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PREDICTORS OF WORKING ALLIANCE EFFICACY AMONG STATE VR COUNSELORS AS A FUNCTION OF EX-OFFENDER STATUS

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ABSTRACT

The purpose of this study was to determine if statistically significant relationships existed between burnout, stigma, flourishing, caseload size, experience, and working alliance self-efficacy and to assess the predictive power of these variables on levels of working alliance self-efficacy with clients with disabilities alone and clients with disabilities with criminal histories in state VR providers. A non-experimental survey research design was used in this study. Participants completed instruments related to stigma (Attitudes towards Mental Illness Questionnaire), burnout (Counselor Burnout Inventory), flourishing (Flourishing Scale), and working alliance self-efficacy (Working Alliance Self-Efficacy Estimates Scale). Using a two-tailed Pearson correlation analysis and multiple regression, this study showed that counselors with higher levels of working alliance self-efficacy tended to have higher levels of well-being, contentment, satisfaction, hope, and happiness (flourishing) and had lower levels of burnout and stigma. Post-hoc t-tests also showed that providers who worked with a greater proportion of clients with disabilities and criminal histories had higher levels of working alliance efficacy compared to those working with lower proportions. The effect of double stigma, in addition to burnout and flourishing, explained nearly one third of the variance in provider working alliance efficacy with clients who had two stigmatizing identities (disability plus criminal history) compared to a disability alone (6% of the variance explained).
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"When I thought I couldn't go on, I forced myself to keep going. My success is based on persistence, not luck."
~Estee Lauder

As I think back about this entire process, there are so many times that I wanted to give up and it seemed like all my confidence was lost. Oddly enough, looking back, those moments have been some of the most valuable to me. It was those times when I realized just how much I was loved and just how much people had invested in me; how much they believed in my ability to succeed even when I did not. Deirdre, you have been so helpful to me throughout this program and have reminded me time and again if I put in the effort and believe in my own abilities, I will get the job done. Thank you is simply not enough to express how much I appreciate you. Dr. Herbert, by believing in my ability to do well in this program, you have helped me tremendously. You have helped me to know both my strengths and weaknesses and I am so thankful for that balanced perspective. I have no doubt that it will keep me level-headed as I move forward. Dr. Yoder, you have done something I never thought was possible—you have made statistics accessible to me and significantly contributed to my success as a result. I cannot thank you enough for that. You took something frightening and explained it with baking analogies. Who could ask for more from a teacher? Peggy, you have encouraged me more than I can say and I aspire to be as kind, generous, and supportive as you are to my own students. It is nearly impossible to talk with you and not feel joy at some point in the conversation. Accordino, thank you so much for your belief in me! Stuart, Nancy, and Matt—I am honored to be your colleague. Finally, I need to thank my family for their unwavering support and willingness to stand with me through my periodic freak-outs; it means more than any of you will ever know. I never once doubted your belief in me and that is pretty special.
CHAPTER 1

INTRODUCTION

Working Alliance

The working alliance is an essential component in the process of change for helping relationships (Bordin, 1979; McMahon, Shaw, Chan, & Danczyk-Hawley, 2004; Hewitt & Coffey, 2005; Taber, Leibert, & Agaskar, 2011). The alliance between counselor and client has been consistently connected to successful counseling outcomes (Bordin, 1979; Horvath & Symonds, 1991; Strauser, Lustig, & Donnell, 2004; Howard, Turner, Olkin, & Mohr, 2006; Lustig, Strauser, Rice, & Rucker, 2002; Tryon, Blackwell, & Hammel, 2007). The working alliance is not bound to a particular counseling theoretical orientation; rather the construct can be applied across orientations and techniques (Strauser et al., 2004; Horvath & Bedi, 2002). Bordin (1979) further stated that the working alliance between the client and provider may be the key to the change process. Working alliance can be understood as collaboration between the counselor and client with three central components: development of bonds, an agreement on goals, and the assignment of tasks (Bordin, 1979).

The development of bonds, linked to both agreement on goals and tasks of the counseling process, focuses on the personal interactions and attachments between the counselor and client (Bordin, 1979; Chan et al., 1997). Bonding can be expressed in various ways including liking one another, mutual trust, and a sense of shared purpose or meaning (Lustig et al., 2002). The development of bonds occurs through interaction between counselor and client (Bordin, 1994). The degree of bonding varies with the tasks; for example, exploring personal feelings and experiences requires a deeper level of 
trust and bond than does the completion of intake paperwork (Bordin, 1979). Bordin (1979) further stated that the goals and tasks are “intimately related” to bonds and that when attention is paid to the “protected, inner recesses” of client experience, deeper bonds develop (p. 254). Moreover, the concept of bonds is related to levels of trust and rapport that exists in the counseling relationship; the stronger the bonds, the stronger the alliance.

The second component of a strong working alliance is mutual agreement and valuing of counseling goals; both the counselor and client have influence over the designation of goals (Chan, Shaw, McMahon, Koch, & Strauser, 1997; Bordin, 1979). During goal development, the counselor and client assess each other’s commitment to the process and levels of motivation. The client also evaluates the counselor’s commitment to assisting him or her and whether or not the counselor perceives the client as a collaborative partner or a dependent (Bordin, 1979). The degree to which the client understands the goals of counseling may also influence his or her level of motivation (Lustig et al., 2002); Bordin (1979) believed that this understanding served a therapeutic purpose and initiated early change processes. The process of establishing and agreeing upon goals helps to facilitate the development of counselor-client bonds (Lustig et al., 2002). Further, identifying and agreeing upon a change goal helps determine the tasks to be carried out in order to reach it (Lustig et al., 2002).

Tasks are the techniques or counselor behaviors that characterize the counseling process (Bordin, 1994). Tasks vary depending on the counselors’ theoretical orientation. Behavioral counselors, for example, may focus on the frequency of current behaviors and accompanying rewards rather than past experiences. Gestalt counselors may focus more
on client actions over thought content, whereas psychodynamic counselors may spend time analyzing inner experiences of clients (Bordin, 1979; Lustig et al., 2002). Client-centered therapies, in contrast, may never explicitly state the tasks, but instead let them naturally emerge over the course of the relationship. The degree of responsibility for the inclusion of tasks also varies across theoretical orientations, but Bordin (1994) noted that the counselor and client must each accept responsibility for meaningful participation related to tasks. Further, the effectiveness of tasks is not linked to counselor theoretical orientation, but to the degree that counselors are able to connect the task to the prospect of change in relation to each client’s circumstances (Bordin, 1979). The more convinced the client is that the tasks are purposeful and goal-oriented, the stronger the alliance. In contrast, disagreement on goals and tasks coupled with a weak counselor-client bond will likely lead to less client engagement and less favorable treatment outcomes (Chan et al., 1997; Bordin, 1979).

Diagnosis category in combination with level of provider experience also appears to have an effect on perceptions of working alliance (O’Sullivan, in press; Tryon et al., 2007). Clients without addiction and experienced providers had similar ratings of working alliance when compared to clients and trainee therapists. Clients with addiction, however, consistently rated their alliances with experienced providers more positively than the counselor when compared to clients without substance abuse (Tryon et al., 2007). Increased provider experience with a specialized population does not always lead to higher levels of confidence in forming a working alliance with that population and may actually have an inverse effect (O’Sullivan, in press). Increased experience with clients with psychiatric diagnoses did not increase working alliance efficacy with that client.
population, although increases were seen with regards to clients with physical disabilities (O’Sullivan, in press).

Client dropout is also more commonly connected to inexperienced therapists than experienced providers, strongly suggesting a connection between provider experience and working alliance (Roth & Fonagy, 1996). Further, Carmel and Friedlander (2009) found that having increased levels of confidence and efficacy in one’s work with clients who have sexually offended was the single most important factor in the providers’ perceptions of the relationship. Years of experience was found to be a statistically significant predictor of such efficacy and subsequently predicted strong working alliance perceptions among counselors (Carmel & Friedlander, 2009).

As previously noted, researchers have found a robust link between the working alliance and client outcome (Horvath & Symonds, 1991; Horvath & Bedi, 2002). An alliance that experiences a rupture which is subsequently repaired is related to more positive outcomes when compared with an alliance with no ruptures, or an alliance with a rupture that is not mended; such evidence speaks to the resilience of the alliance (Stiles et al., 2004). More specifically, the interpersonal learning and immediacy characteristic of strong alliances contribute to the rebound of the relationship while positively influencing overall client outcomes (Stiles et al., 2004). Many variables have the potential to impact the strength or quality of the alliance including provider empathy and well-being, stigma, client education, provider experience, treatment setting, and the degree of bonding between provider and client (Sharf, Primavera, & Diener, 2010; Bordin, 1979).
Stigma

Researchers have noted that positive attitudes and the expression of empathy from providers towards clients are essential in the formation and maintenance of the working alliance (Keane, 1990; Yuker, 1995). Provider stigma in particular may impair the providers’ ability to connect to and work collaboratively with clients, thereby impeding the formation of bonds which may ultimately lead to reduced levels of working alliance efficacy (Bordin, 1979; Yuker, 1995).

Several definitions of stigma exist in the literature. Stigma can be defined as an objectionable social mark that discredits members of a social group (Major & O’Brien, 2005) including people with disabilities and ex-offenders. The concept has expanded over time to include any mark of a perceived deviation from the socially defined norm (Jones et al., 1984). Goffman (1963) characterized stigma as a socially defined attribute that is “deeply discrediting” (p.3), effectively blemishing one’s social identity, and preventing full social acceptance.

Stigma has also been defined as an unwanted, usually undesirable attribute that discredits the stigmatized individual in the eyes of others (Link, Cullen, Mirotznik, & Struening, 1992; Corrigan & Penn, 1999). People who are stigmatized have social identities or membership in a social category which calls into question his or her full humanity (Crocker, Major, & Steele, 1998; Shih, 2004). Further, such individuals are commonly devalued in the eyes of others, viewed as flawed, deviant, and undesirable (Shih, 2004; Jones et al., 1986). Essentially, stigmatization occurs when differences in behaviors or characteristics are identified, labeled, and subsequently linked with negative attitudes or stereotypes (Fortney et al., 2004). Moreover, stigmas are social marks that
may lead to prejudice when observed or perceived by a majority group member (Corrigan & O'Shaughnessy, 2007; Pryor, Reeder, Yeadon, & Heeson-McInnis, 2004).

The impact of stigma on attitudes towards people with disabilities is of significant concern in the general population, but may be even more salient in helping professionals. Yuker (1995) stated that attitudes towards clients are one of the most important aspects in determining an individual’s response to treatment and rehabilitation. Positive attitudes towards people with disabilities generally lead to positive feelings and interactions whereas negative attitudes often lead to bias and discriminatory behaviors (Yuker, 1995). Further, positive attitudes among helping professionals towards clients have been described as a crucial ingredient in the formation and maintenance of the working alliance (Keane, 1990). Clients show greater improvements with professionals who demonstrate high levels of empathy compared to clients working with professionals who function at lower levels of empathy (Keane, 1990; Yuker, 1995).

Stigmatizing attitudes towards people with disabilities can impact overall well-being and recovery processes, particularly through reduced employment and social/community isolation (Rao, Horton, Tsang, Shi, & Corrigan, 2010). Stigma may impact the willingness to engage in treatment, the working alliance, self-esteem, and has the potential to impact rehabilitation outcomes (Mann & Himelein, 2008; Corrigan & Penn, 1999; Corrigan et al., 2000; Penn, Kommana, Mansfield, & Link, 1999; Johnstone, 2001; Overton & Medina, 2008; Corrigan & Watson, 2002). Researchers have also suggested that stigma-driven (based on faulty assumptions) responses to clients with mental illness may not only contribute to stigma, but may worsen symptoms (Penn & Martin, 1998; Sadow, Ryder, & Webster, 2002).
Garske and Stewart (1999) added that vocational counselors may unknowingly reinforce stigma through interactions with clients by holding faulty ideals regarding the nature of the disability, and through the perpetuation of negative stereotypes and expectations regarding treatment adherence, dependency roles, and the inappropriate use of work placements (i.e., limiting work placements to the four Fs [food service, flowers, folding, and filth]) (Garske & Stewart, 1999; Dovidio, Pogatto, & Hebl, 2011). Provider stigma and its impact on factors associated with client outcomes and working alliance must be investigated further, particularly in the rehabilitation counselor population; studies relating specifically to rehabilitation counselor provider stigma are currently lacking.

Moreover, stigma becomes a primary concern when people with disabilities are seeking or working to maintain gainful employment, the primary goal of vocational counseling. False perceptions of dangerousness or responsibility for his or her condition by providers can lead to self-stigma and lower self-esteem, less social support, denial of employment, and less willingness to engage in the working alliance or counseling relationship (Corrigan, Larson, & Kuwabara, 2007; Yuker, 1995).

**Burnout**

Burnout, a second factor, must also be investigated in the context of the working alliance. Similar to provider stigma, burnout has the potential to reduce the strength of the working alliance and overall quality of the counseling relationship by limiting the degree of bonding between provider and client. Burnout can be understood as a multidimensional state with three central components: emotional exhaustion, depersonalization, and a lack of personal accomplishment (Maslach, 2005; Maslach &
Emotional exhaustion occurs when one’s emotional resources are depleted; individuals may also feel used-up and overworked, having nothing left to give. Factors such as low control in the workplace, high caseload and work demands, and insufficient resources or time in which to complete assignments are primary contributors to counselor burnout (Harris, 1984; Osborn, 2004). Not surprisingly, counselors are prone to burnout as a result of role expectations and the emotionally demanding nature of the work (Kirk-Brown & Wallace, 2004).

Negative attitudes towards clients and others are indicative of depersonalization and may lead to responsibility attributions (Maslach, 2005, Corrigan & Watson, 2007). Lack of personal accomplishment refers to feelings of unhappiness about oneself and one’s work-related achievements. Burnout is frequently associated with extended periods of stress in combination with feelings of helplessness, inflexibility, and negative thought patterns (Osborn, 2004, Harris, 1984). Related to the current investigation, burnout has the potential to reduce the quality of care provided to clients, and may directly impact the providers’ ability to enter and maintain a quality working alliance (McCarthy & Frieze, 1999). It is also possible that the combination of burnout and stigma may have a synergistic effect with burnout acting as a contributor to provider stigma; the two constructs have yet to be studied in combination in the rehabilitation counselor population.

Despite the connection of provider burnout with client outcomes, there is a significant research gap related to burnout among vocational rehabilitation counselors. Studies focusing on burnout in the rehabilitation counselor population are more than 20
years old and conceptual in nature. Nonetheless, burnout has been linked to rehabilitation counselor turnover and poor counselor performance (Riggar, Garner, & Hafer, 1984; Maslach & Florian, 1988). A new concept known as flourishing has surfaced over the last decade and may add to the literature on protective factors related to burnout.

**Flourishing**

The concept of flourishing emerged from the school of positive psychology. Positive psychologists assert that the field of psychology has largely focused on healing and repairing damage according to the disease model (Seligman & Csikszentmihalyi, 2000). Further, it is suggested that the field has exclusively focused on pathology and as such, inadvertently ignores individuals who are “fulfilled” (Seligman & Csikszentmihalyi, 2000, p. 5). Positive psychologists, in contrast, present a strengths-based approach focused on identifying and enhancing the positive qualities of both clients and providers.

According to Seligman and Csikszentmihalyi (2000), positive psychology is centered on “valued subjective experiences” (p. 5) including well-being, contentment, past and present satisfaction, hope for the future, and present happiness (Diener, Suh, Lucas, & Smith, 1999). These qualities or experiences comprise the notion of flourishing (Diener et al., 2010). This philosophy of empowerment fits well within the rehabilitation counseling philosophy (Commission on Rehabilitation Counselor Certification (CRCC) (2011) which also emphasizes advocacy, abilities, and utilization of personal resources.

The primary message of positive psychology is that the study of pathology, weakness and psychological damage is limited; the ideas of strength and virtue must also be included for a complete psychological picture to take shape (Seligman &
Csikszentmihalyi, 2000). Treatment, therefore, should focus both on repairing damage and deficits as well as nurturing the positive attributes of clients. Prevention is crucial to this approach; research on protective factors has shown that strengths such as resilience and hope can serve as buffers against mental illness and substance use (Hawkins, Catalano, & Miller, 1992).

The concept of flourishing is an outcrop of subjective well-being (SWB). Subjective well-being is a category of phenomena, according to Diener et al. (1999), and includes emotional responses and global judgments of life satisfaction. SWB researchers argue the value of individual experiences and subjective views in evaluating one’s life (Diener et al., 1999). It is also believed that social indicators such as age, marital status, and economic status do not define quality of life (Diener & Suh, 1997). People are thought to evaluate circumstances and conditions through a unique, subjective lens based on individual expectations, values, and life experiences.

The basic ideas of positive psychology are also being integrated into the field of criminology and the treatment of ex-offenders in the form of positive criminology (Ronel & Elisha, 2011). Positive criminology refers to a focus on individuals’ encounters with positive influences, effectively distancing them from deviance and crime. Examples include counseling and therapy, social acceptance, exposure to goodness, and the enhancement of positive personal traits such as resilience (Ronel & Elisha, 2011).

Similar to positive psychology, positive criminology focuses on understanding the factors which lead individuals to a negative way of living and to combat them by enhancing ones’ strengths and personal resources. Moreover, there is a focus on what keeps individuals away from crime and not only on what drives them towards it.
Connecting this emerging perspective to the current investigation, it is essential to understand the different lenses through which providers may view clients with criminal histories and how those perspectives may protect against burnout and stigma.

Rationale for Current Study

The working alliance is an integral piece of the counseling relationship (Bordin, 1979; McMahon et al., 2004; Hewitt & Coffey, 2005; Taber et al., 2011). As a result, it is imperative to understand how provider perceptions and characteristics can influence the formation of this alliance. Provider experience has also been shown to impact perceptions of the working alliance, along with caseload size and make up (i.e., client disabilities). Further, the impact of stigma on counselor attitudes towards clients with disabilities and criminal histories is a salient issue in the rehabilitation counseling field (Yuker, 1995; Keane, 1990; Schneider & McKim, 2003). Yuker (1995) stated that attitudes towards clients are one of the most important aspects in determining an individual’s response to treatment and rehabilitation. Stigmatizing attitudes can impact the formation of the working alliance, the willingness of clients to engage in treatment, impact levels of self-esteem, and negatively influence overall client outcomes (Mann & Himelein, 2008; Corrigan & Penn, 1999; Corrigan et al., 2000; Penn et al., 1999; Johnstone, 2001; Overton & Medina, 2008; Corrigan & Watson, 2002). Importantly, positive attitudes towards clients may be a defining component of the helping relationship and working alliance, an alliance that has been consistently linked to positive client outcomes (Keane, 1990; Bordin, 1979; Horvath & Symonds, 1991; Strauser et al., 2004; Howard et al., 2006; Lustig et al., 2002; Tryon et al., 2007).
Similarly to stigma, counselor burnout can also influence the quality of care provided to clients and levels of job and life satisfaction (flourishing) in the counselors (Min Lee et al., 2010; McCarthy & Frieze, 1999; Osborn, 2004; Sprang et al., 2007). Recent research related to burnout in rehabilitation counselors is currently lacking. Burnout has been described as rehabilitation counselors’ “hidden handicap” (Emener, 1979, p.58). Smith (1984) later stated that burnout was partially responsible for turnover in rehabilitation agencies and that it has been linked to poor rehabilitation counselor performance (Riggar, Garner, & Hafer, 1984). Flourishing research is similarly lacking despite its likely connection to counselor burnout. No studies specifically examining the impact of vocational rehabilitation counselor stigma and burnout on perceived ability to work with disability groups and ex-offenders could be located. Further, no studies could be located which examined the predictive qualities of stigma, burnout, flourishing, and experience on perceptions of rehabilitation counselor working alliance with client groups.

Purpose of Current Study

The current investigation will begin to fill these gaps, investigating the rehabilitation counselor burnout, stigma, flourishing, and work experience. The impact of these variables will be investigated in relation to counselor perceptions of working alliance with clients who have disabilities alone and disabilities with criminal histories. This research will provide more up to date information regarding stigma, burnout, flourishing, experience, and working alliance efficacy in the vocational rehabilitation counselor population. This information has the potential to inform workshops and trainings for practicing rehabilitation counselors working with clients with disabilities and criminal histories as well as rehabilitation counselors-in-training. CORE and
CACREP programs could potentially incorporate such information into the curriculum around working with diverse client populations. Opportunities for professional development seminars around working alliance efficacy, burnout, and stigma also exist.
CHAPTER 2
REVIEW OF THE LITERATURE

Working Alliance Efficacy

The working alliance construct has been well established in the research literature and has been consistently linked to client outcomes. Horvath and Symonds (1991) conducted a meta-analysis of 24 studies which examined the relationship between working alliance and client outcomes in psychotherapy. Outcome variables differed across studies and included variables such as depressive symptoms, premature termination, termination outcomes, social adjustment, drug use, employment status, and satisfaction with treatment (Horvath & Symonds, 1991). The researchers calculated a composite effect size ($r = .26$) that was found to be moderate and statistically significant. Moreover, the review found that the strength of the working alliance was a stronger predictor of positive client outcomes than type of counseling, intervention, or treatment length (Horvath & Symonds, 1991).

Based on their review, researchers concluded that the working alliance robustly links psychotherapy processes to client outcome. Further, working alliance as a contributor to client outcomes was found across therapeutic orientation and a moderate, reliable association between working alliance and outcome was found overall regardless of treatment length (Horvath & Symonds, 1991). Other meta-analyses have lent further support, noting that the alliance is an important aspect of all types of treatment and is not contingent on which type of intervention is used (Horvath & Bedi, 2002; Martin, Garske, & Davis, 2000). Finally, the clients’ assessment of the quality of the working alliance was also tied to outcomes, with client assessment acting as a predictor of the strength or
quality of the working alliance (Horvath & Symonds, 1991). A more recent meta-analysis by Martin et al. (2000) analyzed 79 studies, finding similar results. A consistent relationship existed between working alliance and client outcome while controlling for other variables which influenced the relationship.

Client Dropout

Working alliance has also been connected to client engagement and treatment retention. Sharf et al. (2010) conducted a meta-analysis based on previous research demonstrating the link between client dropout and working alliance (Roth & Fonagy, 1996; Wierzbicki & Pekarik, 1993). Researchers noted that recent meta-analytic reviews of dropout primarily focused on client demographic variables predictive of dropout (i.e., minority racial status, low education, and low socioeconomic status) and not on client-counselor interactions. Breaking away from that trend, eleven studies focused on the relationship between psychotherapy dropouts and working alliance were reviewed; all studies centered on adult individual psychotherapy.

Effect sizes were aggregated across studies (Sharf et al., 2010). In addition, continuous moderator analyses were conducted using mixed effects meta-regression analyses; the average effect size for each study served as the dependent variable with the continuous moderator (client education, treatment length, and setting) acting as the covariate. Researchers (Sharf et al., 2010) also noted that each covariate was analyzed using a separate meta-regression. Across the eleven studies, over one thousand participants were included ($N = 1,301$) with individual studies ranging from 20 to 451 participants ($M = 118$, $SD = 115$).
Effect sizes for the differences in dropout rate and WA were calculated for each of the eleven studies and weighted. Results indicated that clients with weaker working alliances were more likely to drop out of treatment when compared with those clients who had stronger alliances (weighted mean $d = .55$, 95% CI [.37, .73], $Z = 5.92$, $p <.001$). Client education, treatment length, and treatment setting were all found to be statistically significant moderators of the relationship between the WA and dropout (Sharf et al., 2010). Studies with higher proportions of people who completed high school or higher degrees of education demonstrated weaker associations between alliance and dropout when compared with clients who did not complete high school ($p = .045$). Longer treatment periods demonstrated stronger relationships between alliance and dropout ($p = .01$); increasing from nine to 16 sessions and from 16 to 40 sessions produced an increase of .42 effect size units (Sharf et al., 2010).

Inpatient settings produced the largest weighted effect size average ($d = .98$) compared to both outpatient settings ($d = .68$), research clinics ($d = .46$) and finally counseling centers ($d = .33$). Researchers concluded that strengthening the quality of the working alliance may be one way to effectively reduce client drop out; the moderating variables of client education, treatment length, and setting are also important considerations. Moreover, if providers are not able to form a strong working alliance with clients, higher rates of dropout may result, subsequently lowering client outcomes. These results are in contrast with previous meta-analyses (Horvath & Symonds, 1991; Horvath & Bedi, 2002; Martin et al., 2000) which found that the alliance, not client or treatment characteristics (i.e., client level of education, treatment length), was the most important aspect of treatment.
Client Diagnosis

The influence of client diagnosis on perceptions of working alliance has also been noted in the literature. In a meta-analysis of 53 studies of counselor and client working alliance ratings, Tryon et al. (2007) noted that clients presenting with substance abuse (SA) problems had larger discrepancies ($Z = 13.03, p > .001$) in their ratings of the relationship with experienced counselors than did clients without SA issues (Tryon et al., 2007). Further research has supported the influence of substance abuse and dependence on ratings of working alliance (Cecero et al., 2001; Connors, Carroll, DiClemente, Longabaugh, & Donovan, 1997; Meier, Donmall, Barrowclough, McElduff, & Heller, 2005).

Clients with substance abuse or substance dependency consistently rated the relationship more positively than the counselor or therapist ratings ($d = .96$). Some researchers have suggested that clients may be viewing the relationship through a lens which compares the counseling alliance to other relationships, such as with a physician who assumes a more dominant role or with friends or clergy who may offer more directives (Tryon et al., 2007). It is also possible that lower ratings of the alliance by providers may be attributable to stigma, burnout, category of disability, or level of experience (O’Sullivan, in press). Additionally, researchers commonly list multiple diagnoses in participant summaries, but do not typically include diagnosis type in the final analyses as a variable of interest (Tryon et al., 2007). As a result, a gap remains in the literature around how dual or multiple diagnoses influence working alliance perceptions from the perspectives of both provider and client. O’Sullivan (in press) noted a similar trend stating that while research has consistently connected client perceptions of
the working alliance to outcomes, less is known about provider perceptions.

Additional evidence exists to suggest that type of disability in combination with level of experience plays a role in working alliance perceptions and efficacy. O’Sullivan (in press) found a positive, statistically significant relationship \( r = .32 \) between number of years working with people with physical disabilities and working alliance efficacy scores related to clients with physical impairments; a statistically significant interaction effect was also noted \( F(1, 90) = 8.97, (p > .01) \) with a medium effect size \( \eta^2 = .09 \). The relationship between years of experience working with people with psychiatric disabilities and working alliance efficacy scores for that group did not produce a positive relationship however. Further, years of experience with people with psychiatric disabilities did positively relate \( r = .31 \) to working alliance efficacy scores for people with physical disabilities (O’Sullivan, in press). Moreover, increased work experience with people with psychiatric disabilities does not necessarily increase working alliance efficacy with this population, but increases are seen in other disability groups. The author noted that an explanation for this discrepancy may be burnout and stigma among providers due to the unpredictable or unstable nature of some psychiatric disabilities (O’Sullivan, in press). The difficulties around placement and job retention for some individuals in this population may also contribute to a perceived lack of accomplishment in the provider, a central component in counselor burnout (Maslach, 2005).

**Professional Characteristics of Providers**

Provider experience has also been shown to impact perceptions of the working alliance. Mallinckrodt and Nelson (1991) found that alliance ratings differed depending on provider experience from the perspectives of both therapists and clients. A review of
twelve studies related to the impact of experience in psychotherapy revealed a small positive association between provider experience and the quality of the relationship early in treatment (Auerbach & Johnson, 1977). Therapist ratings, however, have not been shown to consistently predict client ratings of the alliance (Dunkle & Friedlander, 1996; Hersoug, Hoglend, Monsen, & Havik, 2001). Client dropout is more commonly connected to inexperienced therapists than experienced providers, however, signifying a connection between provider experience and WA (Roth & Fonagy, 1996). Trainees have also been found to develop skills for building the working alliance early on, followed by use and mastery of techniques, and finally the adoption of a professional theoretical identity. The ability to form a strong working alliance then is essential to further professional development (Mallinckrodt, 2000).

Further research on the professional and personal characteristics of providers has also connected level of experience and skill to ratings of working alliance with psychiatric populations. Hersoug et al. (2001), as part of the Norwegian Multisite Project on Process and Outcome of Psychotherapy (NMSPOP), investigated professional variables (i.e., formal training, experience, self-rated skill), therapists’ self-reports on personal characteristics (i.e., interpersonal problems, early parental bonding), and client-therapist similarities in characteristics and values as related to ratings of working alliance. Client participants ($N = 270$) were sampled from seven outpatient psychiatric clinics. Six of the sites offered open-ended psychodynamic therapy with no specific end date while the remaining site had a maximum of 40 sessions though operated from a similar theoretical standpoint; treatments were not standardized with individual therapists proceeding based on his or her clinical inclinations. Exclusion criteria included clients
under 20 years old, psychosis, addiction as the primary diagnosis, mental retardation, and acute crisis situations (i.e., suicidal) (Hersoug et al., 2001).

Professional identities of participating providers varied, with 39 providers identifying as clinical psychologists, 13 as psychiatrists, four as social workers, and three as nurses (Hersoug et al., 2001). Working alliance was measured by the *Working Alliance Inventory* (WAI) (Horvath & Greenberg, 1989). The widely used WAI assesses three aspects of the working alliance: Bonds, Tasks, and Goals. Professional variables were assessed by the *Development of Psychotherapists’ Common Core Questionnaire (CCQ)* (Orlinsky, Ambuehl, Ronnestad, et al., 1999). Experience was defined as years of postgraduate clinical practice, training as the years of postgraduate formal training as a psychotherapist, and skill as the ability to engage clients in the WA and general therapy skills as rated on a 5-point Likert scale. Personal variables were measured by the *Inventory of Interpersonal Problems (IIP-C)* (Horowitz, Rosenberg, & Baer et al., 1988), the *Structural Analysis of Social Behavior* (SASB) (Benjamin, 1974), the *Parental Bonding Instrument (PBI)* (Parker, Tuplin, & Brown, 1979), and self-reports; clients filled out parallel versions of each instrument. Working alliance was rated after sessions three, twelve, twenty, and then after every twenty sessions thereafter; data from sessions three and twelve were subsequently analyzed.

Moderate correlations were found between client-rated and therapist-rated alliance scores following session three (\( r = .37, p < .01 \)) and twelve (\( r = .43, p < .01 \)). Researchers argued that these findings were in line with previous research stating that clients and therapists have different interpretations of the WA. On average, clients (\( M = 4.94, SD = 1.08 \)) rated the WA higher compared with therapists \( M = 4.66, SD = .82 \) after
three sessions and twelve sessions (client: $M = 5.15$, $SD = .96$; therapist: $M = 4.89$, $SD = .79$) (Hersoug et al., 2001). On the whole, results were mixed. The relationships between training, experience, and WA scores were inconsistent and clients and providers differed in their ratings. Skill was related to WA, but only as rated by providers. Interpersonal problems of therapists, such as a tendency for aggression had a negative impact on the alliance from both the clients’ and therapists’ perspectives. As well, value similarity was related to a higher quality alliance as rated by clients, but not therapists.

Professional variables were predictive of alliance both early and later in the relationship with provider self-rated skill being the most robust predictor (Hersoug et al., 2001). Increased amounts of training were associated with a higher quality alliance after session twelve, while experience was associated with a lower quality alliance after three sessions according to client ratings. Researchers suggested that a poor client understanding of psychodynamic therapy may have resulted in lower alliance ratings early in the process of treatment (Hersoug et al., 2001).

More experience, training, and professional skill did not significantly impact client ratings of the working alliance. Researchers suggested that higher scores of self-rated skill from therapists may reflect higher levels of efficacy around possessing and using these skills with clients despite the contrary ratings of clients (Hersoug et al., 2001). Overall, therapist characteristics, including experience, accounted for 27 percent of the variance in working alliance ratings following the twelfth session based on provider ratings and 20 percent according to client ratings. Moreover, professional characteristics of the provider, such as experience and skill level, have an impact on the
quality of the working alliance; further investigation is needed however to provide more clarity on the nature of these connections.

*Criminal History*

Working alliance is starting to emerge in the corrections literature as well. Researchers have found evidence that the relationship between probation officers and probationers predicted future violations (Skeem, Louden, Polashek, & Camp, 2007; Tatman & Love, 2010). Additionally, Polashek and Ross (2010) examined the relationship between early-treatment therapeutic alliance, ratings of motivation to change, and initial change on dynamic risk factors in a sample of offenders engaged in an eight month cognitive-behavioral group treatment program in a New Zealand penal facility. The study was conducted over a three and a half year period and included seven group treatment cohorts ($N = 70$), two therapists per group, and treatment observers.

Prisoner ratings of alliance with the therapist were highly and significantly correlated with therapist ratings ($r = 0.69$, $p < .01$); observer ratings were similarly high ($r = 0.69$, $p < .01$) as were the ratings from each independent group leader ($r = 0.42$, $p < .01$). Prisoners reported the strongest alliances and they grew stronger over time; men who had the greatest increases in therapeutic alliance also made the most change in dynamic risk factors for violence; a moderate effect was found ($r = 0.32$, $p < 0.01$). These results lend further support to the notion that the alliance between counselor and client is connected to positive outcomes across settings and orientations to treatment.

Some researchers have found that the therapist-ratings of the alliance are not always significantly associated with client outcome measures (Horvath & Symonds, 1991; Howard et al., 2006). In explaining this, researchers suggested that providers may
view his or her ability to create a strong alliance as an indirect measure of competence, thereby inflating scores and underreporting difficulties or doubts; further research in this area was recommended (Howard et al., 2006). In order to clarify such discrepancies, working alliance efficacy must be assessed in relation to other variables which may influence outcomes such as provider stigma, burnout, and flourishing. Further investigation is needed.

Carmel and Friedlander (2009) also examined the impact of experience on providers’ perceptions of working alliance. More specifically, burnout, compassion fatigue and satisfaction, and secondary trauma were assessed in relation to experienced therapists’ perceptions of working alliance with clients who have committed sexual abuse. Providers working with clients who have committed crimes of a sexual nature have reported increased burnout, including diminished hope, cynicism and pessimism, and emotional exhaustion (Farrenkopf, 1992). Of note to the current investigation is the tendency for providers to subsequently feel and show less empathy for clients and for this emotional exhaustion to transcend the counseling relationship and enter the provider’s personal lives, diminishing life satisfaction (flourishing) (Farrenkopf, 1992; Carmel & Friedlander, 2009).

Researchers have also noted that clients convicted of crimes are likely to enter treatment with lower self-esteem and are therefore more attuned to therapist behaviors and characteristics (Marshall, Fernandez, et al., 2003). This population of clients, as a result of lower self-esteem, may rely more on counselor validation and are essentially more sensitive to signs of provider flourishing and/or burnout; a strong working alliance is essential (Marshall, Fernandez, et al., 2003). Participants \( N = 106 \) included therapists...
working in any therapeutic setting which served male clients convicted of a sexual offense. All participants identified as specialists in the area of sex offender treatment. Experience ranged from .83 years to 38 years of general clinical experience ($M = 12.70$, $SD = 8.66$) and specialized treatment ($M = 11.61$, $SD = 8.14$); average percentage of caseload with convictions was approximately 75 percent ($M = 76.03$, $SD = 30.60$) (Carmel & Friedlander, 2009).

Researchers (Carmel & Friedlander, 2009) found that high working alliance ratings had a statistically significant, positive relationship with high compassion satisfaction scores ($r = .60$) and a negative association with low scores on secondary trauma symptoms ($r = -.38$), compassion fatigue ($r = -.29$), and burnout ($r = -.29$). No statistically significant association was noted between gender and working alliance scores, although age ($r = .21$, $p < .05$), years of clinical experience ($r = .20$, $p < .05$), and years working with clients who have sexual offenses ($r = .30$, $p < .01$) did significantly correlate to WA scores. Hierarchical regression was calculated to determine the predictive qualities of the independent variables on working alliance scores. Age, years of clinical experience, and years working with clients who have sexual offenses were analyzed as covariates; years working with clients who have sexually offended emerged as the only uniquely statistically significant predictor ($\beta = .26$, $t(96) = 2.08$, $p < .04$). When the second set of predictor variables was added (compassion satisfaction, compassion fatigue, and burnout), the full model was statistically significant ($F(7, 92) = 8.11$, $p < .00$, $R^2 = .38$, adjusted $R^2 = .34$, $\Delta R^2 = .31$) (Carmel & Friedlander, 2009).

Researchers found that compassion fatigue, compassion satisfaction, specialized work experience with the population, and burnout accounted for 31 percent of the
variance in working alliance scores ($\Delta F = 11.37, p < .00$). Moreover, perceived alliances were strongest for providers who had more experience with clients who sexually offended compared to those with less experience. These results are in contrast with O’Sullivan (in press) who found that increased experience with a specialized psychiatric population did not increase provider perceptions of the working alliance. Finally, provider confidence in his or her abilities and a sense of satisfaction from the work were the most important factors impacting perceptions of working alliances with clients who had sexually offended (Carmel & Friedlander, 2009).

**Vocational Rehabilitation and Counseling Outcomes**

Lustig et al. (2002) examined the relationship between working alliance and vocational rehabilitation outcomes in the state-federal system. Researchers reviewed existing survey data ($n = 2732$) and found that working alliance was significantly related to client perceptions of future employment prospects (employed: $r = 0.51, p < .001$; unemployed: $r = 0.52, p < .001$) and levels of satisfaction with current employment ($r = 0.15, p < .001$). Moreover, the stronger the working alliance, the more positive the view of the client’s employment future for both employed and unemployed groups (Lustig et al., 2002).

Researchers have also examined working alliance in the context of rehabilitation counseling, focusing on its impact related to work with different disability groups. Howgego, Yellowlees, Owen, Meldrum, and Dark (2003) reviewed 84 studies from 1986 to 2001 related to therapeutic alliance and outcomes for individuals with mental illness. Working alliance was found to be positively associated with client outcomes such as medication compliance, life satisfaction, symptomatology, treatment compliance, and
community living. It also acted as a predictor of such outcomes for individuals engaged in community mental health and case management services. Strauser et al. (2004) examined the impact of working alliance on treatment outcomes for clients with mild mental retardation. Similar to Lustig et al. (2002), employed and unemployed participant ratings of working alliance were significantly correlated with future employment beliefs for this disability group ($r = 0.54, p < .001$, $r = 0.42, p < .001$ respectively) (Strauser et al., 2004). Working alliance has also been found to mediate the relationship between interpersonal problems and depression outcome in clients with multiple sclerosis. Clients who reported a stronger alliance demonstrated greater decreases in depressive symptoms (Howard et al., 2006).

Positive outcomes for clients with traumatic brain injury (TBI) have also been linked to working alliance (Schonberger, Humle, Seeman, & Teasdale, 2006). Researchers studied 98 individuals with acquired TBIs who were enrolled in a neuropsychological rehabilitation program involving cognitive, physical, and social training. Working alliance and compliance with treatment were rated independently by staff (neuropsychologist and physiotherapist) based on components similar to Bordin (1979). Compliance and alliance were strongly associated (Cramer’s statistic = 0.79, 0.76, $p < .001$ for the respective ratings) (Schonberger et al., 2006). Compliance was associated with a strong working alliance rating and low compliance ratings were associated with low alliance ratings. Researchers also found positive associations between alliance and post-treatment employment; clients with higher alliance ratings were more likely to be employed at follow-up ($M = 16$ months; $SD = 9$ months).
Moreover, it was concluded that a strong working alliance was a prerequisite for clients to willingly engage in treatment for his or her TBI (Schonberger et al., 2006).

**Self-efficacy and Rehabilitation Counseling**

Self-efficacy is the degree to which individuals believe themselves capable of performing an activity (Bandura, 1977). Self-efficacy theory assumes that a person’s sense of confidence in oneself “mediates the relationship between what people know how to do and what they actually do (Larson, Susuki, Gillespie, Potenza, Bechtel, & Toulouse, 1992, p. 105).” Essentially, how one perceives his or her self-efficacy related to a certain task shapes their corresponding behavior, thought patterns, and emotional responses (Larson et al., 1992; Bandura, 1982; Bandura, Barbaranelli, Caprara, & Pastorelli, 2001; Cramer, Neal, & Brodsky, 2009).

Strauser (1995) applied Bandura’s (1977) self-efficacy theory to rehabilitation counseling. While this paper was focused on applying efficacy concepts to rehabilitation clients, several concepts discussed are relevant to the current investigation. The author focused on the centrality of efficacy expectations to outcome expectations. Efficacy expectations are the individuals’ belief that he or she can perform certain behaviors to reach a desired outcome (Bandura, 1977). Outcome expectations were defined as the belief that these behaviors will result in certain outcomes. Individuals, who believe that certain actions produce certain results, but who doubt their ability in performing those actions, are unlikely to behave in a way consistent with outcome expectations (Strauser, 1995). Moreover, if an individual does not believe they can perform the behaviors needed to achieve the desired result, a different course of action may be taken, resulting in questionable or unknown outcomes. Supporting this notion, Sipps, Sugden, and Faiver
(1988) and Larson et al. (1992) found positive correlations ($r = .77, .75$ respectively) between counseling self-efficacy and outcome expectancies. The current investigation will not be measuring the actual alliance between counselor and client, but rather efficacy levels will act as a way to measure self-reports of working alliance (O’Sullivan & Strauser, 2009).

In addition to adequate efficacy, Strauser noted that adequate levels of incentive must also be present for the individual to perform desired behaviors (1995); lack of incentive can result in capable individuals exerting less effort to reach desired outcomes. Connecting these concepts to the current investigation, it is possible that burnout or stigma towards clients with disabilities and criminal histories may act as a disincentive for counselors, therefore reducing levels of efficacy or willingness to perform desired behaviors such as working alliance formation. In contrast, it is also possible that increased levels of flourishing or life satisfaction may provide incentive and mediate levels of burnout and stigma leading to higher levels of working alliance efficacy.

**Stigma**

The negative impact of living with stigma and discrimination is pervasive. As such, it is an important phenomenon worthy of continued examination, particularly for the most stigmatized conditions and circumstances. Individuals who are stigmatized often encounter discrimination and decreased opportunities in the areas of housing, employment, healthcare, relationships, and legal affairs (Corrigan et al., 2000; Shivy, Wu, Moon, Mann, Holland, & Eacho, 2007). These reduced opportunities lessen economic prosperity, quality of life, and psychological and physical health (Quinn &
Individuals who experience stigma and discrimination report lower levels of self-esteem and life satisfaction (flourishing) (Pyne et al., 2004).

The invisible barriers caused by external (societal) stigma may also influence an individual’s treatment outcome (Wong, Chan, Da Silvo Cardoso, Lam, & Miller, 2004; Shivy et al., 2007); there is evidence that stigma acts as a barrier to mental health services (Corrigan, Markowitz, Watson, Rowan, & Kubiak, 2003). To further describe this phenomenon, a review of the research literature related to stigma and people with disabilities and individuals with criminal histories is included.

People with Disabilities

Researchers have documented the existence of stigma and its negative effects on various disability groups. For individuals with psychiatric disabilities, the stigma associated with severe mental illness leads to prejudicial treatment and discrimination and may be as harmful as the effects of the disability itself (Corrigan & Penn, 1999; Garske & Stewart, 1999). As well, individuals who are seen as in control of their disability are met with higher levels of stigma; the level of perceived control an individual has is directly linked with level of stigma (Corrigan et al., 2000; Strauser, Ciftci, & O’Sullivan, 2009).

Theories of attribution attempt to explain stigmatizing attitudes and discriminatory behaviors. Two major theories have addressed the attributional process in the counseling literature. Weiner (1995) focused on attributions related to internal versus external control and level of stability. A second model of attribution distinguishes between responsibility for the cause of the condition and responsibility for the solution (Brickman et al., 1982).
Attribution theory (Weiner, 1995) is a social cognitive model of attribution focusing on a cognitive-emotional process that occurs when viewing stigmatized groups (Corrigan et al., 2003; Murdock, 2001). This model provides a framework for understanding the phenomenon of stigma. The stigmatization process is characterized by attributions of cause and controllability for one’s condition or circumstances which subsequently leads to judgments about personal responsibility and the potential for rehabilitation. Once made, these judgments can trigger strong emotional reactions that either support or discourage helping behaviors. Corrigan et al. (2003) cited anger and pity as two examples, the former likely leading to punishing behaviors such as discrimination or further stigmatization, and the latter likely leading to helping behavior. Controllability and stability are primary components of this theory (Corrigan, 2000; Strauser et al., 2009; Corrigan & Wassel, 2008; Murdock, 2001).

Controllability is viewed as the degree to which the individual is seen as being responsible for the condition, specifically, the cause is perceived to be a result of either internal factors (person/individual) or external circumstances (Murdock, 2001; Corrigan et al., 2000; Corrigan et al., 2003; Boysen & Vogel, 2008). For example, voluntary behaviors that are seen as directly contributing to the disability or circumstance would account for high control. Comparatively, low controllability for a disability or circumstance may be attributed to outside forces such as a genetic predisposition.

Stability is the degree to which the individual is expected to respond to treatment or rehabilitation efforts (Strauser et al., 2009; Corrigan et al., 2003; Murdock, 2001; Chan, 2005). High stability connotes a lower expectation of recovery; these individuals are more likely to be stigmatized (Boysen & Vogel, 2008; Clark & Artiles, 2000). Mental
retardation was cited as an example of a disability that while low on control, is high on stability, and as such is a stigmatized condition (Chan, 2005).

According to attribution theory, when an individual is presented with a person with a stigmatized condition or circumstance, there is an effort to determine where, or with whom, the responsibility lies (Weiner, 1995; Corrigan et al., 2003; Murdock, 2001). The individual then makes assumptions of the cause and the level of control the identified individual can assert. If personal control is perceived, then the individual is often held responsible for their situation (ex. drug-induced psychosis, addiction, imprisonment/criminal record) (Weiner, 1995; Corrigan et al., 2003). On the other hand, if an external influence on behavior is perceived, for example a genetic abnormality, then the attribution of responsibility significantly lowers (Corrigan et al., 2003). Essentially, if the individual is perceived as lacking control over the cause of the disability or circumstance, and the individual is perceived as responding to treatment or rehabilitation, the stigma is reduced, resulting in a more favorable attitude toward the individual or group (Lavack, 2007; Corrigan et al., 2000; Murdock, 2001). Researchers have suggested that as a result of such attributional assessments, individuals with substance abuse or addiction are seen as less worthy of help and more deserving of punishment when compared to individuals with physical disabilities (Corrigan et al., 2000).

Corrigan et al. (2000) examined stigmatizing attributions and mental illness, focusing on perceptions of controllability and stability. To measure these concepts, researchers constructed the *Psychiatric Disability Attribution Questionnaire (PDAQ)*. The PDAQ was based on earlier work on disability attributions by Weiner, Perry, and Magnusson (1988). Essentially, the PDAQ measures the levels of perceived
controllability (responsibility for condition) and stability (degree of response to treatment) across six disability groups (subscales): cocaine addiction, acquired immune deficiency syndrome (AIDS), cancer, psychotic disorders, depression, and mental retardation. High scores on controllability represent a negative attribution about the disability group; a perception of high controllability equates to an attribution of responsibility for the condition and may lead to avoidance and blaming behaviors (Corrigan et al., 2000; Weiner, 1995). High scores on stability, likewise, represent a negative attribution; perceptions of high stability indicate that the person is not believed to be capable of improvements over time and will likely not respond to treatment.

Results from this investigation suggested that stigma is not distributed equally across disability groups. Rather, the students sampled (n = 152) responded more negatively to cocaine addiction and psychotic disorders than physical disorders. Corrigan et al. (2000) also noted that participants discriminated within disability groups based on the type of attribution. Individuals seen as in control or as the cause of their condition were viewed more negatively than those who were not. Similarly, participants indicated more negative views towards individuals who had higher stability attributions; mental retardation had the highest stability and was thus viewed most negatively.

Heider (1958) offers a similar model related to causal attributions for criminal behavior. As in Weiner’s (1995) model, Heider stated that criminal behavior that is perceived to be caused by internal personal characteristics is more stigmatized than behavior believed to result from external circumstances. Subsequently, a perception of internal, personal control leads to more punitive attitudes and judgments regarding punishment (Heider, 1958; Sims, 2003). The concept of stability has also been connected
to criminal behavior. Offenders whose behavior was believed to be stable and under internal, personal control were less likely to be paroled than individuals whose behavior was externally attributed and believed to be temporary (low stability) (Carroll, 1978).

Attributions related to criminal behavior can therefore influence one’s belief in the value of rehabilitation for offenders (Carroll, 1978; Sims, 2003).

Social stigma is also heavily associated with addiction and substance abuse (Room, 2005; Lavack, 2007). Substance dependence has been found to be one of the most stigmatized illnesses, and as such persons who live with this type of disability are at a higher risk for experiencing a lower quality of life, including reduced opportunities for treatment (Lavack, 2007; Fortney et al., 2004). As noted with psychiatric disabilities, controllability related to substance dependence has been linked to higher levels of stigma (Corrigan et al., 2000; Lavack, 2007).

Rao et al. (2009) examined attitudes of health professionals towards people with active opiate and alcohol dependencies compared with those who were currently abstinent and employed. Attitudes were measured using the Attitudes towards Mental Illness Questionnaire (AMIQ). Participants were presented with vignettes about a fictitious client and then answered five Likert-type questions (ex. “Do you think this would affect Philip’s career?” (Rao et al., 2009, p.284). In an effort to control for existing attitudes about substance dependent individuals, researchers randomly assigned participants into either a control or experimental group. The control group’s ($n = 54$) vignette contained a simple description of a client with opiate dependence or alcoholism while the experimental group ($n = 54$) received a vignette with a more favorable description (abstinent and working) (Rao et al., 2009).
Researchers found that professionals had lower scores related to the actively using client, indicating a high level of stigma. When the client was presented as working and abstinent, a statistically significant improvement was noted for both groups ($p < 0.05$); data was analyzed using Mann-Whitney non-parametric tests. No statistically significant differences emerged between mental health professionals and participants from other backgrounds (e.g., nursing). Of the 108 participants, 36 percent worked in an acute hospital setting, 52 percent were mental health professionals, and the remaining 12 percent did not specify their vocational setting. The authors stated that these results dispute the belief that healthcare and mental health workers have less biased views of people with mental health and addiction issues, noting that stigmatized views also exist within healthcare and rehabilitation settings (Rao et al., 2009).

Discrimination of people with intellectual disabilities has been attributed to faulty assumptions and fear of the unknown (While & Clark, 2010). Additionally, people with intellectual disabilities are prone to abuse and social rejection as a result of stigma attached to hospital stays or institutionalization (Jahoda & Markova, 2004). Researchers have noted that increased understanding of the medical basis of such diagnoses reduces negative attitudes; genetic attributions seem to reduce stigma related to this disability group (While & Clark, 2010).

Researchers studying students with learning disabilities (LDs) found that teacher stigma and behaviors resulted in feelings of low-ability and self-esteem in students with LDs (Clark & Artilles, 2000). As noted with other disability groups, controllability was also linked to higher levels of stigma in people with LDs. Students who were viewed as in control of their learning disability were subject to higher levels of stigma when
performance was below teacher expectations. Researchers have also found that individuals with traumatic brain injury (TBI) contend with misconceptions that the invisible nature of the disability equates to no real injury and as a result, are expected to perform at pre-injury levels (McClure, 2011; Quinn & Chaudoir, 2009).

**Ex-offenders**

Ex-offenders are a highly stigmatized group; the effects of stigma can be problematic when offenders are working to reintegrate into the community upon release and thereafter (Celinska, 2000; Shivey et al., 2007). While successful reintegration is essential in working to reduce recidivism, the stigma associated with imprisonment is pervasive, affecting not only the ex-offender, but his or her family and the community to which they are returning (Celinska, 2000). The stigmatization process does not end upon release, but is carried with the individual in the form of labels such as “ex con”; such a label and status impacts economic adjustment, the ability to find gainful employment, and/or the opportunity to advance in education (Celinska, 2000; Nagin & Waldfogel, 1998; Copenhaver, Edwards-Willey, & Byers, 2007; Krienert, Henderson, & Vandiver, 2003).

Similarly to people with disabilities, providers working with ex-offenders may hold stigmatizing beliefs which may negatively impact client outcomes (Schneider & McKim, 2003). Researchers have asserted that if reentry providers intend to reduce recidivism and encourage reintegration, negative attitudes must be ascertained and addressed (Schneider & McKim, 2003). No studies specifically examining rehabilitation counselor stigma towards ex-offenders could be located; the present study will attempt to fill this gap in the literature.
The presence of a disability or disabilities is another source of stigma for a number of ex-offenders. The proportion of people with disabilities in prisons is higher than in the general population (Smith, 2005; Groom, 1999; Russell & Stewart, 2001). In 1998, approximately 283,000 prisoners were diagnosed with a mental illness (The Sentencing Project, 2002); persons with psychiatric disabilities are overrepresented in corrections settings (Human Rights Watch, 2003; Lurigio, 2001; Smith, 2005). One year earlier, nearly 26 percent of state level inmates reported the presence of a hearing, visual, or physical disability (Marushack & Beck, 2001); intellectual disabilities are also prevalent among prisoners (Cockram, Jackson, & Underwood, 1998; Krienert et al., 2003). It has been estimated that as many as 38 percent of inmates have been diagnosed with mental retardation (Anno, 2001). Up to 75 percent of U.S. inmates are estimated to have learning disabilities (Jordan, 1996; Smith, 2005).

In a 2004 study examining the triple stigma of offender status, mental illness, and substance abuse, 70 percent of the sample \( (n = 501) \) were offenders with mental illness who also had a dual diagnosis for substance abuse (Hartwell, 2004). Moreover, inmates and ex-offenders with disabilities represent a sizeable client population that contends with stigma associated with multiple facets of their identity; the combination of which may further inhibit employment outcomes.

Tschopp, Perkins, Hart-Katuin, Born, and Holt (2007) examined employment barriers and strategies for individuals with psychiatric disabilities and criminal histories. Researchers conducted focus groups with supported employment providers to identify components of vocational rehabilitation for this population. Two structured focus groups \( (n = 13) \) explored providers’ perspectives on working with individuals with both mental
illness and a criminal history. Participants were employed in community mental health employment programs; all had experience with the target population.

Participants completed demographic questionnaires and engaged in discussions based off a set of structured questions; groups were audio taped and facilitated by the first author. Questions related to service provision with these clients and were reportedly selected based on their relationship to the process of vocational rehabilitation, but were not included in the research report (Tschopp et al., 2007). Questions reportedly centered on the services provided and did not directly refer to the stigma associated with clients who have both a disability and criminal history.

Transcripts were analyzed using a grounded theory approach, specifically data reduction, category development, and the division of text into identified categories (Tschopp et al., 2007). Participants experience ranged from 10 months to 45 years in a vocationally service-oriented field. Job titles included employment service administrator, employment specialist, job coach, and case manager (Tschopp et al., 2007). Following analysis, four main themes were identified in the data: barriers to successful employment outcomes, contributors to successful outcomes, supportive interventions in job placement, development, and retention, and employment and recovery. Of note to the current investigation, some participants identified their own attitudes as barriers to successful client outcomes (Tschopp et al., 2007).

Within the first theme, centered on barriers to successful employment outcomes, participants noted that they anticipated added challenges to working with clients who had psychiatric disabilities and criminal histories (Tschopp et al., 2007). More specifically, some participants admitted to feeling “uncomfortable” (p. 178) providing employment
services to clients with criminal backgrounds. One participant stated, “Should I be concerned about the person being violent or what kind of criminal history? If I place someone, I feel responsible for sharing that kind of information” (Tschopp et al., 2007, p. 178). In contrast, other participants stated that they did not view these clients differently than clients without criminal histories, adding that differential treatment and attitudes detracts from the counseling relationship. One participant said, “The fact that I don’t have a different attitude towards these people helps. I just don’t treat them any differently. These are people who have a specific illness that has gotten in their way in life, or really society has gotten in their way (Tschopp et al., 2007, p. 181).”

The authors also noted that participants believed the stigma related to the criminal history-mental illness combination was prevalent among potential employers. Moreover, results regarding the existence of stigma in the vocational providers and the impact of that stigma on work with clients with psychiatric disabilities and criminal histories in this study were mixed; further investigation is needed.

**Burnout**

Burnout has been described at length in the general employment and counseling research literature (Angerer, 2003; Bakker, Van Der Zee, Lewig & Dollard, 2006; Burke, Carruth, & Prichard, 2006; Christopher & Maris, 2010; Ducharme, 2008; Gibson, Grey, & Hastings, 2009; Lambie, 2006; Lambie, 2007; Min Lee, Ho Cho, Kissinger, & Ogle, 2010), though needs updating with regard to vocational rehabilitation counselors. Burnout has been defined by some as a syndrome characterized by symptoms of emotional exhaustion, depersonalization, and a lack of personal accomplishment (Maslach, 2005; Maslach & Florian, 1988; Maslach, Jackson, & Leiter, 1996). Emotional
exhaustion refers to a depletion of one’s emotional resources; individuals may also feel that he or she has nothing left to give to others. Depersonalization is the development of negative attitudes towards clients and may lead to the belief that he or she deserves whatever has brought them to treatment (Maslach, 2005). Lack of personal accomplishment refers to feelings of unhappiness about oneself and one’s work-related achievements.

Another conceptualization of burnout highlights a process of physical and emotional depletion that results from extended periods of stress related to the working environment (Osborn, 2004). Specific affective and attitudinal states related to this phenomenon include feelings of helplessness, hopelessness, powerlessness, inflexibility, and negative thought patterns (Harris, 1984; Min Lee, Ho Cho, Kissinger, & Ogle, 2010). Research related specifically to counselor burnout has defined it as the counselor having significant levels of difficulty in executing the necessary functions of his or her job (i.e., formation of the working alliance) in an objective, competent manner (Min Lee et al., 2010; Malach-Pines & Yafi-Yani, 2001; Emerson & Markos, 1996; McCarthy & Frieze, 1999).

Counselor burnout can influence the quality of care provided to clients and levels of job and life satisfaction (flourishing) in the counselors (Min Lee et al., 2010; McCarthy & Frieze, 1999; Osborn, 2004; Sprang, Clark, & Whitt-Woosley, 2007). Recent research related to burnout in rehabilitation counselors is currently lacking, with the majority of studies conducted over two decades ago. Emener (1979) described burnout as rehabilitation counselors’ “hidden handicap” (p.58). Smith (1984) later stated that burnout was partially responsible for turnover in rehabilitation agencies and that it
has been linked to poor rehabilitation counselor performance (Riggar, Garner, & Hafer, 1984).

Maslach and Florian (1988) examined burnout in rehabilitation counselors, noting the paucity of research in this counselor population; as noted, this gap continues to exist. Sixty rehabilitation counselors in San Francisco were invited to participate in the study; 38 completed questionnaires, yielding a 63 percent response rate. The sample included 21 females and 17 males with an average age of 37 years. Thirty-one participants identified as Caucasian, four as Asian-American, and three as Latino (Maslach & Florian, 1988). All participants had been employed as rehabilitation counselors for a minimum of one year with an average of seven years of experience. Researchers used the *Maslach Burnout Inventory* (Maslach & Jackson, 1986) and a five-point Likert-type questionnaire related to job aspects such as caseload size, work tasks, and satisfaction regarding contact with clients, supervision, and the physical work environment. A third questionnaire consisted of questions related to perceived knowledge and skills, level of control over the work environment, and job-related goals.

Burnout scores of sampled rehabilitation counselors were compared with American norms for social service workers from a previous study (Maslach & Jackson, 1986) and found to be similar in terms of emotional exhaustion ($M = 19.24, SD = 7.65$; $M = 21.35, SD = 10.51$) and depersonalization ($M = 7.37, SD = 3.60$; $M = 7.46, SD = 5.11$). Scores related to personal accomplishment, however, showed significantly less burnout in the rehabilitation counselor sample ($t = 10.37, df = 1574, p < .001$). Researchers concluded that the sample felt very positive about their achievements on the job despite the moderate levels of emotional exhaustion and depersonalization (Maslach & Florian,
Further, the dimension of emotional exhaustion related to job satisfaction and aspects of the work setting.

Emotional exhaustion was higher for rehabilitation counselors who did not believe they had control over his or her work \( (r = -.47, p < .001) \) and who had larger caseload assignments \( (r = .35, p < .05) \). An inverse relationship was found between emotional exhaustion and two areas of job satisfaction: promotion opportunities \( (r = -.32, p < .05) \) and relationship with administrators \( (r = -.36, p < .05) \). Moreover, emotional exhaustion is more likely in job settings where employees have high caseloads, are overloaded, feel out of control, and lack the opportunity for promotion. Maslach and Florian (1988) added that differences in emotional exhaustion may be explained by the work tasks and expectations for rehabilitation counselors. A client-oriented, direct care approach may put more of a demand on the emotional resources of counselors than it does on interpersonal attitudes or sense of self-worth.

Several limitations were noted in this study including sample size and a non-random sampling procedure. In addition, the sample was not demographically diverse and therefore, has limited generalizability. Researchers noted that these limitations may have accounted for the positive results regarding personal accomplishment despite levels of emotional exhaustion and depersonalization (Maslach & Florian, 1988); moderate to low correlation coefficients are also noted by this writer. Researchers suggested continued research into the existence of burnout in rehabilitation counselors, the sources or causes, and specific interventions for reducing levels in this counselor population.

In 2010, Lambert, Hogan, Altheimer, Jiang, and Stevenson examined the relationship between burnout and support for either treatment or punishment of offenders
in a correctional setting. The authors theorized that burnout may influence an employee’s
views of inmates and the services provided; higher levels of burnout may cause workers
to blame inmates for his or her circumstances and therefore lead to increased support for
punishment and decreased support for treatment. Staff at a Midwestern maximum-
security institution were sampled \((n = 200)\); 80 percent returned completed surveys \((n = 160)\). Sixty-two percent were correctional officers, three percent management staff,
including counselors, four percent educators, and thirteen percent worked in other areas
of the institution (Lambert et al., 2010). The median age was 33 years; median experience
was 17 months.

Researchers used 4-item Likert scale to measure support for punishment; items
were summed with higher scores indicating increased support \((\alpha = .67)\). Participants were
asked about his or her opinion of the efficacy of rehabilitation, the amenities deserved by
offenders, and the quality of life in prison. Support for treatment was measured using six
Likert-type items which were also indexed and found to have a Chronbach’s alpha of
0.74. Questions centered on the importance of rehabilitation programs, if programs
should be expanded, appropriation of funds for rehabilitation programming, and if
offenders should be treated with compassion. All questions were based on previous
research by Cullen, Link, Wolfe, and Frank (1985) (Lambert et al., 2010). Burnout was
measured using the *Maslach Burnout Inventory* subscales of emotional exhaustion,
depersonalization, and personal accomplishment (Maslach & Jackson, 1981).

Researchers found positive, statistically significant correlations between
depersonalization and lack of personal accomplishment \((r = .42)\) (i.e., ineffectiveness)
and support for punishment \((r = .30)\). Researchers inferred that increases in certain
dimensions of burnout lead to greater support for punishment and less support for
treatment (Lambert et al., 2010). Depersonalization and lack of personal accomplishment
had significant inverse relationships with support for treatment ($r = -.46, r = -.42$
respectively). Researchers believed these results supported the notion that as aspects of
burnout decrease, support for treatment increases. Researchers further stated that these
results suggested that burnout does have a significant influence on both support for
treatment and punishment of offenders (Lambert et al., 2010).

Ordinary least squares (OLS) regression equations were also calculated to
estimate the effects of burnout on support for punishment and treatment while controlling
for demographic variables. Depersonalization was found to significantly influence
support for punishment; for every standard deviation increase in depersonalization,
support for punishment increased by 0.32 standard deviations. Among control variables,
position was found to influence support for punishment; non-custody staff were less
likely to endorse punishment than custody staff ($R^2 = 0.28$). All three dimensions of
burnout were statistically significant predictors of support for treatment (Lambert et al.,
2010). Depersonalization and lack of personal accomplishment were inversely related to
support for treatment; for every standard deviation increase in depersonalization, support
for treatment decreased by 0.34 standardized units. Further, for each standard deviation
increase in lack of personal accomplishment, support for treatment decreased by 0.31
standardized units. Of note, emotional exhaustion was positively associated with support
for treatment (for each $SD$ increase, support increased by 0.18 $SD$ units). Researchers
suggested that one explanation for this result is that correctional staff members who
experience emotional exhaustion do not blame inmates for the feelings, but rather
organizational factors such as lack of training and opportunities for self-care (Lambert et al., 2010).

Non-custody staff members (counselors, case managers, and medical staff) were more likely to support treatment for offenders than were custody staff members. Researchers concluded that as staff experienced burnout, support for punishment increased and support for treatment decreased (Lambert et al., 2010). In connecting these results to the current study, it is possible that burnout among rehabilitation counselors may influence beliefs towards ex-offenders in treatment. In the context of the current investigation, rehabilitation counselors who have higher levels of burnout may also have higher levels of stigma towards clients with criminal histories; further investigation is needed.

**Flourishing**

The concept of flourishing, otherwise understood as subjective well-being, has been connected to overall counseling self-efficacy and burnout; it is plausible then that working alliance efficacy may also be impacted. Flourishing has also been linked to levels of stress, well-being, and job and life satisfaction in counselor populations (Luszczynska, Gutierrez-Dona, & Schwarzer, 2005; Min Lee et al., 2010; McCarthy & Frieze, 1999; Osborn, 2004; Sprang, Clark, & Whitt-Woosley, 2007). Empirical research focused on the presence and determinants of flourishing in providers is currently lacking, however research does exist which equates mental health and flourishing, defining flourishing as the presence of positive feelings and functioning (Keyes, 2002).

As noted, Keyes (2002) equated a state of positive mental health with flourishing and further defined the absence of mental health as languishing. Keyes (2002)
investigated the prevalence of flourishing, languishing, and moderate mental health in the United States. The connection between languishing and major depression and flourishing and whether or not flourishing was associated with increased psychosocial functioning relative to major depression and languishing was also examined. Data were derived from the MacArthur Foundation’s Midlife in the United States Survey; the survey was a random-digit-dialing sample of non-institutionalized English-speaking adults in the contiguous 48 states (Keyes, 2002). According to the researcher, the sample was stratified by both age and sex. Participants were contacted and interviewed by study personnel; participation included a 30-minute telephone interview and two hard copy questionnaires which were mailed to the respondent’s homes. The final combined response rate was 61 percent, with a 70 percent response rate for phone interviews and 87 response rate for hard copy questionnaires (N = 3,032).

Results indicated that most adults (85.9%) did not experience a depressive episode in the previous 12 months. Only 17.2 percent of adults who did not have depression, however, were flourishing in life (Keyes, 2002) while 12.1 percent were languishing and slightly more than half of respondents were deemed moderately mentally healthy. Twenty-eight percent of languishing adults had major depression, while only 13.1 percent of moderate mental health and 4.9 percent of flourishing adults had a history of depressive episodes (Keyes, 2002). The researcher concluded that when compared with flourishing adults, moderately healthy adults were approximately 2.1 times more likely to have had a major depressive episode during the past year, with languishing adults 5.7 times more likely. Moreover, the absence of flourishing may be a risk factor for depression (Keyes, 2002).
Flourishing adults were reported to be three times more likely than moderately well individuals to be in good or excellent emotional health. Extending the results into the world of work, adults who were languishing and had experienced a major depressive episode missed an average of 2.6 more days of work than those who were moderately well (Keyes, 2002). Further, flourishing adults had the fewest number of workdays lost. Demographically, flourishing is more prevalent among males, adults between the ages of 45 and 74, and individuals with 16 or more years of education. Connecting these results to the current investigation, it is likely that respondents with high levels of burnout will have low levels of flourishing and that flourishing may act as a protective factor for burnout in providers.

Flourishing is an emerging concept in the research literature in relation to mental health and rehabilitation providers and to vocational rehabilitation counselors in particular. As noted, high levels of flourishing may act as a protective factor for burnout just as low levels may contribute to stigmatizing beliefs held by providers. For these reasons, it is important to determine the impact of flourishing on such constructs and the potential influence on client outcomes.
CHAPTER 3
METHODOLOGY

This section builds upon the literature review and provides information regarding research questions, sampling procedures and participants, research design and data collection, as well as statistical analyses. In addition, the instruments are described in terms of their relevance to this investigation and their psychometric properties.

**Research Design**

A non-experimental survey research design was used in this study. Survey research is one of the most widely used research methods in the social sciences (Heppner, Wampold, & Kivlighan, 2008). This method was chosen as survey research serves to document the nature or frequency of a particular variable or variables (Heppner et al., 2008); in this case, levels of stigma, burnout, and working alliance efficacy. The advantages of survey research designs have been well documented. Heppner et al. (2008) noted the primary advantage being ease of data collection, particularly when the researcher is attempting to reach participants across a wide geographic area. Survey designs are also cost effective models for collecting large amounts of data in an efficient manner (Tian, Tang, Liu, Tan, & Tang, 2011). Further, researchers have argued that survey research is an essential first step in a process that has an eventual goal of changing or manipulating variables (Greenberg, 1986).

In order to answer the proposed research questions in this investigation, counselor attitudes, perceptions, and self-estimates were ascertained. Surveys provided an appropriate and efficient means for collecting this data. The accumulation of descriptive data for these constructs also allowed this researcher to make comparisons across
demographic variables (i.e., caseload size) and to describe the levels for each variable.

Six self-report questionnaires were distributed in addition to a demographic
questionnaire; measures are described in detail later in this section.

Participants

The target population for this investigation was state vocational rehabilitation
counselors working in state agencies serving clients with disabilities who are seeking
employment. Three states agreed to participate in this study and represented different
geographic regions of the United States: one state was located in the mid-Atlantic region
(New York), the second in the Midwest (Illinois), and the third in the Western part of the
country (Utah). State agency directors were contacted by this researcher through email.
Directors were provided with a summary of the investigation, time requirements,
proposed methodology, and perceived benefits to the agency and profession. Follow-up
phone conferences also occurred with two of the three states to answer remaining
questions.

As previously stated, this study aimed to assess the levels of provider stigma,
burnout, flourishing, experience, and caseload size and make up on perceptions of
working alliance formation in state vocational rehabilitation counselors in regards to
clients with disabilities and criminal histories. As such, an inclusion criterion for
participants included current employment at a state vocational rehabilitation agency in
the capacity of counselor; participants also had to exceed 18 years of age. The researcher
was interested in all vocational rehabilitation counselors’ levels on the independent
variables and therefore did not restrict the study to counselors who currently had these
clients on his or her caseload. Additionally, each state contact noted that while some
specilaty caseloads existed, clients with ex-offender status were distributed to all counselor’s; therefore all counselors had an equal chance of working with this client group.

Participants were recruited from three state vocational rehabilitation agencies; director contact information was obtained through the Council of State Administrators of Vocational Rehabilitation (CSVAR) website (rehabnetwork.org). The three states selected represented geographic diversity and administrative approval for participation was granted from each agency. Utah yielded 44 completed surveys, comprising 29.5 percent of the sample (32% response rate [140 total counselors]), Illinois had 56 completed surveys, making up 37.6 percent of the sample (41.5% response rate [135 total counselors]), and New York submitted 49 completed surveys, representing the final 32.9 percent of the sample (16% response rate [estimated 300 total counselors]. Overall response rate then, equates to approximately 26 percent. According to Hamilton (2003), 30 percent is considered an adequate response rate for online surveys. An accurate response rate is hard to determine for New York State due to firewall glitches which prevented the completion of 38 additional surveys. Following recognition of the glitch, an email was sent indicating the survey was again available, but this error may have caused hesitation in respondents.

Table 1 provides a summary of demographic data. Demographic data was reported by all participants ($N = 149$). Females dominated the sample at 70.5 percent ($n = 105$); males comprised the remaining 29.5 percent ($n = 44$). More than 75 percent of the sample identified as Caucasian (75.2%, $n = 112$); Black/African American and Hispanic/Latino identities rounded out the top three representing 12.1 percent ($n = 18$).
and 8.1 percent \( (n = 12) \) respectively. The remaining racial/ethnic categories, in
descending order, included participants who Preferred Not to Answer \( (2.7\%, n = 4) \),
Other/Multi-Racial \( (1.3\%, n = 2) \), and Native American/Alaska Native \( (0.7\%, n = 1) \);
Asian, Pacific Islander was also included on the demographic form although no responses
were indicated.

Ninety-four percent of participants had a master’s degree \( (n = 140) \), six
individuals held a bachelor’s degree \( (4.0\%) \), two held a doctorate \( (1.3\%) \), and one
indicated some college as the highest level of education \( (0.7\%) \). All participants worked
with clients with a variety of disabilities. More specifically, approximately 93 percent of
participants \( (n = 139) \) indicated that clients with physical, cognitive, and psychiatric
disabilities were represented on their current caseload. Of the remaining ten participants,
approximately three percent \( (n = 4) \) worked with clients who had physical and psychiatric
disabilities, but not cognitive, approximately two percent \( (n = 3) \) worked with clients with
psychiatric and cognitive disabilities, but not physical, and less than one percent \( (n = 1) \)
noted working with physical and cognitive, but not psychiatric. Two remaining
participants \( (approximately 1.3\%) \) indicated that they are currently not working with any
clients within these disability categories and are assumed to fill a supervisory role.

Years of experience as a vocational rehabilitation service provider ranged from
less than one year to 37 years \( (M = 12.53, SD = 9.46) \). Participants working for less than
one year made up 5.8 percent of the sample \( (n = 8) \); those working for more than one year
dominated with 94.6 percent \( (n = 141) \). Age ranged from a minimum of 25 years to 67
years \( (M = 46.11, SD = 10.37) \). Current caseload size ranged from a minimum of 0 to a
maximum of 300 \( (M = 148.9, SD = 61.85) \); participants with zero clients \( (n = 3) \) are
assumed to fill a supervisory role. Average caseload size over one’s career as a vocational rehabilitation service provider ranged from a minimum of 3 to maximum of 400 ($M = 161.61$, $SD = 65.85$). Finally, the percentage of clients who have criminal histories on one’s current caseload ranged from zero percent to 90 percent ($M = 27.27$, $SD = 22.45$).
Table 1

*Participant Demographic Characteristics (N = 149)*

<table>
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<tr>
<th></th>
<th>n</th>
<th>% of sample</th>
<th>M</th>
<th>SD</th>
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<td>10.37</td>
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</table>
Data Collection and Procedures

Data was collected through electronic surveys. State agency directors or a member of the administration sent a mass email to all qualified participants with a link to the survey embedded in the email; this approach alleviated agency privacy concerns around disclosure of individual counselor email addresses. Implied consent procedures were used to protect the identities of potential participants. For individuals who decided to take part in the study, the link directed them to the surveys for completion; it was anticipated that completion would require between 15 and 20 minutes.

An online survey company (Survey Gizmo) was located which met the standards for accessibility and usability set forth by section 508 of the Rehabilitation Act. Hard copies were available upon request; no such requests were made. The accessible survey design offered by this company allowed users of screen readers and users with keyboard-only navigation the ability to complete the survey. This design also allowed any individual with reduced motor controls who had difficulty clicking precisely to participate, as well as individuals with visual impairments who required a screen reader, larger type face, or higher contrast colors.

One continuing education unit (CEU) was approved through the Commission on Rehabilitation Counselor Certification (CRCC) for participants who completed the surveys. The CEU form was the last page of the online survey. Upon completion, participants were instructed to print the form, fill in his or her information, and mail it to CRCC for credit; this researcher never had contact with completed forms.
**Instruments** (Appendix H)

**Demographic Questionnaire.** Participants were asked to complete a demographic questionnaire developed by this researcher for the purposes of this investigation. Participants were asked to report their age in years, gender, race/ethnicity, years of experience in the current position, approximate caseload size, level of education, caseload make up, and if they currently had clients with criminal histories on their caseloads or if they had prior experience working with such clients.

**Working Alliance Efficacy Estimate Scale (WAEES).** The WAEES was developed by this researcher and her dissertation chair for the current investigation. It was based on a similar measure developed for a previous study (O’Sullivan, in press) that is currently in press. The WAEES is based on the Rehabilitation Service Provider Working Alliance Efficacy Scale (RSPWAS) developed by O’Sullivan (in press) to assess rehabilitation counselor working alliance efficacy in line with Bordin’s (1979) three domains of the working alliance. The WAEES was an 18-item measure also intended to assess rehabilitation counselor efficacy levels in the three domains of the working alliance (WA): bonds, goals, and tasks (Bordin, 1979). Confidence in each domain was assessed across three major disability categorizations (physical, cognitive/developmental, and psychiatric) with a disability only and with a disability in addition to a criminal history. The RSPWAS, in contrast, assessed specific disabilities (i.e., cerebral palsy) rather than broader categories of disability (i.e., physical disability) in the current investigation. Further, the measure created by O’Sullivan (in press) did not assess perceptions related to the criminal history component.
O’Sullivans’ (in press) measure was found to have excellent internal reliability ($\alpha = .92$). A cluster analysis using Ward’s method also revealed two subscales with good to excellent internal reliability (O’Sullivan, in press). More specifically, all six items clustered together were related to cerebral palsy and spinal cord injury and comprised the Physical Disability Working Alliance Efficacy Subscale ($\alpha = .87$). Nine items which clustered together related to depression, bipolar disorder, and substance dependence made up the Psychiatric Disability Working Alliance Efficacy Subscale ($\alpha = .92$) (O’Sullivan, in press). The author also noted that three items related to mental retardation were not clustered with either subscale, though remained in the total scale.

Three stems which spoke directly to Bordin’s (1979) domains were included in the WAEES: (a) “I am confident in my ability to develop an effective rehabilitation counseling relationship, characterized by mutual trust and rapport, with an individual who has…” (bonds); (b) “I am confident in my ability to identify appropriate employment goals for an individual with ….” (goals); and (c) “I am confident in my ability to identify the necessary and appropriate tasks needed to obtain employment in the current labor market for an individual with…” (tasks). Thus, two example questions for the first domain (bonds) were: I am confident in my ability to develop an effective rehabilitation counseling relationship, characterized by mutual trust and rapport, with an individual who has… (1) a physical disability AND a criminal history (2) a physical disability and NO criminal history. Each of the remaining disability categorizations followed in kind, resulting in six questions per WA domain (18 total items).

Participants were asked to read each question stem and rate his or her confidence in their ability to accomplish each of the three counseling tasks with the client profiles
presented. Level of perceived efficacy was rated on a 7-point Likert scale (1 = no confidence, 7 = high confidence); the higher the rating, the higher the perceived efficacy. Means and standard deviations were calculated for each disability category across the three domains of working alliance and are reported in the results section.

**Attitudes to Mental Illness Questionnaire (AMIQ).** The AMIQ is a brief instrument aimed at identifying stigmatizing attitudes towards people with mental illness. This was accomplished through a series of 7 short vignettes followed by five questions regarding the perceptions and comfort of the respondent towards the subject (Luty, Fekadu, Umoh, & Gallagher, 2006). Vignette subjects included an individual with active heroin use, a person with depression and a medication overdose, an individual with alcoholism who is entering recovery, an individual convicted of multiple crimes and currently on bail, a person with diabetes, an individual with schizophrenia and associated delusions, and finally a practicing Christian.

The AMIQ was adapted from Cunningham, Sobell, and Chow (1993) and a pilot study was carried out through phone interviews consisting of open-ended questions (n = 20). The final questionnaire was then sent to randomly selected adults solicited through newspaper advertisements and through random selection of street addresses from the phone directory Luty et al., 2006). Participants were asked to read a short vignette describing one of five imaginary individuals and answer five Likert-type questions. Three vignettes were intended to produce strongly negative or positive responses to assess the face validity (Luty et al., 2006). Vignettes were randomized and scored on a 5-point Likert scale (maximum +2, minimum -2) with blank questions or neutral responses scored as zero. Scores were then summed to produce an overall score between -10 and
A follow-up study added two additional vignettes including the individual with schizophrenia and a person with alcoholism. Questions on the follow-up study were drawn from the Psychiatric Disability Attributions Questionnaire (PDAQ) (Corrigan et al., 2003).

A total of 1079 questionnaires were received for validation analyses. The mean age of participants was 46.3 years ($SD = 15.7$) and more than half (55%) were employed. Males represented slightly more than one third of respondents (36%) with females making up the majority of the sample (64%) (Luty et al., 2006). Factor analysis using principal component analysis with varimax rotation revealed that one component accounted for more than 80 percent of the variance (80.2%) and involved significant contributions from all five questions; the factor was labeled “stigmatization” (Luty et al., 2006, pg. 258). Even though three questions (1, 4, and 5) were based on other people’s expectations of the individual’s future with remaining questions (2 and 3) focused on social distance, no individually distinct factors emerged. As a result of the factor analysis, the authors concluded the instrument had excellent construct validity (Luty et al., 2006).

Follow-up questionnaires were sent to a sample after two to four weeks ($n = 256$) to assess test re-test reliability; it was found to be adequate ($r = 0.702$). To assess alternate test reliability, the AMIQ was compared with the PDAQ by Corrigan et al. (2003), a questionnaire also aimed at assessing stigma towards individuals with mental illness. Fifty participants completed both measures for the schizophrenia vignette. The PDAQ was scored from zero to a maximum of 64 with a mean score of 38.7 ($SD = 1.8$). Kendall’s tau ($b = 0.563$, $p < 0.001$) and Spearman’s rank ($rho = 0.704$, $p < 0.001$) correlation indicated good alternate test reliability.
The authors concluded that the AMIQ had psychometric properties and is appropriate for use in most situations. Content validity and reliability were found to be high as indicated by the Chronbach’s alpha score, factor analysis, test-retest correlation coefficients, and the alternate test comparison with the PDAQ (Luty et al., 2006). Vignettes describing highly stigmatized individuals such as those with addiction and criminal histories produced consistently negative scores. In contrast, vignettes describing non-stigmatized individuals such as the practicing Christian and the individual with diabetes produced more positive scores (Luty et al., 2006). Results were in line with previous studies that individuals with mental illness and particularly addiction are highly stigmatized and viewed negatively (Corrigan et al., 2003; Luty & Grewal, 2002, Byrne, 2000).

**Counselor Burnout Inventory (CBI).** Developed by Min Lee et al. (2007), the CBI is a 20-item measure designed to assess burnout in counselors. Unlike other measures of burnout, this inventory is specifically intended for professional counselor populations and incorporates both individual and organizational dynamics of burnout; essentially, the individual is evaluated in the context of his or her work environment. Two independent samples were collected and used for the development of this measure. The first sample included professional counselors recruited from professional listservs (i.e., CESNET, College Counseling Email Group) (Min Lee et al., 2007). A web-based survey was used and facilitated data collection from various demographic regions of the United States (58% from the South, 18.4% Midwest, 14.7% Northeast, and 8.9% from the West). The final sample (n = 257) represented varying counseling specialties: seven percent family counselors, 24.4 percent college counselors, four percent rehabilitation counselors,
and approximately nine percent indicating membership in more than one specialty group (Min Lee et al., 2007). Years of experience ranged from one to 46 years ($M = 12.83$, $SD = 8.94$) with women dominating the sample (77.5%). Approximately 87 percent of the sample identified as Caucasian, three and a half percent as African American, and less than two percent Hispanic; nearly eight percent noted membership in more than one ethnic group. Finally, ages ranged from 24 to 65 years ($M = 43.50$, $SD = 10.92$).

The second sample was recruited through a state counseling association conference in the southeastern region of the United States. A paper-based survey was used in this instance, with 132 completed surveys returned (Min Lee et al., 2007). Specialties in this sample also varied: nearly two percent were career counselors, roughly eight percent college counselors, 25.3 percent mental health counselors, 43.2 percent school counselors, nine percent family counselors, just over four percent rehabilitation counselors, and slightly more than nine percent indicating membership in multiple specialties (Min Lee et al., 2007). Years of experience ranged from one to 33 years ($M = 11.31$, $SD = 8.37$), with women also dominating this sample (83.3%). Nearly all respondents were Caucasian (94.7%), with three percent identifying as African American, one and a half percent Hispanic, and less than one percent indicating membership in more than one group. Ages ranged from 25 to 67 years ($M = 46.20$, $SD = 11.37$).

Items were developed with the intent of indicating various levels of burnout. A number ($N = 296$) of potential items were developed through focus groups, individual interviews, and reviews of the existing research literature on burnout (Min Lee et al., 2007). Researchers conducted a pilot study in which 60 counselors selected and refined
items, assigning them to hypothesized dimensions of burnout; participating counselors represented various local agencies and schools. In addition to the pilot study, expert reviews were used to identify 40 items related to five dimensions: (1) exhaustion, (2) negative work environment, (3) devaluing client, (4) incompetence, and (5) deterioration in personal life (Min Lee et al., 2007). Participants then rated themselves using a 5-point Likert scale (1 = never true, 5 = always true). Researchers also had this second sample complete an existing burnout scale, the Maslach Burnout Inventory (MBI) (Maslach & Jackson, 1981), along with seven items adapted from the Educational Longitudinal Survey Questionnaire (National Center for Educational Statistics, 2002) which focused on levels of job satisfaction, training, promotion opportunities, pay, and the challenge of work, and finally Rosenberg’s Self-Esteem Inventory (Rosenberg, 1965).

Construct validity was established through two phases of analysis: an exploratory factor analysis of the 40 original items with scores from sample one (N = 258) for data reduction (phase one) and confirmatory factor analysis on the revised instrument from phase one as completed by the second sample (N = 132). Five factors emerged from the data and accounted for 54.58 percent of the total variance. Researchers labeled these factors: (1) Incompetence, (2) Deterioration in Personal Life, (3) Exhaustion, (4) Negative Work Environment, and (5) Devaluing Client (Min Lee et al., 2007). Researchers further reduced the number of items to 20 by only retaining the four highest salient factor pattern coefficients per factor. The exploratory factor analysis with the second sample resulted in a five-factor structure as well, although the ordering had changed: (1) Negative Work Environment (coefficient = .81, eigen value = 3.85), (2) Devaluing Client (coefficient = .79, eigen value = 3.36), (3) Deterioration in Personal
Life (coefficient = .77, eigen value = 4.18), (4) Exhaustion (coefficient = .74, eigen value = 4.57), and (5) Incompetence (coefficient = .77, eigen value = 3.91). Factors in this analysis accounted for 66.97 percent of the total variance (Min Lee et al., 2007). Factor loading coefficients exceeded .40 and eigen values were all greater than one (Min Lee et al., 2007).

Confirmatory factor analysis was used to test for goodness-of-fit; a cutoff value of 0.95 was set for the comparative fit index (CFI) and Tycker-Lewis index (TLI). A cutoff value of 0.08 was set for the standardized root mean square residual (SRMR), and 0.06 for the root mean square error of approximation (RMSEA) (Min Lee et al., 2007). The five-factor model for the CBI indicated adequate data fit: CFI = 0.957, TLI = 0.948, SRMR = 0.052, RMSEA = 0.050. Researchers also tested for equivalence among factor covariance and mean structure between the first and second samples. Essentially they wanted to check whether the subscales of the CBI had the same meaning across the two samples; a satisfactory fit was found for both samples (Min Lee et al., 2007). Researchers further investigated the appropriateness of the 5-point scale using the WINSTEPS computer program (Linacre, 2002); the five category scoring method was found to be appropriate for the CBI items.

Convergent validity was evidence by correlating the subscales of the CBI with scores from the MBI burnout subscales (emotional exhaustion, depersonalization, and personal accomplishment). Concurrent validity was determined through correlations between CBI subscale scores and scores on the job satisfaction and self-esteem measures; negative relationships were anticipated (Min Lee et al., 2007). Positive correlations were found between the Emotional Exhaustion and Depersonalization subscales of the MBI
and the CBI Exhaustion subscale \( (r = 0.73, p < 0.01, r = 0.23, p < 0.05 \) respectively), Negative Work Environment subscale \( (r = 0.62, p < 0.01, r = 0.27, p < 0.01 \) respectively), Deterioration in Personal Life subscale \( (r = 0.62, p < 0.01, r = 0.22, p < 0.05 \) respectively), Devaluing Client subscale \( (r = 0.31, p < 0.01, r = 0.56, p < 0.01 \) respectively), and the Incompetence subscale \( (r = 0.30, p < 0.01, r = 0.35, p < 0.01 \) respectively) (Min Lee et al., 2007). As anticipated, the Personal Accomplishment subscale of the MBI was negatively correlated with the CBI subscales: Incompetence \( (r = -0.38, p < 0.01) \), Devaluing Client \( (r = -0.23, p < 0.05) \), and Exhaustion \( (r = -0.18, p < 0.05) \) (Min Lee et al., 2007).

The job satisfaction scale was also negatively correlated with four CBI subscales: Negative Work Environment \( (r = -0.53, p < 0.01) \), Exhaustion \( (r = -0.46, p < 0.01) \), Deterioration in Personal Life \( (r = -0.33, p < 0.01) \), and Devaluing Client \( (r = -0.31, p < 0.01) \). The Incompetence subscale was the only CBI subscale to correlate significantly with the self-esteem scale \( (r = -0.31, p < 0.01) \). Internal consistency for the final 20-item inventory was found to be adequate with a Chronbach ‘s alpha of 0.88. The Chronbach ‘s alphas for each subscale were also found to be adequate, ranging from 0.80 to 0.84 for sample one and from 0.73 to 0.85 for sample two (Min Lee et al., 2007). Finally, test-retest reliability was determined through a 6-week retest of 18 sample two participants. Pearson product-moment correlations were computed between the two sets of responses for each subscale; the correlation coefficient across all five subscales was .81 indicating adequate test-retest reliability of CBI scores (Min Lee et al., 2007).

**Flourishing Scale (FS).** Both counseling self-efficacy and burnout have been linked to levels of stress, well-being, and job and life satisfaction in counselor
populations (Luszczynska, Gutierrez-Dona, & Schwarzer, 2005; Min Lee et al., 2010; McCarthy & Frieze, 1999; Osborn, 2004; Sprang, Clark, & Whitt-Woosley, 2007). As such, flourishing was also investigated in the current study; this construct is rooted in positive and humanistic psychology (Gable & Haidt, 2005; Ryan & Deci, 2000; Ryff, 1989). The *Flourishing Scale (FS)* (Diener et al., 2010) is a brief 8-item measure of participants’ self-perceived success in life areas that contribute to overall well-being/flourishing: relationships, self-esteem, purpose, and optimism (Diener, 2000; Wilson, 1967; Diener, Suh, Lucas, & Smith, 1999).

The FS includes eight items which describe aspects of human functioning ranging from positive human relationships and feelings of competence to perceptions of meaning and purpose in one’s life (Diener et al., 2010). Each item is presented on a Likert scale which ranges from one to seven (1 = *strong disagreement*, 7 = *strong agreement*). Scores for each individual item are later summed and the total score, therefore can range from eight (strong disagreement across all items) to 56 (strong agreement across all items). The higher the score, the more positively the participant perceives his or her functioning. The scale is a summary measure, providing an overview of positive functioning across the included domains (relationships, self-esteem, purpose, and optimism) (Diener et al., 2010).

Data was collected in 2008 at six different universities, each yielding a different number of participants. The first sample was from psychology students at the University of Illinois (N = 74); participants completed the surveys two times, with a one month interval. The second, third, and fourth samples included 86 students from the College of New Jersey, 181 participants from the Singapore Management University, and 64
students from the California State University East Bay, respectively (Diener et al., 2010). The final two samples were collected from East Carolina University (N = 168; also completed survey packets twice) and the University of Virginia (N = 116). The final combined sample was 689 participants, 468 of which were female; no other demographic information was provided.

To assess convergent validity, participants at different locations were asked to complete various established measures of well-being (Satisfaction with Life Scale (SLS), Diener, Emmens, Larson, & Griffin, 1985), optimism (Life Orientation Test-Revised (LOT-R), Scheier, Carver, & Bridges, 1994), poor social relationships (UCLA Loneliness Scale (UCLA-LS), Russell, 1996), competence and supportive relationships (Basic Need Satisfaction Scale (BNS), Ryan & Deci, 2000), and autonomy, purpose, growth, mastery, and self-esteem (Scales of Psychosocial Well-being (SPWB), Ryff, 2008) (Diener et al., 2010). The FS was found to have moderately high convergent validity, correlating strongly with the summed scores for the SPWB and BNS scales (r = 0.78, p < 0.05, r = 0.73, p < 0.05 respectively). The FS also moderately correlated with the SLS (r = 0.62, p < 0.05) and negatively correlated with the LOT-R and UCLA-LS (r = -0.59, p < 0.05, r = -0.28, p < 0.05 respectively) (Diener et al., 2010). Moreover, the FS is a good assessment of overall self-reported psychological well-being.

Results for the Flourishing Scale yielded an overall mean of 44.97 (SD = 6.56); no statistically significant differences between males and females were found. The reliability of the scale was found to be adequate with a Chronbach’s alpha of 0.87; authors also noted a temporal reliability coefficient of 0.71 indicating some change in scores across the test-retest period (one month) (Diener et al., 2010). A principal factor
analysis revealed one robust factor with an eigen value of 4.24 and accounting for 53 percent of the variance in the items. No other eigen value exceeded 1.0; factor loadings ranged from 0.61 to 0.77. Diener et al. (2010) have concluded that after initial psychometric analysis, the FS is an adequate measure of overall psychological well-being.

**Reliability and Cluster Analyses**

Reliability analyses for the current sample were conducted for each instrument prior to analysis. Internal consistency was adequate for the five dimensions of burnout: exhaustion ($\alpha = .86$), incompetence ($\alpha = .67$), negative work environment ($\alpha = .82$), devaluing client ($\alpha = .70$), and deterioration of personal life ($\alpha = .80$). Reliability was also adequate for the Flourishing Scale ($\alpha = .90$) and AMIQ vignettes. Chronbach’s alpha values for the individual vignettes were as follows: active heroin user ($\alpha = .64$), individual with depression ($\alpha = .74$), individual in recovery through Alcoholics Anonymous ($\alpha = .72$), convicted felon ($\alpha = .74$), individual with diabetes ($\alpha = .81$), individual with schizophrenia ($\alpha = .79$), and a practicing Christian ($\alpha = .79$).

For the current sample, the WAEES had excellent internal reliability ($\alpha = .94$) overall. A hierarchical cluster analysis of the items in the total scale using Ward’s method was also conducted. The dendogram plot clearly identified two subscales appropriate to answer the research question for this study, each with excellent internal reliability. Nine items related to clients with disabilities with a criminal history across the three domains of the working alliance clustered together ($\alpha = .95$). Another nine items clustered together and related to clients with disabilities and no criminal history across the three working
alliance domains ($\alpha = .91$). Thus, two subscales emerged: Criminal History and No Criminal History.

**Variables and Research Questions**

The alliance between counselor and client has been consistently connected to successful counseling outcomes (Bordin, 1979; Horvath & Symonds, 1991). Stigma has been shown to impact factors related to client outcomes such as level of engagement in treatment and formation of a working alliance with the counselor (Corrigan, 2003, Boysen et al., 2008; Shivy et al., 2007; Overton & Medina, 2008). As such, this construct must be further researched in the vocational rehabilitation counselor population to assess the presence and strength of counselor stigma associated with specific client groups and its impact on counseling behaviors related to positive client outcomes. Burnout research in the rehabilitation counselor population is sparse despite this construct’s connections to counselor job and life satisfaction and quality of client care (Min Lee et al., 2010; McCarthy & Frieze, 1999; Osborn, 2004; Sprang et al., 2007). A current examination of this construct and its impact on counseling beliefs and behaviors was warranted.

Provider experience has also been shown to impact perceptions of the working alliance, along with caseload size and make up (i.e., client disabilities), though little research has focused on this specific counselor population (Roth & Fonagy, 1996; Tryon et al., 2007; O’Sullivan, in press). Flourishing, an emerging concept connected to positive psychology, is essential to understand as counselor worldview can also impact perceptions of clients and how those perspectives may protect against burnout and stigma (Diener et al., 1999; Ronel & Elisha, 2011). This investigation worked to fill these research gaps, specifically targeting the vocational rehabilitation counselor population.
The relationships between burnout, stigma, experience, caseload size, and flourishing were assessed in relation to working alliance self-efficacy with clients with disabilities alone and with disabilities and criminal histories.

The primary dependent variables in this investigation were working alliance self-efficacy with and without criminal histories. More specifically, one’s perceived confidence in his or her ability to form a working alliance with clients who have disabilities alone and with clients who have disabilities and criminal histories based on the three components of Bordin’s (1979) model: agreement on goals, tasks, and bonding. Levels of counselor stigma, burnout, flourishing, and counselor experience served as the independent variables in this investigation. Working alliance efficacy levels were measured through the Working Alliance Efficacy Estimate Scale (WAEES).

The predictor variables provider experience (as reported in years) and current caseload size (continuous) were collected through a demographic questionnaire created for this investigation. Stigma was assessed through the Attitudes to Mental Illness Questionnaire (AMIQ). The score for each of the seven vignettes was computed, giving a total score for each vignette between -10 and +10 with negative numbers indicating higher levels of stigma (Luty et al., 2006).

Five dimensions of burnout were measured by the Counselor Burnout Inventory (CBI; Min Lee, 2007); scores for each dimension were summed to produce a total score. Finally, flourishing was assessed by the Flourishing Scale (FS) (Diener et al., 2010). Responses were summed for all eight items to create a total score. The possible range of scores was from eight to 56 with a higher score representing a person with ample
psychological resources and strengths and a lower score representing a person with fewer internal resources (Diener et al., 2010).

Based on a review of the literature and continued gaps regarding the contributions of burnout, flourishing, stigma, experience, and caseload size to working alliance self-efficacy, the principal research questions for this investigation were as follows:

1. Do burnout, stigma, flourishing, caseload size, experience, and working alliance self-efficacy relate to one another significantly?

2. How do burnout, stigma, flourishing, caseload size, working alliance efficacy, and experience predict working alliance self-efficacy with clients with and without a criminal history?

One post-hoc analysis was also conducted to answer the following question:

a. Do differences in the statistically significant independent and dependent variables (AMIQ convict and depression, flourishing, WA self-efficacy) exist between counselors whose caseload had 25% or more \((n = 77)\) criminal makeup compared with counselors whose caseloads had less than 25% criminal makeup \((n = 72)\)?

**Data Analysis**

In assessing research question one a two-tailed Pearson correlation analysis was used. In addressing research question two, simultaneous multiple regressions were used to determine the predictive qualities of provider stigma, burnout, flourishing, experience [years], and caseload size on the dependent variables of working alliance self-efficacy with disabilities only and disabilities with a criminal history. Nominal variables were dummy coded for analysis and the assumptions for regression were checked prior to analysis. Linear models such as regression have a number of statistical assumptions
which need to be met in order for correct interpretation of data. If one or more of the assumptions are violated, the results may be incorrect or misleading (type I or type II errors may occur; Tabachnick & Fidell, 2007).

Regression analysis relies on the assumptions of normality, homoscedasticity (equal variance), independence, linearity, and normal distribution of residuals. It is also important for researchers to check for outliers and multicollinearity when using regression (Tabachnick & Fidell, 2007). The assumption of normality was checked through examination of skewness (-1 to +1), box plots, and kurtosis values (under 10). Additionally, a scatterplot was used to check to see if the errors of prediction were normally distributed around each predicted criterion as well as a histogram to be sure the errors of residuals were normally distributed (Tabachnick & Fidell, 2007).

Scatterplots were used to check the assumption of homoscedasticity. Further, the Durbin-Watson test was used to be sure that the errors of residuals were independent of one another. Scatterplots were used to examine the linearity assumption and box plots assisted in the detection of outliers (Tabachnick & Fidell, 2007; Huck, 2008). Finally, correlations were checked for multicollinearity and the variance inflation factor (VIF) and tolerance values were calculated. The VIF provides an index of measurement which indicates how much of the variance of the regression coefficient is inflated as a result of collinearity; tolerance is an indicator of how much variability on the independent variable is not explained by the other variables (Tabachnick & Fidell, 2007; Pallant, 2010). As noted, post hoc analyses were added to examine differences between high and low criminal caseload makeup on the statistically significant independent variables; independent t-tests were used and are discussed in more depth in the results section.
Power Analysis

Power Analysis. An a priori power analysis was conducted using G*Power 3.1 (Faul & Erdfelder, 1992), a web-based statistical program used for power estimation. A medium effect size of .15 and an alpha level of .05 were used to calculate power based on previous literature (O’Sullivan, in press). The analysis indicated that a minimum sample of 146 participants was needed to provide sufficient statistical power for the regression analysis; the final sample included 149 participants with completed surveys. Thirty-eight additional surveys were left incomplete; the majority of these (n = 31) can be explained by a temporary firewall error in the New York State VR internal computer network. This temporary glitch prevented these participants from completing these submissions and was later remedied by the agency’s technical support team; these respondents were not included in the analysis as surveys were incomplete.
CHAPTER 4

RESULTS

This chapter provides a descriptive analysis of the sample and results of completed online surveys \((N = 149)\). A correlation analysis was conducted along with two multiple regressions to address the primary research questions of this investigation. The assumptions for the proper use of linear multiple regression were checked prior to analysis and are reviewed in this chapter. Additionally, a rationale for post-hoc analyses is discussed along with the results.

Preliminary Analyses

Data Re-coding

Following data entry, data were re-coded in order to score the instruments using SPSS version 19.0. The AMIQ data were re-coded into different variables to account for positive and negative values attached to each response (questions 1, 4, and 5 for each vignette and then questions 2 and 3). Once recoded, the AMIQ vignette items were then computed into a total score variable which fell between -10 and +10; this was done for each of the seven vignettes.

For the WAEES, the three dimensions of working alliance were totaled into two scores for each: one for those with a criminal history, one for those without. A total of six scores for the WAEES, two for each working alliance dimension were calculated. Next, a variable was computed to sum the scores of each dimension for those with a criminal history and provided an average score across the three dimensions of the working alliance. The same was done for the three dimensions for those without a criminal history. Since the WAEES employed a 7-point Likert response scale, the highest average
score (when summed and then divided by three) would be 7, indicating high confidence, the lowest 1, indicating no confidence for that dimension. Two total scores were then computed for the WAEES; one for clients with no criminal history and one for those with a history. The total score for the WAEES with clients who had criminal histories served as the dependent variable in the regression analysis.

The five dimensions of burnout were scored individually. A total burnout score was also calculated for use in the regression analysis. This score can range from 20 (no burnout/never true) to 100 (high burnout/always true). According to established norms (Min Lee et al., 2007) a score of 20 indicates no burnout, 40 indicates minimal burnout, 60 signifies low to moderate burnout, 80 represents moderate to high burnout and 100 notes a high level of burnout. The Flourishing Scale was also summed for a total score and can range from a low of 8 (strong disagreement with all items, low flourishing) to a high 56 (strong agreement with all items, high flourishing).

Statistical Assumptions

Linear models such as multiple regression have a number of statistical assumptions which need to be met in order for correct interpretation of data. If one or more of the assumptions are violated, the results may be incorrect or misleading (Tabachnick & Fidell, 2007). The assumptions inherent in linear models also assist the researcher in selecting the most appropriate and powerful tests for analysis. Multiple regression relies on the assumptions of normality, homoscedasticity (equal variance), independence, linearity, and normal distribution of residuals. It is also important for researchers to check for outliers and multicollinearity when using regression (Tabachnick & Fidell, 2007).
In assessing normality, data were examined to check for skewness and kurtosis; all values were adequate and fell within acceptable ranges. In addition, histograms and box plots were used to check for normality in each of the independent and dependent variables (see Appendix A). Normal Q-Q plots were also examined (see Appendix B). Normal Q-Q plots show the observed value for each score plotted against the expected value from the normal distribution; a reasonably straight line suggests a fairly normal distribution (Pallant, 2010). Normal P-P plots later confirmed that there were no major deviations from normality for regressed variables (see Appendices C & D).

To assess homogeneity of variance along with normality of the error terms (residuals), Normal P-P plots and a scatterplot of the regression standardized residual were generated. There should be similar variance in the dependent variable across the values of the independent variables (Pallant, 2010). Plots appeared adequate for all independent and dependent variables (WAEES with no criminal history \([M = .00, SD = .80]\); WAEES with criminal history \([M = .00, SD = 1.01]\)) providing evidence that the residuals or error terms were normally distributed. The assumption of homoscedasticity was also met as points were randomly dispersed and no patterns were present in the scatterplot of residuals (See Appendices C & D).

Linearity was assessed through scatterplots between the dependent variable subscales and the independent variables. Plots indicated that the linearity assumption for each stigma scale, flourishing, burnout, years of experience, and current caseload size was met for both WAEES with no history and WAEES with a criminal history (see Appendices E & F).
No extreme outliers were noted through examination of box plots (see Appendix A); standardized residual values also fell within the -3.3 and 3.3 range for both regression models confirming that no concerning outliers were present (Pallant, 2010). A correlation analysis was conducted to check for potential multicollinearity and independence (see Table 2). Multicollinearity exists when there is a strong correlation (.80 and above) between two or more independent variables in a regression model (Field, 2005). No potential multicollinearity was noted between variables; the highest correlation was .50 between AMIQ convict and heroin. Tolerance levels were high ranging from .71 to .95 in model one and .64 to .92 in model two providing additional evidence that collinearity was not present. In addition, the variance inflation factor (VIF) values were well below 10 for both models, providing further evidence that the predictor variables were not highly related (see Tables 5 & 7).

The Durbin-Watson test (see Tables 5 & 7) was used along with Normal P-P plots (see Appendices C & D) to determine independence of residuals. Both WAEES scales exceeded 1.9; as the values approached 2, there is little chance of autocorrelation, indicating independence. If the error terms were highly positively correlated, the statistic would be less than 1 and could fall near zero. If the error terms were highly negatively correlated, the statistic would be greater than 3 and could reach near the upper limit of 4 (Pallant, 2010). Thus, the assumptions were met for regression analysis.

**Primary Analyses**

*Research Question 1: Two-Tailed Pearson Correlation Analysis*

For research question one, a correlation analysis was conducted to examine the relationships among the variables. Statistically significant correlations were seen between
multiple independent variables and the dependent variable. Flourishing positively
correlated with WA self-efficacy with disabilities alone as well as disabilities with a
criminal history ($p = .02, r = .20; p = .00; r = .30$), suggesting that counselors with higher
levels of flourishing also have higher levels of WA self-efficacy with clients with and
without criminal histories. AMIQ schizophrenia was the only stigma variable to
significantly correlate to WA efficacy with disabilities alone ($p = .01, r = .20$). In
contrast, AMIQ heroin, AMIQ depression, AMIQ convict, and AMIQ schizophrenia all
positively correlated with WA self-efficacy with a criminal history ($p = .01, r = .20; p =
.00, r = .38; p = .00, r = .35; p = .00, r = .40$). To clarify, as higher positive ratings on the
AMIQ stigma scale indicate less stigma, as the WA self-efficacy for clients with criminal
history goes up, stigma goes down. Burnout also significantly negatively correlated with
WA self-efficacy with disabilities alone and disabilities with a criminal history ($p = .01, r
= -.21; p = .00; r = -.26$); individuals with higher burnout had lower levels of working
alliance efficacy. Finally, working alliance self-efficacy with no criminal history was
significantly correlated with WAEES with criminal history scores ($p = .00, r = .75$).

In addition to the relationships between the independent and dependent variables,
several statistically significant correlations were seen between and within the independent
variables. A positive correlation was seen between current case load size and burnout ($p
= .05; r = .21$) indicating that providers with larger caseloads also experience greater
burnout. Lending further support to that notion, a negative relationship was found
between flourishing and caseload size although it was not found to be statistically
significant ($p = .21, r = -.10$). A moderate negative correlation was seen between burnout
and flourishing ($p = .00, r = -.53$); such a relationship was expected due to the contrary
nature of these variables. Burnout also significantly correlated with AMIQ heroin ($\alpha = .04, r = -.17$) and AMIQ schizophrenia ($p = .01, r = -.22$). As burnout levels increased, levels of stigma towards these groups also increased.

Statistically significant positive relationships were also seen between the stigma vignettes. AMIQ depression positively correlated with AMIQ heroin ($p = .00, r = .25$) and AMIQ convict ($p = .00, r = .32$). AMIQ convict and AMIQ heroin positively correlated as well ($p = .00, r = .50$). Further, AMIQ heroin correlated negatively with AMIQ diabetes ($p = .00, r = -.41$) and AMIQ Christian ($p = .00, r = -.31$). AMIQ schizophrenia and AMIQ heroin positively correlated ($p = .00, r = .23$), as did AMIQ convict and AMIQ schizophrenia ($p = .00, r = .40$). AMIQ Alcoholics Anonymous recovery positively correlated with AMIQ diabetes ($p = .00, r = .24$) and AMIQ convict negatively correlated with AMIQ diabetes and AMIQ Christian ($p = .00, r = -.48; p = .00, r = -.33$). Years of experience produced a statistically significant negative correlation with only one variable, AMIQ schizophrenia ($p = .02; r = -.17$); as positive scores indicate less stigma, this negative correlation suggests that as years of experience increase, stigma for individuals with schizophrenia also increases. In addition to the significant relationships noted, several non-significant relationships were found; see Table 3 for the complete correlation matrix.
### Table 2

**Two-tailed Pearson Correlations Among Independent and Dependent Variables**

<table>
<thead>
<tr>
<th></th>
<th>1 Current Caseload Size</th>
<th>2 Flourishing Scale</th>
<th>3 AMIQ Heroin</th>
<th>4 AMIQ Depression</th>
<th>5 AMIQ AA</th>
<th>6 AMIQ Convict</th>
<th>7 AMIQ Diabetes</th>
<th>8 AMIQ Schizophrenia</th>
<th>9 AMIQ Christian</th>
<th>10 WAEES with History</th>
<th>11 WAEES with no history</th>
<th>12 Burnout Total Score</th>
<th>13 Years Experience</th>
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<td>0.01</td>
<td>0.19*</td>
<td>-0.01</td>
<td>0.30**</td>
<td>0.20*</td>
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<td>0.50**</td>
<td>-0.41**</td>
<td>0.23**</td>
<td>-0.31**</td>
<td>0.20*</td>
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<td>0.32**</td>
<td>-0.08</td>
<td>0.37**</td>
<td>-0.05</td>
<td>0.38**</td>
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<td>-0.02</td>
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<td>0.24**</td>
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<td>-0.04</td>
<td>-0.03</td>
<td>0.07</td>
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<td>-0.33**</td>
<td>0.35**</td>
<td>0.08</td>
<td>0.04</td>
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<td>-0.09</td>
<td>0.40**</td>
<td>0.20*</td>
<td>0.22**</td>
<td>-0.17*</td>
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<td>-0.08</td>
<td>0.12</td>
<td>-0.10</td>
<td>-0.05</td>
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<td>10</td>
<td></td>
<td></td>
<td>0.75**</td>
<td>-0.26**</td>
<td>0.03</td>
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<tr>
<td>11</td>
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<td>-0.21*</td>
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<td>0.13</td>
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<td></td>
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</tr>
</tbody>
</table>

* Correlation is statistically significant at $p < .05$

**Correlation is statistically significant at $p < .01$
Research Question 2: Simultaneous Multiple Regressions

For research question two, simultaneous multiple regression was used to assess if the independent variables predicted levels of working alliance self-efficacy with disabilities alone and disabilities with criminal histories in state vocational rehabilitation counselors. Based on the preliminary correlation analysis, the following independent variables were retained for the first regression model with disabilities alone: AMIQ schizophrenia, flourishing, and burnout. The following independent variables were retained for the second regression with a criminal history: AMIQ heroin, AMIQ convict, AMIQ depression, AMIQ schizophrenia, burnout, and flourishing (see Table 3). Disability caseload makeup and education level did not show sufficient variability within the sample to regress; both were excluded from further analysis.

The model summary for regression one (no history) indicated that the regression model was statistically significant ($p = .01, F = 4.04$) (see Table 4); the adjusted R Square value of 0.06 indicated that 6% of the variance in working alliance self-efficacy with disabilities alone was explained by the independent variables (AMIQ schizophrenia, Burnout, & Flourishing) (see Table 5). The adjusted R Square value is preferable to R Square as it accounts for sample size to provide a better estimate of the true population value. The adjusted R Square (adj. $R^2 = .06$) and R Square ($R^2 = .08$) values were close to one another, indicating that the sample statistics were close to the larger population statistics (Pallant, 2010) (see Table 5).

To assess the individual contributions of each independent variable in predicting the dependent variable, the standardized coefficients beta values were examined.

Standardized coefficients (versus unstandardized coefficients) mean that the values have
been converted to the same scale for comparison (Pallant, 2010). When assessing beta values, the positive and negative signs are unimportant; the individual contributions are assessed by the absolute beta value. AMIQ schizophrenia ($\beta = .16, p = .06$) made the largest contribution in explaining the dependent variable when the variance for all other independent variables was controlled for. Burnout had the second largest beta value ($\beta = -.12, p = .21$), followed by flourishing ($\beta = .11, p = .27$). None of the predictor variables made unique statistically significant contributions, however, indicating that the shared variance of the model was more impactful than the individual contributions of the predictor variables.
Table 3
*Descriptive Statistics for Selected Predictor and Dependent Variables*

<table>
<thead>
<tr>
<th>Variables</th>
<th>M</th>
<th>SD</th>
<th>Median</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMIQ heroin</td>
<td>-5.46</td>
<td>2.75</td>
<td>-6.00</td>
</tr>
<tr>
<td>AMIQ depression</td>
<td>-.375</td>
<td>3.28</td>
<td>.00</td>
</tr>
<tr>
<td>AMIQ convict</td>
<td>-5.08</td>
<td>3.12</td>
<td>-5.00</td>
</tr>
<tr>
<td>AMIQ schizophrenia</td>
<td>-1.06</td>
<td>3.28</td>
<td>.00</td>
</tr>
<tr>
<td>Flourishing</td>
<td>6.07</td>
<td>.73</td>
<td>6.13</td>
</tr>
<tr>
<td>Burnout</td>
<td>45.17</td>
<td>10.61</td>
<td>44.00</td>
</tr>
<tr>
<td>WAEES with No Criminal History</td>
<td>5.93</td>
<td>.83</td>
<td>6.00</td>
</tr>
<tr>
<td>WAEES with Criminal History</td>
<td>5.24</td>
<td>1.31</td>
<td>5.33</td>
</tr>
</tbody>
</table>

a. AMIQ scores: -10 (high stigma), +10 (low stigma); Flourishing: 8 (low flourishing), 56 (high flourishing); Burnout: 20 (no burnout), 100 (very high burnout); WAEES scores: 1 (no confidence), 7 (high confidence)
Table 4
Regression Model 1: Analysis of Variance$^b$

<table>
<thead>
<tr>
<th>Model</th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Regression</td>
<td>7.908</td>
<td>3</td>
<td>2.636</td>
<td>4.035</td>
</tr>
<tr>
<td></td>
<td>Residual</td>
<td>94.712</td>
<td>145</td>
<td>.653</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>102.620</td>
<td>148</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

a. Predictors (Constant), Flourishing, Burnout, AMIQ Schizophrenia
b. Dependent Variable: WAEES with No Criminal History
Table 5
WAEES with No Criminal History Regressed on Selected Predictor Variables

<table>
<thead>
<tr>
<th>Model</th>
<th>Unstandardized Coefficients</th>
<th>Standardized Coefficients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B</td>
<td>Std. Error</td>
</tr>
<tr>
<td>1 (Constant)</td>
<td>5.667</td>
<td>.880</td>
</tr>
<tr>
<td>AMIQ schizophrenia</td>
<td>.040</td>
<td>.021</td>
</tr>
<tr>
<td>Flourishing</td>
<td>.121</td>
<td>.108</td>
</tr>
<tr>
<td>Burnout</td>
<td>-.009</td>
<td>.007</td>
</tr>
</tbody>
</table>

Model Summary: R = .278, R Square =.08, Adj. R Square = .06, Std. Error of the Estimate = .80820, Durbin-Watson = 1.891
Table 5 (continued)

**WAEES with No Criminal History Regressed on Selected Predictor Variables**

<table>
<thead>
<tr>
<th>Lower Bound</th>
<th>Upper Bound</th>
<th>Zero-Order</th>
<th>Partial</th>
<th>Part</th>
<th>Tolerance</th>
<th>VIF</th>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-.002</td>
<td>.081</td>
<td>.202</td>
<td>.156</td>
<td>.152</td>
<td>.945</td>
<td>1.058</td>
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<tr>
<td>-.093</td>
<td>.334</td>
<td>.196</td>
<td>.092</td>
<td>.089</td>
<td>.718</td>
<td>1.393</td>
</tr>
<tr>
<td>-.024</td>
<td>.005</td>
<td>-.209</td>
<td>-.104</td>
<td>-.100</td>
<td>.705</td>
<td>1.418</td>
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</tbody>
</table>

Model Summary: R = .278, R Square = .08, Adj. R Square = .06, Std. Error of the Estimate = .80820, Durbin-Watson = 1.891
Regression model two (with history) was also statistically significant ($p = .00, F = 11.02$) (see Table 6); the adjusted R Square value of 0.30 indicated that 30% of the variance in working alliance self-efficacy with ex-offenders was explained by the independent variables (AMIQ heroin, AMIQ schizophrenia, AMIQ convict, AMIQ depression, Burnout, and Flourishing) (see Table 7). The adjusted R Square (adj. $R^2 = .30$) and R Square ($R^2 = .32$) values were close to one another, again indicating that the sample statistics were close to the larger population statistics (Pallant, 2010).

To assess the individual contributions of each independent variable in predicting the dependent variable, the standardized coefficients beta values were examined. AMIQ convict ($\beta = .26, p = .00$) made the largest contribution in explaining the dependent variable when the variance for all other independent variables is controlled for. In descending order of remaining beta values: AMIQ Depression ($\beta = .25, p = .00$), Flourishing ($\beta = .20, p = .02$), Burnout ($\beta = .14, p = .09$), AMIQ Schizophrenia ($\beta = .14, p = .09$) and AMIQ Heroin ($\beta = -.08, p = .48$) (see Table 7). Thus, flourishing, AMIQ convict, and AMIQ depression significantly contributed to the prediction equation.

Part correlations were calculated to determine how much each statistically significant independent variable uniquely contributed to total R squared; any overlaps and shared variance is partialled out (Pallant, 2010). Part correlations also indicate how much R square would drop if the variable was not included in the model (Pallant, 2010). Flourishing part correlation was equal to .17 with a squared value of .03, the AMIQ convict part correlation was equal to .21 with a squared value of .04, and the AMIQ depression part correlation was equal to .23 with a squared value of .05 (see Table 7).
These values indicated that these variables accounted for a respective three, four, and five percent of the unique variance in working alliance self-efficacy with ex-offenders apart from the other independent variables. As these part correlations were small (Tabachnick & Fidell, 2007), the shared variance of the model was more impactful than the individual contributions of the predictor variables. Moreover, the combined model made a meaningful contribution, but apart, the effects were minimal.
Table 6
*Regression Model 2: Analysis of Variance*<sup>b</sup>

<table>
<thead>
<tr>
<th>Model</th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F</th>
<th>Sig.</th>
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</thead>
<tbody>
<tr>
<td>2 Regression</td>
<td>80.657</td>
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<td>13.443</td>
<td>11.018</td>
<td>.000&lt;sup&gt;a&lt;/sup&gt;</td>
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<tr>
<td>Residual</td>
<td>173.254</td>
<td>142</td>
<td>1.220</td>
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<tr>
<td>Total</td>
<td>253.911</td>
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</table>

c. Predictors (Constant), Flourishing, Burnout, AMIQ Convict, AMIQ Depression, AMIQ Schizophrenia, AMIQ heroin
d. Dependent Variable: WAEES with Criminal History
Table 7
WAEES with Criminal History Regressed on Selected Predictor Variables

<table>
<thead>
<tr>
<th>Model</th>
<th>Unstandardized Coefficients</th>
<th>Standardized Coefficients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B</td>
<td>Std. Error</td>
</tr>
<tr>
<td>2 (Constant)</td>
<td>4.323</td>
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</tr>
<tr>
<td>AMIQ heroin</td>
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<td>.039</td>
</tr>
<tr>
<td>AMIQ depression</td>
<td>.101</td>
<td>.031</td>
</tr>
<tr>
<td>AMIQ convict</td>
<td>.110</td>
<td>.037</td>
</tr>
<tr>
<td>AMIQ schizophrenia</td>
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<td>.033</td>
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<tr>
<td>Flourishing</td>
<td>.356</td>
<td>.149</td>
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<tr>
<td>Burnout</td>
<td>-.018</td>
<td>.010</td>
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</table>

Table 7 (continued)

*WAEES with Criminal History Regressed on Selected Predictor Variables*

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<th>Upper Bound</th>
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<th>Partial</th>
<th>Part</th>
<th>95% Confidence Interval for B</th>
<th>Correlations</th>
<th>Collinearity Statistics</th>
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<td>-.116</td>
<td>.040</td>
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<td>-.080</td>
<td>-.066</td>
<td>.701</td>
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<tr>
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<td>.003</td>
<td>-.256</td>
<td>-.141</td>
<td>-.117</td>
<td>.681</td>
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<td>1.468</td>
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</tbody>
</table>

Post-Hoc Analysis: Independent t-tests

AMIQ depression, AMIQ convict, and flourishing were found to be statistically significant predictors of working alliance self-efficacy with ex-offenders (model 2). As such, post-hoc independent t-tests were conducted to determine if statistically significant mean differences existed between counselors with a high proportion of clients with criminal histories (> 25%, n = 72) and counselors with a low proportion of clients with criminal histories (< 25%, n = 77) on these variables. Variables were chosen based on the unique contributions they made to the prediction equation.

Prior to conducting the t-tests, a new variable was created to dichotomize caseload criminal make up to 25% and up (n = 72) and 24% and below (n = 77). Data naturally split around the 25% mark and this cutoff was used to dichotomize the sample following consultation with the state director of a participating vocational rehabilitation agency and two rehabilitation educators, each with more than 20 years of experience in the field. Each agreed that counselors would have regular contact with this proportion of his or her caseload (defined as bi-weekly face-to-face contact and monthly phone contact).

Prior to testing for mean differences on the selected variables, independent t-tests were conducted to see if the high proportion criminal caseload and low proportion criminal caseload groups were evenly matched on current caseload size ($M = 158.80$, $SD = 58.35$; $M = 139.64$, $SD = 63.94$) and years of experience ($M = 13.10$, $SD = 9.70$; $M = 12.00$, $SD = 9.10$); both have been connected to working alliance self-efficacy, stigma, and burnout in the past (O’Sullivan, in press; Mallinckrodt & Nelson, 1991; Harris, 1984; Osborn, 2004; Carmel & Friedlander, 2009). Results indicated that no statistically
significant mean differences existed between groups on either variable \((t (147) = -1.91, p = .06; t (139) = - .67, p = .50)\); both groups were reporting comparable values.

As a control for the alpha inflation that can occur with multiple \(t\)-tests, a post-hoc power analysis was conducted using G*Power version 3.1, with a .008 alpha, medium effect, and sample sizes for each group. Power was estimated to be .70; as this was lower than the desired .80, effect sizes were calculated for each comparison to account for the increased possibility of error. The statistical assumptions for independent \(t\)-tests were also checked prior to analysis. All variables were continuous and as such, the level of measurement assumption was met. While random sampling was not employed in this investigation, the sample was geographically diverse and represented counselors from the east, west, and mid-western parts of the country. In addition, independent \(t\)-tests are robust and can withstand a violation of this assumption (Pallant, 2010).

Observations were independent and individual responses did not influence one another; therefore the assumption of independence was satisfied. Data for these variables were normally distributed (see Appendix A). Homogeneity of variance was assessed using Levene’s test; this assumption was violated for group differences \((p = .00)\) on WAEES with a criminal history and as such the adjusted \(t\) values were reported to account for unequal variances.

Results for independent \(t\)-tests (see tables 8-10) were not statistically significant for AMIQ depression, AMIQ convict, or flourishing \((t (147) = - .19, p = .06; t (147) = -1.43, p = .15; t (147) = - .65, p = .51)\), indicating that both groups were fairly evenly matched. Cohen’s \(d\) effect sizes were calculated to account for reduced power. Despite statistically
non-significant results, AMIQ depression and AMIQ convict mean differences produced small effects ($d = -0.31; d = -0.24$); flourishing, however, produced little effect ($d = -0.11$). A statistically significant mean difference was found between high proportion ($M = 5.58, SD = 1.01$) and low proportion criminal caseloads ($M = 4.92, SD = 1.50$) and working alliance self-efficacy with ex-offenders ($t(134.75) = -3.16, p = .00$); a moderate effect was noted ($d = -.52$) (see Table 11).
<table>
<thead>
<tr>
<th>Levene’s Test for Equality of Variances</th>
<th>t-test for Equality of Means</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>t</td>
</tr>
<tr>
<td>AMIQ Depression</td>
<td></td>
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<tr>
<td>Equal variances assumed</td>
<td>1.218</td>
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<tr>
<td>Equal variances not assumed</td>
<td>-1.874</td>
</tr>
</tbody>
</table>
Table 8 (continued)

*Independent Samples t-test High/Low Proportion Criminal Caseload*

<table>
<thead>
<tr>
<th>AMIQ Depression</th>
<th>95% Confidence Interval of the Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equal variances assumed</td>
<td>Lower: $-2.05011$</td>
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<tr>
<td>Equal variances not assumed</td>
<td>Upper:  $0.05804$</td>
</tr>
<tr>
<td>Equal variances assumed</td>
<td>Lower: $-2.04622$</td>
</tr>
<tr>
<td>Equal variances not assumed</td>
<td>Upper:  $0.05416$</td>
</tr>
</tbody>
</table>
Table 9  
*Independent Samples t-test High/Low Proportion Criminal Caseload*

<table>
<thead>
<tr>
<th></th>
<th>Levene’s Test for Equality of Variances</th>
<th>t-test for Equality of Means</th>
<th></th>
<th></th>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>F</td>
<td>Sig.</td>
<td>t</td>
<td>df</td>
<td>Sig. (2-tailed)</td>
<td>Mean Difference</td>
<td>Std. Error Difference</td>
<td>d</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AMIQ Convict</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Equal variances assumed</td>
<td>.764</td>
<td>.384</td>
<td>-1.434</td>
<td>147</td>
<td>.154</td>
<td>-.73323</td>
<td>.51129</td>
<td>-.24</td>
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</tr>
<tr>
<td>Equal variances not assumed</td>
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<td>146.886</td>
<td>.152</td>
<td>-.73323</td>
<td>.50965</td>
<td></td>
<td></td>
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</table>
Table 9 (continued)

*Independent Samples t-test High/Low Proportion Criminal Caseload*

<table>
<thead>
<tr>
<th>AMIQ Convict</th>
<th>95% Confidence Interval of the Difference</th>
<th></th>
<th></th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>Lower</td>
<td>Upper</td>
</tr>
<tr>
<td>Equal variances assumed</td>
<td></td>
<td>-1.74366</td>
<td>.27721</td>
</tr>
<tr>
<td>Equal variances not assumed</td>
<td></td>
<td>-1.74042</td>
<td>.27397</td>
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</table>
Table 10

*Independent Samples t-test High/Low Proportion Criminal Caseload*

<table>
<thead>
<tr>
<th>Levene’s Test for Equality of Variances</th>
<th>t-test for Equality of Means</th>
</tr>
</thead>
<tbody>
<tr>
<td>F</td>
<td>Sig.</td>
</tr>
<tr>
<td>---</td>
<td>------</td>
</tr>
<tr>
<td><strong>Flourishing</strong></td>
<td></td>
</tr>
<tr>
<td>Equal variances assumed</td>
<td>.384</td>
</tr>
<tr>
<td>Equal variances not assumed</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>


Table 10 (continued)

*Independent Samples t-test High/Low Proportion Criminal Caseload*

<table>
<thead>
<tr>
<th></th>
<th>95% Confidence Interval of the Difference</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Lower</td>
</tr>
<tr>
<td><strong>Flourishing</strong></td>
<td></td>
</tr>
<tr>
<td>Equal variances assumed</td>
<td>-.31306</td>
</tr>
<tr>
<td>Equal variances not assumed</td>
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</table>
Table 11
Independent Samples t-test High/Low Proportion Criminal Caseload

<table>
<thead>
<tr>
<th></th>
<th>Levene’s Test for Equality of Variances</th>
<th>t-test for Equality of Means</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>F</td>
<td>Sig.</td>
</tr>
<tr>
<td>WAEES with Criminal History</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Equal variances assumed</td>
<td>16.644</td>
<td>.000</td>
</tr>
<tr>
<td>Equal variances not assumed</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>-3.157</td>
<td>134.746</td>
</tr>
</tbody>
</table>
Table 11 (continued)

*Independent Samples t-test High/Low Proportion Criminal Caseload*

<table>
<thead>
<tr>
<th></th>
<th>95% Confidence Interval of the Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Lower</td>
</tr>
<tr>
<td>WAEES with Criminal History</td>
<td></td>
</tr>
<tr>
<td>Equal variances assumed</td>
<td>-1.19531</td>
</tr>
<tr>
<td>Equal variances not assumed</td>
<td>-1.18928</td>
</tr>
</tbody>
</table>
The working alliance between counselor and client has been consistently connected to successful counseling outcomes (Bordin, 1979; Horvath & Symonds, 1991; Strauser et al., 2004). The working alliance can be understood as collaboration between the counselor and client with three central components: development of bonds, an agreement on goals, and the assignment of tasks (Bordin, 1979). Stigmatizing attitudes can impact the formation of the working alliance, the willingness of clients to engage in treatment, impact levels of self-esteem, and negatively influence overall client outcomes (Mann & Himelein, 2008; Corrigan & Penn, 1999; Corrigan et al., 2000; Penn et al., 1999; Johnstone, 2001). In addition to stigma, level of experience and caseload size has been shown to impact perceptions of the working alliance and levels of provider burnout. Burnout, in turn, has been shown to influence levels of life satisfaction (flourishing) in providers (Min Lee et al., 2010; Sprang et al., 2007; Hersoug et al., 2001). As the working alliance is an integral piece of the counseling relationship, the goals of this study were to examine the relationships between the factors of stigma, burnout, flourishing, provider experience, and caseload size and to determine if they were predictive of provider working alliance self-efficacy with clients who have disabilities alone, as well as with those who are ex-offenders.

In order to evaluate the first research question, a correlation analysis was conducted to examine the relationships between variables. Positive statistically significant correlations were seen between flourishing and working alliance self-efficacy
for clients both with and without criminal histories indicating that counselors who had higher levels of flourishing also had higher WA self-efficacy. In addition, burnout total score negatively correlated with WA self-efficacy with and without criminal histories indicating that providers with lower levels of burnout also have higher levels of working alliance self-efficacy. Positive psychologists have stated that “valued subjective experiences” (VSEs; Seligman & Csikszentmihalyi, 2000, p. 5) make up the concept of flourishing. Well-being, contentment, past and present satisfaction, hope for the future, and present happiness were the primary VSEs noted by researchers (Diener et al., 1999).

Therefore, counselors with higher levels of working alliance self-efficacy in this sample tended to have higher levels of well-being, contentment, satisfaction, hope, and happiness (flourishing) and had lower levels of burnout. A negative relationship also existed between burnout and flourishing supporting the idea that flourishing may act as a protective factor to burnout; it also stands to reason that the more satisfied, content, hopeful, and happy one is, the less likely he or she is to report burnout. The negative relationships between burnout and working alliance self-efficacy also corresponded with previous research which found that high working alliance ratings negatively associated with burnout (Carmel & Friedlander, 2009). The less burnt out one is, the more effective he or she feels as a rehabilitation service provider.

The stigma scales for heroin, depression, convict, and schizophrenia significantly correlated with WA self-efficacy with ex-offenders indicating that as stigma improves, so does working alliance self-efficacy with criminal histories. In comparison, the stigma scale for schizophrenia was the only one to significantly correlate with WA self-efficacy
with disabilities alone. This difference suggests that stigma has a greater impact on working alliance self-efficacy with clients who have disabilities and a criminal history compared to clients with a disability alone. Previous research supports this conclusion noting that the presence of a disability or disabilities is another source of stigma for ex-offenders (Smith, 2005; Groom, 1999; Russell & Stewart, 2001). Hartwell (2004) examined the triple stigma of offender status, mental illness, and substance abuse and found that this client population contends with stigma associated with multiple facets of their identity.

Previous researchers have found that increased contact and education reduces stigmatizing attitudes (Corrigan et al., 2003; Corrigan & Wassel, 2008; Corrigan et al., 2000). Years of experience had a statistically significant relationship with only one variable, AMIQ schizophrenia; as years of experience increased, stigma also increased. In other words, the longer a person had worked as a rehabilitation service provider, the more stigma he or she had towards this client group. In a similar finding, O’Sullivan (in press) noted a negative relationship between years of experience working with people with psychiatric disabilities and WA self-efficacy scores for that group. However, years of experience with people with psychiatric disabilities did positively relate to WA self-efficacy scores for people with physical disabilities (O’Sullivan, in press). Moreover, increased work experience with people with psychiatric disabilities did not necessarily increase WA self-efficacy with that population, but increases were seen in other disability groups. Stigma and burnout were thought to be contributing factors; the current investigation supports these assumptions.
Past research on the impact of experience in reducing stigma is mixed. The results of the current investigation are in contrast with previous stigma research in which increased contact with a stigmatized population has led to decreased stigma (Corrigan et al., 2003; Corrigan, 2001; Murdock, 2001). The current investigation did not find years of experience to be significantly related to working alliance efficacy with clients who have disabilities alone or clients with disabilities and criminal histories. Carmel and Friedlander (2009), however, found that years of experience was a statistically significant predictor of working alliance self-efficacy and subsequently predicted strong working alliance perceptions among counselors. In a different study, client dropout was more commonly connected to inexperienced therapists than experienced providers, suggesting a connection between provider experience and working alliance (Roth & Fonagy, 1996).

Statistically significant correlations existed between stigma for depression, heroin, schizophrenia, and convict; as stigma for one increased, the others increased as well. These results were somewhat expected as each of these groups is highly stigmatized; previous research on attribution theory (Wiener, 1995) supported these findings. Individuals with addiction are often perceived to have high control and high stability, leading to higher levels of stigma (Corrigan et al., 2000; Room, 2005; Lavack, 2007). As well, individuals with schizophrenia are often associated with higher stability attributions and higher stigma (Corrigan et al., 2003); researchers have stated that some believe depression is the result of “weak-mindedness” or improper diet in addition to hereditary factors (Han, Chen, Hwang, & Wei, 2006, p. 663). Individuals with criminal histories are also subject to negative attributions and stigma. Heider (1958) stated that criminal
behavior that is perceived to be caused by internal personal characteristics is more stigmatized than behavior believed to result from external circumstances. Subsequently, a perception of internal control leads to more punitive attitudes and judgments regarding punishment (Heider, 1958; Sims, 2003). The AMIQ stigma vignette used in this study presented an individual with multiple convictions (i.e., theft) and no mitigating reason for the crimes; it is therefore likely that negative attributions resulted and negatively influenced responses. Previous researchers (Tschopp et al., 2007) have also found high stigma towards individuals with both mental illness and a criminal history.

Statistically significant correlations also existed between AMIQ heroin and AMIQ diabetes; as stigma for heroin users went up, stigma for individuals with diabetes went down. A similar relationship was seen between heroin users and practicing Christians. As expected, the Alcoholics Anonymous vignette significantly related to the diabetes vignette; as stigma decreased for one, it also decreased for the other. Finally, the convict vignette significantly correlated with the diabetes and practicing Christian vignettes; as stigma for the convict increased, stigma for the individual with diabetes and the practicing Christian decreased. These were also anticipated relationships according to attribution theory research (Wiener, 1995; Corrigan et al., 2003; Corrigan, 200; Corrigan et al., 2000); stigma increased for individuals historically perceived to have higher control and stability (convict, intravenous heroin user) and decreased for individuals perceived to have lower control and stability (diabetes, practicing Christian, individual in AA recovery). Rao et al.’s (2009) findings also correspond with the current investigation;
stigma towards people with active opiate dependencies is higher when compared with those who are currently abstinent and employed.

In the current study, statistically significant positive relationships existed between burnout and stigma for active injection heroin users and individuals with schizophrenia. Past researchers have found that increases in burnout lead to greater support for punishment and less support for treatment (Lambert et al., 2010). Burnout and working alliance efficacy (with and without criminal history) did significantly relate and providers with higher burnout had lower levels of working alliance efficacy with clients with and without criminal histories. As one would expect, providers experiencing higher burnout are likely to be less engaged and effective in working with clients (Maslach, 2005). Notably, correlations between burnout and other highly stigmatized groups (i.e., convict and depression) were not statistically significant. Past researchers examining correctional staff offered a possible explanation for these results. Lambert et al. (2010) found that emotional exhaustion (a component of burnout) was positively associated with support for treatment and that correctional staff may have blamed organizational factors rather than inmates for work-related stress.

Current caseload size was also significantly related to burnout in this investigation; providers with larger caseloads experienced greater burnout. This result was somewhat expected as the more clients one is responsible for, the more work there is, and the greater the stress; burnout is characterized as a reaction to chronic stress (Freudenberger, 1974). Maslach and Florian (1988) found similar results. Emotional exhaustion, a dimension of burnout was found to be higher for rehabilitation counselors.
who had larger caseload assignments. The negative relationship between flourishing and caseload size, although not statistically significant, lends further support to contrary nature of flourishing and burnout (Diener et al., 2010).

In order to answer the second research question, two simultaneous multiple regressions were computed to assess the predictive qualities of stigma, burnout, and flourishing on working alliance self-efficacy. The first regression included the predictor variables of burnout, flourishing, and AMIQ schizophrenia; working alliance self-efficacy with disabilities alone served as the criterion. The second regression included the predictor variables of burnout, flourishing, and stigma (heroin, convict, depression, schizophrenia); working alliance self-efficacy with disabilities and a criminal history served as the criterion. Variables were included in the regression models based on their statistically significant relationships with respective working alliance self-efficacy scores in the correlation analysis.

The first regression model was statistically significant and indicated that six percent of the variance in working alliance self-efficacy with disabilities alone was explained by burnout, flourishing, and the stigma scale for schizophrenia. None of the predictor variables made unique statistically significant contributions, however, indicating that the shared variance of the model was more impactful than the individual contributions of the predictor variables. Based on the results of the correlation analysis, these results were not surprising as counselors with higher levels of flourishing, and lower levels of burnout and stigma for schizophrenia had higher levels of working alliance self-efficacy with clients with disabilities alone. These results also align with
previous research findings in which stigma, burnout, and counselor well-being have been shown to impact working alliance formation (Sharf et al., 2010; Bordin, 1979). The relative impact of these predictors for working alliance self-efficacy with people with disabilities alone is rather weak, however, only accounting for six percent of the variance in the criterion; the remaining 94 percent of the variance remained unaccounted for.

The second model was also statistically significant. Thirty percent of the variance in working alliance self-efficacy with client with disabilities and criminal histories was explained by the combination of selected stigma scales, burnout, and flourishing. Within the model, three variables made unique statistically significant contributions: flourishing, stigma towards convicts, and stigma towards people with depression. Breaking these unique contributions down further, flourishing accounted for three percent of the variance, convict stigma accounted for four percent, and depression stigma accounted for five percent of the variance in working alliance efficacy with ex-offenders. While these variables did significantly contribute in a unique way, the individual impacts were small (Tabachnick & Fidell, 2007). The collective impact of flourishing, burnout, and the stigma scales for depression, convict, heroin and schizophrenia on working alliance self-efficacy with ex-offenders with disabilities was statistically meaningful; essentially, the sum was greater than its parts. In understanding the true impact of this model, one must also consider that AMIQ convict likely acted as a suppressor variable, suppressing the effect of AMIQ heroin as a predictor. According to Cohen (1988), suppression occurs because the variables share variance and influence. The correlation between AMIQ convict and WAEES with history was .40. This .40 correlation was larger than each of
the part and partial correlations of the other independent variables, a key indicator of a suppressor variable (Cohen, 1988). In addition, the correlation between AMIQ convict and AMIQ heroin was .50. Essentially the effect of AMIQ heroin was suppressed in the regression model because it absorbed some of the error variance rightly attributed to AMIQ convict. The general idea is that there is some error in AMIQ convict that is not correlated with WAEES with history, but is correlated with AMIQ heroin (Cohen, 1988). By including AMIQ heroin one suppresses or accounts for this error, and leaves AMIQ convict as an improved predictor of WAEES with history. Moreover, this effect must be considered when making practical conclusions about the data; AMIQ heroin may have more of an influence as a predictor variable than was seen in this regression equation.

The shared variance between stigma, burnout, and flourishing explained nearly one-third of the variance in working alliance self-efficacy with a criminal history. As previously noted, stigma, burnout, and counselor well-being have been shown by previous researchers to impact working alliance formation (Sharf et al., 2010; Bordin, 1979). In addition, as working alliance self-efficacy for clients with criminal history increased, flourishing also went up and both stigma and burnout decreased. The relationships between these predictor variables must be considered in understanding their collective impact on working alliance self-efficacy with ex-offenders: as burnout increased, stigma also tended to increase and as flourishing increased, both burnout and stigma tended to decrease. Past researchers have also found that providers working with ex-offenders tended to subsequently feel and show less empathy for clients and for this emotional exhaustion (burnout) to transcend the counseling relationship and enter the
provider’s personal lives, diminishing life satisfaction (flourishing) (Farrenkopf, 1992; Carmel & Friedlander, 2009).

It stands to reason that one’s perception of his or her ability to work with clients who have both a disability and a criminal record would be influenced by the pervasive social stigmas that exist regarding these groups (Corrigan et al., 2003; Celinska, 2000; Shivey et al., 2007; Shih, 2004; Jones et al., 1986). The influence of AMIQ depression, addiction, schizophrenia, and convict on efficacy levels with ex-offenders speaks to the stigma these groups are ascribed based on their violation of cultural norms. Negative stigmatizing attitudes impair the bonding process which then impacts agreement on goals and task assignment (Bordin, 1979; Lustig et al., 2002). Moreover, the concept of bonds is related to levels of trust and rapport that exists in the counseling relationship; the stronger the bonds, the stronger the alliance (Bordin, 1979).

The results of this investigation are in line with previous research. Past researchers have noted that positive attitudes and the expression of empathy from providers towards clients are essential in the formation and maintenance of the working alliance (Keane, 1990; Yuker, 1995). Provider stigma and burnout can impair the providers’ ability to empathize with clients, thereby impeding the formation of bonds and ultimately leading to reduced levels of working alliance (Keane, 1990; Farrenkopf, 1992; Carmel & Friedlander, 2009; Yuker, 1995). Clients have been shown to make greater improvements with professionals who demonstrate higher levels of empathy compared to clients working with professionals who function at lower levels of empathy (Keane,
The current results concur with this notion; the less stigma one has towards a client, the stronger the working alliance efficacy (with and without history).

As previously noted, multiple stigma scales significantly related to working alliance efficacy scores when a criminal history was added. The second regression model explained nearly one-third of the variance in efficacy scores with a criminal history compared to only six percent with disabilities alone in the first model. Comparing the results of the first regression model to the second, it appears that the effects of multiple stigmas, in addition to burnout and flourishing, do impact working alliance efficacy with clients who have two stigmatizing identities: a disability and a criminal history. Previous research supports this conclusion. The presence of a disability or disabilities is another source of stigma for ex-offenders (Smith, 2005; Groom, 1999; Russell & Stewart, 2001); in essence, individuals live with double or triple stigma (Hartwell, 2004). Moreover, double and/or triple stigma (i.e., multiple disabilities plus a criminal history) is a salient issue that needs to be addressed in the rehabilitation counseling field.

Based on the results of regression model two (with history), post-hoc independent t-tests were conducted to determine if statistically significant mean differences existed between counselors with a high proportion of clients with criminal histories and counselors with a low proportion of clients with criminal histories on statistically significant predictor variables. Flourishing and the stigma scales for convict and depression were chosen based on the unique contributions they made to the model. No statistically significant differences between the groups were noted on either of the stigma scales or in flourishing indicating that both groups were similar. Essentially, providers
who had more clients with criminal histories on his or her caseload did not statistically
differ on levels of stigma or flourishing compared to providers with lower proportions of
ex-offenders.

A statistically significant mean difference with a moderate effect was found,
however, between high proportion and low proportion criminal caseloads and working
alliance self-efficacy with ex-offenders. These results indicated that providers who
worked with a greater number of ex-offenders with disabilities had higher levels of
working alliance efficacy compared to those who worked with less. Past researchers have
found similar results. Carmel and Friedlander (2009) found that increased experience
with sexual offenders was a unique predictor of working alliance scores. The implications
of these results are discussed in the following section.

**Implications and Directions for Future Research**

The positive associations between flourishing and WA self-efficacy for clients
with and without histories, in addition to the negative relationships between burnout and
efficacy suggests that flourishing, and thus Valued Subjective Experiences (VSEs),
contributed to perceived ability to connect and work effectively with clients. With lower
levels of burnout and higher levels of flourishing, these providers may be more resilient
practitioners in working with challenging client circumstances (i.e., the presence of one
or more stigmatizing conditions).

As noted, correlations between burnout and some highly stigmatized groups (i.e.,
convict and depression) were not statistically significant. Past researchers examining
correctional staff offered a possible explanation for these results. Lambert et al. (2010)
found that emotional exhaustion (a component of burnout) was positively associated with support for treatment. Researchers suggested that one explanation for this result is that correctional staff members who experienced emotional exhaustion did not blame inmates for the feelings, but rather faulted organizational factors such as lack of training and opportunities for self-care (Lambert et al., 2010). It may be that rehabilitation counselor burnout and stigma is also associated with low workplace satisfaction; further investigation is needed.

The significant correlations between the stigma scales (depression, convict, heroin, schizophrenia) and working alliance self-efficacy with ex-offenders with disabilities suggested that increases in provider self-efficacy reduced the impact of stigmatizing attitudes. More specifically, the effects of stigma may be less detrimental to client care in the face of higher levels of efficacy. It may also be that individuals with lower stigma have higher working alliance efficacy and decreases in stigma may elevate efficacy ratings; the direction of this effect is not fully known and further investigation is needed.

As noted, the current investigation and results from O’Sullivan’s study (in press) are in contrast with previous research in which increased contact with a stigmatized population has led to decreased stigma and where increased years of experience significantly impacted working alliance scores (Corrigan et al., 2003; Carmel & Friedlander, 2009). It is possible that stigma inhibits the development of working alliances over time. One must also consider that previous researchers were measuring the
working alliance rather than working alliance efficacy; differences in measurement may also account for these differences.

The quality of education programs also varies and it may be that providers with lower stigma and higher self-efficacy were exposed to more information regarding such populations while in school. Both contact and education have been shown to reduce stigma in previous research (Corrigan et al., 2003; Corrigan, 2001; Murdock, 2001). Providers with lower stigma and higher levels of working alliance efficacy may also have higher levels of self-awareness with regard to personal biases and are therefore able to keep his or her personal feelings out of the professional realm. Providers with less stigma may have also sought out more contact with stigmatized populations due to increased comfort, thereby increasing efficacy. In contrast, providers with higher stigma and lower working alliance self-efficacy may have had less contact and education around stigmatized populations. Workshops centered on increasing self-awareness and privilege may be useful in combatting stigma. If providers can better understand why his or her clients are acting as he or she does and also increase self-awareness around personal biases and how they are socially constructed, a rise in self-efficacy may be seen.

Moreover, further research is needed to determine if these contact and/or educational deficits exist and whether they can be remediated in working professionals.

Attribution theory (Weiner, 1995) may help explain results related to stigma. This theory states that a cognitive-emotional process occurs when viewing stigmatized groups (Corrigan et al., 2003; Murdock, 2001). The stigmatization process is characterized by attributions of cause and controllability for one’s condition or circumstances which
subsequently leads to judgments about personal responsibility and the potential for rehabilitation. Once made, these judgments can trigger strong emotional reactions that either support or discourage helping behaviors.

The higher stability attributions seen in previous research with individuals with schizophrenia may explain why increased work experience with these individuals does not result in lower stigma (Corrigan et al., 2003). Stability is the degree to which the individual is expected to respond to treatment or rehabilitation efforts (Strauser et al., 2009; Corrigan et al., 2003; Murdock, 2001; Chan, 2005). High stability connotes a lower expectation of recovery and these individuals are more likely to be stigmatized (Boysen & Vogel, 2008; Clark & Artiles, 2000). It may be that providers who have had more experience with individuals with schizophrenia are more familiar with the fluctuating nature of the disorder for many individuals (i.e., periods of decompensation and stability); these observations may contribute to or confirm stigmatizing beliefs over time. Further research is needed to determine if stability attributions differ between experienced and inexperienced providers. Work-related client contact alone (i.e., appointments) may not be enough in reducing or eliminating stigma and raising WA self-efficacy. Providers may benefit from supplemental exposure. More specifically, re-familiarizing oneself with individuals across the spectrum of stability may help to balance provider perspectives and reduce stigmatizing generalizations. Workshops could assist in this contact effort, as could volunteer work (may also increase flourishing). Additional research is also needed with regard to the connection between flourishing and stigma.
Providers experiencing greater burnout may have less patience with the fluctuating nature of these disorders (active heroin use, depression, schizophrenia) resulting in higher blaming and negative attributions. Maslach (2005) noted that depersonalization, a component of burnout, may lead to the belief that clients deserve whatever has brought him or her to treatment. Higher levels of burnout may lead to client blaming and stigma may exacerbate the problem. It is also possible that the high stability (lower expectation of recovery) associated with these disorders makes successful vocational closures more difficult, resulting in higher burnout and blaming. Further research is needed to determine if the individual dimensions of burnout, when combined with stigma, lead to negative attributions, client blaming, poor working alliances and subsequently reduced work performance (i.e., case closures).

Moreover, stigma and burnout seem to have a synergistic effect, building off one another, whereas flourishing either counteracts or insulates providers from both burnout and stigma. Individuals with higher flourishing experienced lower levels of burnout providing further evidence that a higher level of flourishing may increase resistance to burnout. Perhaps the concept of flourishing is more apt and impactful in a profession that works from an empowerment model (CRCC, 2011). If levels of flourishing can be increased in providers through self-care interventions, WA self-efficacy is likely to increase as well. Taking a positive approach to the interventions is in line with the wellness model and interventions may not necessarily be standardized, having unique strategies for each individual (i.e., no one defines happiness in exactly the same way). At the very least, the well-being of the providers would increase and the likelihood of
burnout would decrease. Future studies may be helpful in narrowing down the focus of interventions. Moreover, additional empirical studies are needed to better understand the impact of flourishing.

The combined explanatory power of stigma, burnout, and flourishing accounted for nearly one-third of the variance in working alliance efficacy with clients who have disabilities and criminal histories compared to only six percent for clients with disabilities without a criminal history; a cyclical process may be occurring in both cases. If counselors have higher levels of stigma that leads to lower working alliance efficacy with select clients, the relationship will be less effective and the likelihood of successful vocational closures could decrease. Decreased closures could lead to inadequate or unsatisfactory performance evaluations. The existing stigma coupled with feelings of low effectiveness, could potentially lead to burnout, inhibit or reduce flourishing, and negatively impact working alliance efficacy even further. Conversely, with stronger working alliance efficacy, bonds may form more easily leading to stronger alliances and improved outcomes. A greater sense of flourishing would likely develop and thereby decrease or prevent burnout and stigma, leading to even higher levels of working alliance efficacy. A hierarchical regression in the future may be useful in partialling out which factor is having the most impact or triggering the turn of events with clients with disabilities alone and when a criminal history is added. An investigation into the impact of case closure rate on levels of working alliance efficacy, stigma, burnout, and flourishing would also provide valuable information. Moreover, the presence of a criminal history adds something. Stigma is more impactful when there is more than one
stigmatizing identity. This double stigma impacts how providers view his or her ability to work effectively with clients; previous research further supports this conclusion (Smith, 2005; Groom, 1999; Russell & Stewart, 2001; Hartwell, 2004). Investigations around the contributions of client race, socioeconomic status, and/or sexual orientation in combination with a criminal history and disability would also be helpful in more fully understanding the impact of double or triple stigma on working alliance efficacy.

The comparisons of high and low proportion criminal caseloads also indicated a need for further research. No statistically significant differences between groups were noted on either of the stigma scales or in flourishing indicating that both groups were fairly evenly matched. Despite non-significant results, small effects were noted indicating that further investigation with increased statistical power is needed for stigma and flourishing with regard to criminal caseload makeup.

A need for further research is also signaled by the significant mean difference between high proportion and low proportion criminal caseloads on WA self-efficacy with ex-offenders along with past research that increased experience with offenders predicts WA. Caseload makeup and specialized experience impacted working alliance efficacy but not levels of stigma or flourishing between high and low proportion caseloads. Moreover, years of experience are less important than caseload makeup and proportion of experience/contact with regard to WA self-efficacy. As previously noted double stigma is a salient issue for VR counselors and must be addressed. Specialized caseloads may be one way to reduce stigmatizing attitudes and the subsequent impact on working alliance self-efficacy. Years of experience did not significantly impact working alliance efficacy.
in this investigation, however, the proportion of clients with criminal histories on one’s caseload did have an effect on perceptions of efficacy. Specialized caseloads may therefore be more effective in helping clients with more than one stigmatizing identity; practice may make perfect (or at least better). A study which compares providers working exclusively with ex-offenders to those not working with any may confirm if overall experience versus experience with specialized client populations significantly impacts working alliance efficacy with ex-offenders who have disabilities.

**Limitations and Additional Research Implications**

Results of this study should be considered in the context of its limitations. The lack of gender and racial diversity in the sample limit generalizability. More than 70 percent of the sample identified as female and two-thirds identified as Caucasian or White. In addition, participants self-selected and it is possible that the subsequent sample is unique and not fully representative of the larger vocational rehabilitation counselor population. No social desirability scale was used in this investigation and it is possible that the responses to the stigma, burnout, and efficacy scales were underestimated as a result; the anonymity of the survey likely reduced this to some degree, but to what degree remains unknown. Limitations also exist in how one can interpret the findings related to flourishing. As empirical research related to this concept is limited in the counseling literature, it is difficult to draw solid conclusions based on the available evidence provided within this investigation; further research is still needed.

As previously noted, further research is needed to determine if contact and/or educational deficits exist in providers with higher levels of stigma and whether they can
be remediated in working professionals. Data regarding the specific educational backgrounds of participants (i.e., rehabilitation counseling vs. social worker) were not collected in this investigation. As a result, it is not known whether educational background has influenced levels of stigma and subsequently levels of working alliance self-efficacy. A follow-up study which distinguishes between human service disciplines may provide additional insight into whether academic focus impacts stigma and ultimately working alliance efficacy related to clients with disabilities alone and with a criminal history. Information regarding personal and professional experiences with people with disabilities and criminal histories would also be valuable in understanding if and how such contact impacts these levels above and beyond years of working experience.

Perhaps the largest limitation in this investigation relates to the interpretive power of the dependent variables. The variables of working alliance self-efficacy both with and without criminal history are not necessarily reflective of the actual relationship between provider and client. They are instead self-estimates of one’s own ability to work with specified clients. Further research is needed to determine if self-estimates are truly reflective of provider behaviors and the working alliance; a longitudinal design would be useful to document provider perceptions over time as well as the actual working alliance from both client and provider perspectives. As a result, definitive statements cannot be made at this time regarding the impact of flourishing, burnout, and the selected stigma scales (depression and convict) on the actual working alliance. Moreover, additional
information is needed to determine if provider perceptions, as noted in this investigation, actually impacts work with clients.

**Conclusion**

The purpose of this study was to determine if relationships existed between burnout, stigma, flourishing, caseload size, experience, and working alliance self-efficacy and to assess the predictive influence of these variables on levels of working alliance self-efficacy with clients with disabilities with and without criminal histories in state VR providers. Using inferential and descriptive statistics, this study showed that many of these variables related to one another and further explained the variance in working alliance efficacy for clients with and without criminal histories.

Notably, counselors with higher levels of working alliance self-efficacy tended to have higher levels of well-being, contentment, satisfaction, hope, and happiness (flourishing) and had lower levels of burnout and stigma. The less burnt out one was, and the higher his or her flourishing, the more effective he or she felt as rehabilitation service providers. Post-hoc tests also showed that providers who worked with a greater proportion of clients with disabilities and criminal histories had higher levels of working alliance efficacy compared to those working with lower proportions; specialized experience seems to matter more than overall years in the field.

Perhaps the most significant outcome of this investigation is the evidence that stigma has a greater impact on working alliance self-efficacy with clients who have disabilities and a criminal history compared to clients with a disability and no criminal history. More specifically, the effects of multiple stigmas, in addition to burnout and
flourishing, explained nearly one third of the variance in provider working alliance efficacy with clients who had two stigmatizing identities (disability plus criminal history) compared to a disability alone (6% of the variance explained). Ultimately, this investigation has provided greater insight into the relationships between stigma, flourishing, and burnout and how those variables interact to predict working alliance self-efficacy for clients with disabilities alone and in combination with criminal histories.
References


APPENDIX A

HISTOGRAMS AND BOX PLOTS FOR REGRESSED VARIABLES

![Histogram and Box Plot for Burnout_Total_Score](image)
Mean = -1.00
Std. Dev. = 3.284
N = 745
APPENDIX B

NORMAL Q-Q PLOTS OF REGRESSED VARIABLES

Normal Q-Q Plot of Burnout_Total_Score

Normal Q-Q Plot of Flourishing_Scale
APPENDIX C

REGRESSION MODEL 1 STANDARDIZED RESIDUAL PLOTS

Normal P-P Plot of Regression Standardized Residual
Dependent Variable: WAEES_D123_NO_Hx_TOTAL_Score

Scatterplot
Dependent Variable: WAEES_D123_NO_Hx_TOTAL_Score
APPENDIX D

REGRESSION MODEL 2 STANDARDIZED RESIDUAL PLOTS

Normal P-P Plot of Regression Standardized Residual

Dependent Variable: WAEES_D123_WITH_Hx_TOTAL_Score

Scatterplot

Dependent Variable: WAEES_D123_WITH_Hx_TOTAL_Score
APPENDIX E

CURVE ESTIMATIONS OF INDEPENDENT VARIABLES WITH WORKING

ALLIANCE EFICACY WITH NO CRIMINAL HISTORY

---

**AMIQ heroin total score**

- Observed data points
- Linear trend line
- Quadratic trend line

**AMIQ Depression total score**

- Observed data points
- Linear trend line
- Quadratic trend line

---

WAEES_D123_NO_Hx_TOTAL_Score
Please indicate the current size (approximate) of your caseload:
Years: Total years of experience as a vocational rehabilitation service provider.

- Observed
- Linear
- Quadratic

WAEES_D123_NO_Hx_TOTAL_Score
APPENDIX F

CURVE ESTIMATIONS OF INDEPENDENT VARIABLES WITH WORKING ALLIANCE EFICACY WITH CRIMINAL HISTORY

![Graph 1: Burnout_Total_Score](image1)

![Graph 2: Flourishing_Scale](image2)
Please indicate the current size (approximate) of your caseload:

![Graph showing data distribution with linear and quadratic trends.](image)
Years: Total years of experience as a vocational rehabilitation service provider.
APPENDIX G

HISTOGRAMS FOR HIGH AND LOW PROPORTION CRIMINAL CASELOADS

Mean = 10.51
Std. Dev. = 6.791
N = 75

Mean = 49.07
Std. Dev. = 19.039
N = 59
APPENDIX H

INSTRUMENTS

DEMOGRAPHIC QUESTIONNAIRE

1. Age: ____________ (in years)

2. Gender: _______ male  _______ female (check one)

3. Race/ethnicity (check one):
   _____ Black/African American
   _____ White, non-Hispanic
   _____ Latino/Latina
   _____ Asian/Pacific Islander
   _____ Other

4. Years of experience as a VR service provider: _____(months)______(years)

5. Please indicate the current size of your case load: ____________ (#)

6. Average caseload size over your career? ______________(#)

7. Approximate # of clients on current case load that have a criminal history? ______(#)

8. Please check each disability group that is represented on your case load:
   _____ Physical Disabilities
   _____ Psychiatric Disabilities (including addiction)
   _____ Cognitive/Developmental Disabilities (including TBI)

9. Level of education (check one): some college_____  bachelor’s degree_____
   master’s degree_____  doctorate degree_____

10. In which state do you currently work:
    _____ Utah
    _____ New York
    _____ Illinois
COUNSELOR BURNOUT INVENTORY

Instructions: This questionnaire is designed to measure the counselor’s burnout level. There are no right or wrong answers. Try to be as honest as you can. Beside each statement, circle the number that best describes how you feel.

<table>
<thead>
<tr>
<th></th>
<th>1 Never True</th>
<th>2 Rarely True</th>
<th>3 Sometimes True</th>
<th>4 Often True</th>
<th>5 Always True</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Due to my job as a counselor, I feel tired most of the time.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. I feel I am an incompetent counselor.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. I am treated unfairly in my workplace.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. I am not interested in my clients and their problems.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. My relationships with family members have been negatively impacted by my work as a counselor.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6. I feel exhausted due to my work as a counselor.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7. I feel frustrated by my effectiveness as a counselor.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8. I feel negative energy from my supervisor.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>9. I have become callous toward clients.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>10. I feel like I do not have enough time to engage in personal interests.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>11. Due to my job as a counselor, I feel overstressed.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>12. I am not confident in my counseling skills.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>13. I feel bogged down by the system in my workplace.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>14. I have little empathy for my clients.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>---</td>
<td>-------------------------------------------------------------------------------------------</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>15.</td>
<td>I feel I do not have enough time to spend with my friends.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16.</td>
<td>Due to my job as a counselor, I feel tightness in my back and shoulders.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17.</td>
<td>I do not feel like I am making a change in my clients.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18.</td>
<td>I feel frustrated with the system in my workplace.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19.</td>
<td>I am no longer concerned about the welfare of my clients.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20.</td>
<td>I feel I have poor boundaries between work and my personal life.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
FLOURISHING SCALE

Below are 8 statements with which you may agree or disagree. Using the 1–7 scale below, indicate your agreement with each item by indicating that response for each statement.

7 Strongly agree
6 Agree
5 Slightly agree
4 Mixed or neither agree nor disagree
3 Slightly disagree
2 Disagree
1 Strongly disagree

____ I lead a purposeful and meaningful life
____ My social relationships are supportive and rewarding
____ I am engaged and interested in my daily activities
____ I actively contribute to the happiness and well-being of others
____ I am competent and capable in the activities that are important to me
____ I am a good person and live a good life
____ I am optimistic about my future
____ People respect me
ATTITUDES TOWARDS MENTAL HEALTH QUESTIONNAIRE (AMIQ)

Please read each scenario and answer each question by circling the response that best represents your opinion.

A. John has been injecting heroin daily for one year.
1. Do you think that this would damage John’s career?

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly disagree</th>
<th>Don’t know</th>
</tr>
</thead>
</table>

2. I would be comfortable if John was my colleague at work?

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly disagree</th>
<th>Don’t know</th>
</tr>
</thead>
</table>

3. I would be comfortable about inviting John to a dinner party?

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly disagree</th>
<th>Don’t know</th>
</tr>
</thead>
</table>

4. How likely do you think it would be for John’s wife to leave him?

<table>
<thead>
<tr>
<th>Very likely</th>
<th>Quite likely</th>
<th>Neutral</th>
<th>Unlikely</th>
<th>Very Unlikely</th>
<th>Don’t know</th>
</tr>
</thead>
</table>

5. How likely do you think it would be for John to get in trouble with the law?

<table>
<thead>
<tr>
<th>Very likely</th>
<th>Quite likely</th>
<th>Neutral</th>
<th>Unlikely</th>
<th>Very Unlikely</th>
<th>Don’t know</th>
</tr>
</thead>
</table>

B. Tim is depressed and took a paracetamol overdose last month to try and hurt himself.

1. Do you think that this would damage Tim’s career?

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly disagree</th>
<th>Don’t know</th>
</tr>
</thead>
</table>

2. I would be comfortable if Tim was my colleague at work?

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly disagree</th>
<th>Don’t know</th>
</tr>
</thead>
</table>

3. I would be comfortable about inviting Tim to a dinner party?

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly disagree</th>
<th>Don’t know</th>
</tr>
</thead>
</table>

4. How likely do you think it would be for Tim’s wife to leave him?

<table>
<thead>
<tr>
<th>Very likely</th>
<th>Quite likely</th>
<th>Neutral</th>
<th>Unlikely</th>
<th>Very Unlikely</th>
<th>Don’t know</th>
</tr>
</thead>
</table>
5. How likely do you think it would be for Tim to get in trouble with the law?

Very likely       Quite likely       Neutral       Unlikely       Very Unlikely       Don’t know

C. Steve has been drinking heavily for 5 years. He is now going for treatment and has started attending Alcoholics Anonymous meetings.

1. Do you think that this would damage Steve’s career?

Strongly agree       Agree       Neutral       Disagree       Strongly disagree       Don’t know

2. I would be comfortable if Steve was my colleague at work?

Strongly agree       Agree       Neutral       Disagree       Strongly disagree       Don’t know

3. I would be comfortable about inviting Steve to a dinner party?

Strongly agree       Agree       Neutral       Disagree       Strongly disagree       Don’t know

4. How likely do you think it would be for Steve’s wife to leave him?

Very likely       Quite likely       Neutral       Unlikely       Very Unlikely       Don’t know

5. How likely do you think it would be for Steve to get in trouble with the law?

Very likely       Quite likely       Neutral       Unlikely       Very Unlikely       Don’t know

D. Robert is a convicted criminal. He has spent time in prison for several convictions for theft and shoplifting and is currently on bail for fraud and burglary.

1. Do you think that this would damage Robert’s career?

Strongly agree       Agree       Neutral       Disagree       Strongly disagree       Don’t know

2. I would be comfortable if Robert was my colleague at work?

Strongly agree       Agree       Neutral       Disagree       Strongly disagree       Don’t know

3. I would be comfortable about inviting Robert to a dinner party?

Strongly agree       Agree       Neutral       Disagree       Strongly disagree       Don’t know

4. How likely do you think it would be for Robert’s wife to leave him?
5. How likely do you think it would be for Robert to get in trouble with the law?

Very likely  Quite likely  Neutral  Unlikely  Very Unlikely  Don’t know

E. Peter has diabetes. He needs to inject insulin every day and has a special diet.

1. Do you think that this would damage Peter’s career?

Strongly agree  Agree  Neutral  Disagree  Strongly disagree  Don’t know

2. I would be comfortable if Peter was my colleague at work?

Strongly agree  Agree  Neutral  Disagree  Strongly disagree  Don’t know

3. I would be comfortable about inviting Peter to a dinner party?

Strongly agree  Agree  Neutral  Disagree  Strongly disagree  Don’t know

4. How likely do you think it would be for Peter’s wife to leave him?

Very likely  Quite likely  Neutral  Unlikely  Very Unlikely  Don’t know

5. How likely do you think it would be for Peter to get in trouble with the law?

Very likely  Quite likely  Neutral  Unlikely  Very Unlikely  Don’t know

F. Michael has schizophrenia. He needs an injection of medication every 2 weeks. He was detained in hospital for several weeks 2 years ago because he was hearing voices from the Devil and thought he had the power to cause earthquakes. He has been detained under the Mental Health Act (1983) in the past.

1. Do you think that this would damage Michael’s career?

Strongly agree  Agree  Neutral  Disagree  Strongly disagree  Don’t know

2. I would be comfortable if Michael was my colleague at work?

Strongly agree  Agree  Neutral  Disagree  Strongly disagree  Don’t know

3. I would be comfortable about inviting Michael to a dinner party?
Strongly agree   Agree   Neutral   Disagree   Strongly disagree   Don’t know

4. How likely do you think it would be for Michael’s wife to leave him?

Very likely   Quite likely   Neutral   Unlikely   Very Unlikely   Don’t know

5. How likely do you think it would be for Michael to get in trouble with the law?

Very likely   Quite likely   Neutral   Unlikely   Very Unlikely   Don’t know

G. Steven is a practicing Christian. He attends church every Sunday and attempts to lead a Christian life.

1. Do you think that this would damage Steven’s career?

Strongly agree   Agree   Neutral   Disagree   Strongly disagree   Don’t know

2. I would be comfortable if Steven was my colleague at work?

Strongly agree   Agree   Neutral   Disagree   Strongly disagree   Don’t know

3. I would be comfortable about inviting Steven to a dinner party?

Strongly agree   Agree   Neutral   Disagree   Strongly disagree   Don’t know

4. How likely do you think it would be for Steven’s wife to leave him?

Very likely   Quite likely   Neutral   Unlikely   Very Unlikely   Don’t know

5. How likely do you think it would be for Steven to get in trouble with the law?

Very likely   Quite likely   Neutral   Unlikely   Very Unlikely   Don’t know
WORKING ALLIANCE EFFICACY ESTIMATE SCALE (WAEES)

Please read each question stem below and rate your confidence in your ability to accomplish each of the three counseling tasks with the client profiles presented.

A. I am confident in my ability to develop an effective rehabilitation counseling relationship, characterized by mutual trust and rapport, with an individual who has...

1. a physical disability and NO criminal history
   1  2  3  4  5  6  7
   No confidence  high confidence

2. a physical disability AND a criminal history
   1  2  3  4  5  6  7
   No confidence  high confidence

3. a cognitive/developmental disability (including TBI) and NO criminal history
   1  2  3  4  5  6  7
   No confidence  high confidence

4. a cognitive/developmental disability (including TBI) AND a criminal history
   1  2  3  4  5  6  7
   No confidence  high confidence

5. a psychiatric disability (including substance abuse/addiction) and NO criminal history
   1  2  3  4  5  6  7
   No confidence  high confidence

6. a psychiatric disability (including substance abuse/addiction) AND a criminal history
   1  2  3  4  5  6  7
   No confidence  high confidence

B. I am confident in my ability to identify appropriate employment goals for an individual with .....
3. a cognitive/developmental disability (including TBI) and NO criminal history

4. a cognitive/developmental disability (including TBI) AND a criminal history

5. a psychiatric disability (including substance abuse/addiction) and NO criminal history

6. a psychiatric disability (including substance abuse/addiction) AND a criminal history

C. I am confident in my ability to identify the necessary and appropriate tasks needed to obtain employment in the current labor market for an individual with....

1. a physical disability and NO criminal history

2. a physical disability AND a criminal history

3. a cognitive/developmental disability (including TBI) and NO criminal history

4. a cognitive/developmental disability (including TBI) AND a criminal history

5. a psychiatric disability (including substance abuse/addiction) and NO criminal history
6. a psychiatric disability (including substance abuse/addiction) AND a criminal history
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EDUCATION

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M.S., Rehabilitation Counseling and Disability Studies, Springfield College, 2007

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CREDENTIALS

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TEACHING EXPERIENCE

Assistant Professor, Department of Rehabilitation and Counseling, The University of Wisconsin-Stout, Spring 2012-present.

Instructor, Department of Counselor Education, Counseling Psychology, and Rehabilitation and Human Services, Penn State University, Fall 2010, Summer 2011, Fall 2011.

Adjunct Faculty, Department of Rehabilitation and Disability Studies, Springfield College, Springfield, MA, January 2008 – May 2009.

COUNSELING EXPERIENCE

Career Counselor, Bank of America Career Services Center, Penn State University, August 2011 – December 2011.


PUBLICATIONS