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ABSTRACT

The primary purpose of this study was to test the hypothesis that Hope Scale scores would play a significant role in predicting the effectiveness of a five-session career planning workshop for 61 adults. The results of three hierarchical regressions suggest that the trait hope does not play a significant role in predicting participants' career decidedness, career decision-making self-efficacy, or vocational identity after completing the workshop. Second, this study's purpose was also to investigate the effectiveness of this five-session career planning workshop for adults. Repeated measures, single sample t-tests were performed. Significant change scores were found on four of the five repeated measures including pre- to post-treatment scores on career decidedness, vocational identity, career decision-making self efficacy, and state hope. Only work hope scores did not change significantly from pre- to post-treatment. Results suggest that while the participants in this workshop changed significantly from pre- to post-workshop, trait hope did not play a significant role in the participants' outcome. (Contains 148 references.) (Author/VWC)

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THE ROLE OF HOPE IN AN ADULT CAREER DECISION MAKING WORKSHOP

By

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B.A., University of Tulsa, 1994

Submitted to the Department of Psychology and Research in Education and the
Faculty of the Graduate School at The University of Kansas in partial fulfillment
of the requirements for the degree of Doctor of Philosophy.

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ABSTRACT

The primary purpose of the present study was to test the hypothesis that Hope Scale scores played a significant role in predicting the effectiveness of a five session career planning workshop for 61 adults. The results of three hierarchical regressions suggest that trait hope does not play a significant role in predicting participants' career decidedness, career decision-making self efficacy, or vocational identity after completing the workshop. Secondly, this study's purpose was to investigate the effectiveness of this five session career planning workshop for adults. Repeated measures, single sample t-tests were performed. Significant change scores were found on four of the five repeated measures including pre- to post-treatment scores on career decidedness, vocational identity, career decision-making self efficacy, and state hope. Only work hope scores did not change significantly from pre- to post-treatment. Results suggest that while the participants in this workshop changed significantly from pre- to post-workshop, trait hope did not play a significant role in the participants' outcome.

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CHAPTER 1

Introduction

Few things in life hold more meaning or importance for people than work. It is more than simply a means to a paycheck. Work is central to a person's identity and self-esteem. Unfortunately, few choices in life are as difficult as choosing a satisfying career. Financial considerations, the expectations of significant others, and the rapidly changing and unstable world of work impede the career decision-making process. Compounding matters further, society expects initial career choices to be made by age 20, before many young people have had enough time to discover who they are and adequately explore the world of work. In the face of such challenges, it is understandable that as many as 8 out of 10 Americans are dissatisfied in their present careers (Bolles, 1998). For almost a century, the field of vocational psychology has successfully helped individuals to find and maintain satisfying careers. Numerous career interventions exist including: individual and group career counseling, short-term workshops, semester long undergraduate career planning classes, and computerized career guidance interventions. Outcome studies over the last half of this century have convincingly documented that career interventions work (Whiston, Sexton, & Lasoff, 1998).

Introduced almost 50 years ago, career planning workshops and classes are currently the most utilized, researched, cost efficient, and time efficient of all career counseling interventions (Whiston, Sexton & Lasoff, 1998). With overall effectiveness of career decision-making interventions well established, researchers have ceased asking “Does career counseling work?” (Rounds & Tinsley, 1984). Instead, assuming that the highest limits of effectiveness have yet to be reached, researchers have called for investigations to determine what interventions work best for whom (Fretz, 1981). Specifically, career planning intervention outcome studies should seek to identify client attributes which significantly impact the outcome of career interventions (Osipow & Betz, 1991). Such investigations have been termed attribute-treatment interaction (ATI) studies because they seek to understand the relationship between certain client attributes and treatment outcome.

Despite a half century of researchers calling for ATI studies, few such studies have been conducted (Whiston, Sexton, & Lasoff, 1998). Only a handful of client characteristics have been studied, and they include anxiety, locus of control, self concept, goal instability, and decision-making style (Whiston, Sexton, & Lasoff, 1998). To date, ATI studies have suggested that matching clients’ social orientation or goal directedness to treatment format may increase the effectiveness of career counseling interventions (Kivlighan, Hageseth, Tipton,

& McGovern, 1981; Robbins & Tucker, 1986), and that clients' career decision-making self efficacy may predict vocational exploratory behaviors (Bluestein, 1989a). Snyder's, (1989) concept of hope appears to be a logical next step in career planning intervention ATI research. Snyder and colleagues' (1991) definition of hope incorporates an individual's directedness and general self-efficacy toward accomplishing life goals.

Although it dates back to Greek mythology, the concept of hope has only recently been specifically defined and measured. Considered by early psychology researchers as the "positive expectation for goal attainment," Snyder's (1989) more recent definition proposes that there are two major ingredients to hope. First, the agency component is a sense of energy or determination to achieve one's goals. Second, the pathways component involves the perceived ability to plan and overcome barriers en route to one's goals.

Hope impacts the way that people view and interpret situations in their lives. High-hope people view stressful situations as challenges and opportunities for growth and success. On the other hand, low-hope people view goals as insurmountable obstacles and opportunities for certain failure. As a result, high-hope people set more goals, more difficult goals, and have goals across a greater number of life arenas (work, family, leisure) (Snyder, 1994a). In fact, hope has been shown to be extremely valuable for athletes, students, trauma sufferers, and

for people in general. Hope, rather than core mental or physical abilities or talents, significantly predicts outcomes in a large number of diverse life situations. In almost all situations, people with high hope out-perform their low-hope counterparts (Snyder, 1994a).

Significance of Study

From the first job out of school to the 5-7 career changes throughout a career, individuals express interest in and pursue many career and life goals. Because goal setting plays such a pivotal role in career development throughout the life span, understanding the role of hope is essential to understanding career development and implementing career decision-making interventions. People lower in hope probably have more barriers and issues to overcome when deciding on a career. As a result, they may require more intensive and closely supervised interventions than individuals higher in hope who may even benefit from a self-directed intervention format. In addition, while it would be a strength of high-hope individuals, people low in hope may require extensive discussions of goal-setting, decision-making, and overcoming barriers to career planning. Nonetheless, the role of hope in career decision-making has remained unexplored by personality researchers and career counseling practitioners and researchers. This may be due to the fact that, until recently, a theoretical model of hope and an associated standardized measurement were not available. Accordingly, the present

study provided an initial investigation of the role of hope in the career development and goal-setting of adults in a career decision-making workshop offered at a suburban community college.

This intervention targets adults, which is a population that has been historically underserved by career interventions and outcome studies (Whiston, Sexton, & Lasoff, 1998). The vast majority of career interventions and outcome research target high school and college populations. However, many adults require and seek career planning assistance as they voluntarily or involuntarily face a career transition (Arbeiter, Aslanian, Schmerbeck, & Brickell, 1978). The importance of studying adult populations is increased by findings which suggest that older participants may have greater decision-making difficulty, receive less help from interventions, and face more barriers to deciding on a career (Krumboltz, 1979; McAuliffe & Fredrickson, 1990). While research on adults has increased slightly in the last decade, still little is known about the treatment formats that are most effective for adult populations (Whiston, Sexton, & Lasoff, 1998).

In addition, this study utilizes a voluntary client population in response to Oliver and Spokane's (1988) call for more career intervention outcome research on actual clients who are seeking treatment.

Outcome measures most frequently involve career decidedness, career maturity, and/or vocational identity (Spokane & Oliver, 1988). However, self-concept, locus of control, and anxiety have also been used in a small number of studies as additional outcome measures (Spokane & Oliver, 1983). Therefore, domain specific work hope as measured by the Domain Specific Work Hope Scale (Simpson, et al., 1997) as an outcome appears to be a relevant adjustment variable that may be meaningful to study.

The present study aims to assess the relationship between participants' hope and their outcome from a career decision-making workshop. The population consists of adults in a career transition who are seeking career assistance at a suburban community college. The impact of the workshop on vocational identity, career decidedness, career decision-making self-efficacy, state hope, and domain specific work hope also were explored.

Purpose of Study

The current study responds to many researchers' calls to investigate the relationship between specific client attributes and outcome from a career decision-making intervention. Specifically, this study investigated the relationship of an individual's pre-treatment level of hope on his/her career decidedness, career decision-making self-efficacy, and vocational identity after participating in a short-term career decision-making workshop. In addition, this study also follows

the call for more career intervention outcome research on adult populations and for the study of actual client populations.

To accomplish these goals, participants' levels of dispositional hope, state hope, and domain specific work hope, career decision-making self efficacy, career decidedness, and vocational identity, were assessed at the beginning of the first session. State hope was assessed again at the end of the first session and at the end of the third session. Then, at the conclusion of session 5, the participants' levels of state hope, domain specific work hope, career decision-making self efficacy, career decidedness, and vocational identity again were measured.

Career decidedness was measured by a single item which states, "I am entirely certain of what career to pursue" (1-Definitely False, 2-Mostly False, 3-Somewhat False, 4-Slightly False, 5-Slightly True, 6-Somewhat True, 7-Mostly True, 8-Definitely True). Vocational identity was measured by Holland et al.'s (1980) Vocational Identity Scale from My Vocational Situation which assesses the clarity and stability of a person's understanding of his/her goals, interests, personality, and talents. Career decision-making self-efficacy was measured by the Career Decision-Making Self Efficacy Scale - Short Form (Taylor & Betz, 1983). The Hope Scale (Snyder et al., 1991) measures one's dispositional drive and energy toward accomplishing goals and the perception of one's ability to generate methods to overcome obstacles in order to achieve goals. The State Hope

Scale (Snyder, Sympson, et al., 1996) assesses one's "here and now" hope, and the Domain Specific Hope Scale (Sympson, 1997) measures one's hope specifically regarding work.

Question #1: At the end of the career decision-making workshop, adults with pre-treatment high-hope scores, ranging from 50 to 64 on the Hope Scale (Snyder et al., 1991), will exhibit significantly greater change scores on career decidedness, as measured by a decidedness item.

Null hypothesis #1: At the end of the career decision-making workshop, adults with pre-treatment high-hope scores, ranging from 50 to 64 on the Hope Scale (Snyder et al., 1991) versus those with pre-treatment low-hope scores, ranging from 8-46 on the Hope Scale (Snyder et al., 1991), will show no greater change scores on career decidedness, as measured by a decidedness item.

Question #2: At the end of the career decision-making workshop, adults with pre-treatment high-hope scores, ranging from 50 to 64 on the Hope Scale (Snyder et al., 1991), will exhibit significantly greater change scores on career decision-making self-efficacy, as measured by the Career Decision-Making Self Efficacy Scale - Short Form (Betz et al., 1996).

Null hypothesis #2: At the end of the career decision-making workshop, adults with pre-treatment high-hope scores, ranging from 50 to 64 on the Hope Scale (Snyder et al., 1991) versus those with pre-treatment low-hope scores,

ranging from 8-46 on the Hope Scale (Snyder et al., 1991), will show no greater change scores on career decision-making self-efficacy, as measured by the Career Decision-Making Self Efficacy Scale - Short Form (Betz et al., 1996).

Question #3: At the end of the career decision-making workshop, adults with pre-treatment high-hope scores, ranging from 50 to 64 on the Hope Scale (Snyder et al., 1991), will exhibit significantly greater change scores on Vocational Identity, as measured by the Vocational Identity Scale of My Vocational Situation (Holland et al., 1980a).

Null hypothesis #3: At the end of the career decision-making workshop, adults with pre-treatment high-hope scores, ranging from 50 to 64 on the Hope Scale (Snyder et al., 1991) versus those with pre-treatment low-hope scores, ranging from 8-46 on the Hope Scale (Snyder et al., 1991), will show no greater change scores on Vocational Identity, as measured by the Vocational Identity Scale of My Vocational Situation (Holland et al., 1980a).

Question #4: All participants in the career decision-making workshop will exhibit significant pre-treatment to post-treatment change scores in career decidedness, as measured by a decidedness item.

Null hypothesis #4: From pre-treatment to post-treatment, participants will exhibit no significant change scores in career decidedness, as measured by a decidedness item.

Question #5: All participants in the career decision-making workshop will exhibit significant pre-treatment to post-treatment change scores in career decision-making self efficacy, as measured by the Career Decision-Making Self Efficacy Scale - Short Form (Betz et al., 1996).

Null hypothesis #5: From pre-treatment to post-treatment, participants will exhibit no significant change scores in career decision-making self efficacy, as measured by the Career Decision-Making Self Efficacy Scale - Short Form (Betz et al., 1996).

Question #6: All participants in the career decision-making workshop will exhibit significant pre-treatment to post-treatment change scores in Vocational Identity, as measured by the Vocational Identity Scale of My Vocational Situation (Holland et al., 1980a).

Null hypothesis #6: From pre-treatment to post-treatment, participants will exhibit no significant change scores in Vocational Identity, as measured by the Vocational Identity Scale of My Vocational Situation (Holland et al., 1980a).

Question #7: All participants in the career decision-making workshop will exhibit significant pre-treatment to post-treatment change scores in state hope, as measured by The State Hope Scale (Snyder, Sympson et al., 1996).

Null hypothesis #7: From pre-treatment to post-treatment, participants will exhibit no significant change scores in state hope, as measured by the State Hope Scale (Snyder, Sympson et al., 1996).

Question #8: All participants in the career decision-making workshop will exhibit significant pre-treatment to post-treatment change scores in domain specific work hope, as measured by the work subscale of the Domain Specific Hope Scale (Sympson, 1997).

Null hypothesis #8: From pre-treatment to post-treatment, participants will exhibit no significant change scores in domain specific work hope, as measured by the work subscale of the Domain Specific Hope Scale (Sympson, 1997).

CHAPTER 2

Review of Literature

History of Career Interventions and Outcome Research

While specific effectiveness may vary, decades of research have demonstrated that career interventions have beneficial outcomes for their participants (Babcock & Kaufman, 1976; Barker, 1979; Bartsch & Hackett, 1979; Davidshofer, Thomas, & Preble, 1976; Fretz, 1981; Gonyea, 1962; Holland, Magoon, & Spokane, 1981; Krivatsy & Magoon, 1976; Krumboltz, Becker-Haven, & Burnett, 1979; Myers, 1971, 1986; Oliver & Spokane, 1988; Rounds & Tinsley, 1984; Schenck, Johnson, & Jacobsen, 1979; Spokane & Oliver, 1983; Whiston, Sexton, & Lasoff, 1998). The average treated individual is better off on the outcome measures than 66-80% of the untreated control group participants (Oliver and Spokane, 1988; Spokane and Oliver, 1983). As a result of such overwhelming and consistent evidence, Fitzgerald and Rounds (1989) suggest, "Any type of career counseling intervention has a moderate to strong effect on any type of client measured by any type of outcome (p. 122). Therefore, the question, "Does career counseling work?" is no longer asked (Rounds & Tinsley, 1984).

Group career interventions emerged in the 1950s along with the advent of counseling group procedures (Davis & Horne, 1986). Ranging from one session workshops to 3 credit hour college courses, career workshops are currently offered

by 83.7% of colleges and universities (Collins, 1998). Group interventions remain a primary means of providing career assistance to greater numbers of clients (Collins, 1998; Holland, Magoon & Spokane, 1981) and are the most frequently studied career intervention format (Whiston, Sexton & Lasoff, 1998). Although not the most potent treatment (Whiston, Sexton, & Lasoff, 1998), groups are the most cost-effective career intervention (Oliver & Spokane, 1988; Whiston, Sexton, & Lasoff, 1998). In addition, some evidence suggests that classes and workshops actually produce better treatment outcomes than individual career counseling (Fretz, 1981; Rounds & Tinsley, 1984; Spokane & Oliver, 1983). However, these findings may simply result from the greater amount of time in treatment (Oliver & Spokane, 1988).

Career interventions appear to work for a variety of age groups across the life span from high school students to adult populations (Whiston, Sexton, & Lasoff, 1998). However, few suppose that the highest limits of the effectiveness of career interventions have been reached. General effectiveness may signify that interventions only work for specific populations or what Fretz (1981) termed a “great impact for some but nothing for others” (p. 77). Research has not supported the idea that the same career intervention works equally well for all types of clients. Therefore, career planning interventions must be based on the understanding that career indecision is not a unidimensional construct (Fretz,

1981; Hartman, Fuqua, and Jenkins, 1986), is more complex than the degree of a person's decidedness (Jones, 1989), and there are multiple reasons for being undecided and therefore seeking career counseling (Appel, Haak, & Witzke, 1970; Holland & Holland, 1977; Jones & Chenery, 1980; Kinnier et al., 1990; Lucas & Epperson, 1990).

Attribute Treatment Interaction Studies

Based on findings that all treatments are not equally effective for all career clients, research on career counseling should aim to further the understanding of what treatments work best with whom and under what conditions (Fretz, 1981; Rounds & Tinsley, 1984; Osipow & Betz, 1991; Savickas, 1989). This goal for career counseling outcome literature was first put forth over a half century ago (Williamson & Bordin, 1941). In the decades since, many have called for investigations of the specific client attributes that affect the efficacy of treatments (Fretz, 1981; Holland, Magoon & Spokane, 1981; Kivlighan, 1990; McAuliffe, 1991; Rounds & Tinsley, 1984; Spokane & Oliver, 1983; Whiston, Sexton, & Lasoff, 1998). To do this, the individual variables that account for differential treatment effectiveness must be examined (Osipow & Betz, 1991). These variables include (a) demographic variables of gender, race, and age; (b) psychological variables such as intelligence, need for achievement, self confidence, defensiveness, and personality types (e.g., Holland's themes or the

Myers-Briggs types); and (c) career-related variables including career maturity, type of undecidedness, career decision-making style, and motivation for treatment (Fretz, 1981). Client attributes can have an important role in the outcomes of career interventions (Fretz, 1981). Matching treatments to personality types may increase client gains (Barak & Friedkes, 1981; Kivlighan, et al., 1981).

Despite 50 years of writers calling for attribute x treatment interaction (ATI) studies, Whiston, Sexton, and Lasoff (1998) found few studies that examined ATIs. Only a limited range of client characteristics have been investigated, therefore demanding more research on the relationship of client attributes to career intervention outcome and treatment choice (Kivlighan, 1990). Client-treatment interactions are especially important in career workshops and courses because they are so widely used and reach such a large number of career counseling clients.

In ATI studies, the most frequently researched variables include anxiety, locus of control, and self-concept (Pickering & Vacc, 1984). In addition, various researchers have analyzed the moderating influences of sociability (Kivlighan, Hageseth, Tipton, & McGovern, 1981), self-esteem (Zager, 1982), goal instability (Robbins & Tucker, 1986), and decisional style (Krumboltz, Kinnier, Rude, Scherba, and Hamel, 1986) on career intervention outcome in group and workshop treatments. Kivlighan, Hageseth, Tipton, and McGovern (1981) found

that matching treatment type to client personality type (interactional treatment for socially oriented clients and individual problem solving treatment for non-socially oriented clients) increased the effectiveness of the counseling approaches. Barak and Friedkes (1981) found that indecision subtypes significantly impacted the effectiveness of a career intervention. Clients who lack structure have been shown to gain the most from treatment while those who perceive an external barrier and experience personal conflict gain the least from treatment (Barak & Friedkes, 1981). Utilizing the Goal Instability Scale (GIS; Robbins & Patton, 1985), McAuliffe (1990) suggested self-worth building and supportive counseling practices be used with people high in goal instability to help those rethink their negative assumptions about themselves. High-scorers on the GIS report difficulty accomplishing goals and lacking the energy to complete projects. Following such findings, Snyder et al.'s, (1989) Hope Scale logically fits as a follow-up trait measure to examine ATIs.

Numerous studies have looked at goal-directedness and its impact on career counseling outcomes. Utilizing the Goal Instability Scale (GIS; Robbins & Patton, 1985), people with highly unstable goals were found to perform better in interactional career planning workshops than in self-directed career workshops (Robbins & Tucker, 1986). People high in goal instability were found to have lowered self-esteem and an inability to make a career decision after participating

in information centered career interventions (Robbins & Tucker, 1986). Goal instability has been used to predict performance in learning skills classes as well as personal/emotional and academic adjustment of college freshman before and after their first year (Scott & Robbins, 1985; Robbins & Schwitzer, 1985). Goal instability research suggests that a lack of orienting goals inhibits the ability to utilize traditional information-based instruction in a career development workshop. This may result from people with high goal instability finding it difficult to participate in the career development process without the support of others who may provide the energy and direction for success. On the other hand, it is suggested that those with low goal instability have the inner direction and energy to formulate and pursue career objectives without others' support (Robbins & Tucker, 1986). Along similar lines, an individual's career decision-making self-efficacy (confidence and competence in one's ability to make successful career decisions) was found to significantly impact vocational exploratory behaviors (Blustein, 1989b).

Oliver and Spokane (1988) questioned whether individuals with poor sociability or goal instability may fare better from more intense or structured interventions. In fact, the same may be said for the construct of hope. The Hope Scale may be a useful instrument in determining which participants were responsive to what type of treatment intervention. The Domain Specific Work

Hope Scale (Snyder, 1997) may also be a useful outcome measure from treatments.

Adults in Career Transition

ATI studies are particularly needed with adult populations who are experiencing a voluntary or involuntary career transition. Career indecision is a pervasive issue that not only affects high school students (Hartman & Hartman, 1982; Prediger & Sawyer, 1986), and college students (Carney, Savitz, & Weiskott, 1979; Fuqua & Hartman, 1983a, 1983b; Hartman & Fuqua, 1982). It impacts adults as well (Arbeiter, Aslanian, Schmerbeck, & Brickell, 1978). According to Arbeiter, Aslanian, Schmerbeck, and Brickell (1978), 36% of adult Americans are in the career transition process. Their problems include preparing for and entering a career, adjustment once on the job, feeling underemployed, adapting to the organization, career change at mid-life, work productivity, and retirement (Arbeiter, Aslanian, Schmerbeck, & Brickell, 1978).

Studies suggest older participants in career workshops may have greater difficulty with decision making (Krumboltz, 1979; McAuliffe & Fredrickson, 1990). In two studies, participants over 25 years old received less aid from the career intervention than younger participants (Krumboltz, 1979; McAuliffe & Fredrickson, 1990). If older clients do in fact encounter greater difficulties in

deciding on a career, research needs to explore why that is and modify treatments appropriately.

Despite the large numbers of adults who are in a career transition and the unique difficulties which they face, few career interventions have targeted older individuals (Haney & Howland, 1978; Whiston, Sexton, & Lasoff, 1998). Most career counseling takes place at educational institutions thereby over-serving younger populations (Osipow & Betz, 1991). While research on adult populations has increased slightly since 1983, still little is known about the types of treatments that are effective for adult populations (Oliver & Spokane, 1988; Whiston, Sexton, & Lasoff, 1998). To this point, 75% of outcome studies have been performed on college-age students or high school-age subjects (Osipow & Betz, 1991). Given demographic changes in America's workforce, this is an important area for investigation. Osipow (1982) and Whiston, Sexton, and Lasoff (1998) suggest more attention should be paid to career interventions with adults. In fact, McAuliffe and Fredrickson (1991), found those participants over 24 years of age scored lower on pre-test decision-making skills, actual plans, and posttest satisfaction with occupational plans. Older career counseling clients may have more difficulty with career decision making than younger clients (McAuliffe & Fredrickson, 1991). This may be due to several reasons. First, older clients who enroll in career workshops may have more "chronic" indecision than younger

clients. Second, older clients may have more negative self-attitudes in regards to being undecided and unsatisfied at a later age, thereby experiencing an underlying psychological characteristic that may limit the career planning process (McAuliffe & Fredrickson, 1990). If so, group career interventions should assess individual attitudes, levels of information, and decision-making skills prior to treatment (McAuliffe & Fredrickson, 1990). Career interventions for individuals at different life stages must vary according to life stage and context of decisions to be made (Osipow & Betz, 1991).

History of Hope

While a detailed history of the concept of hope is beyond the scope of the current study, the evolution of Snyder's, (1989) definition of hope will be highlighted. The concept of hope was first elaborated in the myth of Pandora of Greek mythology. Ever since, although some see hope as good and others see it as bad, writers appear to agree that hope is definitely important (Snyder, Irving, & Anderson, 1991). Modern writers share the view that foolish hope, defined as positive expectations not grounded in sound judgment, is negative. On the other hand, genuine hope, defined as positive expectations related to goal directed energy and plans, is very productive (Snyder, Irving, & Anderson, 1991). However, finding a clear distinction between when hope is foolish and when it is not has been difficult.

While holistic medicine practitioners accept “hope cures” as genuine due to no distinction between the mental and bodily states, the traditional medical community historically regarded “hope cures” as placebo effects, or ingenuine treatment effects. The last several decades, however, has seen a growing list of practitioners argue that hope and positive emotions are essential to all types of healing or treatment, and therefore should be targeted in order to enhance treatment effects (Ader, 1981; Frank, 1968, 1973, 1975; Locke & Colligan, 1986; Menninger, 1959; Miller, Duncan & Hubble, 1997; Pelletier, 1979; Siegel, 1986; Simonton, Matthews-Simonton, & Creighton, 1978).

Throughout the 1950s and 1960s, hope, defined as a “positive expectation for goal attainment” received a great deal of attention by psychotherapy researchers (Frank, 1968; Frankl, 1963; Melges & Bowlby, 1969; Menninger, 1959; Schachtel, 1959; Cantril, 1964; Farber, 1968; Mowrer, 1960; Stotland, 1969). Despite promising findings from this research, it was followed by a decade of lack of interest. Research on stress, coping, and illness revived interest in hope in the mid-1970s (Snyder, Irving, & Anderson, 1991). Based on research suggesting that negative thoughts and emotions adversely impact recovery from illness and general well-being, scientists sought to prove that positive processes, like hope, might promote well-being. As a result, a number of studies

demonstrated that positive self-evaluations and perceptions of control or mastery promote psychological and physical well-being (Snyder, 1989; Taylor, 1983).

Recently, many researchers have ceased viewing hope as a loose, philosophical notion that is impossible to measure (Snyder, 1994a). In opposition to historical views of hope as a counterproductive concept, coping and performance research has demonstrated that elevated levels of hope are quite adaptive (Snyder, 1994a).

Several theoretical constructions of hope have resulted from such research. Some have speculated that hope is a unidimensional construct involving a general perception that goals can be met (Cantril, 1964; Erickson, Post, & Paige, 1975; Farber, 1968; Frank, 1968; Frankl, 1963; French, 1952; Gottschalk, 1974; Lewin, 1938; Melges & Bowlby, 1969; Menninger, 1959; Mowrer, 1960; Schachtel, 1959; Stotland, 1969). Accordingly, behavior can be explained by simply looking at expectancies for goal attainment. Physically and mentally healthy individuals will exhibit favorable expectancies (Erickson, Post, & Paige, 1975; Gottschalk, 1974; Melges & Bowlby, 1969). The predictive value of such theories is weakened by ignoring the strategies that people utilize to attain goals (Lee, Locke, & Latham, 1989). For the purposes of this study, the view of hope proposed by Snyder and colleagues (Snyder, 1989; Snyder et al., 1991) will be utilized.

Snyder's Definition of Hope

Snyder's (1989) theory of hope emphasizes both "the individual's desires and the strategies by which those desires are met" (Snyder, Irving, & Anderson, 1991, p. 287). Snyder and his colleagues (Snyder, 1989; Snyder et al., 1991) propose that there are two major, interrelated ingredients in hope. First, hope is "fueled by a sense of successful goal directed determination (the agency component)" (Snyder, Irving, & Anderson, 1991, p. 287). Second, hope includes a "successful sense of planning to meet one's goals (the pathways component)." (Snyder, Irving, & Anderson, 1991, p. 287). In other words, hope equals a positive motivational state based on both a sense of successful goal directed energy (agency) and planning to meet one's goals (pathways) (Snyder, Irving & Anderson, 1991).

The agency component consists of the cognitive willpower, determination, and energy to move toward one's goals or an individual's perceived ability to begin and continue movement toward a chosen goal. Agency also may be viewed as the determination to meet personal goals and the energy for the process of negotiation (Elliott, Witty, Herrick, & Hoffman, 1991). Agency, in part, is based on one's history of successfully seeking and attaining goals. In other words, agency taps one's sense of successful meeting of goals in the past, present, and future (Snyder, 1994a).

The pathways component involves the perceived ability to generate methods or avenues to accomplish one's goals. It reflects the person's perceived capacity to find a route or routes to reach a goal destination, or their perceived availability of methods to attain a goal (Babyak, Snyder, & Yoshinobu, 1993; Snyder, 1995b). Like agency, pathways thoughts are based, in part, on a history of successfully finding one or more methods of obtaining one's goals. Pathways thoughts are enhanced by success in finding new routes to goals once the original path is blocked. Individuals who are high in pathways thinking believe they can find multiple ways to reach goals (Snyder, 1994b).

More specifically, Snyder, Harris, et al., (1991, p. 571) define hope as a "cognitive set that is based on a reciprocally derived sense of successful (a) agency (goal-directed determination) and (b) pathways (planning of ways to meet goals). In other words, high hope reflects a mental combination of the perceived agency and pathways to reach our goals, even in the face of difficulties. Individuals with higher hope possess an elevated mental energy and pathways for their goals (Snyder, 1995b). In order for goal directed action to take place, both agency and pathways must be operating (Snyder, 1994a). Though they are not synonymous, the two ingredients of hope are reciprocal, additive, and positively related (Snyder et al., 1991).

Hope is not present when there is only one, either pathways or agentic thinking. Consider, for example, Person A who can think of many different ways to research career information, but who is not motivated to take advantage of such resources. Conversely, Person B may be highly motivated to explore career information, but may lack the means or methods by which to do so. In essence, a high-hope individual, or in this case, career planner, must have both pathways and agentic thought.

Stability of Hope

Snyder's (1989) model assumes that hope is stable across time and situations (Snyder, 1995a). Over intervals up to three months, scores remain relatively stable (correlation of .8) (Snyder et al., 1991). Hope appears to be an enduring pattern of viewing oneself in relation to one's life goals (Snyder, 1994b). Cross-sectional studies have not found differences in levels of hope across age groups ranging from their 20's to 40's (Langelle, 1989). While hope is quite stable for most people, there is some room for change in most people and considerable possibility for change in some people. Both naturally occurring and human-engineered events can move one's hope higher or lower (Snyder, 1994b). However, the key remains that hope is a relatively enduring characteristic established by age 20 (Snyder, 1994b). Hopeful thinking is not static, and there is a natural ebb and flow to it over time. Hope may wane after a loss or losses of

some meaning, and then increase following successes. Hope does not necessarily disappear, however, in difficult times. On the contrary, hope helps people through their lowest moments (Snyder, 1996).

Laboratory and applied research has demonstrated that positive changes in Hope Scale scores result in enhanced performances (Snyder, 1994a).

Manipulations or treatments which enhance goal-directed expectancies increase behaviors aimed at goal attainment (Snyder, 1994a). For example, individuals who benefit from psychotherapy are said to “have increased their sense of positive goal-related expectancies in their lives” (Snyder, 1994a, p. 538).

Based on Snyder and colleagues’ (Snyder, 1989; Snyder, et al., 1989) hope theory, the Hope Scale was constructed. Later research studies have suggested that Hope Scale scores predict goal-directed behaviors in six life arenas (Langelle, 1989) as well as responses related to agency and pathway behaviors in the face of obstacles (Yoshinobu, 1989). Higher hope has been found to be related to numerous positive outcomes related to goal setting, achievement, and coping with stressors.

Benefits of High Hope

High-hope people are more likely to interpret stressful situations as challenging rather than threatening (Snyder, Irving, & Anderson, 1991). In the face of adversity, individuals with high hope have been shown to use more

vigorous and diverse coping strategies including “rational action, perseverance, positive thinking, intellectual denial, restraint, self-adaptation, drawing strength from adversity, and humor” (Snyder, Irving, & Anderson, 1991, p. 293).

In viewing their personal goals, high-hope individuals have been found to focus more of their attention on the consequences of success and to estimate a greater chance of success than those with low hope (Anderson, 1988). They view goals as challenges to be conquered rather than as burdens (Snyder, 1994a). In addition, by expecting success, people may actually improve their chances of succeeding by promoting positive emotional states which are related to greater behavioral persistence and organized action (French, 1952; Greenwald, 1980; Lewinsohn, Mischel, Chaplin, & Barton, 1980; Stotland, 1969; Taylor, 1983). On the other hand, persons with lower hope approach goals with negativity, ambivalence, and a focus on failure (Snyder, 1995).

While high-hope people pursue difficult or “stretch” goals because of their challenge, they do not view these goals as burdens (Snyder, Cheavens, & Sympson, 1997). Since these high-hope people truly believe they will obtain their goal with their focus on success, they are not worried about not reaching them (Snyder, 1994b; Snyder, Harris, et al., 1991; Snyder, McDermott, Cook & Rapoff, 1997).

High-hope individuals have been found to have a greater number of goals across life arenas (i.e. family, friendships, marriage, health, employment, spiritual development) (Langelle, 1989); they have multiple goals within each life arena (Snyder, 1996); they have greater success achieving their goals (Snyder, 1994b; Snyder, Harris, et al., 1991; Snyder, Sympson, Ybasco, et al., 1996; Snyder, McDermott, Cook & Rapoff, 1997); they sustain agency and pathway behaviors in the face of obstacles to their goals (Yoshinobu, 1989); they set more difficult goals to attain (Harris, 1988; Sigmon & Snyder, 1990b); they set higher grade goals, perceive higher probability of achieving higher grade goals, and actually attain higher grades (Anderson, 1988). These results were found even though hope is unrelated to intelligence (Irving, et al., 1990; Snyder, Harris, et al., 1991; Snyder, McDermott, Cook, & Rapoff, 1997) or grades (Harney, 1989).

In essence, high-hope individuals are not narrow in their goal focus. They are easily able to shift attention from one goal to another. This multi-goal approach is especially beneficial in the face of goals that become or appear impossible to attain. A flexible approach to goal-setting enables hope to remain alive when one goal is unreachable (Snyder, 1994b).

High-hope persons generally experience positive self-esteem across a variety of situations (Barnum, 1993; Munoz-Dunbar, 1993; Sympson, 1993).

Barnum (1993), for example, found that higher-hope teenagers had higher self-esteem than their lower-hope counterparts.

Low-hope people, on the other hand, approach goals with a sense of ambivalence or even doubt, focus on failing, perceive poor odds of goal attainment, and possess a negative emotional state (Snyder, 1994a).

Hope is particularly useful in the face of barriers or obstacles. When barriers to goals occur, higher-hope individuals interpret these as normal and an inevitable part of life. They are not particularly disturbed by such stressors. For example, in the face of academic difficulty, high-hope individuals have been found to report much higher agency and pathways thinking than low-hope counterparts (Yoshinobu, 1989). Obstacles elicit agency and pathways thinking in high-hope persons. In the face of traumatic injuries, patients with higher-hope scores expressed significantly less depression and overall impairment due to the injury. Agency and pathways thinking were each correlated with better adjustment immediately following the injury and sustained adjustment over the following months (Elliott, et al., 1991). In teenagers with traumatic burns, the higher-hope individuals exhibited fewer behavioral problems, a general marker for adjustment, even with the impact of perceived disability, social support, and social status removed (Barnum, 1993). In Laird (1992), higher Hope Scale scores predicted better adjustment in arthritis patients. Finally, high-hope workers cope

significantly better with the psychological and physical demands placed on them by stressful work settings (Anderson, 1992; Sherwin, et al., 1992).

Hope has been shown to be extremely valuable among athletes as well. Athletes with higher hope perform significantly better, even when removing statistically the natural physical abilities as rated by their coaches (Curry, Snyder, Cook, Ruby & Rehm, 1997). Hope scores can be used to predict the performance of college runners when the effects of practice, self-esteem, confidence, and mood are removed statistically (Curry, Snyder, Cook, Ruby & Rehm, in press in 97). Among athletes, higher hope was found to be related to greater competitiveness as well (Snyder et al., 1991).

Opponents of hope theory argue that hope is the result rather than the cause of positive performances. However, research strongly suggests that hope is not simply a consequence of successful goal attainment. In fact, hope is a facilitator of goal attainment (Snyder, Cheavens, & Sympson, 1997). When equal in ability, the people with higher hope consistently outperform the lower-hope individuals (Snyder, Cheavens, & Sympson, 1997).

High-hope thinking characteristically reflects a perceived 50% probability of achieving one's goals (Snyder, 1996). Such probabilities demonstrate that high-hope people know they do not always achieve their goals (Snyder, 1996). High-hope individuals expect they will encounter barriers or setbacks during their

pursuit. However, they believe they will achieve their goals in the end (Snyder, 1996). In addition, high-hope individuals' pursuit of multiple goals in multiple life arenas enhances their ability to cope with setbacks, because there are other goals on which to focus when one appears unobtainable (Snyder, 1994b, 1996). The idea that goal objects are not always attainable is essential to hope. When one goal becomes unobtainable, the focus can turn to another goal (Snyder, 1996).

The advantages of high hope are particularly clear when people encounter obstacles or setbacks (Barnum et al., 1998; Elliott, Witty, et al., 1991; Irving, Snyder, & Crowson, 1996; Sherwin, Elliott, et al., 1992; Snyder 1994b, 1996; Snyder, Harris, et al., 1991; Snyder, Hoza, et al., 1997; Snyder, Irving, & Anderson, 1991). High hope enables people to perceive events in their lives as less disruptive (Anderson, 1988; Snyder, 1994a; Snyder et al., 1991). Higher-hope people know that things will pass, enabling them to cut stress off before it becomes a big problem (Snyder, 1994b). Snyder et al. (1991) found that higher-hope people focus more on the task than on their own personal feelings about goals (which often becomes a counterproductive cycle ending in extreme self-doubt) (Pyszczynski, Hamilton, Greenberg, & Becker, 1991). Focusing on the goal allows higher-hope individuals to form plans of how to cope especially well (Snyder, et al., 1991). In the face of blocked goals, higher-hope individuals are better equipped to generate alternative paths than lower-hope people (Snyder,

Harris, et al., 1991). At the same time, people with lower hope who are less clear about the pathways to their goals, become stuck more often when encountering barriers along that pathway (Snyder, 1996).

People's attributions and/or internal dialogue during their work toward goals may contribute to the difference between high-hope and low-hope individuals' accomplishments. High-hope individuals who do not succeed attribute their failures to not using the best strategy rather than to a deficit in ability or talents (Rieger, 1993). In fact, high-hope people actually expect mistakes during pursuit of their goals (Snyder, Cheavens, & Sympson, 1997). Following this view, they sustain mental energy toward their goals by viewing mistakes as clues to what may work in the future (Ames, 1984; Diener & Dweck, 1978; Dweck, 1986; Elliott & Dweck, 1988). Laboratory research has found that high-hope people have an ongoing self dialogue of affirming, energizing statements including "I can," "I'll make it," and "I won't give up" (Snyder, LaPointe, Croswon, & Early, 1996). Evidence suggests those with lower hope attribute greater importance to arenas of their lives that they perceive as inadequate (Sympson & Snyder, 1997).

In general, high-hope individuals report that they are not lonely (Rieger, 1993). They typically have strong social support networks which they can utilize in times of need. Higher-hope individuals also are very adept at understanding

others' points of view (Dalfiume, 1993). Such an ability should help high-hope people to deal more successfully with their relationships. More so than lower-hope people, high-hope individuals also utilize humor to cope with small problems in life (Sigmon & Snyder, 1993). They are able to laugh at the events in their lives as well as themselves, especially when facing barriers to their goals. Higher Hope Scale scores, in particular those high in agency, are related to prayer among the religious (Laird, 1992). In essence, prayer is one method to enhance one's agency thoughts, but is less connected to pathways thinking.

People with high hope are not lonely or isolated (Snyder & Cheavens, 1997; Snyder, McDermott, Cook, & Rapoff, 1997), they perceive social support is available to them (Snyder & Cheavens, 1997), they are not nervous about their social interactions (Snyder, & Cheavens, 1997), and they are able to take the perspectives of others (Rieger, 1993).

The impact of higher hope extends to the realm of physical health as well. Higher-hope people are more likely to exercise (Harney, 1989). The benefits of exercise to hope include added mental energy and time to clear the mind, positive feelings resulting from endorphins being released in the body, and an actual increase in physical energy (Snyder, 1994b). Higher-hope people are more healthful than those low in hope. They are more aware of the impact of unhealthy behaviors, more willing to perform physical self-examinations, and more likely to

consult a doctor (Irving, 1991). Higher-hope people also may be better able to combat sickness due to their increased pathways thinking (Snyder, 1994b).

The impact of stress including job loss, divorce, or birth of a child, on health has been well documented (Dekker & Webb, 1974; Dohrenwend & Dohrenwend, 1974; Markush & Favero, 1974; Sarason, Johnson, & Siegel, 1978; Warheit, 1979). Anderson (1988) found that hope scores were significantly predictive of reported mental health symptoms due to life stressors.

Although their definition of hope differed from that of Snyder and colleagues (1989), two studies found that pretreatment levels of hope were significant predictors of patient improvement in crisis center clients (Gottschalk, 1974) and acute schizophrenics (Erickson et al., 1975). Patients with higher hope before treatment benefited significantly more from treatment. In addition, hope scores among psychiatric patients were improved following treatment (Erickson, et al., 1975). These studies suggest hope may play a facilitative role in mental health. Similar research studies found optimism predicted completion of an alcohol treatment program (Strack, Carver & Blaney, 1987), and is positively related to less postpartum depression in pregnant women (Carver & Gaines, 1987).

Finally, hope has been found to have a positive relationship with the aging process. Dalfiume (1993) found that higher-hope individuals actually aged more

gracefully as evidenced by a continued desire to accomplish things and an investment in the welfare of younger people. In addition, older adults who are higher in hope are more at peace with what happened in their life than lower-hope counterparts, and are better able to accept their mortality and remain active and positive (Dalfiume, 1993).

In all, studies corroborate that individuals with higher dispositional hope expect and actually experience better outcomes in their lives (Snyder, 1995a). Such advantages are numerous. Higher-hope individuals have more goals, more difficult goals, more success in achieving their goals, view goals as challenges, experience greater happiness and less distress, possess better coping skills, recover better from physical injury, and report less burnout from work (Elliott, Witty, Herrick & Hoffman, 1991; Sherwin et al., 1992; Snyder, 1993, 1994a, 1994b, Snyder et al., 1991; Snyder, Irving, & Anderson, 1991). Typically, hope scores predict these outcomes even when one controls for the effects of intelligence, optimism, locus of control, and positive and negative affect on the outcome (Snyder, 1995).

Summary

Over the past century, the field of career counseling and guidance has sought to meet the continually changing needs of each new generation. Group career decision-making interventions are offered at most universities and colleges,

as well as at a number of other locations. While outcome research consistently supports the overall effectiveness of career decision-making interventions, it is not assumed that they are maximally efficient nor effective at this point. The next phase of research then is to identify the specific client attributes that significantly enhance participants' outcome from career planning interventions and to capitalize on such differences.

Hope may be one such client attribute that could be significantly related to participants' outcome from a career decision-making intervention. As defined by Snyder (1989), hope consists of goal-directed energy and planning abilities. The benefits of high hope have been well documented. Individuals with high hope set more goals, have more success in achieving goals, set goals in more life arenas, set more difficult goals, view goals as challenges and opportunities for success, are more healthy, and have better social support networks. Most importantly, though, the benefits of hope are best seen in the face of adversity.

The need for identifying client attributes that relate to participants' outcome from career interventions coupled with the overwhelming benefits of high hope in all life arenas accentuate the need for the current study. Goal setting, achievement, and overcoming obstacles are the essence of the process of a career transition.

The following chapter explains the methodology of the current study. Specifically, information on the participants, design, procedure, and instruments of the study were provided.

CHAPTER 3

Method

Participants

Participants in this study consisted of 61 adults, 21 men and 40 women, drawn from the community of a large Midwestern city. The scores for women and men on each of the variables are presented in Table 1. The combined scores for each of the analyses are presented in Chapter 4.

Table 1 - Scores for Female Participants

<u>Variable</u>	<u><i>n</i></u>	<u><i>M</i></u>	<u><i>SD</i></u>
Trait Hope	40	47.6	8.1
Pre-Treatment Decidedness	40	2.50	1.84
Post-Treatment Decidedness	40	4.60	1.80
Pre-Treatment Vocational Identity	40	5.35	3.29
Post-Treatment Vocational Identity	40	7.55	3.59
Pre-Treatment Career Decision-Making Self Efficacy	40	143.78	36.33
Post-Treatment Career Decision-Making Self Efficacy	40	164.70	25.32
Pre-Treatment State Hope	40	33.18	6.98
Post-Treatment State Hope	40	37.43	4.78
Pre-Treatment Work Hope	40	51.95	5.69
Post-Treatment Work Hope	40	53.18	5.72

Table 2 - Scores for Male Participants

<u>Variable</u>	<u>n</u>	<u>M</u>	<u>SD</u>
Trait Hope	21	48.2	7.5
Pre-Treatment Career Decidedness	21	2.76	2.02
Post-Treatment Career Decidedness	21	4.52	2.06
Pre-Treatment Vocational Identity	21	6.43	3.67
Post-Treatment Vocational Identity	21	8.62	3.84
Pre-Treatment Career Decision-Making Self Efficacy	21	140.48	34.45
Post-Treatment Career Decision-Making Self Efficacy	21	154.81	34.18
Pre-Treatment State Hope	21	32.90	7.76
Post-Treatment State Hope	21	35.67	7.16
Pre-Treatment Work Hope	21	51.71	5.93
Post-Treatment Work Hope	21	52.38	6.18

Men and women participants did not differ significantly on most of the variables in this study. However, men did score one point higher on pre-treatment and post-treatment vocational identity, which follows scores found in the MVS norm group, and women scored ten points higher on post-treatment career decision-making self efficacy.

Each participant reported he/she was experiencing or considering a career transition. The 61 subjects who participated in the study ranged in age from 24 to

54 years. The average age of the participants was 40 years. Of the 61 participants, 58 were Caucasian, two were African American, one was American Indian, 7 had earned a graduate or professional degree, 30 had completed Bachelor's degrees, 6 had finished Associate's degrees, and 17 held high school diplomas.

Following Spokane and Oliver's (1983) suggestion, enrollment for this research outcome study was accomplished through self selection. Each participant was in need of career planning assistance and voluntarily chose to register for a career transitions workshop. Participants learned about the workshop from community services/continuing education mailings, academic advisors, career counseling professionals, friends, and family members. The participants registered for the workshop through the Community Services division at a large suburban community college.

While the participants' reasons for enrolling in the workshop were varied, all were considering a career change or transition. The participants were predominantly full-time workers who were not satisfied with their current occupation. The majority were interested in learning more about their career-related interests, personality, skills, and values, as well as researching career information.

Each workshop, conducted by one instructor, included between 13 and 18 participants. Each individual who attended a first session of any Transitions

workshop offered between December 1998 and March 1999 was asked to voluntarily participate in this study. Subjects assigned themselves to groups by selecting the time and date of the session that worked best with their schedule.

Of the 84 individuals enrolled in the Career Transitions workshop between December 1998 and March 1999, 61 attended all five sessions of the workshops and completed all the necessary questionnaires for this study for a completion rate of 73%. No significant differences in demographic variables were found between the participants who completed the workshop and those who did not complete the workshop. However, the 23 dropouts were found to score significantly higher than those who completed the workshop on all pre-treatment measures (trait hope, state hope, work hope, vocational identity, career decision-making self efficacy, and career decidedness). This suggests that those who did not complete the workshop dropped out because they did not have as much need for it as the 61 who completed the treatment.

Groups

While control groups, random selection, and random assignment of subjects are recommended in career counseling outcome research (Osipow & Betz, 1991), these methods were not employed in the present study. A control group was not utilized due to the established efficacy of career counseling interventions (Whiston, Sexton, & Lasoff, 1998). The primary purpose of this

study was not to determine if this career workshop was effective overall. While that information is beneficial, the central aim of this study was to determine if Hope Scale scores played a role in predicting the participants' outcome from this workshop. In other words, this study investigated whether or not the workshop was differentially effective for individuals who differ on trait hope. The relationship between participants' pre-treatment hope scores and their change scores in vocational identity, career decidedness, and career decision-making self efficacy after participating in a career decision-making workshop were investigated.

Facilitators

Two female instructors and one male instructor facilitated the 6 workshops in this study. One of the leaders is currently working on a Ph.D. degree in counseling psychology. The other two facilitators have master's degrees in counseling or education. All of the leaders have extensive structured group work experience. Pre-session training, teacher's manuals, and post-session debriefings with each instructor assured standardized presentations. As presented in the teacher's manual, the treatment is highly structured, which reduces the likelihood for instructor bias (Crits-Christoph & Mintz, 1991).

Design

To assess the relationship of participants' pre-treatment hope to their change scores in career decidedness, a hierarchical regression was performed (Criterion Variables: Block 1, pre-treatment decidedness; Block 2, pre-treatment hope; Dependent Variable: post-treatment decidedness). To measure the relationship of participants' pre-treatment hope to their change scores in career decision-making self-efficacy, a hierarchical regression was utilized (Criterion Variables: Block 1, pre-treatment career decision-making self efficacy; Block 2, pre-treatment hope; Dependent Variable: post-treatment career decision-making self efficacy). To assess the relationship of pre-treatment hope to their change scores in vocational identity a third hierarchical regression was performed (Criterion Variables: Block 1, pre-treatment vocational identity; Block 2, pre-treatment hope; Dependent Variable: post-treatment vocational identity). The relationship of the career decision-making workshop to changes in participants' state hope, dispositional hope, career decidedness, career decision-making self efficacy, and vocational identity scores were each tested by repeated measures, single sample t tests.

Procedure

Participants signed an informed consent form and completed a career decidedness item and demographic form, dispositional Hope Scale, State Hope

Scale, Domain Specific Work Hope Scale, Career Decision-Making Self Efficacy Scale - Short Form, and My Vocational Situation at the beginning of the first session. The State Hope Scale, Domain Specific Hope Scale, My Vocational Situation, and the career decidedness item were administered again at the end of the fifth session. The State Hope Scale was also administered at the end of sessions 1 and 3.

Undecided individuals are found to have a) an unclear sense of identity and self-knowledge, b) poor decision-making skills, c) a lack of information regarding careers and major areas of study, and d) a lack of information-seeking skills (Ashby, Wall & Osipow, 1966; Holland & Holland, 1977; Taylor & Betz, 1983). As a result, the objectives of this intervention are to increase participants' self-awareness, self-knowledge, decision making skills, and knowledge of careers and majors through researching personal and career information.

The career transitions workshop was created to serve adults from a large Midwestern city who were considering changing careers. The transitions workshop consists of five 2 ½ hour sessions, conducted by one instructor, and held in the evenings, two nights a week, for two and a half weeks. Enrollment is limited to 20 people per workshop to ensure adequate accessibility of the instructor to each participant. The five sessions consist of participants completing career assessments, group interpretations of those career assessments, mini-

lectures on various topics, in-class group exercises, individual study and exploration, and a tour of the career resource library at the community college.

Transitions workshops facilitate the self-discovery of work interests, personality, skills and values, and teach the participants about career/life decision-making, goal setting, and overcoming barriers to career/life plans. While job search and networking are discussed briefly, the program is not primarily a job search program. It is designed to participants' increase self-knowledge, knowledge of the world of work, and knowledge of the career planning process.

Session 1:

Before beginning session 1, the participants were invited to participate voluntarily in the present study. Those who did volunteer then completed the Decidedness Item/Demographic Form, Dispositional Hope Scale, State Hope Scale, Domain Specific Work Hope Scale, Career Decision-Making Self Efficacy Scale - Short Form, and My Vocational Situation. Once those were completed, Session 1 began with introductions. Each participant introduced him/herself, explained why he/she was seeking treatment, and shared his/her personal goals for the workshop. The introduction process had several purposes. It fostered group cohesion and a feeling of universality among the participants. It helped the instructor determine the career needs of each participant and intervene when necessary and appropriate. In addition, it acted as a goal-setting intervention for

each of the participants as they explained their goals and objectives for the career workshop. Once each participant was introduced and had set his/her objectives for the workshop, the instructor provided an overview of the entire five-session workshop. Next, the instructor reviewed a model of the career planning process which was utilized in the Transitions workshop followed by a lecture and some discussion on the importance of career development, self-discovery, and self-esteem.

The career planning process consists of four stages: self-discovery, exploring career/life options, analyzing and integrating information, and goal-setting and implementation. Self discovery consists of the participant learning about his/her interests, personality, skills, and work values as they impact career/life decisions.

Exploring career/life options consists of learning about careers and the world of work. This can be done in three primary modes. First, one can read about careers through books, files, and computer web sites available in the career resource center. Second, one may arrange interviews with workers in prospective occupations to gain more personal information on what a particular job entails, what a typical work day looks like, and how to prepare for that occupation and eventually find a job. Third, the final recommended step of exploring career/life options involves actual experience in one's prospective occupational field. This

can be achieved through internships, taking classes, part-time or full-time work, and/or volunteer experiences.

Analyzing and integrating is the process of evaluating all available information about self and careers. At this step, barriers to potential career/life options are considered and alternative solutions are considered.

Finally, goal setting/implementing is the process of actually deciding on a vocational choice and making plans to achieve that goal. These plans may include further education or training, depending on the participants' current level of skills and experience in that given area. The four stages of the career planning process are not proposed to happen in a systematic and step by step order. On the contrary, they may occur simultaneously and will probably occur more than once during one's life-span.

After the workshop overview and discussion of the career planning process, the participants completed several achievement worksheets, broke down into small groups to perform a skill bombardment exercise, and then individually completed the Eureka Skills Inventory.

Session 2:

Session 2 began with a discussion about the importance of one's work values in the career planning process. The participants completed a work values assessment and broke down into a small group to discuss their results. In the

second half of session 2, the participants completed the Myers-Briggs Type Indicator which was then interpreted by the instructor to the entire group. Time was allowed following the interpretation for the participants to read through their assessment results and explore career options either individually or in small groups.

Session 3:

Session 3 began with a discussion of skills in career development and a group interpretation of the participants' Eureka Skills Inventory results. Following the Eureka, the instructor taught the class about Holland's theory of career interests types. The participants then completed Holland's Self-Directed Search and were given time to read about their results and explore career options either individually or in small groups. In the remaining time, the instructor lectured the class and led a discussion about successful goal setting and decision making strategies.

Session 4:

Session 4 was devoted to learning successful job search techniques and analyzing and integrating assessment results. The instructor covered informational interviewing, networking, resumes, interviewing, salary negotiations, organizing the job search, as well as stress factors and the stages of adjustment to unemployment. With the remaining time, participants analyzed and integrated

their assessment results, explored career options individually and in groups, and prepared themselves to utilize the career resource library in the final session of the workshop.

Session 5:

For session 5, the group met at the career resource library. First, the instructor gave the group a detailed tour and overview of the resources available in the career center. The participants then researched educational programs, occupational information, and job search/employment information. Before the close of the final session, each participant met briefly with the instructor as a final check-up and filled out the decidedness item, brief demographic form, State Hope Scale, Domain Specific Work Hope Scale, My Vocational Situation, and Career Decision-Making Self Efficacy Scale - Short Form.

Instruments

In the current study, outcome from the career transitions workshop was measured by the Vocational Identity Scale of My Vocational Situation, the Career Decision-Making Self Efficacy Scale - Short Form, a decidedness item, the Domain Specific Hope Scale, and the State Hope Scale.

My Vocational Situation

My Vocational Situation (MVS; Holland, et al., 1980a). The MVS consists of an 18-item Vocational Identity scale (VI), a 4-item occupational information

scale, and a 4-item barriers scale. Only the Vocational Identity scale of the MVS was utilized in this study. The VI scale has a test-retest reliability of .84 over a two-week period (Holland et al, 1980b) and has been used in various career intervention outcome studies (Johnson et al., 1981; Rayman, Bernard, Holland, & Barnett, 1983). The scale consists of the first 18 items of the instrument and requires true or false responses. The vocational identity score equals the sum of the false responses. Higher scores equal greater vocational identity, or, “the possession of a clear and stable picture of one’s goals, interests, personality, and talents” (p.5). The Occupational Information scale consists of 4 yes-no items that measure one’s perceived need for vocational information. The Barriers (B) scale includes 4 yes-no items which assess one’s external obstacles or limitations toward choosing a career. The OI and B scales “resemble check lists rather than scales” (Holland, Daiger, & Power, 1980a, p. 3) and should be used as such (Lucas, et al., 1988). The MVS was developed as a screening assessment to distinguish between career counseling clients who were experiencing difficulty deciding on a career due to inadequate vocational identity formation, insufficient occupational information, or environmental/personal barriers (Holland, Daiger, & Power, 1980a). Lower scores in vocational identity also represent more career undecidedness or indecision (Holland, Daiger, & Power, 1980a).

The MVS has been found to be a useful assessment for career outcome intervention studies (Holland, Johnston, & Asama, 1993; Ware, 1985). High vocational identity scores lead to relatively untroubled decision-making and confidence in one's ability to make good decisions in the face of some ambiguity (Holland, Johnston, & Asama, 1993). The KR 20 estimates of the reliability for the VI, OI, and B scales are .85, .78, and .55 respectively (Holland, Daiger, & Power, 1980b).

The VI scale has been studied or utilized in over 50 investigations (Holland, Johnston, & Asama, 1993). The VI scale taps vocational attitudes and commitment, desirable career beliefs and problem solving attitudes, and rational career decision-making styles (Holland, Johnston, & Asama, 1993). High VI scores are positively correlated with declaring a major as the result of a career course (Rayman & Bernard, 1987), job satisfaction in a sample of adult workers (Carson, 1993), focused career exploration activities (Blustein, 1989), and self-esteem (Wanberg & Muchinsky, 1992). Adults and displaced homemakers seeking career counseling have low VI scores (Hughey, Heppner, Johnston, & Rakes, 1989). In addition, the VI is predictive of how well farmers cope with career transitions (Heppner, Cook, Strozier, & Heppner, 1991). High scorers on the VI are "people who possess many constructive beliefs about career decision-making; are interpersonally competent; relatively free of disabling psychological

problems; conscientious, hopeful, and responsible; have a clear sense of identity; and are not easily put off by barriers or environmental ambiguities” (p. 8, Holland, Johnston, & Asama, 1993). On the other hand, individuals who score low on the VI scale “often suffer from many psychological troubles, including low self-esteem, neuroticism, destructive beliefs about self and career decision-making, diffuse identity, dependency, hopelessness, and poor problem-solving attitudes and skills” (p. 8, Holland, Johnston, & Asama, 1993). In all, the VI scale is a reliable general measure of psychological health (Holland, Johnston, & Asama, 1993).

Internal consistency reliability data typically runs in the high .80s. Holland, Johnston, and Asama (1993) determined the test-retest reliability is approximately .75 for 1 to 3 months and .63-.93 for 1 to 2 weeks. Evidence for construct validity is also evident (Fretz & Leong, 1982; Graef, Wells, Hyland, & Muchinsky, 1985; Lucas, Gysbers, Buescher, & Heppner, 1988).

The use of the MVS in the current study answers the call for diagnostic instruments to be utilized in career intervention outcome studies. The MVS was developed as just that, a diagnostic instrument that would identify three problems related to career decision making including: vocational identity, lack of occupational information, and barriers or obstacles to an occupational goal (Holland, Daiger, & Power, 1980). Research supports the use of the MVS

(Holland, Daiger & Power, 1980) as a diagnostic tool for determining the level or amount of career intervention needed (Holland, Johnston, & Asama, 1993) as well as a career intervention outcome measure (Fretz & Leong, 1982; Holland, Johnston, & Asama, 1993; Kivlighan, Johnson & Fretz, 1987; Power, Holland, Daiger & Takai, 1979).

The MVS was selected, in part, due to the criticisms of the use of career maturity as an outcome of vocational interventions (Rounds & Tinsley, 1984). It has been described as a career achievement test which better measures “that the treatment was actually implemented than for assessing the effectiveness of the vocational intervention” (Rounds & Tinsley, 1984 p. 163).

Career Decision-Making Self Efficacy Scale - Short Form (CDMSE-SF)

The Career Decision-Making Self Efficacy Scale - Short Form (CDMSE-SF) (Betz, et al., 1996) is a 25 item self-report measure. Each item is scored on a 10 point Likert scale (0 - No Confidence at All; 1, 2, 3 - Very Little Confidence; 4, 5 - Some Confidence; 6, 7 - Much Confidence; 8, 9 - Complete Confidence). The assessment seeks to measure an individual’s degree of belief that he/she can successfully accomplish tasks necessary to making career decisions. It contains 5 subscales including accurate self appraisal, gathering occupational information, goal selection, making plans for the future, and problem-solving. Each scale consists of 5 items. Values of coefficient alpha for the subscales ranges from .73

(Self-Appraisal) to .83 (Goal Selection). The total scale alpha coefficient is .94, which is almost as high as the value of .97 on the 50-item version of the same scale. Therefore, the 5 scales and the total score are sufficiently reliable, and the 25 item scale measures a highly homogeneous general construct. In addition, the CDMSE-SF was found to have statistically significant concurrent validity with the MVS Vocational Identity scale. With only two exceptions, the concurrent validity correlations were higher for the CDMSE-SF than for original 50 item scale. In all, the psychometric properties of the CDMSE-SF appear to be comparable to or better than the original CDMSE.

Dispositional Hope Scale

The Hope Scale (Snyder et al., 1989) is a self-report scale with twelve 8-point Likert-type items. Subjects are asked to rate each item on the extent it applies to them from 1=Definitely False, 2=Mostly False, 3=Somewhat False, 4=Slightly False, 5=Slightly True, 6=Somewhat True, 7=Mostly True, 8=Definitely True. The Hope Scale includes two subscales, agency (perceived motivation toward pursuing one's goals) and pathways (perception of one's ability to produce routes to goals and to generate methods to overcome obstacles when necessary). The agency subscale consists of Items 2, 9, 10, and 12, and the pathways subscale is derived from Items 1, 4, 6, and 8. The total Hope Scale score is derived from adding the four agency and four pathway items. Items 3, 5, 7, and

11 serve as distracters to obscure the content and purpose of the scale. In addition, when administered, the Hope Scale is titled the Future Scale.

A score of greater than 48 suggests that one usually think in very hopeful ways. To the extent a score is increasingly lower than 48, then the respondents are reporting less goal-directed thinking (i.e. hope). Average or normal scores on the agency and pathways subscales are approximately 24 each.

The highest possible Hope Scale score is 64 while the lowest score possible is 8. For the agency and pathways subscales, the highest possible score is 32 and the lowest possible score is 4. The average total Hope Score for college and non-college samples is approximately 48, and the average agency and pathways subscale scores are each 24. Those seeking psychological counseling and psychiatric inpatient populations evidence significantly lower-hope scores. Approximately 30% of those taking the Hope Scale have both high agency and pathways scores, thereby exemplifying high hope. About 5% of people have truly low hope, which is reflected by relatively low agency and pathways subscale scores. In addition, only 10% of those taking the Hope Scale score in the high-hope range on only one of the two hope components (Snyder, 1995).

The Hope Scale has demonstrated acceptable internal reliability. The item-remainder coefficients for each item are significant ranging from .23 to .63. The coefficient alpha is reasonably high (Cronbach's alphas of .74 to .84).

Confirmatory factor-analytic procedures repeatedly have confirmed the identifiable existence of the posited two subscales as well as the overarching total Hope Scale score (Snyder, 1995). The agency items have been found to positively intercorrelate with each other, as do the pathways items, and factor analyses demonstrate that the agency and pathways are each separately identifiable constructs (Snyder, 1995).

When re-administered to subjects after intervals ranging from 3 to 10 weeks, the test-retest reliability of the Hope Scale consistently falls in the +.80 range, lending support to hope as a dispositional, cross-temporal construct (Snyder, 1995).

Evidence for the Hope Scale's concurrent validity has been supported by positive correlations with measures of self-esteem, perceived problem-solving abilities, appraisals of control in life, optimism, positive affectivity, and positive outcome expectancies (Snyder, 1995). In addition, the Hope Scale correlates negatively with social introversion, depression, negative affectivity, and anxiety (Snyder, 1995).

The discriminant utility was tested in a series of studies (Snyder et al., 1991) which found that the scores on the Hope Scale predict coping, well-being, and reported psychological health, and did so beyond variances related to anxiety, positive and negative affectivity, optimism, positive outcome expectancies, and

locus of control scores. These studies suggest the Hope Scale captures unique predictive variance in predicting and understanding various coping activities (Snyder, 1995).

State Hope Scale

The State Hope Scale (Snyder, Sympson, et al., 1996) is a 6-item self-report scale which seeks to assess a person's "here and now" hope. The items are scored on an 8-point Likert scale (1=Definitely False, 2=Mostly False, 3=Somewhat False, 4=Slightly False, 5=Slightly True, 6=Somewhat True, 7=Mostly True, 8=Definitely True). The scale includes two subscales, agency and pathways, as well as a total score obtained by summing the responses to all six items. The scale has achieved reliability coefficients (Cronbach alphas) of greater than .90, and test-retest correlations as low as .48, which supports its use as a temporally specific or "right now" measure of hope. The agency and pathways factors also have been supported by factor analyses, and other research has demonstrated convergent and discriminant validities of the State Hope Scale (Snyder, 1998).

Work Subscale of the Domain Specific Hope Scale

The Work Subscale of the Domain Specific Hope Scale (Symphon, 1997) consists of 8 items scored on an 8-point Likert scale (1=Definitely False, 2=Mostly False, 3=Somewhat False, 4=Slightly False, 5=Slightly True,

6=Somewhat True, 7=Mostly True, 8=Definitely True). The scale measures goal-directed thoughts and behaviors specifically related to work activities. The scale has demonstrated very strong psychometric properties in terms of its internal consistency (Cronbach alpha > .90) (Snyder, personal communication, 11/98).

Decidedness Item

In addition to the MVS and Hope Scale, a decidedness item was utilized to measure the participants' career decidedness before and after participating in the workshop. There is one item which states, "I am entirely certain of what career to pursue (circle one)" (1=Definitely False, 2=Mostly False, 3=Somewhat False, 4=Slightly False, 5=Slightly True, 6=Somewhat True, 7=Mostly True, 8=Definitely True).

Summary

This study examined the relationship of participants' hope to their outcomes in a career decision-making workshop. Adults from a large mid-western city, voluntarily seeking assistance with a career transition at a local suburban community college, participated. Hierarchical regressions were utilized to measure the relationship of pre-treatment hope on change in scores from pre-treatment to post-treatment on career decidedness, career decision-making self efficacy, and vocational identity. Repeated measures, single sample t-tests were implemented to examine the pre-treatment to post-treatment changes in vocational

identity, career decidedness, career decision-making self-efficacy, work hope, and state hope. Participants attended a five session career decision making workshop which consisted of four career assessments and various lectures on career related topics. At the first session, they completed the MVS, CDMSE-SF, the Dispositional, State, and Work Hope Scales, and a decidedness item/demographic form. At the end of the fifth session, they completed the MVS, CDMSE-SF, the State and Work Hope Scales, and a decidedness item. The following chapter discusses the results of the study.

CHAPTER 4

Results

Introduction

The purpose of the present study is twofold. First, the role of hope in the prediction of participants' outcome, defined as career decidedness, career decision-making self efficacy, and vocational identity, from a career workshop was investigated. Second, the participants' change scores on career decidedness, career decision-making self efficacy, vocational identity, state hope, and work hope, from pre-treatment to post-treatment were gathered to assess the effectiveness of the career transitions workshop.

Analyses

To study the role of hope in the participants' outcome from the career workshop, three hierarchical regressions were performed. The three regressions used post-treatment scores on career decidedness, career decision-making self efficacy, and vocational identity as the dependent variable. The predictor variables were pre-treatment scores on career decidedness, career decision-making self efficacy, and vocational identity, entered in Block 1, and pre-treatment hope scores, entered in Block 2.

To measure the effectiveness of the workshop on participants' career decidedness, career decision-making self efficacy, vocational identity, state hope,

and work hope change scores from pre-treatment to post-treatment, five repeated measures, single sample t-tests were performed. Each repeated measures, single sample t-test assessed the significance of the change in scores from pre-treatment to post-treatment.

Results Pertaining to the Null Hypotheses

The first three research questions in the current study investigated the role of participants' hope in their outcome from the workshop. Specifically, these questions examined whether or not hope plays a role in predicting the changes in scores from pre-treatment to post-treatment on career decidedness, career decision-making self efficacy, and vocational identity.

Hypothesis #1

The first null hypothesis to be investigated was phrased, "At the end of the career decision-making workshop, adults with pre-treatment high-hope scores, ranging from 50 to 64 on the Hope Scale (Snyder et al., 1991) versus those with pre-treatment low-hope scores, ranging from 8-46 on the Hope Scale (Snyder et al., 1991), will show no greater change scores on career decidedness, as measured by a decidedness item."

To test this hypothesis, whether Hope Scale scores provided any additional predictive variance beyond the pre-treatment career decidedness score, a hierarchical regression was utilized. Using the post-treatment career decidedness

scores as the criterion or dependent variable, in the first step, pre-treatment career decidedness scores were not a significant predictor, $R^2 = .015$, $p > .05$; and when pre-treatment hope was entered in Step 2, it did not augment the prediction, $R^2 = .004$, $p > .05$ (See Table 1).

Table 3

<u>Variable</u>	<u>n</u>	<u>M</u>	<u>SD</u>
Pre-Treatment Career Decidedness	61	2.59	1.89
Pre-Treatment Hope	61	47.80	7.84
Post-Treatment Career Decidedness	61	4.57	1.87

Hypothesis #2

The second null hypothesis investigated in the current study was stated, “At the end of the career decision-making workshop, adults with pre-treatment high-hope scores, ranging from 50 to 64 on the Hope Scale (Snyder et al., 1991) versus those with pre-treatment low-hope scores, ranging from 8-46 on the Hope Scale (Snyder et al., 1991), will show no greater change scores on career decision-making self-efficacy as measured by the Career Decision-Making Self Efficacy Scale - Short Form (Betz et al., 1996).”

To test this hypothesis, whether Hope Scale scores provided any additional predictive variance beyond the pre-treatment career decision-making self efficacy

scores, a hierarchical regression was utilized. Using the post-treatment career decision-making self-efficacy scores as the criterion or dependent variable, in the first step, pre-treatment career decision-making self-efficacy scores were a significant predictor, $R^2 = .408$, $p < .001$; when pre-treatment hope was entered in Step 2, it did not augment the prediction, $R^2 = .000$, $p > .05$ (see Table 2).

Table 4

<u>Variable</u>	<u><i>n</i></u>	<u><i>M</i></u>	<u><i>SD</i></u>
Pre-Treatment Career Decision-Making Self Efficacy	61	143.72	35.56
Pre-Treatment Hope	61	47.80	7.84
Post-Treatment Career Decision-Making Self Efficacy	61	161.30	28.79

Hypothesis #3

The third null hypothesis tested in the current study was phrased, “At the end of the career decision-making workshop, adults with pre-treatment high-hope scores, ranging from 50 to 64 on the Hope Scale (Snyder et al., 1991) versus those with pre-treatment low-hope scores, ranging from 8-46 on the Hope Scale (Snyder et al., 1991), will show no greater change scores on Vocational Identity, as measured by the Vocational Identity Scale of My Vocational Situation (Holland et al., 1980a).”

To test this hypothesis, whether Hope Scale scores provided any additional predictive variance beyond the pre-treatment vocational identity scores, a

hierarchical regression was utilized. Using the post-treatment vocational identity scores as the criterion or dependent variable, in the first step, pre-treatment vocational identity scores were a significant predictor, $R^2 = .456$, $p < .001$; when pre-treatment hope was entered in Step 2, it did not augment the prediction, $R^2 = .017$, $p > .05$ (see Table 3).

Table 5

<u>Variable</u>	<u><i>n</i></u>	<u><i>M</i></u>	<u><i>SD</i></u>
Pre-Treatment Vocational Identity	61	5.72	3.43
Pre-Treatment Hope	61	47.80	7.84
Post-Treatment Vocational Identity	61	7.92	3.68

The five additional research questions addressed the effectiveness of the career transitions workshop as measured by changes from pre-treatment to post-treatment on measures of career decidedness, career decision-making self efficacy, vocational identity, state hope, and work hope.

Hypothesis #4

The fourth null hypothesis was stated, “from pre-treatment to post-treatment, participants will exhibit no significant change scores in career decidedness, as measured by a decidedness item.”

To determine if there were significant differences in career decidedness from pre-treatment to post-treatment, the mean of the pre-treatment decidedness scores ($M = 2.59$, $SD = 1.89$) was compared with the mean of the post-treatment decidedness scores ($M = 4.57$, $SD = 1.87$). The post-treatment career decidedness scores were significantly higher than pre-treatment career decidedness scores, $t(60) = 6.214$, $p < .001$ (see Table 4).

Table 6

<u>Variable</u>	<u><i>n</i></u>	<u><i>M</i></u>	<u><i>SD</i></u>
Pre-Treatment Career Decidedness	61	2.59	1.89
Post-Treatment Career Decidedness	61	4.57	1.87

Hypothesis #5

The fifth null hypothesis tested in the current study was phrased, “from pre-treatment to post-treatment, participants will exhibit no significant change scores in career decision-making self efficacy, as measured by the Career Decision-Making Self Efficacy Scale - Short Form (Betz et al., 1996).”

To determine if there were significant differences in career decision-making self efficacy scores from pre-treatment to post-treatment, the mean of the pre-treatment career decision-making self efficacy scores ($M = 143.72$, $SD = 35.56$) was compared with the mean of the post-treatment career decision-making

self efficacy scores ($M = 161.30$, $SD = 28.79$). The post-treatment career decision-making self efficacy scores were significantly higher than pre-treatment career decision-making self efficacy scores, $t(60) = 4.896$, $p < .001$.

Table 7

<u>Variable</u>	<u><i>n</i></u>	<u><i>M</i></u>	<u><i>SD</i></u>
Pre-Treatment Career Decision-Making Self Efficacy	61	143.72	35.56
Post-Treatment Career Decision-Making Self Efficacy	61	161.30	28.79

Hypothesis #6

The sixth null hypothesis investigated in the current study was stated, “from pre-treatment to post-treatment, participants will exhibit no significant change scores in vocational identity, as measured by the Vocational Identity Scale of My Vocational Situation (Holland et al., 1980a).”

To determine if there were significant differences in vocational identity from pre-treatment to post-treatment, the mean of the pre-treatment vocational identity scores ($M = 5.72$, $SD = 3.43$) was compared with the mean of the post-treatment vocational identity scores ($M = 7.92$, $SD = 3.68$). The post-treatment vocational identity scores were significantly higher than pre-treatment vocational identity scores, $t(60) = 5.969$, $p < .001$.

Table 8

<u>Variable</u>	<u>n</u>	<u>M</u>	<u>SD</u>
Pre-Treatment Vocational Identity	61	5.72	3.43
Post- Treatment Vocational Identity	61	7.92	3.68

Hypothesis #7

The seventh null hypothesis tested in the current study was phrased, “from pre-treatment to post-treatment, participants will exhibit no significant change scores in state hope, as measured by the State Hope Scale (Snyder, Sympson et al., 1996).

To determine if there were significant differences in state hope from pre-treatment to post-treatment, the mean of the pre-treatment state hope scores ($M = 33.08$, $SD = 7.20$) was compared with the mean of the post-treatment state hope scores ($M = 36.82$, $SD = 5.72$). The post-treatment state hope scores were significantly higher than pre-treatment state hope scores, $t(60) = 5.021$, $p < .001$.

Table 9

<u>Variable</u>	<u>n</u>	<u>M</u>	<u>SD</u>
Pre-Treatment State Hope	61	33.08	7.20
Post-Treatment State Hope	61	36.82	5.72

Hypothesis #8

The eighth null hypothesis, tested in the current study was stated, “from pre-treatment to post-treatment, participants will exhibit no significant change scores in domain specific work hope, as measured by the Domain Specific Work Hope Scale (Sympson, 1997).

To determine if there were significant differences in work hope from pre-treatment to post-treatment, the mean of the pre-treatment work hope scores ($M = 51.87$, $SD = 5.73$) was compared with the mean of the post-treatment work hope scores ($M = 52.90$, $SD = 5.84$). The post-treatment work hope scores were not significantly different from pre-treatment work hope scores, $t(60) = 1.836$, $p > .05$.

Table 10

<u>Variable</u>	<u><i>n</i></u>	<u><i>M</i></u>	<u><i>SD</i></u>
Pre-Treatment Work Hope	61	51.87	5.73
Post-Treatment Work Hope	61	52.90	5.84

Table 11

Correlations

	Trait Hope	Pre Dec	Post Dec	Pre VI	Post VI	Pre SE	Post SE	Pre-State Hope	Post-State Hope	Pre Work Hope	Post Work Hope
Trait Hope		.07	.07	.44**	.41**	.58**	.37**	.77**	.37**	.57**	.47**
Pre Dec	.07		.12	.36**	.16	.24	.14	.10	.04	-.16	.10
Post Dec	.07	.12		.07	.28*	.10	.35**	.08	.39**	.19	.27*
Pre VI	.44**	.36**	.07		.68**	.49**	.33**	.50**	.29*	.30*	.26*
Post VI	.41**	.16	.28*	.68**		.40**	.46**	.40**	.35**	.32*	.28*
Pre SE	.58**	.24	.10	.49**	.40**		.64**	.62**	.55**	.40**	.35**
Post SE	.37**	.14	.35**	.33**	.46**	.64**		.42**	.68**	.43**	.52**
Pre State Hope	.77**	.10	.08	.50**	.40**	.62**	.42**		.62**	.56**	.53**
Post State Hope	.37**	.04	.39**	.29*	.35**	.55**	.68**	.62**		.46**	.67**
Pre Work Hope	.57**	-.16	.19	.30*	.32*	.40**	.43**	.56**	.46**		.71**
Post Work Hope	.47**	.10	.27*	.26*	.28*	.35**	.52**	.53**	.67**	.71**	

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

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

Pre = Pre-Treatment

Post = Post-Treatment

Dec = Career Decidedness

VI = Vocational Identity

SE = Career Decision-Making Self Efficacy

Summary

In summary, the regression analyses results suggest that hope does not play a significant role in predicting outcome from the transitions workshop as measured by career decidedness, career decision-making self efficacy, and vocational identity. However, significant changes in scores from pre-treatment to post-treatment on career decidedness, career decision-making self efficacy, vocational identity, and state hope were found utilizing repeated measures, single sample t-tests. The work hope scores were the only scores to not evidence significant change from pre-treatment to post treatment on the repeated measures, single sample t-test.

CHAPTER 5

Discussion

Conclusions

The primary purpose of the present study was to investigate the role of hope on participants' outcome from the career workshop. Specifically, this study examined the relationship of pre-treatment Hope Scale scores to changes in scores from pre-treatment to post-treatment on career decidedness, career decision-making self efficacy, and vocational identity.

The current study's findings suggest that pre-treatment Hope Scale scores do not provide any additional information beyond pre-treatment career decidedness, career decision-making self efficacy, or vocational identity scores when trying to predict post-treatment scores on career decidedness, career decision-making self efficacy, or vocational identity.

There are a number of possible reasons for non-significant findings in response to the first three research questions. First, the sample size of 61 may have been too small for the study to have sufficient power to obtain significant results. Second, due to those with higher pre-treatment trait hope scores also having higher pre-treatment outcome assessments scores, regression to the mean on the outcome measures may have contributed to the non-significant findings. Essentially, those lower in trait hope had more to gain from the workshop because

their pre-treatment scores on the outcome assessments were lower than those who scored higher in pre-treatment trait hope. Therefore, those with low-hope scores at pre-treatment evidenced larger change scores from pre- to post-treatment due to their lower beginning scores on the outcome measures of career decidedness, career decision-making self efficacy, and vocational identity.

Third, trait hope may not have predicted outcome in this study because only one of the two subscales, agency or pathways, was significantly related to outcome. However, follow-up analyses of agency only and pathways only did not reveal any significant predictive role of either subscale on outcome from the workshop.

Finally, the lack of a significant relationship between hope and outcome may be the result of the brief time period between pre-test and post-test. There may not have been enough time for hope to make a difference in only a two and a half week period. It may be possible that a long-term follow-up assessment would find that trait hope plays a significant role in predicting career workshop outcome because participants' trait hope had time to make a difference. In essence, all participants, low and high hope alike, experienced moderate short-term gains from the workshop. However, in the long-term, maybe those high in hope would outperform those low in hope because their more goal-oriented mindset and

behaviors would help them progress more effectively through the career planning and job search processes.

The second purpose of this study was to assess the effectiveness of the Career Transitions workshop as demonstrated by change scores from pre-treatment to post-treatment on career decidedness, career decision-making self efficacy, vocational identity, state hope, and work hope.

In regard to these five research questions, this study did show significant differences in change scores from pre-treatment to post-treatment on four out of five of the outcome measures. The participants in the Career Transitions workshop scored significantly higher, after completing the workshop, on career decidedness, career decision-making self efficacy, vocational identity, and state hope. The only non-significant change scores were for the work hope scale.

Therefore, it would appear that those who participate in the Career Transitions workshop experience significant gains in career decidedness, career decision-making self efficacy, vocational identity, and state hope, even though they do not demonstrate significant gains on work hope scale scores.

Limitations

A number of limitations are inevitable with treatment outcome studies such as this one. First, only 73% of the initial participants in the study completed all five sessions of the workshop and all of the questionnaires from pre-treatment

to post-treatment. Despite this moderately large dropout rate, no significant differences were found on any of the demographic variables between those who completed and those who dropped out of the study. Second, the relationship of statistical power and the size of the effect under investigation should be considered when interpreting these findings. Third, a longer term follow-up with participants of career transitions may be a better measure of outcome from the workshop. Follow-up scores would help determine the stability of outcome for the participants' career decidedness, career decision-making self efficacy, and vocational identity. Fourth, the small sample size should merit caution when interpreting the results. Fifth, the current study did not include a control group. Sixth, the quasi-experimental nature of this study also would suggest caution when interpreting results due to the nonrandomization of the participants. Seventh, this study was conducted with solely an adult population. As such, the findings will not generalize to high school or traditional college aged populations. Eighth, the participants in this study were predominantly Caucasian, and therefore not representative of the general population.

Implications of the Study

The lack of relationship found between hope and change scores from pre-treatment to post-treatment does not necessarily suggest there is no use for hope in

career interventions. On the contrary, there may be significant implications for the use of hope in the field of career development.

First, hope may be useful as a diagnostic assessment or intake checklist before a client is referred for services. Pre-treatment Hope Scale scores may aid the planning and process of career counseling by providing much needed information and generating meaningful discussion between counselor and client. Hope may also be a useful attribute to utilize when trying to match treatment type in order to maximize the effectiveness and efficiency of career interventions.

Second, adding workshop components aimed at increasing an individual's hope may significantly enhance the effectiveness of individual and group career interventions. The theory of hope and its accompanying measures serve well to generate meaningful discussion of goals, barriers, problem solving, and achievement oriented motivation. All of these issues are at the core of the career planning process for most individuals.

Third, hope may be significantly related to other outcome variables, or even process variables, within career planning interventions. While hope may not add to the prediction of change scores on some indicators, it may have a more significant relationship to the prediction of career maturity, or other standard career development measures. In addition, linking hope to individual process

variables within career counseling may serve to enhance the effectiveness, efficiency, and appeal of career counseling.

Recommendations for Future Research

In addition to the number of significant implications for career counseling practice, there are a number of future directions for research on hope and career development suggested by this study.

First, Sepich (1987) and others have suggested more study of the impact of specific components of an intervention and how the individual changes in the direction of greater decidedness. Hope may serve a role in expanding current knowledge of how individuals become decided and what specific components of treatment contribute to such gains.

Second, Mitchell and Krumboltz (1984) suggest the need for further research to focus on specific behavioral outcomes of career interventions rather than only self-report measures such as those used in the present study. This need is highlighted when it is considered that the attainment of career decidedness entails specific consequential behaviors (i.e., choice of major and/or career, entry into work, etc.) all of which can be measured. Due to the inherent nature of action and activity in hope's definition, there may be a more significant relationship between individuals' hope and behavioral outcomes of career interventions than was found between hope and attitudinal outcomes.

Third, the appropriateness of decisions made as a result of career workshop must be investigated further. There is risk of making a poor decision as a result of premature foreclosure of career options. Sometimes, the best option is to stay open-minded rather than decide on a career option before one is ready. It is possible that hope plays a meaningful role in predicting the appropriateness of an individual's career decision with or without completing a career intervention.

Fourth, this study is only a beginning, and not the final judgment, on the role of hope in career decidedness, career decision-making self efficacy, and vocational identity. Replications of this study, including a longer-term follow-up assessment, are still needed to know more about the role of hope in the career decision-making process, the relationship of hope to outcome from career interventions, and the predictive utility of hope in career intervention process and outcome.

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APPENDIX A

PARTICIPANT INFORMED CONSENT

The Department of Psychology and Research in Education supports the practice of protection for human subjects participating in research. The following information is provided for you to decide whether you wish to participate in the present study. You should be aware that even if you agree to participate, you are free to withdraw at any time without penalty.

The present study is designed to investigate several aspects of your career transition situation. If you agree to participate, I will ask you to complete a few short questionnaires both at the beginning and end of the study that should not take up more than 15 minutes of your time. It is believed that you will notice some benefits if you participate in this study. Specifically, it may provide you with further insight into your own career transition situation. It is also believed that the results of this study may benefit future individuals experiencing a career transition.

Your participation is solicited, although strictly voluntary. Please note that the type and length of intervention you receive will be the same, regardless of whether or not you participate in this study. Be assured that should you choose to participate, any information you provide will remain completely confidential, and your identity as an individual respondent will remain unknown. The information will be identified only by a number.

The results of this study will be completed by the end of the Spring 1999 semester and you are welcome to contact me (913) 469-3870 if you are interested in discussing them. Two forms have been included. One is for you to sign and keep, while the other should be signed and returned. I thank you in advance for your cooperation.

Sincerely,

Todd Schemmel, B.A.
Primary Investigator

Diane McDermott, Ph.D.
Dissertation Advisor

Signature

Date

With my signature, I acknowledge that I have received a copy of the informed consent form to keep.

APPENDIX B

Date: _____ Last 4 digits of Social Security #: _____

Decidedness Item & Demographic Form

1. I am entirely certain of what career to pursue. (circle one)

- 1 = Definitely False
- 2 = Mostly False
- 3 = Somewhat False
- 4 = Slightly False
- 5 = Slightly True
- 6 = Somewhat True
- 7 = Mostly True
- 8 = Definitely True

Age: _____

Gender: M F

Ethnicity:

- ____ American Indian/Native American
- ____ African American/Black (Non-Hispanic/Latino)
- ____ White/Caucasian (Non-Hispanic/Latino)
- ____ Mexican American/Chicano
- ____ Asian/Pacific American
- ____ Puerto Rican
- ____ Other Hispanic/Latino
- ____ Other: _____

Highest Educational Level Attained:

- ____ Graduate or Professional Degree
- ____ Bachelor's Degree
- ____ Associate's Degree
- ____ High School Diploma or GED
- ____ Other

APPENDIX C

Date: _____

Last 4 digits of Social Security #: _____

THE FUTURE SCALE

Directions: Read each item carefully. Using the scale shown below, please enter the number that best describes you and put that number in the blank provided.

- 1 = Definitely False**
- 2 = Mostly False**
- 3 = Somewhat False**
- 4 = Slightly False**
- 5 = Slightly True**
- 6 = Somewhat True**
- 7 = Mostly True**
- 8 = Definitely True**

- _____ 1. I can think of many ways to get out of a jam.
- _____ 2. I energetically pursue my goals.
- _____ 3. I feel tired most of the time.
- _____ 4. There are lots of ways around any problem.
- _____ 5. I am easily downed in an argument.
- _____ 6. I can think of many ways to get the things in life that are most important to me.
- _____ 7. I worry about my health.
- _____ 8. Even when others get discouraged, I know I can find a way to solve the problem.
- _____ 9. My past experiences have prepared me well for my future.
- _____ 10. I've been pretty successful in life.
- _____ 11. I usually find myself worrying about something.
- _____ 12. I meet the goals that I set for myself.

APPENDIX D

GOALS SCALE FOR THE PRESENT

Directions: Read each item carefully. Using the scale shown below, please select the number that best describes how you think about yourself right now and put that number in the blank before each sentence. Please take a few moments to focus on yourself and what is going on in your life at this moment. Once you have this “here and now” set, go ahead and answer each item according to the following scale:

- 1 - Definitely False**
- 2 - Mostly False**
- 3 - Somewhat False**
- 4 - Slightly False**
- 5 - Slightly True**
- 6 - Somewhat True**
- 7 - Mostly True**
- 8 - Definitely True**

- _____ 1. If I should find myself in a jam, I could think of many ways to get out of it.
- _____ 2. At the present time, I am energetically pursuing my goals.
- _____ 3. There are lots of ways around any problem that I am facing now.
- _____ 4. Right now, I see myself as being pretty successful.
- _____ 5. I can think of many ways to reach my current goals.
- _____ 6. At this time, I am meeting the goals that I have set for myself.

APPENDIX E

GOALS FOR LIFE SCALE

Directions: Please take a moment to contemplate your working life. Think about your job and job history. Once you have this in mind, using the scale shown below, please enter the number that best describes YOU and put that number in the blank provided.

- 1 - Definitely False**
- 2 - Mostly False**
- 3 - Somewhat False**
- 4 - Slightly False**
- 5 - Slightly True**
- 6 - Somewhat True**
- 7 - Mostly True**
- 8 - Definitely True**

- _____ 1. I can think of many ways to find a job.
- _____ 2. I am energetic at work.
- _____ 3. There are lots of ways to succeed at work.
- _____ 4. Even if it's a lousy job, I can usually find something good about it.
- _____ 5. I have a good work record.
- _____ 6. My previous work experiences have helped prepare me for future success.
- _____ 7. I can always find a job if I set my mind to it.
- _____ 8. I can think of lots of ways to impress my boss if the job is important to me.

APPENDIX F

CAREER QUESTIONNAIRE

Directions: For each statement below, please read carefully and indicate how much confidence you have that you could accomplish each of these tasks. Using the scale shown below, please enter the number that best describes YOU and put that number in the blank provided.

No Confidence at all	Very Little Confidence	Some Confidence	Much Confidence	Complete Confidence					
0	1	2	3	4	5	6	7	8	9

HOW MUCH CONFIDENCE DO YOU HAVE THAT YOU COULD:

- _____ 1. Find information in the library about occupations you are interested in.
- _____ 2. Select one major from a list of potential majors you are considering.
- _____ 3. Make a plan of your goals for the next five years.
- _____ 4. Determine the steps to take if you are having academic trouble with an aspect of your chosen major.
- _____ 5. Accurately assess your abilities.
- _____ 6. Select one occupation from a list of potential occupations you are considering.
- _____ 7. Determine the steps you need to take to successfully complete your chosen major.
- _____ 8. Persistently work at your major or career goal even when you get frustrated.
- _____ 9. Determine what your ideal job would be.
- _____ 10. Find out the employment trends for an occupation over the next ten years.
- _____ 11. Choose a career that will fit your preferred lifestyle.
- _____ 12. Prepare a good resume.
- _____ 13. Change majors if you did not like your first choice.

- _____ 14. Decide what you value most in an occupation.
- _____ 15. Find out about the average yearly earnings of people in an occupation.
- _____ 16. Make a career decision and then not worry about whether it was right or wrong.
- _____ 17. Change occupations if you are not satisfied with the one you enter.
- _____ 18. Figure out what you are and are not ready to sacrifice to achieve your career goals.
- _____ 19. Talk with a person already employed in the field you are interested in.
- _____ 20. Choose a major or career that will fit your interests.
- _____ 21. Identify employers, firms, institutions relevant to your career possibilities.
- _____ 22. Define the type of lifestyle you would like to live.
- _____ 23. Find information about graduate or professional schools.
- _____ 24. Successfully manage the job interview process.
- _____ 25. Identify some reasonable major or career alternatives if you are unable to get your first choice.

APPENDIX G

Try to answer all the following statements as mostly TRUE or mostly FALSE. Circle the answer that *best represents your present opinion*.

In thinking about your present job or in planning for an occupation or career:

- | | | |
|--|---|---|
| 1. I need reassurance that I have made the right choice of occupation. | T | F |
| 2. I am concerned that my present interests may change over the years. | T | F |
| 3. I am uncertain about the occupations I could perform well. | T | F |
| 4. I don't know what my major strengths and weaknesses are. | T | F |
| 5. The jobs I <i>can do</i> may not pay enough to live the kind of life I want. | T | F |
| 6. If I had to make an occupational choice right now, I am afraid I would make a bad choice. | T | F |
| 7. I need to find out what kind of career I should follow. | T | F |
| 8. Making up my mind about a career has been a long and difficult problem for me. | T | F |
| 9. I am confused about the whole problem of deciding on a career. | T | F |
| 10. I am not sure that my present occupational choice or job is right for me. | T | F |
| 11. I don't know enough about what workers do in various occupations. | T | F |
| 12. No single occupation appeals strongly to me. | T | F |
| 13. I am uncertain about which occupation I would enjoy. | T | F |
| 14. I would like to increase the number of occupations I could consider. | T | F |
| 15. My estimates of my abilities and talents vary a lot from year to year. | T | F |
| 16. I am not sure of myself in many areas of life. | T | F |
| 17. I have known what occupation I want to follow for less than one year. | T | F |
| 18. I can't understand how some people can be so set about what they want to do. | T | F |



For questions 19 and 20, circle the Y if your answer is YES, the N if your answer is NO.

19. I need the following information:

- | | | |
|--|---|---|
| How to find a job in my chosen career. | Y | N |
| What kinds of people enter different occupations. | Y | N |
| More information about employment opportunities. | Y | N |
| How to get the necessary training in my chosen career. | Y | N |

Other: _____

20. I have the following difficulties:

- | | | |
|--|---|---|
| I am uncertain about my ability to finish the necessary education or training. | Y | N |
| I don't have the money to follow the career I want most. | Y | N |
| I lack the special talents to follow my first choice. | Y | N |
| An influential person in my life does not approve of my vocational choice. | Y | N |

Anything else? _____

Other comments or questions: _____

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