarities and differences between positive psychology and humanistic theoretical orientation helps to shed light on to these relationships. Consistent with positive psychology, humanistic psychology believes human nature to be inherently motivated toward developing its potential (i.e., the self-actualizing tendency; Joseph & Linley, 2004; Rogers, 1963; Seligman & Csikszentmihalyi, 2000). Additionally, humanistic psychologists believe in working with strengths (Joseph & Linley, 2004). Humanistic therapy is furthermore consistent with positive psychology in that they both believe in the importance of how therapists *think* about strengths (i.e., Theory of Intervention). However, humanistic psychology differs from positive psychology in that it does not focus on what therapists *do* with strengths (i.e., Assessing Strengths and Supporting Progress; Gelso & Woodhouse, 2003). Thus, humanistic therapists generally tend to work with asset-based approaches and use a strength-based theory yet pay less specific attention to assessing strengths and explicitly supporting client progress.

The IT-WAS and all three subscales (i.e., Theory of Intervention, Assessment of Strengths, and Supporting Progress) were also found to be positively related to therapists self-rating of adherence to cognitive behavioral therapy (i.e., CBT) theoretical

orientation. The relationship between CBT therapists use of strength-based approaches can be most easily understood in terms of the principle of positive reinforcement. Cognitive behavioral interventions focus not only on decreasing negative client behavior but also on increasing positive behavior (Hosp, Howell, Hosp, 2003). CBT therapists often specifically utilize the principal of positive reinforcement through replacing negative behaviors with more positive behaviors (e.g., Gresham, 2002). Hence, consistent with strength-based therapy approaches, CBT therapists may intentionally encourage progress made by clients in order to reinforce their hard work in therapy (Smith, 2006).

Strength-based approaches can be also incorporated into goal setting strategies often used in CBT. For example, Wong (in press) provides a case example of a married, Asian American client with the goal to increase her strength of forgiveness. However, this client was unable to articulate how her life would be different should become more forgiving. After completing a therapy homework assignment to ask her closest friend how her life would be different, she realized being more forgiving meant that she would ruminate less about her husband's adultery, be more patient with her children, and find a job to support her family. The therapist and client were then able to set smaller goals to work toward building forgiveness. Hence, through the therapist's homework assignment designed to build a foundation for the strength of forgiveness, the client was able to delineate the work that needed to be done to achieve her goal. Such positive goal setting strategies are consistent with cognitive behavioral approaches.

Additionally, through CBT cognitive restructuring techniques, clients are taught to replace negative thoughts with more realistic thoughts (i.e., more balanced thoughts that

take into account both positives and negatives (Greenberger & Padesky, 1995; Padesky & Greenberger, 1995). Integral to such cognitive restructuring techniques are thought records, in which clients learn to identify their negative automatic thoughts and create more rational and realistic responses to counter such thoughts. CBT therapists encourage clients to identify positives within themselves and their situation that had been previously ignored as part of the thought record. Thus, CBT therapists are more likely to utilize a theory related to strength interventions, identify strengths, and reinforce progress.

Therapist self-rating of multicultural/feminist theoretical orientation was also positively correlated with the IT-WAS and all three subscales (i.e., Theory of Intervention, Assessment of Strengths, and Supporting Progress). The concept of empowerment helps explain the use of asset-based therapy approaches in multicultural and feminist theoretical orientations. These theoretical orientations focus special attention on the lack of power provided to disenfranchised populations by society (e.g., minorities of race, gender, ethnicity, sexual orientation, class, religion, etc.; Smith, 2006). From this perspective, clinical practice that relies only on the disease-oriented medical model may act to increase the power differential between therapist and client and thus further “reinforce those social structures that generate and regulate unequal power relationships that victimize clients” (Cowger, 1994, p.206). Hence, pathology-focused approaches are inconsistent with the purpose of multiculturalism and feminism (Fowers & Richardson, 1996). On the other hand, working with the strengths of clients may act to level the playing field and establish more equal power relationships in therapy. Hence, both multicultural and feminist therapists are likely to integrate strength-based approaches into their clinical practice.

The IT-WAS total score and two of its subscales (i.e., Theory of Intervention and Assessment of Strengths) were found to be unrelated to therapist self-rating of psychodynamic theoretical orientation. Moreover, the subscale of Supporting Progress was found to be negatively correlated with psychodynamic theoretical orientation. Psychodynamic and psychoanalytic therapists have historically tended to focus greater attention on psychopathology while ignoring the strengths of even high functioning people (Gelso & Woodhouse, 2003). This pathology focus has been grounded in the traditional analytic view that “the primary task of therapy is to bring to awareness impulses and fantasies that the patient has persistently kept hidden” by intensifying and frustrating the infantile wishes of clients (Wachtel, 1993, p.34-35). Hence, by these standards, to work with client positives would mean a violation of the rule of abstinence and indulge clients’ infantile fantasy wishes (Wile, 1985). For example, to openly compliment a client on their therapeutic progress may be viewed as interfering with the development of transference and perhaps even manipulating the patient by not providing them with the freedom that is necessary for analytic exploration. It appears that this rule of abstinence continues to be presently maintained in the practice of both psychodynamic and analytic therapists (Wachtel, 1993). Hence, consistent with the rule of abstinence, psychodynamic therapists who integrate other clinical theories are less likely to support client progress. Furthermore, it seems that a recent trend toward the incorporation of newer theories into psychodynamic thought that has led to “a ‘softening’ and ‘warming’ of the analytic model of treatment” (Wachtel, 1993, p.39). Consequently, psychodynamic therapists who incorporate other theoretical models appear to still be

relatively unconcerned with overall asset-based approaches, with strength theory, and with assessing strengths.

In contrast to the psychodynamic self-rating, therapists who identified themselves being solely psychodynamic (e.g., object relations, self-psychology, psychoanalytic, etc.) in orientation on the free-response measure were less likely to work with strengths than therapists of other orientations for the IT-WAS total score and for all three subscales (i.e., Theory of Intervention, Assessment of Strengths, and Supporting Progress). These therapists represent more purist views of psychodynamic and psychoanalytic theory and practice, which are less likely to be influenced by the “softening” and “warming” of the model. They are also more likely to adhere to traditional analytic values such as “be(ing) ‘tough’ with the patient is regarded as all right,” while “be(ing) a little gentle with the patient is always suspect” (Langs & Stone, 1980, p.9). By this estimate, utilization of strength-based approaches would be detrimental since they would gratify the infantile impulses of clients and impede the analytic associative process. Hence, work with client strengths is in direct opposition to the values of more classic psychodynamic and analytic therapists.

Therapists who identified as solely cognitive behavioral on the free-response measure were not found to be different than therapists of all other theoretical orientations (e.g., humanistic, psychodynamic, and humanistic/feminist) on the IT-WAS total score and two of its subscales (i.e., Theory of Intervention and Assessment of Strengths). However, CBT therapists were more likely to support their clients’ progress than therapists of all other orientations. Traditional CBT theory is deeply entrenched in the medical model, which focuses primary attention on the application of treatments for

specific DSM diagnoses (e.g., social phobia; Gelso & Woodhouse, 2003). Moreover, traditional CBT theories have concentrated more on decreasing negative thoughts, beliefs, and behaviors than increasing the positive ones. Hence, these CBT therapists appear to use overall asset-based approaches, strength theory, and strength assessment no more than other theoretical orientations.

Nevertheless, the main exception to the traditional cognitive behavioral concentration on pathology lies in the principal of positive reinforcement. Traditional cognitive behavioral theory has always encouraged the reinforcement of desired behavior and/or cognitions in therapy (Gelso & Woodhouse, 2003). Such positive reinforcement typically occurs when therapists verbally reinforce clients when they observe the desired behavior or cognition. For example, CBT therapists may verbally recognize clients' effective and consistent completion of therapy homework and may point out how completing such homework has helped create forward progress toward the achievement of treatment goals. Thus, traditional CBT therapists are more likely to support client progress than therapists of other theoretical orientations.

Implications for Clinical Practice and Training

“On a philosophical level, the intense focus on problems makes it difficult for practitioners to express some of the fundamental values of the profession. The belief in the dignity and worth of each individual and the corresponding belief in individual and collective strength and potential cannot be realized fully in the midst of concerns about assessing liabilities” (Brenner, p. 352).

The present study provides a framework for understanding therapists work with client strengths. Though there has been increasing clinical interest in the topic, very little previous research has examined how client strengths may be integrated into psychotherapy. Results of the emerging factor dimensions furnish a novel way to conceptualize strength-based approaches. Three of the four posited themes emerged from the factor analyses (i.e., Theory of Intervention, Assessment of Strengths, and Supporting Progress). These three subscales had not been previously empirically considered. Additionally, while the fourth theme (i.e., Strength Interventions) did not emerge from the factor analysis, it shared several items in common with another emergent factor (i.e., Theory of Intervention). Hence, the present study has created a new measure that can be used to test recent propositions of strength-based approaches (e.g., Smith, 2006).

While many clinical articles have attempted to describe strength-based theories and techniques, a coherent and research based theory of positive therapy has yet to be developed (Gelso & Woodhouse, 2003; Smith, 2006). As a result, little knowledge has been obtained about the rationale behind using positive strategies in therapy. The current investigation represents the first study to provide empirical insight into therapists' rationale behind positive interventions. Specifically, the Theory of Intervention subscale examines the degree to which therapists utilize and appreciate the underlying principles behind asset-based approaches. This subscale may be used in future research to examine how clinicians' use of positive psychological theory influences therapy process.

Additionally, Brenner (2003) proposed that strengths need to be integrated into psychological assessment work as a way to make assessments more consumer-friendly to clients. Asset-oriented assessments (e.g., Quality of Life Scale, CITE) may be integrated

with more deficit focused assessments (e.g., MMPI-2) to help counterbalance the stigma clients experience as a result of being administered exclusively pathology-based tools. This integration of strength assessments may also further reduce the stigma associated with exclusively pathology-based assessment reports. These strength-based clinical approaches are generally regarded as consumer friendly since they are “congruent with lay people’s conceptualizations of human flourishing and solutions to life’s challenges” (Wong, in press). Through using more consumer friendly strategies such as incorporating client strengths into assessments, psychologists improve their ability to meet the needs of managed care (Brenner, 2003; Wong, in press). The inventory created in the current study provides a means of evaluating the degree to which therapists incorporate strength assessments in their work. Future research may be used to determine how clients perceive therapist work which integrates strength assessments compared to therapist work which only utilizes deficit-orientated clinical assessments. Moreover, the IT-WAS scale as a whole may be eventually used to develop models in which positive psychology theory is integrated with current models of psychopathology through programmatic research (Lampropoulos, 2001; Lopez, Snyder, & Rasmussen, 2003).

The IT-WAS may also be used to train students learning basic counseling skills as well as more seasoned therapists. Previously, therapists have rarely been systematically or formally trained to incorporate strengths-based therapy into their clinical work. The IT-WAS scale may help incorporate positive psychotherapy into training through discussion of subscales and individual items in clinical practica and supervision. For example, supervisors can use the Theory of Intervention subscale as a jumping off point to examine trainees’ conceptualizations of client assets and how they may be linked to

strength-based interventions. The IT-WAS scale may also be reviewed by experienced therapists to help remind them of effective strength-based approaches.

Finally, this study provides further data about the importance of strength-based approaches. Results from this investigation provide evidence of the psychometric validity of a new measure of therapist work with client assets. This measure may be used to better understand the influence of asset-based approaches in therapy and to eventually empirically validate the effectiveness of positive psychology approaches in psychotherapy.

Limitations

Several limitations need to be noted in the current study. For instance, the present investigation used self-report data. As a result, therapists may have found it socially desirable to report using asset-based therapy approaches to higher degree than they actually used in their clinical work. Item means on the IT-WAS may have been inflated as a consequence of such social desirability. However, most scholars view favorable self-presentation as an inevitable part of the context of positive psychology that should be acknowledged but not corrected (Lopez, Snyder, & Rasmussen, 2003). Thus, social desirability seems to be a limitation of the present study as it seems to be with much of positive psychology research.

In addition, by some statistical standards, the return rate for the current study is a potential limitation. However, when compared to other studies examining similar populations, obtaining a 51% and 62% response rate from desired populations (i.e., professional therapist population and university graduate student, staff, and faculty population, respectively) is actually quite good. Still, such a rate leaves the door open for

confounding due to self selection (Heppner, Kivlighan, & Wampold, 1999). The study also used single item measures to assess theoretical orientation, and such items tend to have limited reliability. Furthermore, another limitation is the lack of diversity in the present sample. In particular, the majority of participants were Caucasian, while other populations were less represented. Future studies should examine strength-based approaches used by therapists of other races and ethnicities.

The lack of validity information on some measures is another limitation of the present study. There are virtually no established measures related to therapist work with client strengths. Consequently, measures of therapist work with their most recent client strengths were created to establish the criterion validity of the IT-WAS. Although these measures demonstrated adequate reliability in the current study and yielded theoretically meaningful findings, the data should be interpreted with caution until future research can confirm the reliability and validity of these new measures. Moreover, this limitation points to the need for more research, including instrument development and refinement, in the area of client strengths.

Additionally, the subjective nature of factor analysis is another limitation of the current study. Factor analysis may be thought of as “garbage in, garbage out,” such that factors are determined by the items that were created. Additionally, reading of the scree plot, examining the different possible subscales, and naming the factors are also subjective processes. Hence, this study should be viewed as exploratory and none of the emerging factors should be viewed as being set in stone. It is also possible that future research may uncover different factor structures than the current three factor structure.

Finally, the non-standard administration of the survey is another limitation of the current investigation. No instructions were provided with regard to the time, place, and manner in which the surveys should be completed. Since participants did not complete the measures in a controlled setting (e.g., laboratory), it is possible that their results may have been influenced by external factors. Such factors could have affected the therapists' ratings of their clinical focus on client strengths, and thus, influenced the results of the study.

Future Research

Numerous possibilities exist for the future examination of the IT-WAS and strength-based approaches. Since this is the first validity investigation of the IT-WAS, future research should continue to evaluate the psychometric properties of the IT-WAS. The initial step in this process is to perform a confirmatory factor analysis, which provides an important means to test the stability of the emergent factor structure.

The IT-WAS may also be utilized finally to answer propositions put forth by positive psychology theory. Recently, as part of her major contribution article in *The Counseling Psychologist*, Elsie Smith (2006) offered many relevant propositions which may now be tested. For example, she proposed that asset-based approaches may instill 'strength awareness' in clients, which improves their sense of self-efficacy and authentic self-esteem. Thus, future studies should explore the process by which clinical attention to assets may increase clients' awareness of strengths and examine the effects of such an awareness. Smith further posited that strength-based approaches motivate clients to change to a greater degree than deficit-based approaches. Future investigations may use the IT-WAS to investigate the influence of positive therapy on client motivation to

change. Finally, Smith proposed that therapist encouragement is a key technique to facilitate behavioral client change. Hence, future studies may examine the influence of therapist encouragement on psychotherapy process by using the Supporting Progress subscale of the IT-WAS.

Furthermore, future research may investigate the relationship between theoretical orientation and therapist work with client assets. Since virtually no prior research had been conducted on strength-based psychotherapy, specific hypotheses were not developed in the present study related to various theoretical orientations incorporation of strength-based clinical strategies. Future studies may now examine how a variety of theoretical orientations integrate strength based approaches in clinical work. For example, the Theoretical Orientation Profile Scale-Revised (TOPS-R; Worthington & Dillion, 2003) examines different theoretical orientations on the basis of theoretical identification, conceptualization, and utilization of methods. Moreover, the TOPS-R examines multicultural and feminist approaches separately, in comparison to the current study which looked at these two approaches combined. Hence, the TOPS-R may be correlated with the IT-WAS in future studies to further explore differences in various theoretical approaches and perspectives on client strengths.

The IT-WAS was conceptualized as a trait measure of work with client strengths, and validity and reliability information supports this conceptualization. However, therapists are also likely to work with strengths to varying degrees with different clients on the basis of factors such as degree of pathology. Thus, the creation of a state measure of therapist work with client strengths would also be useful in future research. This state version of the IT-WAS could be useful in examining the process and outcome of strength

based approaches within specific therapy sessions rather than a general clinical approach used across all clients.

Moreover, while the present investigation examined strength-based clinical work from the therapist perspective, future studies may also look at client perceptions. The client perspective of strength-based approaches may be examined both quantitatively (e.g., having clients rate the helpfulness of strength-focused therapy interventions in a single session) and qualitatively (e.g., asking clients to describe most helpful and least helpful strength-based interventions used by therapists). Additionally, the effect of positive therapy approaches on client self-esteem and self-efficacy may also be areas of fruitful future research.

In conclusion, the present study offers a new perspective on the complex yet important construct of strength-based therapy approaches. The subscales that emerged from the factors analysis provide initial insight into the ways in which therapist focus on client strengths. Continued empirical research in this area will help shed further light on a highly relevant yet rarely studied topic.

Appendix A: Inventory of Therapist Work with Assets and Strengths

Instructions: The following 50 items are related to your personal therapy work with clients. Please use the following scale and circle the number that best describes how important the following statements are *in your work with clients*.

1	2	3	4	5	6	7
A Little			Moderately			Extremely
Important			Important			Important

1. Helping clients to see the good already within them.
2. Asking clients what they feel are their greatest strengths.
3. Instilling hope in all my clients that they can change.
4. Selecting assessment tools that take into account clients' strengths.
5. Finding client strengths within most client problems.
6. Consistently pointing clients' attention to their therapeutic progress.
7. Focusing on clients' strengths as a primary way to help them become more confident that they can make changes.
8. Always taking clients strengths into consideration when making therapeutic interventions.
9. Helping all my clients understand their emerging strengths.
10. Shifting clients' attention toward the progress they are currently making in therapy.
11. Questioning clients about their psychological assets during an initial interview.
12. Focusing on clients' strengths as a way to help them be more resilient in dealing with future challenges.
13. Also drawing attention to clients' strengths whenever I point out deficits or problems.
14. Asking about clients' strengths that may be related to their psychopathology or conflicted feelings.
15. Using interventions that point out clients' progress in therapy.
16. Assessing the resiliency of clients.

17. Focusing with clients on the gains they have made in our therapeutic work together.
18. Making an effort to build on clients' strengths in the area of work and/or school.
19. Reminding clients of the insights they have developed as a result of the work in therapy.
20. Helping clients to see that they have the power to change things they do not like in their lives.
21. Working with client strengths to improve their sense of well-being.
22. Using interventions that focus on the positive changes clients have made in therapy.
23. Making special effort to notice even the smallest steps of progress clients make.
24. Building on clients' strengths as a way to increase their quality of life.
25. Helping clients to see themselves in a positive light.
26. Giving equal emphasis to clients' strengths and weaknesses in written reports.
27. Working with the strengths of clients as a way to increase their sense of personal worth.
28. Viewing all my clients as striving to improve their lives.
29. Helping to build clients' resiliency.
30. Letting clients know how they have changed for the better.
31. Calling attention to the confidence clients have gained since beginning therapy.
32. Using therapeutic interventions that take into account the strengths of clients.
33. Reframing the experiences of clients in a positive light.
34. Focusing on strengths as a way to increase clients' hope.
35. Explicitly commenting when my clients take steps in the right direction.
36. Reframing what appears to be a client weakness as a once-appropriate strength that made sense in an earlier context.
37. Interpreting standardized tests (e.g., MMPI-2, Strong Interest Inventory) in the context of clients' strengths.

38. Asking clients about all of the domains in their lives in which they excel.
39. Working with clients' strengths to help them to view themselves as the agent of change.
40. Assessing clients' hope for the future.
41. Discussing clients' views of their psychological assets as a way to lead to new material.
42. Being sure to praise clients when they do good work in the session.
43. Encouraging realistic optimism in clients.
44. Working with the strengths of clients as a primary way to help prevent them from slipping into a relapse.
45. Making special effort to build on clients' healthy coping mechanisms.
46. Noticing the less obvious strengths of clients.
47. Asking my clients about their strengths in the area of work and/or school.
48. Questioning clients about their strengths during a mental status examination.
49. Basing my recommendations to clients on their strengths.
50. Focusing on clients' strengths to help them view their problems as more solvable.

**Appendix B: Factor Loadings of Deleted Items from the Inventory of
Therapist Work with Assets and Strengths**

Item	Factor		
	1	2	3
2. Asking clients what they feel are their greatest strengths.	.39	.32	.35
5. Finding client strengths within most client problems.	.50	.40	.09
8. Always taking clients strengths into consideration when making therapeutic interventions.	.55	.54	.03
11. Questioning clients about their psychological assets during an initial interview.	.08	.32	.18
22. Using interventions that focus on the positive changes clients have made in therapy	.14	.19	.24
24. Building on clients' strengths as a way to increase their quality of life.	.64	.45	.19
31. Calling attention to the confidence clients have gained since beginning therapy.	.41	.66	.19
32. Using therapeutic interventions that take into account the strengths of clients.	.50	.58	.09
34. Focusing on strengths as a way to increase clients' hope.	.61	.25	.42
36. Reframing what appears to be a client weakness as a once-appropriate strength that made sense in an earlier context.	.38	.27	.12
40. Assessing clients' hope for the future.	.22	.36	.31
46. Noticing the less obvious strengths of clients.	.49	.52	.06
49. Basing my recommendations to clients on their strengths.	.45	.49	.27

Appendix C: Philosophies of Human Nature

Instructions: Here is a series of attitude statements. Each represents a commonly held opinion and there are no right or wrong answers. You will probably disagree with some of the items and disagree with others. We are interested in the extent to which you agree or disagree with such matters of opinion.

Read each statement carefully. Then indicate the extent to which you agree or disagree by circling the number in front of each statement. The numbers and their meaning are indicated below:

- If you agree strongly, circle +3
- If you agree somewhat, circle +2
- If you agree slightly, circle +1
- If you disagree slightly, circle -1
- If you disagree somewhat, circle -2
- If you disagree strongly, circle -3

First impressions are usually best in such matters. Read each statement, decide if you agree or disagree and the strength of your opinion, and record your response, using the above scale. *Be sure to answer every statement.*

If you find that the numbers to be used in answering do not adequately indicate your own opinion use the one that is closest to the way you feel.

-3	-2	-1	+1	+2	+3
DISAGREE STRONGLY	DISAGREE SOMEWHAT	DISAGREE SLIGHTLY	AGREE SLIGHTLY	AGREE SOMEWHAT	AGREE STRONGLY

1. Great successes in life, like great artists and inventors, are usually motivated by forces they are unaware of.
2. Most students will tell an instructor when he or she had made a mistake in adding up their score, even if the instructor had given them *more* points than they deserved.
3. Most people will change the opinion they express as a result of an onslaught of criticism, even though they really don't change the way they feel.
4. Most people try to apply the Golden rule even in today's complex society.
5. Our success in life is pretty much determined by forces outside our own control.
6. If you give the average person a job to do and leave him to do it, he will finish it successfully.

7. Nowadays many people won't make a move until they find out what other people think.
8. Most people do not hesitate to go out of their way to help someone in trouble.
9. Attempts to understand ourselves are usually futile.
10. People usually tell the truth, even when they know they would be better off by lying.
11. The important thing in being successful nowadays is not how hard you work but how well you fit in the crowd.
12. Most people will act as "Good Samaritans" if given the opportunity.
13. There's little one can do to alter his fate in life.
14. Most students do not cheat when taking an exam.
15. The typical students will cheat on a test when everybody else does, even though he has a set of ethical standards.
16. "Do unto others as you would have them do unto you" is a motto that most people follow.
17. Most people have little influence over the things that happen to them.
18. Most people are basically honest.
19. It's a rare person who will go against the crowd.
20. The typical person is sincerely concerned about the problems of others.
21. Most people have an unrealistically favorable view of their own capabilities.
22. If you act in good faith with people, almost all of them will reciprocate with fairness toward you.
23. Most people have to rely on someone else to make their important decisions for them.
24. Most people with fallout shelters would let their neighbors stay in them during a nuclear attack.
25. Most people vote for a political candidate on the basis of unimportant characteristics, such as his appearance or name, rather than on the basis of his stand on the issues.

26. Most people lead clean, decent lives.
27. The average person will rarely express his opinion in a group when he sees that others disagree with him.
28. Most people will stop and help a person whose car is disabled.
29. If a person tries hard enough, he will usually reach his goals in life.
30. People claim that they have ethical standards regarding honesty and morality, but few people stick to them when the chips are down.
31. Most people have the courage of their convictions.
32. The average person is conceited.
33. The average person has an accurate understanding of the reasons for his behavior.
34. If you want people to do a job right, you should explain things to them in great detail and supervise them closely.
35. Most people can make their own decisions, uninfluenced by public opinion.
36. It's only a rare person who would risk his own life and limb to help someone else.
37. If people try hard enough, wars could be prevented in the future.
38. If most people could get into a movie without paying and be sure that they were not seen, they would do it.
39. It is achievement, rather than popularity with others, that gets you ahead nowadays.
40. It's pathetic to see an unselfish person in today's world, because so many people take advantage of him.
41. The average person is largely the master of his own fate.
42. Most people are not really honest for a desirable reason, they're afraid of getting caught.
43. The average person will stick to his opinion if he thinks he's right, even if others disagree.
44. People pretend to care more about one another than they really do.

45. In a local or national election, most people select a candidate rationally and logically.
46. Most people would tell a lie if they could gain by it.
47. If a student does not believe in cheating, he will avoid it even if he sees many others doing it.
48. Most people inwardly dislike putting themselves out to help other people.
49. Most persons have a lot of control over what happens to them in life.
50. Most people would cheat on their income tax if they had a chance.
51. The person with novel ideas is respected in our society.
52. Most people exaggerate their troubles in order to get sympathy.
53. Most people have a good idea of what their strengths and weaknesses are.
54. Nowadays people commit a lot of crimes and sins that no one else ever hears about.
55. Most people will speak out for what they believe in.
56. People are usually out for their own good.

Appendix D: World Assumptions Scale

Instructions: Use the scale below to answer how much you agree or disagree with the following statements:

1	2	3	4	5	6
DISAGREE	DISAGREE	DISAGREE	AGREE	AGREE	AGREE
STRONGLY	SOMEWHAT	SLIGHTLY	SLIGHTLY	SOMEWHAT	STRONGLY

1. People are naturally unfriendly and unkind
2. Human nature is basically good.
3. The good things that happen in this world far outnumber the bad.
4. There is more good than evil in the world.
5. People don't really care what happens to the next person
6. The world is a good place
7. People are basically kind and helpful.
8. If you look closely enough, you will see the world is full of goodness.

Appendix E: Survey of Cynicism

Instructions: Here are some statements about how you may or may not feel about other people. Please circle the number below each statement to show how much you agree or disagree with the statement. A “1” means you *strongly agree* with the statement and a “4” means you *strongly disagree* with it. You may circle any number from 1 to 4.

1	2	3	4
DISAGREE STRONGLY	DISAGREE SLIGHTLY	AGREE SLIGHTLY	AGREE STRONGLY

How much do you agree that . . . ?

1. Most people will tell a lie if they can gain by it.
2. People will claim to have ethical standards regarding honesty and morality, but few stick to them when money is at stake.
3. People pretend to care more about another than they really do.
4. It's pathetic to see an unselfish person in today's world because so many people take advantage of him or her.
5. Most people are just out for themselves.
6. Most people inwardly dislike putting themselves out to help other people.
7. Most people are not really honest by nature.

Appendix F: Life Orientation Test - Revised

Instructions: Use the scale below to answer how much you agree or disagree with the following statements:

1	2	3	4	5
DISAGREE		NEUTRAL		AGREE
STRONGLY				STRONGLY

1. In uncertain times, I usually expect the best.
2. It's easy for me to relax.
3. If something can go wrong for me it will.
4. I'm optimistic about my future.
5. I enjoy my friends a lot.
6. It's important for me to keep busy.
7. I hardly ever expect things to go my way.
8. I don't get upset too easily.
9. I rarely count on good things happening to me.
10. Overall, I expect more good things to happen to me than bad.

Appendix G: Self-Consciousness Scale

Instructions: Use the scale below to answer how characteristic you feel the following statements are of yourself:

1	2	3	4
EXTREMELY UNCHARACTERISTIC	SOMEWHAT UNCHARACTERISTIC	SOMEWHAT CHARACTERISTIC	EXTREMELY CHARACTERISTIC

1. I'm concerned about my style of doing things.
2. I'm concerned about the way I present myself.
3. I'm self-conscious about the way I look.
4. I usually worry about making a good impression.
5. One of the last things I do before I leave my house is look in the mirror.
6. I'm concerned about what other people think of me.
7. I'm usually aware of my appearance.

Appendix H: Work with Strengths of Most Recent Client Likert Scale

Instructions: For the following questions, take a moment to think about your *most recent session with your most recent client*. These questions will refer to your work with that particular client. First, write the first name or initials of your most recent client below to help remind you of your last session with this client. Then, circle a number from 1 to 9 for the following questions.

1	2	3	4	5	6	7	8	9
DISAGREE								AGREE
STRONGLY								STRONGLY

The first name or initials of my most recent client is _____.

1. In my most recent session with the above client, I used several interventions that took into account the client's strengths.
2. I questioned the above client about his/her strengths in my most recent session.
3. I worked with many strengths of the above client in my most recent session.
4. In my most recent session with the above client, I asked about the domains in his/her life in which he/she does well.

Appendix J: Demographic Form

- 1) Gender: Female Male
- 2) Age: _____
- 3) Race/Ethnicity:

<input type="checkbox"/> African-American	<input type="checkbox"/> Hispanic/Latino
<input type="checkbox"/> Asian/Pacific Islander	<input type="checkbox"/> Middle Eastern
<input type="checkbox"/> Biracial/Multiracial (Please specify: _____)	<input type="checkbox"/> Native American
<input type="checkbox"/> European American/Caucasian	<input type="checkbox"/> Other (Please specify: _____)
- 4) Highest degree held (e.g., BS, Psy.D., LCSW, MA in Counseling, Ph.D., etc.)

- 5) Year in current graduate program: _____ (If not in graduate school, check here)
- 6) Type of current/last attended graduate program (e.g., Masters in Social Work, Ph.D. in Clinical Psychology, etc.) _____
- 7) If not in graduate school:

Number of years since completing your last graduate degree _____

Number of years of clinical experience after graduate school _____
- 8) Using a 5-point scale, where 5 = very high belief, rate how much you believe in and adhere to the techniques of:

Psychoanalytic/Psychodynamic Therapy

Experiential/Humanistic/Existential Therapy

Behavioral/Cognitive Behavioral Therapy

Multicultural/Feminist Therapy
- 9) Please write in your theoretical orientation:

- 10) Estimated number of clients seen in past 12 months _____
- 11) Would you like to receive a summary of our research findings? YES NO

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