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THE RELATIONSHIP AMONG WELLNESS, SEVERITY OF DISTURBANCE,
AND SOCIAL DESIRABILITY OF ENTERING MASTER'S-LEVEL
COUNSELING STUDENTS

by

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A dissertation submitted in partial fulfillment of the requirements
for the degree of Doctor of Philosophy
in the Department of Child, Family, and Community Sciences
in the College of Education
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ABSTRACT

A wellness paradigm may hold promise for unifying and strengthening the identity of the counseling profession. The construct of wellness may also hold implications for assessment of entering master's-level counseling students, as a tool for continuous evaluation of students, or for overall program evaluation. In this study, the only counseling-based wellness assessment measure, the Five Factor Wellness Evaluation of Lifestyle, was tested for its relationship to two other constructs: psychological disturbance and social desirability. In order to test the research hypotheses, a total of nine programs (in five states) and 204 entering master's-level counseling students completed instrumentation packets comprised of the Five-Factor Wellness Evaluation of Lifestyle, the Marlowe-Crowne Social Desirability Scale, and the Outcome Questionnaire – 45.2.

The results of the analyses indicated statically significant relationships in 52 out of 55 correlations between the instruments' total scores and subscale scores. The first null hypothesis was rejected in favor of the alternative hypothesis; there was a statistically significant negative relationship between level of psychological disturbance and level of wellness. The results of the study failed to reject null hypothesis two; the relationship between wellness and social desirability was found to have no statistical significance after removing the influence of psychological disturbance. Null hypothesis three was rejected in

favor of the alternative hypothesis; there was a statistically significant negative relationship between level of psychological disturbance and social desirability.

Number and percent of participants exceeding psychological disturbance cutoff scores was examined. Measures of central tendency and the effects of demographic variables for each of the instruments were presented. Exploratory data analysis revealed that the first-order wellness factor, second-order wellness factors, and social desirability mean scores of those scoring above the cutoff for Severity of Disturbance, difficulty in Interpersonal Relations, Symptom Distress, and Difficulty in Social Roles were lower than those scoring below each cutoff score. Results of the study were summarized, factors to consider in the interpretation of the results were discussed, and implications for counselor education and future research were provided.

This dissertation is dedicated to my best friend and love, Douglas E. Bennett,
whose consistent encouraging support and love amaze me.

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Knowledge and Faith remind me time and again that all things are related
and affect each other; with awareness, each day we choose how.

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CHAPTER 1: THE PROBLEM

A wellness paradigm may hold promise for unifying and strengthening the identity of the counseling profession (Blocher, 1988; D'Andrea, 1988; Ivey & Ragazio-DiGilio, 1991; McAuliffe & Eriksen, 1999; Myers, Sweeney & White, 2002). The construct of wellness may also hold implications for assessment of entering master's-level counseling students, as a tool for continuous evaluation of students, or for overall program evaluation. In the following study, the only counseling-based wellness assessment measure, the Five Factor Wellness Evaluation of Lifestyle (5F-Wel), was tested for its relationship to two other constructs: psychological disturbance and social desirability.

Theoretical Background

The problem of counselor impairment is well-documented in the literature (Emerson & Markos, 1996; Hazler & Kottler, 1996; Herlihy, 1996; Olsheski & Leech, 1996; Sheffield, 1998). Psychological disturbance, or impaired mental health status, is thought to be the most common form of counselor impairment (Frame, Stevens-Smith, 1995; Gaubatz & Vera, 2002; Li, 2001; Olsheski & Leech, 1996; Sheffield, 1998). O'Halloran & Linton (2000) stated that although counselors have the responsibility to maintain their own health and wellness, most counselors who were trained to care for others overlooked the need to care

for themselves. Consequently, counselors ran the risk of impairment, which could contribute to a diminished ability to act in a manner that promotes the well-being of others (Stebnicki, 2000).

Skovholt (2001) discussed the importance of preparing resilient practitioners. Counselors-in-training are at particular risk for stress and distress in part due to the difficulty in mastering the ambiguity of the counseling process and opening oneself to the often painful experience of the client (Skovholt, 2001). Perhaps one place to strengthen the developmental wellness identity of the counseling profession is within counselor preparatory programs. Hill (2004) used the term isomorphism to describe how counselor educators, counseling students, and clients are connected to each other. Isomorphism refers to the “relationship between two concepts that are mapped on to each other, in such a way that to each part of one structure there is a corresponding part in the other structure, where ‘corresponding’ means that the two concepts play similar roles in their respective structures” (Hofstadter, 1979, p. 49). Hill (2004) believed that counselor educators needed to understand the isomorphic relationship between counselor educator – student counselor and student counselor – client. Isomorphism is the process, for example, that makes role modeling so powerful. The student learns the ways of a role model by observing and practicing the ways of the role model. In a mentoring relationship, role models “demonstrate valued behavior, attitudes, and/or skills that aid the mentee in achieving competence, confidence, and a clear professional identity” (Luna & Cullen, 1998,

p. 325). Witmer and Young (1996) provided an example of isomorphism related to counseling by postulating that “well counselors are more likely to produce well clients” (p. 151). Hill (2004) expanded this belief to “well counselor educators may be more likely to produce well counselors who are more likely to produce well clients” (p. 136).

The profession of counseling originated from a theoretically different perspective of human functioning than other mental health professions (Gladding, 2000; Lambie & Williamson, 2004; Remley & Herlihy, 2001; Young, 2005). Rather than focusing one’s professional expertise on the identification and treatment of pathology, the job of the counselor is to assist in the promotion of optimal functioning through the identification of strengths, context, and developmental processes (McAuliffe & Eriksen, 1999; Ryff & Keyes, 1995; Witmer & Sweeney, 1992). Several models have been proposed to explain the many factors that combine to create optimal or healthy functioning (Myers & Williard, 2003; Ryff & Keyes, 1995; Snyder & Lopez, 2002). Most models, however, have evolved out of the medical sciences grounded in theories derived from the physiological or physical health fields (Myers & Sweeney, 2006).

Sweeney and Witmer (1991) developed the first theoretical model of wellness grounded in counseling theory, the Wheel of Wellness. The Wellness Evaluation of Lifestyle (WEL) inventory was developed to assess each of the individual characteristics in the Wheel of Wellness (Myers, Sweeney, & Witmer, 1996). Through continued research and factor analysis, a new evidence-based

model and instrument was developed called the Indivisible Self model and the 5F-Wel, respectively (Myers & Sweeney, 2004; Myers, Luecht, & Sweeney, 2004).

Significance

Similar to other graduate-level programs offering terminal professional degrees (Crosby, Dunn, Fallacaro, Jozwiak-Shields, & Maclsaac, 2003; Norcross, Kohout, & Wicherski, 2005), counselor education programs consider each applicant's aptitude for graduate-level study and a match between the applicant's career goals and objectives with those of the program and profession. The Council for the Accreditation of Counseling and Related Education Programs (CACREP) requires counselor education programs to consider "each applicant's potential success in forming effective interpersonal relationships in individual and small-group contexts" and "each applicant's openness to self-examination and personal and professional self-development" (CACREP, 2001, I2, I5). Specifically, in addition to academic performance, counseling students are expected to possess personal qualities, characteristics, and evidence of readiness conducive to program preparedness (Nagpal & Ritchie, 2002). Such expectations are also driven by the counseling profession's ethical guidelines and standards of practice; national and state laws and credentialing requirements; and institutional and college accreditation standards (Remley &

Herlihy, 2001). Identifying, monitoring, and ensuring that counseling students possess the personal qualities, readiness, and competencies needed to be successful is a difficult task for counselor educators.

Statement of the Problem

Leaders in the field of counseling have posited that a wellness model of mental health offers the best perspective for helping people resolve their personal and emotional issues and problems (Remley & Herlihy, 2001; Witmer & Young, 1996). The professional organizations representing the counseling profession also place an emphasis on the personal development and wellness of counseling students (AACD, 1991; ACES, 1995). A strengths-based wellness model has been suggested for use not only with clients, but also in the training of counselors (Hill, 2004; Myers, Mobley, & Booth, 2003; Roach, 2005). Roach (2005) found that “both faculty and students believe that their personal wellness is essential for their effectiveness with clients” (p. 75) and suggested that without systematic procedures for evaluating and promoting wellness, counselor educators risk contributing to a work force of impaired counselors (Bradley & Post, 1991). Witmer and Young (1996) suggested that selection of faculty and students for a counselor education program is the first step in preventing impairment.

To date, the profession of counseling offers no systematic recommendations for screening, evaluating, and promoting wellness. This may be due to the lack of causal research connecting wellness to the alleviation of psychological disturbance or to the success of counselors-in-training. Yet, without professionally – established guidance, counseling programs are left to create their own admissions and evaluation procedures which may lead to inconsistent practices within the profession. Admissions might range, for example, from selecting the most qualified applicants to screening out only those who are obviously unsuitable for the profession. Nagpal and Ritchie (2002) found that counselor education programs used admission procedures focusing on nonacademic characteristics to screen out applicants rather than to identify those most qualified.

Continued studies using the 5F-Wel are needed to provide additional support for the only wellness model and instrument based on counseling theory (Hattie, Myers, and Sweeney, 2004; Vanderbleek, 2005). Prior to more expensive research studying causal implications of wellness, research needs to establish the relationship between psychological disturbance and wellness or between indicators of impairment and indicators of strengths.

Definitions and Assumptions

Definition of Terms

Entering master's-level counseling students. The study participants were entering master's-level counseling students at program orientation or within the first four weeks of classroom experience following formal admittance to the master's-level counseling program.

Wellness. For the purpose of this study, wellness was defined as the dynamic interaction of, and self-regulating task of attending to physical, psychological, spiritual, social, intellectual, and occupational health (Sweeney & Witmer, 1991). In a state of wellness, mind, body and spirit become integrated in one's understanding of living more fully (life goal) and living becomes an intentional lifestyle (way of being) approaching optimal functioning. Wellness was further defined as a dynamic and evolutionary process that involves constant growth and adaptation (Hill, 2004).

The evidence-based model used in the study was the Indivisible Self model of wellness. The higher order wellness factor has been called the Indivisible Self because it represents the indivisibility of the human being (Myers & Sweeney, 2005). The Indivisible Self model was created through repeated administrations of the Wellness Evaluation of Lifestyle (WEL) inventory, based upon a theoretical model called the Wheel of Wellness. As the WEL improved

psychometrically, another version was produced called the Five Factor Wellness Evaluation of Lifestyle (5F-WEL). Through confirmatory factor analysis, the 5F-WEL instrument served as the impetus for the creation of the new evidence-based model, the Indivisible Self. According to the Indivisible Self model, total wellness is comprised of and defined by five second order factors: the Creative Self, Coping Self, Social Self, Essential Self, and Physical Self. Seventeen third order factors define the five second order factors as follows: Creative Self (thinking, emotions, control, work, positive humor), Coping Self (leisure, stress management, self-worth, realistic beliefs), Social Self (friendship, love), Essential Self (spirituality, gender identity, cultural identity, self-care), and Physical Self (nutrition, exercise). The factors comprising wellness are understood to function within local, institutional, global, and chronometrical ecological contexts (Hattie, Myers, & Sweeney, 2004).

Severity of disturbance. Severity of disturbance was defined as the total psychological disturbance perceived by an individual through symptoms of emotional conflict within oneself (e.g., depression, anxiety, substance abuse). Psychological disturbance may manifest as problems in interpersonal relationships, and conflict related to employment, family roles, and leisure life (Lambert, Burlingame et al., 1996). The specific manifestations of psychological disturbance used in this study were symptom distress, problems with interpersonal relations, and in social roles.

Social desirability. Researchers have reported validity concerns with self-report measures for many years, but report increased use due to low interference with everyday settings, cost containment, and practicality (Caldwell-Colbert & Robinson, 1984; Motl, McAuley, & DiStefano, 2005; Saunders, 1991). Socially desirable response bias has been cited as a concern with self-report measures of wellness and health behaviors (Myers, Mobley, & Booth, 2004; Motl, McAuley, & DiStefano, 2005). Faking has been found to occur in selection settings and on personality tests (Ones, Viswesvaran, & Reiss, 1996; Rosse, Stechner, Levin, Miller, 1998; Zickar & Robie, 1999). In the following study the researcher wished to address the threat of socially desirable response bias to validity.

Social desirability was defined as the need to obtain approval by responding, unintentionally or intentionally, in a culturally appropriate and acceptable manner (Crowne & Marlowe, 1960). Extremity of social desirability was defined as either needing an abnormally high amount of social approval or having an abnormally low concern for what was considered socially appropriate. Specifically, social desirability refers to reporting many uncommon human behaviors although they are socially approved and/or denying many common behaviors that are socially disapproved (Crowne & Marlowe, 1960).

Assumptions

1. All research participants fit the definition of entering master's-level students as previously defined.
2. Faculty contacts at participating programs followed written instructions and professional best practices for administering research instruments.

Research Question

The research question was as follows: What is the relationship among wellness, psychological disturbance and social desirability in entering master's-level counseling students?

Research Hypotheses

Based upon a review of the literature, the following hypotheses were developed to study the research question above:

Null Hypothesis 1. There is no relationship between level of psychological disturbance and level of wellness in entering master's-level counseling students.

Alternative Hypothesis 1. There is a negative relationship between level of psychological disturbance and level of wellness in entering master's-level counseling students.

Null Hypothesis 2. There is no relationship between level of wellness and social desirability in entering master's-level counseling students.

Alternative Hypothesis 2. There is a positive relationship between level of wellness and social desirability in entering master's-level counseling students.

Null Hypothesis 3. There is no relationship between level of psychological disturbance and social desirability in entering master's-level counseling students.

Alternative Hypothesis 3. There is a negative relationship between level of psychological disturbance and social desirability in entering master's-level counseling students.

Delimitations

Examining relationships between variables precluded the use of causal experimental design and conclusions. Additionally, since the researcher needed to gain entry to various programs, and participation was contingent upon both program approval and voluntary individual participation, population sample could not be randomized. However, the sample was purposive, improving the potential for generalizability of the findings (Shadish, Cook, & Campbell, 2001). Also, due

to the fact that there were low numbers of males ($n = 24$) in comparison to females ($n = 180$) participating in the study, and based on instrument norms that may be overrepresentative of females (there are more females entering counseling programs than males and there are more females seeking counseling services than males), there may not be significant power to completely remove the risk of Type II error. However, the results are still useful and contribute to the growing database of 5F-Wel scores for males. Finally, some master's-level counseling programs allow students to take a limited number of classes prior to admission into the program. This created the potential for some participants to have been exposed to program philosophy within the context of the classroom in contrast to other participants who had yet to begin didactic training. However, lack of socially desirable response bias may indicate lack of this effect's significance.

Summary

There is only one tool available to assess human wellness based upon counseling theory. It may be important to the identity of the profession that the tool, the Five Factor Wel, is further developed, or an alternative tool be pursued. A solid assessment of wellness has implications for assessing entering master's-level counseling students, projecting the developmental wellness needs of entering students, remediating students of identified concern, communicating a

wellness philosophy, and program evaluation. In an era of evidence-based practice, it may be important that the relationship between wellness and psychological disturbance be examined prior to more expensive studies of cause and effect.

Organization of the Study

This study is organized and discussed in five chapters. Chapter one provides an introduction to the topic, a preview of the relevant theoretical and research literature, a rationale for the study, a discussion of the problem, researcher assumptions, the research question, hypotheses, delimitations, and summary. Chapter two provides a review of the literature leading up to the present study. Chapter three presents detailed information about the research methodology including design; defined constructs and variables; participants; instrumentation; statistical tests; and planned data analysis to answer the research question. A description of the data analysis and the results of the study are reported in chapter four. Chapter five includes conclusions drawn from the results, limitations, and implications for the profession and future research.

CHAPTER 2: A REVIEW OF THE LITERATURE

This study is based on a review of the theoretical and research literature and sought to answer the next question pertinent to the line of research: What is the relationship among wellness, psychological disturbance and social desirability in entering master's-level counseling students? The following chapter presents a review of the available literature relevant to this study. The chapter is divided up into six parts: (1) counselor education admissions, (2) evaluation in counselor education, (3) distress and impairment, (4) wellness in counseling, (5) social desirability, and (6) summary.

Counselor Education Admissions

The goal of counselor education programs is to prepare individuals to work as counselors in various settings including: pre-K through 12 schools, higher education, social service and government agencies, hospitals, and private practice. Counselor preparatory programs seek to admit individuals who are likely to succeed in such settings. Programs look for students' ability to counsel, conceptualize cases, and collaborate effectively with colleagues (McKee, Smith, Hayes, Stewart, & Echterling, 1999). The effectiveness of a counselor depends on numerous variables, including personality and background, formal education, theoretical framework, as well as ability to engage in professional activities and

continuing education (Gladding, 2000). Although all are important, the necessary characteristics and personal qualities of effective counselors are discussed in the following section.

The Person of the Counselor

Extensive theoretical knowledge exists for describing the effective counselor. Instrumental in describing the foundation of therapeutic relationships, Carl Rogers believed that the personal characteristics of effective counselors included congruence in affect, behavior, and thoughts; positive regard for people; and a genuine desire to enter the world of another through empathy. Other leaders in the field of counseling (Corey, 2001; Gazda, Asbury, Balzer, Childers, Phelps, & Walters, 1999; Gladding, 2000; Young, 2005) have added to the list: emotional insightfulness; flexibility; being understanding and friendly; curiosity; ability to listen; introspection; tolerance of intimacy; the ability to laugh; the ability to be spontaneous and creative; a sense of stability; a sense of purpose; and being well-adjusted emotionally. Effective counselors are cognizant of their own values, motives, strengths, weaknesses, feelings, purpose in life, and current level of functioning. They are sensitive and respectful of themselves and others; are able to recognize and accept their own power; are open to change; make choices that shape their lives; and have a sense of living fully. Effective counselors are authentic, sincere, and honest; willing to admit mistakes; live in

the present; appreciate the influence of culture; become deeply involved in their work and derive meaning from it; and are able to maintain healthy boundaries (Corey, 2001; Gazda, et al., 1999; Gladding, 2000; Young, 2005). Effective counselors embody a great number of positive qualities and characteristics.

Young (2005) studied the writings of 15 prominent authors in the profession and found 55 characteristics, attitudes, and beliefs of effective helpers including a positive, accepting view of other people; having good self-esteem; a sense of security; being a mentally-healthy person, who is creative and intellectually competent; having good self-care skills; is courageous; and able to look caringly, but with appropriate detachment, at human destruction and see possibilities for healing. Maintaining effectiveness as a counselor included accepting, confronting, and finding meaning in situations; thoughtful assertiveness; and participating in a wellness lifestyle (Gladding, 2000; Remley & Herlihy, 2001; Skovholt, 2001; Witmer & Young, 1996).

The theoretical writings of the above-mentioned leaders in the profession of counseling highlight the importance of the person of the counselor. Research has supported some of the theoretical descriptors of effective therapists. Wiggins and Weslander (1979) found that counselors who were rated “highly effective” scored highest on the social (social, service-oriented) and artistic (creative, imaginative) scales of Holland’s Vocational Preference Inventory. Grencavage and Norcross’ (1990) attempt to bring the many theoretical discussions of common factors together highlighted therapist qualities. Wampold

(2001) emphasized Grencavage and Norcross' (1990) "general positive descriptors" (p. 24) of effective therapists including one who cultivates hope, enhances expectations, and exhibits warmth and positive regard. Wampold concluded that "therapists within a given treatment account for a large proportion of the variance. Clearly, the person of the therapist is a critical factor in the success of therapy" (p. 202).

Yet, in a thorough review of existing research on therapist variables, Wampold also underscored the lack of sufficient research related to the specific impact therapist characteristics and personal qualities have on client outcomes. In the chapter, "Therapist Effects, an Ignored but Critical Factor," he reported a general lack of interest in the characteristics and personal qualities of therapists from those who base their training on the medical model (Wampold, 2001, p. 184-202). Perhaps the field of counseling, rejecting the medical model in its training programs, has the most to gain from such research.

Use of Standardized Assessments

Considering the theoretical picture of the effective counselor, and the potential effect counselors have on client outcomes, it is no wonder that developing admission criteria is a difficult task. Counselor educators have been exploring the topic of applicant selection for counselor preparation programs for several decades (Nagpal & Ritchie, 2002). Research evidence is substantial for

what does not seem to predict successful counseling student outcomes, but little evidence exists for more predictive criteria of success.

In a review of the literature, Markert and Monke (1990) found that many studies highlighted the inadequacy of traditional selection criteria for predicting either counseling success or academic success. Undergraduate grade point average (GPA) and aptitude tests, such as the Graduate Record Examination (GRE) had low positive correlations with academic success and were not very useful in predicting the attainment of counseling skills (Markert & Monke, 1990). Ray (2004) found no significant differences in the demonstration of clinical skills between counseling students with a GRE over 1000 and those students with a GRE score below 1000.

Smaby, Maddux, Richmond, Lepkowski, and Packman (2005) studied the potential to predict whether or not GRE Verbal and Quantitative scores and undergraduate GPA could be used to predict counseling knowledge, personal development, and counseling skills. They found that GRE Verbal scores and undergraduate GPA could be used to predict knowledge of counseling content (as measured by the Counselor Preparation Comprehensive Examination [CPCE] scores); and that this finding seemed logical given that GRE and GPA have been found to predict success on similar tests (e.g., paper-and-pencil knowledge tests). The CPCE was a standard exam that assessed counseling students' knowledge of counseling information. Smaby et al. (2005) did not, however, find a significant model for predicting counseling skills from GRE or

GPA. They concluded that academic tests and grades were not highly predictive of the personal and holistic development necessary for becoming a counselor (Smaby et al., 2005).

Leverett-Main (2004) studied program directors' perceptions of the effectiveness of applicant screening measures currently used in counselor education programs accredited by CACREP and program directors' perceptions of the effectiveness of measures of graduate student success. They found that GRE scores and undergraduate GPA, in combination with personal statements and letters of recommendation, were some of the most commonly used screening measures by counselor education admissions committees. GRE scores and letters of recommendation were perceived to be the least effective screening measures. When asked about the most effective screening measures in place to select counseling applicants, counselor education program directors ranked the personal interview as the most effective (Leverett-Main, 2004).

Use of the Personal Interview

Nagpal and Ritchie (2002) studied the characteristics of applicants that counselor educators look for during selection interviews. They found 10 characteristics grouped under three themes: professional attributes, personal attributes, and interpersonal skill. Professional attributes consisted of goal appropriateness, motivational appropriateness, professional preparedness, and

academic preparedness. It was considered undesirable for applicants to be unclear or to have an unrealistic vision of their professional future. The intent to resolve personal issues through joining a counseling program was also considered an inappropriate goal. Desired personal attributes consisted of personal maturity (ability to be aware of one's self and to monitor one's behaviors), flexibility (openness to ideas, opinions, beliefs, or lifestyles different from one's own), and emotional stability (absence of significant emotional distress, psychological dysfunction, or social maladjustment). Desired interpersonal skills consisted of presence (ability to interact with others in a personal and engaging manner), social appropriateness (the applicant's verbal and nonverbal behaviors appropriate to the interview situation), and verbal skill (the ability to comprehend others and to express oneself clearly and meaningfully through words) (Nagpal & Ritchie, 2002).

The above-mentioned research indicated that GRE and undergraduate GPA scores were not very helpful in predicting counseling student success, but may continue to be used until there is more evidence to support better predictors of success through other assessments that measure other constructs (e.g., desired personal qualities and characteristics). Vacc and Charkow (1999) found that most counselor education programs do not evaluate the quality dimensions that are systematically relevant to the values of the profession or academic program. Hayes (1997) concluded that counseling programs in general, do not

use standardized instruments to assess mental health or mental illness in applicants.

Although desired qualities and characteristics of counseling applicants might be assessed during applicant interviews, there is no standardized framework for assessing them, and thus, no evidence for making generalizations about counselor education program values related to applicant personal qualities and characteristics. Without research knowledge of how the person of the applicant predicts counseling program completion or how the personal qualities and characteristics of the counselor might predict client outcome, an examination of how counselor education programs define student success is necessary.

Evaluation in Counselor Education

In general, students in counselor education programs need to demonstrate both didactic and clinical proficiency prior to program completion. Kerl, Garcia, McCullough, and Maxwell (2002) found that counselor education programs, like many graduate programs, base a significant part of a student's evaluation on factors such as clinical competency and personal aptitude for the profession that are not measured by traditional written examination methods. The Council for the Accreditation of Counseling and Related Education Programs (CACREP) provides some universal guidance for student evaluation. Programs accredited by CACREP require all students to demonstrate knowledge and

engage in curricular experiences in eight common core areas as well as to complete specific practicum and internship requirements (CACREP, 2001).

Under F.9, Evaluation and Remediation of Students, in the American Counseling Association (ACA) Code of Ethics, “counselors clearly state to students prior to and throughout the training program, the levels of competency expected, appraisal methods, and timing of evaluations for both didactic and clinical competencies” (F.9.a, p. 15-16). Section F.9.b provides specific steps that counselor educators need to take if limitations are identified in a student (CACREP, 2001).

Each program, however, is left to decide how to structure curriculum; how to structure and conduct admissions; and how to conduct evaluation of students and the overall program. In order to accomplish this, programs seek additional answers to the following questions.

What is success?

In an era emphasizing accountability, counselor educators need to continually ask what constitutes student success, counseling success, and the success of counselor training programs. Resources available to answer these questions include surveying program directors, examining outcomes research and program evaluation, analyzing how research is conducted, and examining

national standards and ethical guidelines of professional organizations (Leverett-Main, 2004; Robinson, 1994; Vacc & Charkow, 1999; Wampold, 2001).

Leverett-Main (2004) surveyed 91 CACREP-accredited institutions offering master's-degree programs. When asked to rate the assessment measures commonly used by counselor education program faculty to evaluate student success, 86% rated the practicum/internship experience as an excellent measure of student success. What counselor educators look for in applied experiences, however, was debated. For many years, counselor educators have debated whether relationship-building abilities and general personality characteristics, or specific knowledge and skills, are more important to emphasize in preparing counselors. In a review of the literature, Crews, Smith, Smaby, Maddux, Torres-Rivera, Casey, et al. (2005) suggested that there have been conflicting research findings regarding the relative importance of personality traits of participants and systematic skills training. Their study failed to provide support for personality traits having a greater impact than techniques used by counselors.

Other studies, however, have indicated that counselors' personality traits and relationships with clients had a greater impact on client outcomes than the specific theories or techniques used (Stein & Lambert, 1995). Lambert and Barley (2001) concluded in a research summary on therapeutic relationships and psychotherapy outcomes that "emphasizing relationship and other common

factors in practice and research is likely to enhance client outcome far more than the current focus on specific techniques” (p. 359).

Additional assessments counseling faculty reported using to define successful students included psychological fitness (Leverett-Main, 2004). Psychological fitness was defined as the ability to be supervised, to give and receive feedback, tolerance for ambiguity, self-awareness, nonjudgmental attitude, personal maturity, and resourcefulness. Leverett-Main (2004) suggested that trainee success may depend on one’s ability to cope with and adjust to the multiple demands of academic preparation and clinical training requirements. She also suggested that creative or practical intelligence might be better predictors of successful counseling students than what is measured by the GRE (e.g., verbal and quantitative) (Leverett-Main, 2004).

Another resource for defining counseling success (and obtaining clues for defining counseling student success) is through examination of client outcomes research. Since the profession of counseling is relatively new, outcomes research specific to counseling is sparse. Instead, the profession continues to learn from the research of other mental health specialists. Lambert and Lambert (1999) discussed how some mental disorders easily lend themselves to analysis of important changes, because improvement could be defined as the absence of a behavior, such as cessation of drinking, smoking, or drug use. Unfortunately, most symptoms targeted could not be defined and measured so clearly, and even where the absence of a behavior could be easily quantified, there was a

lack of consensus about the proper procedure (Lambert & Lambert, 1999).

Wampold (2001) stated “if one were to ask prominent researchers to list important psychotherapeutic principles that have been scientifically established and generally accepted by most psychotherapy researchers, the list would indeed be short” (p. 1).

Therefore, the lack of clarity in client outcomes research might affect the lack of clarity in admissions criteria and other methods of evaluation in counselor education. Nevertheless, counselor educators must recognize that client outcomes should be the ultimate driving force behind the definition of success in counselor training programs (E. H. Robinson III, personal communication, June 21st, 2005).

The profession of counseling also needs to look critically at how research is conducted including: studying variables that promote effective outcomes during pre-service and in-service training of counselors, and through the promotion of practitioners’ research interests (Robinson, 1994). Wampold (2001) presented a provocative case for studying psychotherapy outcomes research and rejecting the medical model that most psychotherapy training programs seek to emulate. Counselor education programs could help to define success by deciding more firmly how to exist separately from what the medical model (and all other mental health specialties) values. Wampold (2001) explained three choices: learning how to assimilate into the dominant culture (medical model), complete separation as a minority culture, or deciding to stand side by side as equals. The last choice

would require a commitment to researching an apparent source of variability in counseling outcomes, the therapist (Wampold, 2001, p. 230).

What isn't success?

Defining and measuring success in counselor education is difficult due to the lack of research on client outcomes related to therapist effects, measurement of the complex personal qualities and characteristics necessary for counselors, and the evolving identity of the profession of counseling. Discovering what is successful sometimes follows critical examination of what has not been successful. Resources available to answer, *what isn't successful* in counseling and counselor education, include consulting with experts in the profession; understanding the rationale behind, and development of national standards and ethical guidelines; and legal findings related to counselor education and related programs (ACA, 2005; Bradley & Post, 1991; Emerson & Markos, 1996; Frame & Stevens-Smith, 1995; Hazler & Kottler, 1996; Herlihy, 1996; Kerl, Garcia, McCullough, & Maxwell, 2002; Lumadue & Duffey, 1999; Olkin & Gaughen, 1991).

According to Fong (1990), the term mental health covered a broad continuum of states from well-being to distress, and it seemed “peculiar that many counselor educators and practitioners read the term mental health and think mental illness” (p. 107). As the only mental health profession not

embracing the medical model, counseling could be seen as a minority culture attempting to define itself amidst the dominant culture. The scientific method, on which the medical model is based holds the superordinate position in academia, particularly in the research environment (Wampold, 2001). Additionally, practitioners have increasingly felt enormous economic pressure to conform to the medical model (Wampold, 2001) as reimbursements require diagnoses and treatment plans for mental “illnesses.”

In the following section, the opposite of success, counseling student and counselor impairment, is explored.

Distress and Impairment

Frame and Stevens-Smith (1995) described a psychological health continuum in which mental health was at the positive end, emotional distress in the middle, and impairment at the opposite end. Mental health, the positive end, has been defined as “a state of mind characterized by emotional well-being, relative freedom from anxiety and disabling symptoms, and a capacity to establish constructive relationships and cope with the ordinary demands and stress of life” (Goldenson, 1984, p. 451). Gladding (2001) defined mental health as “a state of positive wellness and emotional well-being free from excessive stress” (p. 74). Emotional distress, located in the middle of the continuum, has been defined as a state in which psychological problems exist that the individual

is aware of, but functioning has not yet reached impairment (Frame & Stevens-Smith, 1995). Skovholt (2001) stated that emotional distress may be indicated by confusion, frustration, discouragement, anxiety, and anger on the part of the counselor.

According to Webster's Ninth New Collegiate Dictionary (1990), the word "impair" means "to damage or make worse by or as if by diminishing in some material respect" (p. 603). Over the years, different helping professions have identified and defined impairment. The American Medical Association described it as, "the inability to deliver competent patient care resulting from alcoholism, chemical dependency or mental illness, including burnout or the sense of emotional depletion which comes from stress" (Stadler, Willing, Eberhage, & Ward, 1988, p. 258). Swearingen (1990) defined impaired psychiatrists as "having significant difficulty in carrying out the requisite tasks of the psychiatrist's job at a level objectively approaching competence" (p. 2). Emerson and Markos (1996) concluded that there were several types of impairment including: burnout; depression; temporary emotional imbalance or disturbance (e.g., from sudden traumatic event); drug and alcohol abuse; sexual exploitation; overinvolvement and overwork; and contagion.

Li (2000) reported the results of a survey in which 41 CACREP academic unit leaders provided information related to impairment drawing from a total of 86 cases of impaired students. Of the 17 predetermined non-academic behavior indicators of impairment derived from the literature, all 17 were believed by the

unit leaders to be reasons to terminate students from the program. The indicators that were cited most frequently included difficulty receiving supervision, deficient interpersonal skills, inappropriate boundaries, lying, and having a personality disorder (Li, 2000).

In addition to the expert knowledge in the profession of counseling, there are also ethical guidelines and legal precedents to guide counselor educators. Following is a review of the ethical and legal literature regarding counselor impairment.

Professional Guidelines

The American Counseling Association's Code of Ethics requires that counselors AND counselors-in-training avoid providing services when their personal issues are likely to cause harm to clients (ACA, 2005). Specifically Section C.2.g. and F.8.b states

Counselors are alert to the signs of impairment from their own physical, mental, or emotional problems and refrain from offering or providing professional services when such impairment is likely to harm a client or others. They seek assistance for problems that reach the level of professional impairment, and, if necessary, they limit, suspend, or terminate their professional responsibilities until such time it is determined that they may safely resume their work. Counselors assist colleagues or

supervisors in recognizing their own professional impairment and provide consultation and assistance when warranted with colleagues or supervisors showing signs of impairment and intervene as appropriate to prevent imminent harm to clients (p. 9-10).

And,

Counselors-in-training refrain from offering or providing counseling services when their physical, mental, or emotional problems are likely to harm a client or others. They are alert to the signs of impairment, seek assistance for problems, and notify their program supervisors when they are aware that they are unable to effectively provide services. In addition, they seek appropriate professional services for themselves to remediate the problems that are interfering with their ability to provide services to others (p. 15).

In addition, the Association for Counselor Education and Supervision (ACES) Ethical Guidelines for Counseling Supervision (1995) provide the following, “supervisors should not endorse a supervisee for certification, licensure, completion of an academic training program, or continued employment if the supervisor believes the supervisee is impaired in any way that would interfere with the performance of counseling duties” (2.13).

Legal Implications

In a review of the literature and court cases regarding the legal aspects of evaluating counseling and other clinical training program students, Olkin and Gaughen (1991) found that when qualified faculty followed structured evaluation processes and professional ethical guidelines, courts consistently demonstrated reluctance to overturn program dismissal decisions. Additionally, Remley and Herlihy (2001) found that courts would defer to educators in making admissions decisions if the educators had not discriminated against a protected category of students (for more on this topic see the Americans with Disabilities Act).

Due process is the right of all students and the level of procedural due process required prior to dismissal depends on whether the dismissal occurred for academic or disciplinary reasons (i.e., breaking rules of conduct) (Olkin & Gaughen, 1991). Olkin and Gaughen (1991) and Kerl, Garcia, McCullough, and Maxwell (2002) found that courts viewed counseling and other programs of clinical practice uniquely. While personal attitudes or behaviors might be seen as disciplinary concerns in other kinds of programs, in counseling programs, they were seen as academic concerns. These areas included demonstrated knowledge, technical and interpersonal skill, attitudes, and professional character (Olkin & Gaughen, 1991). Kerl, Garcia, McCullough, and Maxwell (2002) found several case decisions in support of the performance of skills (e.g., impulse control) and techniques as academic performance in counseling. Another

example included the U. S. Supreme Court's approval of a medical school's decision that a "student's clinical skills, appearance, and general demeanor" indicated that she was not qualified to be a physician (Kerl, Garcia, McCullough, & Maxwell, 2002).

Counselor education faculty may be reluctant to dismiss students for reasons other than the student's failure to complete written academic work because of "the combination of possible litigation and personal recrimination" (Frame & Stevens-Smith, 1995, p. 122). Similar fears may occur in faculty during admissions or other evaluation procedures. However, the above-referenced literature clarifies that it is the responsibility of counselor education programs to consider practical, professional, ethical, and legal perspectives ensuring that students become both academically and clinically proficient.

A Paradigm for the Profession of Counseling: Wellness

Central to the identity of a profession is its unique philosophy. Counselor education programs do not identify with the medical or illness model of viewing clients (Myers, 1992; Remley, 1991). While other mental health fields study the curative and the pathological in order to "treat" patients, "heal" mental illness, and "remediate" social problems, the philosophy of counseling evolved out of a developmental model, influenced by the field of education. As the profession of counseling examines its philosophy and continues to carve out its place, it may

need to find a stronger voice amidst the dominant culture—those mental health professions that use an illness model.

McAuliffe and Eriksen (1999) called for “a reclaiming of the counseling field’s commitment to universal development and its embrace of a strengths-oriented approach to helping” (p. 267). The opposite of an illness philosophy is a wellness philosophy. Leaders in the field of counseling have posited that a wellness model of mental health offers the best perspective for helping people resolve their personal and emotional issues and problems (Remley & Herlihy, 2001; Witmer & Young, 1996). The professional organizations representing the counseling profession have also placed an emphasis on the personal development and wellness of counseling students (AACD, 1991; ACES, 1995). Many have suggested that a strengths-based wellness model should be used in the training of counselors (Hill, 2004; Myers, Mobley, & Booth, 2003; Roach, 2005). Roach (2005) found that “both faculty and students believe that their personal wellness is essential for their effectiveness with clients” (p. 75) and suggested that without systematic procedures for evaluating and promoting wellness, counselor educators risk contributing to a work force of impaired counselors (Bradley & Post, 1991).

Myers, Sweeney, and Witmer (2000) defined wellness as a lifestyle focused on promoting health and well-being and supporting a balance between spirit, body, and mind. Total wellness, or holistic wellness, was defined as the dynamic interaction of, and self-regulating task of attending to physical,

psychological, spiritual, social, intellectual, and occupational health (Sweeney & Witmer, 1991). Wellness has been described as a dynamic and evolutionary process that involves constant growth and adaptation (Hill, 2004).

The History and Theoretical Foundations of Wellness

How the study of wellness emerged in Western society is a debate. Perhaps more importantly, what has evolved from the study of wellness has tremendous potential for reorganizing the way society views the needs of people. Wellness embraces a holistic approach that integrates all aspects of the self. There are many variations of the definition of wellness. In 1947, the World Health Organization (WHO) defined health as “a state of complete physical, mental, and social well-being, not merely the absence of disease or infirmity” (WHO, 1958). Ardell (1986) concluded that one could strive towards wellness even in the midst of illness, and that anyone could make positive lifestyle choices. For counselors, wellness refers to personal growth and professional competence achieved and maintained by attending to one’s mental, emotional, social, physical, vocational, and spiritual well-being (Witmer & Young, 1996).

Ideas leading up to the formal study of wellness in the profession of counseling can be traced from traditional psychology – Humanism and Existentialism – to the current study of Positive Psychology. In the early 1900’s, Carl Jung’s work focused on the search for meaning and integration in life. He

postulated that this search lead to a deeper focus and closeness among people or the greater wholeness/universe (Rogers, 1961).

Alfred Adler and the Individual Psychology movement focused on the self in relationship to context. Adler (1956) believed that people could overcome feelings of inferiority through their attitude toward life and their degree of social interest. Myers' and Sweeney's (2004) Indivisible Self Model of Wellness was derived from Adler's theory, connecting the individual with social context.

In the 1960's Carl Rogers and Abraham Maslow studied how to nurture excellence in people by focusing on their strengths. Rogers believed that people were basically good and healthy and had a tendency to strive toward self-actualization (1961). Maslow (1968), often referred to as the father of humanistic psychology, created a model which is known today as Maslow's Hierarchy of Needs. His hierarchy described a general motivational process of human efforts. Maslow believed that people were motivated primary to satisfy physiological needs and once met, moved to "higher" needs. Ultimately, he believed that a person could reach a level of self-actualization. The level of self-actualization was different than the lower levels because the focus was on striving to fulfill one's potential in connection to greater society. Maslow's work emphasized a more positive approach to man's search for meaning and purpose in life. The strengths-based approach to human functioning was foundational to humanistic theory and the development of the current construct of wellness.

Viktor Frankl (1967) explained that happiness was achieved through the pursuit of meaningful life activities. His work on the search for meaning became the foundation for existentialism. Frankl's (1967) description of the three dimensions of human existence: soma (physical), psyche (emotions), and noetic (spirit), were foundational to the mind, body, spirit focus of the construct of wellness. Meaning and purpose in life was a central premise. These theoretical models have contributed to a shift in focus from a strictly pathological model of mental health to a focus on positive individual traits and strengths that offer hope for improving quality of life, enhancing personal development, and preventing impairment. Wellness models have grown out of these more positive, strengths-based approaches to human growth and development.

Snyder and Lopez (2002) presented a comprehensive look at the study of positive psychology. Positive psychology includes the study of prevention, identifying strengths, and deconstructing the illness ideology. Such concepts as subjective well-being, happiness and life satisfaction, and the concept of flow are being studied (Snyder & Lopez, 2002). Positive psychology also includes the social construction of self esteem, emotional intelligence, and creativity. It seeks to understand the phenomena of optimism, hope, self-efficacy, authenticity, forgiveness, gratitude, empathy and altruism. Positive psychology posits inclusion of the pursuit of meaning, the use of humor, and spirituality (Snyder & Lopez, 2002).

Indivisible Self Model of Wellness

Several models have been proposed to explain the many factors that combine to create healthy functioning (Myers & Williard, 2003). However, most models have evolved out of the medical sciences grounded in theories derived from the physiological or physical health fields (Myers & Sweeney, 2006). Sweeney and Witmer (1991) developed the first theoretical model of wellness grounded in counseling theory, the Wheel of Wellness. Sweeney and Witmer (1991) and Witmer and Sweeney (1992) reviewed literature across disciplines in an attempt to discover the characteristics of healthy people over the life span. They examined the results of research and theoretical perspectives including behavioral medicine, stress management, psychoneuroimmunology, anthropology, sociology, religion, education, stress management, ecology, contextualism, and across psychology specialities – clinical, health, personality, social and developmental psychology. The Wellness Evaluation of Lifestyle (WEL) inventory was developed to assess each of the individual characteristics in the Wheel of Wellness (Myers, Sweeney, & Witmer, 1996).

Through continued research and factor analysis, a new evidence-based model and instrument was developed called the Indivisible Self model and the 5F-Wel, respectively (Myers & Sweeney, 2004; Myers, Luecht, & Sweeney, 2004). Using the Indivisible Self model of wellness (Myers, Luecht, & Sweeney, 2004) total wellness is comprised of five second order factors (Creative Self,

Coping Self, Social Self, Essential Self, and Physical Self). Seventeen third order factors group within the five second order factors as follows: Creative Self (thinking, emotions, control, work, positive humor), Coping Self (leisure, stress management, self-worth, realistic beliefs), Social Self (friendship, love), Essential Self (spirituality, gender identity, cultural identity, self-care), and Physical Self (nutrition, exercise). These factors comprising wellness are seen to function within local, institutional, global, and chronometrical ecological contexts (Myers, Luecht, & Sweeney, 2004).

Need for Further Validation

Hermon and Hazler (1999) stated that “a basic assumption regarding the value of any wellness model is that those who adhere to the model would somehow be noticeably better off than those who do not” (p. 340). The field of counseling is economically pressured to compete with other mental health professionals for managed care dollars, including pressure to produce/use empirically supported treatments (EST's) and manualized treatments (Young, 2005). In order to provide support for wellness counseling, research needs to show a specific connection between wellness and client outcome (E. H. Robinson III, personal communication, June 21st, 2005).

What is the relationship, for example, between an evidence-based model of wellness built upon counseling theory and psychological symptomology? To

date, there is no research that shows the relationship between symptoms of psychological disturbance (that which the majority of clients seek counseling services) and wellness. This study sought to examine the nature of the relationship between wellness and psychological disturbance. Once the nature of such a relationship is known, additional research might examine how counseling student wellness and level of psychological disturbance relate to counseling success or counselor education success.

Witmer, Sweeney, and Myers (1993) found that experiencing success in the self-regulating tasks of wellness (managing stress, sense of worth, control, emotional responsiveness and management, intellectual challenge, nutrition, exercise, sense of gender, and cultural identity) seemed to be associated with higher levels of psychological well-being. The next step in the line of research was to study if lower success levels of self-regulating tasks (wellness) were correlated with higher levels of psychological disturbance. Granello (2000) stated that “mental health professionals are uniquely suited to assisting clients with the psychological and social mediators that may affect health and wellness behaviors” (p. 3). Mental health counselors have the potential to be service providers in medical settings, using an alternative or complementary approach to medical treatments, especially if they can support their practices with research based upon traditionally-accepted methodology (Degges-White, Myers, Adelman, & Pastoor, 2003).

More research using the 5F-Wel is needed to provide additional support for the validity and applicability of the instrument, (Hattie, Myers, and Sweeney, 2004; Vanderbleek, 2005) including the possibility that counseling students experiencing lower levels of wellness than reported may be responding in a socially desirable manner (Myers, Mobley, & Booth, 2003). The following section reviews the construct of faking good and the operational definition of social desirability.

Social Desirability and Faking Good

The susceptibility of items to distortion on any given test threatens its generalizable usefulness, specifically its reliability and validity. Graham, McDaniel, Douglas, and Snell (2002) reviewed literature describing response distortion on noncognitive-oriented measures. They found that terms such as social desirability, impression management, faking, intentional distortion, and self enhancement had been used to describe response distortion. To clarify the use of terms regarding response distortion, research studying faking has used scores on social desirability scales as an operational definition of faking (Graham, McDaniel, Douglas, & Snell, 2002; Peeters & Lievens, 2005).

Several research lines have been identified in the faking literature (Ones, Viswesvaran, & Reiss, 1996). One line of research involved experimental studies in laboratory settings with participant instructions to fake good or to be

honest in their responses. Another line of research on faking compared various groups in real-world settings where there was motivation to distort responses (e.g., student or job applicants compared to those already in positions) (Ones, Viswesvarn, & Reiss, 1996). Although social desirability scales have been found to not capture all faking variance (for more on this see Ellingson, Sackett, & Hough, 1999), the decision to study social desirability in the present study was made for several reasons. First, a major criticism of self-report instruments, particularly psychological surveys, is susceptibility to socially desirable response bias (Crowne & Marlowe, 1960; Edwards, 1957, 1990; Mabe & West, 1982; Beretvas, Meyers, & Leite, 2002). Second, the “Standards of Educational and Psychological Testing” (American Educational Research Association, 1999) recommend that the interpretation of test results in the assessment process should be partly guided by an analysis of response styles that may reflect construct-irrelevant variance, such a social desirability, which may affect test scores. Third, although the 5F-Wel has been deemed psychometrically valid for research use (Hattie, Myers, & Sweeney, 2004), one of the test’s authors recommended studying the possibility that counseling students could fake good on wellness assessments (Myers, Mobley, & Booth, 2003). Lastly, how entering counseling students respond to socially approved but uncommon behaviors and socially disapproved but common behaviors may be of future interest to counselor educators.

Summary

This chapter presented a review of the literature providing the foundation on which this study is based. The streams of literature pertinent to this study included counselor education admissions, evaluation in counselor education, distress and impairment, wellness in counseling, and the potential for socially desirable response bias in self-report measures. Olkin and Gaughen (1991) emphasized that counselor educators are responsible for ensuring that students are both academically and clinically proficient upon graduation. Given the large number of positive personal qualities and characteristics used to describe counselors in combination with the skills, techniques, and written work required, it is no wonder that predicting the successful counseling student is so difficult. While much research is needed to determine counselor effects in outcomes of therapy, there is sufficient evidence to suggest that they may account for a large portion of the variance. Therefore it is critical that research supports continued investigation into the personal characteristics and qualities of effective counselors and counseling students.

Although counselor training programs may be required to collect traditional admissions criteria, (e.g., GPA and GRE if required by a separate entity like a Graduate School) previous research suggested they have been demonstrated to be of little statistical significance as predictors of success. The personal interview is used by many counselor education programs and may be seen as

effective because it allows faculty to assess applicant personal qualities and characteristics, albeit informally. Counselor education programs face the difficult task of deciding how to structure admissions and student evaluations because there are no structured recommendations for doing so. Obtaining a picture of the wellness of entering master's-level counseling students may provide evidence for the strengths that they bring to the program. Likewise, obtaining a snapshot of their psychological disturbance may indicate what resources and continuing evaluation is needed in the program. Lastly, the validity of the only measure of wellness based in counseling theory needs to be studied if the profession of counseling is to present a unique wellness identity in outcomes research.

CHAPTER 3: METHODOLOGY

This chapter is divided up into four major parts: (1) participants, (2) materials, (3) research design, and (4) procedures. All play a role in laying the foundation on which the validity of this study is based.

Participants in the Study

Students

The target population for the problem investigated included all master's-level counseling students in which entry into a typical setting could be attained. Counseling programs located in Florida, Mississippi, Ohio, Alabama, Arkansas, New Mexico, Louisiana, Tennessee, North Carolina and South Carolina were invited to participate. Students completed the instruments either during program orientation or during a class gathering within the first four weeks following formal admission to their program.

To enhance the potential for external validity, only entering master's-level counseling students were invited to participate. Reactive or interaction effects of testing were assumed to be minimal since the population represented individuals entering the program, all with undergraduate degrees in other fields, and thus, not likely to have been previously exposed to the study's instruments in an

academic setting. Furthermore, inventories, questionnaires, and rating scales, such as the ones used in the present study, are usually less subject to such effects than tests (e.g. achievement tests) (Hadley & Mitchell, 1995). To control for internal validity, instruments were administered to each individual at one point in time, controlling for effects of history, maturation, testing, instrumentation, and experimental mortality.

A total of nine programs (in five states) and 204 students participated. Of the 204 participants 180 were female and 24 were male, with ages ranging from 21 years to 51 years (mode 24; mean 27.8). In response to a fill-in-the-blank question asking ethnicity/race: 1 wrote "Native American", 3 "Asian", 7 "Multiracial", 23 "Hispanic" or "Latino", 34 "African American" or "Black", and 136 "White" or "Caucasian." In response to a fill-in-the-blank question asking years of professional experience related to counseling, responses ranged from 0 – 30 years, with an average of 2.2 years and 80% having equal to or less than 3 years of professional experience related to counseling. In regard to having ever participated in personal counseling, 115 (56.4%) indicated participation, 87 (42.6%) indicated no experience with personal counseling, and 2 participants left the item blank. Of those who had participated in personal counseling, the number of sessions experienced ranged from 0 – 100 (mean 12.3 sessions; 75% responded \leq 12 sessions).

Faculty Contacts

Faculty members of master's-level counseling programs were contacted and invited to participate in the research study. The faculty member contacts then sought formal program approval. Following host program approval, the researcher mailed out packets of instruments to each faculty contact. As an incentive to participate, programs were offered a summary of both their program's and the study's results upon completion of the research, unless low number of participants would threaten individuals' confidentiality. No other incentives were offered to students, faculty or host programs.

Materials

Three constructs were examined in this study: wellness, psychological disturbance and social desirability. The primary variables used to examine the constructs included Total Wellness, Creative Self, Coping Self, Social Self, Essential Self, Physical Self; Severity of Disturbance, Symptom Distress, Interpersonal Relations, Social Role functioning; and attribution and denial of Social Desirability. Three instruments were used to measure the variables in the study: the Five Factor Wellness Evaluation of Lifestyle (5F-Wel; Myers & Sweeney, 2005), the Outcome Questionnaire – 45.2 (OQ-45.2; Lambert et al., 2004), and the Marlowe-Crowne Social Desirability Scale (MCSDS; Crowne &

Marlowe, 1960). Additionally, a questionnaire collected fill-in-the-blank responses for age, gender, ethnicity/race, undergraduate major, duration of professional experience related to counseling, number of personal counseling sessions experienced, and motivation for entering the counseling program. Forced-choice questions collected type of professional experience related to counseling, knowledge of program CACREP status, and knowledge of a personal counseling requirement of the program the individual was entering. In the following sections, each instrument is described and psychometric properties are examined.

The Five Factor Wellness Evaluation of Lifestyle

The 5F-Wel is an evidence-based tool designed to assess characteristics of wellness and is the only wellness instrument derived from counseling theory (Sweeney & Witmer, 1991). The construct of wellness was based on a holistic view of humans, in which context is recognized to affect functioning. An emphasis on the integrated whole, or the indivisible self, was central to the development of the 5F-Wel. Wellness can also be described as a series of choices in which mind, body and spirit become integrated in one's understanding of life. Living becomes an intentional lifestyle about optimal functioning and living more fully.

Developed through structural equation modeling analysis from an older version, the Wellness Evaluation of Lifestyle (WEL; Myers, Sweeney, & Witmer, 1996), the 5F-Wel includes 73 items measuring the higher order Wellness factor, five second order factors and 17 third order factors. Individual test items were shown to have statistically significant structure coefficients for the higher order Wellness factor (Myers & Sweeney, 2005). The higher order Wellness factor has been called the *Indivisible Self*, defined and found to represent the indivisibility of the human being (Myers & Sweeney, 2005). The five second order factors make up the indivisible self and are named the creative self, coping self, social self, essential self, and physical self.

Psychometric properties of the 5F-Wel were reported in the instrument's manual (Myers & Sweeney, 2005). Cronbach's alpha coefficients were reported from a sample of 2,093 participants and found to have high internal consistency: total wellness (.90), coping self (.85), social self (.85), essential self (.88) and physical self (.88) (Hattie, Myers, & Sweeney, 2004). This research study found comparable or acceptable Cronbach's alpha coefficients: total wellness (.898, n=197), coping self (.664, n=201), social self (.750, n=199), essential self (.811, n=199) and physical self (.879, n=201).

Norms for the adult version of the 5F-Wel were based upon 1,899 persons recruited through university classes, professional workshops, and through research projects. The maximum item reading level was assessed to be ninth grade. Norms range on a scale from 1-100, with 100 indicating the highest level

of wellness possible. The normed means reported were: Total Wellness 76.22, 77.80 for the second-order factor Creative Self, 72.36 for Coping Self, 84.06 for Social Self, 78.90 for Essential Self; and 70.98 for Physical Self. Norms were also available for each of the third order factors, gender, ethnicity, and for other versions of the 5F-Wel (e.g., Teen). The higher order factor, Total Wellness (or the Indivisible Self), in combination with the profile of the second order factor scores have been suggested and used as a screening tool to determine where wellness interventions are needed (Degges-White, Myers, Adelman, & Pastoor,, 2003; Myers & Sweeney, 2005; Tanigoshi, 2004).

The Marlowe-Crowne Social Desirability Scale

The Marlowe-Crowne Social Desirability Scale (MCSDS) is a 33-item measure of a person's tendency to distort self-presentation toward a socially desirable bias. The MCSDS is the most commonly used tool designed to assess social desirability (Beretvas, Meyers, & Leite, 2002), and it does not contain pathology-related content (Crowne & Marlowe, 1960). The scale has been used predominantly to evaluate discriminant validity in personality assessment (Arroyo & Zigler, 1995; Campbell, Trapnell, Heine, Katz, Lavalley, 1996; Heatherton & Polivy, 1991; Zuckerman, Kuhlman, Joireman, Teta, & Kraft, 1993) or as a covariate to adjust for the potential influence of response bias (Hewitt & Flett, 1991; Pierce, Sarason & Sarason, 1992). The MCSDS has also been

characterized as a measure of psychological defensiveness (Weinberger, 1990; Weinberger, Schwartz, & Davidson, 1979). The MCSDS was originally designed for use with college students and the expected range of scores within that population is well established (Evans, 1982).

Baseline data exists for college students, noncollege adults, and clinical groups. Using the MCSDS with a total of 33 possible points, mean scores for both male and female college students ranged between 12 and 17 (Crowne & Marlowe, 1964; Cosentino & Kahn, 1967; Evans, 1982; Barger, 2002). Norms for clinical groups were between 16.73 and 19.20 for male prisoners (Fisher & Parsons, 1962; Fisher, 1967, 1969); between 15.22 and 21.08 for alcoholics (Hoffman, 1970; Weissbach, Vogler, & Compton, 1976; Krasnoff, 1976); 18.50 in psychiatric patients (Boor, 1973); 19.56 among people diagnosed with hypertension (Wennerholm & Zarle, 1976); and 18.94 for other medical patients (Wennerholm & Zarle, 1976). Andrews and Meyer (2003) suggested that scores of ≥ 29 could represent deceptive self-presentation and scores ≤ 12 could indicate feelings of being overwhelmed, defenseless, or overly critical of self.

Loo and Thorpe (2000) used confirmatory factor analysis as well as item and scale analyses to evaluate the adequacy of the full version of the MCSDS compared to shortened versions. They found the reliability to be .72 and concluded that the continued use of the full scale was a prudent approach for researchers and practitioners alike. Respondent ratings in the present study were judged to be modestly reliable for the master's-level counseling students to

whom it was given, with a reliability coefficient of .7344 for the attribution items and .6222 for the denial items. A review of the corrected item total correlations suggested that item number three, “It is sometimes hard for me to go on with my work, if I am not encouraged” did not correlate with the corrected total very well. Removal of the item may make for a more parsimonious scale. Removing the item may further be motivated by the anticipated increase in the reliability coefficient reported in the output (i.e., increasing the denial items reliability coefficient to .7650).

The Outcome Questionnaire – 45.2

The OQ-45.2 is a measure of psychological disturbance or total severity of emotional disturbance as perceived by the assessed individual. The 45-item measure was written at the fifth grade reading level and provides a total score (Severity of Disturbance) with three subscores. The three subscores were labeled Symptom Distress, Interpersonal Relations, and Social Role. Symptom Distress was defined as the subjective discomfort related to the most common known affective symptoms such as depression, anxiety, and substance abuse. A cutoff score of 36 indicated the individual was experiencing symptoms similar to those measured on diagnostic instruments such as the Beck Depression Inventory or the State Trait Anxiety Inventory. Interpersonal Relations referred to the satisfaction with and problems in friendships, family, and marriage/significant

relationships. Social Role functioning referred to the level of dissatisfaction or distress related to functioning in employment, school, family, and leisure life. Internal consistency was deemed very good for the Total Score (Severity of Disturbance) .93, and for subscale Symptom Distress .92. Subscales Interpersonal Relations and Social Role were deemed to have modest internal consistency with .74 and .70, respectively (Lambert, et al., 2004).

Cutoff scores for social role (12) suggested dissatisfaction, conflict, distress, and inadequacy in performance of the individual's social role. The cutoff score for interpersonal relations (15) suggested friction, conflict, inadequacy, and/or withdrawal in friendships, family, and intimate significant relationships. The total score cutoff (63) suggested that the individual had endorsed a large number of items indicating disturbance within the three subscores (Lambert, et al., 2004).

Research Design

The design implemented in this study was an ex post facto, cross-sectional, correlational design. A correlational design was chosen for this research to examine variables as they occurred in their natural state (i.e., without manipulation). The major purpose of such research is to clarify understandings of important phenomena by identifying relationships among variables (Fraenkel & Wallen, 2006), including both the degree and direction of the relationship.

Furthermore, a correlational design does not infer causal relationships and is therefore more conducive to purposive sampling. Finally, the correlational approach is a relatively inexpensive test of hypotheses, which can then be checked through more expensive experimental manipulation (Campbell & Stanley, 1963).

Procedures

Prior to beginning the study, the researcher followed and obtained all institutional requirements for research involving human participants. The Institutional Review Board (IRB) formal approval letter is included in Appendix A. Faculty members from 18 master's-level counseling programs were contacted, provided a description of the study, and invited to ask any questions related to involvement in the study. Faculty from nine programs were able to facilitate program approval and assisted with data collection for the present study. The researcher obtained permission and/or licenses for each instrument used (see Appendix B) and prepared all instruments for administration including number coding. Boxes were sent to faculty contacts that included written directions for test administration (see Appendix E), contact information of the researcher, and instructions and paid postage for returning the data to the researcher. Each research participant then completed a consent form (see Appendix C), a demographic questionnaire (see Appendix D), the 5F-Wel, the MCSDS, and the

OQ-45.2. The United States Postal Service (USPS) was used to send coded sets of assessment instruments organized in individual packets to be administered to each participant.

Data Analysis

After the data collection process, several parametric statistical procedures were implemented and relationships between the variables determined. Data for parametric procedures were entered into a database and analyzed by Statistical Package for the Social Sciences (SPSS, 2001) using Pearson's Product Moment Correlation, partial correlation, one-sample t-tests, and ANOVA. The variables examined in this study were Total Wellness (x_1), Creative Self (x_2), Coping Self (x_3), Social Self (x_4), Essential Self (x_5), and Physical Self (x_6); Social Desirability (y); Severity of Disturbance (z_1), Symptom Distress (z_2), Interpersonal Relations (z_3), and Social Role (z_4). Cronbach's alpha reliability coefficient was used to check the internal consistency of the instruments. Analysis of variance (ANOVA) was used to examine the differences among groups based upon age, ethnicity/race, undergraduate major, and number of personal counseling sessions experienced.

Statistical Treatments

SPSS 11.5 (2001) was the statistical package used to analyze the data in this study. The following statistical treatments were determined to be the best for answering the research question and studying the research hypotheses.

Pearson Product Moment Correlation. The Pearson product-moment correlation is a parametric measure of association for two variables. It measures both the strength and direction of a linear relationship. If one variable X is an exact linear function of another variable Y, a positive relationship exists if the correlation is 1 and a negative relationship exists if the correlation is -1. If there is no linear predictability between the two variables, the correlation is 0. If the two variables are normal with a correlation 0, the two variables are deemed independent. For the purpose of reducing the risk of error, the sample contained more than the general rule of 10 (approximately 18) participants for each variable in the correlation matrix (Shannon & Davenport, 2001).

Partial Correlation. Partial correlation was employed to rule out the influence of one measured variable (Social Desirability) upon the criterion (Total Wellness) in order to clarify the role of another variable (Psychological Disturbance). Partial correlation is a procedure that measures the region of three-way overlap precisely, and then removes it in order to determine what the

correlation between any two of the variables would be if they were not each correlated with the third variable. Partial correlation determines what the correlation would be (hypothetically) between any two of the variables if the third variable was held constant.

One Sample T-Test. One sample t-test is used to compare a sample mean to a hypothesized population mean. Specifically, a one-sample t-test helps to determine the likelihood that the sample came from a population, given specific conditions. In this study, a one sample t-test was used to compare the study's sample means with the instruments' normed means.

ANOVA. In general, the purpose of analysis of variance (ANOVA) is to test for significant differences between means. In this study, ANOVA was used to compare groups of people with respect to one or more independent variables (e.g., gender), testing for significant differences related to the dependent variables (e.g., MCSDS mean scores). Only one of two conditions can be violated using ANOVA: (1) equal variance assumptions (homogeneity of variance assumptions), or (2) equal "n" assumptions.

CHAPTER FOUR: FINDINGS

The following chapter (1) reviews the research question and hypotheses, (2) describes the results of measures of central tendency for each of the instruments' variables, (3) presents the results of the statistical tests previously described, (4) describes the rationale and results of exploratory data analyses, and (5) summarizes the findings.

Research Question and Hypotheses

The research question was as follows: What is the relationship among wellness, psychological disturbance and social desirability in entering master's-level counseling students? Based upon a review of the literature, the following hypotheses were developed to study the research question:

Null Hypothesis 1. There is no relationship between level of psychological disturbance and level of wellness in entering master's-level counseling students.

Alternative Hypothesis 1. There is a negative relationship between level of psychological disturbance and level of wellness in entering master's-level counseling students.

Null Hypothesis 2. There is no relationship between level of wellness and social desirability in entering master's-level counseling students.

Alternative Hypothesis 2. There is a positive relationship between level of wellness and social desirability in entering master's-level counseling students.

Null Hypothesis 3. There is no relationship between level of psychological disturbance and social desirability in entering master's-level counseling students.

Alternative Hypothesis 3. There is a negative relationship between level of psychological disturbance and social desirability in entering master's-level counseling students.

Measures of Central Tendency

Marlowe-Crowne Social Desirability Scale (MCSDS)

Measures of central tendency and range for MCSDS scores are displayed in table 1. Using the MCSDS with a total of 33 possible points, published mean scores for both female and male college students were 16.82 (SD = 5.50) and 15.06 (SD = 5.58), respectively (Crowne & Marlowe, 1964). The mean score for this study's sample was 16.97 (SD = 6.44) for females and 17.33 (SD = 7.94) for males, and a combined mean of 17.01 (SD = 6.62). No statistically significant difference was found between the test's normed means categorized by gender

and the means of the present study ($p > .05$). Evans (1982) conducted a meta-analysis of college-sample studies using the MCSDS, finding means for 27 female samples, 38 male samples, and 19 combined female and male samples. He found that “very rarely (4% females; 2% male samples) do MCSDS sample means exceed 17 among college students” (Evans, 1982, p. 421). In the present study 96 participants (47.8% of the sample) had a total MCSDS score above 17.

Outcome Questionnaire – 45.2 (OQ-45.2)

Lambert, et al. (2004) provided normative information for the OQ-45.2 total scores and subscores. Normative groups came from Utah, Idaho, Ohio, and Massachusetts. Sample sets included undergraduate students, a community sample drawn randomly from phone books and businesses, a university counseling center, an EAP program, and outpatient and inpatient clinics. Normative means and standard deviations for undergraduate students for total score (Severity of Disturbance) were 42.5 (16.61) to 51.34 (24.45). Other sample means were as follows: community 45.19 (18.57), EAP 73.61 (21.39), university counseling center 75.16 (16.74), outpatient clinics 83.09 (22.23), and inpatient 88.8 (26.66). Normative means and standard deviations for the subscales for undergraduate student samples are as follows: Symptom Distress 22.96 (10.48) to 27.51 (14.55); Interpersonal Relations 8.78 (4.97) to 12.42 (7.20); and Social Role 10.13 (3.69) to 11.41 (4.73) (Lambert, et. al., 2004).

The means and standard deviations for the present study's sample were total score (Severity of Disturbance) 42.32 (17.40); Symptom Distress 24.40 (11.40); Interpersonal Relations 9.60 (5.11); and Social Role 8.38 (3.61). Measures of central tendency and range for OQ-45.2 scores are displayed in table 1. This study's sample means and standard deviations appear similar to those published with the exception of Social Role. This study's sample means indicated less reported problems in social roles than the undergraduate student samples published as norms in the OQ-45.2 test manual. One sample t-tests were not performed for OQ-45.2 scores because a closer examination of cutoff scores was deemed more meaningful for this study.

Cutoff Scores

Lambert, et al. (2004) provided cutoff scores to indicate the level in which scores change between those of the average population and those of patient populations. The cutoff score for Symptom Distress was > 36 , which would indicate an individual is experiencing symptoms similar to patients' scores on widely used diagnostic instruments such as the Beck Depression Inventory or the State Trait Anxiety Inventory. The Social Role cutoff score of > 12 would suggest dissatisfaction, conflict, distress, and inadequacy in performance of an individual's social role; the cutoff score for Interpersonal Relations (> 15) would suggest friction, conflict, inadequacy, and/or withdrawal in friendships, family,

and significant intimate relationships. The total score cutoff (> 63) would suggest that an individual had endorsed a large number of items indicating distress or total disturbance within the three subscale scores. Compared to the cutoff scores on the OQ-45.2, the present study's sample means and medians indicated average human functioning in each of the subscale scores and total OQ-45.2 score.

However, because there were a significant number of participants endorsing Severity of Disturbance above cutoff scores (n = 21, 10.7% sample) and above each of the subscale cutoff scores: Symptoms of Distress (n = 28, 14.2%), difficulty with Interpersonal Relationships (n = 33, 16.8%), and difficulty in Social Roles (n = 33, 16.8%), exploratory data analysis was conducted to further define the relationship between Severity of Disturbance and Wellness (see exploratory data analysis at the end of this chapter). Table 2 contains a summary of the number and percent of participants above OQ-45.2 cutoff scores.

Five Factor Wellness Evaluation of Lifestyle (5F-Wel)

Norms for 1,899 persons were used to compile the published norms for the 5F-Wel - A (Myers & Sweeney, 2005). The published means and standard deviations for the first and second order factors were as follows: Total Wellness 76.22 (12.51), Creative Self 77.80 (12.99), Coping Self 72.36 (10.63), Social Self 84.06 (17.82), Essential Self 78.90 (16.15), and Physical Self 70.98 (17.00). The

test's authors recommend development and use of local norms for score interpretation due to some known deviations from national population statistics (Myers & Sweeney, 2006). During initial examination, the present study's means appeared to be higher on all of the first and second order factors when compared to the test's norms. Additionally, the standard deviations appeared to have less deviation from the mean than those published in the test manual. Thus, one sample t-tests were used to determine statistical significance of the difference between the test manual's mean scores and the current study's mean scores. All of this study's means were statistically significantly different ($p < .05$) than the normed means except for Realistic Beliefs, Physical Self, and Nutrition.

Measures of central tendency and range for 5F-Wel scores are displayed in Table 3. Results of one sample t-tests comparing the 5F-Wel's normed mean scores with the present study's sample means is presented in Table 4.

Table 1. Central Tendency and Range of Social Desirability (MCSDS) and Disturbance (OQ-45.2) Scores

Variable	N	Min.	Max.	Mean	St. Dev.
Social Desirability	201	0	32	17.01	6.62
Symptom Distress	197	2	67	24.40	11.14
Interpersonal Relations	197	0	23	9.60	5.11
Social Role	197	0	20	8.38	3.61
Total Severity of Disturbance	197	4	106	42.32	17.40

Table 2. Number and Percent of Sample Meeting OQ-45.2 Cutoff Scores

Variable	Cutoff Score	Number Meeting Cutoff (out of 197)	Percent of Sample
Symptom Distress	> 36	28	14.2%
Interpersonal Relations	> 15	33	16.8%
Social Role	> 12	33	16.8%
Total Severity of Disturbance	> 63	21	10.7%

Table 3. Central Tendency and Range of First, Second, and Third Order Factor Scores

Variables	N	Min.	Max.	Mean	St. Dev.
TOTAL WELLNESS ¹	201	65.41	98.97	81.6528	6.27813
CREATIVE SELF ²	201	66.25	100.00	83.4842	6.82649
Thinking ³	201	56.25	100.00	83.7998	9.12743
Emotions ³	201	50.00	100.00	82.4834	10.04822
Control ³	201	68.75	100.00	86.1629	9.49713
Work ³	201	50.00	100.00	81.0323	10.99322
Positive Humor ³	201	56.25	100.00	83.9552	10.30154
COPING SELF ²	201	55.26	96.05	76.8984	7.48590
Leisure ³	201	41.67	100.00	80.7421	12.20223
Stress Management ³	201	43.75	100.00	78.1095	10.77331
Self Worth ³	201	56.25	100.00	86.4739	10.56585
Realistic Beliefs ³	201	30.00	90.00	63.6567	12.10110
SOCIAL SELF ²	201	65.63	100.00	93.2125	7.62483
Friendship ³	201	56.25	100.00	89.8839	10.35693
Love ³	201	68.75	100.00	96.5485	7.01145
ESSENTIAL SELF ²	201	50.00	100.00	84.8399	10.14841
Spirituality ³	201	25.00	100.00	80.1493	20.23555
Self Care ³	201	37.50	100.00	91.6148	12.41890
Gender Identity ³	201	50.00	100.00	85.1679	12.84687
Cultural Identity ³	200	33.33	100.00	83.2500	13.67623
PHYSICAL SELF ²	201	27.50	100.00	72.6866	15.99988
Nutrition ³	201	25.00	100.00	69.4030	19.36212
Exercise ³	201	25.00	100.00	75.9701	17.18805

Table 4. Comparison of Normed 5F-Wei Test Means with those of the Study's Sample Means

Variables	N	Study Means	Normed Means	Significance (2-tailed)
Total Wellness ¹	201	81.6528	76.22	.000**
Creative Self ²	201	83.4842	77.80	.000**
Thinking ³	201	83.7998	78.31	.000**
Emotions ³	201	82.4834	77.64	.000**
Control ³	201	86.1629	78.31	.000**
Work ³	201	81.0323	75.02	.000**
Positive Humor ³	201	83.9552	79.79	.000**
Coping Self ²	201	76.8984	72.36	.000**
Leisure ³	201	80.7421	76.65	.000**
Stress Management ³	201	78.1095	76.00	.006**
Self Worth ³	201	86.4739	79.90	.000**
Realistic Beliefs ³	201	63.6567	62.25	.101
Social Self ²	201	93.2125	84.06	.000**
Friendship ³	201	89.8839	82.64	.000**
Love ³	201	96.5485	85.57	.000**
Essential Self ²	201	84.8399	78.90	.000**
Spirituality ³	201	80.1493	76.90	.024*
Self Care ³	201	91.6148	84.72	.000**
Gender Identity ³	201	85.1679	78.74	.000**
Cultural Identity ³	200	83.2500	74.82	.000**
Physical Self ²	201	72.6866	70.98	.132
Nutrition ³	201	69.4030	68.48	.500
Exercise ³	201	75.9701	73.46	.040*

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

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

Effects of Demographic Variables

One-way ANOVA

To understand if there was a mean difference in OQ-45.2, 5F-Wel, or MCSDS scores with respect to gender, ethnic/racial identity, or age, one-way ANOVA procedures were used. No statistically significant mean difference was found between males and females in total OQ-45.2, 5F-Wel, or MCSDS scores. No statistically significant mean difference was found between ethnicity / racial identity groups in 5F-Wel scores. Although a statistically significant mean difference was found between ethnicity / racial identity groups in OQ-45.2 ($F = 2.85$, $df = 5$, $p < .05$) and MCSDS scores ($F = 2.59$, $df = 5$, $p < .05$), the overall relationship may be too small to be practically or theoretically meaningful (7% and 6.3%, respectively). No statistically significant mean difference was found between age groups in Social Desirability (MCSDS) scores or Severity of Disturbance (OQ-45.2) scores. There was a statistically significant mean difference ($F = 2.87$, $df = 4$, $p < .05$) between the age group 21-24 years old and 35-39 years old in total Wellness (5F-Wel) scores. About 5.3% of the variance in scores can be explained by age group. A Scheffe post hoc was run because it is a conservative test that allows for comparison between unequal-sized groups. Although the 21-24 age group mean ($x = 80.50$) was statistically significantly

different than the 35-39 age group mean ($x = 86.68$), the difference may be too small of be of practical or theoretical significance.

Statistical Tests of the Hypotheses

Pearson Product-Moment Correlation

The Pearson correlation coefficients are displayed in Table 5. Each correlation was deemed to be statistically significant ($p < .01$) except Social Desirability (MCSDS) with Social Self (5F-Wel second order factor); Social Role (OQ-45.2 subscale) with Essential Self (5F-Wel second order factor); and Interpersonal Relations (OQ-45.2 subscale) with Essential Self (5F-Wel second order factor). The strongest correlation to occur between instruments total scales was Severity of Disturbance (Total OQ-45.2 score) and Social Desirability (MCSDS score). The reported Pearson correlation coefficient was $r(196) = -.518, p < .01$ indicating a moderate-to-good negative correlation.

The next strongest correlation existed between Total Wellness (total 5F-Wel score) and Severity of Disturbance (Total OQ-45.2 score). The Pearson correlation coefficient was, $r(195) = -.482, p < .01$ indicating a moderate negative correlation. The least strong of the correlations existed between Total Wellness (5F-Wel) and Social Desirability (MCSDS), with a correlation coefficient of

$r(198) = .291, p < .01$, indicating a moderate positive, statistically significant relationship. The coefficients can be squared to produce the coefficients of determination. In these cases, $(-.518)^2 = .2683$; $(-.482)^2 = .2323$; $(.291)^2 = .0847$. In other words, approximately 26.8% of the variance in Severity of Disturbance (total OQ-45.2) can be attributed to Social Desirability (MCSDS) and vice versa; 23.23% of the variance in Severity of Disturbance (OQ-45.2) can be attributed to Total Wellness (5F-Wel), and 8.47% of the variance in Total Wellness (5F-Wel) can be attributed to Social Desirability (MCSDS) and vice versa.

Table 5. Pearson Correlation Coefficients, Sig. (2-tailed); N

	Symptom Distress	Interpersonal Relations	Social Role	SEVERITY OF DISTURBANCE	SOCIAL DESIRABILITY	TOTAL WELLNESS	Creative Self	Coping Self	Social Self	Essential Self	Physical Self
Symptom Distress	1 .000 197	.599(**) .000 197	.680(**) .000 197	.949(**) .000 197	-.502(**) .000 196	-.446(**) .000 195	-.276(**) .000 195	-.505(**) .000 195	-.242(**) .001 195	-.191(**) .008 195	-.308(**) .000 195
Interpersonal Relations	.599(**) .000 197	1 .000 197	.572(**) .000 197	.791(**) .000 197	-.378(**) .000 196	-.421(**) .000 195	-.335(**) .000 195	-.436(**) .000 195	-.429(**) .000 195	-.103 .152 195	-.262(**) .000 195
Social Role	.680(**) .000 197	.572(**) .000 197	1 .000 197	.802(**) .000 197	-.427(**) .000 196	-.377(**) .000 195	-.302(**) .000 195	-.445(**) .000 195	-.286(**) .000 195	-.028 .701 195	-.289(**) .000 195
SEVERITY OF DISTURBANCE	.949(**) .000 197	.791(**) .000 197	.802(**) .000 197	1 .000 197	-.518(**) .000 196	-.482(**) .000 195	-.331(**) .000 195	-.539(**) .000 195	-.340(**) .000 195	-.155(*) .030 195	-.330(**) .000 195
SOCIAL DESIRABILITY	-.502(**) .000 196	-.378(**) .000 196	-.427(**) .000 196	-.518(**) .000 196	1 .000 201	.291(**) .000 198	.288(**) .000 198	.215(**) .002 198	.020 .777 198	.189(**) .008 198	.201(**) .004 198
TOTAL WELLNESS	-.446(**) .000 195	-.421(**) .000 195	-.377(**) .000 195	-.482(**) .000 195	.291(**) .000 198	1 .000 201	.752(**) .000 201	.702(**) .000 201	.552(**) .000 201	.652(**) .000 201	.727(**) .000 201
Creative Self	-.276(**) .000 195	-.335(**) .000 195	-.302(**) .000 195	-.331(**) .000 195	.288(**) .000 198	.752(**) .000 201	1 .000 201	.422(**) .000 201	.503(**) .000 201	.329(**) .000 201	.402(**) .000 201
Coping Self	-.505(**) .000 195	-.436(**) .000 195	-.445(**) .000 195	-.539(**) .000 195	.215(**) .002 198	.702(**) .000 201	.422(**) .000 201	1 .000 201	.337(**) .000 201	.227(**) .001 201	.403(**) .000 201
Social Self	-.242(**) .001 195	-.429(**) .000 195	-.286(**) .000 195	-.340(**) .000 195	.020 .777 198	.552(**) .000 201	.503(**) .000 201	.337(**) .000 201	1 .000 201	.226(**) .001 201	.243(**) .001 201
Essential Self	-.191(**) .008 195	-.103 .152 195	-.028 .701 195	-.155(*) .030 195	.189(**) .008 198	.652(**) .000 201	.329(**) .000 201	.227(**) .001 201	.226(**) .001 201	1 .000 201	.283(**) .000 201
Physical Self	-.308(**) .000 195	-.262(**) .000 195	-.289(**) .000 195	-.330(**) .000 195	.201(**) .004 198	.727(**) .000 201	.402(**) .000 201	.403(**) .000 201	.243(**) .001 201	.283(**) .000 201	1 .000 201

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

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

Partial Correlation

A partial correlation was then computed between total Wellness (5F-Wel) and Severity of Disturbance (OQ-45.2), holding constant or controlling for Social Desirability (MCSDS). If Social Desirability, or socially desirable response bias, is a principle determinant of Wellness, the partial correlation between Wellness and Severity of Disturbance should not be significant. The results suggest, however, that Wellness scores were still moderately negatively related to Severity of Disturbance, $r(191) = -.39$, $p < .01$, when extracting the effects of Social Desirability. This coefficient could also be squared to produce the coefficient of determination. In this case, $(-.3885)^2 = .1509$. When compared to the coefficient of determination from the zero order partials between total Wellness and Severity of Disturbance, $r(192) = -.4795$, and $(-.4795)^2 = .2299$, it could be said that using a zero order partial variance of 23.0%, approximately 15.1% of the variance in total Wellness could be attributed to Severity of Disturbance and vice versa. Zero order partials and partial correlation results are summarized in Tables 6, 7, 8, and 9.

A second partial correlation was computed between total Wellness (5F-Wel) and Social Desirability (MCSDS), holding constant or controlling for Severity of Disturbance (total OQ-45.2). If Severity of Disturbance is a principle determinant of Wellness, the partial correlation between Wellness and Social Desirability should not be significant. The results confirm this as wellness scores

were not statistically significantly related to Social Desirability, $p > .05$, when extracting the effects of Severity of Disturbance.

Finally, a partial correlation was computed between Social Desirability and Severity of Disturbance, holding constant or controlling for Wellness. If Wellness is a principle determinant of Social Desirability, the partial correlation between Social Desirability and Severity of Disturbance should not be significant. The results suggest, however, that Social Desirability scores were still moderately negatively related to Severity of Disturbance, $r(191) = -.4354$, $p < .01$, when extracting the effects of Wellness. This coefficient could also be squared to produce the coefficient of determination. In this case, $(-.4354)^2 = .1896$. When compared to the coefficient of determination from the zero order partials between Severity of Disturbance and Social Desirability, $r(192) = -.5147$, and $(-.5147)^2 = .2649$, it could be said that when comparing the zero order partial variance of 26.5%, approximately 19.0% of the variance in Social Desirability could be attributed to Severity of Disturbance when removing the effects of Wellness and vice versa.

Table 6. Zero Order Partial

	Severity of Disturbance (Total OQ-45.2)	Total Wellness (5F-Wel)	Social Desirability (MCSDS)
Severity of Disturbance (Total OQ-45.2)	1.0000 (0) P = .	-.4795 (192) P = .000	-.5147 (192) P = .000
Total Wellness (5F-Wel)	-.4795 (192) P = .000	1.0000 (0) P = .	.3179 (192) P = .000
Social Desirability (MCSDS)	-.5147 (192) P = .000	.3179 (192) P = .000	1.0000 (0) P = .

(Coefficient / (D.F.) / 2-tailed Significance)

". ." is printed if a coefficient cannot be computed

Table 7. Partial Correlation Controlling for Social Desirability (Total MCSDS)

	Severity of Disturbance (Total OQ-45.2)	Total Wellness (5F-Wel)
Severity of Disturbance (Total OQ-45.2)	1.0000 (0) P= .	-.3885 (191) P= .000
Total Wellness (5F-Wel)	-.3885 (191) P= .000	1.0000 (0) P= .

(Coefficient / (D.F.) / 2-tailed Significance)

". ." is printed if a coefficient cannot be computed

Table 8. Partial Correlation Controlling for Severity of Disturbance (Total OQ-45.2)

	Social Desirability (MCSDS)	Total Wellness (5F-Wel)
Social Desirability (MCSDS)	1.0000 (0) P= .	.0945 (191) P= .191
Total Wellness (5F-Wel)	.0945 (191) P= .191	1.0000 (0) P= .

(Coefficient / (D.F.) / 2-tailed Significance)

". ." is printed if a coefficient cannot be computed

Table 9. Partial Correlation Controlling for Total Wellness (Total 5F-Wel)

	Severity of Disturbance (Total OQ-45.2)	Social Desirability (MCSDS)
Severity of Disturbance (Total OQ-45.2)	1.0000 (0) P= .	-.4354 (191) P= .000
Social Desirability (MCSDS)	-.4354 (191) P= .000	1.0000 (0) P= .

(Coefficient / (D.F.) / 2-tailed Significance)

". ." is printed if a coefficient cannot be computed

Statement about Research Hypotheses

Null Hypothesis 1. There is no relationship between level of psychological disturbance and level of wellness in entering master's-level counseling students. This null hypothesis was rejected in favor of the alternative hypothesis.

Alternative Hypothesis 1. There is a negative relationship between level of psychological disturbance and level of wellness in entering master's-level counseling students. The alternative hypothesis was supported.

Null Hypothesis 2. There is no relationship between level of wellness and social desirability in entering master's-level counseling students. Although initial analysis suggested significance related to rejecting the null, further analysis failed to reject the null.

Alternative Hypothesis 2. There is a positive relationship between level of wellness and social desirability in entering master's-level counseling students. The alternative hypothesis was not supported in favor of the null hypothesis.

Null Hypothesis 3. There is no relationship between level of psychological disturbance and social desirability in entering master's-level counseling students. This null hypothesis was rejected in favor of the alternative hypothesis.

Alternative Hypothesis 3. There is a negative relationship between level of psychological disturbance and social desirability in entering master's-level counseling students. The alternative hypothesis was supported.

Exploratory Data Analysis

The decision was made to further explore the mean Wellness (5F-Wel first and second factor) scores for participants who scored above and below clinical significance on the OQ-45.2. This decision was made because of the statistical significance of 22 out of the 24 correlations generated between the total and subscale scores of the 5F-Wel and the OQ-45.2; because the partial correlation was statistically significant between Severity of Disturbance (OQ-45.2) and total Wellness (5F-Wel), even after removing the effects of Social Desirability (MCSDS); and because cutoff scores for the OQ-45.2 have been established as clinically relevant (Lambert, et al., 2004). Every total Wellness and second-order factor mean scores of those scoring above the cutoff for Severity of Disturbance, difficulty in Interpersonal Relations, Symptom Distress, and Difficulty in Social Roles were lower than those scoring below each cutoff score (see Table 10).

Table 10. Comparison of Mean Wellness (5F-Wel) and Social Desirability (MCSDS) Scores for Participants Who Scored Above and Below Clinical Cutoff Scores for Disturbance (OQ-45.2)

	Clinical Cutoff	Total Wellness	Creative Self	Coping Self	Social Self	Essential Self	Physical Self	Social Desirability
Severity of Disturbance (Total OQ-45.2)	> 63	76.27	80.05	69.11	88.18	82.88	63.70	11.00
	≤ 63	82.31	83.79	78.03	93.81	85.12	73.82	18.03
Difficulty in Interpersonal Relations	≥ 15	78.44	80.12	72.69	88.16	84.33	68.79	14.55
	< 15	82.32	84.04	77.91	94.22	84.99	73.47	17.83
Symptom Distress	≥ 36	76.75	80.46	69.59	89.24	81.83	64.81	12.39
	< 36	82.45	83.85	78.22	93.83	85.37	73.94	18.09
Difficulty in Social Roles	≥ 12	76.63	79.54	70.97	87.89	82.96	62.42	13.24
	< 12	82.65	84.13	78.21	94.24	85.26	74.69	18.09

CHAPTER FIVE: DISCUSSION

In chapter four, the statistical results exploring the relationships among the individual variables of Wellness, Severity of Disturbance, Social Desirability, and their subscales were presented. The results showed statistically significant relationships between 52 out of 55 correlations between scale and subscale scores measuring the above-mentioned variables.

Next, the results will be discussed. This chapter is organized into the following sections: (1) a brief overview of the study, (2) factors to consider in interpreting the results, (3) a discussion of the results presented in chapter four, (4) implications for the profession of counseling, (5) suggestions for future research, and (6) conclusion.

Overview of the Study

A wellness paradigm may hold promise for unifying and strengthening the identity of the counseling profession. The construct of wellness may also hold implications for assessment of entering master's-level counseling students, as a tool for continuous evaluation of students, or for overall program evaluation. In the current study, the only counseling-based wellness assessment measure, the Five Factor Wellness Evaluation of Lifestyle (5F-Wel), was tested for its

relationship to two other constructs: psychological disturbance and social desirability.

The ability of a wellness instrument to reflect differences in psychological disturbance is particularly important in the field of counseling. Gladding (2001) defined counseling as “the application of mental health, psychological or human development principles, through cognitive, affective, behavioral or systematic interventions, strategies that address wellness, personal growth, or career development, as well as pathology” (p. 32). Additionally, the susceptibility of items to distortion on any given test threatens its generalizable usefulness, specifically its reliability and validity. A major criticism of self-report instruments, particularly psychological surveys, is susceptibility to socially desirable response bias (Crowne & Marlowe, 1960; Edwards, 1957, 1990; Mabe & West, 1982; Beretvas, Meyers, & Leite, 2002).

This study was designed to explore the relationships among wellness, severity of disturbance, and social desirability in entering master’s-level counseling students. In order to test the research hypotheses, a total of nine programs (in five states) and 204 students completed instrumentation packets comprised of the Five-Factor Wellness Evaluation of Lifestyle (5F-Wel), the Marlowe-Crowne Social Desirability Scale (MCSDS), and the Outcome Questionnaire – 45.2 (OQ-45.2).

The results of the study were explored by first examining the effects of gender, ethnicity / race, and age through the use of ANOVA. Next, measures of

central tendency and ranges were examined in relation to the instruments' normed means and cutoff scores using one sample t-tests and case selection. Then, the relationships among the variables were studied by examining the correlations between scale and subscale scores. The possibility of one construct mediating the relationship between the other two was further examined through partial correlation of variables intended to measure the constructs. The effects of one variable were removed to better examine the relationship between the other two main variables of interest. Finally, a comparison of Wellness scores were compared based upon the grouping of participants above or below cutoff scores for Severity of Disturbance.

The results of the analyses indicated statically significant relationships in 52 out of 55 correlations. No mean differences in scores were found in regard to gender, ethnicity / race, and age except for small differences in ethnicity / racial identity groups in OQ-45.2 and MCSDS scores, (7% and 6.3% of the variance, respectively and post hoc analysis did not detect any significance between specific groups) and between the age group 21-24 years old and 35-39 years old in total Wellness (5F-Wel) scores (5.3% of the variance). Scheffe post hoc analysis revealed the statistically significant difference in means ($p < .05$) between age group 21-24 years old and 35-39 years old in total Wellness (5F-Wel) scores.

Factors to Consider in Interpretation of Results

Examining relationships between variables precluded the use of causal experimental design and conclusions. Additionally, since the researcher needed to gain entry to various programs, and participation was contingent upon both program approval and voluntary individual participation, population sample could not be randomized. Also, due to the fact that there were low numbers of males ($n = 24$) in comparison to females ($n = 180$) participating in the study, and based on means that may be overrepresentative of females (there are more females entering counseling programs than males and there are more females seeking counseling services than males), there may not be significant power to completely remove the risk of Type II error. Caution should be exercised in the application of this study's findings. Due to the large number of white/Caucasian women in their 20s ($n = 84$; 41.2%), findings may be more applicable to entering master's-level counseling student representing the same group than students representing other combinations of race/ethnicity, age, and gender. However, the results are still useful and contribute to the growing database of 5F-Wel mean scores. Finally, some master's-level counseling programs allow students to take a limited number of classes prior to admission into the program. This created the potential for some participants to have been exposed to program philosophy within the context of the classroom compared to other participants who had yet to

begin didactic training. However, lack of social desirability response bias indicated lack of some of this effect's significance.

Discussion of the Results

Numerous peer-reviewed articles in professional counseling journals have raised the concern about counselor trainee or counselor impairment (Emerson & Markos, 1996; Frame & Stevens-Smith, 1995; Gaubatz & Vera, 2002; Hazler & Kottler, 1996; Herlihy, 1996; Li, 2001; Olsheski & Leech, 1996; and Sheffield, 1998). Simultaneously, the professional organizations representing the counseling profession have placed an emphasis on the personal development and wellness of counseling students (AACD, 1991; ACES, 1995). Yet, no research study published in the counseling literature to date has specifically established the relationship between the wellness and psychological disturbance of counseling students, counselors, or clients. Furthermore, the only instrument measuring wellness based upon counseling theory has yet to be tested for socially desirable response bias (Myers, Mobley & Booth, 2003). Thus, the purpose of this study was to contribute to an understanding of the relationship among wellness, psychological disturbance, and social desirability in entering master's-level counseling students by examining the variables Wellness, Severity of Disturbance, and Social Desirability. Alternative hypotheses stated that

differences would be observed among the variables in entering master's-level counseling students.

The results of the study found two statistically significant relationships between the main variables of interest, thus, rejecting null hypotheses 1 and 3. Alternative hypotheses 1 and 3 were supported in the stated direction. The results of the study failed to reject null hypothesis 2. Overall, the results of this study suggest that both wellness and social desirability are negatively related to psychological disturbance. Although deemed statistically significant initially, the relationship between wellness and social desirability was found to have no statistical significance after removing the influence of the third mediating variable. Next, a discussion of each of the hypotheses in relation to this study's findings and the existing body of literature is discussed.

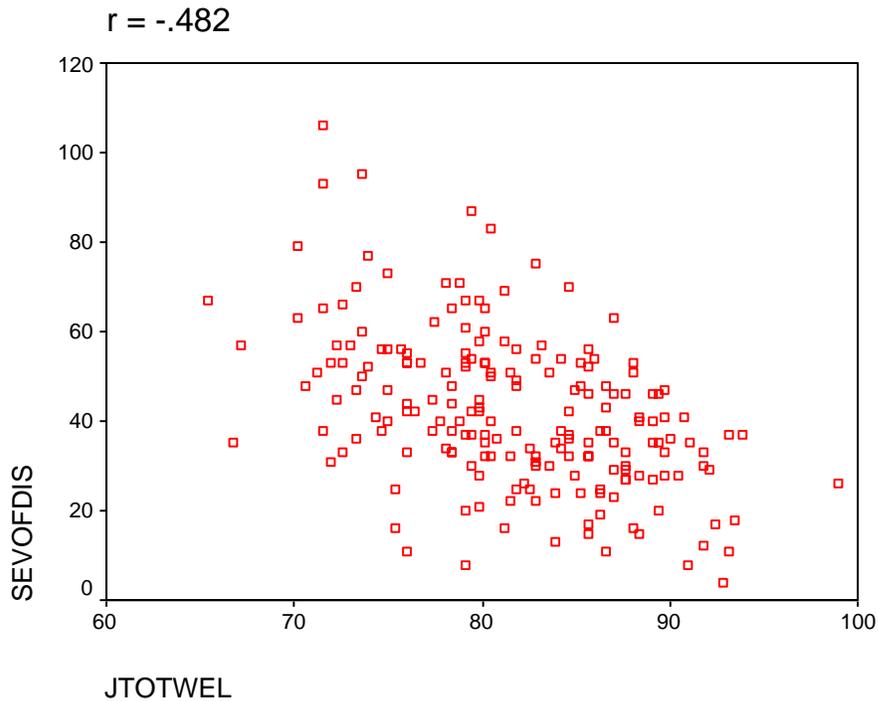
Results and Integration of Hypothesis 1

White (1980) found that almost half of all full-time counselor education faculty valued personal development more than any other factor in the discrimination between successful counseling students and unsuccessful ones. Roach (2005) found that both faculty and students believed that their personal wellness was essential for their effectiveness with clients. However, there is no research to date that has studied the causal relationship between wellness and client outcome. One reason for this may be due to the fact that causal research

is expensive and there are no correlational studies defining a specific relationship between psychological disturbance and wellness.

One purpose of this study, then, was to examine the relationship between wellness as measured by the only instrument measuring wellness based on counseling theory, and psychological disturbance as measured by a well-established outcome measure, the Outcome Questionnaire-45.2. The null hypothesis was rejected in favor of the alternative hypothesis; there was a negative relationship between level of psychological disturbance and level of wellness in entering master's-level counseling students (see Figure 1). This finding was deemed statistically significant even after removing the effects of social desirability. This relationship is indicative of a valid instrument purporting to measure the construct wellness. This study contributes to the construct validity of the 5F-Wel because the results demonstrate an inverse relationship to severity of disturbance.

Figure 1. Pearson Correlation Coefficients Scatterplot for Wellness and Severity of Disturbance



Results and Integration of Hypothesis 2

Even very ordinary questions that seem, on the surface, to have little social desirability consistently have been found to exhibit a socially desirable response effect (Dillman, 2000). Studies measuring behaviors known to be socially desirable, such as physical exercise, have detected socially desirable response bias (Motl, McAuley, & DiStefano, 2005). Myers, Mobley, and Booth (2003) suggested the possibility that counseling students might be “faking good”

in their responses to questions measuring wellness. Another purpose of the present study was to examine the relationship between wellness and social desirability.

Initially, the Pearson product moment correlation coefficient calculated a statistically significant positive relationship between Wellness and Social Desirability scores. However, upon further statistical testing removing the effects of Severity of Disturbance, the relationship between Wellness and Social Desirability was found to have no statistically significant relationship. Therefore, the results failed to reject the null hypothesis. This finding contributes to the reliability and validity of the 5F-Wel by suggesting that there was no linear pattern between responses to items measuring wellness and responses to items measuring social desirability in entering master's-level counseling students.

Results and Integration of Hypothesis 3

Mental health providers are a diverse group with regard to training standards, licenses, theoretical orientations, histories, philosophies, and specialties (Fall, Levitov, Jennings, & Eberts, 2000). Yet, the clients served and the services provided are often similar (Hanna & Bemak, 1997). In an era of managed health care and other accountability pressures, mental health care providers must be able to justify their services as well as maximize their service-

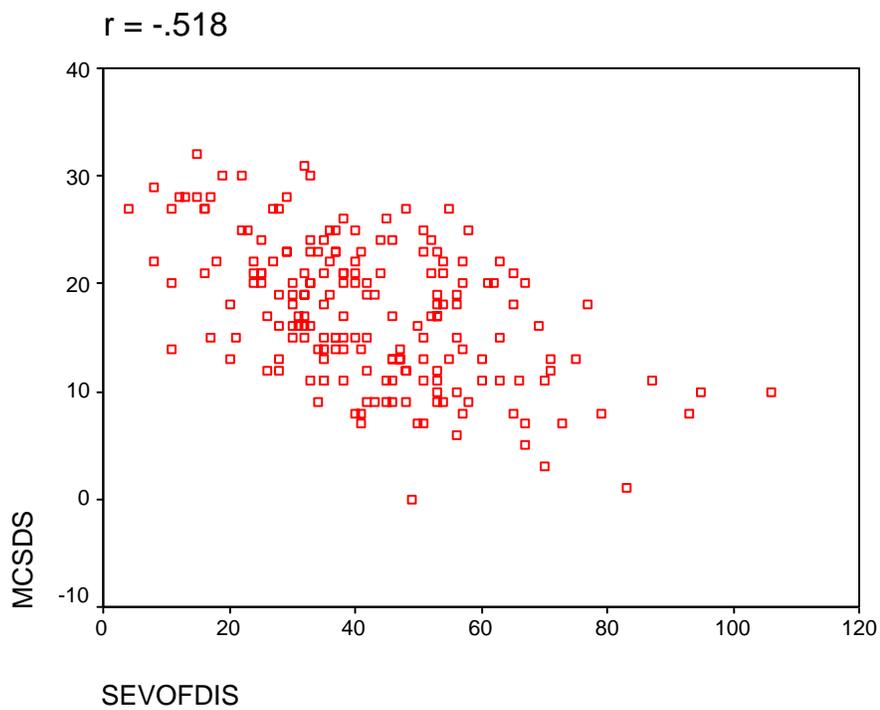
to-cost ratio (Lambert & Finch, 1999). Faced with these conditions, the need to communicate a unique identity becomes all the more crucial (Fall, et. al., 2000).

The profession of counseling could communicate a unified philosophy and decide more firmly how to exist separately from what the medical model (and all other mental health specialties) values. Wampold (2001) explained three choices: learning how to assimilate into the dominant culture (medical model), complete separation as a minority culture, or deciding to stand side by side as equals. Wellness could be a construct the profession of counseling chooses for its unique identity, particularly if research of traditional methodology supports the effectiveness of wellness related to client outcomes. This study was necessary to establish and define the relationship between psychological disturbance and wellness. The last major purpose of this study was to examine the relationship that completes the triangle in the current research. In this study, the OQ-45.2 was tested for its susceptibility to social desirability as well as the possibility that the MCSDS could be measuring more than only social desirability (Miotto, De Coppi, Frezza, Rossi, & Preti, 2002).

The strongest relationship was found to exist between level of psychological disturbance and social desirability (see Figure 2). Even after removing the effects of wellness, the correlation coefficient suggested a statistically significant moderate negative relationship. Therefore null hypothesis 3 was rejected in favor of the alternative hypothesis. As would be expected, this finding suggests that psychological disturbance was not socially desirable.

Moreover, those participants scoring above cutoff scores on the OQ-45.2 consistently indicated lower mean social desirability and wellness scores (see Table 10 in chapter 4).

Figure 2. Pearson Correlation Coefficients Scatterplot for Severity of Disturbance and Social Desirability



Implications

Counselor Education

Skovholt (2001) discussed the importance of preparing resilient practitioners. Counselors-in-training are at particular risk for stress and distress in part due to the difficulty in mastering the ambiguity of the counseling process and the nature of working with clients who often are experiencing great pain (Skovholt, 2001). Perhaps one place to strengthen the developmental wellness identity of the counseling profession is within counselor preparatory programs. Counselor education programs could use wellness models and / or a wellness instrument to initiate discussions about the importance of self-care for professionals in the field of counseling. Myers and Sweeney (2005) believed that the most important use of wellness models was “as a basis for self-understanding and intentional decision making to enhance wellness in a positive direction” (p. 39). Additionally, use of a wellness instrument could assist in communicating a strengths-based focus for conceptualizing human functioning rather than pathological models used by other mental health professions.

This study established a clear inverse relationship between the most common form of counselor impairment, psychological distress or compromised mental health, and wellness in entering master’s level counseling students. This suggests that information obtained through wellness assessment might be useful

in addressing impairment or other psychologically-related concerns affecting didactic or clinical performance.

Overall, this study supports previous research indicating that counseling students may have higher levels of wellness than the normed population (Myers, Mobley, & Booth, 2003) (see Table 4 in chapter 4). This study also addressed the need to test the 5F-Wel for its susceptibility to socially desirable response bias and to determine the wellness of counseling students at the time they begin taking classes (Myers, Mobley, & Booth, 2003). Results indicated that responses on the 5F-Wel were not statistically significantly related to Social Desirability after removing the effects of Severity of Disturbance. This finding addresses some of the concern related to validity of self-report instruments in regard to the risk of distortion. Results also provide mean wellness, disturbance, and social desirability scores for master's-level counseling students at the time of entry into the program.

Additionally, this study found that while overall, counseling students report higher levels of wellness than the normed population, there was a proportion of entering master's-level students who were at clinically significant disturbance levels upon entering their programs. Considering the potentially harmful and costly consequences of impaired graduate students (Bemak, Epp, & Keys, 1999), the results of this study may provide support for use of a wellness instrument for screening, evaluating, and promoting wellness in graduate counseling programs.

This study found that 10.7% of the sample scored above the clinical cutoff score for severity of disturbance, indicating that they were currently experiencing levels of anxiety, depression, somatic problems, stress, as well as interpersonal difficulties and difficulties in social roles at levels seen in patients in clinical settings. The highest percent of the sample above cutoff subscale scores was 16.8% for each of two subscales: Interpersonal Relationships and Social Roles. This indicates that 16.8% of the sample was experiencing clinically significant difficulty in interpersonal relationships with complaints such as loneliness, conflict with others, and marriage and family difficulties. Also, 16.8% indicated clinically significant difficulties fulfilling workplace, student, or home duties, and more specifically, conflicts at work, overwork, distress and inefficiency in these roles (Lambert et. al., 2004).

Another possible explanation for the rates of those indicating clinical levels of disturbance is that entering master's-level counseling students may be more aware of, more willing to admit to, or place a higher significance on personal psychological disturbance, thereby scoring abnormally high in relation to normed populations. Further research might indicate more appropriate OQ-45.2 cutoff scores for entering master's-level counseling students.

Future Research

This study provides necessary information to support several areas of future research. Such research might include studying the effect of wellness counseling on the severity of disturbance found in master's-level counseling students or other populations of interest. Counselor education programs might also wish to assess their students and compare their findings to those in this study for purposes of program evaluation.

Next, the 5F-Wel offers a holistic assessment of the person of the counselor in ways that other instruments cannot (i.e., those measuring specific psychological constructs such as personality). It might be necessary to study how the highest and lowest mean wellness second and third order factor scores relate to counseling students' abilities to expand upon the importance of individual factors in their own counseling with clients. For example, this study found the highest second order wellness factor to be Social Self and the highest third order factor to be Love, which is a supporting factor of Social Self. The lowest third order factor was Realistic Beliefs, which is a supporting factor of Coping Self. The lowest second order factor was Physical Self supported by the second-to-lowest third order factor, Nutrition.

Lastly, given that 10.7% of the sample scored above the clinical cutoff score for severity of disturbance, further research might address specific study of this population. Although this study did not support the finding that counseling

students have higher levels of psychological disturbance than the general populace (White & Franzoni, 1990), more research is needed to examine the relationship between participation in the program and disturbance, specifically, how counselor educators might assist these students once they have gained admission to their programs. Lastly, the question of ethical responsibility upon finding severity of disturbance levels above clinical cutoff scores in entering master's-level counseling students needs to be addressed.

Conclusion

The predominant rationale of the study was to test the 5F-Wel's ability to measure the construct wellness in its relationship to the constructs psychological disturbance and social desirability. Due to the importance of admissions and evaluation procedures in counselor education, as well as the importance of strengthening the counseling profession's unique identity, this study could benefit counselor education programs throughout the United States. Additionally, this study could serve as the precursor to more expensive studies of the effect of wellness on client outcomes.

This study established a clear connection between wellness and psychological disturbance. As the profession of counseling decides its fate related to professional identity, it is projected that one of three things will happen Wampold (2001): we will learn how to assimilate into the dominant culture

(medical model), choose separation or become isolated as a minority culture, or decide to stand side by side as equals, but with a unique alternative or complementary approach to mental health. The results of this study offer support for any of the three choices, but might best offer support for a unique identity for the profession of counseling to stand side by side as equals in the array of services offered to clients.

In the Report of the Surgeon General, Executive Summary, Department of Health and Human Services (1999), David Satcher, Surgeon General U.S. Public Health Service, stated that “promoting mental *health* (this author’s emphasis) for all Americans will require scientific know-how but, even more importantly, a societal resolve that we will make the needed investment. The investment does not call for massive budgets; rather, it calls for the willingness of each of us to educate ourselves and others about mental *health* and mental illness” (p. 5).

APPENDIX A: IRB LETTER



Office of Research & Commercialization

August 10, 2005

Ms. Heather L. Smith
c/o Dr. David Carson
University of Central Florida
College of Education
Orlando, FL 32816-1250

Dear Ms. Smith:

With reference to your protocol #05-2782 entitled, "**The Relationship among Wellness, Psychological Distress, and Need for Social Approval of Entering Master's Level Counseling Students**" I am enclosing for your records the approved, expedited document of the UCFIRB Form you had submitted to our office. **This study was approved on 8/9/05 and the expiration date will be 8/8/06.** Should there be a need to extend this study, a Continuing Review form must be submitted to the IRB Office for review by the Chairman or full IRB at least one month prior to the expiration date. This is the responsibility of the investigator. **Please notify the IRB office when you have completed this research study.**

Please be advised that this approval is given for one year. Should there be any addendums or administrative changes to the already approved protocol, they must also be submitted to the Board through use of the Addendum/Modification Request form. Changes should not be initiated until written IRB approval is received. Adverse events should be reported to the IRB as they occur.

Should you have any questions, please do not hesitate to call me at 407-823-2901.

Please accept our best wishes for the success of your endeavors.

Cordially,

Barbara Ward
Barbara Ward, CIM
IRB Coordinator

Copies: IRB File
David Carson, Ph.D.

BW:jm

12443 Research Parkway • Suite 302 • Orlando, FL 32826-3252 • 407-823-3778 • Fax 407-823-3299

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APPENDIX B: PERMISSION TO USE THE 5F-WEL AND THE OQ-

45.2

PERMISSION TO USE THE 5F-WEL

The authors of the 5F-Wel and I are happy to give our permission for your use of the instrument in your research. We will provide scoring services per the following procedures:

1. I will send you:

one copy of the 5F-Wel which you can copy .
one copy of a standard NCS five-response answer sheet if you do not have one or the number of NCS sheets you will need for your study (the cost is 5 cents each); otherwise I will send a data set up for SPSS or Excel so you can e-mail the raw data for scoring. It is essential that the proper answer sheet be used or it cannot be scanned. You may copy the 5F-Wel and can purchase answer sheets for your use.

2. You will need to specify the nature of your population. I will then assign you a three digit key code which can be written and bubbled in on all of your forms.

3. If you will be using the scantrons, as a pilot, please complete one answer sheet and mail it to me. This is to verify that all instructions are followed and all data requested are provided. You will need to assure that all of your participants provide *all* of the requested data.

4. When you have collected all of your data, review your bubble sheets and edit them as necessary for demographic items and missing data. Then, put them all in the same order (one edge of the page is cut so they can be matched, all right side up and facing forward). It is always recommended that you edit your data sets in advance of scoring to assure accurate scores. I have verification procedures to assure that certain aspects of your data have been coded accurately and I will check these before scoring.

5. I will have the data scanned, which takes anywhere from one day to two weeks, depending on when it arrives. We are on a semester system and scanning of midterms and finals takes priority. No scanning services are available during university breaks and holidays. I may not be available on regular university breaks and holidays for scoring assistance. You will need to keep me apprised of your timeline so that I can coordinate my schedule with yours to assure that your scores arrive in a timely manner.

6. I will score the data using SPSS for windows. My preference is to e-mail the data file to you. It can also be sent on a disk, but you will have to provide the disk and pay postage. The data file will contain all of the demographic

information, item responses, and subscale scores for your participants. I will include raw scores and J-scores, which are explained in the manual (2005 edition).

7. I will provide a syntax file to assist you in interpreting the variables in the data set. I will not provide you with the scoring protocol - that is, I will not tell you which items score on which subscales. The authors are continually revising the instrument and have agreed to maintain control of the scoring so as not to have multiple copies of various versions of the instrument in circulation.

8. The manual includes all of the psychometric data you will need for your research proposal, and numerous articles and recent book explain the Indivisible Self Model. Please let me know if you need references or copies of articles. A number are listed on my web page, some of which are in press (<http://www.uncg.edu/~jemyers>).

9. We have instituted a fee of \$1.00 per 5F-Wel for scoring services and appreciate your cooperation in sending a check with your bubble sheets or separately at the time you send your electronic file. Scores will be returned after payment is received.

10. We assume that you will follow requisite IRB procedures at your institution and obtain informed consent from all of your participants. We reserve the right to include your data in our main data set for instrument development and do not think you need to include this information in your consent form, as no individual scores or information from your data individually or collectively will ever be used in our work with the 5f-Wel. Your data may be part of a large data set that we analyze at some point in the future as the instrument continues to evolve.

Please let me know if there is anything else I can do to assist you in your research.

Jane Myers, Ph.D., LPC

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(20050501 Mail or Fax Form)

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9. Construction. The language used in this Agreement is the language chosen by the Parties to express their mutual intent, and no rule of strict construction shall be applied against any Party.

10. Entire Agreement. This Agreement is the entire agreement of the Parties relating to the QQ® Product.

11. Governing Law. This Agreement is made and entered into in the State of Utah and shall be governed by the laws of the State of Utah. In the event of any

litigation or arbitration between the Parties, such litigation or arbitration shall be conducted in Utah and the Parties hereby agree and submit to such jurisdiction and venue. Notice to commence any litigation or arbitration should be directed to: OQ MEASURES LLC, 2150 S 1300 E, Ste 529, Salt Lake City, Utah 84106.

12. Modification. This Agreement may not be modified or amended.

13. Transferability. This Agreement may not be transferred, bartered, loaned, assigned, leased or sold by the licensee.

14. Violations. Violations of any provision or stipulation of this Agreement will result in immediate revocation of this license. Punitive damages may be assessed.

APPENDIX C: INFORMED CONSENT

Consent for Participation

Researcher Information:

Name: Ms. Heather L. Smith
Address: College of Education
University of Central Florida
P. O. Box 161250
Orlando, FL 32816
Phone: (407) 823-1339

Name: Dr. David Carson
Address: UCF Academy for Teaching,
Learning and Leadership
University of Central Florida
TA 93, Room 420
Post Office Box 161250
Orlando, FL 32816-1250
Phone: (407) 823-2140

Thank you for agreeing to participate in this study which will take place from August 18, 2005 to February 1, 2006. This form outlines the purposes of the study and provides a description of your involvement and rights as a participant.

The purpose of this project is to gain insight regarding individuals' self-report upon entering their master's-level counseling programs. Participation is voluntary and participants will be asked to complete research questionnaires that will take approximately 25-30 minutes total. Research coordinators will be available to answer questions during the completion of the questionnaires. All materials necessary (number-coded questionnaires, pencils, and tables/desks) will be provided for completing the questionnaires. This consent form will be kept separate from the number-coded questionnaires, and therefore your responses will be confidential and secured. No compensation will be offered for participation.

You are encouraged to ask any questions at any time about the nature of the study and the methods used. Your suggestions and concerns are important to me; please contact me at any time at the address/phone number listed above.

I guarantee that the following conditions will be met:

- 1) Your name will not be used at any point of data analysis, data storage, or in the written case report; instead, data will be compiled and variables will be examined by statistical software, SPSS. All written records and reports will be based upon the compiled data. At the conclusion of the study, all consent forms with your signature will be destroyed.
- 2) Upon your granting permission for this research, the information collected will not be used for any purpose other than for this research study under the Principal Investigator.
- 3) Your participation in this research is voluntary; you have the right to withdraw at any point of the study, for any reason, and without any prejudice, and the information collected will be turned over to you.

I agree to the terms and that I am 18 years of age or older.

Respondent _____ Date _____

Researcher _____ Date _____

APPENDIX D: DEMOGRAPHIC QUESTIONNAIRE

Demographic Questions:

1. Your age: _____
2. Your gender: _____
3. Ethnicity/race: _____
4. Undergraduate major(s): _____
5. Professional experience related to counseling (please circle all that apply below):
 - a. I have experience working in schools
 - b. I have worked within an agency where professional counseling services were provided
 - c. I have worked in career counseling or advising
 - d. other (please write in): _____
6. How many years of experience in the above response? _____
7. Is your program CACREP-accredited? Yes No
8. Does your program require mandatory personal counseling? Yes No
9. Have you ever received personal counseling? Yes No
10. Approximately how many sessions of counseling have you had in your life?

11. What is your motivation for entering the master's counseling program?

Thank You!

APPENDIX E: LETTER OF INSTRUCTION TO FACULTY
CONTACTS

Dear Dr. _____,

Thank you for assisting with my dissertation research, *The Relationship among Wellness, Psychological Disturbance and Social Desirability in Entering Master's-Level Counseling Students*. Here are some brief instructions:

Please give each student an envelope. Each envelope includes:

- Participant Instructions
- Informed Consent
- Demographic Questionnaire
- 5F-Wel – Adult Version
- Bubble sheet for 5F-Wel responses (please use No. 2 pencil included)
- Personal Reaction Inventory
- OQ-45.2

Students are to complete the assessments according to the instructions. When they are finished, they are to put everything (except the Informed Consent) back into their envelope and seal it. They will give you the sealed envelope and their Informed Consent to be put in the separate envelope labeled "Informed Consents." The ONLY place where they put their names is on the Informed Consent, which will be kept separate from the individual instrument packets.

Please put the sealed envelopes with the completed instruments and the envelope with the Informed Consents into the pre-paid postage package I have included and mail to:

Heather L. Smith
585 Rachael Court
Oviedo, FL 32765

My number is 407-359-8871 and my email is heathersmith@earthlink.net
Feel free to contact me if you have any additional questions.

Thank you very much for your help.

Sincerely,

Heather L. Smith
Doctoral Candidate
Counselor Education
University of Central Florida

APPENDIX F: LETTER OF INSTRUCTION TO PARTICIPANTS

Thank you for participating in this research.

Enclosed in this packet are:

- The Informed Consent
- Demographic Questionnaire
- 5F-Wel – Adult Version
- Bubble sheet for 5F-Wel responses
- Personal Reaction Inventory
- OQ-45

Please follow these instructions:

1. Read, sign and date the Informed Consent.
2. Complete the Demographic Questionnaire.
3. Complete **on the bubble sheet** for the 5F-Wel:

Your gender and birth date only.

Items 1 – 100:

- a. Items 1 – 91: A – Strongly Agree
 B – Agree
 C – Disagree
 D – Strongly Disagree

- b. Items 92 – 100: More demographic questions

4. Complete the Personal Reaction Inventory and the OQ-45.
5. When you are finished place everything EXCEPT the Informed Consent back into your envelope and seal it. Give your sealed envelope and Informed Consent back to the person who handed out your packet.

Please note:

Your I. D. number is already completed.

Please do not put your name on anything except the Informed Consent.

Thank you.

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