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The Helping Professional Wellness Discrepancy Scale (HPWDS): Development and Validation

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THE HELPING PROFESSIONAL WELLNESS DISCREPANCY SCALE (HPWDS): DEVELOPMENT AND VALIDATION

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ABSTRACT

Wellness is an integral component of the helping professions (Myers & Sweeney, 2005; Witmer, 1985). Specifically, wellness is included in ethical codes, suggestions for practice, and codes of conduct throughout counseling, psychology, and social work fields (see American Counseling Association *Code of Ethics*, 2014; American Psychological Association *Ethical Principles of Psychologists and Code of Conduct*, 2010; National Association of Social Workers *Code of Ethics*, 1996). Even so, wellness in helping professionals is a difficult construct to measure. Thus, the purpose of the research investigation was to develop the *Helping Professional Wellness Discrepancy Scale* (HPWDS) and examine the psychometric features of the HPWDS in a sample of helping professionals and helping professionals-in-training. A correlational research design was employed for this investigation (Gall, Gall, & Borg, 2007). Specifically, the researcher examined: (a) the factor structure of the HPWDS with a sample of helping professionals; (b) the internal consistency reliability of the HPWDS; (c) the relationship between HPWDS scores and *Counseling Burnout Inventory* (CBI) scores; (d) the relationships between helping professionals' HPWDS scores and their reported demographic data; and (e) the relationship between HPWDS factor scores and the *Marlowe-Crowne Social Desirability Scale-X1* (MCSDS-X1). The research questions were examined using: (a) Factor Analysis (FA), (b) Cronbach's alpha, (c) Spearman Rho correlation, (d) Multiple Linear Regression (MLR) and (e) internal replication analysis.

A review of the literature is provided, discussing theoretical and empirical support for all the items on the initial model of the HPWDS (n = 92) as well as for all the items included on the final HPWDS exploratory model (n = 22). The researcher investigated helping professionals' perceived levels of wellness, aspirational levels of wellness, and the discrepancy between

perceived and aspirational levels of wellness. The data was collected via online, mail out, and face-to-face administration to increase methodological rigor. The sample size for the investigation was 657, with 88 coming from Face-to-Face sampling, 87 from mail out sampling, and 484 from online/email sampling. Data analysis resulted in a five-factor exploratory HPWDS model that accounted for 69.169% of the total variance. Model communalities were considered acceptable with only three communalities below the recommended .5 value. Factor 1 represented *Professional & Personal Development Activities* and accounted for 32.605% of the variance, Factor 2 represented *Religion/Spirituality* and accounts for 13.151% of the variance, Factor 3 represented *Leisure Activities* and accounted for 9.443% of the variance, Factor 4 represented *Burnout* and accounted for 7.198% of the variance, and Factor 5 represented *Helping Professional Optimism* and accounted for 6.773% of the variance.

In addition to a literature review, the research methodology and research results are provided. Results of the research investigation are discussed and areas for future research, limitations of the study, and implications for the helping professions are presented. Some implications of the findings include: (a) a theoretically and methodologically sound instrument for assessing wellness discrepancies in helping professionals is important; (b) helping professionals should be aware of both the personal and professional activities they are engaging in to increase their knowledge and self-efficacy, as well as their leisure activity engagement; (c) it is advantageous for researchers to use the scale development procedures, rigorous sampling methodologies, and FA guidelines outlined throughout Chapters 3 and 4 when developing new assessments for evaluating helping professionals; and (d) a five factor wellness assessment allowing helping professionals to evaluate themselves in Professional & Personal Development

Activities, Religion/Spirituality, Helping Professional Optimism, Leisure Activities, and Burnout arenas is integral in assessing wellness discrepancies in helping professionals.

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CHAPTER ONE: INTRODUCTION

Though definitions of wellness vary within the literature, the World Health Organization defines wellness as "physical, mental, and social wellbeing not merely in the absence of disease" (WHO, 1958, p. 1). A key aspect of the aforementioned definition of wellness is that freedom from illness does *not* equate to being well. Consequently, though many individuals may *not* possess an illness or disease, they are *not* holistically well. Further, certain individuals may have a higher propensity for becoming unwell. For instance, a population that is susceptible to unwellness is the helping profession (Lawson, 2007; Lawson & Myers, 2011; Skovolt, 2001). Thus, for the purpose of this research study, the term *helping professional* includes counselors, psychologists, and social workers as well as counselors-in-training, psychologist-in-training, and social worker-in-training.

Wellness is an integral component of the helping professions (Myers & Sweeney, 2005; Witmer, 1985). Specifically, wellness is included in ethical codes, suggestions for practice, and codes of conduct throughout counseling, psychology, and social work fields (see American Counseling Association *Code of Ethics*, 2014; American Psychological Association *Ethical Principles of Psychologists and Code of Conduct*, 2010; National Association of Social Workers *Code of Ethics*, 1996). Even so, individuals in the helping professions do *not* necessarily practice wellness or operate from a wellness paradigm. In addition, helping professionals are susceptible to becoming unwell, due to the nature of their job (Lawson, 2007; Skovholt, 2001). Further, susceptibility of experiencing burnout, compassion fatigue, vicarious traumatization, and other illness-enhancing issues increase the propensity for helping professionals becoming unwell (e.g., Bakker, Demerouti, Taris, Schaefeli, & Schreurs, 2003; Lambie, 2007; Puig, Baggs, Mixon,

2012; Young & Lambie, 2007). Prolonged periods of stress can also lead to helping professional impairment and burnout, and can influence the quality of services clients receive (Lambie, 2007). Thus, helping professionals who are unwell may *not* offer the best services to their clients (Lawson, 2007) and further, may in turn harm their clients. Thus, it is imperative that wellness of helping professionals is assessed.

As such, assessing wellness is difficult. Though there are scales and assessments for measuring wellness within the literature, *no* assessments are normed to a population of helping professionals. In addition, only a few wellness measures were designed using appropriate scale development procedures as outlined by prominent scale construction scholars (e.g., Crocker & Algina, 2005; DeVellis, 2012; Dimitrov, 2012) and applicable statistical analyses (e.g., Factor Analysis). Further, the majority of wellness scales were created to measure multidimensional qualities of *reported* wellness (e.g., *Five Factor Wellness Inventory*; Hattie, Myers, & Sweeney, 2004; *Lifestyle Assessment Questionnaire*; National Wellness Institute; 1983; *Perceived Wellness Model*; Adams, 1995; Adams, Bezner, & Steinhardt, 1997). Within the multidimensional assessments, constructs such as physical wellness, coping wellness, or occupational wellness are assessed. Thus, a wellness scale measuring different qualities of wellness is innovative. Likewise, a scale assessing for *perceived* (current) wellness, *aspirational* (ideal) wellness, and the discrepancy between perceived and aspirational wellness is progressive. For the aforementioned reasons, the research study cultivated a new wellness scale that was constructed via scale development procedures. In addition, the researcher assessed the factor structure of the wellness scale by exploring the statistics of the developed wellness assessment. Reliability and validity of the model was also assessed with a population of helping professionals.

Background of the Study

The concept of wellness has been around for hundreds of years. Early civilizations discussed wellness and promoted well-being on individual and collective levels (Myers & Sweeney, 2005). In addition, the idea of a wellness/illness continuum has existed for years, with illness receiving most of the attention in medical and treatment-based arenas (Keyes, 2002). The helping professions however, are embracing a holistic, wellness-oriented approach that opposes the traditional medical/reductionist models (Myers & Sweeney; 2004; 2005; Myers, Sweeney, & Witmer, 2000). Such a wellness approach is supported by: optimistic, health-enhancing, and prevention-oriented ideals as well as the idea of healing others while promoting optimal human functioning and flourishing (Fredrickson, 2000; 2001; Keyes, 2002; 2007). Helping professionals *not* only serve as agents of wellness promotion in others, but as models of wellness by practicing well-being in their personal lives.

The quote "Therapist, heal thyself" originated in biblical writings and has since been used by a number of writers from Jung, to Maslow, to Michelle Weiner Davis, to promote the idea that therapists need to be fully functioning in order to heal others. The quote illustrates that though helping professionals aid others in working through mental illness(es), difficult life situations, and other pressing concerns, they are human beings. As such, helping professionals are susceptible to the same problems and concerns faced by the clients with whom they serve. In other words, helping professionals need the ability to work through difficult times, life events, and illnesses, in order to continue to be effective in their work (Venart, Vassos, & Pitcher-Heft, 2007). Similarly, wellness provides the foundation of helping professionals' work with clients (Myers & Sweeney, 2004; Venart et al., 2007). The question arises however, how do helping professionals go about healing themselves?

Similar to other life situations, awareness allows for identification of individuals feelings and needs, and increasing awareness of wellness can facilitate decision-making and actions toward meeting individual needs (Venart et al., 2007). Thus, increasing helping professionals' awareness of their current wellness and/or unwellness states is an integral component in maintaining wellness, promoting wellness, and healing towards holistic wellness. Furthermore, increasing knowledge of aspirational levels of wellness can promote awareness of where individuals would like their personal wellness to be (Venart et al., 2007). For these reasons, the proposed wellness model aims at increasing helping professionals' wellness by assessing current wellness (perceived) and future/ideal (aspirational) wellness. Finally, examining the discrepancy between current perceived wellness and future aspirational wellness may encourage helping professionals to evaluate their wellness, make changes if needed/wanted, and begin a healing process towards wellness if need be. Thus, gauging the discrepancy between perceived wellness and aspirational wellness *not* only adds a unique component to the wellness assessment, but also promotes awareness of individual wellness.

History of Wellness

Holistic wellness is influenced by a number of factors, including engaging in physical exercise, maintaining a healthy weight for body height, maintaining nutrition, stress management, coping skills, self-responsibility, appraising health status, environmental sensitivity, and making positive lifestyle changes (Witmer, 1985). Early on, Sweeney and Witmer (1991) stated that much of their work branched from Adler's ideas of individual psychology and his five life tasks of: (a) love, (b) friendship, (c) self, (d) spirituality, and (e) work/leisure. Subsequently, Witmer and Sweeney (1991) developed one of the first wellness models (i.e., the *Lifespan Development Model*) to highlight the importance of wellness and a

holistic view of human potential. Further, Witmer (1985) was one of the first scholars to develop a wellness course and both he and Sweeney worked to develop the *Wheel of Wellness* (Witmer & Sweeney, 1992) based off of *Lifespan Development Model* concepts (i.e., Adlerian tasks). With today's knowledge, Sweeney and Witmer (1991) stated that Adler would be inclined to say that striving for wellness, holism, and the search for optimal human functioning are the ultimate goals of human potential.

Branching off from Witmer and Sweeney's work, Myers and Sweeney propelled counseling forward in the modern wellness movement. Their work on the *Indivisible Self Model* and the *Five Factor Wellness Inventory* (Myers, Leucht, & Sweeney, 2004; Myers & Sweeney, 2005) influenced the counseling literature and expanded the use and assessment of wellness with a variety of populations. Witmer and Young (1996) have also been influential in emphasizing the impact of wellness in the counseling field. Both researchers have worked to accentuate the importance of wellness in counselor education programs as well as the idea that both faculty and students can benefit from a wellness paradigm (Witmer & Young, 1996). As a result, Mark E. Young, Mel Witmer, Jane Myers, and Thomas Sweeney were influential in the wellness movement. In addition to the aforementioned individuals, scholars such as Dunn, Hettler, and Ardell were also groundbreakers in the wellness movement.

Halbert Dunn (1961) is often credited as the architect of the wellness movement. He emphasized the idea of high-level wellness and that individuals have a desire to be well. Dunn suggested that counselors are in a unique position to help individuals achieve high levels of wellness (Dunn, 1977). While Dunn is considered the architect, Hettler (1980) is often deemed the father of the modern wellness paradigm. Hettler (1980) designed the *Hexagonal Model of Wellness* and also helped establish the National Wellness Institute (NWI; 1983) in Stevens Point,

Wisconsin. Hettler (1980) defined wellness in terms of an active process in which individuals become more aware and make healthy lifestyle choices to support a healthier existence. Other influential contributors include Travis and Ryan (1981; 1988) who developed one of the first wellness/illness continuum models to look at the dualistic sides of health and wellness, and Ardell (1977) who similar to Dunn, discussed high-level wellness and the need to break away from doctors, diseases, and the reductionist/negativistic view of individuals.

In summary, many scholars (e.g., Dunn, 1961; Hettler, 1980; Myers & Sweeney, 2005; Witmer & Young, 1996) contributed to the modern wellness movement in counseling and related helping fields. Their contributions have led to a more holistic, positive, and strengths-based view of human beings and an overall focus on human potential and optimum human functioning. In addition, wellness models and assessments were created in order to assess individual holistic wellness, as well as areas of concern (i.e., unwellness/illness). The next sections of this chapter present wellness models and wellness assessments.

Wellness Models

Wellness models within the helping profession literature represent a diverse array of conceptualizations of well-being. Many wellness models share the phenomena viewed as common to achieving wellness in the helping profession literature. Models that are reviewed include: (a) Hettler's *Hexagonal Model of Wellness* (NWI, 1980); (b) *Lifespan Development Model* (LDM; Sweeney & Witmer, 1991); (c) *Wheel of Wellness* (Sweeney & Witmer, 1991; Witmer & Sweeney, 1992); (d) *Zimpher's Wellness Model* (Zimpher, 1992); (e) *Model of Spiritual Wellness* (Chandler, Miner Holden, & Kolander, 1992); (f) *Perceived Wellness Model* (PWM; Adams, 1995; Adams, Bezner, & Steinhardt, 1997); and (g) *Clinical and Educational Model of Wellness* (CEMW; Granello, 2000).

Hettler (1980) developed a six-dimensional model known as the Hettler's *Hexagonal Model of Wellness* or Hettler's *Six Dimensions of Wellness*, for the NWI in 1980. The Hexagonal Model is composed of six paradigms: (a) occupational, (b) social, (c) spiritual, (d) physical, (e) emotional, and (f) intellectual. The *Hexagonal Model of Wellness* was developed to highlight the areas that influence overall wellness and has since, been integral in the creation of numerous wellness assessments such as the *Lifestyle Assessment Questionnaire* (LAQ, National Wellness Institute, 1983).

Similar to the Hettler model, Sweeney and Witmer (1991) created the *Lifespan Development Model* (LDM), which demonstrated the interconnectedness of the characteristics of healthy people (Witmer & Sweeney, 1992). The LDM was developed based off of Adlerian life tasks (i.e., love, spirituality, self, work, and friendship) and encompassed a holistic view of well-being. Theoretical concepts from sociology, religion, education, psychology, and anthropology are incorporated in the LDM (Witmer & Sweeney, 1992). In addition to incorporating Adlerian life tasks, Sweeney and Witmer discussed the impact of life forces (e.g., religion, education, and media) and global events (e.g., hunger, poverty) as influential in maintaining and achieving holistic wellness. Essentially, the LDM is a human development model that was comprised to formulate a holistic view of human functioning and wellbeing within the contexts of one's environment. Witmer and Sweeney used information from the LDM to construct the *Wheel of Wellness* (Sweeney & Witmer, 1991).

Another model, the *Wheel of Wellness* (Sweeney & Witmer, 1991; Witmer & Sweeney, 1992) was created to align with Individual Psychology tenets. The *Wheel of Wellness* model includes a number of areas that correlate with healthy living, longevity, and quality of life (Myers & Sweeney, 2005). Life tasks of love, work and leisure, friendship, self-direction, and

spirituality are viewed as integral in supporting holistic wellness. Areas that comprise the life tasks include: (a) stress management, (b) self-care, (c) exercise, (d) nutrition, (e) sense of humor, (f) problem solving and creativity, (g) emotional awareness and coping, (h) realistic beliefs, (i) sense of control, (j) sense of worth, (k) cultural identity, and (l) gender identity (Sweeney & Witmer, 1991). In addition, the *Wheel of Wellness* incorporates the effects of society and other external realms on overall wellness, supporting the idea that Adlerian life tasks interact with one another and with life forces (Sweeney & Witmer, 1991) in comprising overall well-being.

Zimpher (1992) offers a unique model of wellness that focuses on well-being in clients with cancer and other chronic diseases (Zimpher, 1992). In Zimpher's model, wellness refers to positioning all available resources so that they are used to their maximum advantage in wellness promotion. In other words, individuals suffering from cancer or other diseases allow their bodies to take advantage of all of their capacities for healing and moving toward health. Healing in this realm involves bodily recovery and use of personal potential (Zimpher, 1992).

The *Zimpher Wellness Model* is based on the underlying principles that: (a) individuals have an innate urge toward health; (b) attitudes influence treatment; (c) individuals must have a will to live and take a responsibility for health and healing; (d) individuals must believe cancer is beatable and that cancer involves stress; (e) that therapists serve as empowerment-agents; (f) and that individuals have some level of internal control (Zimpher, 1992). In addition, some of the realms of the Zimpher model include: (a) immune functioning, (b) medical issues, (c) interpersonal support, (d) psychodynamics, and (e) energy sources.

Chandler, Miner Holden, and Kolander (1992) developed the *Model of Spiritual Wellness*, a holistic model of wellness comprised of physical, emotional, occupational, social, and intellectual paradigms. Within the model, spirituality was viewed as an integral component

of each wellness paradigm an as an entity that influenced optimal wellness (Chandler et al., 1992). Furthermore, within the *Model of Spiritual Wellness*, individuals who had an appropriate balance and developed potential in the personal realm and the spiritual realm where considered optimally well (Chandler et al., 1992). The Chandler and colleagues (1992) model is unique in that spirituality is *not* only central, but is viewed as influential to *all* aspects of holistic wellness.

The *Perceived Wellness Model* (PWM; Adams, 1995; Adams, Bezner, & Steinhardt, 1997) is a multidimensional model that supports wellness as a manner of individual *being*, that allows for experiences of balanced and consistent development in spiritual, social, emotional, intellectual, physical, and psychological tenets of human existence. The PWM posits that when individuals view their wellness tenets as equal, they are healthier.

The last wellness model reviewed is the *Clinical and Educational Model of Wellness* (CEMW; Granello, 2000). The CEMW was created for use with clients in clinical settings and is useful as an example of what contributes and may influence individual wellness. The areas of the CEMW model are: (a) creativity, (b) social relationships, (c) physical and nutritional concerns, (d) emotional regulation, (e) cultural and environmental context, (f) preventative self-care, (g) cognition, and (h) spirituality (Granello, 2013). A focus of the CEMW is that *all* areas are interactive and that every individual should be viewed in the context of his or her own life.

Wellness Models

Similar to wellness models (e.g., pictorial representations of wellness), there are a number of wellness assessments (e.g., used to measure wellness tenets or holistic wellness) within the helping professional literature. The majority of the assessments examined include multidimensional components of wellness. The assessments that are reviewed include: (a) *Wellness Evaluation of Lifestyle* (WEL; Myers, Sweeney, & Witmer, 1998); (b) *Five Factor*

Wellness Evaluation of Lifestyle (5F-Wel; Myers et al., 2004); (c) *Health Promoting Lifestyle Profile-II* (HPLPII, Walker, Sechrist, & Pender, 1987); (d) *Perceived Wellness Survey* (PWS; Adams, Bezner, & Steinhardt, 1997); (e) *Lifestyle Assessment Questionnaire* (LAQ; NWI, 1983); (f) *Professional Quality of Life Scale-Third Edition-Revised* (PRO-QOL-III-R; Stamm, 2005); (g) *Maslach Burnout Inventory – Human Services Scale* (MBI-HSS; Maslach & Jackson, 1996); and (h) *Counselor Burnout Inventory* (CBI; Lee et al., 2007).

The *Wellness Evaluation of Lifestyle* (WEL; Myers et al., 1998) is a paper-and-pencil assessment that was developed to measure wellness as based on the *Wheel of Wellness* model. Theoretically, the WEL conceptualizes wellness based on Adlerian life tasks (i.e., self, love, friendship, work, and spirituality) and incorporates global occurrences and life forces as wellness influencing events (Hattie et al., 2004). Essentially, the WEL was developed to assess the five life tasks and subtasks in the *Wheel of Wellness*.

In an initial study by Myers et al. (1998), the WEL was created from a pool of more than 500 items. A 5-point Likert type scale was implemented from *strongly agree* to *strongly disagree.* The first form of the WEL consisted of 114 items and was administered to a convenience sample of 18-91 year-old individuals (N = 723). In original analysis, only 9 of the 16 scales had alpha reliability assessments above .60 (Myers et al., 1998). Thus, a series of studies were conducted to improve the weaker scales with a variety of populations (e.g., high school students, graduate students, undergraduate students).

Hattie and colleagues (2004) noted that following a series of studies that were conducted to improve the psychometric properties of the WEL, although the psychometric properties of the instrument were supported, the data did *not* support the hypothesized model (i.e., the Wheel of Wellness). Thus, though the WEL supported the idea that wellness could be multidimensional, it

did *not* fully support Wheel of Wellness model from which it was derived. Examination of the data led to the creation of a new model of wellness, the *Indivisible Self Model of Wellness* (IS-WEL, Myers, Leucht, & Sweeney, 2004).

The *Five Factor Wellness Evaluation of Lifestyle* (5F-Wel; Myers et al., 2004) is based off of the *Indivisible Self Model* and is comprised of creative, physical, coping, social, and essential factors (Hattie et al., 2004). The 5F-Wel is a 90-120-item questionnaire (based on the intended population) that was created to assess overall wellness. The 5F-Wel was developed using factor analysis on the original assessment, the WEL (Sweeney & Witmer, 1992). In addition to the factors (e.g., coping, social, essential, creative, physical), Myers and Sweeney (2004) illustrate the influence of contextual systems on individual wellness. Specifically, neighborhood, community, and family, environment, culture, global events, and life span development contribute to overall life satisfaction and create a holistic view of wellness (Myers & Sweeney, 2004).

The 5F-Wel (Myers et al., 2004) is a popular assessment of wellness and has been used in several studies in relation to variables such as spirituality (Gill, 2004), ethnic identity (Dixon Rayle, 2002; Spurgeon, 2002), self-esteem (Spurgeon, 2002), relationship self-efficacy (Shurts, 2004), and acculturation (Dixon Rayle, 2004; Mitchell, 2001, Spurgeon, 2002). Internal consistency for the 5F-Wel ranges from .80 to .96 and the instrument has been normed on populations with varying degrees of ethnicity, gender, age, and education level (Myers & Sweeney, 2005). Though the scale was used in many research investigations with a variety of populations, some caution the rigor of the internal consistency values because they are reported via the author's themselves from an enclosed dataset. Further, the scale is quite lengthy which

makes application difficult for everyday use. Another limitation of the 5F-Wel is the cost, where individuals wanting to use the scale must pay for the assessment, the manual, and data analysis.

The *Health Promoting Lifestyle Profile-II* (HPLPII, Walker, Sechrist, & Pender, 1987) assesses an overall view of "a positive approach to living that leads individuals toward realizing their highest potential for well-being" (p. 76). The HPLPII is a 52-item assessment that includes a 4-point Likert-type scale ranging from *Never* to *Routinely*. The HPLPII is comprised of six subscales of: (a) Spiritual Growth, (b) Interpersonal Relations, (c) Nutrition, (d) Physical Activity, (e) Health Responsibility, and (f) Stress Management and assesses frequency individuals report engaging in health related activities that enhance or maintain their well-being, fulfillment, and self-actualization (Walker et al., 1987). In the initial study of the HPLPII, Walker et al. (1987) used item analysis, factor analysis, and reliability measures with a population of adults (N = 952). A six factors structure resulted and the factors accounted for 41% of the total variance (Walker et al., 1987), which is considered low in the social sciences. Walker, Sechrist, and Pender (1995) report Cronbach's alpha levels ranging from .79 to .87 in the subscales of the HPLIII with a total of .94.

The *Perceived Wellness Survey* (PWS; Adams, Bezner, & Steinhardt, 1997) is based off of the PWM (Adams et al., 1995; Adams et al., 1997) and is a 36-item self-report wellness measure designed to assess the degree to which adults perceive themselves as being well across the PWM dimensions (e.g., spiritual, social, emotional, intellectual, physical, psychological). The PWS is comprised of 6-point Likert scaling from 1 (*very strongly disagree*) to 6 (*very strongly agree*) and involves scoring in each wellness dimension as well as an overall composite wellness score. Wellness magnitude scores, wellness balance scores, and wellness composite scores can also be calculated. Overall, empirical evidence on the validity of the PWS is mixed (Adams et al., 1995;

Adams et al., 1997; Harari, Waehler, & Rogers, 2005; Sigman, D'Abundo, & Hritz, 2009). In addition, the majority of the studies using the PWS are with a predominantly college-level, white, female population and thus, the results are *not* generalizable to a larger population (Adams et al., 1995; Adams et al., 1997; Harari et al., 2005). As a result, the PWS should be used with caution in diverse populations and as a multidimensional wellness measure.

The *Lifestyle Assessment Questionnaire* (LAQ; NWI, 1983) was based off of Hettler's (1980) *Hexagonal Model of Wellness*. Hettler's original model was comprised of: (a) occupational wellness, (b) spiritual wellness, (c) physical wellness, (d) intellectual wellness, (e) emotional wellness, and (f) social wellness (1980). The LAQ is a 100-item measure that assesses four dimensions including wellness and medical alert. The LAQ is comprised of questions with 5-point Likert scaling, with lower scores equating to lower levels of wellness.

Cooper (1990) examined the factor structure of the LAQ and the results did *not* support the six subscales of the instrument and instead, a two-factor structure of behavior well-being and cognitive well-being was identified. Similarly, Palombi (1993) reported the LAQ measured a unidimensional construct. She found the internal consistency of the LAQ subscales ranged from .67 to .94 (Palombi, 1993; Richers, 1992). In addition, Palombi reported coefficient alpha of the total LAQ score as .93. DeStefano and Richardson (1992) used the LAQ with a sample of college freshman and found low to moderate correlations between the subscales. Using factor analysis, DeStefano and colleagues found the LAQ yielded a three factor model and reported limited support for external validity of the LAQ.

The *Professional Quality of Life Scale-Third Edition-Revised* (PRO-QOL-III-R; Stamm, 2005) measures the professional quality of life of an individual in reference to their work as a helping professional (Stamm, 2010). The PRO-QOL-III-R incorporates the dimensions of

compassion satisfaction and compassion fatigue, which is comprised of burnout and secondary trauma (Stamm, 2010). The PRO-QOL-III-R allows respondents to report the frequency of specific experiences on a scale of 0 (*never*) to 5 (*very often*) via a 30-item, frequency questionnaire. Stamm (2005) noted that the PRO-QOL-III-R is divided into three main scales (Burnout, Compassion Fatigue/Secondary Trauma, and Compassion Satisfaction) that have alpha reliabilities of .87, .72, and .80 for Compassion Satisfaction, Burnout, and Compassion Fatigue/Vicarious Traumatization respectively.

Lawson (2007) used the PRO-QOL-III-R in a study investigating the wellness and wellness strategies of ACA members (N = 501). Specifically, the PRO-QOL-III-R was used to assess counselor professional well-being and Lawson (2007) found that the counseling population involved in the investigation scored significantly higher on the Compassion Satisfaction scale (M = 39.84, SD = 6.43, α = .77), lower on the Burnout Scale (M = 18.37, SD = 6.0, α = .82), and lower on the Compassion Fatigue/Vicarious Traumatization scale (M = 10.05, SD = 5.91, α = .85), than the original normed sample.

The *Lifestyle Coping Inventory* (LCI; Hinds, 1983) was developed for adults and college students to assess current wellbeing and/or current illness. The LCI allows for assessing wellness and also serves as a tool to evaluate the risks individuals are taking and life choices individuals are making (Hinds, 1983). The LCI contains 142 questions and 7 dimensions of wellness: nutritional actions, physical care actions, cognitive and emotional actions, coping style actions, low-risk actions, environmental actions, and social support actions (Hinds, 1983). Items in the LCI are on a 5-point Likert scale ranging from *very often* to *never*. The model has internal consistencies ranging from .70 to .90 in the literature (Hinds, 1983; Palombi, 1993).

The *Maslach Burnout Inventory-Human Services Scale* (MBI-HSS; Maslach & Jackson, 1996) is a 22-statement scale that evaluates burnout and work-related exhaustion. The MBI-HSS assesses for depersonalization, emotional exhaustion, and devaluing achievement and success (Maslach & Jackson, 1996) and is one of the most widely used burnout assessments, which has been applied in approximately 90% of all empirical burnout studies (Schaufeli & Enzmann, 1998). Thus, the MBI-HSS is used in numerous empirical investigations with a plethora of populations.

The *Counselor Burnout Inventory* (CBI; Lee et al., 2007) is a 20-item, self-report questionnaire comprised of the five subscales of: (a) Exhaustion, (b) Incompetence, (c) Negative Work Environment, (d) Devaluing Client, and (e) Deterioration in Personal Life that was created to assess burnout specifically in counselors. Each item has a 5-point Likert response scale ranging from 1 (*never true*) to 5 (*always true*). Examples of CBI items are "I feel frustrated with the system in my workplace" and "I do not feel like I am making a change in my clients." The CBI contains items that are reflective of various levels of burnout (Lee, Cho, Kissinger, & Ogle, 2010).

Lee and colleagues (2007) developed the CBI from an initial pool of 296 items. Initially, 40 items were related to five burnout dimensions: Dimension 1 (exhaustion), Dimension 2 (negative work environment), Dimension 3 (devaluing client), Dimension 4 (incompetence), and Dimension 5 (deterioration in personal life). Following item reduction, Lee et al. (2007) performed two analyses, EFA and CFA with two independent samples. For the first sample of counselors (N = 258), Lee et al. (2007) and a five-factor model was determined that accounted for approximately 55% of the total variance (Lee et al., 2007). Based on examination of factor pattern coefficients, items were reduced to 20. Lee and colleagues (2007) then ran a second EFA

on sample two (*N* = 132) to determine if simple structure was achieved. The second EFA again yielded a five factor structure that accounted for approximately 67% of the variance, with all items associating to their factor. In the second independent sample (*N* = 132) of counselors, a maximum-likelihood CFA was conducted and goodness-of-fit indices indicated adequate fit of the data (CFI = .957; TLI = .948; SRMR = .052; RMSEA = .050; Lee et al., 2007).

The majority of the aforesaid wellness assessments were constructed to measure multidisciplinary components of wellness (e.g., physical, coping, intellectual, spiritual). The LAQ, 5F-Wel, WEL, and the PWS were initially developed to measure secondary factors that contributed to total or holistic wellness. However, empirical research findings support that the PWS and the LAQ measure the construct of wellness unidimensionally (e.g., Palombi, 1992). Similarly, the subscales of the WEL do *not* meet statistical standards found in the literature (Costello & Osborne, 2005; Crocker & Algina, 2008; Mvududu & Sink, 2013). Furthermore, the majority of the models reviewed measure wellness within the confines of a defined wellness model. For example, the WEL measures wellness based off of the *Wheel of Wellness* map. Likewise, the 5F-Wel measures wellness based on the *Indivisible Self Model*. As a result, the assessments are confined to their respective models of wellness when determining individual levels of well-being. As a common wellness assessment, the 5F-Wel has been used in research investigations surrounding wellness, with approximately 3,000 participants completing the assessment. Though there is some empirical research supporting the multidisciplinary aspects of the instrument (i.e., five secondary factors of wellness), the statistics are reported mostly by the authors in the assessment manual. All data collected with the 5F-Wel must be sent to the authors for analysis; therefore, a limitation of the assessment is that only the authors are permitted to conduct data analysis on the instrument.

Another limitation of the majority of the wellness assessments is that they were *not* constructed via appropriate scale development procedures as outlined by Crocker and Algina, (2006), DeVellis, (2012), and Dimitrov (2012). As a result, the methodology behind constructing many of the assessments may be questionable. In addition, of the assessments described, no wellness assessment exist that measure perceived wellness, aspirational wellness, and the discrepancy between perceived and aspirational wellness. Thus, this research investigation examined the aforementioned tenets to address the problems with the current wellness assessments.

Statement of the Problem

The helping professions have a number of codes and guidelines supporting the wellness paradigm; specifically, ACA (2014) states that counselors must monitor themselves "for signs of impairment from their own physical, mental, or emotional problems" (*Standard* C.2.g, p. 9). Moreover, counselors are advised to monitor themselves for signs of impairment and "refrain from offering or providing professional services when such impairment is likely to harm clients" (*Standard* F.5.b, p. 13). For psychologists, the APA (2010) notes that professionals should refrain from providing services to clients when their personal problems may interfere with their work or when they know there is a likelihood that their personal issues may influence their competence (*Standard* 2.06). The Council for Accreditation in Counseling and Related Education Programs (CACREP, 2009) also supports the idea that helping professionals should have an orientation to wellness and prevention (Section II.5.a) and that they have a duty to promote optimal wellness and growth in clients (Section II.2.e). Thus, wellness and the prevention of impairment are intertwined throughout the standards of the helping professions.

Consequently, it is unethical for helping professionals to operate while personally and/or professionally impaired and/or unwell.

When counselors (i.e., helping professionals) take care of themselves, they are more able provide quality care and meet the needs of their clients (Lawson, 2007; Witmer & Granello, 2005; Witmer & Young, 1996). In relation to helping profession students and faculty, Roach and Young (2007) found that counselors-in-training and counseling faculty (*N* = 204) reported personal wellness as integral in promoting effectiveness with clients. In addition, Skovholt (2001) stated that counselors-in-training are at risk for distress and stress because of working with people who are experiencing pain and because of the challenge in mastering the ambiguity of the counseling process. Thus, helping professional personal wellness is important because individuals who are unwell are not able to provide optimal services to clients (Lawson, Venart, Hazler, & Kottler, 2007).

Helping professionals are vulnerable to becoming ineffective because of the nature of their work (Skovholt, 2001). In addition, Skovholt (2001) noted that empathy and attachment (common helping profession principles) involve therapists' vulnerable side, a part that can be hurt during the process. For this reason, counselors and helping professionals continuously place themselves at risk because of the nature of their work.

Though wellness is viewed as the backbone of the counseling profession and integral to other helping professions, many of the individuals in helping professions do *not* practice wellness or promote it in their own lives (Granello, 2013; Witmer & Young, 1996). Many of the individuals attracted to and entering into the helping professions are already impaired and have an increased likelihood for adjustment issues and personality concerns (Witmer &Young, 1996). Cummins and colleagues (2007) iterate that counselors and counselors-in-training are often

remiss about taking their own advice about wellness. As such, counselors and counselors-in-training that are considered *well* are more likely to help their clients become more *well* (Lawson et al., 2007). Consequently, impaired counselors are more likely to harm their clients (Lawson et al., 2007; Witmer & Young, 1996). As a result, it is imperative that we assess wellness in helping professionals and helping professionals-in-training.

Regarding practicing helping professionals, Lambie et al. (2009) asserted that counselor functioning and therapeutic effectiveness is influenced by overall wellness. Further, even a good support system and sufficient supervision may *not* buffer the effects of distress faced by helping professionals (Cummins et al., 2007). Pope, Tabachnick, and Keith-Spiegel (1987) found that nearly 60% of the psychologists reported working when they were too distressed to be effective with clients. In addition, Sherman and Thelen (1998) found that life events and personal illness caused therapists (N = 522) to feel significant distress. Consequently, Cummins et al. (2007) stated that distress can lead to dissatisfaction with work and result in cancellations of therapy sessions with clients, reduced ability to be empathic towards clients, and failure to meet basic requirements of the helping profession.

Corey (2000) noted "it is not possible to give to others what you do not possess" (p. 29). As such, helping professionals who are *not* well will struggle to promote wellness in others (Lawson et al., 2007). Similarly, unwellness factors (i.e., distress, illness) can lead to ineffective helping professionals and influence individuals on personal and professional levels. As a result, helping professionals should assess wellness and strive for increasing awareness on the holistic components to overall wellness via learning about the theoretical and empirical research on wellness models and wellness assessments/scales.

Significance of the Study

Helping professionals' wellness is integral in promoting sound, efficacious work with clients. The development of a psychometrically sound assessment to measure wellness aids in promoting health and wellness in helping professionals, as well as promotes awareness about the discrepancy between perceived and aspirational levels of wellness. Further, use of a psychometrically sound wellness assessment may also relate to increased effectiveness of counseling services with clients (i.e., influence client outcomes). Additionally, a new wellness scale measuring the discrepancy between perceived and aspirational wellness may serve as a method of formative and summative feedback for helping professionals and helping professionals-in-training. Similarly, a wellness assessment that is sensitive to change (i.e., shows differences in wellness discrepancies over time) could be used as a tool for individuals to assess personal well-being.

Purpose and Research Questions

Scholars defining wellness and/or creating wellness models and assessments agree that wellness is multidimensional in nature (Ardell, 1977; Dunn, 1977, Hettler, 1980, Myers et al., 2004). Additionally, wellness is *not* merely the absence of disease (Ardell, 1977; Edlin, 1988; Lafferty, 1979; Teague, 1987). Furthermore, wellness approaches are holistic in nature and involve both personal (self) and environmental (external) influences (Roscoe, 2009). The dynamic nature of wellness and idea that healthy individuals strive towards optimal functioning is supported in the literature (Ardell, 1977; Dunn, 1977; Hettler, 1980; Roscoe, 2009). Similarly, wellness is dependent upon individual motivation (Ardell, 1977; Dunn, 1977; Hettler, 1980) and self-responsibility (Dunn, 1977). Therefore, it is hypothesized that the *Helping Professional Wellness Discrepancy Scale* (HPWDS) will yield a multimensional factor structure of wellness,

which incorporates internal and external influences. However, because of the exploratory nature of developing a new wellness measure, hypotheses about the factor structure of the model were *not* assumed. Thus, research questions supporting the exploration of the HPWDS were warranted.

The purpose of developing the HPWDS was to examine the psychometric properties of wellness (as measured by the HPWDS) in a sample of helping professionals (i.e., psychologists, social workers, and counselors). The specific research questions that were investigated included the following:

Research Question 1

What is the factor structure of the items on the HPWDS with a sample of helping professionals?

Research Question 1a

What is the factor structure of the perceived items on the HPWDS with a sample of helping professionals?

Research Question 1b

What is the factor structure of the aspirational items on the HPWDS with a sample of helping professionals?

Research Question 1c

What is the factor structure of the discrepancy between the perceived items and aspirational items on the HPWDS with a sample of helping professionals?

Research Question 2

What is the internal consistency reliability of the HPWDS with a sample of helping professionals?

Research Question 3

What is the relationship between HPWDS scores and CBI scores with a sample of helping professionals (examining the discriminant validity of the HPWDS)?

Research Question 4

What are the relationships between helping professionals' HPWDS scores and their reported demographic data?

Research Question 5

What is the relationship between HPWDS scores and MCSDS scores with a sample of helping professionals (examining social desirability of participant answers)?

Research Design

The research design for the investigation was a correlational design (Gall, Gall, & Borg, 2007). The research design was correlational, as the investigation examined the relationships between variables (without manipulation). This research investigation focused on developing the *Helping Professional Wellness Discrepancy Scale* (HPWDS) and testing the validity of the initial model with a population of helping professionals.

Population and Sample

The population for the investigation of the HPWDS consisted of practicing counselors, practicing psychologists, and practicing social workers as well as master's level counselors-in-training, master's level social workers-in-training, and master's level psychologists-in-training. The practicing counselors included certified and/or licensed: (a) marriage, couple, and family therapists; (b) school counselors; and (c) mental health counselors. The practicing psychologist participants included licensed psychologists (i.e., counseling, clinical, and school psychologists). Similarly, the practicing social workers included licensed clinical social workers. The

counselors-in-training population included students of counseling in: (a) marriage, couple, and family therapist; (b) school counseling; and (c) mental health counseling tracks. The psychologists-in-training included graduate-level counseling, clinical, and school psychology students and the social workers-in-training included graduate-level social work students. In summary, the sample of social workers, counselors, and psychologists comprised the helping professional population in this research investigation.

The data was collected via online, mail-out, and face-to-face administration. For the online version, counselors, psychologists, and social workers were randomly selected from the Department of Health helping professional contact listserves from two Southern states. Email lists were gathered and emails were sent following the *Tailored Design Method* (Dillman, Smyth, & Christian, 2009) and helping professionals participated via online survey administration through Qualtrics. For the mail-out option, participants were randomly selected from the Department of Health helping professional contact listserves from two Southern states. Mail lists were gathered and letters were sent following the *Tailored Design Method* (Dillman, Smyth, & Christian, 2009). For the face-to-face administration, participants were given the assessment packet in a graduate class and asked to participate in the investigation.

In determining an appropriate sample size for the research investigation, Hair, Black, Babin, Anderson, and Tatham (2006) were consulted. Specifically, Hair and colleagues (2006) suggested a sufficient sample size for test development and the identified statistical analyses as approximately 100 participants. Additionally, the minimum sample size should be at least five times larger than the number of variables being analyzed in the investigation. Thus, the desired sample size for appropriately examining the psychometric properties of the HPWDS was based on the number of cases to the number of item ratio (Costello & Osborne, 2005; Everitt, 1975;

Mvududu & Sink, 2013). Plainly, an *N*:*p* (*N* being the number of cases or participants and *p* being the number of items) was implemented (Hair et al., 2006). For the social sciences, appropriate item/participant ratios should be 10:1 or 20:1 (Hair et al., 2006; Mvududu & Sink, 2013; Tinsley & Tinsley, 1987).

Costello and Osborne (2005) noted that although item to participant ratios varies depending on strength of data, researchers should aim high and attempt to establish a 20:1 ratio. In their research however, Costello and Osborne (2005) analyzed the average *N*:*p* ratio used in EFAs over a two year time period and found that the majority (62%) of researchers used only a 10:1 or less *N*:*p* ratio for data analysis. In addition, approximately one-sixth of the sample used 2:1 *N*:*p* ratios for their data analysis. Nevertheless, for this investigation a 20:1 ratio was attempted.

Based on the literature review (Chapter 2), it was hypothesized that through statistical analysis (i.e., EFA), the data will yield a six-factor structure. This being said, the researcher started with at least 10 items (i.e., questions) for each individual factor. Using the ratio, we had 60 total items or *p*. Thus, in calculating the overall *N*:*p* ratio, in order to establish a 20:1 ratio the number of cases or participants desired were 1,200 (i.e., 1,200:60 equates to the 20:1 ratio). Additional support for a large sample size comes from Comrey and Lee (1992) who created a range of populations from 50 to 1000. Ideally, according to Comrey and Lee (1992), a sample of 500 is *very good* and a sample of 1000 is considered *excellent.* Hair and colleagues (2006) noted that a sample size employing the research design and factor analysis should include a minimum of 100 participants. Finally, with the sample size (over 1200) data would have been generalizable to the larger population of helping professionals (Costello & Osborne, 2005

Instrument Procedures and Instrumentation

The research investigation focused on developing the HPWDS and examining the psychometric properties of the HPWDS. Additionally, the researcher developed a general demographic form for helping professionals. Furthermore, participants in the study received a statement of informed consent and voluntarily agreed to participate in the study that was approved by UCF's Institutional Review Board (IRB).

The steps in constructing an instrument vary within the literature (Crocker & Algina, 2006; DeVellis, 2012; Dimitrov, 2012). For the purposes of this research investigation, a combination of the aforementioned authors' step-wise processes was followed. The specific steps that were followed included: (a) determine clearly what is being measured, (b) creating an item pool, (c) determining the type of scale measurement, (d) having the items reviewed by a team of experts, (e) considering inclusion of validation items, (f) administering the scale to a development sample, (g) evaluating the items following statistical analysis, and (h) optimizing scale length.

A manual for the HPWDS was created to explain how to administer the instrument and serves as a training tool and assist individuals administering the HPWDS. In addition, the manual served as reference guide to scoring the HPWDS. The manual contains: (a) a review of the literature from which the HPWDS was constructed, (b) definitions for each item, (c) directions for administration, and (d) directions for scoring the HPWDS. See Appendix Q for manual.

Four instruments were utilized within the present study. The first instrument was the HPWDS, which was developed in the present research investigation. A second instrument, a helping professional general demographic form, was administered in order to collect demographic information about the helping professional participants. A third instrument, the

MCSDS-X1 (Strahan & Gerbasi, 1972) was administered to assess for social desirability within the sample. Finally, the CBI (Lee et al., 2007) was included to assess for criterion-related validity.

Helping Professional General Demographic Questionnaire

The second instrument was a demographic questionnaire to assess the general demographics of the helping professional population. The questionnaire allowed helping professionals to provide their demographic information such as gender, age, race/ethnicity, years in practice, and years of schooling. Additionally, the questionnaire has areas that include: (a) area of specialty, (b) theoretical orientation, and (c) primary population served.

Marlowe-Crowne Social Desirability Scale-X1

The third data collection instrument, the *Marlowe-Crowne Social Desirability Scale-X*1 (MCSDS-X1; Strahan & Gerbasi, 1972) was used to assess social desirability within the sample of helping professionals. The MCSDS-X1 is a 10-item instrument that is a shortened version of the original 33-item *Marlowe-Crowne Social Desirability Scale* (MCSDS; Crowne & Marlowe, 1960). The MCSDS-X1 item scoring is based on a *1* (items that are socially desirable) and *0* (items that are not socially desirable) range, with total scores on the assessment ranging from 0 to 10. High scores on the MCSDS-X1 indicate participants answering in a socially desirable way.

Counselor Burnout Inventory

The *Counselor Burnout Inventory* (CBI; Lee et al., 2007) was used to assess the levels of unwellness/impairment in the helping professional population. In addition, CBI subscale scores and HPWDS scores will be correlated to evaluate the criterion-related validity (discriminant validity) of the HPWDS. A negative correlation was expected between outcomes in the CBI and outcomes on the HPWDS. The CBI (Lee et al., 2007) is a 20-item, self-report questionnaire

comprised of the five subscales of: (a) Exhaustion, (b) Incompetence, (c) Negative Work Environment, (d) Devaluing Client, and (e) Deterioration in Personal Life that was created to assess burnout specifically in counselors. Each item has a 5-point Likert response scale ranging from 1 (*never true*) to 5 (*always true*).

Data Collection

The researcher obtained IRB permission before collecting data. After receiving IRB approval, the HPWDS was distributed to helping professionals and helping professionals-in-training population. The data collection procedures were in three forms: (a) face-to-face administration, (b) mail outs, and (c) web-based survey. Using three forms of data collection allowed for a more diverse representation of participants as well as an increase in the overall sample size and generalizability of the research.

After receiving IRB approval from our university, face-to-face data collection began. The face-to-face collection began September 1st, 2014 and was completed December 1st, 2014 and involved the researcher administering the HPWDS and affiliated scales (i.e., CBI, MCSDS, Demographic Form) to a diverse array of counseling students. For the web-based and mail out survey data collection procedures, Dillman's *Tailored Design Method* (Dillman, et al., 2009) was implemented. Specifically, the *Tailored Design Method* for emailing was followed with a three-fold focus of: establishing trust with participants, increasing benefits for participants, and decreasing costs of administration. Dillman and colleagues (2009) suggest for web-based survey implementation and propose that researchers: send out three emails, make the emails personalized to each participant, send out specific codes for each participant, and send all emails from the same address to promote trust and increase the overall sample size. Thus, the *Tailored Design Method* was implemented for collecting the web-based data.

For the mail out option, a similar three-contact *Tailored Design Method* (Dillman, et al., 2009) was followed. The first contact included a letter of contact describing the research investigation and information participants that they will be receiving an assessment packet in the near future. An initial sample letter is included in Appendix K. For the second participant contact; a letter was included which described the investigation, along with an informed consent document; and the assessment packet, including the HPWDS, the MCSDS-X1, the CBI, and a general demographic form. A sample of the second contact letter is included in Appendix L. For the final contact, a post card was sent highlighting the main tenets of the study and informing participants that data collection would soon be ending. A sample of the final contact post card is available in Appendix M. Thus, for the online, mail out, and face-to-face data collection procedures, rigorous methods were implemented to insure quality data collection.

Ethical Considerations

In the present research investigation ethical guidelines were followed. Specifically, the researcher obtained university IRB approval before conducting any data collection. In addition, prior to data collection *all* potential participants were informed about the research investigation, the purpose of the study, and the study procedures. A letter of informed consent was used for the study and *all* participation was on a strictly voluntary basis. In order to ensure participant confidentiality, *all* study documents were coded. Participants were informed that *all* of their responses would remain anonymous. Lastly, *all* results were in a format that would *not* identify individual participants.

Limitations of the Study

Limitations within the current research investigation warrant consideration when interpreting the study's results. One of the expected limitations included sample size. For the

nature of the research investigation and data analysis, a large sample size was required and was ideal. The researcher was *not* able to gain the ideal sample size (i.e., 1,200), and thus, data analysis could have been affected and the 20:1 participant/item (*N*/*p* ratio) was *not* achieved. In addition, obtaining IRB approval from universities outside of our university was difficult and influenced the amount of individuals available for participation in the study.

Another study limitation necessitating consideration was the generalizability of the data. The sampling criterion specified participants who were helping professionals (i.e., counselors, psychologists, social workers, counselors-in-training, psychologists-in-training, and social workers-in-training) but equal representations of each area were not achieved. Additionally, participants were from a narrow range of geographical locations (South and South East) and thus, do *not* represent all helping professionals in the United States. Further, sample demographics were not diverse. Consequently, perspectives from a variety of cultures may not have been achieved.

In regards to instrument development, a limitation of the investigation included the researcher potentially overlooking items that may have been relevant to the construct of interest. As such, the HPWDS model might *not* include all of the items that measure holistic wellness. As a result, areas that are relevant to measuring wellness in helping professionals may not be included in the final HPWDS.

Therefore, the present study has limitations that will influence the interpretation of the results in a population of helping professionals. Even so, the limitations include areas for future research. Accordingly, the researcher will attempt to strengthen the HPWDS by addressing the limitations in future research endeavors.

Chapter Summary

The development of a psychometrically sound instrument with diverse sampling to measure perceived wellness, aspirational wellness, and the discrepancy between perceived and aspirational wellness is described within this chapter. A brief review of the wellness literature, the history of wellness in the helping professions, and the modern wellness movement was presented. Furthermore, the chapter explored the rationale for a new wellness assessment, including the lack of research regarding the development of a wellness measure for helping professionals, constructed via appropriate statistical procedures, and constructed using correct scale development procedures. Finally, the chapter concluded with an explanation of the present research investigation, which identified the proposed research methodology and statistical analysis of developing a psychometrically sound wellness assessment for helping professionals. Chapter 2 includes an exhaustive literature review of the history of wellness in the helping professions, wellness models, wellness assessments, and phenomena contributing to wellness and unwellness.

CHAPTER TWO: REVIEW OF THE LITERATURE

Introduction

Chapter 2 begins with a review of the history of wellness, including the differences between the wellness and illness paradigms. In addition, this chapter presents (a) the historical overview of the wellness paradigm, (b) definitions of wellness, (c) wellness in the helping professions, (d) models of wellness, (e) wellness assessment instruments developed to measure wellness in diverse populations, and (f) the importance of a wellness focus in the helping professions. Furthermore, phenomena related to wellness and unwellness/illness are discussed.

Historical Overview

Wellness/Illness Paradigms

According to Keyes (1998) the concept of wellness is viewed from two divergent perspectives. Followers of the illness or "clinical" tradition view well-being through measures of disease, physical illness, and mental illness; whereas the supporters of the health or "psychological" tradition view well-being in terms of evaluation of individualized life satisfaction (Keyes, 1998). Historically, the focus of healthcare is rooted in this illness paradigm with emphasis on the treatment of sickness, disease, and unwellness (Granello, 2013; Myers & Sweeney, 2005; Swarbrick, 2006). Further, healthcare services (in the United States) *treat* unwell individuals rather than promoting *prevention* of illness and unwellness. When comparing the medical/disease model with a wellness oriented modality, inherent differences exist. For instance, the medical model focuses on symptom reduction, stabilization, and interventions related to treating illness (Swarbrick, 2006). In addition, the medical model is deficit-based in that individuals are viewed in terms of their disease (e.g., symptomology) rather than in terms of

their positive attributes and strengths (Seligman, 2002; Swarbrick, 2006). Another key difference is that the medical model contains different primary components than the wellness paradigm.

Wampold, Ahn, and Coleman (2001) noted that the medical model consists of five constituents: (a) client presents with a problem/disorder, (b) an explanation for the problem is given, (c) sufficient theoretical knowledge and conceptualization promote a change in the client, (d) helping professionals administer therapeutic ingredients to explain the change, and (e) the benefits and changes for clients are due to the specific prescribed ingredients. In other words, individuals report a problem and helping professionals prescribe numerous "fixes" to solve the problem. Thus, the medical model supports the idea that when something is wrong with an individual, it is the responsibility of a clinician to solve the problem and "cure" the individual of all symptomology (Keyes, 2002). In summary, by focusing on sickness and unwellness, the medical/disease model reduces human capacity to specific illness, promoting the idea that health is a consequence of an absence of illness. However, the absence of symptoms and problems does *not* equate to health and well-being (Foltz, 2006).

A wellness approach, on the other hand, is strength-based, positivistic, and empowering in nature (Myers & Sweeney, 2008). Wellness models focus on preventing unwellness by promoting health and well-being. Furthermore, Swarbrick (2006) stated that wellness allows for an optimistic view of human capacity and a focus on positive human attributes rather than sickness or problems. Within a wellness paradigm, individuals are allowed to be responsible for their health and be proactive in practicing behaviors that will allow for a balanced lifestyle (Swarbrick, 1997). In summary, following a wellness paradigm allows for viewing individuals as whole beings with unique strengths, rather than reducing people to their problems and issues.

The helping professions are embracing holistic, wellness-oriented approaches that oppose the traditional medical/reductionist models (Myers & Sweeney; 2004; 2005; Myers, Sweeney, & Witmer, 2000). Even with a transition away from the traditional medical model towards a more holistic, positive view of human capacity, the statistics on treating illness and unwellness have exacerbated in the last decade. More than half of all premature deaths in the United States are attributed to modifiable lifestyle factors (Myers, Sweeney, & Witmer, 2005). Furthermore, the U.S. Department of Health and Human Services (U.S. DHHS; 2010) stated that the U.S. federal government spends more than 75% of its health care dollars caring for people with chronic diseases such as heart disease, strokes, and cancer. In addition, the U.S. is now among the top three nations in healthcare spending. Specifically, the U.S. spends over 10% of its gross domestic product on healthcare (Reinhardt, Hussey, & Anderson, 2004). At federal and state levels, the U.S. spends less than 1% of funds and 2% of funds respectively, on prevention of illness (Encyclopedia of Social Work, 1995).

According to U.S. DHHS (2010), healthcare in the United States consumes more of the gross domestic product than any other cost (e.g., food, defense spending). As a result, the primary focus of healthcare remains on treatment of illness rather than on preventions of illness. With the insurmountable amounts of money, time, and efforts spent on treatment of illness and disease, a focus on prevention is warranted. Thus, a wellness paradigm for promoting prevention is essential to moving forward towards improving overall health in the United States.

Keyes (2007) stated that "there is mounting empirical evidence that the paradigm of mental health research and services in the United States must change in the 21st century" (p. 95). There has been an over commitment of helping professionals and resources to remediating problems rather than supporting individual strengths and wellness. In relation to a wellness

paradigm in the helping professions, Witmer and Sweeney (1992) suggested there is growing body of research and literature to support the concept that our society would do well to reassess our model for human development and health services. Thus, the next sections of this chapter defines the concept of wellness, addresses the importance of the wellness movement, and discusses models and assessments of wellness in order to support the idea of prevention and optimal functioning in the helping professions.

Definitions of Wellness

Across the medical and helping profession literature, the definition of wellness varies. In 1947, the World Health Organization developed a definition of wellness as being the "physical, mental, and social wellbeing not merely in the absence of disease" (WHO, 1958, p. 1). This definition influenced all later conceptions of health and wellness. Yet, wellness also focuses on empowering the individual. Wellness is a conscious, thoughtful process that requires increased awareness of choices that are being made towards a more satisfying lifestyle (Johnson, 1986; Swarbrick, 1997). Johnson (1986) further elaborates that wellness involves behaviors leading to improved health and life satisfaction. Wellness is a lifestyle choice that includes a balance of healthy habits and holistic actions (i.e., creating a life-balance). Further, Cohen (1991) describes wellness as an idealistic state in which individuals strive to attain, and as something situated along a continuum. Therefore, people experience bouts of wellness and unwellness throughout their lifetime.

For helping professionals, wellness involves personal growth and professional competence that is accomplished through continuous growth in physical, social, vocational, spiritual, emotional, and mental well-being areas (Witmer & Young, 1996). Similarly, Witmer and Sweeney (1992) depict wellness as interconnectedness between health characteristics; life

tasks (i.e., spirituality, love, work, friendship, self); and life forces (family, community, religion, education). Additionally, Roscoe (2009) described wellness as a holistic archetype that includes physical, emotional, social, occupational, spiritual, intellectual, and environmental components. Dunn (1961) described wellness as "an integrated method of functioning which is oriented toward maximizing the potential of which the individual is capable" (p. 4). Wellness is also illustrated as "the good life" (Diener, 2000) and the positive evaluation of life, including positive emotions, satisfaction, and meaning making (Seligman, 2002). In summary, varying definitions of wellness exist across the helping professions; nevertheless, wellness is a strong theoretical foundation in the helping profession fields.

Theoretical Foundations of Wellness in the Helping Professions

During last 50 years, a shift from the illness model to a more holistic, wellness-oriented paradigm has occurred in many of the helping professions (Granello, 2013; Witmer & Sweeney, 1992). With the shift towards a wellness paradigm, the idea of wellness is anything but new. As early as 5th Century B.C., Aristotle discussed wellness and what it meant to be "whole." In relation to the helping fields (i.e., counseling, psychology, social work) though, the *practice* of wellness is relatively young (Granello, 2013; Myers & Sweeney, 2008).

Early shifts toward wellness are found in psychological and counseling theories (i.e., Humanistic Psychology; Positive Psychology; Strengths Counseling; Counseling Psychology). The origin and nature of wellness as emphasizing wholeness was discussed in Adler's (1954) early writings regarding individual psychology. In his early work on individual psychology, Adler (1954) stated that human beings strived for holism and had a purpose of to continuing their existence on earth. Adler (1956) believed that individuals were continuously striving towards life mastery and that their degrees of social interest and attitudes toward life were of greatest

importance. Adler (1956) also rejected the notion of classifying individuals into categories of dysfunctional behavior and emphasized an understanding of individuals based on a social context. Furthermore, Adler emphasized the idea of *life-style* as referring to the unity within people. Overall, the ideas of social interest and life-style are fundamental to wellness theory, wellness models, and theoretical assessments of wellness and well-being. Furthermore, Adler emphasized that individuals needed wholeness (a balance in life) in order to achieve wellness. Along with Adler, Jung (1958), Rogers (1961), and Maslow (1970) were trailblazers of the wellness movement in the helping professions.

Like Adler, Jung (1958) stressed the idea that individual psyches yearned for integration; that people had an instinctual desire to be balanced and whole. In addition, searching for meaning and integration in life promoted a sense of wholeness and closeness to people in Jung's work (Jung, 1933). Rogers (1961) also contributed to the wellness movement in his writings on the strengths and capacities of human beings. He coined the term "fully-functioning" person to describe individuals practicing health and self-actualization (Rogers, 1961). Rogers (1961) based his humanistic theory on the actualizing tendency of individuals and stressed the idea that people have the capacity to grow and progress into their best selves. Additionally, Rogers specified that human growth and progression involved individuals gaining greater awareness, trust, creativity, and openness (1961). Overall, progressing into more self-actualized individuals allowed for development of well-being and increased levels of personal wellness.

Similar to Adlerian tenets, Maslow (1970) felt that individuals had the propensity for self-actualization and self-realization and that they had the ability to change and grow into what they wanted to become. Maslow (e.g., 1954, 1968, 1970) supported the idea that psychology and other fields were wrong in studying only negative behaviors and illness. Consequently, Maslow

(1954) supported the notion that the human experience is much more than a reductionist/disease oriented perspective. Maslow (1968) studied individuals who he termed self-actualized and identified that people needed certain things to be happy. Ultimately, Maslow (1968) indicated that people needed wholeness, uniqueness, simplicity, effortlessness, playfulness, truth, goodness, self-sufficiency, meaningfulness, and beauty in their lives in order to become self-actualized individuals.

The aforementioned individuals had a lasting and influential impact on the history of wellness in the helping professions (Granello, 2013). The work of Maslow, Jung, Rogers, and Alfred Adler sparked the modern wellness movement of today by providing the theoretical basis for holism and the consideration of positive traits rather than merely focusing on what Maslow (1954) called "a crippled psychology" (p. 234).

Modern Wellness Movement in the Helping Professions

Holistic wellness is influenced by a number of factors, including engaging in physical exercise, maintaining a healthy weight for body height, maintaining nutrition, stress management, coping skills, self-responsibility, appraising health status, environmental sensitivity, and making positive lifestyle changes (Witmer, 1985). Early on, Sweeney and Witmer (1991) stated that much of their work branched from Adler's ideas of individual psychology and his five life tasks of: (a) love, (b) friendship, (c) self, (d) spirituality, and (e) work/leisure. Subsequently, Witmer and Sweeney (1991) developed one of the first wellness models (i.e., the *Lifespan Development Model*) to highlight the importance of wellness and a holistic view of human potential. Further, Witmer (1985) was one of the first individuals to develop a wellness course and both he and Sweeney worked to develop the *Wheel of Wellness* (Witmer & Sweeney, 1992) based off of *Lifespan Development Model* concepts (i.e., Adlerian

tasks). With today's knowledge, Sweeney and Witmer (1991) stated that Adler would be inclined to say that striving for wellness, holism, and the search for optimal human functioning are the ultimate goals of human potential.

Branching from Witmer and Sweeney's work, Myers and Sweeney propelled counseling forward in the modern wellness movement. Their work on the *Indivisible Self Model* and the *Five Factor Wellness Inventory* (Myers, Leucht, & Sweeney, 2004; Myers & Sweeney, 2005) influenced the counseling literature and expanded the use and assessment of wellness with a variety of populations. Witmer and Young (1996) have also been influential in emphasizing the impact of wellness in the counseling field. Both researchers have worked to stress the importance of wellness in counselor education programs as well as the idea that both faculty and students can benefit from a wellness paradigm (Witmer & Young, 1996). Young, Witmer, Myers, and Sweeney were influential in the wellness movement in the helping professions, with additional scholars such as Dunn, Hettler, and Ardell helping to propel the wellness movement forward.

Halbert Dunn (1961) is often credited as the architect of the wellness movement. He stressed the idea of high-level wellness and that individuals have a desire to be well. Dunn suggested that counselors are in a unique position to help individuals achieve high levels of wellness (Dunn, 1977). While Dunn is considered the architect, Hettler (1980) is often deemed the father of the modern wellness paradigm. Hettler (1980) designed the *Hexagonal Model of Wellness* and also helped establish the National Wellness Institute (NWI; 1983) in Stevens Point, Wisconsin. Hettler (1980) defined wellness in terms of an active process in which individuals become more aware and make healthy lifestyle choices to support a healthier existence. Other influential contributors include Travis and Ryan (1981; 1988) who developed one of the first wellness/illness continuum models to look at the dualistic sides of health and wellness, and

Ardell (1977) who similar to Dunn, discussed high-level wellness and the need to break away from doctors, diseases, and the reductionist/negativistic view of individuals.

In summary, many scholars (e.g., Dunn, 1961; Hettler, 1980; Myers & Sweeney, 2005; Witmer & Young, 1996) contributed to the modern wellness movement in counseling and related helping fields. Their contributions have led to a more holistic, positive, and strengths-based view of human beings and an overall focus on human potential and optimum human functioning. In addition, wellness models and assessments were created in order to assess individual holistic wellness, as well as areas of concern (i.e., unwellness/illness). The next sections of this chapter present wellness models and wellness assessments.

Survey of Wellness Models

Granello (2013) recommended that individuals who operate from a wellness paradigm use a model as a type of background or theoretical framework to increase intentionality when working with clients. A number of wellness models are available in the counseling and psychology literature and thus, helping professionals seeking a basis for wellness interventions have a variety of theoretical models from which to choose. Ten common wellness models are described below in chronological order of their creation.

Hettler's Hexagonal Model

Hettler developed a six-dimensional model known as the Hettler's *Hexagonal Model of Wellness* or Hettler's *Six Dimensions of Wellness,* for the NWI in 1980. The Hexagonal Model is composed of six paradigms: (a) occupational, (b) social, (c) spiritual, (d) physical, (e) emotional, and (f) intellectual. In the occupational paradigm, personal satisfaction and enrichment in life as they pertain to an individual's work are recognized. Moreover, at the center of occupational wellness is the idea that people must have a positive attitude toward their work and that work can

be both meaningful and rewarding (Hettler, 1980). In the social area of the model, contributing to the environment and community are highlighted. Social wellness includes individuals being active in the world through communication with others and contributions to the common welfare of human beings (Hettler, 1980). The spiritual category of wellness involves people searching for meaning and purpose in life. According to the *Hexagonal Model of Wellness*, individuals know they have reached spiritual well-being when their actions become more consistent with personal values and beliefs (Hettler, 1980). In the physical arena, Hettler (1980) describes wellness as a need for regular activity. Furthermore, learning about appropriate nutrition standards and risky behaviors (i.e., alcohol consumption and smoking) are of importance. In the physical paradigm, Hettler (1980) states that individuals can achieve optimal wellness through finding a balance of exercise and eating habits (Hettler, 1980).

In reference to the emotional paradigm, individual awareness and acceptance of feelings are paramount. Emotional wellness involves feeling positive and enthusiastic about one's self and one's life (Hettler, 1980). Lastly, in the intellectual paradigm individuals' mental activities are highlighted. The *Hexagonal Model of Wellness* highlights areas such as knowledge, skill, creativity, problem solving, and learning in the intellectual paradigm. The six dimensions of wellness combine and allow individuals to increase their awareness on the interconnectedness of areas contributing to holistic wellness. In summary, the *Hexagonal Model of Wellness* supports optimal human functioning through education on the six wellness paradigms of (a) physical, (b) spiritual, (c) intellectual, (d) emotional, (e) occupational, and (f) social functioning.

Hettler (1980) constructed the *Hexagonal Model of Wellness* to highlight areas influencing overall wellness and the model has been integral in the creation of numerous wellness assessments such as the *Lifestyle Assessment Questionnaire* (LAQ, National Wellness

Institute, 1983), which assesses overall wellness and other related subscales. The LAQ is discussed in greater detail in the wellness assessments section of this chapter.

Lifespan Development Model

Sweeney and Witmer (1991) created the *Lifespan Development Model* (LDM), which demonstrated the interconnectedness of the characteristics of healthy people (Witmer & Sweeney, 1992). The authors used Adlerian life tasks (i.e., love, spirituality, self, work, and friendship) to develop the LDM and strived for a holistic view of well-being. The LDM incorporated theoretical concepts from sociology, religion, education, psychology, and anthropology (Witmer & Sweeney, 1992). In addition to Adlerian life tasks, Sweeney and Witmer discussed the impact of life forces (e.g., religion, education, and media) and global events (e.g., hunger, poverty) as influential in maintaining and achieving holistic wellness. Essentially, the LDM was created as a human developmental model that formulated a holistic view of human functioning and wellbeing within the contexts of one's environment. Witmer and Sweeney used information from the LDM to construct the *Wheel of Wellness* (Sweeney & Witmer, 1991).

Wheel of Wellness

Sweeney and Witmer (1991) and Witmer and Sweeney (1992) created the *Wheel of Wellness* to align with Individual Psychology tenets. The *Wheel of Wellness* model included a number of areas correlating with healthy living, longevity, and quality of life (Myers & Sweeney, 2005). These healthy living areas contained components such as: physical, social, spiritual, occupational, and nutritional, and incorporated the effects of society and other external realms on overall wellness. In addition, the *Wheel of Wellness* model was supported by Adlerian

life tasks and the interactions of life tasks with one another and with other life forces (Sweeney & Witmer, 1991) in comprising overall well-being.

Life task one, *Spirituality* involved purposiveness in life, optimism, harmony and values for character development (Sweeney & Witmer, 1991). Life task two, *Self-Regulation* was comprised of sense of worth, sense of control, realistic beliefs, creativity, spontaneity and emotional responsiveness, sense of humor, and physical fitness and nutrition (Sweeney & Witmer, 1991). Sense of worth and sense of control focused on self-esteem and self-efficacy and individuals' ability to have realistic beliefs and realistic expectations about both categories in order to have life stability and healthy lifestyle choices. Moving on to creativity and emotional responsiveness, Witmer and Sweeney stressed the idea that positive emotional states enhance immune function (Dillon, Minchoff, & Baker, 1985). In addition, Maslow (1970) credited creativity as being integral to fully self-actualized behaviors. Sense of humor was also seen as important to self-regulation. Furthermore, physical fitness, exercise, and nutrition were related to good health and longevity (Belloc, 1973; Sweeney & Witmer, 1991).

Sweeney and Witmer (1991) described life task three, *Work*, as one of the most fundamental life tasks. Specifically, work encompassed everything individuals' did to sustain themselves and contribute to the sustenance of other individuals (Adler, 1954; Witmer & Sweeney, 1992). Sustenance of self and others included involvement in: jobs, careers, volunteering, and other activities. Life tasks four and five (i.e., *Friendship* and *Love*) although similar, differed in that love involved more intimate, committed relations between individuals. Friendship involved a connection with another being, either in a group (i.e., community) or individually. Again, the friendship connection is *not* sexual or intimate in nature (Witmer & Sweeney, 1992).

Though the *Wheel of Wellness* is a frequently cited wellness model and the first model based on counseling theory, limited empirical evidence exists supporting the usefulness of the instrument (Myers & Sweeney, 2005). Thus, Myers (1998) and Myers, Witmer, and Sweeney, (1996) developed the *Wellness Evaluation of Lifestyle* (WEL) to assess the components in the *Wheel of Wellness* model. The WEL is reviewed further in the wellness assessment section.

Indivisible Self Model

Myers, Leucht, and Sweeney (2004) revised the *Wheel of Wellness* model into the *Indivisible Self: An Evidence-Based Model of Wellness* (IS-WEL). The five-factor model conceptualized wellness as a higher order factor with secondary factors of (a) coping, (b) physical, (c) essential, (d) social, and (e) creative paradigms. The second order factors are comprised of 17 third-order areas: *Coping Self* (leisure, self-worth, realistic beliefs, stress management); So*cial Self* (love, friendship); *Essential Self* (spirituality, self-care, cultural identity); *Physical Self* (exercise, nutrition); and *Creative Self* (emotions, control, work, humor, thinking). The unifying factor of wellness is congruent with other theories that view individuals holistically. Specifically, the unifying concept of wellness is similar to Adlerian concepts of wholeism; seeking purpose and meaning making (Adler, 1956; Rogers, 1961); and finding life balance (Hettler, 1984). The five, second order factors listed above (i.e., Creative Self, Coping Self, Physical Self, Essential Self, and Social Self) are combined to encompass the "whole" human being. Each factor has tenets (third order factors) that make each wellness domain unique.

The *Creative Self* second order factor involves ways in which individuals make sense of their world. The third order factors included in this arena are: emotions, positive humor, work, thinking, and control (Myers & Sweeney, 2004). Myers and Sweeney (2004) and Sweeney and Witmer (1992) noted that emotions are comprised of feelings and levels of awareness that allow

people to experience both positive and negative responses. Positive humor includes laughter, the ability to laugh at errors made, and using humor in different capacities of life. Adlerian tenets support humor in that Adler reinforced that helping professionals must have a positive, humor-filled outlook (Sweeney & Witmer, 1992). The work (occupational) tenet involved satisfaction with career, job, or vocational choice. The occupational area also included feeling appreciated at work, having sufficient and sustaining work relationships, and coping with work-related stressors (Myers & Sweeney, 2004). The thinking factor was comprised of open-mindedness, curiosity, and creativity, as well as the ability to appropriately use the three areas to solve problems and cope with stressful situations. Finally, the control dimension encompassed beliefs regarding self-competence, locus of control (i.e., external and internal), and assertiveness in expressing wants and needs (Sweeney & Witmer, 1992). In summary, the Creative paradigm allows for creativity in thoughts and feelings, and expression of humor in a variety of situations.

The *Coping Self* factor included stress management, leisure, realistic beliefs, and worth (Myers & Sweeney, 2004). Coping referred to individuals managing life events and how they reacted to life events. Within the stress management area of Coping, the ability to manage life events was paramount. Leisure time included activities away from work such as personal time and "free" time, and the balance between time spent at work and at leisure. Realistic beliefs centered around an understanding of reality, knowing that life is *not* perfect and that mistakes, errors, and flawed choices will be made. Finally, worth was comprised of self-value and the amount of personal acceptance an individual possesses (Sweeney & Witmer, 1992).

The *Physical Self* factor was composed of nutrition and exercise and involves engaging in physical activity in the promotion of personal wellness. Nutrition referred to individuals eating a balanced diet and maintaining a healthy body weight (Myers & Sweeney, 2004). Furthermore,

the *Physical Self* involves prevention techniques such as weight training, cardiovascular exercise, eating healthy foods, and participating in other physical activities to promote health and wellness.

The *Essential Self* component included gender identity, cultural identity, spirituality, and self-care (Myers & Sweeney, 2004). Essential referred to individual meaning-making and involved taking into account individual satisfaction with gender, level of cultural identity and feelings of cultural acceptance, personal beliefs and belief in a higher power, optimism and hope, purpose in life and transcendence, and valuing the self by practicing safe and preventative behaviors.

Social Self refers to personal interactions with others, including how people connected with others. Love and friendship are included in this dimension and indicated the ability to be in a lasting, committed relationship and to be involved in a supportive, trusting relationship. Love involved respect, growth, shared values, communication and appreciation. Friendship was less involved and was comprised of a non-judgmental, empathic connection (Myers & Sweeney, 2004).

As such, the IS-WEL (Myers et al., 2004) was a holistic wellness model that encompassed many aspects of health and well-being. Contextual factors such as community, family, and social and political systems were also viewed as influential to the model. Together with the five, second order factors and 17 third order factors, the external influencers comprised a holistic view of individual wellness.

Wellness Index & Iceberg Model of Health

Travis and Ryan (1981, 1988) supported the idea that wellness could be present even in the face of illness or disease. They developed a wellness model on a wellness/illness continuum,

with illness on one pole and wellness on another. In Zimpher's model (which is reviewed later), wellness was treated via a medical model and wellness was supported via education, awareness of healthcare needs, and positive growth (Myers & Sweeney, 2005). The midpoint of the wellness/illness continuum, health, involves a neutral setting where illness and health are absent. Lifestyle choices and the dynamic nature of wellness are integral to the Travis and Ryan model of wellness.

In addition to the illness/wellness continuum, Travis (1978) discussed wellness using an iceberg metaphor and labeled it the *Iceberg Model of Health* (Myers & Sweeney, 2005). Current health was situated at the top of the iceberg, and three underlying levels depicted lifestyle and behavior, cultural/psychological/motivational, and spiritual/meaning/being. Though the illness/wellness continuum and the iceberg model are attainable, little empirical support for the wellness/illness continuum model and the *Iceberg Model of Health* exists.

Zimpher Wellness Model

Zimpher (1992) offered a unique model of wellness that focused on well-being in clients with cancer and other chronic diseases (Zimpher, 1992). In Zimpher's model, wellness referred to positioning all available resources so that they are used to their maximum advantage in wellness promotion. In other words, individuals suffering from cancer or other diseases allowed their bodies to take advantage of all of their capacities for healing and moving toward health. Healing in this realm involves bodily recovery and use of personal potential (Zimpher, 1992).

Zimpher (1992) created his wellness model based on the underlying principles that: (a) individuals have an innate urge toward health, (b) personal attitudes influenced treatment, (c) individuals must have a will to live and take a responsibility for their health and healing, (d) individuals must believe cancer is beatable and that cancer implies stress, (e) individuals work

with therapists that serve as empowerment-agents, and (f) that individuals believe they have some level of internal control (Zimpher, 1992). In addition, some of the realms of the Zimpher model included: (a) immune functioning, (b) medical issues, (c) interpersonal support, (d) psychodynamics, and (e) energy sources.

The Zimpher Wellness Model differs from the other wellness models in that the presence of severe illness or disease is necessary. The Zimpher model includes stages of counseling for recovery that allow for individuals to progress and recycle through a number of predictable levels during their battle with cancer. Stages of counseling for recovery include: (a) entering into a stage of panic or shock when receiving initial diagnosis, (b) restoring independence through counseling and gaining a sense of control, (c) regaining the spirit to consider living and becoming empowered, and (d) reaching out to help others as individuals progress emotionally (Zimpher, 1992). Essentially, Zimpher's model focuses on utilizing resources to maximize holistic wellness in the face of severe chronic illness.

Model of Spiritual Wellness

Chandler, Miner Holden, and Kolander (1992) developed the *Model of Spiritual Wellness*, a holistic model of wellness comprised of (a) physical, (b) emotional, (c) occupational, (d) social, and (e) intellectual paradigms. Within the model, Chandler and colleagues (1992) viewed spirituality as an integral component of each wellness paradigm and as an entity that influenced optimum wellness. Furthermore, within the *Model of Spiritual Wellness*, individuals who have an appropriate balance and developed potential in the personal realm and the spiritual realm where considered optimally well (Chandler et al., 1992). The Chandler and colleagues (1992) model is unique in that spirituality is *not* only central, but is viewed as influential to all aspects of holistic wellness.

Perceived Wellness Model

The *Perceived Wellness Model* (PWM; Adams, 1995; Adams, Bezner, & Steinhardt, 1997) was created as a multidimensional model supporting wellness as a manner of individual *being*; allowing for experiences of balanced and consistent development in spiritual, social, emotional, intellectual, physical, and psychological tenets of human existence. The PWM posits that when individuals view their wellness tenets as equal, they are healthier. A limitation of the PWM is that in order for individuals to achieve maximum or high level wellness, *all* domains must be equal. Consequently, the authors of the PWM model posit that wellness paradigms must be equal (e.g., a balance between paradigms such as spiritual, social, and physical), which is challenged by individuals who think that wellness domains are individualized; that depending on the individual, certain domains may be of more importance and thus, an equal representation would *not* equate to wellness.

Clinical and Educational Model of Wellness

The last wellness model reviewed is the *Clinical and Educational Model of Wellness* (CEMW; Granello, 2000). The CEMW was created for use with clients in clinical settings and is useful as an example of what contributes to and influences individual wellness. The areas of the CEMW model are: (a) creativity, (b) social relationships, (c) physical and nutritional concerns, (d) emotional regulation, (e) cultural and environmental context, (f) preventative self-care, (g) cognition, and (h) spirituality (Granello, 2013). A focus of the CEMW is that all areas are interactive and that every individual should be viewed in the context of his or her own life. To date, no studies were found assessing the psychometrics of the CEMW. Thus, use of the instrument should be done so with caution, as reliability and validity with specific populations has yet to be evaluated.

Summary

This section of the chapter reviewed models of wellness and the factors influencing holistic well-being. Most of the wellness models contain some holistic component and highlight the balance of different constructs contributing to overall wellness. The discussion included models incorporating multidisciplinary components of wellness, models for special populations (i.e., chronic illness, spiritual wellness focus), wellness continuums, and models incorporating internal (e.g., physical, intellectual) and external (e.g., community, global) wellness influencers. Wellness models were discussed and a review of the literature was conducted to depict the models' purpose, components of wellness, and intentions for use. The next section reviews wellness assessments, many of which stem from the wellness models presented in the aforementioned section.

Survey of Wellness Assessments

Within the helping professions are a number of wellness models that depict either unidimensional wellness constructs and/or multidimensional wellness components (i.e., Hettler, 1980; Sweeney & Witmer, 1991; Zimpher, 1992). However, the models are *not* always sufficient in *evaluating* individual level(s) of wellness because models are used for a pictorial representation of wellness rather than assessing individual wellness levels. Thus, wellness assessments that are used to evaluate individual wellness are needed.

Wellness-related assessments exist, though many are *not* effective measurement tools (Hattie et al., 2004). Moreover, in the considerable breadth of literature in counseling, nursing, psychology, and social work; an absence of theory-based interpretations of well-being exists (Ryff & Keyes, 1995). Although there are a plethora of assessments for measuring wellness, many are *not* theoretically and/or empirically supported (Hattie et al., 2004). In addition, many of

the available wellness assessments were *not* developed via appropriate scale development steps (Crocker & Algina, 2006; DeVellis, 2012; Dimitrov, 2012). In this section, nine different wellness assessments are introduced. Theoretical foundations of the wellness assessments, empirical support for the instruments, and research related to the measurers are reviewed.

Wellness Evaluation of Lifestyle

The *Wellness Evaluation of Lifestyle* (WEL; Myers, Sweeney, & Witmer, 1998) is a paper-and-pencil assessment developed to measure wellness. The WEL is based on the *Wheel of Wellness* model and the authors' conceptualize wellness based on Adlerian life tasks (i.e., self, love, friendship, work, and spirituality) and incorporate global occurrences and life forces as wellness influencing events (Hattie et al., 2004). Essentially, the WEL is used to assess the five life tasks and subtasks in the *Wheel of Wellness*.

The WEL was created from a pool of more than 500 items in an initial study by Myers et al. (1998). A 5-point Likert type scale was implemented from *strongly agree* to *strongly disagree.* The first form of the WEL consisted of 114 items and was administered to a convenience sample of 18-91-year-old individuals (N = 723). In original analysis, only 9 of the 16 scales had alpha reliability assessments above .60 (Myers et al., 1998). Thus, a series of studies were conducted to improve the weaker scales with a variety of populations (e.g., high school students, graduate students, undergraduate students).

Hattie and colleagues (2004), used the WEL with a large sample (N = 3,043) of university students, young adults, middle-aged adults, older adults, and 18-year-olds. The sample contained 54% male and 46% female participants and approximately 80% White individuals. A maximum-likelihood exploratory factor analysis (EFA) was conducted and specified 17 factors and 103 items loading on those factors with average factor loadings of .62 (Hattie et al., 2004).

Hattie and colleagues found statistically significant main effects for age $F(68, 11049) = 5.14$, $p < .001$; and ethnicity, $F(34, 5630) = 2.53$, $p < .001$, and no significant interactions. An additional EFA yielded a five-factor structure and a confirmatory factor analysis (CFA) indicated that the data had an acceptable fit to the WEL theoretical model (RMSEA = .042; $\chi^2 = 8261$, $df = 2533$).

Hermon and Hazler (1999) used the WEL to investigate the relationship between psychological well-being and quality of life in a sample of undergraduate college students (N = 155). Herman and Hazler explored the nature and strength of relationship between psychological well-being and students five factor holistic wellness (i.e., spirituality; work; recreation, and leisure; self-regulation; friendship; and love). The authors used the WEL and the *Memorial University of Newfoundland Scale of Happiness* (MUNSH; Kozma & Stones, 1994) and a relationship between reported adherence to a wellness model (WEL), state of wellness, and trait aspects of psychological well-being was found. In addition, Hermon and Hazler (1999) found the five WEL variables to be significantly related to self-reported levels of psychological well-being, $F = 10.43$, $p < .01$, $df = 10{,}296$. Thus, Herman and Hazler (1999) suggested that college-level students would benefit from programs and activities that aid in developing self-regulating wellness behaviors.

Myers, Mobley, and Booth (2003) used the WEL to assess counseling students (N = 263) levels of wellness. The authors expected to find "low levels of wellness within the student population" (p. 270). However, graduate level students (entry-level master's students and doctoral students) had higher levels of overall wellness than the general adult norm group; however, the effect sizes were small ($p = .001$, $d = .24$ for master's level and norm group and $d = .29$ for doctoral students and the norm group), indicating that practical significance was not achieved. In addition, doctoral level students experienced higher levels of wellness than entry-

level master's students (Myers et al., 2003); however, entry-level students reported statistically significant scores on Self-Care (p = .001, d = .27), Gender Identity (p = .001, d = .22), Friendship (p = .001, d = .21), and love (p = .001, d = .26)

Ultimately, counseling students presented with higher levels of overall wellness as measured by the WEL (Myers et al., 2003). Nevertheless, the participants' wellness could have been influenced by a number of extraneous factors such as: (a) being in a counseling program; (b) being familiar with the wellness paradigm; or (c) having completed course work such as assessment, development, and counseling theories in their counseling program. As such, individuals who choose counseling or helping fields may simply be "healthier" than the general population or participation in their programs may impact their wellness awareness and result in increased holistic well-being.

In order to evaluate discriminant validity with other wellness measures, Myers et al. (2003) compared the WEL with the *Testwell* (NWI, 1983) and found that it did *not* correlate as high as expected (e.g., .60 for spirituality, .38 for sense of control, .47 for problem solving and creativity, .61 for exercise, .74 for nutrition, .48 for self-care, .41 for work, and .45 for emotional control; Hattie et al., 2004). However, the majority of the items loaded on the five factors sufficiently with only two items (i.e., self aware and essence) loading lower than a .50. The remaining WEL items ranged from .59 to .91.

According to Hattie et al. (2004) following a series of studies conducted to improve the psychometric properties of the WEL, although the psychometric properties of the instrument were supported, the data did *not* support the hypothesized model (i.e., the *Wheel of Wellness*). Thus, though the WEL supported the idea that wellness could be multidimensional, it did *not* fully support Wheel of Wellness model from which it was derived. Examination of the data led

to the creation of a new model of wellness, the *Indivisible Self Model of Wellness* (IS-WEL, Myers, Leucht, & Sweeney, 2004).

Five Factor Wellness Inventory

The new *Indivisible Self Model* was comprised of creative, physical, coping, social, and essential factors (Hattie et al., 2004). As stated, the second order factors consisted of intelligence, control, emotion, humor, and work under the Creative category, leisure, stress, worth, and beliefs under Coping, essence, self-care, gender identity, and cultural identity under the Essential factor, friends and love under Social, and nutrition and exercise under the Physical realm. The wellness assessment associated with this revised model is the *Five Factor Wellness Evaluation of Lifestyle* (5F-Wel; Myers et al., 2004).

The 5F-Wel is a 90-120-item questionnaire (based on the intended population the number of items changes) that was created to assess overall wellness. Sweeney and Witmer (1992) developed the 5F-Wel using factor analysis on the original assessment, the WEL. In addition to the second and third order factors listed above, Myers and Sweeney (2004) illustrate the influence of contextual systems on individual wellness. Specifically, neighborhood, community, family, environment, culture, global events, and life span development contribute to overall life satisfaction and create a holistic view of wellness (Myers & Sweeney, 2004).

The 5F-Wel (Myers et al., 2004) is one of the most frequently used assessments of wellness. Internal consistency for the 5F-Wel ranges from .80 to .96 and the instrument was normed on a plethora of populations (Myers & Sweeney, 2005). Though the scale was used in many research investigations with a variety of populations, some researchers caution the rigor of the internal consistency values because they are reported via the authors themselves from an enclosed dataset. Further, the scale is quite lengthy which makes application difficult for

everyday use. Another limitation of the 5F-Wel is the cost, where individuals wanting to use the scale must pay for the assessment, the manual, and data analysis.

Health Promoting Lifestyle Profile-II

The *Health Promoting Lifestyle Profile-II* (HPLPII; Walker, Sechrist, & Pender, 1987) assesses an overall view of "a positive approach to living that leads individuals toward realizing their highest potential for well-being" (p. 76). The HPLPII is a 52-item assessment that includes a 4-point Likert-type scale ranging from *Never* to *Routinely*. The HPLPII is comprised of six subscales of: (a) Spiritual Growth, (b) Interpersonal Relations, (c) Nutrition, (d) Physical Activity, (e) Health Responsibility, and (f) Stress Management and assesses frequency individuals report engaging in health related activities that enhance or maintain their well-being, fulfillment, and self-actualization (Walker et al., 1987). In the initial study of the HPLPII, Walker et al. (1987) used item analysis, factor analysis, and reliability measures with a population of adults (N = 952). A six factors structure resulted and the factors accounted for a small, 41% of the total variance (Walker et al., 1987). Walker, Sechrist, and Pender (1995) report Cronbach's alpha levels ranging from .79 to .87 in the subscales of the HPLIII with a total of .94.

Fowler (1997) used the HPLPII with a sample of 42 chronically ill adults (n = 30 males; n = 12 females). Fowler's (1997) purpose of the study was to add to the empirical literature on the relationship between health-promoting behaviors and hope. The HPLPII was used in conjunction with the *Herth Hope Index* (HHI; Dufault & Martocchio, 1985). Fowler (1997) found a small relationship between hope and health-promoting behaviors (r = .40) in her study, indicating that individuals who are chronically ill may have a limited range of health-promoting behaviors. In addition, Fowler (1997) reported alpha levels for the HPLPII subscales ranging from .80 to .92, with a total coefficient alpha of .94.

Perceived Wellness Survey

The *Perceived Wellness Survey* (PWS; Adams, Bezner, & Steinhardt, 1997) stems from the *Perceived Wellness Model* (Adams et al., 1995; Adams et al., 1997) and is a 36-item self-report wellness measure designed to assess the degree to which adults perceive themselves as being well across the PWM dimensions (e.g., spiritual, social, emotional, intellectual, physical, psychological). The PWS is comprised of 6-point Likert scaling from 1 (*very strongly disagree*) to 6 (*very strongly agree*) and involves scoring in each wellness dimension as well as an overall composite wellness score. Wellness magnitude scores, wellness balance scores, and wellness composite scores can also be calculated.

Adams and colleagues (1997) examined construct-related validity for the by conducting a CFA on a sample (N = 359). Goodness of fit (GFI) and average standardized residual (ASR) coefficients were .82 and .045 respectively. Though the factor structure of the PWS was analyzed, Adams et al. (1997) used a principal-component analysis (PCA), which is *not* the best analysis for the nature of the study. However, according to Adams, Bexner, Garner, and Woodruff (1998), the PWS has shown construct validity and reliability as a wellness measure. In addition, the items in the PWS were shown to have internal reliability (α = .91) and consistency in the subscales (Adams et al., 1997; Bezner & Whistler, 1999).

Harari and colleagues (2005) examined the psychometric properties of the PWS and the degree to which the PWS reflected the PWM in a population of college-level students (N = 317). Participants were psychology undergraduates and were comprised of a majority female (70%) and white (66.9%) population. The purpose of the study was to investigate the factor structure of the PWS, the validity of the subscales in relation got the factor model, and the criterion-related validity of the PWS scores (Harari et al., 2005). Harari and colleagues conducted an exploratory

factor analysis and found one interpretable general factor of perceived wellness, rather than a six-factor subscale. In fact, the six factors *all* had significant positive correlations ($p < .001$), resulting in the PWS inaccurately representing the PWM (Harari et al., 2005). Additionally, internal consistency for the PWS ($\alpha = .91$) in the Harari et al. (2005) study was consistent with other research (Adams, 1995; Adams et al., 1998) and was found to support a unidimensional model. In relation to criterion-related validity, Harari and colleagues revised the PWS model and found that the total score correlated with lower scores on psychological functioning measures (e.g., BAI; Beck & Steer, 1993; BDI-II; Beck, Steer, & Brown, 1996). Specifically, the total PWS score relates to individual reports of depression and anxiety. Essentially, Harrari and colleagues (2005) stated that the PWS provides a global but not multidimensional measure of perceived wellness.

Sigman and colleagues (2009) examined the relationship between perceived wellness (as measured by the PWS) and exercise self-efficacy in a college population ($N = 611$). The participants completed the PWS and the *Self-Efficacy and Exercise Habits Survey* (Sallis, Pinski, Grossman, Patterson, & Nader, 1990), which were used to assess perceived wellness and exercise self-efficacy. Sallis and colleagues (1990) found that individuals who were in a basic studies lifetime physical activity and wellness course had self-efficacy levels that were significantly related to wellness and the subscales of wellness on the PWS. In addition, exercise self-efficacy was a predictor of spiritual, intellectual, emotional, psychological, and physical wellness (Sallis et al., 1990). The results in Sallis and colleagues (1990) research identified that feelings regarding exercise correlate with areas of wellness beyond physical realms. Furthermore, perceived wellness appeared to influence participants' holistic wellness. While the research has practical implications for helping professionals at the college level, results were

limited and potentially confounded because the participants were actively involved in a wellness course during the study. For this reason, participant responses could have been biased by the fact that they were learning about wellness-related content such as physical wellness or nutritional wellness for example, during the research investigation. Learning about wellness tenets during the research study could have influenced participant responses on the PWS.

Overall, empirical evidence on the validity of the PWS is mixed. While there is some evidence in the literature supporting the subscales of the PWS measuring overall well-being, other studies do not support the PWS as a measure of multidimensional facets of wellness. In addition, the majority of the PWS studies reviewed include a predominantly college-level, white, female population: thus, the results may not be generalizable to a larger population. As a result, the PWS should be used with caution in diverse populations and as a multidimensional wellness measure.

Lifestyle Assessment Questionnaire

The *Lifestyle Assessment Questionnaire* (LAQ; NWI, 1983) was based off of Hettler's (1980) *Hexagonal Model of Wellness*. Hettler's original model was comprised of: (a) occupational wellness, (b) spiritual wellness, (c) physical wellness, (d) intellectual wellness, (e) emotional wellness, and (f) social wellness (1980). The LAQ is a 100-item measure that assesses four dimensions including wellness and medical alert. The LAQ is comprised of questions with 5-point Likert scaling, with lower scores equating to lower levels of wellness.

Cooper (1990) examined the factor structure of the LAQ and found that it failed to support the six subscales of the instrument and instead, a two-factor structure of behavior well-being and cognitive well-being was identified. Similarly, Palombi (1993) reported the LAQ measured a unidimensional construct. She found the internal consistency of the LAQ subscales

ranged from .67 to .94 (Palombi, 1993; Richers, 1992). In addition, Palombi reported coefficient alpha of the total LAQ score as .93. DeStefano and Richardson (1992) used the LAQ with a sample of college freshman and found low to moderate correlations between the subscales. Using factor analysis, DeStefano and colleagues found the LAQ yielded a three factor model and reported little support for external validity of the LAQ (1992). Thus, research supporting a factor structure of the LAQ is mixed, with a variety of factor models being reported.

Sanders (1998) used the LAQ and the *Irrational Beliefs Test* (IBT; Jones, 1969) to examine irrational beliefs and wellness in counselors-in-training (N = 121). Sanders (1998) found a significant difference between beginning counselors-in-training and advanced counselors-in-training in regards to wellness, but no statistical difference between advanced counselors-in-training and beginning counselors-in-training in reference to irrational beliefs. Furthermore, Sanders (1998) concluded that as individuals become more autonomous, they also become more aware as a result of their training.

Lifestyle Coping Inventory

Hinds (1983) developed the *Lifestyle Coping Inventory* (LCI) for adults and college students to assess current wellbeing and illness. The model allows for assessing wellness and also serves as a tool to evaluate the risks individuals are taking and life choices individuals are making (Hinds, 1983). The LCI contains 142 questions and 7 dimensions of wellness: nutritional actions, physical care actions, cognitive and emotional actions, coping style actions, low-risk actions, environmental actions, and social support actions (Hinds, 1983). Items on the LCI are on a 5-point Likert scale ranging from *very often* to *never*. The LCI has internal consistencies ranging from .70 to .90 in the literature (Palombi, 1993).

On the other end of the spectrum from wellness-based assessments (i.e., pathology realm) are assessments that measure constructs that are theoretically found as representative of unwellness in helping professionals. The assessments reviewed in next section represent three of the most widely used instruments in assessing helping professional burnout and related issues corresponding with being unwell.

Maslach Burnout Inventory-Human Services Scale

The *Maslach Burnout Inventory-Human Services Scale* (MBI-HSS; Maslach & Jackson, 1996) is a 22-statement scale that is used to evaluate burnout and work-related exhaustion. The MBI-HSS can be used to assess for depersonalization, emotional exhaustion, and devaluing achievement and success (Maslach & Jackson, 1996) and is one of the most widely used burnout assessments, which has been applied in approximately 90% of all empirical burnout studies (Schaufeli & Enzmann, 1998). Internal consistency for the MBI-HSS ranges from .60 to .80 (Maslach & Jackson, 1996). The MBI-HSS has been used in numerous empirical investigations with a plethora of populations.

According to Kristensen, Borritz, Villadsen, and Christensen (2005), the MBI is an insufficient measure to assess burnout. Kristensen and colleagues (2005) provide six reasons for developing a new burnout inventory, the *Copenhagen Burnout Inventory* including: (a) a circular argument, (b) unclear relationship between the MBI and the concept of burnout, (c) mixture of an individual state, a coping strategy, and an effect, (d) unacceptable assessment questions, (e) questions about what the MBI measures, and (f) availability (Kristensen et al., 2005). In summary, Kristensen and colleaguies (2005) criticize the MBI because of the nature of the questions, the issue that the new forms of the MBI are *not* generic (as the authors intended), and that the MBI versions are *not* available in the public domain.

Counselor Burnout Inventory

The *Counselor Burnout Inventory* (CBI; Lee et al., 2007) is a 20-item, self-report questionnaire comprised of the five subscales of: Exhaustion, Incompetence, Negative Work Environment, Devaluing Client, and Deterioration in Personal Life that was created to assess burnout in counselors. Each item has a 5-point Likert response scale ranging from 1 (*never true*) to 5 (*always true*). Examples of CBI items are "I feel frustrated with the system in my workplace" and "I do not feel like I am making a change in my clients." The CBI contains items that are reflective of various levels of burnout (Lee, Cho, Kissinger, & Ogle, 2010).

Lee and colleagues (2007) developed the CBI from an initial pool of 296 items. Sixty counselors participated in a pilot study with the initial items and five experts in the counseling and measurement field reviewed the initial items. Through the pilot study and expert reviews, Lee et al. (2007) found 40 items that were related to five burnout dimensions: Dimension 1 (exhaustion), Dimension 2 (negative work environment), Dimension 3 (devaluing client), Dimension 4 (incompetence), and Dimension 5 (deterioration in personal life). Following item reduction, Lee et al. (2007) performed two analyses, EFA and CFA with two independent samples. For the first sample of counselors (N = 258), Lee et al. (2007) and a five-factor model was determined that accounted for approximately 55% of the total variance (Lee et al., 2007). Based on examination of factor pattern coefficients, items were reduced to 20. Lee and colleagues (2007) then ran a second EFA on sample two (N = 132) to determine if simple structure was achieved. The second EFA again yielded a five factor structure that accounted for approximately 67% of the variance, with all items associating to their factor. In the second independent sample (N = 132) of counselors, a maximum-likelihood CFA was conducted and

goodness-of-fit indices indicated adequate fit of the data (CFI = .957; TLI = .948; SRMR = .052; RMSEA = .050; Lee et al., 2007).

Lee and colleagues (2007) compared the CBI with the MBI-HSS (Maslach & Jackson, 1996) to provide evidence of convergent and criterion-related validity and found support for convergent validity through correlations with MBI-HSS subscale scores. Lee and colleagues (2007) found the exhaustion subscale of the MBI-HSS as positively correlated with the Emotional Exhaustion subscale of the CBI ($r = .73$, $p < .01$), followed by Negative Work Environment ($r = .62$, $p < .01$), Devaluing Client ($r = .31$, $p < .01$), and Incompetence ($r = .30$, $p < .01$). The Depersonalization subscale of the MBI-HSS strongly correlated with the Devaluing Client subscale of the CBI ($r = .56$, $p < .01$) and the Personal Accomplishment subscale of the MBI-HSS was negatively correlated with the CBI subscales of Incompetence, Devaluing Client, and Exhaustion (Lee et al., 2007). Overall internal consistency of the 20-item CBI subscales ranged from .80 to .84. Lastly, test-retest reliability was examined with 18 participants from sample two. Participants were contacted six weeks later and completed an additional CBI survey. Pearson product-moment correlations of the two responses were .85 for Exhaustion, .82 for Devaluing Client, .72 for Negative Work Environment, .73 for Deterioration in Personal Life, and .72 for incompetence (Lee et al., 2007) thus indicating sound test-retest reliability of CBI scores.

In a second study, Lee et al. (2010) investigated the burnout typologies among professional counselors by using the CBI and the MBI-HSS (Maslach & Jackson, 1981) with a population of 132 professional counselors. The sample consisted of approximately 44% school counselors, 9% family counselors, 25% mental health counselor, 8% college counselors, 4% rehabilitation counselors, 2% career counselors, and 10% who provided multiple responses (Lee

et al., 2007). Years of counselor experience ranged from 1 year to 33 years (*M* = 11.31, *SD* = 8.37) and the majority of the sample were female (84%). Alpha coefficients for the population were .85 (Exhaustion), .83 (Negative Work Environment), .78 (Deterioration in Personal life), .80 (Devaluing Client), and .73 (Incompetence).

In the Lee and colleagues (2010) investigation, burnout was found to include specific typologies of: cluster one (low scores on all subscales, Exhaustion, Incompetence, Negative Work Environment, Devaluing Client, and Deterioration in Personal Life), cluster two (medium scores on Exhaustion, Negative Work Environment, and Deterioration in Personal Life subscales, high Incompetence and Devaluing Client scores), and third cluster (high Exhaustion, Negative Work Environment, and Deterioration in Personal Life scores and moderate to low scores on the Incompetence and Devaluing Client subscales). The first cluster was labeled well-adjusted counselors (WAC) because of the low scores on the burnout subscales, the second cluster was labeled disconnected counselor (DC) due to the depersonalization and unresponsiveness from clients' needs, and cluster three was labeled persevering counselor (PC) because though the counselors had the highest Exhaustion, Work Environment, and Deterioration in Personal Life subscales, Incompetence and Devaluing Client scores were low to moderate (Lee et al., 2010). The WAC cluster was found to be the most common typology, and counselors in this realm scored lowest on the Depersonalization and Emotional Exhaustion subscales of the MBI-HSS and received highest scores on Personal Accomplishment (Lee et al., 2010). Individuals in the DC cluster scored higher on the Depersonalization scale of the MBI-HSS. Finally, cluster three (PC) counselors were flexible and responsive to client needs (Lee et al., 2010).

The CBI is a sound scale for assessing helping professional burnout and includes items related to personal life, work environment, and feelings of competency (Lee et al., 2007). Furthermore, the CBI was constructed through sound scale development procedures including item-analysis, EFA, and CFA. Though the CBI has strengths, a limitation is the self-report nature of the assessment and the risk of environment, moods, and feelings influencing results (Lee et al., 2007). In addition, the Lee et al. (2007) implemented an EFA and CFA on the same sample (sample two), something that is considered incorrect in the scale development literature (e.g., Costello & Osborne, 2005). Even with limitations, the CBI provides a clearer picture of helping professional burnout and allows for increasing awareness on different aspects of burnout in personal and professional realms.

Summary

In comparing the assessments of wellness, the majority of the instruments were constructed to measure multidisciplinary components of wellness (e.g., physical, coping, intellectual, spiritual). Specifically, the LAQ, 5F-Wel, WEL, and the PWS were developed to measure secondary factors that contributed to total or holistic wellness. However, empirical research findings support that the PWS and the LAQ measure the construct of wellness unidimensionally (e.g., Palombi, 1992). Similarly, the subscales of the WEL do *not* meet statistical standards found in the literature. The WEL, 5F-Wel, Hettler's Model, the Zimpher Model, and the PWS were designed to measure wellness within the confines of a defined wellness model. For example, researchers can use the WEL to measure wellness based off of the *Wheel of Wellness* map. Likewise, the researchers can use the 5F-Wel to measure wellness based on the *Indivisible Self Model*. As a result, the assessments are confined to their respective models of wellness when determining individual levels of well-being. As a commonly used assessment,

the 5F-Wel has been implemented in a plethora of research investigations surrounding wellness. Though there is empirical research supporting the multidisciplinary aspects of the instrument (i.e., five secondary factors of wellness), the majority of the statistics for the 5F-Wel are reported by the authors in the assessment manual (Myers, Sweeney, & Witmer, 2005). All data collected with the 5F-Wel must be sent to the authors for analysis; therefore, this procedure is a weakness of the assessment because the only the authors of the 5F-Wel are permitted to conduct data analysis on the instrument.

Another limitation of the 5F-Wel, WEL, PWS, LAQ, PWS, Zimpher Model, and the CEMW Model is that they were not constructed via appropriate scale development procedures as outlined by Crocker and Algina, (2006), DeVellis, (2012), and Dimitrov (2012). Specifically, none of the authors of the assessments stated that the instruments were designed using the suggested scale development steps (e.g., defining clearly what to measure, developing initial item pool, having the items reviewed by experts). As a result, the methodology behind constructing many of the assessments may be weak or questionable. In addition, of the assessments described and in an exhaustive review of the literature, none measured perceived wellness, aspirational wellness, and the discrepancy between perceived and aspirational levels of wellness. Thus, the wellness model for this research investigated the aforementioned tenets.

Importance of Wellness in the Helping Professions/Problem Statement

Operating from a wellness paradigm allows helping professionals to follow a salutogenic (health enhancing) standard in promoting health and well-being. Similarly, educating and promoting wellness in others allows for an increase in personal wellness arenas. According to Pence Wolf, Thompson, and Smith-Adcock (2012), counselors benefit from realizing their humanness and admitting that they need time for self-care and healthy lifestyles. Furthermore,

helping professionals must shift away from the illness/deficit paradigm and embrace self-care in order to foster a health environment.

In the helping professions, a number of codes and guidelines supporting the wellness paradigm exist. For instance, the American Counseling Association (ACA, 2014) *Code of Ethics* states that counselors must monitor themselves "for signs of impairment from their own physical, mental, or emotional problems" (Standard C.2.g, p. 9). Moreover, counselors are advised to monitor themselves for signs of impairment and "refrain from offering or providing professional services when such impairment is likely to harm clients" (Standard F.5.b, p. 13). The American Psychological Association *Ethical Principles of Psychologists and Code of Conduct* (2010) also suggests that psychologists should refrain from providing services to clients when their personal problems may interfere with their work or when they know there is a likelihood that their personal issues may influence their competence (Standard, 2.06). The Council for Accreditation in Counseling and Related Education Programs (CACREP, 2009) *Standards* also supports the idea that helping professionals should have an orientation to wellness and prevention (Section II.5.a) and that they have a duty to promote optimal wellness and growth in clients (Section II.2.e). Thus, wellness and the prevention of impairment are intertwined throughout the standards of the helping professions. Consequently, it is unethical for helping professionals to operate while personally or professionally impaired and/or unwell.

Helping professional personal wellness is important because individuals who are unwell are *not* able to provide optimal services to clients (Lawson, 2007). Furthermore, when counselors (i.e., helping professionals) take care of themselves, they are more able provide quality care and meet the needs of their clients (Lawson, 2007). In relation to helping profession students and faculty, Roach and Young (2007) found that counselors-in-training and counseling faculty (*N* =

204) reported personal wellness as an integral component to promote effectiveness with clients. In addition, Skovholt (2001) stated that counselors-in-training are at risk for distress and stress because of working with people who are experiencing pain and because of the challenge in mastering the ambiguity of the counseling process.

Counselors and other helping professionals are vulnerable to becoming ineffective because of the nature of their work (Skovholt, 2001). Because helping professions are highly active, individuals working in these fields must engage and disengage with clients numerous times throughout their careers (Cummins, Massey, & Jones, 2007), which is referred to as the *caring cycle* (Skovholt, 2001) and involves helping professionals repeatedly engaging via empathic attachment and becoming actively involved in therapy with clients, and then disengaging via actively becoming separated with clients (Cummins et al., 2007). According to Skovholt (2001), empathy and attachment involve therapists' vulnerable side, a part that can be hurt during the process. For this reason, counselors and helping professionals continuously place themselves at risk because of the nature of their work.

Young and Lambie (2007) and Skovolt (2001) supported the idea that counselor effectiveness included confronting, accepting, and finding meaning in situations; thoughtful assertiveness, and partaking in wellness lifestyles. Furthermore, helping professionals who struggle finding meaning, being thoughtful, and implementing wellness lifestyles may struggle thriving in a profession where working with difficult clientele is commonplace. Likewise, helping professional preparation programs should integrate wellness instruments and psychoeducation into the curriculum to emphasize wellness, to promote self-care, and to increase awareness about the importance of well-being in the helping fields. As such, helping

professionals should integrate wellness into their daily lives. (Lambie, Smith, & Ieva, 2009; Young & Lambie, 2007).

As stated, though wellness is viewed as the backbone of the counseling profession and integral to other helping professions, many of the individuals in helping professions do *not* practice wellness or promote it in their own lives (Granello, 2013; Witmer & Young, 1996). According to Witmer and Young (1996), many of the individuals attracted to and entering into the helping professions are already impaired and have an increased likelihood for adjustment issues and personality concerns. Further, White and Franzoi (1990) stated that counselors-in-training have a higher propensity for physiological distress than the general public. Cummins and colleagues (2007) iterated that counselors and counselors-in-training are often remiss about taking their own advice about wellness. Why does this matter? Counselors and counselors-in-training that are considered *well* are more likely to help their clients become more *well* (Lawson et al., 2007). Consequently, impaired counselors are more likely to harm their clients (Lawson et al., 2007; Witmer & Young, 1996). As a result, it is imperative that we assess wellness in counselors and counselors-in-training.

Regarding practicing helping professionals, Lambie et al. (2009) asserted that counselor functioning and therapeutic effectiveness is influenced by overall wellness. Further, even a good support system and sufficient supervision may *not* buffer the effects of distress faced by helping professionals (Cummins et al., 2007). Pope, Tabachnick, and Keith-Spiegel (1987) found that nearly 60% of the psychologists surveyed reported working when they were too distressed to be effective with clients. In addition, Sherman and Thelen (1998) found that life events and personal illness caused therapists (N = 522) to feel significant distress. Consequently, Cummins et al. (2007) stated that distress can lead to dissatisfaction with work and result in cancellations of

therapy sessions with clients, reduced ability to be empathic towards clients, and failure to meet basic requirements of the helping profession.

Corey (2000) noted "it is not possible to give to others what you do not possess" (p. 29). As such, helping professionals who are *not* well will struggle to promote wellness in others. Similarly, unwellness factors (i.e., distress, illness) can lead to ineffective helping professionals and influence individuals on personal and professional levels. As a result, helping professionals should assess wellness and consistently strive for increasing awareness on the holistic components to overall wellness via learning about the theoretical and empirical research on wellness models and wellness assessments/scales.

Dimensions Influencing Wellness

The literature on wellness includes a number of phenomena that are supported in influencing holistic wellness. Dimensions that will be highlighted in the following section include: (a) physical, (b) social/relational, (c) occupational, (d) emotional, (e) intellectual, (f) psychological, (g) coping, (h) spiritual, (i) optimism, (j) self, (k) flow, (l) flourishing, (m) gratitude, (n) hope, and (o) career sustaining behaviors.

Physical Domain

Hettler (1980) defined physical fitness as a wellness component that encompasses physical health in the realms of strength, flexibility, fitness, and cardiovascular exercise. Adams and colleagues (1997) described physical wellness as positive expectations and optimistic perceptions of physical health. Belloc (1973) and Belloc and Breslow (1972) established a relationship between health habits, health, and life expectancy. In addition, studies by Penedo and Dahn (2005), and Warburton, Nicol, and Bredin (2006) supported the link between physical activity and positive health.

Moreover, researchers have investigated assessing the risk of physical inactivity (Berlin & Colditz, 1990; Kohl, 2001; Lee, Hseih, & Paffenbarger, 2000) on life longevity and death. Similarly, increasing physical fitness reduces the risk of premature death (Erikssen, 2001; Warburton et al., 2006). Furthermore, physical activity is associated with decreased risk of diabetes (U.S. Department of Health and Human Services, 1991; Warburton, Gledhill, & Quinney, 2001a; Warburton, Gledhill, & Quinney, 2001b) reduction in specific cancers (Paffenbarger, Lee, & Wing, 1992; Sesso, Paffenbarger, & Lee, 1998; Wannamethee, Shaper, & Macfarlane, 1993), prevention of osteoporosis (Warburton et al., 2006), and improved psychological well-being (Warburton et al., 2001a, 2001b; Dunn, Trivedi, & O'Neal, 2001). Similarly, Warburton and colleagues found routine physical activity to have an effect on hypertension, obesity, and depression.

Belloc (1973) and Belloc and Breslow (1972) examined seven factors in approximately 7,000 adults and found the following behaviors associated with life expectancy: eating three meals a day, eating breakfast every day, moderate exercise two to three times per week, adequate sleep of seven to eight hours a night, non-smoking, being of moderate weight, and non-alcohol consumption or consumption only in moderation. According to Pelletier (1981), exercise reversed what had originally been attributed to aging. Dixon, Mauzey, and Hall (2003) noted that exercise is important in increasing overall life quality and longevity of life. Furthermore, Dubbert (2002) found in her review of the 1996 *Surgeon General's Report* that physical fitness was associated with living longer. In relation to mental health, physical activity decreases levels of anxiety and depression in individuals who are less active (Dubbert, 2002). In addition, Sallis and colleagues (1990) found exercise self-efficacy to be a predictor of spiritual, intellectual, emotional, psychological, and physical wellness.

Physical activity is also associated with life satisfaction (Elavsky, 2005; Elavsky & McAuley, 2005) and enhances physical self-worth, self-efficacy, affect, and mental health (Elavsky et al., 2005; Elavsky & McAuley, 2005). Maher and colleagues (2012) investigated the association between physical activity and satisfaction with life in emerging adults (18-25 years) in a sample of 63 university students (*M* age = 21.0) who were 60% female and 87% White. Satisfaction with life (SWL) was assessed using a single item from the *Satisfaction With Life Scale* (SWLS; Diener, Emmons, Larsen, & Griffin, 1985). The SWLS item read "I was satisfied with my life today." Physical activity (PA) was assessed using a version of the *Interaction Physical Activity Questionnaire* (IPAQ; Booth, 2000; Sjöström, Ainsworth, Bauman, Bull, Craig, & Sallis, 2002). Results identified a small but positive correlation (r^s = .04 and .10) between SWL and PA in emerging adults (Maher et al., 2012). The small correlation could be attributed to the fact that Maher et al. (2012) used abbreviated versions of assessments (i.e., IPAQ and SWLS). In addition, all of the measures implemented were self-report in nature and thus, levels of PA could have been overestimated. As a result, Maher et al. (2012) stated that daily PA can "improve evaluative aspects of well-being in emerging adults" (p. 654). Thus, physical activity or lack of physical activity has an effect on overall health and well-being. For the aforementioned reasons, physical activity items were included in the HPWDS assessment.

Within the physical paradigm, nutrition is also viewed as integral to individual wellness (Myers & Sweeney, 2004; Venart, Vassos, & Pitcher-Heft, 2007; Witmer & Sweeney, 1992). Wurtman (1986) supported a relationship between what individuals eat, their moods, their health, and overall performance. In addition, though nutrition varies individually, eating breakfast, drinking water, and learning to recognize hunger are strategies that everyone can use to promote improved nutritional well-being (Skovholt, 2001). The Health Resources and Services

Administration (HRSA; 2000) suggests eating healthy servings of fruits, vegetables, and grains, drinking water frequently, limiting sugar consumption, and reducing alcohol consumption. In addition, the HRSA (2000) suggests limiting cholesterol intake and diets with high saturated fats. As a result, nutrition is an important component in promoting and maintaining overall wellness.

Social/Relational Domain

Adler (1954) was one of the earliest helping professionals to emphasize social interest and social connectedness. He described social interest as innate to human nature in that individuals are born with the capacity and need to be connected with others (Adler, 1954). Further, Adler (1954) described social interest as a motivating behavior for human kind. Hettler (1980) defined social wellness in terms of relations to the environment and relations to others. In addition, Hettler went on to define socially-well individuals as those who live in harmony with others and have an appropriate balance with others and self (Roscoe, 2009). Similarly, Adams, Bezner and Steinhardt (1997) determined that social wellness was more dependent on personal relationships, rather than emphasizing an external (environmental) component. As a result, giving and receiving support were integral to Adams et al. (1997) views of social wellness. Though different definitions of social wellness exist, many of the wellness authors (i.e., Adler, 1954; Hettler, 1980; Myers & Sweeney, 2005) support the idea of differing levels of social relationships.

As noted, a number of definitions and variables that contribute to social interest exist. Among the most popular are friendship and love (Witmer & Sweeney, 1992). Friendship covers the social relationships that involve a connection with others either individually or in community, but do *not* have a marital, sexual, or familial commitment (Sweeney & Witmer, 1991). In addition, love involves relationships involving emotional intimacy, sexual intimacy, or both, and

includes family and sexual partners (Witmer & Sweeney, 1991). Both friendship and love are components of overall social connectedness or what Adler (1954) referred to as individuals having a social interest.

Social interest and social connectedness have a number of health benefits. For one, social connectedness is linked to lower levels of blood pressure and lower levels of stress hormones such as cortisol, epinephrine, and norepinephrine (Uchino, Cacioppo, & Kiecolt-Glaser, 1996). In a nine-year longitudinal study, Berkman and Syme (1979) found individuals (*N* = 7000) that were single, widowed or individuals with few friends and family, and those who did *not* participate in community organizations died at rates two to five times greater than those with more extensive ties. The results were regardless of race, income, gender, ethnic background, age, and other lifestyle factors (Sweeney & Witmer, 1991). Similarly, Lynch (1977) confirmed the health benefits of intimate relationships and found that non-married individuals had higher death rates, sometimes as much as five times higher than those of married individuals. In addition, the death rates above were congruent for all causes of death (Lynch, 1977).

In further support of the importance of social interest, House, Robbins, and Metzner (1982) found that people (*N* = 2,754) with less social contacts had two to four times the mortality rate of more socially connected people; therefore, being socially involved appears to influence life expectancy and promote health in individuals who engage in meaningful social interactions and was assessed in the HPWDS instrument.

Occupational Domain

Campbell (1981), Sweeney and Witmer (1991), and Witmer and Sweeney (1992) support the idea of work or having an occupation as being important to wellness. Dreikurs (1953) described the inability to achieve this task as a symptom of illness. Further, Sweeney and Witmer

(1991) stated that work was one of the most fundamental life tasks and researchers identified a correlation between work satisfaction and longevity (Danner & Dunning, 1978), productivity (Pelletier, 1984), and decreased stress, anxiety, and physical symptoms (Witmer et al., 1983). Work/occupation includes everything we do to sustain ourselves and contribute to the sustenance of others (Adler, 1954). As a result, work goes beyond having a steady job or career. It can include volunteering, donating time and effort in helping others, and spending time doing something meaningful (i.e., students studying for a test, participating community cleanup projects; Witmer & Sweeney, 1992).

Pelletier (1984) stated that during periods of economic decline, negative events such as suicide, mental illness, heart disease, divorce, domestic violence, child abuse, and murder increased. In addition, House, Strecher, Metzner, and Robbins (1986) found increased job stress and pressure increased alcohol and smoking in individuals (N = 1,215). Likewise, the authors concluded that job pressures and tensions are associated with morbidity and even mortality (House et al., 1986). Thus, including work/occupational tenets are integral in assessing individual wellness and was included in the HPWDS model. Specifically, individual satisfaction relating to their job/career/related activities were explored because work stress and associated behaviors such as smoking and alcohol consumption may influence individual health and overall wellness.

Emotional Domain

Hettler (1980) described emotional wellness as the acceptance and awareness of a range of positive and negative feelings and the ability to effectively manage, express, and integrate feelings (Roscoe, 2009). Adams and colleagues (1997) followed a similar definition of emotional wellness, one that involved self-esteem and having a positive sense of self. Emotional wellness

has also been viewed as the acceptance and management of one's feelings (Leafgren, 1990) and the coping ability, self-image, and self-awareness of emotions (Crose, Nicholas, Gobble, & Frank, 1992). As a result, emotional wellness is comprised of awareness of feelings and the ability to manage positive and negative feelings in lieu of life events.

Fredrickson (2001) expanded upon definitions of emotional well-being and stated that positive emotions contribute to psychological growth and promote improved well-being. Fredrickson (2001) posited that positive emotions alter people's mindsets, alter bodily systems, predict resiliency (Fredrickson, Tugage, Waugh, & Larkin, 2003), happiness (Fredrickson & Joiner, 2002), and psychological growth (Fredrickson et al., 2003), and predict longevity (Fredrickson & Losada, 2005). In relation to mindset, positive affect widens attention (Fredrickson & Branigan, 2005). Experiments identify that the positive affect enhances recovery from the cardiovascular effects of negativity (Fredrickson, Mancuso, Branigan, & Tugade, 2000). In addition, a link between positive affect and how long individuals live has been established (Danner, Snowdown, & Friesen, 2001; Levy, Slade, Kunkel, & Kasl, 2002). In Fredrickson's (2001) *broaden-and-build* theory, she states that emotions broaden the scopes of cognition, action, and attention and build individuals' intellectual, physical, and social resources. Furthermore, positive emotions influence resilience, the effects of negative emotions, and emotional well-being (Fredrickson, 2001).

Lyumbomirsky (2001) investigated happiness and feelings and emotions associated with being happy and asserted that motivational processes and cognitive processes were integral in maintaining wellness. In addition, she found that happiness was influenced by psychological processes and individuals who reported as happy were less likely to be influenced by positive

and negative life events, moods, the outcome of events, and social comparison (Lyumbomirsky, 2001).

Salovey, Rothman, Detweiler, and Steward (2000) examined the influence of emotions on physiological functioning and found negative emotional states were associated with drinking, smoking, and binge eating and were associated with unhealthy patterns of psychological functioning. Positive emotional states were associated with healthier patterns of functioning as well as promoting healthy behavioral practices (Salovey et al., 2000). In addition, emotional states influenced individuals' willingness to seek healthcare. Salovey and colleagues (2000) found that emotions influenced physiological functioning. With the information obtained through the research of Salovey and colleagues (2000), Lyumbomirsky (2000), Fredrickson (2001), and Fredrickson and colleagues (2000), emotions were tied to individual wellness. As a result, items assessing emotional wellness were included in the HPWDS.

Intellectual Domain

Intellectual wellness is referred to as the engagement or stimulation of the mind in meaningful, knowledge-inducing, and creative activities (Adams et al., 1997; Hettler, 1980; Leafgren, 1990). Moreover, intellectual well-being encompasses personal achievement in education, personal growth, and creativity (Renger et al., 2000). Leafgren (1990) stated that intellectual wellness involved creativity and stimulating activities and that intellectual well-being could be promoted via the use of individual resources to expand, share, and improve knowledge and skills. In summary, wellness in the intellectual paradigm involves supporting optimal functioning through education, knowledge obtainment, and stimulating activities and intellectual items were included on the HPWDS.

Psychological Domain

Adams and colleagues (1997) defined psychological wellness as optimism that is experienced as a result of positive outcomes and positive life events (Adams et al., 1997). Investigations on psychological well-being conceptualize the phenomena as being comprised of: positive and negative affect (Bradburn, 1969), and life satisfaction (Ryff & Keyes, 1995). However, there is limited research on what it means to achieve psychological wellness (Ryff & Keyes, 1995) and few wellness models containing a psychological wellness component exist (Roscoe, 2009).

Ryff and Keyes (1995) attempted to create a theory-based conceptualization of well-being by investigating a multidimensional model of well-being in a nationally representative sample. A shortened scale (20-items) was developed from "multiple theoretical accounts of positive functioning" (Ryff & Keyes, 1995, p. 720) and used with a sample of 1,108 Americans (59% Female, 87% white) to assess the factor structure of psychological well-being. Analysis resulted in a six-factor model that included: Self-Acceptance, Environmental Mastery, Positive Relations, Purpose in Life, Personal Growth, and Autonomy components of well-being. Confirmatory factor analysis supported the idea of a multidimensional construct of well-being. Coefficient alphas however, were modest ranging from .13 to .56 for the factors (Ryff & Keyes, 1995). Even so, psychological well-being can be viewed as a multidimensional construct that may be influenced by positive social relationships, self (i.e., growth, awareness and acceptance, and level of autonomy), and environmental mastery. For these reasons, psychological well-being was assessed in the HPWDS.

Coping Domain

Myers and Sweeney (2005) noted that coping involves an awareness of feelings and an ability to effectively respond to life events. Further, coping includes expressing both positive and negative emotions appropriately and actively responding to life events. In addition, individual abilities to monitor emotions and to positively manage emotions allows for healthy functioning (Myers & Sweeney, 2005). In summary, coping refers to the ability to monitor reactions to life events as well as transcend negative effects of life situations, which contributes to overall health and well-being (Myers & Sweeney, 2005).

Coping is a broad term that represents the actions or activities that individuals do in order to manage or overcome professional and personal life challenges. Examples of coping may include: (a) physical activities, (b) social support, (c) spiritual activities, (d) positive emotions/optimistic views, (e) counseling/psychotherapy, or (f) engagement in hobbies. El-Ghoroury, Galper, Sawaqdeh, and Bufka (2012) examined stress, coping, and barriers to wellness in a sample of psychology students (N = 387) and found that the most frequent form of coping was social support. Moreover, exercising, participating in exercise, partaking in hobbies, and spending more time on school were all frequent forms of coping strategies employed by the participants (El-Ghoroury et al., 2012). In addition, barriers to employing coping strategies included time, financial constraints, motivation, worry, embarrassment, and discouragement or hopelessness (El-Ghoroury et al., 2012). El-Ghoroury and colleagues (2012) stated that cost and lack of time are the biggest barriers to using wellness strategies and that a large majority of helping professionals in the study experienced at least one stressor. As a result, El-Ghoroury and colleagues suggested helping professionals have an ethical obligation to practicing self-care, developing healthy habits, maintaining competence, and maintaining ability to be effective with

clients. Thus, coping strategies are integral to individual health and in promoting effectiveness, competence, and health in helping professionals and were included as items on the HPWDS.

Spiritual Domain

Many of the wellness models (e.g., 5F-Wel, WEL, Hettler's Model, Zimpher Model) reviewed contained some component of spirituality (Hettler, 1984; Roach & Young, 2007; Witmer & Sweeney, 1992; Zimpher, 1992). Often, definitions of spiritual wellness include components of meaning making, purpose in life, acceptance, and understanding one's place in life (Adams et al., 1997; Hettler, 1980; Roscoe, 2009). Myers and Sweeney (2005) define spirituality as an "awareness of being or force that transcends the material aspects of life and gives a deep sense of wholeness or connectedness" (p. 20). Meaning and purpose are considered components of spiritual well-being and are often incorporated central to holistic models of wellness (e.g., Chandler et al., 1992; Hettler, 1984; Myers et al., 1999; Zimpher, 1992).

Consequentially, meaning may have positive effects on individual wellness and influence individual beliefs, values, and sense of identity (Sovalaine & Granello, 2002). Furthermore, meaning can influence individual behaviors and intrapersonal and interpersonal functioning (Sovaliane & Granello, 2002), as well as have a stress-buffering effect (Drew & Kiecolt-Glaser, 1998). Key aspects of spiritual wellness include finding meaning and purpose in life, relations with others and the environment, shared community experience, and the creation of individualized beliefs and values systems (Roscoe, 2009). As a result of the shared definitions in the literature, spiritual wellness is integral in individual meaning-making, purpose, and connection with others, the environment, and a higher power (Roscoe, 2009).

Savolaine and Granello (2002) researched purpose and meaning in relation to spiritual wellness and concluded that meaning and wellness are significantly related. In addition, Roach

and Young (2007) stated that spirituality and religion played a vital part in the human condition. Further, religious activities and spiritual beliefs were linked to stress management and improved health (Roach & Young, 2007). With researchers supporting spirituality as a key component to overall wellness (Chandler et al., 1992; Hettler, 1984; Myers et al., 1999; Savoliane & Granello, 2002; Zimpher, 1992); therefore, spirituality was included in the HPWDS.

Optimism Domain

Optimism is a biological phenomenon and human beings have an innate capacity to maintain an optimistic view of the future (Tiger, 1979). Carver, Scheier, Miller, and Fulford (2009) define optimism as peoples' expectations for the future of optimism vary within the literature; however meta-analyses by Andersson (1996), Carver, Scheier, and Segerstrom (2010), and Scheier and Carver (1992) have demonstrated that optimism is linked to improved psychological health. Furthermore, Aspinwall and Taylor (1992) and Gallagher and Lopez (2009) found optimism predicted higher levels of well-being in a population of graduate-level individuals. In summary, individuals who are more optimistic report higher levels of well-being (Gallagher, Lopez, & Pressman, 2012). Carver and colleagues (2009) stated that optimism also related to improved physical health. In addition, optimistic people report higher levels of physical health (Gallagher et al., 2012).

Gallagher and colleagues (2012) examined benefits and origins of optimism in a sample from 142 countries (N = 150,048). Specifically, Gallagher et al. (2012) were interested in determining if optimism was a universal construct, demographic effects on optimism, if optimism was associated with improved subjective well-being, and if country gross domestic product related to optimism, well-being, and physical health. In relation to universal optimism, Gallagher et al. (2012) found that regardless of race, age, education, and socioeconomic status,

individuals were “generally optimistic and that the populations of most countries are optimistic” (p. 438). Furthermore, well-being and optimism had a clear relationship with strongest correlates between optimism and physical activity and optimism and life satisfaction (Gallagher et al., 2012). Similarly, a small, positive correlation between higher optimism and perceived health was found. No significant relationships between gross domestic product and optimism and life expectancy and optimism were found (Gallagher et al., 2012). In summary, Gallagher and colleagues (2012) claimed that optimism is a universal construct and that optimism is associated with improved health and well-being world-wide.

Witmer, Rich, Barcikowski, and Mague (1983) studied a nonclinical, general population for psychosocial characteristics associated with the stress response. Optimism was found to be one of the prime variables that characterized the good copers who had less anxiety and fewer physical symptoms. A follow up study in a nonclinical population was conducted by Witmer and Rich (1991) and confirmed the initial findings. As optimism has been found to influence coping, life satisfaction, and improved physiological health, it is an integral component to individual wellness. Thus, items to assess optimism were included in the HPWDS.

Self Domain

Young and Witmer (1985) depict moral values as guiding behaviors in acting for our own wellness and being respectful and compassionate to ourselves and to others. Maslow (1968) stated that humans need a framework of values and a morally sound philosophy of life. Furthermore, having sound moral framework and value system can lead to higher overall well-being (Young & Witmer, 1985). Similarly, a strong sense of self includes a number of variables that contribute to the construct. Sense of worth, sense of control, having realistic beliefs, spontaneity and emotional responsiveness, creativity, and sense of humor are a few that are

supported in the literature (e.g., Fry & Salmeh, 1987; Locke & Colligan, 1986; Maslow, 1970; Witmer & Sweeney, 1992).

Sense of worth is comprised of self-esteem and is closely related to self-control (Witmer & Sweeney, 1992). Self-esteem involves accepting oneself as a human being and a person of worth (Sweeney & Witmer, 1991) and is the greatest single factor that affects individual growth and behavior (Frey & Carlock, 1989; Witmer, 1985). The California Department of Mental Health (1979) found that sense of worth or self-esteem is related to physical and mental health. In addition, low self-esteem was related to physical illness and higher marital problems, emotional problems, and financial problems (California Department of Mental Health, 1979).

Similar to sense of worth is sense of control, which involves a sense of competence, locus of control, or self-efficacy (Sweeney & Witmer, 1992; Witmer et al., 1983). Control is the opposite of powerlessness (Kobasa, 1979) and Lazurus and Folkman (1984) stated that there are unique differences in relation to internal and external locuses of control. Specifically, individuals with an internal locus of control believe that events can be changed and that they are contingent upon personal actions during situations (Lazurus & Folkman, 1984). On the other end of the spectrum, individuals with an external locus of control believe that events are essentially, out of their control and that things are depended upon such things as luck, fate, or chance (Lazarus & Folkman, 1984).

Another area representing the construct of self is realistic beliefs (Witmer & Sweeney, 1992), which involves having a keen sense of reality. In addition, having realistic beliefs equates to positive health. Sweeney and Witmer (1991) noted that the greater the discrepancy between an individual's private logic and their reality, the greater the propensity for poor responses to life events.

Spontaneity and emotional responsiveness involves being extemporaneous in life, thoughts, desires, and actions (Witmer & Sweeney, 1992). Maslow (1970) described self-actualizing people as being more emotionally responsive and spontaneous, and having a childlike authenticity in response to events. Along similar lines, positive emotional states and relaxation appear to strengthen immune functioning (Dillon et al., 1985).

Having creativity and a sense of humor are also viewed as integral in promoting a healthy *self*. Maslow (1970) found creativity to be universal in self-actualized individuals he studied. Witmer and Sweeney (1992) propose that humor, especially when accompanied with laughter has health benefits. Specifically, humor promotes physiological, psychological, and social change (Witmer & Sweeney, 1992). In addition, when individuals use humor and respond to humor, muscles become more relaxed, breathing changes, brain releases chemicals that are positive to our well-being. Adler (1954) noted that psychotherapists should have a jovial attitude and incorporate humor into daily life. Further, Fry and Salameh (1987) described the effects of humor in counseling and psychotherapy as being useful in establishing relationships with clients, helping the client change, and as integral to termination with clients.

The sense of worth, sense of control, having realistic beliefs, spontaneity and emotional responsiveness, creativity, and sense of humor tenets that comprise the *self* category of wellness are supported in the literature. Therefore, items related to sense of worth, sense of control, having realistic beliefs, spontaneity and emotional responsiveness, creativity, and sense of humor were included in the HPWDS.

Flow Domain

Mihaly Csikzentmihalyi (1990, 1993, 1997) introduced the term “flow” originally referring to the experience painters have when they feel totally involved when painting (Keyes,

2002). Csikzentmihalyi (1997) extended the notion of flow to individuals participating in any activities in which they feel totally absorbed. Flow can be described then, as any activity in which an individual experiences total involvement in an endeavor and is totally absorbed in the activity (Keyes, 2002). Partaking in activities that allow bodies to be absorbed and focused can allow individuals to be present and in-the-moment. Thus, experiencing flow can act as a buffer against mental illness (Seligman & Csikzentmihalyi, 2000). Furthermore, participating in activities for enjoyment can lead to personal growth and happiness (Seligman & Csikzentmihalyi, 2000). Because flow can have a positive influence on wellness and act as a buffer against mental illness, the HPWDS included items that aim at assessing the flow capacities in helping professionals.

Flourishing Domain

Well-being and ill-being (unwellness) differ in the neuro-circuitry in the brain (Davidson, 1998; Urry et al., 2004). Moreover, effects of living well are different from those of ill-being, and there may be different mechanisms of well-being that enhance prevention of illness, risk taking, and disease (Ryff & Singer, 2005). Corey Keyes is one of the leading contributors to the positive psychology movement and is a proponent of the idea that tenets of well-being can be used as a buffer against illness (Keyes, 2002). He describes healthy individuals as "flourishing," something that involves the maintenance of genuine mental health functioning (Keyes, 2002, 2003, 2004). Fredrickson (2001) describes flourishing as functioning optimally while striving for goodness, growth, resilience, and generativity. On the opposite end of the spectrum, Keyes (2007) describes "languishing" as the absence of mental health (p. 95). Furthermore, Keyes affirms the idea that mental health and wellness are *not* the absence of disease, but rather, the

presence of something positive. Therefore, flourishing is a key component to holistic health and wellness.

Keyes (2005b) identified 13 dimensions of flourishing: (a) positive affect, (b) quality of life, (c) self-acceptance, (d) personal growth, (e) life purpose, (f) environmental mastery, (g) autonomy, (h) positive relationships, (i) social acceptance, (j) social actualization, (k) social contribution, (l) social coherence, and (m) social integration. The aforementioned dimensions comprise three factors of *positive emotions*, *positive psychological functioning,* and *positive social functioning.* In addition, Keyes (2002, 2004, 2005a, 2005b) analyzed data provided by the MacArthur Foundation's Midlife in the United States (MIDUS) survey (Brim, Ryff, & Kessler, 2004). His analysis supports the idea that flourishing (complete mental health) is optimal and that anything less results in increased impairment and disability. Further, adults who were considered languishing functioned worse than individuals who were considered to have moderate mental health (Keyes, 2007). Similarly, individuals who had moderate mental health functioned less well than individuals who were flourishing (Keyes, 2007). Flourishing individuals missed less work, had the lowest levels of health limitations, lowest health care utilization, highest levels of self-reported resilience, and highest level of functional goals (Keyes, 2007). As a result, flourishing appears to be an important construct to health and mental functioning and was included in the HPWDS.

Gratitude Domain

Gratitude is defined as an unmerited favor (Watkins, VanGelder, & Frias, 2009) and contains the three components of: appreciation for a person or thing, having a sense of goodwill toward a person or thing, and having the appreciation and goodwill to act positively (Fitzgerald, 1998). The effects of gratitude have been well established in the helping profession literature.

Researchers have concluded that gratitude: (a) increases positive emotions (e.g., Emmons & McCullough, 2003; Fredrickson, 2004); (b) acts as a buffer against depression and stress (e.g., Wood, Maltby, Gillett, Linley, & Joseph, 2008); (c) enhances optimism (Emmons & McCullough, 2003); (d) enhances resilience (Fredrickson, Tugade, Waugh, & Larkin, 2003); and (e) is negatively associated with self-blame, substance use, and denial (Wood, Joseph, & Linley, 2007).

Young and Hutchinson (2012) stated that gratitude effected mental health. Moreover, research on gratitude identified that having gratituded improved well-being and happiness (e.g., Froh, Yurkewicz, & Kashdan, 2009; Wood et al., 2008), improved social functioning (e.g., McCullough 2002; Wood et al., 2007), improved sleep (e.g., Emmons & McCullough, 2003; Wood, Joseph, Lloyd, & Atkins, 2009), and serves as a buffer of mental health symptoms (e.g., Fredrickson et al., 2003). In addition, Fredrickson's (2001) *broaden-and-build* theory suggests that increasing positive emotions and gratitude are effective mental health treatments. Specifically, increasing gratitude and positive emotions allows for people to become aware of more possibilities (broaden) in situations and gain (build) more resiliency and recover from negative emotions (Fredrickson, 2001; Young & Hutchinson, 2012).

Gratitude increases positive emotions, buffers against depression and stress, enhances optimism and resilience, and helps reduce self-blame, substance use, and denial. For these reasons, gratitude is viewed as an important tenet of individual wellness. Gratitude is included in the HPWDS so that helping professional gratitude can be assessed and influences of gratitude on individual wellness can be evaluated.

Hope Domain

Snyder (2002) defines *hope theory* as the capability to construct pathways to desired goals and the individual motivation and thought about using the pathways. Further, Menninger (1959) and Snyder (2002) agreed that hope was a way of thinking, and feelings played an integral role. Hope is most often noted in the helping profession practice by its absence (Kinghorn, 2013). Feeling hopeless is a key marker in depression and is listed as a marker for suicide in the majority of psychiatric texts and the absence of hope often correlates with decreased mental health and wellness (Kinghorn, 2013). Individuals have viewed the concept of hope and the absence of hope contrarily across the helping professions. For example, Bandura (1994), Seligman (2006), and Snyder (2002) have discussed hope within the contexts of self-efficacy, helplessness, hopefulness, and optimism, and motivation respectively.

Albert Bandura's (1994) concept of self-efficacy has been paramount in the modern day hope movement (Kinghorn, 2013). Bandura states that individuals' beliefs regarding their personal capabilities can influence their lives. Similarly, the idea of self-efficacy can correlate with self-reports of hopefulness and optimism (Kinghorn, 2013).

Seligman (2006) also promotes the idea of hope in his work on learned helplessness and optimism. Specifically, Seligman found that individuals who are passive and helpless in situations believe they cannot overcome the situation (2006). Similar to learning helpless behaviors, individuals can learn and practice learned optimism and hope (Kinghorn, 2013). Seligman found optimistic people to have more positive views of life events and that optimism translated to individuals' viewing bad events as temporary and situation specific. Thus, being optimistic about a situation can have advantageous effects on hopefulness and wellness.

Snyder (2002) developed the *hope theory*, which draws upon the work of Seligman (1991) and Bandura (1977). Snyder noted that hope is comprised of "a positive motivational state that is based on an interactively derived sense of successful agency and pathways" (p. 250). In reference to agency, Snyder depicts hope as a goal-directed energy. How individuals plan to meet goals depicts Snyder's ideas of pathways towards hope (Snyder, 2002). Snyder discussed the role of hope in the context of prevention of physical illness. Specifically, hope can influence primary prevention, or thoughts and actions that promote increased psychological or physical health and decrease issues or illnesses before they arise (Snyder, 2002). In addition, hope influences secondary prevention, which involves thoughts or actions aimed at reducing issues or illnesses that have already surfaced (Snyder, 2002). To stress the importance of hope on wellness, Sagan (1987) stated that the decline in death worldwide is influenced more by "hope and the decline in despair and hopelessness" (p. 184) rather than the increase in sanitation, water, medical care, and nutrition. Following Bandura's (1994), Seligman's (2006), and Snyder's (2002) research supporting the influence of hope on well-being, hope was assessed using the HPWDS.

Career Sustaining Behaviors Domain

Career Sustaining Behaviors (CSBs; Kramen-Kahn & Hansen, 1998) may also be integral to health and wellness in helping professionals. CSBs help counselors to function effectively and maintain a positive attitude. CSBs can be assessed using the *Career-Sustaining Behaviors Questionnaire* (CSBQ, Stevenovic & Rupert, 2004) which is a 34-item Likert-style questionnaire measuring the importance of specific strategies in promoting functioning and positive attitudes in helping professionals. Kramen-Kahn and Hansen (1998) used the CSBQ and found the use of CSBs to be positively correlated with personal rewards and negatively correlated with hazards.

In their study with psychotherapists (*N* = 208), Kramen-Kahn and Hansen (1998) found that the most highly rated CSBs included: humor, perceiving client problems as interesting, seeking case consultation, engaging in leisure activities for renewal, and engaging in leisure activities for relaxation. In addition, Kramen-Kahn and Hansen (1998) found the CSBQ to have a moderate level of internal consistency with a Cronbach's alpha of .71 for total score.

Additional CSBs include maintaining self-awareness, using positive self-talk, spending time alone in self-reflection, limiting time spent with clients, and participating in personal therapy (Lawson, 2007). Lawson (2007) investigated ACA members (*N* = 501) and asked them to rate the importance of a list of 34 CSBs. Lawson (2007) compared less satisfied counselors and more satisfied counselors' responses on the importance of CSBs and found that more satisfied counselors rated the importance of 14 CSB strategies significantly higher than their less satisfied counterparts. The top six of the *important* CSB's included: (a) maintaining a sense of humor, (b) spending time with partner/family, (c) maintaining balance between professional and personal lives, (d) maintaining self-awareness, (e) maintaining sense of control over work responsibilities, and (f) reflecting on positive experiences (Lawson, 2007). Interestingly, participating in support groups, receiving regular supervision, and participating in personal therapy (see Bell, Kulkarni, & Dalton, 2003; Orlinsky, Norcross, Rønnestad, & Wiseman, 2005) were among the lowest rated CSBs (Lawson, 2007). Further, Lawson (2007) found that counselors receiving increased supervision and those who participated in personal therapy actually scored higher on the Burnout scale of the PRO-QOL-II-R (Stamm, 2005) than did counselors who had never been to counseling. As a result, Lawson's (2007) study involving CSB's can be implemented when finding items for the HPWDS. Specifically, the top CSB's can be integrated into the scale and questions regarding those specific topics (i.e., humor, time with

family, self-awareness, sense of control, balance, and positive reflection) can be developed into specific questions to assess helping professionals and helping professional's-in-training wellness.

Stevanovic and Rupurt (2004) also examined CSBs and found that psychologists (N = 286) who implement more CSBs were more satisfied with their job. Further, individuals who participated in fewer CSBs were at greater risk for professional impairment and burnout (Stevanovic & Rupurt, 2004). Specifically, the top six CSBs found in "higher satisfied" psychologists were: (a) varying work responsibilities, (b) using positive self-talk, (c) balancing personal and professional lives, (d) spending time with partner/family, (e) taking vacations, and (f) maintaining professional identity (Stevanovic & Rupurt, 2004). Based on the aforementioned studies of CSBs, the top behaviors supporting helping professional wellness were included as items in the HPWDS.

Lawson and Myers (2011) investigated the factors that keep helping professionals well. In a sample of professional counselors (N = 506) measures of wellness, quality of life, and CSB's were completed. Specifically, the 5F-Wel (Myers et al., 2004), the ProQOL (Stamm, 2005), and the CSBQ (Stevanovic & Rupert, 2004) were used and descriptive statistics, Analyses of variance (ANOVAs) and t tests were used to examine the mean differences between groups. Correlational analyses were conducted to examine relationships among the variables. Lawson and Myers (2011) found wellness scores as measured by the 5F-Wel to be significantly higher for the participants than the general population ($p < .01$) with effect sizes on each subscale (i.e., creative, coping, social, essential, physical) and overall scale (total wellness) ranging from d = .45 to d = 76, indicating moderate to large effects.

Lawson and Myers (2011) also found that participants scored higher than the normed sample on the Compassion Satisfaction (t [967] = 8.76, $p < .01$, d = .54) subscale, significantly

lower on the Burnout subscale (t [967] = 7.01, $p < .01$, d = .32), and significantly lower than the normed sample on the Compassion Fatigue subscale (t [967] = 7.01, $p < .01$, d = .44) of the Pro-QOL. In addition, ProQOL and 5F-Wel scores related to one another (Lawson & Myers, 2011). Total Wellness as measured by the 5F-Wel correlated with Compassion Satisfaction (r = .57, p = <.001, r^2 = .32), and Total Wellness correlated negatively with Burnout (r = -.37, p = <.001, r^2 = .14). Finally, Lawson and Myers (2011) found that their participants noted CSBs similar to Setvenovic and Rupert's (2004) study: spending time with others, maintaining a sense of humor, maintaining professional identity, and maintain life balance was rated similarly in both samples. However, counselors rated self-awareness, reflection on positive events, maintaining objectivity about clients, and engaging in leisure activities as high whereas psychologists reported CSBs such as using positive self-talk, taking vacations, and reading literature to keep up to date higher than their counselor counterparts (Lawson & Myers, 2003). Because of the research supporting the influence of CSBs on wellness and unwellness, CSBs were included on the HPWDS.

Dimensions Influencing Unwellness

Although helping professionals may promote wellness in their clients, they often struggle to engage in well-lifestyles themselves (Cummins et al., 2007; O'Halloran & Linten, 2000). Further, because of the nature of their job, helping professionals are at an increased risk for becoming unwell and are vulnerable to becoming ineffective with clients (Skovholt, 2001). Pope and colleagues (1987) found nearly 60% of the psychologists reported seeing clients when they were too distressed to be effective. In addition, an ACA (2010) survey identified that approximately 75% of professionals reported that impaired health professionals are a threat to the profession. Likewise, nearly 65% of those surveyed reported knowing a colleague whom they believe is impaired (ACA, 2010). Consequently, Cummins et al. (2007) stated that helping

professionals face challenges that influence their wellness. In addition, unwellness in helping professionals can result in the failure to meet basic requirements of the helping profession. For the aforementioned reasons, it is important for helping professionals to perform self-assessments and insure that they are maintaining an appropriate balance between caring for others and caring for themselves (Skovholt, 2001). Thus, examining the areas that influence both wellness and unwellness are integral in assessing the factors that influence holistic well-being.

The literature includes a number of phenomena that are supported in influencing unwellness in helping professionals. Dimensions that will be highlighted in the following section include: (a) burnout, and (b) compassion fatigue/vicarious traumatization.

Burnout Domain

The arenas in which helping professionals' work are often stressful (Puig, Baggs, Mixon, 2012; Young & Lambie, 2007). Helping professionals experience job stressors such as financial constraints, heavy caseloads, demands for shorter therapy options, and managed care limitations (O'Halloran & Linton, 2000). Furthermore, Bakker, Demerouti, Taris, Schaefeli, and Schreurs (2003) stated that health professionals are at an increased risk of burnout. Thus, prolonged periods of stress can lead to helping professional impairment and burnout and lead to deterioration of the quality of services clients receive (Lambie, 2007).

Leiter and Harvie (1996) found that mental health professionals are experiencing burnout. Burnout has been defined as "to fail, wear out or become exhausted by making excessive demands on energy, strength, or resources" (Freudenberger, 1974, p. 159). Additionally, Maslach and Pines (1977) defined burnout as an emotional exhaustion in helping professionals that involves a loss of positive feelings, respect, and sympathy for clients' feelings. In other words, burnout involves emotional exhaustion and depersonalization (Puig et al., 2012). Lee, Cho,

Kissinger, and Ogle (2010) noted that helping professionals who are struggling to monitor job stressors may be at risk becoming burnt out, and their overall wellness and treatment effectiveness may be affected.

Ackerley, Burnell, Holder, and Kurdek (1988) examined psychologists working in mental health agencies and found that more than one third reported experiencing high levels of burnout. Similarly, Puig et al. (2012) examined the relationship between dimensions of personal wellness and dimensions of job burnout in mental health professionals (N = 129). Puig and colleagues (2012) assessed burnout via the *Counselor Burnout Inventory* (CBI; Lee, Baker, Cho, Heckathorn, Holland, & Newgent 2007) and wellness was assessed via the 5F-Wel-A (Myers & Sweeney, 2004). The population was made up of 82.2% women, 88.4% White individuals, with a mean age of approximately 40 years. Puig and colleagues (2012) found that all the subscales of burnout on the CBI (with the exception of Negative Work Environment) significantly predicted a large amount of variance in the wellness dimensions. Moreover, exhaustion burnout predicted physical self wellness. Specifically, individuals who are exhausted from job-related stress do not exercise or maintain their nutrition properly.

In addition, the Incompetence burnout subscale of the CBI was negatively related to Essential Self, Social Self, Creative Self, and Coping Self subscales on the 5F-Wel-A. Thus, when helping professionals do not feel competent they may struggle in their work settings and may *not* be able to cope with job-related stress or personal stress effectively (Puig et al., 2012). Puig and colleagues (2012) also found the *Devaluating Client* burnout subscale to relate to the *Creative Self* wellness subscale. Furthermore, the *Deterioration in Personal Life* burnout dimension was negatively related to the *Coping Self* wellness subscale. Essentially, helping professionals who are experiencing burnout are influenced on both personal and professional

levels (Puig et al. 2012). As a result, burnout is a major influencing factor to helping professional wellness in the job setting and in their personal life settings and thus, helping professionals' levels of burnout and wellness should be assessed.

Compassion Fatigue & Vicarious Trauma Domains

Counselors who are experiencing trauma in their personal lives or are working with clients who are experiencing trauma are at an increased risk for experiencing compassion fatigue and vicarious traumatization (Pearlman & Mac Ian, 1995). Vicarious traumatization (VT; McCann & Pearlman, 1990) has been used to describe the secondary reactions helping professionals have when exposed to clients' traumatic experiences (Trippany, White Kress, and Wilcoxon, 2004). The reactions are the result of repeatedly empathizing and engaging with clients and cause a shift in the way helping professionals perceive themselves, perceive others, and the view world (Trippany et al., 2004).

Helping professionals in all work settings will work with clients who have experienced trauma or are experiencing trauma (Trippany et al., 2004). According to Lawson (2007) nearly 40% of counselors are working with clients that are trauma survivors. Individuals who experience VT may experience behavioral symptoms, emotional symptoms, physical symptoms, and work-related problems (Trippany et al., 2004). As Trippany and colleagues (2004) discuss typical symptoms of individuals experiencing VT, they also talk about buffers to VT. Buffers of VT include: peer supervision, psychoeducation, agency responsibility, personal coping mechanisms, spirituality, and lower and less severe caseloads.

Compassion fatigue on the other hand, encompasses the emotional and behavioral costs of empathizing and caring about clients who have or are experiencing difficult life circumstances (Figley, 2002). Additionally, helping professionals who experience compassion fatigue tend to

disregard self-care and personal wellness (Figley, 2002). In fact, the act of being empathic and compassionate towards clients puts helping professionals at risk for enduring compassion fatigue. Like other types of fatigue, experiencing compassion fatigue lowers individual capacity to bear the struggles of others (Figley, 2002). According to Figley (2002) there are 11 variables that predict compassion fatigue: (a) empathic ability, (b) empathic concern, (c) exposure to the client, (d) empathic response, (e) compassion stress, (f) sense of achievement, (g) disengagement, (h) prolonged exposure, (i) traumatic recollections, and (j) life disruption. As such, empathy is included as a primary component in buffering against compassion fatigue and other forms of impairment.

Empathic ability refers to a helping professional's ability to notice pain in others (Figley, 2002). Similarly, empathic concern involves the motivation to respond to individuals who are experiencing pain or are in need (Figley, 2002). Exposure to the client allows for helping professionals to experience genuine client emotions and empathic response involves making an effort to help clients reduce their suffering through empathic understanding (Figley, 2002). According to Figley (2002), compassion stress includes experiencing the demands of working with clients' deep emotional energies. Sense of achievement on the other hand can lower compassion stress. When helping professionals feel satisfied with their work they are less likely to experience negative feelings in regards to the delivery of their services (Figley, 2002).

Disengagement from work life or client experiences can lower or prevent compassion stress (Figley, 2002). When helping professionals actively distance themselves from client experiences they can disengage and actively work to maintain their self-care and provide appropriate services to clients. Helping professionals often experience prolonged exposure to client issues and feel a sense of responsibility for the well-being and improvement of their

clients' life situations. Furthermore, the impact of traumatic recollections and life disruptions faced with clients during sessions can also influence helping professionals' levels of compassion. In summary, there are a number of factors contributing to reduction in compassion in the helping professions. By actively working to maintain self-care, empathy, and appropriate distance from client concerns, helping professionals can increase and maintain their capacity to help individuals in need.

Chapter Summary

The literature review contained seven main sections. The first section focused on reviewing the history of the wellness paradigm. The second and third areas reviewed definitions of wellness and the role of wellness in the helping professions. Sections four and five presented models of wellness and wellness assessments used across the helping professions. Sections six and seven reviewed the importance of operating from a wellness paradigm in the helping professions and the phenomena related to wellness and unwellness in the literature. The reviewed literature reviewed in the seven sections bolster a continued need for a wellness focus, and a new wellness assessment that is (a) developed by sound scale development procedures; (b) derived from theoretical foundations of wellness and unwellness; and (c) measures new areas of perceived wellness, aspirational wellness, and the discrepancy between the two. Chapter 3 presents the research methodologies that were employed within the present study.

CHAPTER THREE: METHODOLOGY

Chapter 3 presents the research methods utilized to develop the *Helping Professional Wellness Discrepancy Scale* (HPWDS) and examine the psychometric properties of the HPWDS with a sample of helping professionals. Specifically, the chapter reviews the following information regarding the investigations: (a) research design, (b) population and sample, (c) data collection, (d) instrument development procedures, (e) instrumentation, (f) research purpose and hypotheses, (g) assessing psychometric properties and statistical analysis, (h) ethical considerations, and (i) potential limitations of the study.

Research Design

A correlational research design was employed for this investigation (Gall, Gall, & Borg, 2007). The research design is correlational, as the investigation examined the relationships between variables (without manipulation). This research investigation focused on developing the *Helping Professional Wellness Discrepancy Scale* (HPWDS) and testing the validity and reliability of the initial model with a population of helping professionals.

Population and Sample

The population for the investigation of the HPWDS consisted of practicing counselors, practicing psychologists, and practicing social workers as well as master's level counselors-in-training, master's level social workers-in-training, and master's level psychologists-in-training. The practicing counselors included certified and/or licensed: (a) marriage, couple, and family therapists; (b) school counselors; and (c) mental health counselors. The practicing psychologist participants include licensed psychologists (i.e., counseling, clinical, and school psychologists). Similarly, the practicing social workers included licensed clinical social workers. The researcher aimed at obtaining a sample of helping professionals-in-training. Though counselors-in-training,

social workers-in-training, and psychologists-in-training were recruited, only counselors-in-training were obtained for the research investigation. The counselors-in-training population included students of counseling in: (a) marriage, couple, and family therapist; (b) school counseling, and (c) mental health counseling tracks. The psychologists-in-training that were recruited included graduate-level counseling, clinical, and school psychology students. Finally, the social workers-in-training that were recruited included graduate-level social work students. In summary, the sample of social workers, counselors, and psychologists comprised the helping professional population in this research investigation.

The data was collected via online, mail out, and face-to-face administration. For the online version, counselors, psychologists, and social workers were randomly selected from the Department of Health helping professional contact listserve. Email lists were gathered and emails were sent following the *Tailored Design Method* (Dillman, Smyth, & Christian, 2009). The online/email sample of helping professionals participated via online survey administration through Qualtrics. For the face-to-face administration participants were given the assessment packet in a graduate class and asked to participate in the investigation. For the mail out administration, participants were sent information following the *Tailored Design Method* (Dillman et al., 2009) utilizing three letters of contact, similar to the online/email methodology.

In determining an appropriate sample size for the research investigation, Hair, Black, Babin, Anderson, and Tatham (2006) were consulted. Specifically, Hair and colleagues (2006) suggested a sufficient sample size for test development and the statistical analyses as approximately 100 participants. Additionally, the minimum sample size should be at least five times larger than the number of variables being analyzed in the investigation. Thus, the desired sample size for appropriately examining the psychometric properties of the HPWDS was based

on the number of cases to the number of item ratio (Costello & Osborne, 2005; Everitt, 1975; Mvududu & Sink, 2013). Plainly, an *N*:*p* (*N* being the number of cases or participants and *p* being the number of items) was implemented (Hair et al., 2006). For the social sciences, appropriate item/participant ratios should be 10:1 or 20:1 (Hair et al., 2006; Mvududu & Sink, 2013; Tinsley & Tinsley, 1987).

Costello and Osborne (2005) noted that although item to participant ratios varies depending on strength of data, researchers should aim high and attempt to establish a 20:1 ratio. In their research however, Costello and Osborne (2005) analyzed the average *N*:*p* ratio used in EFAs over a two year time period and found that the majority (62%) of researchers used only a 10:1 or less *N*:*p* ratio for data analysis. In addition, approximately one-sixth of the sample used 2:1 *N*:*p* ratios for their data analysis. Nevertheless, for this investigation, a 20:1 ratio was attempted.

It was hypothesized that through statistical analysis (i.e., EFA), the data would yield a six-factor structure; therefore, the researcher started with at least 10 items (i.e., instrument questions) for each individual factor. Using the ratio, we had 60 total items or *p*. Thus, in calculating the overall *N*:*p* ratio, in order to establish a 20:1 ratio the number of cases or participants desired were 1,200 (i.e., 1,200:60 equates to the 20:1 ratio). Additional support for a large sample size comes from Comrey and Lee (1992) who created a range of populations from 50 to 1000. Ideally, according to Comrey and Lee (1992), a sample of 500 is *very good* and a sample of 1000 is considered *excellent.* Hair and colleagues (2006) noted that a sample size for factor analysis should include a minimum of 100 participants. Finally, with the sample size (over 1200) data would have been generalizable to the larger population of helping professionals (Costello & Osborne, 2005; Krejcie & Morgan, 1970). A population of 1,200 participants

supported a 10:1 ratio (600 for EFA and 600 for CFA). For the research investigation, the researcher obtained a final sample of 657 participants, which yielded an initial response rate of 7.14%.

Data Collection

The researcher obtained Institutional Review Board (IRB) permission before collecting data. After receiving IRB approval, the HPWDS was distributed to helping professionals and helping professionals-in-training population. The data collection procedures were in three forms: (a) face-to-face administration, (b) mail outs, and (c) web-based survey. Using three forms of data collection allowed for a more diverse representation of participants as well as an increase in the overall sample size and generalizability of the research.

After receiving IRB approval from UCF, face-to-face data collection began. The face-to-face collection began September 1st, 2014 and was completed December 1st, 2014 and involved the researcher administering the HPWDS and affiliated scales (i.e., CBI, MCSDS, Demographic Form) to a diverse array of counseling students. For some classrooms, the course instructor administrated the assessment packets. For the instances where other representatives administered the assessment packet, a formulized training manual was provided to ensure accurate and reliable data collection procedures.

For the web-based and mail out survey data collection procedures, *Tailored Design Method* (Dillman, et al., 2009) was implemented. Specifically, the *Tailored Design Method* for emailing was followed with a three-fold focus of: establishing trust with participants, increasing benefits for participants, and decreasing costs of administration. Dillman and colleagues (2009) suggests for web-based survey implementation that researchers: send out three emails, make the emails personalized to each participant, send out specific codes for each participant, and send all

emails from the same address to promote trust and increase the overall sample size. Thus, the *Tailored Design Method* was implemented for collecting the web-based data. Examples of web-based recruitment letters are available in Appendix H, Appendix I, and Appendix J.

For the mail out option, a similar three-contact *Tailored Design Method* (Dillman et al., 2009) was followed. The first contact included a letter describing the research investigation and provided information regarding the assessment packets individuals would be receiving in the near future. An initial sample letter is included in Appendix K. For the second participant contact, a letter was included which described the investigation, along with an informed consent document, and the assessment packet that included the HPWDS, the MCSDS-X1 (Strahan & Gerbasi, 1979), the CBI (Lee et al., 2007), and a general demographic form. A sample of the second contact letter is included in Appendix L. For the final contact, a post card was sent highlighting the main tenets of the study and informing participants that data collection would soon be ending and requesting their participation. A sample of the final contact post card is available in Appendix M. Thus, for the online, mail out, and face-to-face data collection procedures, rigorous methods were implemented to support the quality of the data.

Instrument Development Procedures

The research investigation focused on developing the *Helping Professional Wellness Discrepancy Scale* (HPWDS) and examining the psychometric properties of the HPWDS with a sample of helping professionals. Additionally, the researcher developed a general demographic form for helping professionals. Furthermore, participants in the study received a statement of informed consent and voluntarily agreed to participate in the study that was approved by the researcher's IRB.

The steps in constructing an instrument vary within the literature (Crocker & Algina, 2006; DeVellis, 2012; Dimitrov, 2012). For the purposes of this research investigation, a combination of the processes suggested by Crocker and Algina (2006), DeVellis (2012), and Dimitrov (2012) were followed. The specific instrument development steps employed were: (a) determine clearly what is being measured, (b) creating an item pool, (c) determining the type of scale measurement, (d) having the items reviewed by a team of experts, (e) considering inclusion of validation items, (f) administering the scale to a development sample, (g) evaluating the items following statistical analysis, and (h) optimizing scale length.

Step 1: Determining clearly what is Being Measured

In order to determine what the assessment would be measured, it was important to review the wellness literature and comprise a definition of wellness. Because wellness is a difficult construct to define (e.g., as indicated by the plethora of definitions in the literature), the researcher included the qualities of wellness most cited within the literature and developed a definition for the research study. Step 1 involved being clear regarding identification of the construct (DeVellis, 2012). For the purpose of constructing the HPWDS, the construct of interest was identified as wellness, which related to the factors that comprised holistic health and well-being. Additionally, the wellness literature supported wellness as unique to the individual and included factors such as: (a) physical, (b) intellectual, (c) emotional/psychological, (d) relational, and (e) spiritual. Thus, for the purposes of this research investigation, *wellness* was defined as the factors comprising individual well-being and promoting a healthy and balanced life.

Step 2: Creating an Item Pool

Creating an item pool consisted of developing HPWDS items that theoretically contributed to the construct of wellness. The researcher conducted an extensive literature review

to examine the existence of items contributing to wellness. The examination of the literature involved reviewing instruments that measured similar constructs (e.g., 5F-Wel; LAQ; Pro-Qol) as well as diverse models of wellness across the helping professions (e.g., Hettler's *Hexogonal Model of Wellness*; *Indivisible Self Model*; *Zimpher's Wellness Model*). The researcher examined the existence of potential factors that contributed to holistic wellness. Additionally, the researcher reviewed the CACREP (2009) *Standards*, the ACA (2014) *Code of Ethics*, the American Psychological Association (2010) *Ethical Principles of Psychologists and Code of Conduct*, and the National Association for Social Workers (1996) *Code of Ethics*. During this item development step, the researcher modified the existing list of items by adding and deleting items based on the wellness literature.

Step 3: Determining the Format for Measurement

The third instrument development step involved choosing the appropriate type of scaling for the HPWDS. Mvududu and Sink (2013) and DeVellis (2012) suggested that Likert-type scaling was relevant for factor analysis and common in social sciences literature, and thus, a five to seven point Likert scale format was selected. However, for the purposes of the HPWDS, a verbal frequency scale was implemented instead of the traditional Likert-type scaling. A verbal frequency scale was selected because assessing the amount of time spent in behaviors and experiences addresses what is happening in the lives of helping professionals and allows for an opportunity to discuss the frequencies of activities as well as the discrepancies between the actual amount of time spent doing something, and the amount of time the helping professional aspires to participate in the activities. The verbal frequency scale measured how often a wellness activity was performed rather than a Likert scale measuring strength of agreement (Scarborough, 2005).

Step 4: Having Initial Item Pool Reviewed by Experts

Following the initial item development of the HPWDS, items selected based on theory and a review of the literature, a team of experts reviewed the items to maximize content validity of the instrument. The expert review process involved individuals who were familiar with the wellness literature as well as individuals who were familiar with opposing constructs (i.e., illness paradigm) such as emotional fatigue, burnout, and illness. The expert panel included 10 individuals and represented a diverse background of helping professionals with experience with wellness and illness paradigms and scale development procedures. Having an expert pool of 10 individuals allowed for a collection of knowledgeable feedback related to the construct of interest (i.e., wellness), the population of interest, and scale development procedures (Dimitrov, 2012). The researcher sent the instrument to the panel of experts for review and feedback on the scale and scale items and provided a manualized, step-wise process for each expert reviewer. The reviewer instructions can be found in Appendix O.

Step 5: Consideration of Inclusion of Validation Items

Next, HPWDS items were considered for validation and inclusion. Specifically, Step 5 included two types of items: items to detect problems and items relating to construct validity (DeVellis, 2012). Social desirability is an example of a common issue faced when using self-report measures (Crowne & Marlowe, 1960). Thus, the researcher employed the *Marlowe-Crowne Social Desirability Scale-X1* (MCSDS-X1; Strahan & Gerbasi, 1972) in the data collection process to assess for participants' levels of social desirability. The 10-item, true and false MCSDS-X1 is a shortened version of the original 33-item MCSDS (Crowne & Marlowe, 1960), which is a frequently used measurement of social desirability (Beretvas, et al., 2002). The MCSCS-X1 items that measure social desirability receive a score of 1, while items that are not

measuring social desirability receive a score of 0 (participant scores ranging from 0 – 10). The MCSDS-X1 has a similar effect size to the original scale (e.g., .96; Cohen, 1992) and has an internal consistency range of around .50 to .90 (Ballard, 1992; Barger, 2002; Fischer & Fink, 1993; Strahan & Gerbasi, 1972). Mullen, Lambie, and Conley (2014) found the Kuder-Richardson 20 reliability of the MCSDS-X1 as .69 in a population of mental health counselors, marriage and family therapists, and school counselors (*N* = 584). The population in the Mullen et al. (2014) investigation was similar to the helping professional population in this investigation focused on the development of the HPWDS. Thus, the MCSDS-X1 is a cost-effective, shortened social desirability scale that allowed for assessment of the level of social desirability in helping professional responses in this research investigation.

An additional method of examining the validity of items was through testing discriminate construct validity, which was assessed via comparing the HPWDS scores to the *Counselor Burnout Inventory* (CBI; Lee et al., 2007). Specifically, the researcher explored the correlation between the CBI and the HPWDS. It was expected that a negative correlation would transpire as the CBI measures unwellness/illness in helping professionals and the HPWDS measures perceived and aspirational wellness and the discrepancy between perceived and aspirational wellness.

Step 6: Administering Items to a Development Sample

The HPWDS was administered to a development sample. Administering the HPWDS to an initial sample was the first round of data collection for the HPWDS assessment (i.e., future studies assessing the reliability and validity of the HPWDS with diverse samples will be completed). Further, the HPWDS was administered to helping professionals as a norm population (e.g., psychologists, counselors, social workers). The researcher aimed at a

development sample of 1,200 participants to satisfy a 10:1 participant/item ratio. As such, anything over 1,000 participants was viewed as an "excellent" sample size for the nature of the statistical analysis of this study (Everitt, 1975). However, the researcher ended up with a total sample of 657 participants, yielding a participant/item ratio of approximately 7:1.

Step 7: Evaluation of Items

Following administration of the HPWDS to the sample of helping professionals, items were evaluated via a variety of procedures to evaluate validity and reliability of the HPWDS. Validity was assessed to evaluate (a) criterion-related validity, (b) face validity, (c) construct validity, and (d) content validity. Additionally, the Cronbach's alpha of the HPWDS was examined to evaluate the internal consistency reliability of the HPWDS. The psychometric properties of the HPWDS were examined through different statistical analysis procedures used within the study that are presented in the data analysis section of this chapter. Specifically, the statistical analysis employed in this research investigation was exploratory factor analysis (EFA) for each portion of the HPWDS scale (i.e., perceived wellness, aspirational wellness, the discrepancy between perceived and aspirational wellness, and an overall HPWDS model), and internal consistency reliability.

Step 8: Optimizing Scale Length

The final step in scale development included adjusting the scale length by reducing items based on statistical analysis results and theory (DeVellis, 2012). Following data analysis, the researcher deleted or retained items based on criteria for item retention. The following criteria were used for item retention: (a) a value of 0.5 or greater for Kaiser-Meyer-Olkin (KMO) sampling adequacy for the entire assessment, (b) a significant Bartlett's test of sphericity, (c) a 0.5 or greater measurement sample accuracy (MSA) for each item, (d) a 0.2 or greater difference

between factor loadings, and (e) a factor loading of 0.3 or greater (Hair et al., 2010; Mvududu & Sink, 2013). The process of optimizing scale length enhanced the development of a psychometrically sound instrument to measure helping professional wellness discrepancies.

Manual Development

The researcher created a test manual for the HPWDS to explain how to administer the instrument. A panel of experts (N = 10) reviewed and edited the HPWDS manual and changes were made in accordance with experts' suggestions. The manual served as a training tool and assisted individuals other than the researcher in administering the HPWDS. The manual contained: (a) a review of the literature from which the HPWDS was constructed, (b) definitions for each item, and (c) directions for administration. In the future, the manual will also serve as a reference guide to scoring the HPWDS. The HPWDS manual (Appendix Q) was developed to assist individuals administering the assessment.

Instrumentation

There were four data collection instruments utilized within this study. The first instrument was the HPWDS, which was developed during this investigation. A second instrument, a helping professional general demographic questionnaire was administered in order to collect demographic information about the helping professional participants. A third instrument, the MCSDS-X1 (Strahan & Gerbasi, 1972) was administered to assess for social desirability within the sample. Finally, the CBI (Lee et al., 2007) was included to assess for criterion-related validity (discriminant validity) and assess levels of helping professional burnout.

Helping Professional General Demographic Questionnaire

The second instrument included a demographic questionnaire to assess the general demographics of the helping professional population. The questionnaire allowed helping professionals to provide their demographic information such as gender, age, race/ethnicity, years in practice, and years of schooling. Additionally, the questionnaire had areas including: (a) area of specialty, (b) theoretical orientation, and (c) primary population served. Counselor education faculty members and counselor education doctoral students reviewed the general demographic questionnaire to support the content validity of the instrument. Individuals' choosing to review the demographic form did so on a voluntary basis and were not participants in the research investigation.

Marlowe-Crowne Social Desirability Scale

The third data collection instrument, the *Marlowe-Crowne Social Desirability Scale-X*1 (MCSDS-X1; Strahan & Gerbasi, 1972) was used to assess social desirability within the sample of helping professionals. The MCSDS-X1 is a 10-item instrument that is a shortened version of the original 33-item *Marlowe-Crowne Social Desirability Scale* (MCSDS; Crowne & Marlowe, 1960). The MCSDS is frequently used to measure social desirability with diverse samples (Beretvas, Meyers, & Leite, 2002) and thus provides merit for its use. Specifically, the MCSDS version X1 was used because it is shorter than the original scale and has a high effect size with the original 33-item version (e.g., .96; Cohen, 1992; Fisher & Fink, 1993). Sample items from the MCSDS-X1 include: " I'm always willing to admit it when I make a mistake" and "I like to gossip at times." Furthermore, MCSDS-X1 item scoring is based on a *1* (items that are socially desirable) and *0* (items that are not socially desirable) range, with total scores on the assessment

ranging from 0 to 10. Internal consistency reliabilities for the MCSDS-X1 range from .50 to .88 (Ballard, 1992; Barger, 2002; Fischer & Fink, 1993; Strahan & Gerbasi, 1972).

Counselor Burnout Inventory

The *Counselor Burnout Inventory* (CBI; Lee et al., 2007) was used to assess the levels of unwellness/impairment in the helping professional population. In addition, CBI scores and HPWDS scores were correlated to evaluate the construct-related validity (discriminant validity) of the HPWDS. A negative correlation was expected between outcomes in the CBI and outcomes on the HPWDS.

The CBI (Lee et al., 2007) is a 20-item, self-report questionnaire comprised of the five subscales of: (a) Exhaustion, (b) Incompetence, (c) Negative Work Environment, (d) *Devaluing Client*, and (e) Deterioration in Personal Life, that was created to assess burnout specifically in counselors. Each item has a five-point Likert response scale ranging from 1 (*never true*) to 5 (*always true*). Examples of CBI items are "I feel frustrated with the system in my workplace" and "I do not feel like I am making a change in my clients." The CBI contains items that are reflective of various levels of burnout (Lee, Cho, Kissinger, & Ogle, 2010). The CBI assesses broader dimensions of burnout than other burnout scales (i.e., the MBI) and thus, can be applied to counselors and other helping professionals (Lee et al., 2007). In addition, because helping professionals face similar work environments, work with clients, and face personal life concerns, the CBI should apply to *all* helping professionals. Finally, inventories such as the MBI-HSS (Maslach & Jackson, 1981) assess burnout on individual levels rather than organizational levels (Vredenburgh, Carlozzi, & Stein, 1999). Because helping professionals operate within an organization and their levels of burnout are influenced by internal and external factors, a burnout assessment that considers both organizational and individual qualities is necessary. Hence, the

CBI was utilized to assess both individual and organizational aspects of the helping professionals' level of burnout.

Lee and colleagues (2007) developed the CBI from an initial pool of 296 items. Initially, 40 items were related to five burnout dimensions: Dimension 1 (exhaustion), Dimension 2 (negative work environment), Dimension 3 (devaluing client), Dimension 4 (incompetence), and Dimension 5 (deterioration in personal life). Following item reduction, Lee et al. (2007) performed two analyses, EFA and CFA with two independent samples. For the first sample of counselors (N = 258), a five-factor model was determined that accounted for approximately 55% of the total variance (Lee et al., 2007). Based on examination of factor pattern coefficients, items were reduced to 20. Lee and colleagues (2007) then ran a second EFA on sample two (N = 132) to determine if simple structure was achieved. The second EFA again yielded a five factor structure that accounted for approximately 67% of the variance, with all items associating to their factor. In the second independent sample (N = 132) of counselors, a maximum-likelihood CFA was conducted and goodness-of-fit indices indicated adequate fit of the data (CFI = .957; TLI = .948; SRMR = .052; RMSEA = .050; Lee et al., 2007). Lee and colleagues (2007) reported internal consistency reliability estimates for the CBI as: Exhaustion (α = .80), Negative Work Environment (α = .83), Devaluing Client (α = .83), Incompetence (α = .81), and Deterioration in Personal Life (α = .84).

Carrola, Yu, Sass, and Lee (2012) used the CBI with a population of U.S. and Korean counselors. The authors assessed for: factorial validity, internal consistency reliability, measurement invariance, and convergent and discriminant validity of the CBI within their sample (Carrola et al., 2012). Carrola and colleagues (2012) conducted the first CBI investigation in a cross-cultural population, as initial studies were based heavily on European

Americans. Two independent samples were collected in order to assess the psychometric properties of the CBI across U.S. counselors (*n* = 363) and Korean counselors (*n* = 379). The U.S. participants were comprised of 75% female with a mean age of approximately 45 years. The Korean participants were 83% female with a mean age of approximately 35 years.

Carrola and colleagues (2012) found evidence for factorial validity in both samples. As such, the five factor structure of the CBI was retained in the U.S. and Korean samples. In addition, internal consistency reliability coefficients indicated sufficient internal consistencies for the entire sample (U.S. and Korean combined) and for each group individually. The only between-group difference emerged in the Incompetence latent factor (Carrola et al., 2012). Carrola and colleagues (2012) suggested that reason for the difference in the Incompetence factor could be related to the idea that collectivist cultural backgrounds (i.e., Korean) may influence self-efficacy more so than individualist cultures (i.e., U.S.).

The CBI was found to be a reliable and valid inventory in a population of Japanese counselors (Yagi, Lee, Puig, & Lee, 2011). Furthermore, goodness-of-fit indices indicated an adequate model fit. In addition, Shin, Yuen, Lee, and Lee (2013) used the Chinese translation of the CBI in a cross-cultural validation study with school counselors (*N* = 489) in Hong Kong. The original five-factor CBI model fit the data as indicated by appropriate goodness-of-fit indices (Yagi et al., 2011). Furthermore, the five-factor model resulted in greater parsimony than two other models that were tested (a one-factor model and second-order factor model). Internal consistency reliability for Hong Kong counselors in this sample ranged from .77 to .87, indicating acceptable reliability. Finally, effect sizes between Hong Kong counselors and American counselors (from previous studies) were small indicating that the CBI subscales were similar between both populations.

In summary, the CBI has been used with a diverse array of populations both nationally and internationally. Statistical evidence for the five-factor model was supported (Carrola et al., 2012; Lee et al., 2007; Yagi et al., 2011). In addition, internal consistency for the CBI was established, as indicated by the aforementioned research discussions.

Purpose and Research Hypothesis

Scholars defining wellness and/or creating wellness models and assessments agree that wellness is multidimensional in nature (Ardell, 1977; Dunn, 1977, Hettler, 1980, Myers et al., 2004). Additionally, wellness is *not* merely the absence of disease (Ardell, 1977; Edlin, 1988; Lafferty, 1979; Teague, 1987). Furthermore, wellness approaches are holistic in nature and involve both personal (i.e., internal) and environmental (i.e., external) influences (Roscoe, 2009). The dynamic (changes with time) nature of wellness and the idea that healthy individuals strive towards optimal functioning is supported in the literature (Ardell, 1977; Dunn, 1977; Hettler, 1980; Roscoe, 2009). Similarly, wellness is dependent upon individual motivation (Ardell, 1977; Dunn, 1977; Hettler, 1980) and self-responsibility (Dunn, 1977). Therefore, the researcher hypothesized that the HPWDS would yield a multimensional factor structure of wellness. However, because of the exploratory nature of developing a new wellness measure, hypotheses about the factor structure of the model were *not* assumed. Thus, research questions supporting the exploration of the HPWDS were warranted.

The purpose of developing the HPWDS was to examine the psychometric properties of wellness (as measured by the HPWDS) in a sample of helping professionals (i.e., psychologists, social workers, counselors). The specific research questions that were investigated included the following:

Research Question 1

What is the factor structure of the items on the HPWDS with a sample of helping professionals?

Research Question 1a

What is the factor structure of the perceived items on the HPWDS with a sample of helping professionals?

Research Question 1b

What is the factor structure of the aspirational items on the HPWDS with a sample of helping professionals?

Research Question 1c

What is the factor structure of the discrepancy between the perceived items and aspirational items on the HPWDS with a sample of helping professionals?

Research Question 2

What is the internal consistency reliability of the HPWDS with a sample of helping professionals?

Research Question 3

What is the relationship between HPWDS scores and CBI scores with a sample of helping professionals (examining the discriminant validity of the HPWDS)?

Research Question 4

What are the relationships between helping professionals' HPWDS scores and their reported demographic data?

Research Question 5

What is the relationship between HPWDS scores and MCSDS scores with a sample of helping professionals (examining social desirability of participant answers)?

Assessing Psychometric Properties and Statistical Analysis

In developing the HPWDS, the researcher assessed the validity and reliability of the instrument. Specifically, the researcher explored the validity of the measure by examining: (a) criterion-related validity, (b) face validity, (c) construct validity, and (d) content validity. In addition, the researcher assessed the internal consistency reliability of the HPWDS in a population of helping professionals. Data analysis was conducted in the Statistical Package for Social Science (SPSS; 2013) software package for Mac and Windows Version 22.0.

Reliability

In order for a scale to be valid, it must be reliable (Reynolds, Livingston, & Willson, 2009). An instrument that has a high level of reliability produces consistent scores that are *not* influenced by large degrees of instrument error (Reynolds et al., 2009). Furthermore, in relation to measurement, the more accurate and consistent scores, the higher their reliability (DeVellis, 2012). The reliability measure that was assessed in the HPWDS was internal consistency. In order to assess internal consistency reliability of the HPWDS, Cronbach's coefficient alpha was used (Cronbach, 1951).

Cronbach's Alpha & Internal Consistency

Cronbach's coefficient alpha (1951) is an internal consistency method that allows researchers to assess for sampling error in an assessment within a single administration (Dimitrov, 2012). Additionally, Cronbach's alpha involves the degree of correlation between item scores (Dimitrov, 2012) and is one of the most widely used forms of assessing the reliability

of a scale (Streiner, 2003). Furthermore, when items are highly correlated, they are thought to measure a similar construct (Dimitrov, 2012). Adversely, when items have a low correlation to other items, they may be a poor representation of the construct being measured (i.e., wellness). The Cronbach's alpha range for the HPWDS assessment was between 0 and 1 (DeVellis, 2012), with values falling closer to 1 representing higher reliability (Crocker & Algina, 2006; Dimitrov, 2012). A value of .70 generally indicates appropriate internal consistency of item scores. However, alpha is influenced by the length of the scale (Streiner, 2003) with scales over 20 items having acceptable alpha values and thus, the .70 value was used as a reference point rather than an absolute criterion. As another point of caution, values over .90 may reflect unnecessary duplications of items (Streiner, 2003).

Validity

An essential component of a sound assessment instrument is the validity of the measure with diverse samples. As such, in order for an assessment to be valid, it must be reliable. Validity involves whether an assessment "measures what it purports to measure" (Dimitrov, 2012, p. 41). Cronbach (1971) described validity as a process a test developer goes through to collect evidence to support inferences that are to be derived from the scores on an assessment. Of importance when assessing validity, is the idea that an instrument or an assessment cannot be deemed valid or invalid. Moreover, validity relates to an explanation of data that is obtained through the use of a scale, rather than the scale itself (Dimitrov, 2012). There is a debate throughout the literature as to how many forms of validity exist/should be assessed (DeVellis, 2012; Messick, 1989). For example, DeVellis (2012) highlights three main types of validity (i.e., content validity, construct validity, and criterion validity). Messick (1989) on the other hand ascribes to six types of validity. Further, he defines validity as an "integrative evaluative judgment of the degree to

which empirical evidence and theoretical rationales support the adequacy and appropriateness of inferences and actions based on test scores or other modes of assessment" (p. 13). Likewise, when assessing the validity of a scale, there are a variety of areas to consider in testing the psychometric properties of an instrument (DeVellis, 2012). For the purposes of developing the HPWDS, the validity explored included: (a) criterion-related validity, (b) construct validity, and (d) content validity.

Criterion Validity

In order for the HPWDS to achieve criterion-related validity, the items within the scale needed to have an empirical association with a specified criterion. For the purposes of this investigation, the named criterion was wellness. Generally, criterion-related validity is comprised of *concurrent* and *predictive* validity (DeVellis, 2012). Concurrent validity refers to a criterion being measured at the same time as the scale is being administered (Reynolds et al., 2009). Predictive validity refers to a scale being administered, followed by a time interval, and then a criterion being measured. The researcher assessed the concurrent validity during this research investigation because the HPWDS was given concurrently with the other assessments (specifically the CBI) in order to assess that the HPWDS was measuring something different than the CBI (via a negative correlation with CBI subscales).

Construct Validity

Construct validity relates to the degree to which an assessment measures the construct is was developed to measure (DeVellis, 2012). Construct validity is composed of *discriminant* and *convergent* validity. Researchers can assess discriminant validity by comparing an assessment with another instrument that is measuring dissimilar constructs (Reynolds et al., 2009). In order to assess for discriminant validity in this research investigation, the researcher calculated the

correlation between the HPWDS and the CBI. A negative correlation between the HPWDS and the CBI was desired. Convergent validity on the other hand, is obtained by correlating an assessment with other existing assessments measuring similar constructs. To assess for convergent validity, the researcher could assess the degree to which the HPWDS correlates with an existing instrument that is measuring a similar construct. To assess for convergent validity the researcher could correlate scores on the HPWDS with the 5F-Wel in a population of helping professionals in a future research investigation. An EFA was utilized in order to assess for construct validity of the HPWDS with a sample of helping professionals by examining initial factor structure of the HPWDS and examining the correlations between items on the HPWDS and CBI.

Content Validity

The final type of validity assessed was content validity, which involves the extent to which a set of items reflects the content of an assessment (DeVellis, 2012). Content validity involves sampling adequacy (DeVellis, 2012). In order to examine content validity, a well-defined content domain must be established (Messick, 1995). In addition, in order to assess for content validity, *all* items on an assessment must represent dimensions of the construct being measured (Crocker & Algina, 2006). In order to assess the content validity domain within the HPWDS, experts were asked to review the content of the scale. In addition, all of the items comprising the HPWDS scale were ground in literature and theory relating to wellness and unwellness (see the HPWDS manual, Appendix O).

Factor Analysis

For the nature of the research investigation, factor analysis (FA) was employed. Factor analysis is a method that allows for patterns amongst several variables to be explored and is a

method to assess construct validity in assessments (Crocker & Algina, 2006). FA involves: (a) finding factors associated with a specific set of variables, (b) discovering what variables load on specific factors, (c) examining the correlations of variables with factors, (e) examining (if any) the correlations among factors, and (f) determining the maximum variance accounted for by the factors (Dimitrov, 2012). The ultimate goal of FA is to cover a maximum variance with the fewest amounts of factors and instrument items.

For the nature of the data in this research investigation, an exploratory factor analysis (EFA) was conducted. The EFA is the appropriate technique because of the exploratory basis of the research investigation (Crocker & Algina, 2006; Mvududu & Sink, 2013). Typically, when researchers in the social sciences do *not* have enough evidence to predict how many factors underlie variables or which variables comprise a particular factor, an EFA is a sufficient statistical method for providing such information (DeVellis, 2012). Ultimately, when constructing a scale, the EFA is an appropriate introductory statistical method (DeVellis, 2012; Mvududu & Sink, 2013).

Though Principal Component Analysis (PCA) is the default setting in most statistical software when conducting an EFA and is often used as a factor extraction method, it is *not* the most appropriate statistical analysis for scale development. Additionally, researchers support that PCA is *not* a true form of factor analysis (Costello & Osborne, 2005) and caution its use. Thus, it is recommended that *Maximum Likelihood* (ML) and/or *Principal Axis Factoring* (PAF) be selected for the FA method (Costello & Osborne, 2005). Furthermore, ML is commonly used when data is slightly non-normal and PAF is implemented when data has severe non-normality, which is often the case in the social sciences and in the helping professions (Costello & Osborne, 2005; Mvududu & Sink, 2013).

The researcher employed a *principal factor analysis* (PFA) in constructing of the HPWDS was a *principal factor analysis* (PFA). Within the PFA, resulting factor solutions are classified as principal axis factors and thus, the procedure of determining the factor solution is called *principal axis factoring* (PAF; DeVellis, 2012). An area of caution when using PAF involves Haywood cases that can occur when communality elements are greater than 1.0 (DeVellis, 2012). In reference to the rotation of the factors, the researcher chose between orthogonal and oblique rotations, which are explained in greater detail below.

Orthogonal rotations are selected if there is an assumption of the factors being uncorrelated or unrelated (DeVellis, 2012). The orthogonal rotation method yields factors that are independent. A frequently used method of orthogonal rotation is a *varimax rotation*. Within a *varimax rotation* the "variance of the squared factor loadings across all factors is maximized" (DeVellis, 2012, p. 77) and thus, the *varimax rotation* allows for explanation of the maximum amount of shared variance across factors.

On the other hand, oblique rotation is appropriate when factors are assumed as being correlated or related (DeVellis, 2012). The main approaches to oblique rotation are: (a) *quartimax rotation*, (b) *equimax rotation*, (c) *direct oblimin rotation*, and (d) *promax rotation*. A *quartimax rotation* "minimizes the sum of the cross-products of the squared variable loadings" (DeVellis, 2012, p. 78) and is *not* beneficial to exploratory research because it yields to a general factor in which most variables will correlate to. The *eqimax rotation* "compromises between varimax and quartimax criteria" (DeVellis, 2012, p. 78). *Direct oblimin rotation* produces higher eigenvalues but the factors are difficult to interpret (DeVellis, 2012). Finally, *promax rotation* uses the initial orthogonal solution to produce an "ideal oblique solution" (DeVellis, 2012, p. 78). For development of the HPWDS, the choice of rotation was dependent on the assumptions

of the data. The researcher chose an oblique rotation based on the idea that that in the social sciences, researchers can expect some degree of correlation among instrument items (Costello & Osborne, 2005). Thus, the researcher chose the oblique rotation method to allow items on the HPWDS the freedom to correlate.

Following rotation of factors in FA, the factors are interpreted. DeVellis (2012) suggested that in order for a factor to be meaningful and defined, it should contain at least two variables. Gorsuch (1997) also states that the variables loading on the factors must have a salient loading of at least .30. Once sufficient factors are established, the researcher names the factors in such a way that will *not* influence participants taking the assessment. Finally, it is important to state that factor structure from EFA analysis does *not* result in a final, all-or-nothing model. Thus, confirming validation of the concept structure is warranted.

As stated, EFA is just that, an exploration of the factors that describe a structural pattern among a set of observed variables. When determining the number of factors that will be retained in an EFA model, the eigenvalues or *characteristic roots* of each factor are examined (DeVellis, 2012). A cutoff value for factor eigenvalues is *1* (Crocker & Algina, 2008; DeVellis, 2012; Dimitrov, 2012). The eigenvalues work well when the sample size is large and the number of variables in an assessment is less than 40 (DeVellis, 2012). Though the eigenvalues can be a useful mode for assessing factor amount, it is *not* the only test available.

The scree test is viewed as an accurate method for assessing the number of factors in an EFA (DeVellis, 2012; Mvududu & Sink, 2013). Further, the test depicts factor numbers plotted against eigenvalues in descending order of their magnitudes (DeVellis, 2012). Determining the number of factors involves identifying the factors that are represented above the elbow or break in the eigenvalues (Mvududu & Sink, 2012).

As noted, the eigenvalues are susceptible to inflation due to sample size and variable amount. Thus, the eigenvalues often overrepresent the number of factors in a model, so a replication analysis was conducted to examine the stability of the final EFA solution (Osborne & Fitzpatrick, 2012). In order to conduct an internal replication analysis, the researcher split the sample (N = 657) into two random samples (n = 328 and n = 328), with item/participant ratios around 15:1. Then, the researcher extracted standardized factor loadings from each sample. Finally, the researcher reviewed the factor loadings and structures for comparison. In order to supersede the limitation of only using eigenvalues to determine number of factors and to support the final factor solution in the EFA, replication analysis was conducted.

Before conducting the initial EFA; however, the data was cleaned and vetted for missing, irregular, or outlying data. In addition, there are numerous assumptions that were explored within the data. Specifically: (a) normality of the data; (b) *Bartlett's sphericity test* (Bartlett, 1950); (c) *Kaiser-Meyer-Olkin* (KMO) *Measure of Sampling Adequacy* (Kaiser, 1974) and (d) multicullinearity were assessed. In order to examine the normality of the data, histograms, quartile – quartile plots, probability – probability plots, and skewness and kurtosis values were evaluated. Data figures on the plots must appear normal (i.e., fit a close bell-shaped curvature) with skewness values greater than two and kurtosis values greater than seven indicating non-normality (Pallant, 2013). Once normality or non-normality was established (i.e., the data does *not* have to be normal to continue with EFA, it just changes some of the later steps), outliers were examined and generally removed (Mvududu & Sink, 2013).

Following normality checking, the appropriateness of the data was examined by conducting the two statistical tests, *Bartlet's test of sphericity* (Bartlett, 1950) and the KMO (Kaiser, 1974). In order for the data to be appropriate for an EFA, *Bartlet's sphericity test* must

yield significant results and the KMO score must be approximately .60 (Crocker & Algina, 2006). KMO values of .80 to .90 found are considered excellent for EFA (Costello & Osborne, 2005; Crocker & Algina, 2006).

Finally, the assumption of multicollinearity was assessed for an EFA (Mvududu & Sink, 2013) and a value of at least .20 was viewed as ideal. According to Costello and Osborne (2005), correlations of .85 or higher in datasets suggest multicollinearity and the data set needs to be further evaluated. Once all assumptions were met, the most appropriate approach to EFA was selected.

In summary, the research investigation involved the development of the HPWDS instrument and examined the psychometric properties of the assessment with a sample of helping professionals. Further, through the research investigation, validity and reliability of the HPWDS were examined with a sample of helping professionals and an EFA was conducted to evaluate initial factor structure of the HPWDS. As a result, the present research investigation aimed at developing a psychometrically sound scale for assessing perceived wellness, aspirational wellness, and the discrepancy between aspirational and perceived wellness in a sample of helping professionals.

Ethical Considerations

In the present research investigation ethical guidelines were followed. Specifically the researcher obtained appropriate approval from her institution's IRB before conducting any data collection. In addition, prior to data collection *all* potential participants were informed about the research investigation, the purpose of the study, and the study procedures. A letter of informed consent was used for the study and all participation was on a strictly voluntary basis. In order to ensure participant confidentiality, *all* study documents were coded. Participants were informed

that all of their responses would remain anonymous. Lastly, all results were in a format that would not identify individual participants.

Limitations of Study

The researcher expected various limitations in the present research investigation. One of the expected limitations included sample size. For the nature of the research investigation and data analysis, a large sample size is required and is ideal. Thus, as the researcher was not able to gain the ideal 1,200 sample size, data analysis could have been affected and the initial participant/item (*N*/*p* ratio) of 20:1 was not achieved. In addition, though the researcher recruited helping professionals-in-training, only counseling students were obtained as participants for the investigation. Thus, data might not be generalizable to social workers-in-training or psychologists-in-training.

Another limitation also involves the generalizability of the data. The sampling criterion specified participants who were helping professionals (i.e., counselors, psychologists, social workers, counselors-in-training, psychologists-in-training, and social workers-in-training) but equal representations of each area were not achieved. Additionally, participants were from a narrow range of geographical locations (South and South East) and thus, do not represent all helping professionals in the United States. Further, sample demographics may not be diverse. Consequently, perspectives from a variety of cultures may *not* have been achieved.

In regards to instrument development, a limitation of the investigation includes the researcher overlooking items that may have been relevant to the construct of interest. As such, the HPWDS model may not include all of the items that measure holistic wellness. As a result, areas that are relevant to measuring wellness in helping professionals may not have been included in the final HPWDS.

Therefore, the present study has limitations that influence the interpretation of the results in a population of helping professionals. Even so, the limitations include areas for future research. Accordingly, the researcher will attempt to strengthen the HPWDS by addressing the limitations in future research endeavors.

Chapter Summary

The purpose of the present research investigation was to develop the HPWDS and assess the psychometric properties of the HPWDS in a sample of helping professionals. This chapter presented the investigation's (a) research design, (b) population and sampling procedures, (c) data collection procedures, (d) instrument development procedures, (e) instrumentation, (f) purpose and research hypothesis, (g) assessing psychometric properties and statistical analysis, (h) ethical considerations, and (i) limitations of the research investigation. Chapter 4 builds upon Chapter 3 and presents the results of the research study.

CHAPTER FOUR: RESULTS

Chapter four presents the results of the research questions that were investigated in this study. Specifically, this study investigated the psychometric features of the *Helping Professional Wellness Discrepancy Scale* (HPWDS) in a population of helping professionals. The data were analyzed using the Statistical Package for the Social Sciences (SPSS; Mac and Windows Version 21.0) and the research questions were examined using: (a) Factor Analysis (FA), (b) Cronbach's alpha, (c) Spearman Rho correlation, (d) Multiple Linear Regression (MLR) and (e) internal replication analysis. Descriptive statistics for the population and results of the research questions are presented in this chapter in the following order: (a) research question 1, exploratory factor analysis and replication analysis; (b) research question 2, Cronbach's alpha analysis; (c) research question 3, correlation analysis; and (d) research question 4, MLR analysis.

Sampling and Data Collection

The population for this research investigation involved practicing helping professionals (i.e., counselors, psychologists, and social workers) and helping professionals-in-training (i.e., counselors-in-training). The practicing helping professionals were recruited from two Southern states and the helping professionals-in-training were recruited from one large, CACREP accredited, Southeastern University.

Prior to recruiting participants for the investigation, the researcher obtained Institutional Review Board (IRB) approval from her university. Following IRB approval of the study, the researcher implemented three methods of data collection: face-to-face administration, mail-out administration, and online survey administration. All methods included the same information: (a) the HPWDS instrument, (b) the *Marlowe-Crowne Social Desirability Scale-X1* (MCSDS-X1; Strahan & Gerbasi, 1979), (c) the *Counselor Burnout Inventory* (CBI; Lee et al., 2007), and (d) a

General Demographic Questionnaire. In addition, all forms of data collection presented the instruments in the same packet format; the HPWDS was first, followed by the MCSDS-X1, the CBI, and the General Demographic Questionnaire.

Face-to-Face Data Collection Participants

The researcher acquired participants in several manners to promote rigorous sampling methodology. For the face-to-face administration, a convenience sample of participants was recruited from classes at a large Southeastern University. First, an email contact was made to the professors of the courses requesting permission to enter the classroom. Once permission was granted, the researcher actively recruited participants from the classroom and offered face-to-face administration of instrument packets. In total, 88 participants were recruited via face-to-face administration. Participants in the face-to-face data collection method consisted only of counselors-in-training.

Mailed Data Collection Participants

Individuals in the mailed data collection methodology were randomly selected from a combination of the Florida Department of Health Helping Professional online list and the Texas Department of Health Helping Professional online list. Both lists contained participant licensure information and mailing addresses, while only the Florida Department of Health Helping Professional List contained participant email addresses. In total, 42,081 participants were on the lists (i.e., n = 17,729 individuals on the Florida Department of Health Helping Professional list and n = 24,353 individuals on the Texas Department of Health Helping Professional list). From the total list (N = 42,081), participants were randomly stratified sampled into equal sample sizes for each helping professional group. That is, 167 individuals were randomly selected for the Social Work Helping Professionals group, 167 individuals were randomly selected for the

Counseling Helping Professionals group, and 167 individuals were randomly selected for the Psychology Helping Professionals group for a total of 501 sampled participants.

In alignment with Dillman's *Tailored Design Method* (Dillman et al., 2009), three contacts were made with participants. First, an informed consent document and a letter were sent informing participants they would be receiving the data collection packet containing the HPWDS, MCSDS-X1, CBI, and General Demographic Questionnaire within a few weeks. The second contact included a letter explaining the research investigation, the instrument packet, and a labeled, stamped envelope for participants to return the instrument packet upon completion. The final contact was a postcard reminding participants that the study was ending and requesting they send in the instrument packet at their earliest convenience.

Online Data Collection Participants

For the final data collection method, participants completed the data collection packet via online survey administration through Qualtrics. Again, Dillman's *Tailored Design Method* (Dillmen et al., 2009) was administered to increase response rate. Participants were contacted three times via email requesting participation in the research investigation. The first email contact included informed consent information, a description of the research investigation, and a link to complete the instruments. The second email contact reminded participants of the investigation, provided information regarding the study, and provided a link to the instruments. The final contact email reminded participants that the study would be closing soon and provided a link to complete the research instruments. All emails offered an opt-out option for participants so that they would *not* receive additional information regarding the study and so that their name would be removed from the recruitment list.

In total, 9,000 participants were emailed the online version of the instrument packet. Individuals in the online data collection methodology were randomly selected from the Florida Department of Health Helping Professional online list. The list contained email and mailing addresses of Helping Professionals, along with licensure information. Initially, the list contained 17,729 (i.e., 7,430 Counseling Helping Professionals, 6,557 Social Work Helping Professionals, and 3,742 Psychologist Helping Professionals). From the original list (*N* = 17,729), random stratified sampling was employed in order to have equal representation for each Helping Professional group. Thus, 3,000 Counseling Helping Professionals, 3,000 Social Work Helping Professionals, and 3,000 Psychologist Helping Professionals were randomly selected for the study. All participants were licensed in their respective professional field.

Sample Demographics and Descriptive Statistics

A total of 9,589 participants were invited to participate in the research investigation. Specifically, 9,000 individuals were invited to participate in an online version via email administration, 501 participants were invited to participate in a paper and pencil version via mail out administration, and 88 participants were invited to participate in a paper and pencil version via face-to-face administration.

Response Rate

In total, 657 individuals participated in the study for an overall useable response rate of 6.8%. In the face-to-face administration, the researcher examined the number of data collection packets versus the number of data collection packets returned. For the face-to-face administration, 88 out of 88 individuals asked to participate in the study chose to participate for a 100% useable response rate. In the mail out data collection process, the researcher tracked the response rate using Excel. Out of the original sample of 501, 95 returned packets (19% response

rate). Of the returned packets, 87 were completed (17.4% useable response rate). Finally, in the online version of participant recruitment, participants were screened using an initial question at the beginning of their survey that asked about their current status as a helping professional. Of the 9,000 potential participants, 936 individuals visited and started the survey for an initial response rate of 10.4%. Of those participants who started the survey however, 495 out of 9,000 potential individuals completed the research investigation for a useable response rate of 5.5%.

In email/web-based surveys, the response rate could have been influenced by whether or *not* the email addresses were correct, whether the emails were opened or sent directly to spam, or whether the email addresses worked for the participant (Granello & Wheaton, 2004). Thus, the actual response rate for the web-based survey might have been higher than the reported value due to some participants never receiving the invitation to participant in the research study.

Participant Personal Characteristics

The participants (*N* = 657) reported gender consisted of 520 females (78.8%) and 136 males (20.6%), with 1 (.2%) of participants reporting gender as other. Reported ethnicity of the participants (*N* = 657) was 34 African American (5.2%), 15 Asian (2.3%), 530 Caucasian (80.3%), 63 Hispanic/Latina/Latino (9.5%), 1 Native American (.2%), and 14 participants identifying as other (2.1%). Marital Status of participants (*N* = 657) was reported as 70 Divorced (10.6%), 394 Married (59.7%), 134 Single (20.3%), 4 Separated (.6%), 24 Widowed (3.6%), and 31 Other (4.7%). The participants' personal characteristics are presented in table 1.

Table 1 Categorical Demographic Variables - Participant Personal Characteristics

Data Category	Total (*n*)	Percentage
Gender (*N* = 657)		
Female	520	78.8%
Male	136	20.6%
Other	1	.2%
Ethnicity (*N* = 657)		
African American	34	5.2%
Asian	15	2.3%
Caucasian	530	80.3%
Hispanic/Latina/Latino	63	9.5%
Native American	1	.2%
Other	14	2.1%
Marital Status (*N* = 657)		
Divorced	70	10.6%
Married	394	59.7%
Single	134	20.3%
Separated	4	.6%
Widowed	24	3.6%
Other	31	4.7%

Participants' Professional Characteristics

Regarding specific Helping Professional groups, the participants (*N* = 657) identified as 271 Counselors (41.2%) and 218 Psychologists (33.2%), 157 Social Workers (23.9%), and 11 individuals identifying as Other (1.7%). Reported Employment Status of participants (*N* = 657) was 411 Employed Full time (62.6%); 122 Employed Part Time (18.6%); 7 Not Working (1.1%); 12 Retired, Not Working (1.8%); 36 Retired, Working Part Time (5.5%); and 69 participants identifying as Students (10.5%). In reference to the participants' reported theoretical orientation (*N* = 657), 10 identified as Adlerian (1.5%), 13 as Behavioral (2.0%), 258 as Cognitive Behavioral (39.3%), 216 as Eclectic/Integrative (32.9%), 12 as Existential (1.8%), 19 as Psychoanalytic (2.9%), 47 as Rogerian/Client-Centered (7.2%), 31 as Systemic (4.7%), and 51

as Other (7.8%). Participants' reported Level of Education and 82 had Bachelor's Degrees (12.4%), 312 had Master's Degrees (47.5%), 8 had Ed.D.'s (1.2%), 86 had PsyD's (13.1%), 159 had Ph.D.'s (24.2%), and 10 reported having Other Degrees (1.5%). Finally, participants' reported that 82 had 0 – 2 years of experience in the field (12.5%), 41 had 3 – 5 years of experience in the field (6.2%), 45 had 6 – 8 years of experience (6.8%), 55 had 9 – 11 years of experience (8.4%) and 434 reported having 12 or more years of experience in the Helping Professional Field (66.1%). The participants' professional characteristics are presented in table 2.

Table 2 Categorical Demographic Variables - Participant Characteristics

Data Category	Total (*n*)	Percentage
Helping Professional Group (*N* = 657)		
Counseling	271	41.2%
Psychology	218	33.2%
Social Work	157	23.9%
Other	11	1.7%
Employment Status (*N* = 657)		
Employed Full Time	411	62.6%
Employed Part Time	122	18.6%
Not Working	7	1.1%
Retired, Not Working	12	1.8%
Retired, Working Part Time	36	5.5%
Student	69	10.5%
Theoretical Orientation (*N* = 657)		
Adlerian	10	1.5%
Behavioral	13	2.0%
Cognitive Behavioral	258	39.3%
Eclectic/Integrative	216	32.9%
Existential	12	1.8%
Psychoanalytic	19	2.9%
Rogerian/Client Centered	47	7.2%
Systemic	31	4.7%
Other	51	7.8%
Degree (*N* = 657)		
Bachelor's Degree	82	12.4%
Master's Degree	312	47.5%
Ed.D.	8	1.2%
PsyD.	86	13.1%
Ph.D.	159	24.2%
M.D.	0	0.0%
Other	10	1.5%
Years in Field (*N* = 657)		
0 – 2 years	82	12.5%
3 – 5 years	41	6.2%
6 – 8 years	45	6.8%
9 – 11 years	55	8.4%
12 or more years	434	66.1%

Data Analysis and Results Based on Research Question

The data were analyzed using the SPSS (Mac and Windows Version 21.0). Prior to examining the research questions, the researcher cleaned and vetted the data for missing data and outliers, and conducted statistical tests to examine the assumptions for the statistical analyses for each research question. The results for the four research questions are reported below.

For Research Question 1, exploratory factor analysis (EFA) was conducted to explore the factor structure of the HPWDS data as well as examine potential correlations between variables (Henson & Roberts, 2010). The goal of EFA is to retain the fewest factors, while explaining the most variance shared among variables (Henson & Roberts, 2006). Through EFA analysis, the researcher attempted to develop a parsimonious model, where the most information could be explained with the least amount of factors and items (Henson & Roberts, 2006). Parsimonious models have greater external validity and have an increased likelihood of being replicated in future research (Henson & Roberts 2006). For the research investigation, Research question 1 was split into four sections (i.e., 1, 1a, 1b, 1c). Research Question 1a involved the exploratory model for all perceived levels of wellness, Research Question 1b included the exploratory model for all aspirational levels of wellness, Research Question 1c involves the exploratory model for the discrepancy between the perceived and aspirational levels of wellness, and Research Question 1 involved examining the overall exploratory model for the combined wellness model.

For Research Question 1a, an EFA was used to examine the factor structure of the data as well as examine the correlations between variables (Henson & Roberts, 2010). For this analysis, HPWDS “a” items were used. HPWDS items were split into three categories: all items under the perceived wellness question “how often do you” were coded as “a” items. Similarly, all items under the aspirational wellness question “how often do you want to” were coded as “b” items.

The discrepancy between all HPWDS “a” items and all HPWDS “b” items were coded as HPWDS “c” items. Research Question 1b was also explored via EFA. For Research Question 1b, all “b” HPWDS items were used in analyses to evaluate the factor structure of the aspirational levels of wellness. All items under the aspirational wellness question “how often do you want to” were coded as “b” items. Research Question 1c assessed the factor structure of the discrepancy between all “a” and “b” items (aspirational versus perceived wellness) on the HPWDS. For the analysis for Research Question 1, the researcher developed an *overall* exploratory scale by combining both the perceived HPWDS scale (“a”) and aspirational HPWDS scale (“b”). Finally, the researcher conducted an internal replication analysis to further support the overall exploratory scale.

For Research Question 2, Cronbach’s alpha was computed to assess the internal consistency reliability. Computing Cronbach’s alpha allows for assessing the degree of correlation between items on a scale. In this research study, HPWDS “a” items were assessed, because the researcher chose to use the perceived wellness items for the final EFA model. According to Tabachnick and Fidell (2013), items having high correlations are measuring a similar construct. Alternatively, items having low correlations may *not* measure the construct of choice. The Cronbach’s α range falls between 0 and 1, with values closer to 0 representing low reliability and values closer to 1 representing higher reliability (DeVellis, 2013). As supported by Mitchell and Jolley (2004) and Sterner (2003), the researcher used a Cronbach’s α value of .70 to indicate internal consistency of items. Cronbach’s α values were calculated for *all* the HPWDS items and for all five factors of the HPWDS to assess overall instrument internal consistency as well as individual factor internal consistency values.

A correlation analysis was used to assess Research Question 3 and the HPWDS final items were correlated with the *Counselor Burnout Inventory* (CBI; Lee et al., 2007). Because of the non-normality of the data, a non-parametric correlation was used. As such, Spearman's rho was calculated to take into account data non-normality and assess the correlations between the HPWDS factors and the CBI subscales of Exhaustion, Incompetence, Uncooperative Work Environment, Devaluing Client, and Deterioration in Personal Life. High scores in any of the CBI subscales indicate a burnout problem (Lee et al., 2007).

The final research question (Research Question 4) was assessed using a multiple regression analysis. The purpose of a multiple regression analysis is to explore the relationship or predictability between variables (Pallant, 2013; Tabachnick & Fidell, 2013). Specifically, the relationships between a dependent variable (DV) such as one of the factors on the HPWDS and several independent variables (IVs) such as variables on the General Demographic Questionnaire were explored. Demographic variables (e.g., ethnicity, gender, education level) collected in this research investigation were coded, and a multiple regression was used to analyze if any of the demographic variables predicted any of the five factors of the HPWDS.

Research Question 1

In order to analyze the exploratory model of the HPWDS, the researcher chose to split the model into categories based on (a) perceived wellness items or "a" (b) aspirational wellness items or "b", and (c) the discrepancy between the perceived wellness items and the aspirational wellness items or "c". All "a" items fell under the HPWDS question of "how often do you," while all "b" coded items fell under the HPWDS question of "how often do you want to," and all "c" items were coded as the discrepancy between "a" items and "b" items. Because of the unique scale characteristics (essentially a three model scale), the researcher chose to develop exploratory

models for the “a” items, the “b” items, and the “c” items, and then use both models to develop a final combined exploratory HPWDS model to answer Research Question 1. The different areas of the HPWDS are differentiated below and the specific steps taken to answer the research questions are explained.

Research Question 1a

For Research Question 1a (What is the factor structure of the perceived items on the HPWDS with a sample of helping professionals?), an EFA was used with the original 92 item HPWDS (N = 657) and to examine construct validity of the HPWDS. Prior to conducting an EFA, a number of statistical assumptions were evaluated in order to assess if data was appropriate for factor analysis (FA). The assumptions that were assessed in this research investigation included: (a) sampling adequacy, (b) linearity, (c) normality, and (d) multicollinearity. With an overall sample of 657 participants and 92 initial scale items, a participant-to-item ratio of around 7:1 was established. A participant-to-item ratio between 5:1 and 10:1 results in a moderately strong ratio of items to participants (Dimitrov, 2012; Hair, Black, Babin, Anderson, & Thatham, 2006). Therefore a minimum amount of data for conducting an EFA with the HPWDS was satisfied. In order to assess for linearity, the researcher examined the associations between variables by inspecting the scatterplots of the variables. No patterns of nonlinear relationships between variables were found and thus, the researcher concluded that the assumption of linearity was satisfied with the dataset.

The assumption of normality was evaluated by examining the (a) skewness and kurtosis values, (b) histograms, (c) Quartile-Quartile (Q-Q) Plots, (d) Probability-Probability (P-P) Plots, (e) multicollinearity, (f) Shapiro-Wilk value, (g) univariate normality, and (h) multivariate normality. Skewness values greater than two and kurtosis values greater than seven indicate non-

normality (Pallant, 2013). For the data, skewness and kurtosis values for *all* items fell within the acceptable range (i.e., skewness > 2 and kurtosis > 7) with the exception of items: 2a (Skewness = 2.9, Kurtosis = 7.89), 39a (Skewness = 3.8, Kurtosis = 18.2), 41a (Skewness = 11.06, Kurtosis = 145.2), 58a (Skewness = 2.9, Kurtosis = 10.16), 66a (Skewness = 5.15, Kurtosis = 33.85), 76a (Skewness = 4.39, Kurtosis = 21.12), 83a (Skewness = 3.4, Kurtosis = 13.4), 91a (Skewness = 2.8, Kurtosis = 7.36), and 92a (Skewness = 5.83, Kurtosis = 54.08). It is important to note however, that Skewness and Kurtosis values are influenced by large sample sizes (Pallant, 2013). Thus, the normality needed to be further assessed using additional statistical methods (i.e., checking normality plots).

After examining the histograms of each individual item on the HPWDS, *all* item data plots suggested non-normality of data (i.e., plots did *not* follow the general bell curved normal shape). Q-Q and P-P plots also suggested non-normality of data. See figures 1, 2, and 3 for examples of HPWDS Item 1.

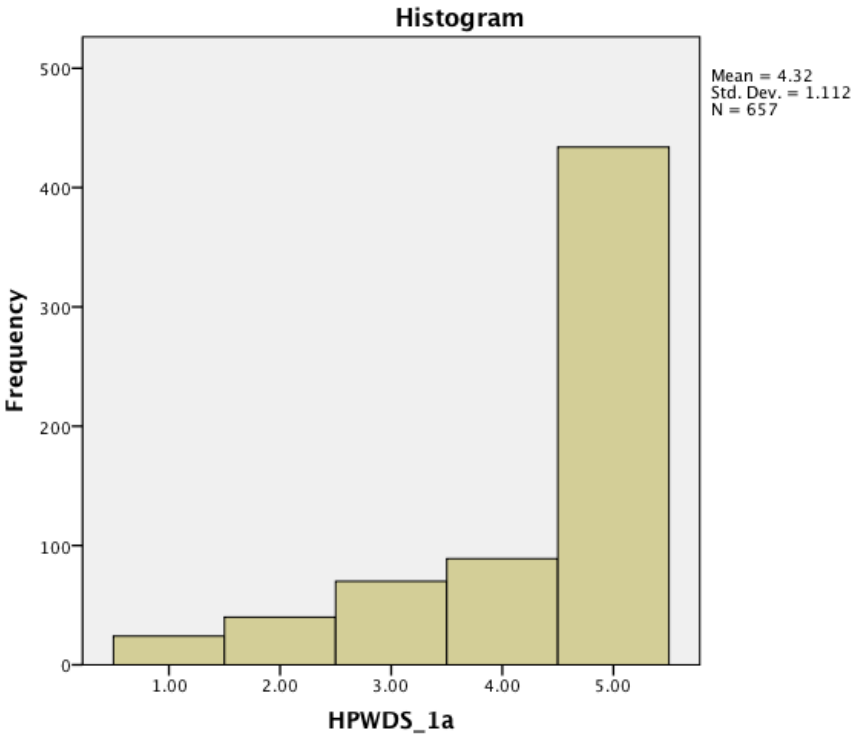


Figure 1: HPWDS Item 1a Histogram

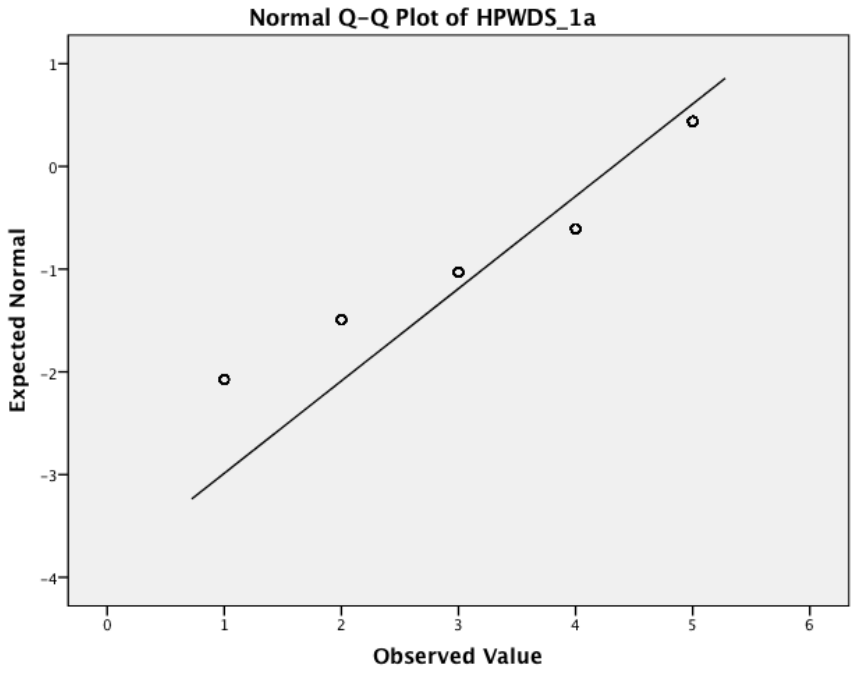


Figure 2: HPWDS Item 1a P - P Plot

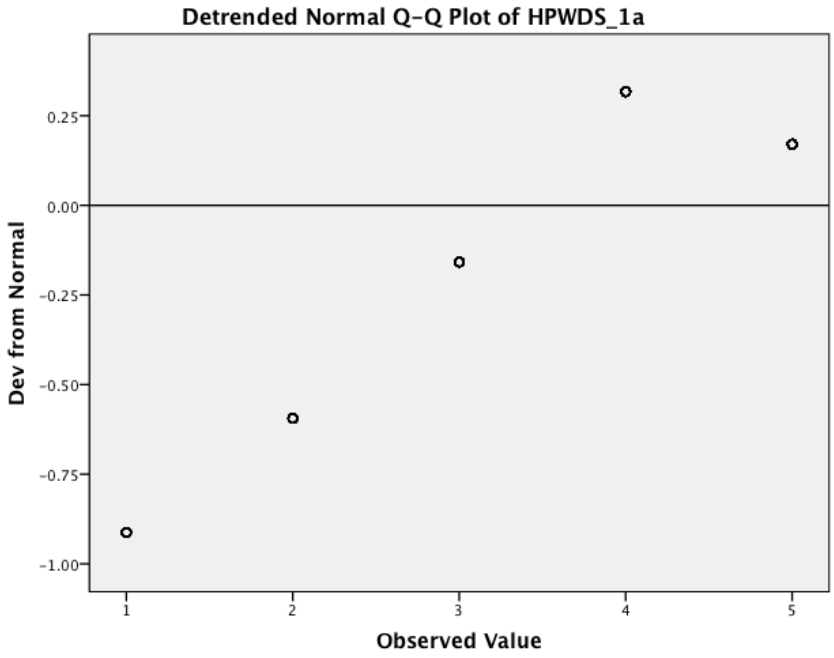


Figure 3: HPWDS Item 1a Q - Q Plot

Evaluating the variance inflation factor (VIF) value and Tolerance value allowed the researcher to assess the multicollinearity assumption of the data. A VIF value of less than 10 and a Tolerance value of greater than .10 is sufficient for EFA (Pallant, 2013) and indicates *no* multicollinearity. All VIF values were less than 10 and all Tolerance values were greater than .10, suggesting that the assumption of multicollinearity was *not* violated with these data.

As suggested by Pallant (2013), the Shapiro-Wilk value was used because the data set was less than 2,000. A Shapiro-Wilk value of significance at the $p < .001$ level indicates non-normality of data. For this research data ($N = 657$), the Shapiro-Wilk value was statistically significant at the $p < .001$ level, which further supported non-normality of data. As the Shapiro-Wilk value is sensitive to large sample sizes (Pallant, 2013), the researcher examined the univariate and multivariate normality of the data by examining the Kaiser-Meyer-Olkin (KMO) Measure of Sampling Adequacy and Bartlett's Test of Sphericity. Because data was non-normal at the univariate level, data could *not* be normal at the multivariate level.

The KMO Measure of Sampling Adequacy and Bartlett's Test of Sphericity were evaluated to assess intercorrelations between variables. According to Pallant (2013), a KMO value of .60 is sufficient for EFA and values of .80 to .90 deem data excellent for EFA. In addition, Bartlett's Test of Sphericity values achieving statistical significance at the $p < .05$ level support the use of EFA for a dataset (Pallant, 2013). Initial KMO value for the 92 HPWDS "a" items was .924 and Bartlett's Test of Sphericity was statistically significant ($\chi^2 = 32290.024$, $df = 4186$, $p < .001$). Based off of the statistical assumptions, the data were non-normal, yet considered appropriate for EFA.

Due to the severe non-normality of the data, the researcher conducted a principal axis factoring (PAF) method with an oblique (Promax) rotation (Costello & Osborne, 2005;

Fabringar, Wegener, MacCallum, & Strahan, 1999). Though principal components analysis (PCA) is the default setting in most SPSS statistical software packages, Costello and Osborne (2005) and Tabachnick and Fidel (2012) stated that PCA was *not* a true form of factor analysis and that PAF or Maximum Likelihood (ML) should be favored over PCA. As ML extraction is consistent for normal data and PAF is sufficient when working with non-normal data sets (Fabringar et al., 1999), the researcher chose a PAF extraction method for this research investigation. Following decisions on the extraction methodology, the researcher chose an oblique, Promax rotation. The oblique rotation was chosen based on the fact that in the social sciences, researchers can expect some degree of correlation among instrument items (Costello & Osborne, 2005). Thus, the researcher chose the oblique rotation method to allow items on the HPWDS the freedom to correlate.

A number of criterions were used to determine the number of factors of the HPWDS "a" items. Hair and colleagues (2006) suggested assessing communalities of items and retaining only items with values over .5 (see Table 3 for communalities of the final HPWDS "a" model). In addition, only factors with eigenvalues 1.0 or higher (e.g., Kaisers rule; Mertler & Vannatta, 2005) were considered sufficient for retention. Examination of the extracted commonalities resulted in the identification of HPWDS "a" items with low commonality (< .5; Hair et al., 2010; Mvududu & Sink, 2013) for item removal. Next, the researcher removed items that had significant cross loadings (e.g., .3 or higher; Hair et al., 2010; Mvududu & Sink, 2013) on more than one factor. Following cross loading item removal, items were added back into the model to reexamine the contribution to the remaining model. If the items fit the retention criteria, they were added back into the HPWDS model. When a statistically sound model was found, a screeplot was examined in order to support the factor solution (see figure 4, Hair et al., 2006). As

suggested by Pallant (2013), a significant break in the scree identifies the factor structure of the model. As shown, a significant break between factors 5 and 6 is depicted in figure 4. The appropriateness of the data for EFA was examined again based on the reduced HPWDS item scale by examining the KMO values and Bartlett's test of sphericity. Bartlett's test of sphericity produced a statistically significant value ($\chi^2 = 7959.00$, $df = 231$, $p < .001$), indicating correlated data. The analysis produced a KMO value of .884, which is considered sufficient for EFA (Dimitrov, 2012, DeVellis, 2013). Using the aforementioned steps, the researcher: (a) ran the EFA with all 92 HPWSD "a" items and assessed the statistics; (b) removed items with low communalities individually until the EFA resulted in an initial model; (c) continued to remove items based on communality values and cross-loading; (d) assessed the model's Eigenvalues for factors; and (e) derived a final exploratory "a" HPWDS model.

The final PAF EFA with an oblique, promax rotation identified a five-factor solution (see table 4) with eigenvalues greater than 1.0 within the data. The five factor model accounted for 68.251% of the variance, which is satisfactory in social science research (Hair et al., 2006). Furthermore, the communalities were considered acceptable with only four of them below the recommended .5 (see table 3). Communalities are important because as MacCallum, Widaman, Zhang, and Hong (1999) noted, the item-to-participant ratio is limited and therefore "communalities play a critical role" (p. 96) in deciding factor analytic solutions. Factor one represents *Professional & Personal Development Activities* and accounted for 33.350% of the variance, Factor two represents *Leisure Activities* and accounted for 12.964% of the variance, Factor three represents *Hope and Optimism* and accounted for 8.480% of the variance, Factor four represents *Burnout* and accounted for 7.083% of the variance, and Factor five represents *Religion/Spirituality* and accounted for 6.354% of the variance. Finally, Kaiser's (1970, 1974)

measurement sampling adequacy (MSA) was examined in order to assess the significance of correlations to assess the "reliability of the relationships between pairs of variables" (Tabachnick & Fidel, 2013, p. 619). A MSA value of .6 is considered sufficient for factor analysis. After examining the MSA values for the HPWDS "a" items, *all* met the minimum .6 cutoff. Please note, all "a" items refer to participants' levels of perceived wellness.

Table 3 Communality Values for Final HPWDS "a" Items

Communalities	Initial	Extraction
Question 4 – Partake in enjoyable activities (i.e., things you enjoy doing)	.591	.586
Question 5 – Immerse yourself in leisure activity/activities with which you participate	.644	.713
Question 8 – Are worn out because of the work you do as a helping professional	.473	.552
Question 38 – Engage in free-time/leisure activity (i.e., time spent away from work or chores)	.620	.668
Question 42 – Feel like you are making a difference as a helping professional	.609	.664
Question 43 – Take the initiative to learn about new research in the helping professions	.552	.596
Question 47 – Find time to relax	.593	.568
Question 48 – Engage in activities to advance your knowledge (e.g., reading, writing)	.568	.575
Question 54 – Partake in activities to increase your knowledge in an area of your choice	.627	.677
Question 56 – Experience optimism about client's futures	.499	.533
Question 57 – partake in activities to further your knowledge as a helping professional	.706	.814
Question 60 – Experience satisfaction with your spiritual or religious activity	.648	.771
Question 62 – Have religious or spiritual beliefs that you feel are sustaining	.630	.755
Question 67 – Believe that your contributions as a helping professional matter	.600	.635
Question 68 – Take time to advance your professional development (i.e., attend conferences or seminars)	.515	.530
Question 69 – Experience exhaustion because of your work as a helping professional	.580	.759
Question 90 – Experience stress from working as a helping professional	.473	.555
Question 73 – Mediate with a focus on a higher power or spiritual entity	.295	.304*
Question 7 – Experience optimism about your future	.445	.425*
Question 70 Experience satisfaction in your life	.676	.643
Question 87 – Experience happiness	.577	.487*
Question 61 – Partake in activities to build your social relationships with others (e.g., spending quality time with others)	.362	.348*

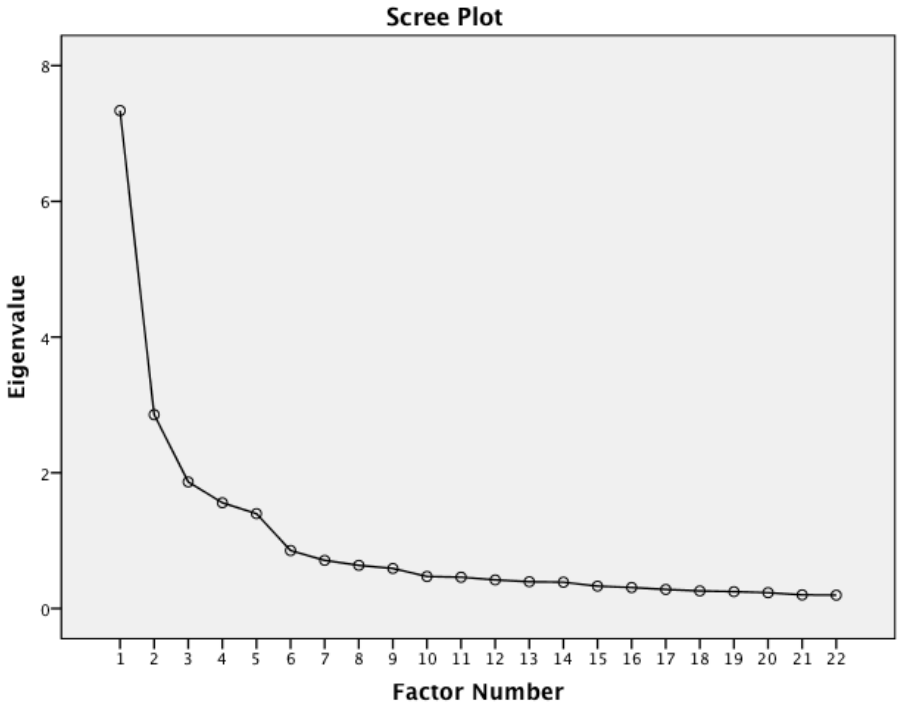


Figure 4: Scree Plot for HPWDS "a" Items

Table 4 Exploratory Factor Analysis of the HPWDS "a" Items

	Factor					
Item	**1**	**2**	**3**	**4**	**5**	**Comm.**
Question 57a	.918					.814
Question 54a	.756					.677
Question 43a	.736					.596
Question 48a	.699					.575
Question 68a	.635					.530
Question 5a		.935				.713
Question 38a		.842				.668
Question 4a		.803				.586
Question 47a		.632				.568
Question 61a		.428				.348
Question 42a			.877			.664
Question 67a			.830			.635
Question 56a			.743			.533
Question 70a			.578			.643
Question 87a			.466			.487
Question 7a			.442			.425
Question 69a				.874		.759
Question 90a				.779		.555
Question 8a				.752		.552
Question 62a					.911	.755
Question 60a					.870	.771
Question 73a					.524	.304
Eigenvalue	7.337	2.856	1.866	1.558	1.398	
Variance (%)	33.350	12.984	8.480	7.083	6.354	

**Denotes low communalities*

Research Question 1b

For Research Question 1b (What is the factor structure of the aspirational items on the HPWDS with a sample of helping professionals?), the researcher used EFA with the original 92 item HPWDS (N = 657) and to examine construct validity of the HPWDS. Prior to conducting an EFA, the researcher evaluated a number of assumptions in order to assess if data was appropriate for FA. The assumptions that were assessed in this research investigation included: (a) sampling adequacy, (b) linearity, (c) normality, and (d) multicollinearity. With an overall sample of 657

participants and 92 initial scale items, a participant to item ratio of around 7:1 was established. A participant to item ratio between 5:1 and 10:1 results in a moderately strong ratio of items to participants (Dimitrov, 2012; Hair et al., 2006). Therefore, a minimum amount of data for conducting an EFA with the HPWDS was satisfied. In order to assess for linearity, the researcher examined the associations between variables by inspecting the scatterplots of the variables. No patterns of nonlinear relationships between variables were found; and thus, the researcher satisfied the assumption of linearity within the dataset.

The researcher evaluated the assumption of normality by assessing the (a) skewness and kurtosis values, (b) histograms, (c) Quartile-Quartile (Q-Q) Plots, (d) Probability-Probability (P-P) Plots, (e) multicollinearity, (f) Shapiro-Wilk value, (g) univariate normality, and (h) multivariate normality. Skewness values greater than two and kurtosis values greater than seven indicate non-normality (Pallant, 2013). For the data, skewness and kurtosis values for all items fell within the acceptable range (i.e., skewness > 2 and kurtosis > 7) with the exception of items: 2b (Skewness = 3.5, Kurtosis = 11.844), 8b (Skewness = 3.043, Kurtosis = 8.840), 27b (Skewness = 4.037, Kurtosis = 18.507), 31b (Skewness = 5.633, Kurtosis = 32.19), 37b (Skewness = 2.608, Kurtosis = 7.676), 39b (Skewness = 7.434, Kurtosis = 58.132), 41b (Skewness = 11.092, Kurtosis = 139.947), 46b (Skewness = 3.622, Kurtosis = 15.049), 58b (Skewness = 4.106, Kurtosis = 17.423), 63b (Skewness = 3.753, Kurtosis = 12.906), 66b (Skewness = 7.873, Kurtosis = 74.307), 69b (Skewness = 3.438, Kurtosis = 12.694), 71b (Skewness = 4.885, Kurtosis = 28.437), 72b (Skewness = 6.993, Kurtosis = 52.252), 75b (Skewness = 4.532, Kurtosis = 21.873), 83b (Skewness = 10.825, Kurtosis = 137.685), 84b (Skewness = 8.332, Kurtosis = 79.438), and 92b (Skewness = 3.911, Kurtosis = 16.428). It is important to note however, that Skewness and Kurtosis values are influenced by large sample

sizes (Pallant, 2013). Thus, the normality needed to be further assessed using additional statistical methods (i.e., checking normality plots).

After examining the histograms of each individual item on the HPWDS, *all* item data plots suggested non-normality of data (i.e., plots did *not* follow the general bell curved normal shape). Q-Q and P-P plots also suggested non-normality of data. See figures 5, 6, and 7 for examples of HPWDS Item 2b.

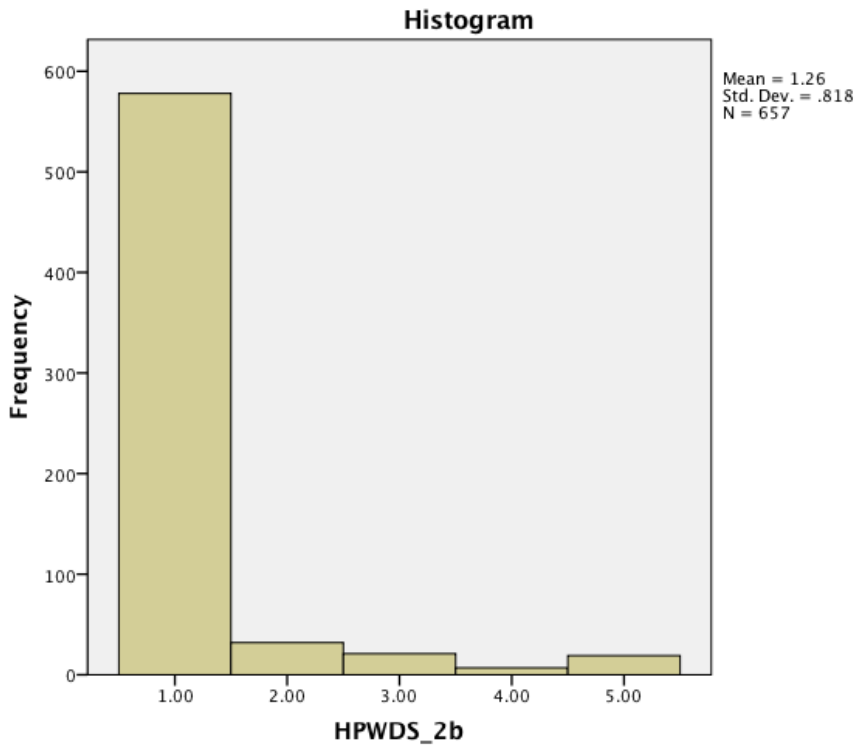


Figure 5: HPWDS Item 2b Histogram

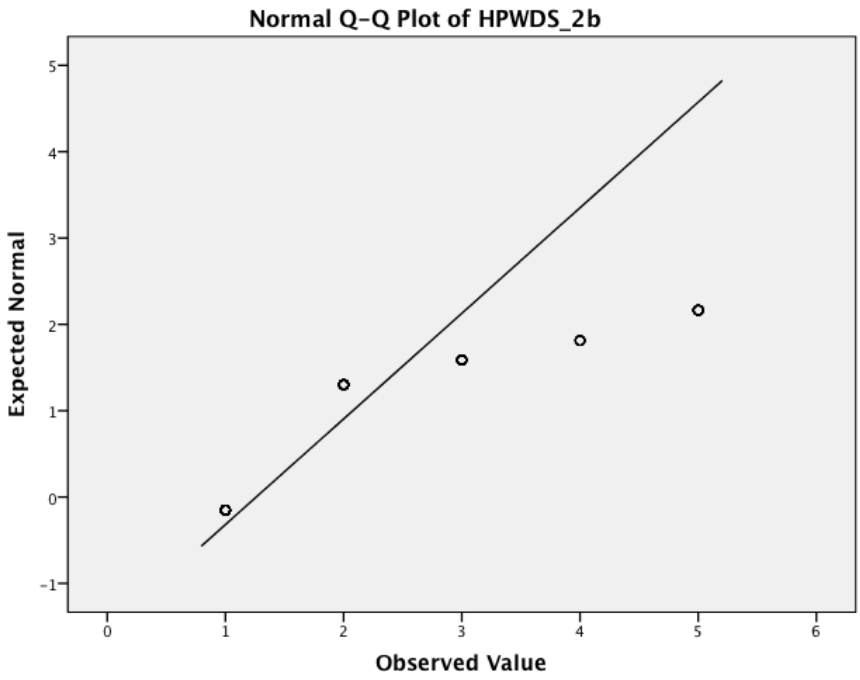


Figure 6: HPWDS Item 2b P - P Plot

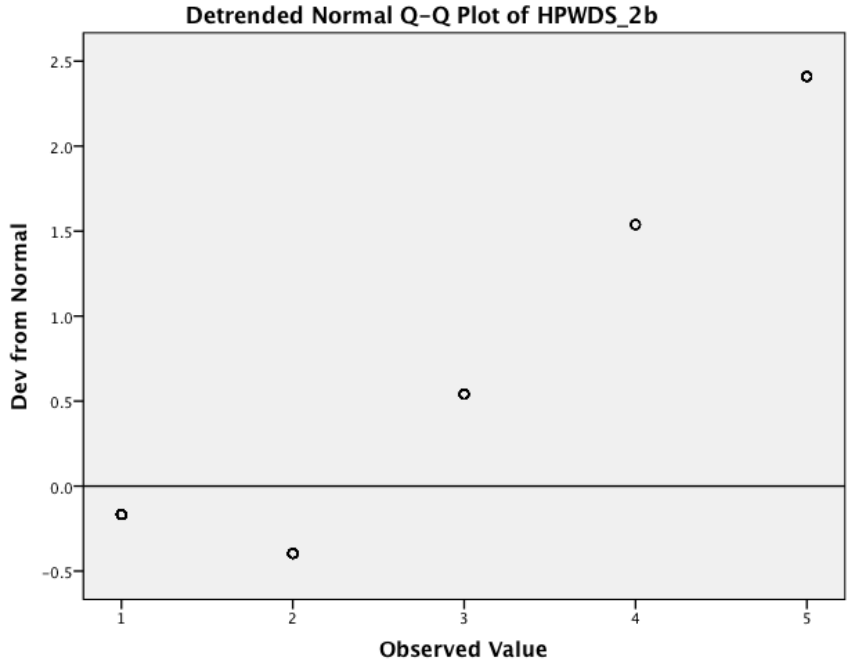


Figure 7: HPWDS Item 2b Q - Q Plot

Evaluating the Variance Inflation Factor (VIF) value and Tolerance value allowed the researcher to assess the multicollinearity assumption of the data. A VIF value of less than 10 and a Tolerance value of greater than .10 is said to be sufficient for EFA (Pallant, 2013) and indicates *no* multicollinearity. All VIF values were less than 10 and all Tolerance values were greater than .10, suggesting that the assumption of multicollinearity was *not* violated.

As suggested by Pallant (2013), the researcher used the Shapiro-Wilk value because the data set was less than 2,000. A Shapiro-Wilk value of significance at the $p < .001$ level indicates non-normality of data. For this research data ($N = 657$), the Shapiro-Wilk value was statistically significant at the $p < .001$ level, which further supported non-normality of data. As the Shapiro-Wilk value is sensitive to large sample sizes (Pallant, 2013), the researcher examined the univariate and multivariate normality of the data by examining the KMO Measure of Sampling Adequacy and Bartlett's Test of Sphericity. Because data was non-normal at the univariate level, data could *not* be normal at the multivariate level.

The researcher also used the KMO Measure of Sampling Adequacy and Bartlett's Test of Sphericity to assess intercorrelations between variables. According to Pallant (2013), a KMO value of .60 is sufficient for EFA and values of .80 to .90 deem data excellent for EFA and Bartlett's Test of Sphericity values achieving statistical significance at the $p < .05$ level support the use of EFA for a dataset. Initial KMO value for the 92 HPWDS "b" items was .927 and Bartlett's Test of Sphericity was statistically significant ($\chi^2 = 30228.496$, $df = 4186$, $p < .001$). Based off of the statistical assumptions, the data were non-normal, yet considered appropriate for EFA.

Based on the non-normality of the data (Costello & Osborne, 2005; Fabringar et al., 1999), the researcher conducted a PAF extraction method with an oblique (Promax) rotation.

Though PCA is the default setting in most SPSS statistical software packages, Costello and Osborne (2005) and Tabachnick and Fidel (2013) stated that PCA is *not* a true form of factor analysis and that PAF or ML should be favored over PCA. As ML extraction is consistent for normal data and PAF is sufficient when working with non-normal data sets (Fabringar et al., 1999), the researcher chose a PAF extraction method for this research investigation.

Following decisions on the extraction method, the researcher chose an oblique, Promax rotation. The researcher chose the oblique rotation based on the fact that in the social sciences, researchers can expect some degree of correlation among instrument items (Costello & Osborne, 2005). Thus, the researcher chose the oblique rotation method to allow items on the HPWDS the freedom to correlate.

The researcher used a number of criterions to determine the number of factors of the HPWDS "b" items. Hair and colleagues (2006) suggested assessing communalities of items and retaining only items with values over .5 (See Table 5 for communalities of the final HPWDS "b" model). In addition, only factors with eigenvalues one or higher (e.g., Kaisers rule; Mertler & Vannatta, 2005) were considered sufficient for retention. Examination of the extracted commonalities resulted in the identification of HPWDS "b" items with low commonality (< .5; Hair et al., 2010; Mvududu & Sink, 2013) for item removal. Next, the researcher removed items that had significant cross loadings (e.g., .3 or higher; Hair et al., 2010; Mvududu & Sink, 2013) on more than one factor. Following cross loading item removal, items were added back into the model to reexamine the contribution to the remaining model. If the items fit the retention criteria, the researcher added items back into the HPWDS model. When the researcher found a statistically sound model, a screeplot was examined in order to support the factor solution (see figure 8, Hair et al., 2006). As suggested by Pallant (2013), a significant break in the scree

identifies the factor structure of the model. As shown, a significant break between factors 5 and 6 resulted (see figure 8). Bartlett's test of sphericity produced a statistically significant value (χ^2 = 6776.904, *df* =1711, $p < .001$), indicating correlated data. The analysis produced a KMO value of .855, which is considered sufficient for EFA (Dimitrov, 2012, DeVellis, 2013). Using the aforementioned steps, the researcher: (a) ran the EFA with all 92 HPWSD "b" items and assessed the statistics; (b) removed items with low communalities individually until the EFA resulted in an initial model; (c) continued to remove items based on communality values and cross-loading; (d) assessed the model's Eigenvalues for factors; and (e) derived a final exploratory "b" HPWDS model.

A five-factor solution was derived (see table 6) and the five factors accounted for 72.104% of the variance, which is satisfactory in social science research (Hair et al., 2006). Furthermore, the communalities were considered acceptable with only four of them below the recommended .5 (see table 5). Communalities are important because as MacCallum et al. (1999) noted, the item-to-participant ratio is limited; and therefore, "communalities play a critical role" (p. 96) in deciding factor analytic solutions. Factor 1 represented *Professional & Personal Development Activities* and accounted for 32.626% of the variance; Factor 2 represented *Religion/Spirituality* and accounted for 12.818% of the variance; Factor 3 represented *Leisure Activities* and accounted for 11.413% of the variance, factor 4 represented *Burnout* and accounted for 8.474% of the variance; and Factor 5 represented *Helping Professional Optimism* and accounted for 6.773% of the variance. Finally, Kaiser's (1970, 1974) Measurement Sampling Adequacy (MSA) was examined in order to assess the significance of correlations to assess the "reliability of the relationships between pairs of variables" (Tabachnick & Fidel, 2013, p. 619). A MSA value of .6 is considered sufficient for factor analysis. After examining the MSA

values for the HPWDS “b” items, *all* met the minimum .6 cutoff. Please note, all “b” items refer to participants’ levels of aspirational wellness.

Table 5 Communality Values for Final HPWDS "b" Items

Communalities	Initial	Extraction
Question 4 – Partake in enjoyable activities (i.e., things you enjoy doing)	.555	.592
Question 5 – Immerse yourself in leisure activity/activities with which you participate	.594	.737
Question 11 – Feel burned out with the work that you do	.668	.772
Question 14 – Discuss new research/information with others in your profession	.492	.535
Question 28 – Become frustrated at work	.669	.803
Question 42 – Feel like you are making a difference as a helping professional	.490	.609
Question 43 – Take the initiative to learn about new research in the helping professions	.561	.608
Question 48 – Engage in activities to advance your knowledge (e.g., reading, writing)	.551	.575
Question 54 – Partake in activities to increase your knowledge in an area of your choice	.619	.659
Question 56 – Experience optimism about client’s futures	.459	.528
Question 57 – partake in activities to further your knowledge as a helping professional	.682	.784
Question 60 – Experience satisfaction with your spiritual or religious activity	.679	.682
Question 62 – Have religious or spiritual beliefs that you feel are sustaining	.705	.767
Question 67 – Believe that your contributions as a helping professional matter	.519	.660
Question 68 – Take time to advance your professional development (i.e., attend conferences or seminars)	.489	.521
Question 73 – Mediate with a focus on a higher power or spiritual entity	.519	.538
Question 88 – Engage in prayer (e.g., praying)	.547	.609
Question 38 – Engage in free-time/leisure (i.e., time spent away from work or chores)	.499	.528
Question 47 – Find time to relax	.467	.427*

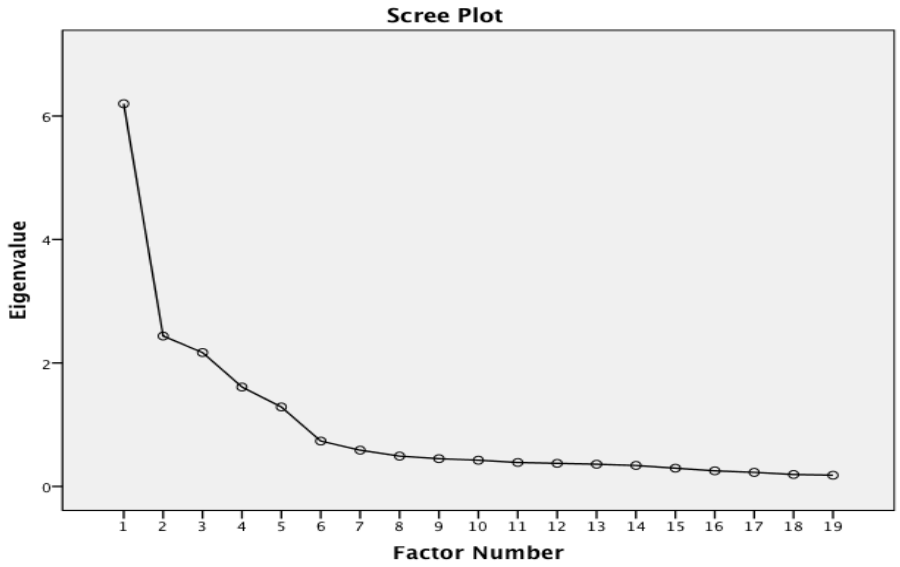


Figure 8: Scree Plot for HPWDS "b" Items

Table 6 Exploratory Factor Analysis of the HPWDS "b" Items

	Factor					
Item	**1**	**2**	**3**	**4**	**5**	**Comm.**
Question 57b	.925					.784
Question 54b	.797					.659
Question 43b	.766					.608
Question 68b	.726					.521
Question 48b	.713					.575
Question 62b		.856				.767
Question 88b		.834				.609
Question 60b		.777				.682
Question 73b		.701				.538
Question 5b			.913			.737
Question 4b			.800			.592
Question 38b			.684			.528
Question 47b			.404			.427*
Question 28b				.922		.803
Question 11b				.894		.772
Question 14b				.664		.535
Question 67b					.830	.660
Question 42b					.782	.609
Question 56b					.722	.528
Eigenvalue	6.199	2.436	2.168	1.610	1.287	
Variance (%)	32.626	12.818	11.413	8.474	6.773	

**Denotes low communalities*

Research Question 1c

For Research Question 1c (What is the factor structure of the discrepancy between the perceived items and aspirational items on the HPWDS with a sample of helping professionals?), an EFA was used with the original 92 item HPWDS (*N* = 657) and to examine construct validity of the HPWDS. Prior to conducting an EFA, the researcher evaluated a number of statistical assumptions in order to assess if data was appropriate for FA. The assumptions that were assessed in this research investigation included: (a) sampling adequacy, (b) linearity, (c) normality, and (d) multicollinearity. With an overall sample of 657 participants and 92 initial scale items, a participant-to-item ratio of around 7:1 was established. A participant-to-item ratio between 5:1 and 10:1 results in a moderately strong ratio of items-to-participants (Dimitrov, 2012; Hair et al., 2006). Therefore, a minimum amount of data for conducting an EFA with the HPWDS was satisfied. In order to assess for linearity, the researcher examined the associations between variables by inspecting the scatterplots of the variables and found no patterns of nonlinear relationships between variables (assumption of linearity was satisfied with the dataset).

The researcher evaluated the assumption of normality by looking at the (a) skewness and kurtosis values, (b) histograms, (c) Quartile-Quartile (Q-Q) Plots, (d) Probability-Probability (P-P) Plots, (e) multicollinearity, (f) Shapiro-Wilk value, (g) univariate normality, and (h) multivariate normality. Skewness values greater than two and kurtosis values greater than seven indicate non-normality (Pallant, 2013). For the data, skewness and kurtosis values for all items fell within the acceptable range (i.e., skewness > 2 and kurtosis > 7) with the exception of items: 41c (Skewness = 7.017, Kurtosis = 164.631), 76c (Skewness = 2.516, Kurtosis = 7.539), 83c (Skewness = 3.366, Kurtosis = 14.509), 84c (Skewness = 2.54, Kurtosis = 7.588), 91c (Skewness

= 2.789, Kurtosis = 9.378), and 92c (Skewness = 6.777, Kurtosis = 143.961). Thus, the normality needed to be assessed using additional statistical methods (i.e., checking normality plots).

After examining the histograms of each individual item on the HPWDS, *all* item data plots suggested non-normality of data (i.e., plots did *not* follow the general bell curved normal shape). Q-Q and P-P plots also suggested non-normality of data. See figures 9, 10, and 11 for examples of HPWDS Item 2c.

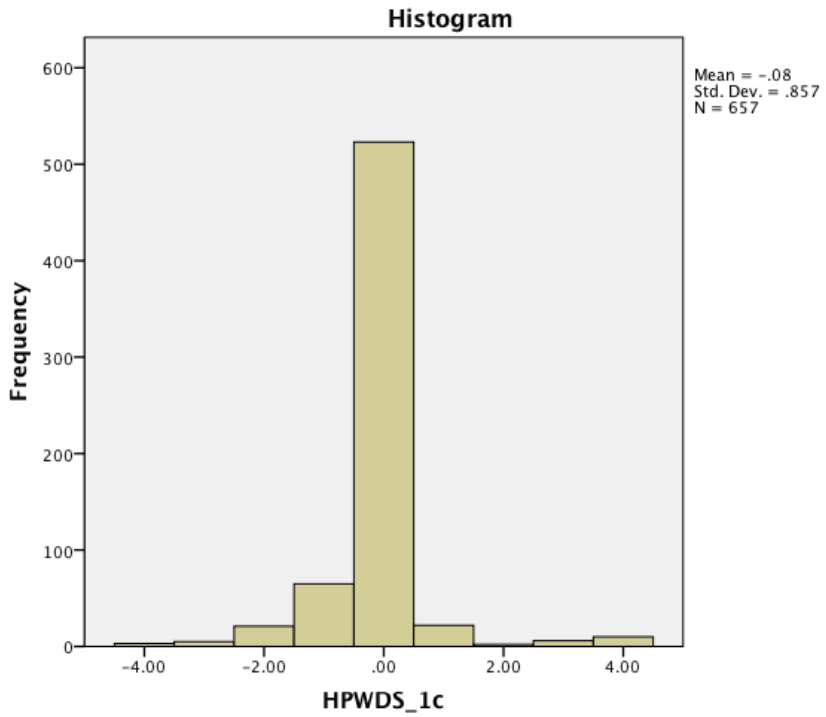


Figure 9: HPWDS Item 1c Histogram

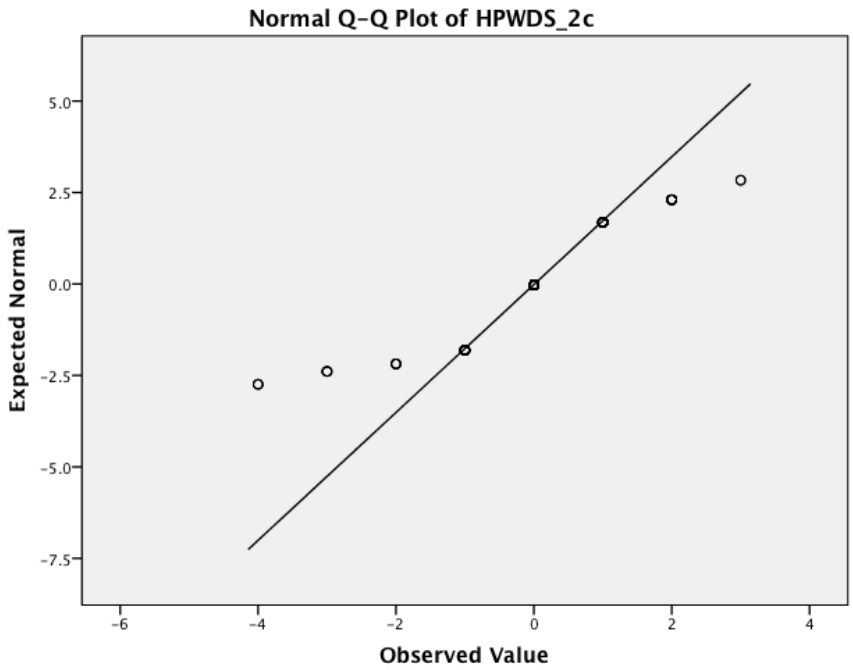


Figure 10: HPWDS Item 2c P - P Plot

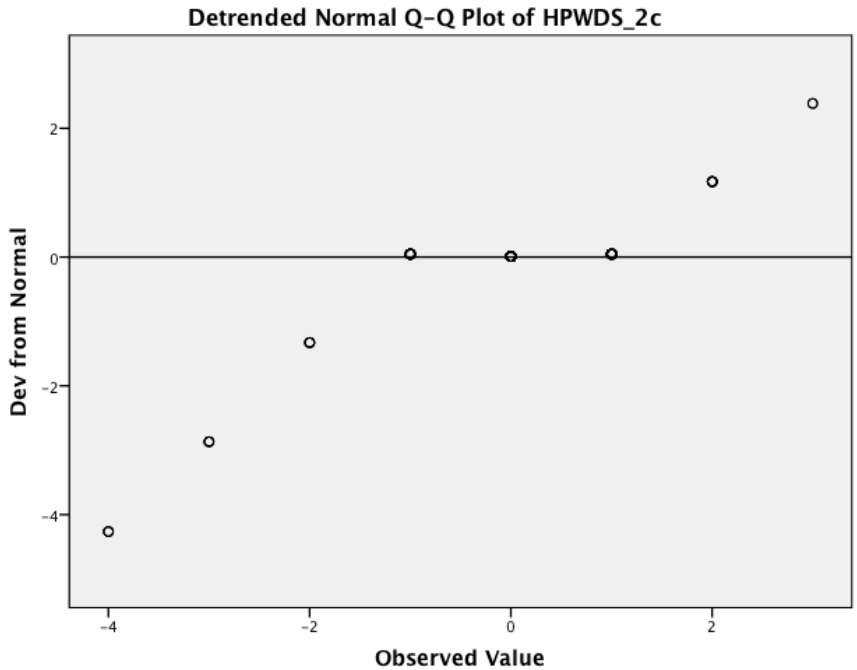


Figure 11: HPWDS Item 2c Q - Q Plot

Evaluating the VIF value and Tolerance value allowed the researcher to assess for the multicollinearity assumption of the data. A VIF value of less than 10 and a Tolerance value of greater than .10 is said to be sufficient for EFA (Pallant, 2013) and indicates *no* multicollinearity. All VIF values were less than 10 and all Tolerance values were greater than .10, suggesting that the assumption of multicollinearity was *not* violated.

As suggested by Pallant (2013), the researcher used the Shapiro-Wilk value because the data set was less than 2,000. A Shapiro-Wilk value of significance at the $p < .001$ level indicates non-normality of data. For this research data ($N = 657$), the Shapiro-Wilk value was statistically at the $p < .001$ level, which further supported non-normality of data. As the Shapiro-Wilk value is sensitive to large sample sizes (Pallant, 2013), the researcher looked at the univariate and multivariate normality of the data by examining the KMO Measure of Sampling Adequacy and Bartlett's Test of Sphericity. Because data was non-normal at the univariate level, data could *not* be normal at the multivariate level.

The researcher evaluated the KMO Measure of Sampling Adequacy and Bartlett's Test of Sphericity to assess intercorrelations between variables. According to Pallant (2013), a KMO value of .60 is sufficient for EFA and values of .80 to .90 deem data excellent for EFA. In addition, Bartlett's Test of Sphericity values achieving statistical significance at the $p < .05$ level support the use of EFA for a dataset (Pallant, 2013). Initial KMO value for the 92 HPWDS "c" items was .929 and Bartlett's Test of Sphericity was statistically significant ($\chi^2 = 28144.438$, $df = 4186$, $p < .001$). Based off of the statistical assumptions, the data were non-normal, yet were appropriate for EFA.

Because of the non-normality of the data (Costello & Osborne, 2005; Fabringar et al., 1999), the researcher conducted a PAF method with an oblique (Promax) rotation. Though PCA

is the default setting in most SPSS statistical software packages, Costello and Osborne (2005) and Tabachnick and Fidel (2013) stated that PCA is *not* a true form of factor analysis and that PAF or ML should be favored over PCA. As ML extraction is consistent for normal data and PAF is sufficient when working with non-normal data sets (Fabringar et al., 1999), the researcher chose a PAF extraction method for this research investigation.

Following decisions on the extraction methodology, the researcher chose an oblique, Promax rotation. The researcher chose the oblique rotation based on the fact that in the social sciences, researchers can expect some degree of correlation among instrument items (Costello & Osborne, 2005). Thus, the researcher chose the oblique rotation method to allow items on the HPWDS the freedom to correlate.

The researcher used a number of criterions to determine the number of factors of the HPWDS "c" items. Hair and colleagues (2006) suggest assessing communalities of items and retaining only items with values over .5 (See table 7 for communalities of the HPWDS "c" model). In addition, only factors with eigenvalues of 1.0 or higher (e.g., Kaisers rule; Mertler & Vannatta, 2005) were considered sufficient for retention. Examination of the extracted commonalities resulted in the identification of HPWDS "c" items with low commonality (< .5; Hair et al., 2010; Mvududu & Sink, 2013) for item removal. Next, the researcher removed items that had significant cross loadings (e.g., .3 or higher; Hair et al., 2010; Mvududu & Sink, 2013) on more than one factor. Following cross loading item removal, items were added back into the model to reexamine the contribution to the remaining model. If the items fit the retention criteria, they were added back into the HPWDS model. When a statistically sound model was found, a screeplot was examined in order to support the factor solution (see figure 12, Hair et al., 2006). As suggested by Pallant (2013), a significant break in the scree identifies the factor structure of

the model. As shown, a significant break between factors 5 and 6 resulted (see figure 12). Using the aforementioned steps, the researcher: (a) ran the EFA with all 92 HPWSD "c" items and assessed the statistics; (b) removed items with low communalities individually until the EFA resulted in an initial model; (c) continued to remove items based on communality values and cross-loading; (d) assessed the model's Eigenvalues for factors; and (e) derived a final exploratory "c" HPWDS model.

The researcher examined the appropriateness of the data for EFA again based on the reduced HPWDS item scale by examining the KMO values and Bartlett's test of sphericity. Bartlett's test of sphericity produced a statistically significant value (χ^2 =6070.502, *df* =190, $p <$ .001), indicating correlated data. The analysis produced a KMO value of .907, which is considered sufficient for EFA (Dimitrov, 2012, DeVellis, 2013). A five-factor solution was derived (see table 8) and the five factors accounted for 66.352% of the variance, which is satisfactory in social science research (Hair et al., 2006). Furthermore, the communalities were considered acceptable with only four of them below the recommended .5 (see table 7). Communalities are important because as MacCallum et al. (1999) noted, the item-to-participant ratio is limited and therefore "communalities play a critical role" (p. 96) in deciding factor analytic solutions. Factor one represents *Professional & Personal Development Activities* and accounts for 37.620% of the variance, factor two represents *Leisure Activities* and accounts for 8.871% of the variance, factor three represents *Religion/Spirituality* and accounts for 7.526% of the variance, factor four represents *Helping Professional Optimism* and accounts for 6.317% of the variance, and factor five represents *Burnout* and accounts for 6.017% of the variance. Finally, Kaiser's (1970, 1974) MSA was examined in order to assess the significance of correlations to assess the "reliability of the relationships between pairs of variables" (Tabachnick & Fidel, 2013,

p. 619). A MSA value of .6 is considered sufficient for factor analysis. After examining the MSA values for the HPWDS “c” items, *all* met the minimum .6 cutoff. Please note, HPWDS “c” items refer to the discrepancy between perceived wellness (i.e., “a” items) and aspirational wellness (i.e., “b” items).

Table 7 Communality Values for Final HPWDS "c" Items

Communalities	Initial	Extraction
Question 4 – Partake in enjoyable activities (i.e., things you enjoy doing)	.551	.615
Question 5 – Immerse yourself in leisure activity/activities with which you participate	.562	.642
Question 8 – Are worn out because of the work you do as a helping professional	.373	.412*
Question 38 – Engage in free-time/leisure activity (i.e., time spent away from work or chores)	.565	.597
Question 42 – Feel like you are making a difference as a helping professional	.451	.594
Question 43 – Take the initiative to learn about new research in the helping professions	.502	.546
Question 47 – Find time to relax	.569	.581
Question 48 – Engage in activities to advance your knowledge (e.g., reading, writing)	.511	.566
Question 54 – Partake in activities to increase your knowledge in an area of your choice	.555	604
Question 56 – Experience optimism about client’s futures	.371	.449*
Question 57 – partake in activities to further your knowledge as a helping professional	.599	.713
Question 60 – Experience satisfaction with your spiritual or religious activity	.537	.649
Question 62 – Have religious or spiritual beliefs that you feel are sustaining	.514	.626
Question 67 – Believe that your contributions as a helping professional matter	.472	.567
Question 68 – Take time to advance your professional development (i.e., attend conferences or seminars)	.411	.437*
Question 69 – Experience exhaustion because of your work as a helping professional	.464	.618
Question 90 – Experience stress from working as a helping professional	.370	.505
Question 70 – Experience satisfaction in your life	.556	.527
Question 87 – Experience happiness	.493	.431*
Question 88 – Engage in prayer (e.g., praying)	.356	.416*

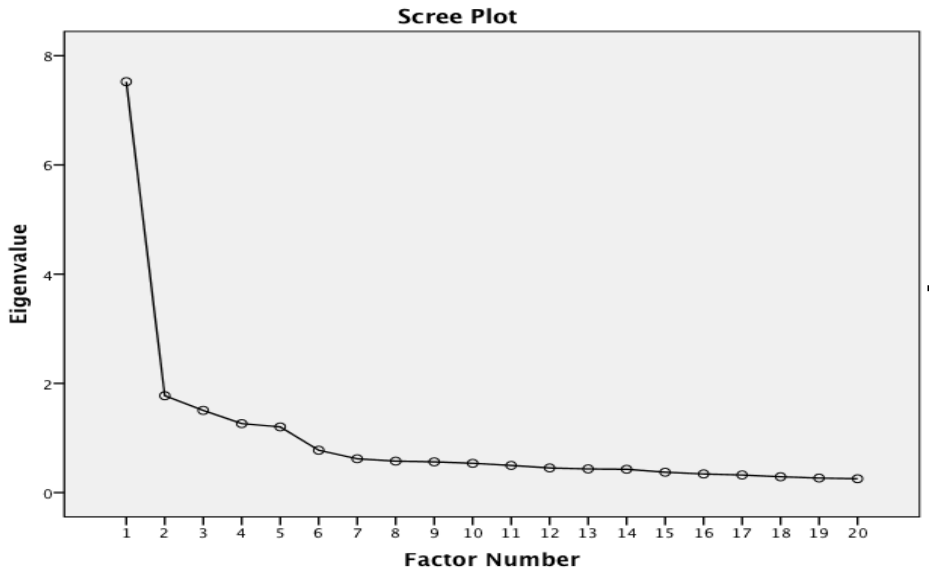


Figure 12: Scree Plot for HPWDS "c" Items

Table 8 Exploratory Factor Analysis of the HPWDS "c" Items

	Factor					
Item	**1**	**2**	**3**	**4**	**5**	**Comm.**
Question 57c	.884					.713
Question 48c	.748					.604
Question 43c	.705					.546
Question 54c	.689					.566
Question 68c	.650					.437*
Question 5c		.895				.594
Question 4c		.861				.567
Question 38c		.731				.449
Question 47c		.639				.527
Question 62c			.855			.431*
Question 60c			.835			.642
Question 88c			.662			.597
Question 87c			.319			.615
Question 42c				.851		.581
Question 67c				.742		.626
Question 56c				.686		.649
Question 70c				.319		.618
Question 69c					.805	.505
Question 90c					.802	.412*
Questions 8c					.572	.416*
Eigenvalue	7.524	1.774	1.505	1.263	1.203	
Variance (%)	37.620	8.871	7.526	6.317	6.017	

**Denotes low communalities*

Research Question 1

In order to derive a final model for the HPWDS, the researcher combined: (a) HPWDS items "a," (b) HPWDS items "b," and (c) HPWDS items "c" exploratory factor models into an overall model. In order to do so, the researcher examined both models and made decisions based on theory (i.e., *all* HPWDS items included were supported by literature; see Chapter 2) and statistics (i.e., guidelines for EFA; Dimitrov, 2013; Fink, 2011; Pallant, 2013) in order to support a final 22-item best-fitting model. The EFA and item deduction process is depicted below.

To explore Research Question 1 (What is the factor structure of the items on the HPWDS with a sample of helping professionals?), an EFA was used with the original 92-item HPWDS (N = 657) and to examine construct validity of the HPWDS. Prior to conducting the final EFA, the researcher evaluated a number of statistical assumptions in order to assess if data was appropriate for FA. The researcher evaluated the assumptions of: (a) sampling adequacy, (b) linearity, (c) normality, and (d) multicollinearity. With an overall sample of 657 participants and 92 initial scale items, a participant-to-item ratio of around 7:1 was established. A participant-to-item ratio between 5:1 and 10:1 results in a moderately strong ratio of items to participants (Dimitrov, 2012; Hair et al., 2006). Therefore, the researcher determined that the minimum amount of data for conducting an EFA with the HPWDS was satisfied. In order to assess for linearity, the researcher examined the associations between variables by inspecting the scatterplots of the variables. No patterns of nonlinear relationships between variables were found and thus, the researcher concluded that the assumption of linearity was satisfied with the dataset.

The assumption of normality was evaluated by looking at the (a) skewness and kurtosis values, (b) histograms, (c) Quartile-Quartile (Q-Q) Plots, (d) Probability-Probability (P-P) Plots, (e) multicollinearity, (f) Shapiro-Wilk value, (g) univariate normality, and (h) multivariate

normality. Skewness values greater than two and kurtosis values greater than seven indicate non-normality (Pallant, 2013). For the data, skewness and kurtosis values for all items fell within the acceptable range (i.e., skewness > 2 and kurtosis > 7) with the exception of items: 2a (Skewness = 2.9, Kurtosis = 7.89), 39a (Skewness = 3.8, Kurtosis = 18.2), 41a (Skewness = 11.06, Kurtosis = 145.2), 58a (Skewness = 2.9, Kurtosis = 10.16), 66a (Skewness = 5.15, Kurtosis = 33.85), 76a (Skewness = 4.39, Kurtosis = 21.12), 83a (Skewness = 3.4, Kurtosis = 13.4), 91a (Skewness = 2.8, Kurtosis = 7.36), and 92a (Skewness = 5.83, Kurtosis = 54.08). It is important to note however, that Skewness and Kurtosis values are influenced by large sample sizes (Pallant, 2013). Thus, the normality needed to be further assessed using additional statistical methods (i.e., checking normality plots). After examining the histograms of each individual item on the final HPWDS model, *all* item data plots suggested non-normality of data (i.e., plots did *not* follow the general bell curved normal shape). Q-Q and P-P plots also suggested non-normality of data.

Evaluating the VIF value and Tolerance value allowed the researcher to assess for the multicollinearity assumption of the data. A VIF value of less than 10 and a Tolerance value of greater than .10 is said to be sufficient for EFA (Pallant, 2013) and indicates *no* multicollinearity. All VIF values were less than 10 and all Tolerance values were greater than .10, suggesting that the assumption of multicollinearity was *not* violated.

As suggested by Pallant (2013), the researcher used the Shapiro-Wilk value because the data set was less than 2,000. A Shapiro-Wilk value of significance at the $p < .001$ level indicates non-normality of data. For this research data ($N = 657$), the Shapiro-Wilk value was statistically at the $p < .001$ level, which further supported non-normality of data. As the Shapiro-Wilk value is sensitive to large sample sizes (Pallant, 2013), the researcher examined the univariate and multivariate normality of the data by examining the KMO Measure of Sampling Adequacy and

Bartlett's Test of Sphericity. Because data was non-normal at the univariate level, data could *not* be normal at the multivariate level.

The KMO Measure of Sampling Adequacy and Bartlett's Test of Sphericity were also evaluated to assess intercorrelations between variables. As stated, a KMO value of .60 is sufficient for EFA and values of .80 to .90 deem data excellent for EFA (Pallant, 2013). In addition, Bartlett's Test of Sphericity values achieving statistical significance at the $p < .05$ level support the use of EFA for a dataset (Pallant, 2013). Initial KMO value for the 92 HPWDS items was .927 and Bartlett's Test of Sphericity was statistically significant ($\chi^2 = 30228.496$, $df = 4186$, $p < .001$). Because of the statistical assumptions results the researcher deemed the data as non-normal, yet appropriate for EFA.

Based on the severe non-normality of the data (Costello & Osborne, 2005; Fabringar et al., 1999), the researcher again conducted a PAF method with an oblique (Promax) rotation. As ML extraction is consistent for normal data and PAF is sufficient when working with non-normal data sets (Fabringar et al., 1999), the researcher chose a PAF extraction method for this research investigation.

Following decisions on the extraction methodology, the researcher chose an oblique, Promax rotation. The oblique rotation was chosen based on the fact that in the social sciences, researchers can expect some degree of correlation among instrument items (Costello & Osborne, 2005). Thus, the researcher chose the oblique rotation method to allow items on the HPWDS the freedom to correlate.

A number of criterions were used to determine the number of factors of the HPWDS final items. Hair and colleagues (2006) suggest assessing communalities of items and retaining only items with values over .5 (See table 9 or communalities of the final HPWDS model). In addition,

only factors with eigenvalues 1.0 or higher (e.g., Kaisers rule; Mertler & Vannatta, 2005) were considered sufficient for retention. Examination of the extracted commonalities resulted in the identification of HPWDS items with low commonality (< .5; Hair et al., 2010; Mvududu & Sink, 2013) for item removal. Next, the researcher removed items that had significant cross loadings (e.g., .3 or higher; Hair et al., 2010; Mvududu & Sink, 2013) on more than one factor. Following cross loading item removal, items were added back into the model to reexamine the contribution to the remaining model. If the items fit the retention criteria, they were added back into the HPWDS model. When a statistically sound model was found, a screeplot was examined in order to support the factor solution (see figure 10, Hair et al., 2006). As suggested by Pallant (2013), a significant break in the scree identifies the factor structure of the model. As shown, a significant break between factors 5 and 6 is depicted (see figure 13). Using the aforementioned steps, the researcher: (a) ran the EFA with all 92 HPWSD items and assessed the statistics; (b) removed items with low communalities individually until the EFA resulted in an initial model; (c) continued to remove items based on communality values and cross-loading; (d) assessed the model's Eigenvalues for factor retention; and (e) derived a final exploratory HPWDS model.

The appropriateness of the data for EFA was examined again based on the reduced HPWDS item scale by examining the KMO values and Bartlett's test of sphericity. Bartlett's test of sphericity produced a statistically significant value ($\chi^2 = 8102.505$, $df = 231$, $p < .001$), indicating correlated data. The analysis produced a KMO value of .879, which is considered sufficient for EFA (Dimitrov, 2012, DeVellis, 2013). A five-factor solution was derived (see table 10) and the five factors accounted for 69.169% of the variance, which is satisfactory in social science research (Hair et al., 2006). Furthermore, the communalities were considered acceptable with only three of them below the recommended .5 (see table 9). Communalities are

important because as MacCallum et al. (1999) noted, the item-to-participant ratio is limited and therefore "communalities play a critical role" (p. 96) in deciding factor analytic solutions. Factor one represents *Professional & Personal Development Activities* and accounted for 32.605% of the variance, factor two represents *Religion/Spirituality* and accounted for 13.151% of the variance, factor three represents *Leisure Activities* and accounted for 9.443% of the variance, factor four represents *Burnout* and accounted for 7.198% of the variance, and factor five represents *Helping Professional Optimism* and accounted for 6.773% of the variance. Finally, the researcher used Kaiser's (1970, 1974) MSA to assess the significance of correlations to assess the "reliability of the relationships between pairs of variables" (Tabachnick & Fidel, 2013, p. 619). A MSA value of .6 is considered sufficient for factor analysis. After examining the MSA values for the final HPWDS items, *all* met the minimum .6 cutoff. The final matrix of association or reproduced correlations and residuals values can be found in Figure 14.

Table 9 Communality Values for Final HPWDS Items

Communalities	Initial	Extraction
Question 57 – Partake in activities to further your knowledge as a helping professional	.705	.816
Question 54 – Partake in activities to further your knowledge in an area of your choice	.626	.674
Question 43 – Take the initiative to learn about new research in the helping professions	.552	.602
Question 48 – Engage in activities to advance your knowledge (e.g., reading, writing)	.567	.583
Question 68 – Take time to advance your professional development (i.e., attend conferences of seminars)	.499	.515
Question 5 – Immerse yourself in leisure activity/activities with which you participate	.641	.721
Question 38 – Engage in free-time/leisure activity (i.e., time spent away from work or chores)	.613	.655
Question 4 – Partake in enjoyable activities (i.e., things you enjoy doing)	.594	.604
Question 47– Find time to relax	.592	.564
Question 42 – Feel like you are making a difference as a helping professional	.610	.642
Question 67 – Believe that your contributions as a helping professional matter	.601	.622
Question 56 – Experience optimism about client's futures	.498	.530
Question 70 – Experience satisfaction in your life	.677	.646
Question 87 – Experience happiness	.576	.487*
Question 7 – Experience optimism about your future	.445	.428*
Question 69 – Experience exhaustion because of your work as a helping professional	.587	.758
Question 90 – Experience stress form working as a helping professional	.477	.555
Question 8 – Are worn out because of the work you do as a helping professional	.472	.549
Question 62 – have religious or spiritual beliefs that you feel are sustaining	.666	.753
Question 60 – Experience satisfaction with your spiritual or religious activity	.651	.684
Question 73 – Meditate with a focus on a higher power or spiritual entity	.378	.390*
Question 88 – Engage in prayer (e.g., praying)	.489	.551

**Denotes low communality*

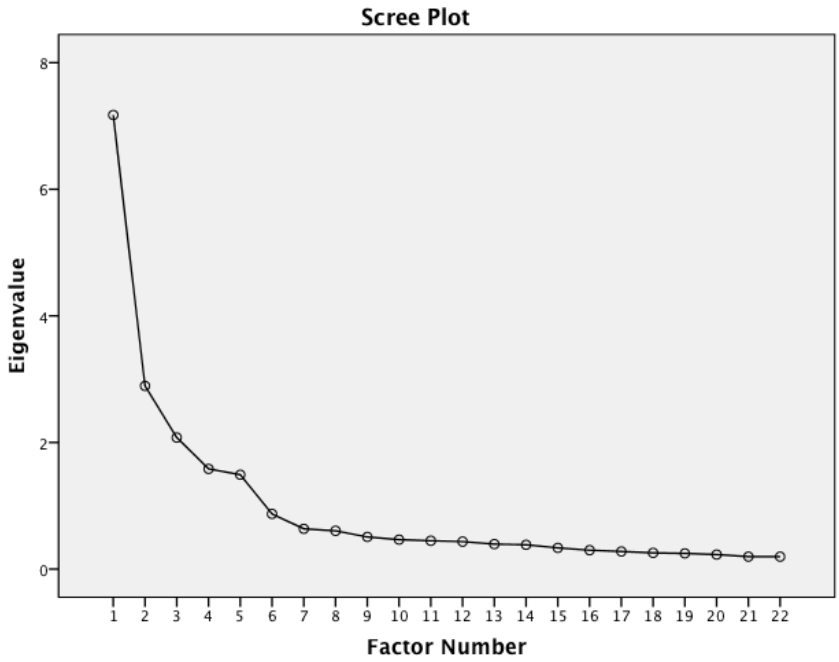


Figure 13: Scree Plot for HPWDS Final Item

Table 10 Exploratory Factor Analysis of the HPWDS Final Items

	Factor					
Item	**1**	**2**	**3**	**4**	**5**	**Comm.**
Question 57	.924					.816
Question 54	.761					.674
Question 43	.743					.602
Question 48	.707					.583
Question 68	.631					.515
Question 42		.855				.642
Question 67		.816				.622
Question 56		.747				.530
Question 70		.634				.646
Question 87		.516				.487*
Question 7		.478				.428*
Question 5			.924			.721
Question 38			.816			.655
Question 4			.800			.604
Question 47			.612			.564
Question 62				.868		.753
Question 88				.793		.551
Question 60				.758		.684
Question 73				.611		.390
Question 69					.872	.758
Question 90					.780	.555
Question 8					.747	.549
Eigenvalue	7.173	2.893	2.077	1.584	1.490	
Variance (%)	32.605	13.151	9.443	7.198	6.773	

**Denotes low communalities*

	Item 57	Item 54	Item 43	Item 48	Item 68	Item 42	Item 67	Item 56	Item 70	Item 87	Item 7	Item 5	Item 38	Item 4	Item 47	Item 69	Item 90	Item 8	Item 62	Item 88	Item 60	Item 73
Item 57																						
Item 54	.000																					
Item 43	.002	-.02																				
Item 48	.004	.037	.02																			
Item 68	.018	.001	.00	.00																		
Item 42	-.04	-.02	.00	.00	.010																	
Item 67	-.01	-.01	.00	.00	.005	.090																
Item 56	.002	-.01	.00	.00	-.01	.056	.024															
Item 70	.018	.031	.00	.02	.009	-.07	-.04	-.07														
Item 87	.042	.007	.00	.04	-.02	-.06	-.09	-.03	.17													
Item 7	.016	.014	.00	.00	.018	-.05	-.04	-.02	.09	.07												
Item 5	-.01	.001	.00	.00	.012	.031	.010	.027	.00	.00	-.01											
Item 38	-.01	.00	.00	.00	.00	.011	.016	.005	.00	.00	-.03	.00										
Item 4	.00	-.01	.00	.00	.002	.020	.023	.016	.0	.00	.022	.09	.00									
Item 47	-.02	-.02	.00	.02	-.02	.030	.030	.003	.00	.00	-.07	.00	.11	-.10								
Item 69	.005	.00	.00	.00	.024	-.03	-.01	-.01	.03	.01	.014	.00	.00	.00	.01							
Item 90	.000	.003	.00	.03	-.03	.008	.001	-.01	.00	.01	-.01	.01	.00	.01	.00	.00						
Item 8	.006	.013	.01	.00	-.01	-.01	-.03	-.01	.01	.04	.010	.00	.01	.00	.02	.01	.003					
Item 62	-.01	.005	.02	.02	-.03	-.02	-.02	.033	.00	.00	-.02	.00	.00	.01	.00	.00	.017	-.01				
Item 88	-.01	-.02	.00	.00	.012	.021	.029	.019	.00	.00	-.02	.03	.00	.00	.01	.00	.029	.00	-.02			
Item 60	.001	.009	.00	.01	.000	-.02	.002	-.03	.01	.01	.026	.00	.00	.00	.00	.02	-.02	.00	.057	.00		
Item 73	.004	.00	.00	.00	.031	.045	.019	-.01	.00	.00	-.01	.00	.01	.01	.01	.00	-.03	.015	-.05	.09	.00	

Extraction Method: Principal Axis Factoring

Figure 14: Reproduced Correlation & Residuals Matrix

Replication Analysis

In the social sciences, there is debate about EFA and the reliability of the outcomes (Ford, MacCallum, & Tait, 1986; Henson & Roberts, 2006; Osborne & Fitzpatrick, 2012). Thus, the researcher chose to conduct an internal replication analysis to examine the stability of the final EFA solution (Research Question 1). In order to conduct an internal replication analysis, the researcher split the sample (N = 657) into two random samples (n = 328 and n = 328), with item-to-participant ratios around 15:1. Then, the researcher extracted standardized factor loadings from each sample. Finally, the researcher reviewed the factor loadings and structures for comparison. Assessing structural replicability and assessing the strength of replication are important components of a replication analysis. Thus, the researcher followed Osborne and

Fitzpatrick's (2012) suggestion and assessed the structural replicability of the models by identifying which items loaded on which factors, and confirming that the same items loaded on the same factors in both Sample 1 and Sample 2 (i.e., congruence across both analyses). The PAF EFA with oblique, Promax rotations were used in both analyses. The researcher assessed the strength of the replication analysis by following Osborne and Fitzpatrick's (2012) suggestion of calculating the magnitude of difference between the two "standardized (rotated) factor loadings, and squaring the difference" (p. 4). The strength of the replication analysis and structural replicability of the models are provided in table 11.

The initial replication criterion, structural replication, was satisfied as the items were identified for the same number of factors for both replication analysis samples (Osborne & Fitzpatrick, 2012) as well as the full EFA sample (HPWDS final model). In addition, the data split analysis confirmed the same factorial structure (same five factor model). Next, the researcher examined the squared difference between factor loadings for each item and between the two split samples (Sample 1 and Sample 2) by subtracting the "standardized (rotated) factor loadings for congruent items, and squaring the difference" (Osborne & Fitzpatrick, 2012, p. 4). Osborne and Fitzpatrick (2012) stated that a squared difference of .04 magnitude or higher (|.20| difference) deemed data as volatile, supporting grounds for item removal. Based on this replication analysis, *all* HPWDS items were deemed strong and worth keeping (Table 11). To further explore the results of the replication analysis, the researcher examined the communality values of *all* the HPWDS items.

Table 11 5 - Factor Replicability Analysis, Principal Axis Factoring, Promax Rotation

	Sample 1 (*n* = 328)						Sample 2 (*n* = 328)						
		Factor Loading						Factor Loading					Analysis
	Comm. Extract	1	2	3	4	5	Comm. Extract	1	2	3	4	5	Squared Diff
Q4	.623		.812				.595			.793			.00036
Q5	.663		.864				.786			.989			.01103
Q7	.427			.520			.444		.441				.00624
Q8	.502					.721	.589					.769	.00230
Q38	.655		.822				.652			.789			.00109
Q42	.597			.773			.687		.910				.01877
Q43	.655	.736					.562	.766					.00090
Q47	.579		.631				.562			.594			.00137
Q48	.535	.694					.626	.710					.00026
Q54	.635	.699					.720	.834					.01823
Q56	.558			.770			.527		.746				.00058
Q57	.758	.902					.877	.942					.00160
Q60	.685				.790		.683				.723		.00449
Q62	.712				.823		.792				.899		.00578
Q67	.589			.742			.650		.853				.01232
Q68	.545	.664					.491	.589					.00563
Q69	.774					.858	.752					.893	.00123
Q70	.632			.640			.670		.640				.00000
Q73	.490				.664		.300				.554		.01210
Q87	.515			.541			.475		.525				.00026
Q88	.551				.799		.555				.783		.00026
Q90	.503					.741	.627					.822	.00656
Eigenvalue		6.953	2.900	2.128	1.659	1.500		7.499	2.872	2.056	1.594	1.383	

Internal Consistency of the Split Samples

The researcher examined the reliability of the split samples in the replication analyses, with Sample 1 having an overall Cronbach's alpha of .871 and Sample 2 having an overall Cronbach's alpha of 867. In Sample 1, Factor 1, *Professional & Personal Development Activities* (items 57, 54, 43, 48, 68) had a Cronbach's alpha of .886; Factor 2, *Religion/Spirituality* (items 5, 38, 4, 47) had a Cronbach's alpha of .870; Factor 3, *Leisure Activities* (items 42, 56, 67, 70, 87, 7) had a Cronbach's alpha of .848; Factor 4, *Burnout* (items 62, 88, 60, 73) had a Cronbach's alpha of .852; and Factor 5, *Helping Professional Optimism* (items 69, 90, 8) had a Cronbach's alpha of .800. Regarding Sample 2, Factor 1, *Professional & Personal Development Activities* (items 57, 54, 43, 48, 68) had a Cronbach's alpha of .896; Factor 2, *Religion/Spirituality* (items

42, 67, 56, 70, 87, 7) had a Cronbach's alpha of .867; Factor 3, *Leisure Activities* (items 5, 4, 38, 47) had a Cronbach's alpha of .871; Factor 4, *Burnout* (items 62, 88, 60, 73) had a Cronbach's alpha of .828; and Factor 5, *Helping Professional Optimism* (items 69, 90. 8) had a Cronbach's alpha of .846. Both Sample 1 and Sample 2 Cronbach's alpha values supported the internal consistency reliability for total models and each individual factor. Overall, the replication analysis results supported the reliability of the HPWDS final items.

Research Question 2

For Research Question 2 (What is the internal consistency reliability of the HPWDS with a sample of helping professionals?), the researcher computed Cronbach's alpha (α) to assess the internal consistency reliability of the HPWDS with these data. The Cronbach's α range falls between 0 and 1, with values closer to 0 representing low reliability and values closer to 1 representing higher reliability (DeVellis, 2013). The researcher used a Cronbach's α value of .70 to indicate internal consistency of items (Mitchell & Jolley, 2004; Sterner, 2003). Cronbach's α values were calculated for all the HPWDS items (N = 657) and for all five factors of the HPWDS to assess overall instrument internal consistency as well as individual factor internal consistency totals.

The Cronbach's α value for the initial 92 items (N = 657) was calculated as .974. The Cronbach's α value for the 22-item total scale (N = 657) was .869. For Factor 1: *Professional & Personal Development Activities,* Cronbach's α value was .892; for Factor 2: *Religion/Spirituality,* Cronbach's α value was .858; Factor 3: *Leisure Activities,* Cronbach's α value was .871; Factor 4: *Burnout,* Cronbach's α value was .841; and Factor 5: *Helping Professional Optimism,* Cronbach's α value was .824. Therefore, *all* Cronbach α values were

above the recommended .70 value and indicate strong internal consistency within the final HPWDS 22-item model. Table 12 represents the central tendencies for the HPWDS.

Table 12 HPWDS Measures of Central Tendencies

2	Mean (*M*)	*SD*	Range	*Mdn*	Mode
Question 57	2.38	1.241	4.00	2.00	2.00
Question 54	2.52	1.29	4.00	2.00	2.00
Question 43	2.39	1.29	4.00	2.00	1.00
Question 48	2.77	1.27	4.00	3.00	2.00
Question 68	1.74	1.19	4.00	1.00	1.00
Question 42	3.55	1.22	4.00	4.00	5.00
Question 67	3.66	1.19	4.00	4.00	5.00
Question 56	3.40	1.21	4.00	3.00	3.00
Question 70	3.75	1.13	4.00	4.00	5.00
Question 87	3.81	1.15	4.00	4.00	5.00
Question 7	3.99	1.15	4.00	4.00	5.00
Question 5	2.98	1.35	4.00	3.00	2.00
Question 38	2.93	1.31	4.00	3.00	2.00
Question 4	3.44	1.26	4.00	3.00	5.00
Question 47	2.98	1.29	4.00	3.00	3.00
Question 62	3.18	1.59	4.00	3.00	5.00
Question 88	2.54	1.61	4.00	2.00	1.00
Question 60	2.93	1.55	4.00	3.00	1.00
Question 73	1.96	1.38	4.00	1.00	1.00
Question 69	2.00	1.19	4.00	2.00	1.00
Question 90	2.37	1.22	4.00	2.00	2.00
Question 8	2.25	1.26	4.00	2.00	1.00

Research Question 3

The researcher used a bivariate correlation to assess Research Question 3 (What is the relationship between HPWDS scores and CBI scores with a sample of helping professionals) and the HPWDS final 22-items (split into their respective five factors) were correlated with the subscales on the *Counselor Burnout Inventory* in order to assess for discriminant validity (CBI;

Lee et al., 2007). Discriminant validity is established by examining relationships between the HPWDS five factors and a variable with which they are *not* expected to correlate (Scarborough, 2005). According to Pallant (2013), correlation analysis is used to evaluate the direction and strength of the linear relationship between variables. The researcher used Spearman's rho correlation coefficient due to the non-normality of the data, and analyzed the correlations between the HPWDS items (split into their respective factors) and the CBI subscales of (a) *Exhaustion*, (b) *Incompetence*, (c) *Uncooperative Work Environment*, (d) *Devaluing Client*, and (e) *Deterioration in Personal Life*.

Before running the correlation analysis, the researcher generated a scatterplot in order to check the statistical assumptions of (a) homoscedasticity and (b) linearity and assessed the normality of the dataset. Normality was assessed prior to running the EFA and data was found to be non-normal, thus influencing the type of correlational analysis that was employed (i.e., Spearman's rho). Homoscedasticity involves having equal variances (Hair et al., 2006; Pallant, 2013) and needed to be examined prior to conducting a correlation analysis. To examine homoscedasticity, the researcher evaluated scatterplots of the standardized residuals of the variables. All of the scatterplots of the standardized residuals resulted in relatively straight lines from bottom left to top right, which identified *no* major deviations from normality (Pallant, 2013) and satisfied the homoscedasticity assumption. To assess for linearity of data, the researcher again checked the pattern of associations between the variables by visually checking their scatterplots. As there were *no* concerns of non-linearity (e.g., relatively straight lines in data scatterplots), the assumption of linearity was met.

The researcher examined the relationships between the items on the HPWDS and the subscales on the CBI (Lee et al., 2007) using Spearman's rho correlation coefficient. The

subscales include: (a) *Exhaustion*, (b) *Incompetence*, (c) *Uncooperative Work Environment*, (d) *Devaluing Client*, and (e) *Deterioration in Personal Life*. The relationship between the HPWDS factors and the CBI subscales are presented in table 13.

Table 13 Spearman Rank Order Correlations between HPWDS Items and CBI Exhaustion Subscale

HPWDS Items	Exhaustion	Incompetence	Uncooperative Work Environment	Devaluing Client	Deterioration in Personal Life
Question 57	ρ = -.090	ρ = -.172	ρ = -.084	ρ = -.158	ρ = -.080
	$p < .05$	$p < .001$	$p < .05$	$p < .001$	$p < .001$
Question 54	ρ = -.150	ρ = -.155	ρ = -.071	ρ = -.132	ρ = -.229
	$p < .001$	$p < .001$	$p > .001$	$p < .01$	$p < .001$
Question 43	ρ = -.037	ρ = -.167	ρ = -.071	ρ = -.0124	ρ = -.097
	$p > .05$	$p > .001$	$p > .05$	$p < .01$	$p > .05$
Question 48	ρ = 0.167	ρ = 0.196	ρ = 0.164	ρ = 0.168	ρ = .202
	$p < .001$	$p < .001$	$p < .001$	$p < .001$	$p < .001$
Question 68	ρ = -.043	ρ = -.165	ρ = -.045	ρ = -.076	ρ = -.144
	$p > .05$	$p > .001$	$p > .05$	$p > .05$	$p < .001$
Question 5	ρ = -.277	ρ = -.216	ρ = -.125	ρ = -.090	ρ = -.393
	$p < .001$	$p < .001$	$p < .05$	$p < .05$	$p < .001$
Question 38	ρ = -.292	ρ = -.220	ρ = -.162	ρ = -.057	ρ = -.459
	$p < .001$	$p < .001$	$p < .001$	$p > .001$	$p < .001$
Question 4	ρ = -.301	ρ = -.238	ρ = -.137	ρ = -.063	ρ = -.371
	$p < .001$	$p < .001$	$p < .001$	$p > .05$	$p < .001$
Question 47	ρ = -.378	ρ = -.321	ρ = -.221	ρ = -.118	ρ = -.500
	$p < .001$	$p < .001$	$p < .001$	$p < .01$	$p < .001$
Question 42	ρ = -.128	ρ = -.423	ρ = -.257	ρ = -.232	ρ = -.153
	$p < .001$	$p < .001$	$p < .001$	$p < .001$	$p < .001$
Question 67	ρ = -.148	ρ = -.427	ρ = -.255	ρ = -.261	ρ = -.207
	$p < .001$	$p < .001$	$p < .001$	$p < .001$	$p < .001$
Question 56	ρ = -.173	ρ = -.307	ρ = -.242	ρ = -.267	ρ = -.194
	$p < .001$	$p < .001$	$p < .001$	$p < .001$	$p < .001$
Question 70	ρ = -.315	ρ = -.367	ρ = -.274	ρ = -.223	ρ = -.387
	$p < .001$	$p < .001$	$p < .001$	$p < .001$	$p < .001$
Question 87	ρ = -.319	ρ = -.283	ρ = -.254	ρ = -.203	ρ = -.321
	$p < .001$	$p < .001$	$p < .001$	$p < .001$	$p < .001$
Question 7	ρ = -.270	ρ = -.284	ρ = -.225	ρ = -.164	ρ = -.305
	$p < .001$	$p < .001$	$p < .001$	$p < .001$	$p < .001$
Question 69	ρ = .630	ρ = .296	ρ = .339	ρ = .183	ρ = .471
	$p < .001$	$p < .001$	$p < .001$	$p < .001$	$p < .001$
Question 90	ρ = .608	ρ = .247	ρ = .368	ρ = .205	ρ = .411
	$p < .001$	$p < .001$	$p < .001$	$p < .001$	$p < .001$
Question 8	ρ = .565	ρ = .287	ρ = .341	ρ = .199	ρ = .388
	$p < .001$	$p < .001$	$p < .001$	$p < .001$	$p < .001$
Question 62	ρ = -.125	ρ = -.144	ρ = -.099	ρ = -.112	ρ = -.127
	$p < .01$	$p < .001$	$p < .05$	$p < .01$	$p < .01$
Question 60	ρ = -.169	ρ = -.163	ρ = -.130	ρ = -.153	ρ = -.188
	$p < .001$	$p < .001$	$p < .001$	$p < .001$	$p < .001$
Question 73	ρ = -.041	ρ = -.004	ρ = -.145	ρ = -.039	ρ = -.095
	$p > .05$	$p > .05$	$p > .05$	$p > .05$	$p < .05$
Question 88	ρ = -.082	ρ = -.049	ρ = -.062	ρ = -.075	ρ = -.102
	$p < .05$	$p > .05$	$p > .05$	$p > .05$	$p < .01$

When interpreting the output of a correlation analysis, it is important to determine the direction of the relationship by considering the sign in front of the correlation coefficient (Pallant, 2013). If the sign is positive (+), there is a positive relationship or correlation between the two variables. Likewise, if the sign is negative (-), there is a negative association or negative relationship between the variables. Following examination of the direction of the correlation, the researcher determined the strength of the relationship by following Cohen's (1988) suggestions of a small correlation ranging from .10 to .29, a medium correlation ranging from .30 to .49, and a large correlation ranging from .50 to 1.0. The value used for assessing the strength of Spearman's rho correlation is denoted by *rs* or ρ. Finally, the researcher examined how much the variance the two variables shared by calculating the coefficient of determination by squaring the ρ value and multiplying it by 100 to convert the value into a percentage. The correlations are explained below.

Relationship between HPWDS and Exhaustion Subscale. The relationships between the HPWDS items and *Exhaustion* subscale on the CBI (Lee et al., 2007) yielded negative correlations for *all* items with the exception of Item 69 (Experience exhaustion because of your work as a helping professional), Item 90 (Experience stress from working as a helping professional), and Item 8 (Are worn out because of the work you do as a helping professional). Because of the nature of these three HPWDS items (69, 90, and 8), which all loaded on the *Burnout* Factor, it is logical that the direction of the relationship was positive with the *Exhaustion* burnout subscale on the CBI (i.e., they are all assessing a form of burnout). Of the HPWDS items with a positive correlation with *Exhaustion*, all three had large, statistically significant relationships; Item 69 ($\rho = .630$, $p < .001$; 39.6% of the variance explained), Item 90 ($\rho = .608$, $p < .001$; 36.9% of the variance explained), and Item 8 ($\rho = .565$, $p < .001$; 31.9% of

the variance explained). Items 73 (ρ = -.041, p > .05; .168% of the variance explained), 43 (ρ = -.037, p > .05; .137% of the variance explained), and 68 (ρ = -.043, p > .05; .185% of the variance explained), though showing a negative correlation value, did *not* have a statistically significant relationship with *Exhaustion*. All other HPWDS items showed small or medium, statistically significant negative correlations with *Exhaustion*; Item 57 (ρ = -.090, p < .05; 0.81% of the variance explained), Item 54 (ρ = -.150, p < .001; 2.25% of the variance explained), Item 48 (ρ = -.167, p < .001; 2.79% of the variance explained), Item 42 (ρ = -.128 p < .01; 1.64% of the variance explained), Item 67 (ρ = -.148, p < .001; 2.19% of the variance explained), Item 56 (ρ = -.173, p < .001; 2.99% of the variance explained), Item 70 (ρ = -.315, p < .001; 9.92% of the variance explained), Item 87 (ρ = -.319, p < .001; 10.2% of the variance explained), Item 7 (ρ = -.270, p < .001; 7.29% of the variance explained), Item 5 (ρ = -.277, p < .001; 7.67% of the variance explained), Item 38 (ρ = -.292, p < .001; 8.53% of the variance explained), Item 4 (ρ = -.301, p < .001; 9.06% of the variance explained), Item 47 (ρ = -.378, p < .001; 14.3% of the variance explained), Item 62 (ρ = -.125, p < .001; 1.56% of the variance explained), Item 88 (ρ = -.082, p < .001; .672% of the variance explained), and Item 60 (ρ = -.169, p < .001; 2.86% of the variance explained).

Relationship between HPWDS and Incompetence Subscale. The relationships between the HPWDS items and *Incompetence* subscale on the CBI (Lee et al., 2007) yielded negative correlations for *all* items with the exception of Item 69 (Experience exhaustion because of your work as a helping professional), Item 90 (Experience stress from working as a helping professional), and Item 8 (Are worn out because of the work you do as a helping professional). Because of the nature of these three HPWDS items (69, 90, and 8), it is logical that the direction of the relationship is positive with the *Incompetence* subscale on the CBI (i.e., they are all

assessing a form of burnout). Of the HPWDS items with a positive correlation with *Incompetence*, *all* three had small, statistically significant relationships; Item 69 (ρ = .296, p < .001; 8.52% of the variance explained), Item 90 (ρ = .247, p < .001; 6.1% of the variance explained), and Item 8 (ρ = .287, p < .001; 8.24% of the variance explained). Of the items with a negative correlation, Item 73 (ρ = -.004, p > .05; .0016% of the variance explained) and Item 88 (ρ = -.049, p > .05; .240% of the variance explained), though showing a negative correlation value, did not have a statistically significant relationship with Incompetence. All other items showed small to medium, statistically significant negative correlations with the *Incompetence* CBI subscale; Item 57 (ρ = -.172, p < .05; 2.96% of the variance explained), Item 54 (ρ = -.155; p < .001; 2.40% of the variance explained), Item 48 (ρ = -.196, p < .001; 3.84% of the variance explained), Item 42 (ρ = -.423 p < .01; 17.89% of the variance explained), Item 67 (ρ = -.427, p < .001; 18.23% of the variance explained), Item 56 (ρ = -.307, p < .001; 9.42% of the variance explained), Item 70 (ρ = -.367, p < .001; 13.47% of the variance explained), Item 87 (ρ = -.283, p < .001; 8.01% of the variance explained), Item 7 (ρ = -.284, p < .001; 8.06% of the variance explained), Item 5 (ρ = -.216, p < .001; 4.66% of the variance explained), Item 38 (ρ = -.220, p < .001; 4.84% of the variance explained), Item 4 (ρ = -.238, p < .001; 5.66% of the variance explained), Item 47 (ρ = -.321 p < .001; 10.3% of the variance explained), Item 62 (ρ = -.144, p < .001; 2.07% of the variance explained), Item 68 (ρ = -.165 p < .001; 2.72% of the variance explained), Item 60 (ρ = -.163, p < .001; 4.28% of the variance explained), and Item 43 (ρ = -.167, p > .05; 2.79% of the variance explained).

Relationship between HPWDS and Uncooperative Work Environment Subscale. The relationships between the HPWDS items and *Uncooperative Work* Environment subscale on the CBI (Lee et al., 2007) yielded negative correlations for *all* items with the exception of Item

69 (Experience exhaustion because of your work as a helping professional), Item 90 (Experience stress from working as a helping professional), and Item 8 (Are worn out because of the work you do as a helping professional). Because of the nature of these three HPWDS items (69, 90, and 8), it is logical that the direction of the relationship is positive with the *Uncooperative Work Environment* subscale on the CBI (i.e., they are all assessing a form of burnout). Of the HPWDS items with a positive correlation with *Uncooperative Work Environment*, *all* three had medium, statistically significant relationships; Item 69 (ρ = .339 p < .001; 11.5% of the variance explained), Item 90 (ρ = .368, p < .001; 13.54% of the variance explained), and Item 8 (ρ = .341, p < .001; 11.62% of the variance explained). Of the items with a negative correlation, Item 68 (ρ = .045, p < .001, .202% of the variance explained), Item 88 (ρ = .062, p < .001; .384% of the variance explained), Item 54 (ρ = .071, p < .001; .504% of the variance explained), and Item 43 (ρ = .071, p < .001; .504% of the variance explained), though showing a negative correlation value, did *not* have a statistically significant relationship with *Uncooperative Work Environment*. All other items showed small to medium, statistically significant negative correlations with *Uncooperative Work Environment*; Item 57 (ρ = -.084, p < .05; .706% of the variance explained), Item 48 (ρ = -.164, p < .001; 2.69% of the variance explained), Item 42 (ρ = -.257 p < .01; 6.6% of the variance explained), Item 67 (ρ = -.255, p < .001; 6.5% of the variance explained), Item 56 (ρ = -.242, p < .001; 5.86% of the variance explained), Item 70 (ρ = -.274, p < .001; 7.5% of the variance explained), Item 87 (ρ = -.254, p < .001; 6.45% of the variance explained), Item 7 (ρ = -.225, p < .001; 5.06% of the variance explained), Item 5 (ρ = -.125, p < .05; 1.56% of the variance explained), Item 38 (ρ = -.162, p < .001; 4.24% of the variance explained), Item 4 (ρ = -.137, p < .001; 3.23% of the variance explained), Item 47 (ρ = -.221, p < .001; 4.91% of the variance explained), Item 62 (ρ = -.099, p < .05; .98% of the variance explained), Item 60 (ρ = -

.130, $p < .001$; 1.69% of the variance explained), and Item 73 ($\rho = -.145$, $p < .001$; 2.10% of the variance explained).

Relationship between HPWDS and Devaluing Client Subscale. The relationships between the HPWDS items and *Devaluing Client* subscale on the CBI (Lee et al., 2007) yielded negative correlations for all items with the exception of Item 69 (Experience exhaustion because of your work as a helping professional), Item 90 (Experience stress from working as a helping professional), and Item 8 (Are worn out because of the work you do as a helping professional). Because of the nature of these three items (69, 90, and 8), which loaded on the *Burnout* factor, it is logical that the direction of the relationship is positive with the *Devaluing Client* subscale on the CBI (i.e., they are all assessing a form of burnout). Of the HPWDS items with a positive correlation with *Devaluing Client*, all three had small, statistically significant relationships; Item 69 ($\rho = .183$, $p < .001$; 3.35% of the variance explained), Item 90 ($\rho = .205$, $p < .001$; 4.20% of the variance explained), and Item 8 ($\rho = .199$, $p < .001$, 3.96% of the variance explained). Items 73 ($\rho = -.041$, $p > .05$; .152% of the variance explained), Item 68 ($\rho = -.076$, $p > .05$; .578% of the variance explained), and Item 38 ($\rho = -.057$, $p > .05$; .325% of the variance explained), Item 4 ($\rho = -.063$, $p > .05$; .397% of the variance explained), and Item 88 ($\rho = -.075$, $p > .05$; .563% of the variance explained), though showing a negative correlation value, did *not* have a statistically significant relationship with *Devaluing Client*. All other items showed small to medium, statistically significant negative correlations with *Devaluing Client*; Item 57 ($\rho = -.158$, $p < .05$; .2.49% of the variance explained), Item 54 ($\rho = -.132$, $p < .01$; 1.74% of the variance explained), Item 43 ($\rho = -.124$, $p < .01$; 1.54% of the variance explained), Item 48 ($\rho = -.168$ $p < .01$; 2.82% of the variance explained), Item 42 ($\rho = -.232$, $p < .001$; 5.38% of the variance explained), Item 67 ($\rho = -.261$, $p < .001$; 6.84% of the variance explained), Item 56 ($\rho = -.267$, $p < .001$; 7.12% of

the variance explained), Item 70 (ρ = -.223, p < .001; 4.97% of the variance explained), Item 87 (ρ = -.203, p < .001; 4,12% of the variance explained), Item 60 (ρ = -.153, p < .001; 2.34% of the variance explained), Item 5 (ρ = -.090, p < .05; .81% of the variance explained), Item 47 (ρ = -.118, p < .01; 1.39% of the variance explained), and Item 62 (ρ = -.112, p < .01; 1.25% of the variance explained).

Relationship between HPWDS and Deterioration in Personal Life Subscale. The relationships between the HPWDS items and *Deterioration in Personal Life* subscale on the CBI (Lee et al., 2007) yielded negative correlations for *all* items with the exception of Item 69 (Experience exhaustion because of your work as a helping professional), Item 90 (Experience stress from working as a helping professional), and Item 8 (Are worn out because of the work you do as a helping professional). Because of the nature of these three items (69, 90, and 8), it is logical that the direction of the relationship is positive with the *Deterioration in Personal Life* subscale on the CBI (i.e., they are all assessing a form of burnout). Of the HPWDS items with a positive correlation with *Deterioration in Personal Life*, all three had medium, statistically significant relationships; Item 69 (ρ = .471, p < .001; 22.18% of the variance explained), Item 90 (ρ = .411, p < .001, 16.89% of the variance explained), and Item 8 (ρ = .388, p < .001; 15.05% of the variance explained). All other items showed small to medium, statistically significant negative correlations with *Deterioration in Personal Life*; Item 57 (ρ = -.180, p < .05; 3.24% of the variance explained), Item 54 (ρ = -.229, p < .001; 5.25% of the variance explained), Item 43 (ρ = -.097, p < .05; .941% of the variance explained), Item 48 (ρ = -.202 p < .001; 4.08% of the variance explained), Item 68 (ρ = -.144; p < .001, 2.07% of the variance explained), Item 42 (ρ = -.153, p < .001; 2.34% of the variance explained), Item 67 (ρ = -.207, p < .001; 4.28% of the variance explained), Item 56 (ρ = -.194, p < .001; 3.76% of the variance explained), Item 70 (ρ =

-.387, $p < .001$; 15.02% of the variance explained), Item 87 ($\rho = -.321$, $p < .001$; 10.30% of the variance explained), Item 7 ($\rho = -.305$, $p < .001$; 9.30% of the variance explained), Item 5 ($\rho = -.393$, $p < .001$; 15.44% of the variance explained), Item 38 ($\rho = -.459$, $p < .001$; 21.1% of the variance explained), Item 4 ($\rho = -.371$, $p < .001$; 13.76% of the variance explained), Item 47 ($\rho = -.500$, $p < .001$; 25% of the variance explained), Item 60 ($\rho = -.188$, $p < .001$; 3.53% of the variance explained), Item 73 ($\rho = -.095$, $p < .05$; .902% of the variance explained), Item 62 ($\rho = -.127$, $p < .01$; 1.62% of the variance explained), and Item 88 ($\rho = -.102$, $p < .01$; 1.04% of the variance explained).

Cronbach's Alpha of CBI. The researcher assessed the internal consistency reliability of the CBI (Lee et al., 2007) with the current sample. The 20-item total CBI had an internal consistency of .893 with the current dataset. The CBI subscale of *Exhaustion* had a Cronbach's α of .890, the *Incompetence* subscale had a Cronbach's α of .752, the *Uncooperative Work Environment* subscale had a Cronbach's α of .868, the *Devaluing Client* subscale had a Cronbach's α of .717, and the *Deterioration in Personal Life* subscale had a Cronbach's α of 764. As advised by Mitchell and Jolley (2004) and Sterner (2003), the researcher used a Cronbach's α value of .70 to indicate internal consistency of items; therefore, the internal consistency reliability for the CBI total items and subscales are sufficient for the current dataset.

Research Question 4

The researcher used a Multiple linear regression (MLR) analysis to explore relationships between a continuous dependent variable (HPWDS scores) and the demographic variables on the General Demographic Questionnaire. The researcher used MLR analysis to examine if the variables identified on the General Demographic Questionnaire predicted certain outcomes. The independent variables that were used included: (a) what helping profession participants fell

under, (b) gender, (c) marital status, and (e) ethnicity. The dependent variables for the MLR were the five factors (*Professional & Personal Development, Helping Professional Optimism, Leisure Activities, Burnout, Religion/Spirituality*) of the HPWDS model.

Prior to conducting the MLRs, the researcher assessed the data for assumptions. The assumptions of sample size, multicollinearity, outliers, normality, linearity, and homoscedasticity were examined. The large sample of $N = 657$ met the sample size requirement for MLR analysis (Tabachnick & Fidell, 2013). Tabachnick and Fidell (2013) recommend the following equation for assessing sample size requirements: $N > 50 + 8m$, where m is the number of independent variables. Because the researcher included four independent variables in the MLR, a minimum of 82 participants was needed to satisfy the sample size requirement. In addition, the researcher looked at the a priori power to determine the minimum sample size needed to conduct a MLR analysis. With a moderate effect size of .15, an alpha of .05, power of .80, and 4 independent variables, total sample size needed was calculated as $N = 43$. Thus, a sample of $N = 657$ was appropriate for MLR analysis.

To assess for multicollinearity, the researcher examined the relationship among the independent variables. As stated, multicollinearity involves variables being highly correlated (around .9 or above). VIF values above 10 and Tolerance values less than .10 support multicollinearity. The researcher assessed the VIF and Tolerance values and found sufficient levels for MLR analysis.

In order to assess for outliers, normality, linearity, and homoscedasticity, the researcher generated a scatterplot. By examining the scatterplot, the researcher was able to determine that there were no outliers in the data. In addition, the researcher examined the Mahalanobis distances that were produced by the MLR analysis at an α level of .001 (Tabachnick & Fidell, 2013). With

a $p < .001$ criterion for Mahalanobis distance and a critical value of Chi Square calculated with the four independent variables as 18.467 (Tabachnick & Fidell, 2013, Table C.4), *no* outliers were identified among the data. To examine homoscedasticity, the researcher evaluated scatterplots of the standardized residuals of the variables. All of the scatterplots of the standardized residuals resulted in relatively straight lines from bottom left to top right, which identified *no* major deviations from normality (Pallant, 2013) and satisfies the homoscedasticity assumption. To assess for linearity of data, the researcher again checked the pattern of associations between the variables by visually checking their scatterplots. As there were *no* concerns of non-linearity (e.g., relatively straight lines in data scatterplots), the assumption of linearity was met. The researcher assessed normality prior to running the MLR and found non-normal data. Thus, the normality assumption was *not* met and results should be considered with caution, as there are no non-parametric tests equivalent to running the MLR.

The linear composite of the predictor variables (Gender, Ethnicity, Marital Status, Helping Profession) predicted approximately ($r = .242$; $r^2 = .058$) and accounted for 3.6% of the variance in HPWDS Factor 1, F (15, 656) = 2.651, $p < .001$. Psychology accounted for the highest Beta value ($\beta = .153$, $p < .001$). The Hispanic/Latina/Latino Ethnicity accounted for the next highest Beta value ($\beta = .152$, $p < .001$). Variables predicting Factor 1 included Social Work, Psychology, and Other in the Helping Professional realm, Native American, African American, Asian, Hispanic/Latino/Latina, and Other in the Ethnicity realm, Male and Other in the Gender realm, and Divorced, Single, Separated, Widowed, and Other in the Marital Status realm. Counseling, Female, Caucasian, and Married variables did *no*t predict the MLR model.

The linear composite of the predictor variables (Gender, Ethnicity, Marital Status, Helping Profession) predicted approximately ($r = .291$; $r^2 = .085$) and accounted for 8.5% of the

variance in HPWDS Factor 2, F (15, 656) = 3.967, $p < .001$. The Single Marital Status accounted for the highest Beta value ($\beta = .238$, $p < .001$). The Asian Ethnicity accounted for the next highest Beta value ($\beta = .123$, $p < .01$). Variables predicting the Factor 2 MLR model included Social Work, Psychology, and Other in the Helping Professional realm, Native American, African American, Asian, Hispanic/Latina/Latino, and Other in the Ethnicity realm, Separated, Widowed, Divorced, Single, and Other in the Marital Status realm and Male and Other in the Gender realm. Variables *not* predicting the model included Counseling, Female, Caucasian, and Married.

The linear composite of the predictor variables (Gender, Ethnicity, Marital Status, Helping Profession) predicted approximately ($r = .195$; $r^2 = .038$) and accounted for 3.8% of the variance in HPWDS Factor 3, F (15, 656) = 1.688, $p < .05$. The Male Gender accounted for the highest Beta value ($\beta = .106$, $p < .01$). The African American Ethnicity accounted for the next highest Beta value ($\beta = .152$, $p < .05$). Variables predicting the model included Social Work, Psychology, and Other in the Helping Professional realm, Native American, African American, Asian, Hispanic/Latina/Latino, and Other in the Ethnicity realm, Separated, Widowed, Divorced, Single, and Other in the Marital Status realm and Male and Other in the Gender realm. Variables *not* predicting the model included Counseling, Female, Caucasian, and Married.

The linear composite of the predictor variables (Gender, Ethnicity, Marital Status, Helping Profession) predicted approximately ($r = .279$; $r^2 = .078$) and accounted for 7.8% of the variance in HPWDS Factor 4, F (15, 656) = 3.605, $p < .001$. The Single Marital Status accounted for the highest Beta value ($\beta = .169$, $p < .001$). The African American Ethnicity accounted for the next highest Beta value ($\beta = .157$, $p < .001$). Variables predicting the HPWDS Factor 4 model included Social Work, Psychology, and Other in the Helping Professional realm, Native

American, African American, Asian, Hispanic/Latina/Latino, and Other in the Ethnicity realm, Separated, Widowed, Divorced, Single, and Other in the Marital Status realm and Male and Other in the Gender realm. Variables *not* predicting the model included Counseling, Female, Caucasian, and Married.

The linear composite of the predictor variables (Gender, Ethnicity, Marital Status, Helping Profession) predicted approximately (r = .185; r^2 = .034) and accounted for 3.4% of the variance in HPWDS Factor 5, F (15, 656) = 1.513, $p > .05$. The Single Marital Status accounted for the highest Beta value (β = .111, $p < .001$). The Asian Ethnicity accounted for the next highest Beta value (β = .083, $p < .05$). Variables predicting the Factor 5 MLR model included Social Work, Psychology, and Other in the Helping Professional realm, Native American, African American, Asian, Hispanic/Latina/Latino, and Other in the Ethnicity realm, Separated, Widowed, Divorced, Single, and Other in the Marital Status realm and Male and Other in the Gender realm. Variables *not* predicting the model included Counseling, Female, Caucasian, and Married.

When looking at the effect sizes of the MLR analyses, the researcher based results on Cohen's (1988) standards of .8 being a large effect, .5 being a moderate effect, and .2 being small in effect. All five MLR analyses have low effect sizes, as indicated by the first (Factor 1, *Professional & Personal Development Activities* and demographic variables) having an effect size of r^2 = .058, the second (Factor 2, *Religion/Spirituality* and demographic variables) having an effect size of r^2 = .085, the third (Factor 3, *Leisure Activities* and demographic variables) having an effect size of r^2 = .038, the fourth (Factor 4, *Burnout* and demographic variables) having an effect size of r^2 = .078, and the fifth (Factor 5, *Helping Professional Optimism* and demographic variables) having an effect size of r^2 = .034. Based on Cohen's (1988) standards, all

MLR effect sizes are considerably small. In addition, based on the sample four of the HPWDS factors in the MLR analyses were statistically significant (Factors 1, 2, 3, and 4); however, because they accounted for a small variances, the significance is relatively meaningless and has *no* real-world implications or practical significance (i.e., none of the independent variables are strongly predicting participant scores on the HPWDS).

Research Question 5

For Research Question 5 (What is the relationship between HPWDS scores and MCSDS scores with a sample of helping professionals), the researcher correlated the *Marlowe-Crowne Social Desirability Scale-X1* (Strahan & Gerbasi, 1979; MCSDS-X1) with the HPWDS five factors. The researcher used the MCSDS-X1 in order to assess the social desirability of the participants' answers. All 657 participants in the research investigation took the MCSDS-X1 and 61.8% of individuals (M = 4.82, SD = 2.92) scored below the recommended amount (e.g., a score of 5 or less) for indication of social desirability. In other words, the majority of participants in the research study were *not* answering in a socially desirable way. The researcher used Spearman's rho correlation coefficient to analyze the MCSDS-X1 items with the HPWDS factors.

Before running the correlation analysis, the researcher generated a scatterplot in order to check the assumptions of (a) homoscedasticity and (b) linearity and assessed the normality of the dataset. Normality was assessed prior to running the EFA and data was found as being non-normal, thus influencing the type of correlation that was run (i.e., Spearman's rho). To examine homoscedasticity, the researcher evaluated scatterplots of the standardized residuals of the variables. All of the scatterplots of the standardized residuals resulted in relatively straight lines from bottom left to top right, which suggested no major deviations from normality (Pallant,

2013) and satisfied the homoscedasticity assumption. To assess for linearity of data, the researcher again checked the pattern of associations between the variables by visually checking their scatterplots. As there were no concerns of non-linearity (e.g., relatively straight lines in data scatterplots), the assumption of linearity was met.

The researcher investigated the relationship between the items on the HPWDS and the MCSDS-X1 (Strahan & Gerbasi, 1979) using Spearman's rho correlation coefficient. The results are displayed in table 14, which shows that HPWDS Factors 1, 2, 3, and 4 had a positive, yet small correlation with participants' (N = 657) total scores on the MCSDS-X1. Specifically, factor correlations were as follows: Factor 1 (ρ = .135, p < .01; 1.8% of the variance explained), Factor 2 (ρ = .196, p < .01; 3.8% of the variance explained), Factor 3 (ρ = .085; p < .05; .722% of the variance explained), and Factor 4 (ρ = .193, p < .01; 3.72% of the variance explained). Factor 5 had a non-statistically significant, negative correlation with participants' MCSDS-X1 total scores (ρ = -.070, p > .05; .49% of the variance explained).

Table 14 Spearman Rank Order Correlations between HWPDS Five Factors and MCSDS-X1

	Factor 1 ***Professional & Personal Development***	**Factor 2** ***Helping Professional Optimism***	**Factor 3** ***Leisure Activities***	**Factor 4** ***Burnout***	**Factor 5** ***Religion / Spirituality***
MCSDS-X1 Total Score	ρ = .135 p < .01	ρ = .196 p < .01	ρ = .085 p < .05	ρ = .193 p < .01	ρ = -.070 p > .05

Cronbach's Alpha of MCSDS-X1. The researcher also assessed the internal consistency of the MCSDS-X1 with the data. The 10-item scale had an internal consistency alpha of .689, which is just below the recommended .70 or higher alpha value (Mitchell & Jolley, 2004). The Cronbach's α range falls between 0 and 1, with values closer to 0 representing low reliability and values closer to 1 representing higher reliability (DeVellis, 2013). The researcher used a Cronbach's α value of .70 to indicate internal consistency of items (Mitchell & Jolley, 2004; Sterner, 2003).

Additional Analyses

The researcher assessed participant discrepancies on the HPWDS by subtracting their perceived wellness scores from their aspirational wellness scores. The researcher then took the absolute value of the discrepancy scores (as positive or negative values do *not* matter for the nature of the analysis), and looked at the final participant discrepancy scores. The largest participant discrepancy scores showed four point discrepancies (i.e., a four point difference between where they were currently (perceived wellness) and where they wanted to be (aspirational wellness). Although four was the greatest participant discrepancy, the average participant discrepancies fell between a 0 point discrepancy or *no* discrepancy and approximately a 1 point discrepancy between perceived and aspirational wellness. The overall average discrepancy was 0.75, indicating that the majority of participants had small discrepancies between where they were currently (perceived wellness) and where they aspired to be (aspirational wellness).

Chapter 4 Summary

Chapter four presented the results for the research investigation. The research questions were analyzed using a variety of statistical analyses: (a) EFA and internal replication analysis,

(b) Internal Consistency testing using Cronbach's Alpha, (c) Spearman's Rho correlation, and (d) MLR. Chapter 5 highlights the research findings as well as the future research considerations and implications for helping professionals.

CHAPTER FIVE: DISCUSSION

Chapter 5 provides a review of the research investigation, research methodology utilized, and a discussion of the results from the investigation. In addition, Chapter 5 reviews the results presented in Chapter 4 and compares them to previous research findings reviewed in Chapter 2. The findings regarding the four research questions are examined and implications for the helping professions are discussed. Furthermore, Chapter 5 offers: (a) the limitations of the research investigation, (b) future research endeavors, and (c) implications for the helping professions.

Introduction and Necessity for the Research Investigation

When helping professionals care for themselves, they are more able to provide quality care and meet the needs of their clients (Lawson, 2007; Witmer & Granello, 2005; Witmer & Young, 1996). Skovholt (2001) stated that counselors-in-training are at risk for distress and stress because of working with people who are experiencing pain and because of the challenge in mastering the ambiguity of the counseling process. In other words, helping professionals are vulnerable to becoming ineffective clinicians because of the nature of their work (Skovholt, 2001). Thus, helping professional's personal wellness is important because individuals who are unwell are *not* able to provide optimal services to clients (Lawson et al., 2007).

As stated, the helping professions have numerous guidelines supporting the wellness paradigm; specifically, the American Counseling Association (ACA, 2014) states that counselors must monitor themselves "for signs of impairment from their own physical, mental, or emotional problems" (*Standard* C.2.g, p. 9). In addition, counselors are advised to monitor themselves for signs of impairment and "refrain from offering or providing professional services when such impairment is likely to harm clients" (*Standard* F.5.b, p. 13). The American Psychological Association (APA, 2010) notes that professionals should refrain from providing services to

clients when their personal problems may interfere with their work or when they know there is a likelihood that their personal issues may influence their professional competence (*Standard*, 2.06). The Counsel for Accreditation of Counseling and Related Educational Programs (CACREP; 2009) also supports that helping professionals should have an orientation to wellness and prevention (Section II.5.a) and that they have a duty to promote optimal wellness and growth in clients (Section II.2.e). Thus, wellness and the prevention of impairment are intertwined throughout the standards of the helping professions. Consequently, it is unethical for helping professionals to provide services while personally and/or professionally impaired.

Though wellness is viewed as the backbone of the counseling profession and integral to other helping professions, many of the individuals in helping professions do *not* practice wellness or promote it in their own lives (Granello, 2013; Witmer & Young, 1996). Many of the individuals attracted to and entering into the helping professions are already impaired and have an increased likelihood for adjustment issues and personality concerns (Witmer &Young, 1996). Cummins and colleagues (2007) iterate that counselors and counselors-in-training are often remiss about taking their own advice about wellness. Lawson and colleagues (2007) noted that counselors and counselors-in-training that are considered *well* are more likely to help their clients become more *well*. Consequently, impaired helping professionals are more likely to harm their clients (Lawson et al., 2007; Witmer & Young, 1996) and as a result, it is imperative that we assess wellness in helping professionals and helping professionals-in-training.

Though it is essential that we assess helping professional wellness, there are *no* research investigations examining helping professional perceived wellness and/or helping professional aspirational wellness. In addition, *no* prior research assesses the discrepancy between helping professionals' perceived wellness and aspirational wellness. Therefore, this research

investigation examined the psychometric properties of wellness (as measured by the HPWDS) in a sample of helping professionals.

Review of Research Methodology

The following section provides a review of the research methodology used in the research investigation. For a detailed description of the research methodology, please consult Chapter 3. This research study utilized a correlational research design (Gall et al., 2007). The primary research questions involved (a) examining the exploratory factor structure of the HPWDS in a sample of helping professionals, (b) examining the internal consistency reliability of the final exploratory HPWDS model, (c) assessing correlations between the HPWDS final exploratory model and the CBI (Lee et al., 2007), and (d) examining the relationships between demographic variables and the factors on the HPWDS exploratory model. In addition, an internal replication analysis was conducting to support the exploratory factor structure of the HPWDS. Prior to any data collection, the researcher received Institutional Review Board (IRB) approval at her university (see Appendix A).

Participants

The sampling procedures involved convenience sampling and stratified random sampling. The convenience sampling consisted of helping professionals-in-training from a large Southeastern university. The stratified random sample was derived from two sources: (a) the Department of Health Florida helping professional list and (b) the Department of Health Texas helping professional list. Both lists were provided to the researcher free of charge for research purposes, and contained email and mail information of licensed psychologists, licensed social workers, and licensed counselors. From the lists, 9,000 participants were randomly selected for the online version of data collection. In addition, 500 participants were randomly selected for the

mail out data collection methodology. Participants who were a part of the online/email methodology were *not* a part of the mail out data collection methodology. For both the online and mail out methodologies, random stratified sampling was employed to ensure that equal representations of helping professional groups (i.e., psychologists, social workers, counselors) were achieved.

Data Collection

The researcher utilized three methods for data collection including: (a) face-to-face administration, (b) email/online administration, and (c) mail out administration. The mail out (N = 500) and email/online (N = 9,000) administration followed the *Tailored Design Method* (Dillman et al., 2009). The researcher invited email/online administration participants to take an online survey (www.qualtrics.com) via email contact. The emails were sent out in three increments: (a) an introductory email, (b) an email reminder, and (c) a final email reminder. The researcher invited the mail out administration participants to participate in the research investigation via three mail contacts of: (a) an introductory letter with informed consent letter; (b) a letter containing the HPWDS packet and an addressed, stamped envelope for packet return; and (c) a reminder post card.

Instrumentation

This researcher utilized a general demographic questionnaire and three data collection instruments. The researcher developed the general demographic questionnaire, which is presented in Appendix D. The general demographic questionnaire contained questions assessing participants: (a) primary helping professional field, (b) ethnicity, (c) gender, (d) marital status, (e) employment status, (f) years of experience in the field, (g) primary theoretical orientation, and (h) primary client population served. In addition, the general demographic questionnaire

contained a 5-point Likert scale with questions assessing participants' feelings regarding their social wellness, physical wellness, occupational wellness, emotional wellness, and spiritual wellness.

The CBI (Lee et al., 2007) is a 20-item, self-report questionnaire comprised of the five subscales of: (a) Exhaustion; (b) Incompetence; (c) Negative Work Environment; (d) Devaluing Client; and (e) Deterioration in Personal Life, which was created to assess burnout in counselors. Each item has a five-point Likert response scale ranging from 1 (*never true*) to 5 (*always true*). Examples of CBI items are "I feel frustrated with the system in my workplace" and "I do not feel like I am making a change in my clients." The CBI contains items that are reflective of various levels of burnout (Lee et al., 2010). Lee et al. (2007) found the total variance for the CBI five factors ranging from 55% to 67% and overall internal consistency of the 20-item CBI subscales ranged from .80 to .84.

Social desirability is an example of a common issue faced when using self-report measures (Crowne & Marlowe, 1960). Thus, the researcher used the MCSDS-X1 social desirability scale for assessment of the level of social desirability in helping professional responses in this research investigation. The MCSDS-X1 (Strahan & Gerbasi, 1979) was used in the study and is a 10-item instrument that is a shortened version of the original 33-item *Marlowe-Crowne Social Desirability Scale* (MCSDS; Crowne & Marlowe, 1960). Sample items from the MCSDS-X1 include: "I'm always willing to admit it when I make a mistake" and "I like to gossip at times." Furthermore, MCSDS-X1 item scoring is based on a *1* (items that are socially desirable) and *0* (items that are not socially desirable) range, with total scores on the assessment ranging from 0 to 10. The MCSDS-X1 has an internal consistency range of around .50 to .90 (Ballard, 1992; Barger, 2002; Fischer & Fink, 1993; Strahan & Gerbasi, 1972).

In the investigation the researcher focused on developing the *HPWDS* and examining the psychometric properties (validity and reliability) of the HPWDS with a sample of helping professionals. In order to develop the HPWDS, a number of theoretically supported steps were followed (Crocker & Algina, 2006; DeVellis, 2012; Dimitrov, 2012). The specific instrument development steps employed were: (a) determine clearly what is being measured, (b) creating an item pool, (c) determining the type of scale measurement, (d) having the items reviewed by a team of experts, (e) considering inclusion of validation items, (f) administering the scale to a development sample, (g) evaluating the items following statistical analysis, and (h) optimizing scale length.

Data Analysis

The initial data analysis for the research investigation involved cleaning the data by assessing for outliers and/or missing data. Next, the researcher examined statistical assumptions to assess the appropriateness of statistical analyses for *all* the research questions. Statistical assumptions varied depending on independent research questions; however, some of the assumptions the researcher tested for included: (a) normality, (b) multicollinearity, (c) KMO value, (d) skewness, (e) kurtosis, and (f) homoscedasticity. The researcher used the Statistical Package Social Sciences (Version 21; SPSS, 2011) for all data analyses.

Discussion

Review of Descriptive Data

A total of 9,588 participants were invited to participate in the research investigation. Specifically, 9,000 individuals were invited to participate in an online version via email administration, 500 participants were invited to participate in a paper and pencil version via mail

out administration, and 88 participants were invited to participate in a paper and pencil version via face-to-face administration.

In total, 657 individuals participated in the study for an overall useable response rate of 6.8%. In the face-to-face administration, the researcher examined the amount of data collection packets versus the number of data collection packets returned. For the face-to-face administration, 88 out of 88 individuals asked to participate in the study chose to participate for a 100% useable response rate. In the mail out methodology, the researcher tracked the response rate using Excel. Out of the original sample of 500, 95 returned packets (19% response rate). Of the 95 returned packets, 87 were completed (17.4% useable response rate). Finally, in the online version of participant recruitment, the researcher screened participants using an initial question at the beginning of their survey that asked about their current status as a helping professional. Of the 9,000 potential participants, 936 individuals visited and started the survey for an initial response rate of 10.4%. Of those participants who started the survey however, 495 out of 9,000 potential individuals completed the research investigation for a useable response rate of 5.4%. Table 15 provides a pictorial representation for the participants' response rates.

Table 15 Sampling and Data Collection Methodology Useable Responses

Data Category	Total (*n*)	Response Rate
Online Sample Group (*N* = 9,000)		
Social Work (*n* = 3,000)	139	4.6%
Counseling (*n* = 3,000)	165	5.5%
Psychology (*n* = 3,000)	180	6.0%
Total	484	5.4%
Face-to-Face Sample Group (*N* = 88)		
Counseling	88	100%
Total	88	100%
Mail Out Sample Group (*N* = 500)		
Social Work (*n* = 167)	1	.59%
Counseling (*n* = 167)	68	40.7%
Psychology (*n* = 167)	18	10.7%
Total	87	17.4%
Data Collection Method Totals (*N* = 9,588)		
Face-to-Face	88	100%
Mail-Out	87	17.4%
Email/Web-Based	482	5.4%
Total	**657**	**6.9%**

Note. *N* denotes total sampled, *n* denotes sample based upon helping profession

In email/web-based surveys, the response rate may have been influenced by whether or *not* the email addresses were correct, whether the emails are opened or sent directly to spam, or whether the email addresses work for the participant (Granello & Wheaton, 2004). Thus, the actual response rate for the web-based survey might be higher than the reported value due to some participants never receiving the invitation to participate in the research study.

The participants (*N* = 657) reported gender consisted of 520 females (78.8%) and 136 males (20.6%), with 1 (.2%) of participants reporting gender as other. Reported ethnicity of the participants (*N* = 657) was 34 African American (5.2%), 15 Asian (2.3%), 530 Caucasian (80.3%), 63 Hispanic/Latina/Latino (9.5%), 1 Native American (.2%), and 14 participants

identifying as other (2.1%). The Martial Status for participants (*N* = 657) was reported as 70 Divorced (10.6%), 394 Married (59.7%), 134 Single (20.3%), 4 Separated (.6%), 24 Widowed (3.6%), and 31 Other (4.7%). For pictorial representation please see Table 1.

Regarding specific Helping Professional groups, the participants (*N* = 657) identified as 271 Counselors (41.2%) and 218 Psychologists (33.2%), 157 Social Workers (23.9%), and 11 individuals identifying as Other (1.7%). Reported Employment Status of participants (*N* = 657) was 411 Employed Full time (62.6%), 122 Employed Part Time (18.6%), 7 Not Working (1.1%), 12 Retired, Not Working (1.8%), 36 Retired, Working Part Time (5.5%), and 69 participants identifying as Students (10.5%). In reference to participant theoretical orientation (*N* = 657) 10 identified as Adlerian (1.5%), 13 as Behavioral (2.0%), 258 as Cognitive Behavioral (39.3%), 216 as Eclectic/Integrative (32.9%), 12 as Existential (1.8%), 19 as Psychoanalytic (2.9%), 47 as Rogerian/Client Centered (7.2%), 31 as Systemic (4.7%), and 51 as Other (7.8%). Participants' reported Level of Education and 82 had Bachelor's Degrees (12.4%), 312 had Master's Degrees (47.5%), 8 had Ed.D.'s (1.2%), 86 had PsyD's (13.1%), 159 had Ph.D.'s (24.2%), and 10 reported having Other Degrees (1.5%). Finally, participants reported that 82 had 0 – 2 years of experience in the field (12.5%), 41 had 3 – 5 years of experience in the field (6.2%), 45 had 6 – 8 years of experience (6.8%), 55 had 9 – 11 years of experience (8.4%) and 434 reported having 12 or more years of experience in the Helping Professional Field (66.1%). For pictorial representation please refer to Table 2.

The researcher did *not* find any previous wellness-related research studies where the sample consisted of a combination of counselors, psychologists, and social workers to comprise the helping professional population. However, the researcher identified numerous studies where one of the three populations was studied (i.e., counseling, psychology, social work; Hattie et al.,

2004; Myers et al., 1998; Myers et al., 2004; Myers et al., 2005) within the context of wellness. Hattie and colleagues (2004) used the WEL with a large sample (*N* = 3,043) of university students, young adults, middle-aged adults, older adults, and 18-year-olds. The sample contained 54% male and 46% female participants and approximately 80% White individuals, similar demographics to the current study. Myers and colleagues (2003) used the *Wellness Evaluation of Lifestyle* (WEL) to assess counseling students (*N* = 263) levels of wellness, while Adams et al. (1997) used the *Perceived Wellness Scale* (PWS) to assess wellness in a sample of adults. Harari and colleagues (2005) examined the psychometric properties of the PWS and the degree to which the PWS reflected the Perceived Wellness Model (PWM; Adams, 1995; Adams et al., 1997) in a population of college-level students (*N* = 317) and Hinds (1983) developed the *Lifestyle Coping Inventory* (LCI) to assess wellness in adults and college students to assess current wellbeing and illness. Though wellness has been assessed in the helping professions (i.e., in college-age adults and adults) in previous studies, the current study remains unique in the sampling methodology used (i.e., combination of face-to-face, mail out, and email/online sampling) as well as in the combination of counselors, social workers, and psychologists as the helping professional population.

The majority of participants in the present research study reported being Caucasian (80.3%) and female (78.8%), which is common in social science research centering on wellness (Hattie et al., 2004; Maher et al., 2012; Ryff & Keyes, 1998). In addition, the majority of individuals' participating in the study reported having a master's degree (*n* = 312, 47.5%) or master's degree or higher (*n* = 565, 86%), which is similar to other helping professional research (Limberg, 2013, Mullen et al., 2014; Scarborough, 2005; Stevanovic & Rupert, 2004). The majority of participants reported having 12 or more years of experience in their respective

helping professional field (66.1%), which was similar to Lee et al. (2010) investigation of professional counselors, where participants (*N* = 132, 20.1%) reported having around 11 years of experience in the field (*M* = 11.31, *SD* = 8.37). In reference to theoretical orientation of the participants, approximately 40% of individuals in the present study reported their primary theoretical orientation as cognitive behavioral, while the next highest (32.9%) reported being eclectic/integrative. Finally, 41.2% of participants identified as counselors, 33.2% as psychologists, 23.9% identified as social workers, and 1.7% of individuals identified as Other. Descriptive data results from this research investigation were consistent with other social science research on the helping professions (Hattie et al., 2004; Ieva, 2010; Limberg, 2013; Maher et al., 2012; Mullen, 2014; Myers et al., 1998; Myers et al., 2004; Myers et al., 2005: Ryff & Keyes, 1998), supporting the generalizability of the findings to similar populations.

Research Question Results

Research Question 1

For Research Question 1, the researcher conducted an exploratory factor analysis (EFA) to examine the factor structure of the HPWDS data as well as examine potential correlations between variables (Henson & Roberts, 2010). Research Question 1 was split into four sections (i.e., 1, 1a, 1b, 1c). Research Question 1a involved the exploratory model for *all* perceived levels of wellness, Research Question 1b included the exploratory model for *all* aspirational levels of wellness, Research Question 1c involved the exploratory model for the discrepancy between the perceived and aspirational levels of wellness, and Research Question 1 involved examining the overall exploratory model for the combined wellness model.

For *all* research questions (e.g., 1, 1a, 1b, 1c), the researcher assessed statistical assumptions prior to data analysis. The researcher assessed and satisfied the statistical

assumptions of: (a) sampling adequacy, (b) linearity, (c) normality, and (d) multicollinearity prior to running the EFA analysis. Based on the severe non-normality of the data (Costello & Osborne, 2005; Fabringar, Wegener, MacCallum, & Strahan, 1999), the researcher conducted a Principal Axis Factoring (PAF) method with an oblique (Promax) rotation for *all* research questions (e.g., 1, 1a, 1b, 1c). The oblique rotation was chosen based on the fact that in the social sciences, researchers can expect some degree of correlation among instrument items (Costello & Osborne, 2005).

For Research Question 1a (perceived wellness), the final PAF EFA with a promax rotation identified a five-factor solution (see table 4) with eigenvalues greater than 1.0 within the data. The five factors accounted for 68.251% of the variance, which is satisfactory in social science research (Hair et al., 2006). Furthermore, the communalities were considered acceptable with only four of them below the recommended .5 (see table 3). Factor 1 represented *Professional & Personal Development Activities* and accounted for 33.350% of the variance, Factor 2 represented *Leisure Activities* and accounted for 12.964% of the variance, Factor 3 represented *Hope and Optimism* and accounted for 8.480% of the variance, Factor 4 represented *Burnout* and accounted for 7.083% of the variance, and Factor 5 represented *Religion/Spirituality* and accounted for 6.354% of the variance.

For Research Question 1b (aspirational wellness), the researcher derived a five-factor solution (see table 6) and the five factors accounted for 72.104% of the variance, which is satisfactory in social science research (Hair et al., 2006). Furthermore, the communalities on the five-factor model were considered acceptable with only four of them below the recommended .5 (see table 5). Factor 1 represented *Professional & Personal Development Activities* and accounted for 32.626% of the variance, Factor 2 represented *Religion/Spirituality* and accounted

for 12.818% of the variance, Factor 3 represented *Leisure Activities* and accounted for 11.413% of the variance, Factor 4 represented *Burnout* and accounted for 8.474% of the variance, and Factor 5 represented *Helping Professional Optimism* and accounted for 6.773% of the variance.

For Research Question 1c (discrepancy between perceived wellness and aspirational wellness), the researcher derived a five-factor solution (see table 8) and the five factors accounted for 66.352% of the variance, which is satisfactory in social science research (Hair et al., 2006). Furthermore, the communalities were considered acceptable with only four of them below the recommended .5 (see table 7). Factor 1 represented *Professional & Personal Development Activities* and accounted for 37.620% of the variance, Factor 2 represented *Leisure Activities* and accounted for 8.871% of the variance, Factor 3 represented *Religion/Spirituality* and accounted for 7.526% of the variance, Factor 4 represented *Helping Professional Optimism* and accounted for 6.317% of the variance, and Factor 5 represented *Burnout* and accounted for 6.017% of the variance.

Finally, for Research Question 1 (final model), the researcher derived a five-factor solution (see table 10) and the five factors accounted for 69.169% of the variance, which is satisfactory in social science research (Hair et al., 2006). Furthermore, the communalities were considered acceptable with only three of them below the recommended .5 (see table 9). Factor 1 represented *Professional & Personal Development Activities* and accounted for 32.605% of the variance, Factor 2 represented *Religion/Spirituality* and accounts for 13.151% of the variance, Factor 3 represented *Leisure Activities* and accounted for 9.443% of the variance, Factor 4 represented *Burnout* and accounted for 7.198% of the variance, and Factor 5 represented *Helping Professional Optimism* and accounted for 6.773% of the variance.

The final HPWDS exploratory factor model includes some factors that were consistent with other wellness related assessments (e.g., *Model of Spiritual Wellness*, *Five Factor Wellness Evaluation of Lifestyle*, *Perceived Wellness Model*). For example, the *Religion/Spirituality* factor (i.e., items 62, 88, 60, 73) found in the HPWDS model was consistent with other wellness scales and models such as: the *Model of Spiritual Wellness* (Chandler et al., 1992), the 5F-Wel (Myers et al., 2004), the PWM (Adams, 1995; Adams et al., 1997), and the *Wheel of Wellness* Model (WEL; Myers et al., 1998). In addition, the *Religion/Spiritual* items included on the HPWDS (i.e., questions 62, 60, 73, 88) were supported by other wellness studies investigating the influence of spirituality on well- being (Roach & Young, 2007; Sovaliane & Granello, 2002) and supporting spirituality as a key component of holistic wellness (Chandler et al., 1992; Hettler, 1984; Myers et al., 1999; Savoliane & Granello, 2002; Zimpher, 1992).

The *Professional & Personal Development Activities* factor (i.e., items 57, 54, 43, 48, 68) and the *Leisure Activities* (i.e., items 5, 38, 4, 47) factor were similar to the occupational and intellectual realms in the 5F-Wel (Myers et al., 2004) and the intellectual factor on the PWS (Adams et al., 1997) in that the items for the *Professional & Personal Development Activities* factor on the HPWDS (i.e., questions 57, 54, 43, 48, 68) included activities such as partaking in actions to further knowledge as a helping professional, furthering knowledge in personal areas, taking initiatives to learn about new research in the helping professions, and engaging in activities to advance general knowledge. Both the 5F-Wel and the PWS (which were normed on helping professional populations) factors included similar items assessing wellness across the intellectual, occupational, and knowledge-based factors, which supports the *Professional & Personal Development Activities* factor HPWDS in a sample of helping professionals.

Falling under the knowledge realm, intellectual wellness is referred to as the engagement or stimulation of the mind in meaningful, knowledge-inducing, and creative activities (Adams et al., 1997; Hettler, 1980; Leafgren, 1990) and encompasses personal achievement in education, personal growth, and creativity (Renger et al., 2000). Sweeney and Witmer (1991) stated that occupational components were fundamental to wellness and researchers identified a correlation between work satisfaction and longevity (Danner & Dunning, 1978); productivity (Pelletier, 1984); and decreased stress, anxiety, and physical symptoms (Witmer et al., 1983). Thus, work-related activities can increase professional and personal characteristics such as knowledge and self-efficacy in performing specific tasks, and can be influential to promoting and maintaining holistic wellness in helping professionals.

The *Leisure Activities* (i.e., questions 5, 38, 4, 47) factor on the HPWDS is similar to the self-care and leisure areas on the 5F-Wel (Myers et al., 2004), the Adlerian life-task of *self* on the WEL (Myers et al., 1998), in that the HPWDS items contain information assessing engagement in leisure activities, free-time activities, and time away from work or chores. Both the 5F-Wel and the WEL self-care and *self*-categories assess similar activities in the promotion of a holistically well individual, and thus, support the leisure factor for use of the HPWDS with helping professionals. Furthermore, leisure and social activities can include time spent alone or with others, which influences individuals' well-being (House et al., 1992; Lynch, 1977; Sweeney & Witmer; 1991). Whether engaging in alone-time leisure or leisure with others, taking time for personal activity is influential in maintaining helping professional wellness.

The *Burnout* factor of the HPWDS (i.e., questions 8, 69, 90) includes how worn out helping professionals are, and the amounts of stress and exhaustion participants are experiencing. Though some of the holistic wellness models and assessments reviewed (see Chapter Two)

include items and factors assessing for self-care, many do *not* take into account helping professional burnout (i.e., 5F-Wel; WEL; PWS; LAQ). The *Counseling Burnout Inventory* (CBI; Lee et al., 2007) and the *Maslach Burnout Inventory-Human Services Scale* (MBI-HSS; Maslach & Jackson, 1996) assess for burnout; however, these two assessments do *not* measure for helping professionals' level of wellness simultaneously. Thus, the HPWDS is unique and adds to the literature because it takes into account discrepancies in both well-being behaviors as well as burnout-related behaviors in helping professionals.

The domains in which helping professionals' work are stressful (e.g., Puig et al., 2012; Young & Lambie, 2007), and helping professionals experience job stressors such as financial constraints, heavy caseloads, demands for shorter therapy options, and managed care limitations (O'Halloran & Linton, 2000). Furthermore, Bakker and colleagues (2003) stated that health professionals are at an increased risk of burnout. Thus, prolonged periods of stress can lead to helping professional impairment and burnout and lead to deterioration of the quality of services clients receive (Lambie, 2007). As noted, burnout should be assessed in a measure of wellness; especially in helping professional populations.

Finally, the *Helping Professional Optimism* factor (i.e., items 42, 67, 56, 70, 87, 7) on the HPWDS is similar to the *Coping* factor on the *Indivisible Self Model of Wellness* (IS-WEL; Myers et al., 2004). The *Coping* factor on the IS-WEL included self-worth, realistic beliefs, and stress management categories, which could *all* support individuals' levels of optimism in that how people feel about themselves, how realistic they are, and how they handle stress influences their ability to be optimistic (Witmer et al., 1983; Witmer & Rich, 1991). Gallagher and colleagues (2012) noted that optimism was a universal construct and that optimism was

associated with improved health and well-being world-wide. Thus, the *Helping Professional Optimism* factor on the HPWDS is warranted for assessing well-being in helping professionals.

In summary, *all* four HPWDS EFA models resulted in similar factor structures, ranging from 19 items to 22 items. For the final HPWDS model, theoretical information, statistical methods, or both supported items for inclusion. For supporting information on the five factor HPWDS structure, 22 assessment items were included in the final version of the HPWDS, please refer to Table 16.

Table 16 HPWDS Items, Associated Factors, & Literature Support

HPWDS Item	Factor Name	Literature Support
Question 57 – Partake in activities to further your knowledge as a helping professional Question 54 – Partake in activities to further your knowledge in an area of your choice Question 43 – Take the initiative to learn about new research in the helping professions Question 48 – Engage in activities to advance your knowledge (e.g., reading, writing) Question 68 – Take time to advance your professional development (i.e., attend conferences of seminars)	Professional & Personal Development Activities	ACA, 2014; Adams et al., 1997; Hettler, 1980; Leafgren, 1990; Renger et al., 2000; Witmer & Sweeney, 1992
Question 42 – Feel like you are making a difference as a helping professional Question 67 – Believe that your contributions as a helping professional matter Question 56 – Experience optimism about client's futures Question 70 – Experience satisfaction in your life Question 87 – Experience happiness Question 7 – Experience optimism about your future	Helping Professional Optimism	Carver et al., 2009; Frey & Carlock, 1989; Fry & Salmeh, 1987; Gallagher et al., 2012; Keyes, 1995; Locke & Colligan, 1986; Maslow, 1970; Ryff & Keyes, 1995; Seligman, 2006; Witmer, 1985; Witmer & Rich, 1991; Witmer & Sweeney, 1992, Witmer et al., 1983
Question 5 – Immerse yourself in leisure activity/activities with which you participate Question 38 – Engage in free-time/leisure activity (i.e., time spent away from work or chores) Question 4 – Partake in enjoyable activities (i.e., things you enjoy doing) Question 47– Find time to relax	Leisure Activities	Csikzentmihalyi, 1990, 1993, 1997; Keyes, 2007; Lynch, 1997; Seligman & Csikzentmihalyi, 2000; Uchino et al., 1996; Witmer & Sweeney, 1992
Question 62 – have religious or spiritual beliefs that you feel are sustaining Question 88 – Engage in prayer (e.g., praying) Question 60 – Experience satisfaction with your spiritual or religious activity Question 73 – Meditate with a focus on a higher power or spiritual entity	Religion / Spirituality	Adams et al., 1997; Chandler et al., 1992; Hettler, 1980; Myers & Sweeney, 2005; Roach & Young, 2007; Roscoe, 2009; Witmer & Sweeney, 1992; Zimpher, 1992
Question 69 – Experience exhaustion because of your work as a helping professional Question 90 – Experience stress form working as a helping professional Question 8 – Are worn out because of the work you do as a helping professional	Burnout	ACA, 2014; Ackerley et al., 1988; Dreikers, 1953; Lambie, 2007; Lee et al., 2007, Lee et al., 2010; Leiter & Harvey, 1996; Puig et al. 2012; Strecher et al., 1986; Sweeney & Witmer, 1991

In further support for the inclusion of the 22 items on the HPWDS, the researcher examined helping professional career sustaining behaviors (CSBs) throughout the social sciences

literature. Kramen-Kahn and Hansen (1998) found that the most highly rated CSBs included: (a) humor, (b) perceiving client problems as interesting, (c) seeking case consultation, (d) engaging in leisure activities for renewal, and (e) engaging in leisure activities for relaxation. Furthermore, Lawson (2007) compared less satisfied counselors and more satisfied counselors' responses (*N* = 501) on the importance of CSBs and found that more satisfied counselors rated the importance of 14 CSB strategies higher than their less satisfied counterparts. The top six of the *important* CSB's for counselors in Lawson's (2007) study included: (a) maintaining a sense of humor, (b) spending time with partner/family, (c) maintaining balance between professional and personal lives, (d) maintaining self-awareness, (e) maintaining sense of control over work responsibilities, and (f) reflecting on positive experiences. Stevanovic and Rupurt (2004) found the top six CSBs found in highly satisfied psychologists were: (a) varying work responsibilities, (b) using positive self-talk, (c) balancing personal and professional lives, (d) spending time with partner/family, (e) taking vacations, and (f) maintaining professional identity. Helping professionals engaging in CSBs may *not* only have better professional careers, but also have more holistic wellness.

The reflecting on positive experiences subscale of the CSB (Lawson, 2007) is similar to the *Helping Professional Optimism* factor on the HPWDS and similar to HPWDS question 87 "Experience Happiness" and question 7 "Experience optimism about your future." The maintaining control over work responsibilities CSB (Lawson, 2007) could fall under the *Burnout* factor on the HPWDS in that if a helping professional struggles to maintain a sense of control over work responsibilities they could feel worn out or stressed (similar to questions 90 and 8 on HPWDS). Finally, balancing personal and professional lives, taking vacations, and spending time with others on the CSBs (Lawson, 2007) are *all* similar to the items in the HPWDS *Leisure Activities* factor (e.g., Engage in free-time/leisure activity, Partake in enjoyable activities, and

Find time to relax) because they *all* include individuals making choices to engage in pleasurable activities.

Kramen-Kahn and Hansen (1998) examined coping mechanisms, occupational hazards, and rewards in a sample psychotherapists (N = 208). Some of the top rated CSB items in the Kramen-Kahn and Hansen (1998) study also related to items on the HPWDS. Specifically, "perceiving client problems as interesting," is similar to the question 67 "Experience optimism about client's futures," and "engaging in leisure activities for renewal" and "engaging in leisure activities for relaxation" are similar to the *Helping Professional Optimism* factor on the HPWDS. Thus, many of the items on the HPWDS are supported by previous research investigations surrounding CSBs and their influence on helping professional wellness in both the work force and in personal arenas.

Though 19 of the 22 items on the HPWDS were supported both theoretically (by existing wellness literature) and statistically (following appropriate scale development procedures (Crocker & Algina, 2006; DeVellis, 2013; Dimitrov, 2012; Tabachnick & Fidel, 2013), three items (i.e., 73, 7, 87) fell below the recommended communality value of .5. Thus, the three items needed to be further supported by theory for inclusion on the HPWDS final exploratory model. Item 73 (Meditate with a focus on a higher power or spiritual entity) is supported in Myers and Sweeney's (2004) IS-WEL model in the *Essential Self* component. Myers and Sweeney (2004) noted that the *Essential Self* referred to individual meaning making and involved taking into account individual satisfaction with personal beliefs and belief in a higher power. According to Roscoe (2009), spiritual wellness is integral in individual meaning making, purpose, and connection with others, the environment, and a higher power (Roscoe, 2009). Furthermore, Roach and Young (2007) stated that spirituality and religion played a vital part in the human

condition and religious activities and spiritual beliefs have been linked to stress management and improved health (Roach & Young, 2007). As such, there are numerous researchers in the wellness literature supporting spirituality as a key component to overall wellness (Chandler et al., 1992; Hettler, 1984; Myers et al., 1999; Savoliane & Granello, 2002; Zimpher, 1992). As a result, the researcher chose to keep item 73 for inclusion in the HPWDS.

For item 7 of the HPWDS (Experience optimism about your future), Andersson (1996); Carver et al. (2010); and Scheier and Carver (1992) identified that optimism was linked to improved psychological health. Similarly, Gallagher and colleagues (2012) claimed that optimism was a universal construct and that optimism was associated with improved health and well-being worldwide. Witmer and colleagues (1983) studied a nonclinical, general population for psychosocial characteristics associated with the stress response and identified that optimism was one of the prime variables that characterized the good copers who had less anxiety and fewer physical symptoms. Therefore, the researcher believed helping professional optimism was an integral component to wellness and chose to include item 7 in the final HPWDS model.

In reference to supporting item 87 (Experience happiness), Lyumbomirsky (2001) investigated happiness and feelings and emotions associated with being happy and asserted that motivational processes and cognitive processes were integral in maintaining wellness. She also found that happiness was influenced by psychological processes and individuals who reported as happy were less likely to be influenced by positive and negative life events, moods, the outcome of events, and social comparison (Lyumbomirsky, 2001). Because happiness has been viewed as integral for positive emotional states, experiencing happiness was considered essential for inclusion in the HPWDS model. For additional references supporting the inclusion of items 87,

7, and 73, please refer to Table 16. For an example of the Path Diagram of the final HPWDS 22-item model refer to Figure 15.

Potential Reasons for Exclusion of Physical and Nutritional Realms. Two wellness-related areas, physical and nutritional, were *not* included on the HPWDS because *all* items assessing physical or nutritional categories factored out of the model. Though physical and nutritional components are supported in the wellness literature (Belloc, 1973; Hettler, 1980; Myers & Sweeney, 2005; Sweeney & Witmer, 1991; Witmer, 1985), none of the items assessing for physical wellness discrepancies or nutritional wellness discrepancies met the minimum statistical qualifications for retention in the HPWDS model. One possible reason for nutritional and physical domains factoring out is that they were too large of constructs to assess within a wellness model, and should therefore be assessed in their own wellness assessment (i.e., a scale only focusing on physical and nutritional areas of wellness).

Another possible reason that both physical and nutritional areas factored out of the HPWDS may have been that for the specific population (i.e., helping professionals), nutritional and physical components of wellness were *not* important to overall wellness discrepancies; therefore, factored out of the HPWDS models. Finally, participants' scores on the HPWDS perceived wellness questions and scores on the HPWDS aspirational wellness questions might have had a small discrepancy (e.g., not a large difference between where they saw themselves and where they wanted to be) in the physical and/or nutritional realms and therefore might have contributed to a limited variance in scoring. Having a limited variance could have influenced a ceiling effect, where the variables were *no* longer measured because the discrepancies were small (Keeley, English, Irons, & Henslee, 2013). Ceiling effects occur when an instrument "does not have sufficient range to produce meaningful variability at the upper or lower ends of possible

scores" (Keeley et al., 2013, p. 441). The researcher hypothesizes that both the physical and nutritional realms are important to helping professional wellness and that a separate assessment for examining the components should be used, rather than combining them with other wellness-related variables. It is possible that both physical and nutritional wellness areas are too expansive to be assessed via a few items on a wellness assessment and therefore, a separate scale assessing the variables might be necessary.

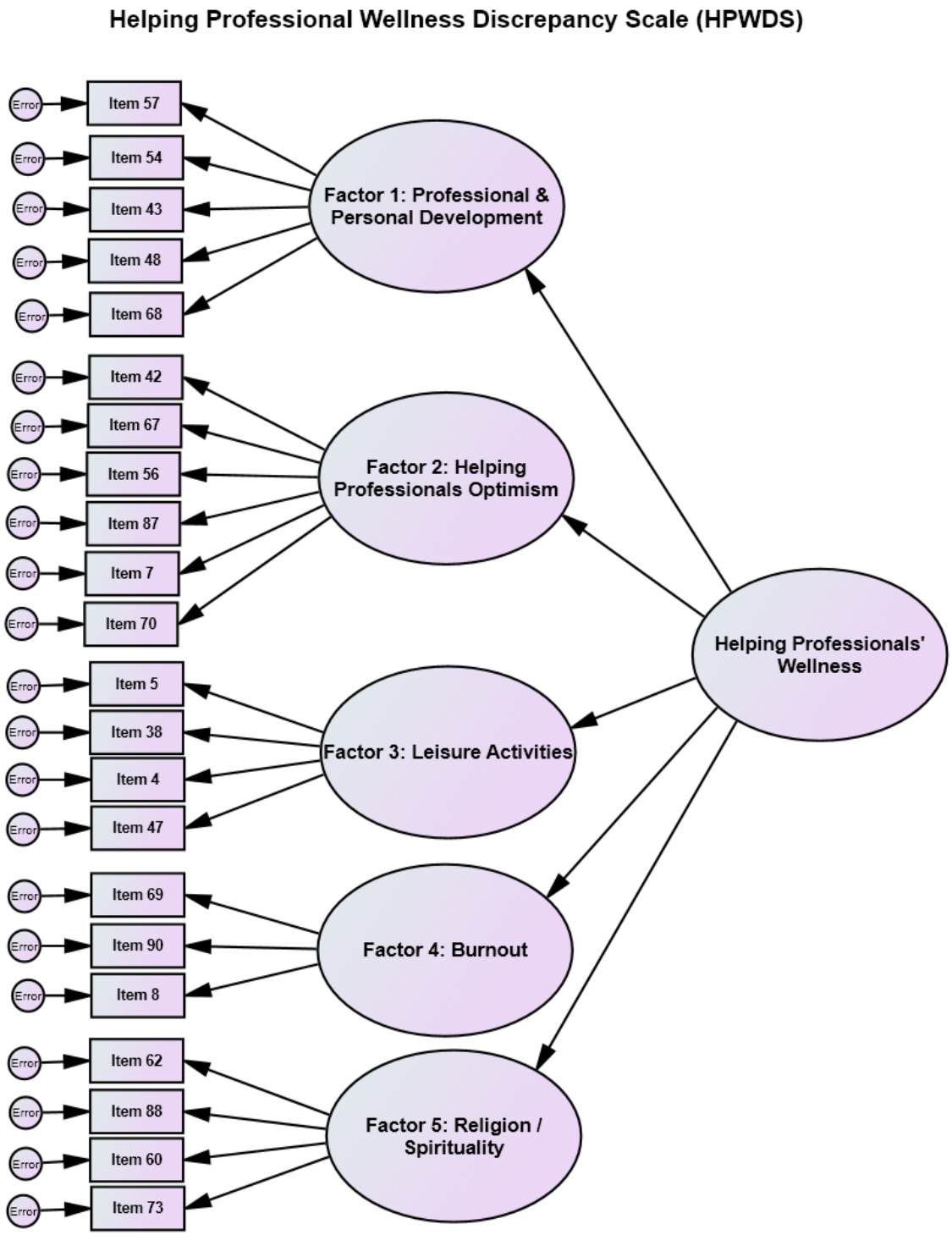


Figure 15: Path Diagram of HPWDS Model

Replication Analysis

In the social sciences, there is debate about EFA and the reliability of the outcomes (Ford et al., 1986; Henson & Roberts, 2006; Osborne & Fitzpatrick, 2012). Thus, the researcher chose to conduct an internal replication analysis to examine the stability of the final EFA solution (Research Question 1). In order to conduct an internal replication analysis, the researcher split the sample (N = 657) into two random samples (n = 328 and n = 328) and randomly deleted one participant in order to insure equal samples, with item/participant ratios around 15:1. Then, the researcher extracted standardized factor loadings from each sample and reviewed the loadings and structures for comparison. The initial replication criterion (structural replication) was satisfied as the items were identified for the same number of factors for both replication analysis samples (Osborne & Fitzpatrick, 2012) as well as the full EFA sample (HPWDS final model). In addition, the data split analysis confirmed the same factorial structure (same five factor model). Based on the replication analysis and conducting the squared difference (i.e., values above .04 are considered volatile), *all* HPWDS items were deemed strong and worth keeping (see table 11 for replication analysis). According to Osborne and Fitzpatrick (2012), conducting a replication analysis on EFA data supports the exploratory factor structure of model; therefore, the structure model for the HPWDS with these data was supported in threefold: (a) by theory, (b) by methodology, and (c) by internal replication analysis.

Research Question 2

For Research Question 2, the researcher computed Cronbach's to assess the internal consistency reliability of the HPWDS with these data. Computing Cronbach's alpha allows for assessing the degree of correlation between items on the HPWDS, and the researcher used a Cronbach's α value of .70 to indicate internal consistency of items (Mitchell & Jolley, 2004;

Sterner, 2003). The Cronbach's α value for the initial 92 items (*N* = 657) was calculated as .974. The Cronbach's α value for the 22-item total scale (*N* = 657) was .869. For Factor 1: *Professional & Personal Development Activities*, the Cronbach's α value was .892; for Factor 2: *Religion/Spirituality*, Cronbach's α value was .858; Factor 3: *Leisure Activities*, Cronbach's α value was .871; Factor 4: *Burnout*, Cronbach's α value was .841, and Factor 5: *Helping Professional Optimism*, Cronbach's α value was .824.

The Cronbach's α range falls between 0 and 1, with values closer to 0 representing low reliability and values closer to 1 representing higher reliability (DeVellis, 2013). By Assessing Cronbach's α of the HPWDS and analyzing the value for the total model as well as for the individual subscales, the researcher determined that the HPWDS has a strong internal consistency. For the research investigation, the researcher found *all* Cronbach α values to be above the recommended .70 value (Mitchell & Jolley, 2004), which indicated strong internal consistency within the final HPWDS 22-item model. In addition, the HPWDS Cronbach's alphas are comparable to the Cronbach's alphas of other leading wellness-related assessments in the literature (.80-.96, 5F-Wel; .67-.94, LAQ; .91; PWS). The HPWDS 22-item scale α value of .879 was comparable to cronbach α values of the 5F-Wel (Myers et al., 2004) that ranged from .80 to .96 (Myers et al., 2004; Myers & Sweeney, 2007; Sweeney & Witmer, 1992). The HPWDS scale α value (.879) was also comparable to the LAQ (NWI, 1983) Cronbach's α values ranging from .67 to .94 (Palombi, 1993; Richers, 1992). Finally, the PWS (Adams et al., 1997) α value of approximately .90 (Adams et al., 1998; Harari et al., 2005) was similar to the Cronbach's α value of the 22-item HPWDS.

Research Question 3

The researcher utilized a bivariate correlation to assess Research Question 3 and correlated the HPWDS final 22-items (split into their respective five factors) with the five subscales on the CBI (Lee et al., 2007). The researcher used a Spearman's rho bivariate correlation (as the data was non-normally distributed) to test for the divergent validity of the HPWDS. The Spearman's rho allowed the researcher to assess the correlations between the HPWDS factors and the CBI subscales of *Exhaustion*, *Incompetence*, *Uncooperative Work Environment*, *Devaluing Client*, and *Deterioration in Personal Life*. High scores in any of the CBI subscales indicated a burnout problem (Lee et al., 2007). For example, individual scores of 14 or higher indicated a burnout problem on the *Exhaustion*, *Uncooperative Work Environment*, and *Deterioration in Personal Life* subscales, a score of 12 or higher on the *Incompetence* subscale indicated burnout, and an individual score of 10 or higher indicated burnout on the *Devaluing Client* subscale of the CBI.

The relationships between the HPWDS items (grouped into factors) and *all* CBI subscales resulted in negative correlations (discriminant validity for the HPWDS scale), with the exception of the *Burnout* factor items: 8, 69, and 90 (see table 13). With *all* subscales on the CBI assessing helping professional burnout, it was logical that the three HPWDS items (8, 69, and 90) measuring burnout in the helping professional had positive correlations (convergent validity). HPWDS Item 8 (Are worn out because of the work you do as a helping professional), Item 69 (Experience exhaustion because of your work as a helping professional), and Item 90 (Experience stress form working as a helping professional) can *all* be labeled as influencing levels of burnout in the helping professional population (e.g., Freudenberger, 1974; Lee et al., 2007; Puig et al., 2012). In examining the relationship between the HPWDS and the CBIs

Exhaustion Subscale, *all* three positive correlations were large, statistically significant relationships; Item 69 (ρ = .630, p < .001; 39.6% of the variance explained), Item 90 (ρ = .608, p < .001; 36.9% of the variance explained), and Item 8 (ρ = .565, p < .001; 31.9% of the variance explained). For the relationship between the HPWDS and the CBIs Incompetence Subscale, *all* three had small, statistically significant relationships; Item 69 (ρ = .296, p < .001; 8.52% of the variance explained), Item 90 (ρ = .247, p < .001; 6.1% of the variance explained), and Item 8 (ρ = .287, p < .001; 8.24% of the variance explained). Of the HPWDS items with a positive correlation with Uncooperative Work Environment, *all* three had medium, statistically significant relationships; Item 69 (ρ = .339 p < .001; 11.5% of the variance explained), Item 90 (ρ = .368, p < .001; 13.54% of the variance explained), and Item 8 (ρ = .341, p < .001; 11.62% of the variance explained). Of the HPWDS items with a positive correlation with Devaluing Client, *all* three had small, statistically significant relationships; Item 69 (ρ = .183, p < .001; 3.35% of the variance explained), Item 90 (ρ = .205, p < .001; 4.20% of the variance explained), and Item 8 (ρ = .199, p < .001; 3.96% of the variance explained). Finally, of the HPWDS items with a positive correlation with Deterioration in Personal Life, *all* three had medium, statistically significant relationships; Item 69 (ρ = .471, p < .001; 22.18% of the variance explained), Item 90 (ρ = .411, p < .001; 16.89% of the variance explained), and Item 8 (ρ = .388, p < .001; 15.05% of the variance explained).

Lee and colleagues (2007) compared the CBI subscales with the MBI-HSS subscales (Maslach & Jackson, 1996) to provide evidence of convergent and criterion-related validity and found support for convergent validity through correlations with MBI-HSS (Maslach & Jackson, 1981) subscale scores, supporting that the CBI was assessing burnout in the participants. Lee and colleagues (2007) found the exhaustion subscale of the MBI-HSS as positively correlated with

the *Emotional Exhaustion* subscale of the CBI ($r = .73$, $p < .01$), which was similar to the HPWDS items correlating with the CBI *Emotional Exhaustion* subscale (correlations ranging from .565 to 630). In the Lee et al. (2007) investigation, the MBI-HSS was positively correlated to the *Negative Work Environment* subscale of the CBI ($r = .62$, $p < .01$), which was higher than the correlations between the CBI and the HPWDS items (correlations ranging from .339 - .368). The *Devaluing Client* subscale of the CBI and the MBI-HSS had a positive correlation ($r = .31$, $p < .01$) that was slightly higher than the correlations between the HPWDS items and the CBI (correlations ranging from .183 - .205). The *Incompetence* subscale of the CBI and the MBI-HHS in the Lee et al. (2007) study also had a positive correlation ($r = .30$, $p < .01$), which was similar to the HPWDS item correlations with the CBI (correlations ranging from .247 - .296). In addition, Lee and colleagues (2007) found the Depersonalization subscale of the MBI-HSS strongly correlated with the *Devaluing Client* subscale of the CBI ($r = .56$, $p < .01$) and the Personal Accomplishment subscale of the MBI-HSS was negatively correlated with the CBI subscales of *Incompetence*, *Devaluing Client*, and *Exhaustion* (Lee et al., 2007). As such, the results of Research Question 3 identified that the HPWDS *Burnout* factor items positively correlate with *all* the subscales of the CBI, supporting the convergent validity of the HPWDS Burnout factor with the CBI with these data.

The HPWDS *Burnout* factor items were also supported in the existing literature. According to Puig et al. (2012), burnout involves emotional exhaustion and depersonalization, which is similar to Item 69 (Experience exhaustion because of your work as a helping professional) on the HPWDS. Further, helping professionals experience job stressors (e.g., financial constraints, heavy caseloads, demands for shorter therapy options; O'Halloran & Linton, 2000), which supports inclusion of the HPWDS Item 90 (Experience stress form working

as a helping professional). Finally, prolonged periods of stress can lead to helping professional impairment and burnout and lead to deterioration of the quality of services clients receive (Lambie, 2007), which can also lead to helping professionals being worn out and tired of the work they are doing. Item 8 (Are worn out because of the work you do as a helping professional) is assessing for such impairment and is important in assessing burnout in the helping professions.

The relationships between the HPWDS Factor 1 (*Professional & Personal Development Activities*), Factor 2 (*Religion/Spirituality*), Factor 3 (*Leisure Activities*), and Factor 5 (*Helping Professional Optimism*) items and *all* CBI subscales resulted in negative correlations. Nineteen of the HPWDS items (all items except the three items measuring burnout) correlated negatively with the CBI subscales and support divergent validity of the HPWDS with the CBI. The HPWDS Factor 4 (*Burnout*) items correlated positively with the subscales on the CBI, thus supporting convergent validity of the HPWDS Burnout subscale. Therefore, because the HPWDS contains items assessing both wellness (Factors 1, 2, 3, and 5) and unwellness qualities (Factor 4), the researcher was able to establish preliminary discriminant and convergent validity by correlating items with the CBI subscales.

Research Question 4

To examine Research Question 4 (What are the relationships between helping professionals' HPWDS scores and their reported demographic data?), the researcher employed multiple linear regression (MLR) analysis. The purpose of a MLR is to explore the relationship or predictability between variables (Pallant, 2013; Tabachnick & Fidell, 2013). Specifically, the researcher explored the relationships between a dependent variable (DV; e.g., HPWDS factor) and several independent variables (IVs; e.g., demographic data such as participants' reported gender). The linear composite of the predictor variables (Gender, Ethnicity, Marital Status,

Helping Profession) predicted approximately 3.6% of the variance (r = .242; r^2 = .058) in HPWDS Factor 1 (*Professional & Personal Development Activities)*, F (15, 656) = 2.651, p < .001. Psychology accounted for the highest Beta value (β = .153, p < .001). The Hispanic/Latina/Latino Ethnicity accounted for the next highest Beta value (β = .152, p < .001). Thus, falling under the Psychology Helping Profession and being of Hispanic/Latina/Latino Ethnicity contributed more than other variables (as indicated by the β value). However, because the model variance was only 3.6%, the effect size is small and has *no* practical significance.

The linear composite of the predictor variables (Gender, Ethnicity, Marital Status, Helping Profession) predicted approximately 8.5% of the variance (r = .291; r^2 = .085) in HPWDS Factor 2 (*Religion/Spirituality)*, F (15, 656) = 3.967, p < .001. The Single Marital Status accounted for the highest Beta value (β = .238, p < .001). The Asian Ethnicity accounted for the next highest Beta value (β = .123, p < .01). Thus, falling under the Single Marital Status and being of Asian Ethnicity contributed more than other variables (as indicated by the β value). However, because the model variance was only 8.5%, the effect size is small and has *no* practical significance.

The linear composite of the predictor variables (Gender, Ethnicity, Marital Status, Helping Profession) predicted approximately 3.8% of the variance (r = .195; r^2 = .038) in HPWDS Factor 3 (*Leisure Activities*), F (15, 656) = 1.688, p < .05. The Male Gender accounted for the highest Beta value (β = .106, p < .01). The African American Ethnicity accounted for the next highest Beta value (β = .152, p < .05). Thus, falling under the Male Gender and being of African American Ethnicity contributed more than other variables (as indicated by the β value). However, because the model variance was only 3.8%, the effect size is small and has *no* practical significance.

The linear composite of the predictor variables (Gender, Ethnicity, Marital Status, Helping Profession) predicted approximately 7.8% of the variance (r = .279; r^2 = .078) in HPWDS Factor 4 (*Burnout*), F (15, 656) = 3.605, p < .001. The Single Marital Status accounted for the highest Beta value (β = .169, p < .001). The African American Ethnicity accounted for the next highest Beta value (β = .157, p < .001). Thus, falling under the Single Marital Status and being of African American Ethnicity contributed more than other variables (as indicated by the β value). However, because the model variance was only 7.8%, the effect size is small and has *no* practical significance.

The linear composite of the predictor variables (Gender, Ethnicity, Marital Status, Helping Profession) predicted approximately 3.4% of the variance (r = .185; r^2 = .034) in HPWDS Factor 5 (*Helping Professional Optimism*), F (15, 656) = 1.513, p > .05. The Single Marital Status accounted for the highest Beta value (β = .111, p < .001). The Asian Ethnicity accounted for the next highest Beta value (β = .083, p < .05). Thus, falling under the Single Marital Status and being of Asian Ethnicity contributed more than other variables (as indicated by the β value). However, because the model variance was only 3.4%, the effect size is small and has *no* practical significance.

Multiple Linear Regression (MLR) analyses between Factor 1 (*Professional & Personal Development Activities*), Factor 2 (*Religion/Spirituality*), Factor 4 (*Burnout*) and the general demographics (Gender, Ethnicity, Marital Status, and Helping Profession) resulted in statistically significant relationships at the p < .001 level. Factor 3 and the general demographics resulted in a statistically significant relationship at the p < .05 level and Factor 5 (*Helping Professional Optimism*) and the general demographics did not result in a statistically significant relationship p > .05. Though the researcher found four out of the five factors (Factors 1, 2, 3, 4) predicting

participant general demographic scores, all of the MLR analyses resulted in small (3.4% - 8.5%) effect sizes; limiting the practical significance of the results.

Research Question 5

The researcher correlated the MCSDS-X1 (Strahan & Gerbasi, 1979) with the HPWDS five factors. The MCSDS-X1 was used in order to assess the social desirability of participant answers as the MCSDS-X1 is suggested in the scale development literature to test for participant social desirability (Beretvas, Meyers, & Leite, 2002; Fisher & Fink, 1993). The MCSCS-X1 items that measure social desirability receive a score of 1, while items that are not measuring social desirability receive a score of 0 (participant scores ranging from 0 – 10). The researcher used Spearman's rho correlation coefficient due to the non-normality of the data, and analyzed the HPWDS factors with MCSDS-X1 items. The results are displayed in Table 14, which identified that HPWDS Factors 1, 2, 3, and 4 had a positive, yet small correlation with participants' (N = 657) total scores on the MCSDS-X1. Specifically, factor correlations were as follows: Factor 1, *Professional & Personal Development Activities* (ρ = .135, p < .01; 1.8% of the variance explained), Factor 2, *Religion/Spirituality* (ρ = .196, p < .01; 3.8% of the variance explained), Factor 3, *Leisure Activities* (ρ = .085, p < .05; .722% of the variance explained), and Factor 4, *Burnout* (ρ = .193, p < .01; 3.72% of the variance explained). Factor 5, *Helping Professional Optimism*, had a statistically insignificant, negative correlation with participants' MCSDS-X1 total scores (ρ = -.070, p > .05; 0.49% of the variance explained). Consequently, participants' answers on the HPWDS factors of (a) *Knowledge Activity*, (b) *Religion/Spirituality*, (c) *Helping Professional Optimism*, and (d) *Leisure Activities* had small, positive correlations with their MCSDS-X1 scores. The participants' scores of the HPWDS Burnout factor had a small, negative correlation with their scores on the MCSDS-X1. As a result, correlations were

identified between the participants' HPWDS scores and their MCSDS-X1 scores; however, the effect sizes were small, supporting the premise that social desirability did *not* have a strong relationship with the participants' scoring on the HPWDS.

Additional Findings

The researcher assessed participant discrepancies on the HPWDS in order to evaluate the differences (if any) between their perceived levels of wellness and their aspirational levels of wellness. By subtracting their perceived wellness scores (i.e., indicated by questions assessing "how often do you") from their aspirational wellness scores (i.e., indicated by questions assessing "how often do you want to"), the researcher was able to evaluate overall participant discrepancy levels. The largest participant discrepancy scores showed four point discrepancies (i.e., a four point difference between where they were currently (perceived wellness) and where they wanted to be (aspirational wellness). Although four was the greatest participant discrepancy, the average participant discrepancies fell between a 0 point discrepancy or no discrepancy and approximately a 1 point discrepancy between perceived and aspirational wellness. The overall average discrepancy was 0.75, indicating that the majority of participants had small discrepancies between where they were currently (perceived wellness) and where they aspired to be (aspirational wellness).

Looking at the participant discrepancies allows for implications for helping professionals. First off, the sample that participated in this research investigation appear to have small discrepancies between their perceived and aspirational levels of wellness. In other words, participants were relatively congruent in relation to their levels of wellness awareness between their actual selves (perceived wellness) and ideal selves (aspirational wellness). Secondly, because of such congruence, it can be posited that the present sample of helping professionals are

satisfied with their current amounts of wellness activities, behaviors, and experiences in the 5-Factor realms indicated on the HPWDS (*Burnout, Helping Professional Optimism, Leisure Activities, Professional & Personal Development, and Religion/Spirituality*). Finally, because of the correlational nature of the research investigation (does not equate to causation), though wellness discrepancies were small (M = 0.75), results do *not* indicate that participants were *well*; they equate to participants having low levels of wellness discrepancies.

Limitations of the Investigation

Limitations relating to Research Design

The researcher implemented a correlational design for the study (Gall et al., 2007) and as is the case with correlations, the researcher was unable to predict causality (Tabachnick & Fidel, 2013). Thus, the participants' results on the HPWDS as well as answers to specific items on the HWPDS do *not* mean that those actions caused wellness or unwellness. Furthermore, the five factors on the HPWDS (*Religion/Spirituality, Professional & Personal Development Activities, Leisure Activities, Helping Professional Optimism, and Burnout*) are *not* necessarily causing helping professionals to be well or unwell. Future researchers could use the HPWDS in studies investigating causality.

Another limitation of the research investigation was the self-report nature of the instruments. Participants answered *all* four instruments (i.e., CBI, HPWDS, and MCSDS-X1, general demographic form) directly, which might have influenced answers if participants' were answering in a socially desirable way. The researcher used the MCSDS-X1 (Strahan & Gerbasi, 1972); however, to assess for participant social desirability and mitigate the effects of self-reported nature of the instruments used in the study.

Sampling Limitations

The researcher attempted to gain a sample of 1,200 participants for the research investigation in order to have a strong participant to item ratio (*N*/*p* ratio) of 20:1 and provide enough participants to conduct an EFA-then-CFA data analysis. The researcher attempted to recruit participants via a variety of methods: (a) face-to-face, (b) mail out, and (c) email/online. However, the researcher was only able to obtain a sample of $N = 657$ participants, so a decision was made to run only an EFA in order to start the HPWDS development with a strong participant to item ratio (approximately 17:1). The researcher implemented a number of steps to support achieving a good response rate. For instance, the researcher acquired participants in several manners to promote rigorous sampling methodology (i.e., face-to-face administration, mail out administration, online/email administration). Furthermore, for the mail out administration and online/email administration the researcher employed Dillman's *Tailored Design Method* (Dillman et al., 2009) with three email or mail contacts in order to support the methodological rigor of sampling and aid in increasing the response rate of participants in the study.

A second limitation of the sampling involves the generalizability of the data. The sampling criterion for the research investigation specified participants who were helping professionals (i.e., counselors, psychologists, social workers, counselors-in-training, psychologists-in-training, and social workers-in-training) but equal representations of each area were not achieved. Moreover, the researcher attempted to recruit equal representations of counselors, psychologists, and social workers, but the final participant sample was made up of 271 Counselors (41.2%), 218 Psychologists (33.2%), 157 Social Workers (23.9%), and 11 individuals identifying as Other (1.7%). Further, the researcher initially attempted to recruit counselors-in-training, psychologists-in-training, and social workers-in-training for the study, but

was only able to enter the classrooms of the counselors-in-training students to recruit the helping professionals-in-training sample. As a result, all helping professionals-in-training were counseling students and thus, results might *not* be generalizable to psychology and social work students. Additionally, participants were from a narrow range of geographical locations (South and South East) and thus, do *not* represent *all* helping professionals in the United States. Further, sample demographics were *not* diverse (based on varying ethnicities, gender, and educational status) and consequently, perspectives from a variety of cultures, ages, or education levels may *not* have been achieved. However, when looking at other research in the helping professions (Hattie et al., 2004; Maher et al., 2012; Ryff & Keyes, 1998), many professionals are of Caucasian ethnicity and female gender and therefore the generalizability of the findings may *not* be an issue of concern.

Instrumentation Limitations

The researcher used three instruments in the research investigation: (a) the HPWDS; (b) the MCSDS-X1 (Strahan & Gerbasi, 1979); and (c) the CBI (Lee et al., 2007) and a general demographic questionnaire that was developed by the researcher. The assessment packets that were administered to the development sample consisted of four assessments and a total of 229 items. As a result, participants may have experienced fatigue when filling out the packets, which could have resulted in some participants *not* completing the packets, participant attrition, and participants falsely responding to items. Though the researcher tested the assessment packets prior to sending to the development sample and found it took approximately 15 – 25 minutes to complete, the length of the assessment packets could have been a limitation of the study.

An additional instrumentation limitation involves item loss due to the researcher potentially overlooking items relating to wellness while creating the HPWDS. Furthermore, the

researcher may have removed items based on statistical suggestions (Crocker & Algina, 2006; DeVellis, 2012; Dimitrov, 2012; Tabachnick & Fidel, 2013) such as values having low communalities or cross-loading on factors. Thus, items may have been removed that actually measure helping professional wellness. Furthermore, by choosing to retain three factors that had communalities under the suggested .5 value (Pallant, 2013; Tabachnick & Fidel, 2013), the researcher may have influenced the final statistics of the HPWDS model (e.g., the Eigenvalues of the factors, variance accounted for). By following literature suggestions for scale development however, the researcher attempted to insure the most reliable, concise, and correlated measure for assessing the discrepancies in helping professional wellness.

Recommendations for Future Research

The researcher provides recommendations for future research to be conducted with the HPWDS, including (a) conducting additional factor analysis (FA) studies; (b) using the HPWDS with diverse samples, (c) conducting an EFA with a larger sample; (d) conducting a qualitative, grounded theory investigation; (e) cross-validating the HPWDS with additional wellness and unwellness assessments; and (f) conducting a longitudinal study to assess if the HPWDS is sensitive to participant change over time.

First, because an EFA was the only form of FA to be completed, there is a need for confirmatory factor analysis (CFA) to be completed in order to further support and confirm the HPWDS model. Second, the researcher suggests using the HPWDS with different populations in order to test the model fit and explore if the five current factors stand with a different sample. Examples of diverse samples to norm the HPWDS with include: (a) other helping professionals (e.g., teachers and nurses); (b) athletes and former student athletes; and (c) college administrators. Third, researchers could attempt to increase the sample size for the HPWDS in

order to have a strong (i.e., 20:1) participant to item ratio for an EFA or CFA investigation. Fourth, future researchers could work backwards from the development of the HPWDS and conduct a grounded theory investigation in order to build up a theory surrounding the HPWDS model from the ground up.

An additional area for future research involves validating the HPWDS with other wellness and unwellness instruments. Specifically, researchers could put the HPWDS up against other common wellness assessments such as the: 5F-Wel (Myers et al., 2004) and the PWS (Adams et al., 1997) and/or common unwellness assessments such as the: MBI-HSS (Maslach & Jackson, 1996) and the *Copenagen Burnout Inventory* (Kristensen et al., 2005) to assess for convergent and discriminant validity. Finally, future researchers could conduct longitudinal studies assessing the HPWDS with a population of helping professionals over a time period. From the longitudinal studies, researchers may be able to assess if participant scores on the HPWDS are sensitive to change.

Implications

The findings from the research investigation contribute to the current literature on wellness in the helping professions (i.e., counseling, psychology, social work). The present research investigation generated a theoretically and methodologically sound instrument for assessing wellness discrepancies in helping professionals. As stated, ACA (2014), APA (2010), and CACREP (2009) *all* support the idea of monitoring helping professional wellness. Thus, using the HPWDS allows for individuals to assess their areas of wellness strengths (low discrepancies between where they are and where they would like to be) and wellness areas for growth (high discrepancies between where they are and where they would like to be) and follow appropriate ethical and theoretical standards for being an effective helping professional.

The findings in Research Question 1 support the idea of a five factor wellness assessment allowing helping professionals to evaluate themselves in Factor 1 (*Professional & Personal Development Activities*), Factor 2 (*Religion/Spirituality*), Factor 3 (*Leisure Activities*) Factor 4 (*Burnout*), and Factor 5 (*Helping Professional Optimism*). The researcher found strong support based on statistical methods used in Research Question 1 and Research Question 2 (i.e., factor analysis, Cronbach's alpha) through discriminant validity in Research Question 3 (correlation with CBI) for the HPWDS factor structure and the items comprising the scale. Thus, a sound 22-item scale for assessing wellness discrepancies between perceived and aspirational wellness was created for use in the helping professions.

Based on the data in the research investigation, helping professionals should be aware of both the personal and professional activities they are engaging in to increase their knowledge and self-efficacy, as well as their leisure activity engagement. Both undertakings appear to be important to helping professionals in the current research study. Additionally, helping professionals need to be aware of how their levels of optimism regarding their personal lives as well as their clients' lives influence their own well-being. Similarly, helping professionals need to be aware of their risks for burnout (i.e., what might contribute to them becoming burned out) based off of the results of the research investigation. Finally, religion and/or spirituality plays an integral part in helping professional wellness awareness and thus, helping professionals should be mindful of the role and importance spiritualty and religion play in their own lives.

Following additional research studies, the HPWDS may be used in helping professional preparation programs as a tool for educators to assess their own wellness discrepancies as well as the wellness discrepancies of their students. Ultimately, the HPWDS could be used as a tool to help increase the awareness surrounding different paradigms of well-being and aid individuals in

not only assessing their personal wellness and/or unwellness, but as a vessel to promote positive lifestyle changes where necessary. Counselor preparation programs could use the five factors identified by the researcher in this research study (*Religion/Spirituality*, *Helping Professional Optimism*, *Burnout*, *Leisure Activities*, and *Professional & Personal Development Activities*) to assess wellness discrepancies in their students. Such assessments could serve as awareness-building activities for students to increase their overall well-being. Furthermore, the HPWDS could be used as a preliminary assessment (during student orientation), as a check-in tool mid-way through the program, and as at the end of the program to insure student growth and development in the respective wellness realms.

Finally, based off of the results of the research investigation it would be advantageous for researchers to use the scale development procedures, rigorous sampling methodologies, and FA guidelines outlined throughout Chapters 3 and 4 when developing new assessments for evaluating helping professionals. Researchers who are studying wellness are encouraged to examined the five factors of: (a) *Religion/Spirituality*, (b) *Helping Professional Optimism*, (c) *Burnout*, (d) *Leisure Activities*, and (e) *Professional & Personal Development Activities* when assessing individual wellness discrepancies within the helping professions. Though the wellness literature supports *golden standards* of wellness (e.g., individuals must do certain things in order to be considered well) such as partaking in exercise, eating nutritionally, finding life balance, and getting appropriate hours of sleep for example, the researcher suggests that it is more important to look at individual discrepancies between their perceived wellness (how well they think they are) and their aspirational wellness (how well they wish they were). Examining the discrepancies between perceived and aspirational wellness can promote awareness in helping professionals and allow for individuals to learn about their areas of wellness strengths, as well as areas for personal

growth. As such, increasing awareness and personal knowledge on wellness can promote a autogenic nature in the helping professions and serve as an agent for change towards preventing helping professional burnout or unwellness, rather than the timely, expensive, and exhaustive pathogenic idea of treating illness/concerns after they occur.

Chapter Five Summary

Chapter 5 summarizes the research findings for the four research questions discussed in detail in Chapter 4. The development and validation of the HPWDS with a sample of helping professionals was completed. Given the limitations of the study however, caution should be used when considering use of the HPWDS with populations other than the normed sample. Furthermore, the findings in the investigation lead to future research endeavors centering on wellness in the helping professions and across other professions. The results of the research study provide implications for the helping professions and add to the existing literature on wellness and unwellness.

APPENDIX A: UNIVERSITY OF CENTRAL FLORIDA INSTITUTIONAL REVIEW FORM

University of Central Florida

University of Central Florida Institutional Review Board
Office of Research & Commercialization
12201 Research Parkway, Suite 501
Orlando, Florida 32826-3246
Telephone: 407-823-2901 or 407-882-2276
www.research.ucf.edu/compliance/irb.html

Approval of Exempt Human Research

From: **UCF Institutional Review Board #1**
FWA00000351, IRB00001138

To: **Ashley Blount**

Date: **August 13, 2014**

Dear Researcher:

On 8/13/2014, the IRB approved the following activity as human participant research that is exempt from regulation:

Type of Review:	Exempt Determination
Project Title:	The Helping Professional Wellness Discrepancy Scale (HPWDS): Development and Validation
Investigator:	Ashley Blount
IRB Number:	SBE-14-10484
Funding Agency:	
Grant Title:	
Research ID:	N/A

This determination applies only to the activities described in the IRB submission and does not apply should any changes be made. If changes are made and there are questions about whether these changes affect the exempt status of the human research, please contact the IRB. When you have completed your research, please submit a Study Closure request in iRIS so that IRB records will be accurate.

In the conduct of this research, you are responsible to follow the requirements of the Investigator Manual.

On behalf of Sophia Dziegielewski, Ph.D., L.C.S.W., UCF IRB Chair, this letter is signed by:

Signature applied by Joanne Muratori on 08/13/2014 04:22:31 PM EDT

Joanne Muratori

IRB Coordinator

APPENDIX B: UNIVERISTY OF CENTRAL FLORIDA INSTITUTIONAL REVIEW FORM ADDENDUM

University of Central Florida Institutional Review Board
Office of Research & Commercialization
12201 Research Parkway, Suite 501
Orlando, Florida 32826-3246
Telephone: 407-823-2901 or 407-882-2276
www.research.ucf.edu/compliance/irb.html

Approval of Exempt Human Research

From: **UCF Institutional Review Board #1**
FWA00000351, IRB00001138

To: **Ashley Blount**

Date: **November 06, 2014**

Dear Researcher:

On 11/06/2014, the IRB approved the following minor modifications to human participant research that is exempt from regulation:

Type of Review:	Exempt Determination
Modification Type:	Uniform sample letters that will be used at three points in the data collection process, per Dillman's Methodology, have been uploaded in iRIS. In addition, the most updated version of the Helping Professional Wellness Discrepancy Scale (HPWDS) has been uploaded.
Project Title:	The Helping Professional Wellness Discrepancy Scale (HPWDS): Development and Validation
Investigator:	Ashley Blount
IRB Number:	SBE-14-10484
Funding Agency:	
Grant Title:	
Research ID:	N/A

This determination applies only to the activities described in the IRB submission and does not apply should any changes be made. If changes are made and there are questions about whether these changes affect the exempt status of the human research, please contact the IRB. When you have completed your research, please submit a Study Closure request in iRIS so that IRB records will be accurate.

In the conduct of this research, you are responsible to follow the requirements of the Investigator Manual.

On behalf of Sophia Dziegielewski, Ph.D., L.C.S.W., UCF IRB Chair, this letter is signed by:

Joanne Muratori

Signature applied by Joanne Muratori on 11/06/2014 04:19:47 PM EST

IRB Coordinator

APPENDIX C: EXPLANATION OF RESEARCH

Version 1.0 10-21-2009

University of Central Florida

EXPLANATION OF RESEARCH

Title of Project: The Helping Professional Wellness Discrepacy Scale (HPWDS): Development and Validation

Principal Investigator: Ashley J. Blount
Faculty Supervisor: Glenn W. Lambie, Ph.D.

You are being invited to participate in a research study. Whether you take part is up to you as participation in the research study is *voluntary*.

Purpose of the study: The purpose of developing the HPWDS is to examine the psychometric properties of wellness (as measured by the HPWDS) in a sample of helping professionals (i.e., psychologists, social workers, and counselors). Helping professional wellness is integral in promoting sound, efficacious work with clients. The development of a psychometrically sound assessment to measure wellness will aid in promoting health and wellness in helping professionals as well as promoting awareness about the discrepancy between perceived and aspirational levels of wellness.

What you will be asked to do in the study: Participants who choose to partake in the research study will be asked to participate Please note that the information obtained in this research may be used in future research. You will be asked to complete a set of questions relating to your wellness.

Time required: We expect that you will be in this research study for no more than 45 minutes.

Age requirement: You must be 18 years of age or older to take part in this research study.

Study contact for questions about the study or to report a problem: If you have questions, concerns, or complaints, or think the research has impacted you negatively in any way, talk to: Ashley J. Blount, Graduate Student, Counselor Education Program, College of Education and Human Performance, (715) 360-2750 or by email at ashleyiwindt@knights.ucf.edu or Dr. Glenn W. Lambie, Faculty Supervisor, Department of Education and Human Performance (407) 823-4779 or by email at Glenn.Lambie@ucf.edu.

IRB contact about your rights in the study or to report a complaint: Research at the University of Central Florida involving human participants is carried out under the oversight of the Institutional Review Board (UCF IRB). This research has been reviewed and approved by the IRB. For information about the rights of people who take part in research, please contact: Institutional Review Board, University of Central Florida, Office of Research & Commercialization, 12201 Research Parkway, Suite 501, Orlando, FL 32826-3246 or by telephone at (407) 823-2901.

APPENDIX D: GENERAL DEMOGRAPHIC FORM

General Demographic Questionnaire

Blount, 2014

ID #: _____ **Date:** _____

Directions: Please circle only one answer or fill in the blank.

1. What Helping Professional group do you fall under?

   A. Counseling
   B. Psychology
   C. Social Work
   D. Other _____

2. What is your gender?

   A. Female
   B. Male
   C. Other _____

3. What is your current marital status?

   A. Divorced
   B. Married
   C. Single
   D. Separated
   E. Widowed
   F. Other _____

4. What is your current employment status?

   A. Employed full timed
   B. Employed part time
   C. Not working
   D. Retired, not working
   E. Retired, working part time
   F. Student

5. What ethnicity do you most closely identify with?

   A. African American
   B. Asian
   C. Caucasian
   D. Hispanic/Latina/Latino
   E. Native American
   F. Other _____

Please continue on the next page…

General Demographic Questionnaire

Blount, 2014

6. What is your primary theoretical orientation?

A. Adlerian
B. Behavioral
C. Cognitive Behavioral
D. Eclectic/Integrative
E. Existential
F. Psychoanalytic
G. Rogerian/Client Centered
H. Systemic
I. Other _____

---

7. What is the highest level of education and degree you have completed?

A. Bachelor's Degree in _____
B. Master's Degree in _____
C. Ed.D. in _____
D. PsyD in _____
D. Ph.D. in _____
E. M.D. in _____
F. Other _____

---

8. How many years have you been working in the field as a Helping Professional?

A. 0 – 2 years
B. 3 – 5 years
C. 6 – 8 years
D. 9 – 11 years
E. 12 or more years

---

9. As a Helping Professional, what is the primary population you serve?

A. Infants (0 – 2 years)
B. Children (3 – 9 years)
C. Pre-Adolescents (10 – 12 years)
D. Adolescents (13 – 17 years)
E. Early Adults (18 – 30 years)
F. Middle Adults (31 – 55 years)
G. Older Adults (56 – 70 years)
H. Senior Adults (71 years and above)

---

10. What licenses or certificates do you possess? _____

Please continue on the next page…

General Demographic Questionnaire

Blount, 2014

Directions: For the remaining questions, please circle the answer that best fits your current level of well-being.	Low	Below Average	Average	Above Average	High
11. Please rate your level of physical well-being.	1	2	3	4	5
12. Please rate your level of social well-being.	1	2	3	4	5
13. Please rate your level of occupational well-being.	1	2	3	4	5
14. Please rate your level of emotional well-being.	1	2	3	4	5
15. Please rate your level of spiritual well-being.	1	2	3	4	5

Thank You For Completing The General Demographic Questionnaire!!!

Please Provide Any Additional Comments

APPENDIX E: HELPING PROFESSIONAL WELLNESS DISCREPANCY SCALE (HPWDS) FINAL FORM

Helping Professional Wellness Discrepancy Scale (HPWDS) Please review the following items and report (circle) how often you ***do*** and how often you ***want to*** engage in the activities or experience the feelings per week.	**How often do you?**					**How often do you want to?**				
	0 – 2 times	**3 – 5 times**	**6 – 8 times**	**9 – 11 times**	**12 or more times**	**0 – 2 times**	**3 – 5 times**	**6 – 8 times**	**9 – 11 times**	**12 or more times**
	↓	↓	↓	↓	↓	↓	↓	↓	↓	↓
1. Partake in activities to further your knowledge as a helping professional	1	2	3	4	5	1	2	3	4	5
2. Feel like you are making a difference as a helping professional	1	2	3	4	5	1	2	3	4	5
3. Immerse yourself in leisure activity/activities with which you participate	1	2	3	4	5	1	2	3	4	5
4. Have religious or spiritual beliefs that you feel are sustaining	1	2	3	4	5	1	2	3	4	5
5. Experience exhaustion because of your work as a helping professional	1	2	3	4	5	1	2	3	4	5
6. Partake in activities to further your knowledge in an area of your choice	1	2	3	4	5	1	2	3	4	5
7. Believe that your contributions as a helping professional matter	1	2	3	4	5	1	2	3	4	5
8. Engage in free-time/leisure activity (i.e., time spent away from work or chores)	1	2	3	4	5	1	2	3	4	5
9. Engage in prayer (e.g., praying)	1	2	3	4	5	1	2	3	4	5
10. Believe that your contributions as a helping professional matter	1	2	3	4	5	1	2	3	4	5
11. Take the initiative to learn about new research in the helping professions	1	2	3	4	5	1	2	3	4	5
12. Experience optimism about client's futures	1	2	3	4	5	1	2	3	4	5
13. Partake in enjoyable activities (i.e., things you enjoy doing)	1	2	3	4	5	1	2	3	4	5

Please Continue On The Next Page...

Helping Professional Wellness Discrepancy Scale (HPWDS) Please review the following items and report (circle) how often you ***do*** and how often you ***want to*** engage in the activities or experience the feelings per week.	**How often do you?**					**How often do you want to?**				
	0 – 2 times	**3 – 5 times**	**6 – 8 times**	**9 – 11 times**	**12 or more times**	**0 – 2 times**	**3 – 5 times**	**6 – 8 times**	**9 – 11 times**	**12 or more times**
	↓	↓	↓	↓	↓	↓	↓	↓	↓	↓
14. Experience satisfaction with your spiritual or religious activity	1	2	3	4	5	1	2	3	4	5
15. Experience optimism about client's futures	1	2	3	4	5	1	2	3	4	5
16. Engage in activities to advance your knowledge (e.g., reading, writing)	1	2	3	4	5	1	2	3	4	5
17. Experience satisfaction in your life	1	2	3	4	5	1	2	3	4	5
18. Find time to relax	1	2	3	4	5	1	2	3	4	5
19. Meditate with a focus on a higher power or spiritual entity	1	2	3	4	5	1	2	3	4	5
20. Take time to advance your professional development (i.e., attend conferences or seminars)	1	2	3	4	5	1	2	3	4	5
21. Experience happiness	1	2	3	4	5	1	2	3	4	5
22. Experience optimism about your future	1	2	3	4	5	1	2	3	4	5

Thank you for taking this Questionnaire!!!

APPENDIX F: THE COUNSELOR BURNOUT INVENTORY (CBI)

Counselor Burnout Inventory
Counselor Education Program
University of Arkansas

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

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

Preliminary Scoring Information for the Counselor Burnout Inventory

This inventory is designed to assess the five dimensions of counselor burnout.

Dimension 1 = Exhaustion

Item 1 ( ) + Item 6 ( ) + Item 11 ( ) + Item 16 ( ) = Total ( )

Dimension 2 = Incompetence

Item 2 ( ) + Item 7 ( ) + Item 12 ( ) + Item 17 ( ) = Total ( )

Dimension 3 = Uncooperative Work Environment

Item 3 ( ) + Item 8 ( ) + Item 13 ( ) + Item 18 ( ) = Total ( )

Dimension 4 = Devaluing Client

Item 4 ( ) + Item 9 ( ) + Item 14 ( ) + Item 19 ( ) = Total ( )

Dimension 5 = Deterioration in Personal Life

Item 5 ( ) + Item 10 ( ) + Item 15 ( ) + Item 20 ( ) = Total ( )

Name:_____ **Gender:**_____ **Age:**_____

	Exhaustion	Incompetence	Uncooperative Work Environment	Devaluing Client	Deterioration in Personal Life
90%	17	15	17	11	17
	16	14	16		16
80%	15	13	15	10	15
	14	12	14		14
70%			13	9	13
	13	11	12		12
60%				8	
	12	10	11		11
50%				7	
	11	9	10		10
40%				6	
	10	8	9		9
30%				5	
	9	7	8		8
20%	8		7	4	7
	7	6	6		6
10%	6	5	5		5
	5	4	4		4

	Burnout Problem
	Potential Burnout Probelm
	Good

APPENDIX G: MARLOWE CROWN SOCIAL DESIRABILITY SCALE-X1 (MCSDS-X1)

Marlowe Crowne Social Desirability Scale – X1 (MCSDS – X1)
Strahan & Gerbasi (1972)

Directions: Please answer true or false.		**True**	**False**
1. I'm always willing to admit it when I make a mistake		**T**	**F**
2. I always try to practice what I preach		**T**	**F**
3. I never resent being asked to return a favor		**T**	**F**
4. I have never been irked when people expressed ideas very different from my own		**T**	**F**
5. I have never deliberately said something that hurt someone's feelings		**T**	**F**
6. I like to gossip at times		**T**	**F**
7. There have been occasions when I took advantage of someone		**T**	**F**
8. I sometimes try to get even rather than forgive and forget		**T**	**F**
9. At times I have really insisted on having things my own way		**T**	**F**
10. There have been occasions when I felt like smashing things		**T**	**F**

APPENDIX H: EMAIL RECRUITMENT LETTER ONE

UCF College of Education and Human Performance

October 1st, 2014

Good morning ${m://FirstName},

You are being invited to take part in a research study that I (Ashley Blount, Doctoral Candidate) am conducting at the University of Central Florida. I am asking individuals like you to reflect on your experiences and behaviors with wellness as helping professionals.

Your responses to the survey are very important and will aid in advancing research on wellness in the helping professions. Whether you take part in the investigation is up to you, as participation in the research study is completely *voluntary*. Below is the purpose of the study, what you will be asked to do for the study, and participant criteria for the study.

Purpose of the study: The purpose of developing the Helping Professional Wellness Discrepancy Scale (HPWDS) is to examine the psychometric properties of wellness (as measured by the HPWDS) in a sample of helping professionals (i.e., psychologists, social workers, and counselors). Helping professional wellness is integral in promoting sound, efficacious work with clients. The development of a psychometrically sound assessment to measure wellness will aid in promoting health and well-being in helping professionals as well as promoting awareness about the discrepancy between perceived and aspirational levels of wellness.

What you will be asked to do in the study: Participants who choose to participate in the research study will be asked to answer questions relating to wellness. The total time to complete the questions is approximately 25 minutes. Please click on the link below to go to the survey website (or copy and paste the survey link into your Internet browser) and then enter the personal access code to begin the survey.
Follow this link to the Survey:
${l://SurveyLink?d=Take the Survey}
Or copy and paste the URL below into your internet browser:
${l://SurveyURL}
Personal Access Code: ${m://ExternalDataReference}

Criteria for the study: Participants must be at least 18 years of age and identify as a helping professional (i.e., counselor, psychologist, social worker, counselor-in-training, psychologist-in-training, or social worker-in-training).

Study contact for questions about the study or to report a problem: I appreciate your time and consideration in completing the survey. Thank you for participating in the research investigation! If you have questions, concerns, or complaints, or think the research has impacted you negatively in any way, please contact Ashley J. Blount (715-360-2750; ashleyjwindt@knights.ucf.edu), Doctoral Candidate, Counselor Education Program, College of Education and Human Performance or Dr. Glenn W. Lambie (407-823-4779; Glenn.Lambie@ucf.edu), Faculty Supervisor, Department Child, Family, and Community Sciences.

IRB contact about your rights in the study or to report a complaint: Research at the University of Central Florida involving human participants is carried out under the oversight of the Institutional Review Board (UCF IRB). This research has been reviewed and approved by the IRB. For information about the rights of people who take part in research, please contact: Institutional Review Board, University of Central Florida, Office of Research & Commercialization, 12201 Research Parkway, Suite 501, Orlando, FL 32826-3246 or by telephone at (407) 823-2901.

Many thanks,

Ashley J. Blount
Doctoral Candidate
University of Central Florida

Dr. Glenn W. Lambie
Professor and Department Chair
University of Central Florida

APPENDIX I: EMAIL RECRUITMENT LETTER TWO

UCF College of Education and Human Performance

October 15th, 2014

Good afternoon ${m://FirstName},

You are being invited to take part in a research study that I (Ashley Blount, Doctoral Candidate) am conducting at the University of Central Florida. I am asking individuals like you to reflect on your experiences and behaviors with wellness as helping professionals.

Your responses to the survey are very important and will aid in advancing research on wellness in the helping professions. Whether you take part in the investigation is up to you, as participation in the research study is completely voluntary. Below is the purpose of the study, what you will be asked to do for the study, and participant criteria for the study.

Purpose of the study: The purpose of developing the Helping Professional Wellness Discrepancy Scale (HPWDS) is to examine the psychometric properties of wellness (as measured by the HPWDS) in a sample of helping professionals (i.e., psychologists, social workers, and counselors). Helping professional wellness is integral in promoting sound, efficacious work with clients. The development of a psychometrically sound assessment to measure wellness will aid in promoting health and well-being in helping professionals as well as promoting awareness about the discrepancy between perceived and aspirational levels of wellness.

What you will be asked to do in the study: Participants who choose to participate in the research study will be asked to answer questions relating to wellness. The total time to complete the questions is approximately 25 minutes. Please click on the link below to go to the survey website (or copy and paste the survey link into your Internet browser) and then enter the personal access code to begin the survey.
Follow this link to the Survey:
${l://SurveyLink?d=Take the Survey}
Or copy and paste the URL below into your internet browser:
${l://SurveyURL}
Personal Access Code: ${m://ExternalDataReference}

Criteria for the study: Participants must be at least 18 years of age and identify as a helping professional (i.e., counselor, psychologist, social worker, counselor-in-training, psychologist-in-training, or social worker-in-training).

Study contact for questions about the study or to report a problem: I appreciate your time and consideration in completing the survey. Thank you for participating in the research investigation! If you have questions, concerns, or complaints, or think the research has impacted you negatively in any way, please contact Ashley J. Blount (715-360-2750; ashleyjwindt@knights.ucf.edu), Doctoral Candidate, Counselor Education Program, College of Education and Human Performance or Dr. Glenn W. Lambie (407-823-4779; Glenn.Lambie@ucf.edu), Faculty Supervisor, Department Child, Family, and

Community Sciences.

IRB contact about your rights in the study or to report a complaint: Research at the University of Central Florida involving human participants is carried out under the oversight of the Institutional Review Board (UCF IRB). This research has been reviewed and approved by the IRB. For information about the rights of people who take part in research, please contact: Institutional Review Board, University of Central Florida, Office of Research & Commercialization, 12201 Research Parkway, Suite 501, Orlando, FL 32826-3246 or by telephone at (407) 823-2901.

Many thanks,

Ashley J. Blount
Doctoral Candidate
University of Central Florida

Dr. Glenn W. Lambie
Professor and Department Chair
University of Central Florida

APPENDIX J: EMAIL RECRUITMENT LETTER THREE

UCF College of Education and Human Performance

November 25, 2014

Good afternoon ${m://FirstName},

I recently sent you an email asking you to participate in a research study by completing a brief survey about your interests and experiences with wellness. I understand how valuable your spare time is and appreciate you taking the time to participate in our research investigation. I am hoping you may be able to give about 20 minutes of your time to help us collect important information for the University of Central Florida on the wellness of helping professionals.

If you have already completed this questionnaire, I thank you for your participation. If you have not yet responded, I would like to ask you to please take the time to complete the survey. I plan to close the study in two weeks, so I wanted to extend a final email to individuals who have not yet had the chance to respond to make sure you had a chance to participate. If you would like to participate please click the link below and enter your personalized access code. If you would like to opt out of this investigation, please click the "opt out" link at the bottom of the survey.

Please click on the link below to go to the survey website (or copy and paste the survey link in your Internet browser) and then enter your personal access code to begin the survey.

Follow this link to the Survey:
${l://SurveyLink?d=Take the Survey}
Or copy and paste the URL below into your internet browser:
${l://SurveyURL}

Personal Access Code: ${m://ExternalDataReference}

Thank you so much for completing the survey. Your responses are important and essential in furthering wellness research in the helping professions. Have a wonderful day.

Sincerely,

Ashley J. Blount
Doctoral Candidate
University of Central Florida

Follow the link to opt out of future emails:${l://OptOutLink?d=Click here to unsubscribe}

1 of 1

APPENDIX K: MAILOUT PRE-NOTICE LETTER ONE

UCF College of Education and Human Performance

October 1st 2014

Dear Helping Professional,

I am writing to ask for your help with an important study being conducted by the University of Central Florida (UCF) to understand the quality of wellness in helping professionals. Wellness is an important component of offering quality and effective services to the individuals' in which we help. In the next few days you will receive a request to participate in this project by answering questions about your experiences with wellness and unwellness.

I would like to do everything I can to make it easy and enjoyable for you to participate in the study. I am writing in advance because many people like to know ahead of time that they will be asked to fill out a questionnaire. Moreover, this research can only be successful with the generous help of individuals like you.

I hope you will take 20-25 minutes of your time to help us with this meaningful investigation. Most of all, I hope that you enjoy the questionnaire and the opportunity as a helping professional to voice your thoughts, opinions, and experiences about your wellness.

All the Best,

Ashley J. Blount
University of Central Florida Doctoral Student

APPENDIX L: MAILOUT LETTER TWO

UCF College of Education and Human Performance

October 10th, 2014

Greetings,

I am writing to ask for your help in understanding the quality of wellness in helping professionals (counselors, psychologists, and social workers). I, along with the support of the University of Central Florida (UCF) am interested in learning more about the wellness of individuals who work in the helping professions. The best way we have of learning about wellness experiences is by asking all different kinds of individuals to share their thoughts and opinions. Your address is one of only a small number that have been randomly selected to help in this study.

The questions should only take about 20 minutes to complete. Your responses are completely *voluntary* and will be kept confidential. Your names are not on our mailing list, and your answers will never be associated with your mailing address. In addition, you will be provided a code for your survey responses to further insure your confidentiality.

If you have any questions about this survey assessing the experiences of wellness of helping professionals, please call Ashley Blount, the study director, by telephone at (715) 360-2750 or by email at ashleyjwindt@knights.ucf.edu. This research has been reviewed and approved by the Institutional Review Board at UCF. For information about the rights of people who take part in research, please contact: Institutional Review Board, University of Central Florida, Office of Research & Commercialization, 12201 Research Parkway, Suite 501, Orlando, FL 32826-3246 or by telephone at (407) 823-2901.

By taking a few minutes to share your thoughts, opinions, and experiences about your wellness as a helping professional you will be helping us out a great deal and we appreciate you taking the time to take our questionnaire.

I hope you enjoy completing the questionnaire and look forward to receiving your responses. When you complete the questionnaire, an addressed and stamped label has been provided for you to send it back.

Many Thanks,

Ashley J. Blount
University of Central Florida Doctoral Candidate

APPENDIX M: MAILOUT REMINDER POST CARD

University of Central Florida

November 24, 2014

A few weeks ago a questionnaire was mailed to you because your address was randomly selected to help in a study about the wellness experiences of helping professionals.

If you have already completed and returned the questionnaire, please accept our sincere thanks. If not, please do so as soon as possible. We are especially grateful for your help with this important study.

If you did not receive the questionnaire, or if it was misplaced, please call us at (715) 360-2750 and we will get another one in the mail for you today.

All the best,

Ashley J. Blount,
University of Central Florida Doctoral Candidate

APPENDIX N: EMAIL PERMISSION TO USE THE CBI

RE: Counselor Burnout Inventory

DELETE REPLY REPLY ALL FORWARD ...

이상민 <leesang@korea.ac.kr>

Mark as unread

Wed 6/11/2014 5:50 PM

Inbox

To: Ashley Windt ;

- Flag for follow up. Start by Tuesday, July 01, 2014. Due by Tuesday, July 01, 2014.
- You replied on 6/13/2014 11:48 AM.

final.pdf
871 KB

Counselor Burnout Inve...
79 KB

Download all

Ashley,

You have my permission to use my CBI.

Sang Min.

----------원본 메세지----------
보낸사람: "Ashley Windt "<ashleyjwindt@knights.ucf.edu>
받는사람: "leesang@korea.ac.kr" <leesang@korea.ac.kr>
보낸시간: 2014-06-11 22:31:36 GMT +0900 (Asia/Seoul)
제목: Counselor Burnout Inventory

APPENDIX O: HPWDS BLUEPRINT/MANUAL

Helping Professional Wellness Discrepancy Scale (HPWDS) ©

Ashley J. Blount, M.S., NCC

The *Helping Professional Wellness Discrepancy Scale (HPWDS ©)* is designed to examine wellness satisfaction in practicing helping professionals (i.e., psychologists, counselors, social workers) and helping professionals-in-training (i.e., students). Specifically, wellness satisfaction refers to how satisfied helping professionals are in different realms. The HPWDS is designed to assess perceived wellness satisfaction, aspirational wellness satisfaction, and the discrepancy between perceived and aspirational wellness satisfaction in a population of helping professionals. The five primary domains examined by the HPWDS include the following: **(a)** spiritual; **(b)** physical; **(c)** nutritional; **(d)** relational; **(e)** emotional and coping; **(f)** intellectual; **(g)** self; **(h)** leisure and play; **(i)** flow; **(j)** psychological; **(k)** career sustaining behaviors; **(l)** risk behaviors; and **(m)** unwellness contributing behaviors in the occupational realm. Please note: content domains are *not* necessarily factors of the HPWDS, they are areas from which items are developed.

Blue Print

Helping Professional Wellness Discrepancy Scale (HPWDS) Blueprint

Information: The development blueprint for the HPWDS serves as a guide articulating different areas of wellness from which the HPWDS assessment derives its questions. Definitions of the wellness areas are provided, along with a brief summary of literature supporting the construct.

Helping Professional Wellness Discrepancy Scale (HPWDS) Blueprint Table			
Content Base Domain	**Definition**	**Frequency of Domain**	**Assigned Questions**
Spiritual	Belief in a higher power, way of being, or entity. Having religious or spiritual beliefs that are sustaining and/or fulfilling (Adams et al., 1997; Hettler, 1980; Roscoe, 2009)	5	60, 62, 73, 88, 91
Physical	Encompassing physical health in the realms of strength, flexibility, fitness, and cardiovascular exercise (Hettler, 1980)	5	16, 26, 30, 50, 80,
Nutritional	The relationship between what individuals eat, their moods, their health, and their overall performance (Wurtman, 1986)	4	15, 23, 33, 74,
Relational	Relationships with others; friendships, family relations, love relations, and intimate relations (Adler, 1954; Bezner &Steinhardt, 1997; Hettler, 1980; Rogers, 1961; Sweeney & Witmer, 1992)	11	10, 17, 18, 25, 29, 32, 44, 52, 61, 77, 82,
Emotional/Coping	The acceptance and awareness of a range of positive and negative feelings and the ability to effectively manage, express, and integrate feelings (Myers & Sweeney, 2005; Roscoe, 2009). In addition, emotional and coping realms include experiencing happiness and satisfaction in life (Fredrickson, 2001; Lyumbomirsky, 2001)	6	24, 70, 75, 76, 86, 87
Intellectual	The engagement or stimulation of the mind in meaningful, knowledge-inducing, and creative activities (Adams et al., 1997; Hettler, 1980; Leafgren, 1990). Includes personal and professional intellectual activities.	6	14, 43, 48, 54, 57, 68,
Self	Sense of self involves individual personhood. For example, individual self-esteem, self-worth, sense of control, creativity, and sense of humor comprise the "self." (Fry & Salmeh, 1987; Locke & Colligan, 1986; Maslow, 1970; Witmer & Sweeney, 1992)	6	9, 19, 22, 36, 53, 81,
Leisure & Play	Participating in activities for fun, participating in activities which allow for flow or feeling totally absorbed in the events (Csikzentmihalyi, 1990, 1993, 1997)	7	4, 20, 38, 47, 49, 55, 65,
Flow	Participating in activities that allow for flow or feeling totally absorbed in the events.	4	5, 35, 45, 79,

Psychological (i.e., hope, gratitude, optimism, flourishing)	Psychological wellness will include hope, optimism, gratitude, and flourishing and involve the ability to be positive and optimistic about the future or about an isolated event (Adams et al., 1997; Ryff & Keyes, 1995). Psychological wellness encompasses the ability to experience hopefulness about personal future and the future of others, having an appreciation for another person or thing; unmerited favor (Seligman, 1991), functioning optimally, and having the ability to thrive in different areas of life (Keyes, 2007) while striving for goodness, growth, resilience, and generativity (Fredrickson, 2001).	9	3, 6, 7, 37, 40, 42, 56, 59, 67,
Career Sustaining Behaviors	The specific strategies in promoting functioning and positive attitudes in the helping professions in order to support career longevity and effectiveness (Kramen-Kahn & Hansen, 1998).	7	1, 12, 13, 51, 64, 78, 85,
Risk Behaviors	Behaviors that increase the propensity for becoming unwell (i.e., smoking, having multiple sexual partners)	4	27, 41, 66, 72,
Unwellness Contributing Behaviors in Occupational Realm	Occupation includes working as a helping professional (i.e., counselor, psychologist, social worker). Occupational tasks may include seeing clients, researching in the helping professions, case conceptualization). Other word for occupation may include job or career. Behaviors contributing to illness or uwellness (burnout, compassion fatigue, vicarious trauma) in helping professionals personal and/or professional life.	18	2, 8, 11, 21, 28, 31, 34, 39, 46, 58, 63, 69, 71, 83, 84, 89, 90, 92

Content Base Domain	Literature Support for Inclusion
Spiritual	The majority of wellness models contain some component that is spiritual in nature (e.g., Hettler, 1984; Roach & Young, 2007; Witmer & Sweeney, 1992; Zimpher, 1992). Often, definitions of spiritual wellness include components of meaning making, purpose in life, acceptance, and understanding one's place in life (Adams et al., 1997; Hettler, 1980; Roscoe, 2009). Roach and Young (2007) stated that spirituality and religion played a vital part in the human condition. Further, religious activities and spiritual beliefs have been linked to stress management and improved health (Roach & Young, 2007).
Physical	There is a link between physical activity and positive health is supported (Penedo & Dahn, 2005; Warburton, Nicol, & Bredin, 2006). Increasing physical fitness reduces the risk of premature death (Erikssen, 2001; Warburton et al., 2006). Furthermore, physical activity is associated with decreased risk of diabetes (U.S. Department of Health and Human Services, 1991; Warburton, Gledhill, & Quinney, 2001a; Warburton, Gledhill, & Quinney, 2001b) reduction in specific cancers (Paffenbarger, Lee, & Wing, 1992; Sesso, Paffenbarger, & Lee, 1998; Wannamethee, Shaper, & Macfarlane, 1993), prevention of osteoporosis (Warburton et al., 2006), and improved psychological well-being (Warburton et al., 2001a, 2001b; Dunn, Trivedi, & O'Neal, 2001). Similarly routine physical activity has an effect on hypertension, obesity, and depression (Warburton et al., 2006). Physical activity is also associated with life satisfaction and enhances physical self-worth, self-efficacy, affect, and mental health (Elavsky et al., 2005; Elavsky & McAuley, 2005)
Nutritional	There is a relationship between what individuals eat, their moods, their health, and overall performance (Wurtman, 1986). In addition, though nutrition varies individually, eating breakfast, drinking water, and learning to recognize hunger are strategies that everyone can use to promote improved nutritional well-being (Skovholt, 2001).
Relational	Social connectedness is linked to lower levels of blood pressure and lower levels of stress hormones such as cortisol, epinephrine, and norepinephrine (Uchino, Cacioppo, & Kiecolt-Glaser, 1996). House, Robbins, and Metzner (1982) found that people (N = 2,754) with less social contacts had two to four times the mortality rate of more socially connected people; therefore, being socially involved appears to influence life expectancy and promote health in individuals who engage in meaningful social interactions.
Emotional/Coping	Emotional wellness has been viewed as the acceptance and management of one's feelings (Leafgren, 1990) and the coping ability, self-image, and self-awareness of emotions (Crose, Nicholas, Gobble, & Frank, 1992). As a result, emotional wellness is comprised of awareness of feelings and the ability to manage positive and negative feelings in lieu of life events. In Fredrickson's (2001) *broaden-and-build* theory she states that emotions can broaden the scopes of cognition, action, and attention and build an individuals' intellectual, physical, and social resources. Furthermore, positive emotions influence resilience, the effects of negative emotions, and emotional well-being (Fredrickson, 2001).
Intellectual	Intellectual well-being encompasses personal achievement in education, personal growth, and creativity (Renger, et al., 2000). Leafgren (1990) stated that intellectual wellness involved creativity and stimulating activities and that intellectual well-being could be promoted via the use of individual resources to expand, share, and improve knowledge and skills.
Self	A strong sense of self includes a number of variables that contribute to the construct. Sense of worth, sense of control, having realistic beliefs, spontaneity and emotional responsiveness, creativity, and sense of humor are a few that are

	supported in the literature (e.g., Fry & Salmeh, 1987; Locke & Colligan, 1986; Maslow, 1970; Witmer & Sweeney, 1992).
Leisure & Play	Furthermore, participating in activities for enjoyment can lead to personal growth and happiness (Seligman & Csikzentmihalyi, 2000).
Flow	Partaking in activities that allow bodies to be absorbed and focused can allow individuals to be present and in-the-moment. Thus, experiencing flow can act as a buffer against mental illness (Seligman & Csikzentmihalyi, 2000).
Psychological (i.e., hope, gratitude, optimism, flourishing)	Psychological wellness is defined as optimism that is experienced as a result of positive outcomes and positive life events (Adams et al., 1997). Optimism is a biological phenomenon and human beings have an innate capacity to maintain an optimistic view of the future (Tiger, 1979). Hope is most often noted in the helping profession practice by its absence (Kinghorn, 2013). Feeling hopeless is a key marker in depression and is listed as a marker for suicide in the majority of psychiatric texts and the absence of hope often correlates with decreased mental health and wellness (Kinghorn, 2013). Gratitude is defined as an unmerited favor (Watkins, VanGelder, & Frias, 2009) and can be viewed as containing the three components of: appreciation for a person or thing, having a sense of goodwill toward a person or thing, and having the appreciation and goodwill to act positively (Fitzgerald, 1998). Researchers have concluded that gratitude: increases positive emotions (e.g., Emmons & McCullough, 2003; Fredrickson, 2004); acts as a buffer against depression and stress (e.g., Wood, Maltby, Gillett, Linley, & Joseph, 2008); enhances optimism (Emmons & McCullough, 2003); enhances resilience (Fredrickson, Tugade, Waugh, & Larkin, 2003); and is negatively associated with self-blame, substance use, and denial (Wood, Joseph, & Linley, 2007). Flourishing is something that involves the maintenance of genuine mental health functioning (Keyes, 2002; 2003, 2004). Fredrickson (2001) describes flourishing as functioning optimally while striving for goodness, growth, resilience, and generativity. On the opposite end of the spectrum, Keyes (2007) describes "languishing" as the absence of mental health (p. 95).
Career Sustaining Behaviors	Career Sustaining Behaviors (CSBs; Kramen-Kahn & Hansen, 1998) may also be integral to health and wellness in helping professionals. CSBs help counselors to function effectively and maintain a positive attitude. The top six of the "important" CSB's included: (a) maintaining a sense of humor, (b) spending time with partner/family, (c) maintaining balance between professional and personal lives, (d) maintaining self-awareness, (e) maintaining sense of control over work responsibilities, and (f) reflecting on positive experiences (Lawson, 2007).
Risk Behaviors	Behaviors contributing to illness or uwellness in helping professionals. Behaviors that increase the propensity for becoming unwell (i.e., smoking, having multiple sexual partners).
Unwellness Attributing Behaviors in Occupational Realm	The idea of work or having an occupation as being important to wellness is supported in the literature (e.g., Campbell, 1981; Sweeney & Witmer, 1991; Witmer & Sweeney, 1992). Sweeney and Witmer (1991) stated that work was one of the most fundamental life tasks and researchers identified a correlation between work satisfaction and longevity (Danner & Dunning, 1978), productivity (Pelletier, 1984), and decreased stress, anxiety, and physical symptoms (Witmer et al., 1983). Work-related behaviors contributing to illness or uwellness in helping professionals. Examples of consequences of unwellness behaviors include: burnout (Bakker, Demerouti, Taris, Schaefeli, & Schreurs, 2003; Lambie, 2007; Puig et al., 2012) compassion fatigue (Pearlman & Mac Ian, 1995), and vicarious trauma (McCann & Pearlman, 1990; Pearlman & Mac Ian, 1995). Professionals who experience compassion fatigue tend to disregard self-care and personal wellness (Figley, 2002).

APPENDIX P: HPWDS EXPERT REVIEWER INSTRUCTIONS

Expert Reviewer Directions:

1. Please briefly review the Blueprint Document that is attached. Information on the construct of wellness satisfaction and other areas comprising wellness as supported in the literature is provided.
2. Please open the attached word document and rate the relevance of each individual item (high, moderate, or low) to the construct of wellness satisfaction in helping professionals. If an item is identified as having low relevance, please note reasoning and comment on any other individual items as you see fit.
3. Please evaluate the items for clarity and readability.
4. Please comment on any items or areas you feel may be missing from the current item pool.

APPENDIX Q: HPWDS MANUAL

Helping Professional Wellness Discrepancy Scale (HPWDS) Manual ©

Helping Professional Version

By
Ashley J. Blount

Introduction

The helping professions have a number of codes and guidelines supporting the wellness paradigm; specifically, American Counseling Association (ACA; 2014) states that counselors must monitor themselves "for signs of impairment from their own physical, mental, or emotional problems" (*Standard* C.2.g, p. 9). Moreover, counselors are advised to monitor themselves for signs of impairment and "refrain from offering or providing professional services when such impairment is likely to harm clients" (*Standard* F.5.b, p. 13). For psychologists, the American Psychological Association (APA; 2010) notes that professionals should refrain from providing services to clients when their personal problems may interfere with their work or when they know there is a likelihood that their personal issues may influence their competence (*Standard* 2.06). The Council for Accreditation in Counseling and Related Education Programs (CACREP, 2009) also supports the idea that helping professionals should have an orientation to wellness and prevention (Section II.5.a) and that they have a duty to promote optimal wellness and growth in clients (Section II.2.e). Thus, wellness and the prevention of impairment are intertwined throughout the standards of the helping professions. Consequently, it is unethical for helping professionals to operate while personally and/or professionally impaired and/or unwell.

When counselors (i.e., helping professionals) take care of themselves, they are more able provide quality care and meet the needs of their clients (Lawson, 2007; Witmer & Granello, 2005; Witmer & Young, 1996). In relation to helping profession students and faculty, Roach and Young (2007) found that counselors-in-training and counseling faculty ($N = 204$) reported personal wellness as integral in promoting effectiveness with clients. In addition, Skovholt (2001) stated that counselors-in-training are at risk for distress and stress because of working with people who are experiencing pain and because of the challenge in mastering the ambiguity of the counseling process. Thus, helping professional personal wellness is important because individuals who are unwell are not able to provide optimal services to clients (Lawson, Venart, Hazler, & Kottler, 2007).

Helping professionals are vulnerable to becoming ineffective because of the nature of their work (Skovholt, 2001). In addition, Skovholt (2001) noted that empathy and attachment (common helping profession

principles) involve therapists' vulnerable side, a part that can be hurt during the process. For this reason, counselors and helping professionals continuously place themselves at risk because of the nature of their work.

Though wellness is viewed as the backbone of the counseling profession and integral to other helping professions, many of the individuals in helping professions do not practice wellness or promote it in their own lives (Granello, 2013; Witmer & Young, 1996). Many of the individuals attracted to and entering into the helping professions are already impaired and have an increased likelihood for adjustment issues and personality concerns (Witmer &Young, 1996). Cummins and colleagues (2007) iterate that counselors and counselors-in-training are often remiss about taking their own advice about wellness. As such, counselors and counselors-in-training that are considered well are more likely to help their clients become more well (Lawson et al., 2007). Consequently, impaired counselors are more likely to harm their clients (Lawson et al., 2007; Witmer & Young, 1996). As a result, it is imperative that we assess wellness in helping professionals and helping professionals-in-training.

Helping Professional Wellness Discrepancy Scale (HPWDS)
Instrument Development

The steps in constructing an instrument vary within the literature (Crocker & Algina, 2006; DeVellis, 2012; Dimitrov, 2012). For the purposes of this research investigation, a combination of the processes suggested by Crocker and Algina (2006), DeVellis (2012), and Dimitrov (2012) were followed. The specific instrument development steps employed in the development of the HPWDS were: (a) determine clearly what is being measured, (b) creating an item pool, (c) determining the type of scale measurement, (d) having the items reviewed by a team of experts, (e) considering inclusion of validation items, (f) administering the scale to a development sample, (g) evaluating the items following statistical analysis, and (h) optimizing scale length.

Population

The norm population for the investigation of the HPWDS consisted of practicing counselors, practicing psychologists, and practicing social workers as well as master's level counselors-in-training. The practicing counselors included certified and/or licensed: (a) marriage, couple, and family therapists; (b) school counselors;

and (c) mental health counselors. The practicing psychologist participants include licensed psychologists (i.e., counseling, clinical, and school psychologists). Similarly, the practicing social workers included licensed clinical social workers. The researcher aimed at obtaining a sample of helping professionals-in-training. The counselors-in-training population included students of counseling in: (a) marriage, couple, and family therapist; (b) school counseling, and (c) mental health counseling tracks. In summary, the sample of social workers, counselors, and psychologists comprised the helping professional population in this research investigation.

Table 1: Norm Sample for Development of the HPWDS

Data Category	Total (n)	Percentage
Gender ($N = 657$)		
Female	520	78.8%
Male	136	20.6%
Other	1	.2%
Ethnicity ($N = 657$)		
African American	34	5.2%
Asian	15	2.3%
Caucasian	530	80.3%
Hispanic/Latina/Latino	63	9.5%
Native American	1	.2%
Other	14	2.1%
Marital Status ($N = 657$)		
Divorced	70	10.6%
Married	394	59.7%
Single	134	20.3%
Separated	4	.6%
Widowed	24	3.6%
Other	31	4.7%

Table 2: Norm Sample Participant Characteristics

Data Category	Total (n)	Percentage
Helping Professional Group (N = 657)		
Counseling	271	41.2%
Psychology	218	33.2%
Social Work	157	23.9%
Other	11	1.7%
Employment Status (N = 657)		
Employed Full Time	411	62.6%
Employed Part Time	122	18.6%
Not Working	7	1.1%
Retired, Not Working	12	1.8%
Retired, Working Part Time	36	5.5%
Student	69	10.5%
Theoretical Orientation (N = 657)		
Adlerian	10	1.5%
Behavioral	13	2.0%
Cognitive Behavioral	258	39.3%
Eclectic/Integrative	216	32.9%
Existential	12	1.8%
Psychoanalytic	19	2.9%
Rogerian/Client Centered	47	7.2%
Systemic	31	4.7%
Other	51	7.8%
Degree (N = 657)		
Bachelor's Degree	82	12.4%
Master's Degree	312	47.5%
Ed.D.	8	1.2%
PsyD.	86	13.1%
Ph.D.	159	24.2%
M.D.	0	0.0%
Other	10	1.5%
Years in Field (N = 657)		
0 – 2 years	82	12.5%
3 – 5 years	41	6.2%
6 – 8 years	45	6.8%
9 – 11 years	55	8.4%
12 or more years	434	66.1%

Reliability

The Cronbach's α value for the initial 92 items (N = 657) was calculated as .974. The Cronbach's α value for the 22-item total scale (N = 657) was .869. For Factor 1: *Professional & Personal Development Activities*, Cronbach's α value was .892; for Factor 2: *Religion/Spirituality*, Cronbach's α value was .858; Factor 3: *Leisure Activities*, Cronbach's α value was .871; Factor 4: *Burnout*, Cronbach's α value was .841; and Factor 5: *Helping Professional Optimism*, Cronbach's α value was .824. Therefore, all Cronbach α values were above the recommended .70 value, indicating strong internal consistency within the final HPWDS 22-item model.

Validity

The HPWDS final 22-items (split into their respective five factors) were correlated with the subscales on the *Counselor Burnout Inventory* (CBI; Lee et al., 2007) in order to assess for discriminant validity. Discriminant validity was established by examining relationships between the HPWDS five factors and a variable with which they were *not* expected to correlate (Scarborough, 2005). The researcher examined the relationships between the items on the HPWDS and the subscales on the CBI (Lee et al., 2007) using Spearman's rho correlation coefficient. The subscales include: (a) *Exhaustion*, (b) *Incompetence*, (c) *Uncooperative Work Environment*, (d) *Devaluing Client*, and (e) *Deterioration in Personal Life*.

The relationships between the HPWDS items (grouped into factors) and *all* CBI subscales resulted in negative correlations (discriminant validity for the HPWDS scale), with the exception of the *Burnout* factor items: 8, 69, and 90 (see table 13). With *all* subscales on the CBI assessing helping professional burnout, it was logical that the three HPWDS items (8, 69, and 90) measuring burnout in the helping professional had positive correlations (convergent validity). HPWDS Item 8 (Are worn out because of the work you do as a helping professional), Item 69 (Experience exhaustion because of your work as a helping professional), and Item 90 (Experience stress form working as a helping professional) can *all* be labeled as influencing levels of burnout in the helping professional population (e.g., Freudenberger, 1974; Lee et al., 2007; Puig et al., 2012). In examining the relationship between the HPWDS and the CBIs Exhaustion Subscale, *all* three positive correlations were large, statistically significant relationships; Item 69 ($\rho = .630$, $p < .001$; 39.6% of the variance explained), Item

90 (ρ = .608, p < .001; 36.9% of the variance explained), and Item 8 (ρ = .565, p < .001; 31.9% of the variance explained). For the relationship between the HPWDS and the CBIs Incompetence Subscale, *all* three had small, statistically significant relationships; Item 69 (ρ = .296, p < .001; 8.52% of the variance explained), Item 90 (ρ = .247, p < .001; 6.1% of the variance explained), and Item 8 (ρ = .287, p < .001; 8.24% of the variance explained). Of the HPWDS items with a positive correlation with Uncooperative Work Environment, *all* three had medium, statistically significant relationships; Item 69 (ρ = .339 p < .001; 11.5% of the variance explained), Item 90 (ρ = .368, p < .001; 13.54% of the variance explained), and Item 8 (ρ = .341, p < .001; 11.62% of the variance explained). Of the HPWDS items with a positive correlation with Devaluing Client, *all* three had small, statistically significant relationships; Item 69 (ρ = .183, p < .001; 3.35% of the variance explained), Item 90 (ρ = .205, p < .001; 4.20% of the variance explained), and Item 8 (ρ = .199, p < .001; 3.96% of the variance explained). Finally, of the HPWDS items with a positive correlation with Deterioration in Personal Life, *all* three had medium, statistically significant relationships; Item 69 (ρ = .471, p < .001; 22.18% of the variance explained), Item 90 (ρ = .411, p < .001; 16.89% of the variance explained), and Item 8 (ρ = .388, p < .001; 15.05% of the variance explained).

Administration

The HPWDS is a self-report measure that is designed for self-administration. The average time for completion is between 5 and 10 minutes. The instrument may be administered in an individual setting or in a group setting. Both paper and pencil and online copies are available. The instructions are printed on each instrument. For individual and group administrations the instructions may be read aloud or individuals may be allowed to read on their own.

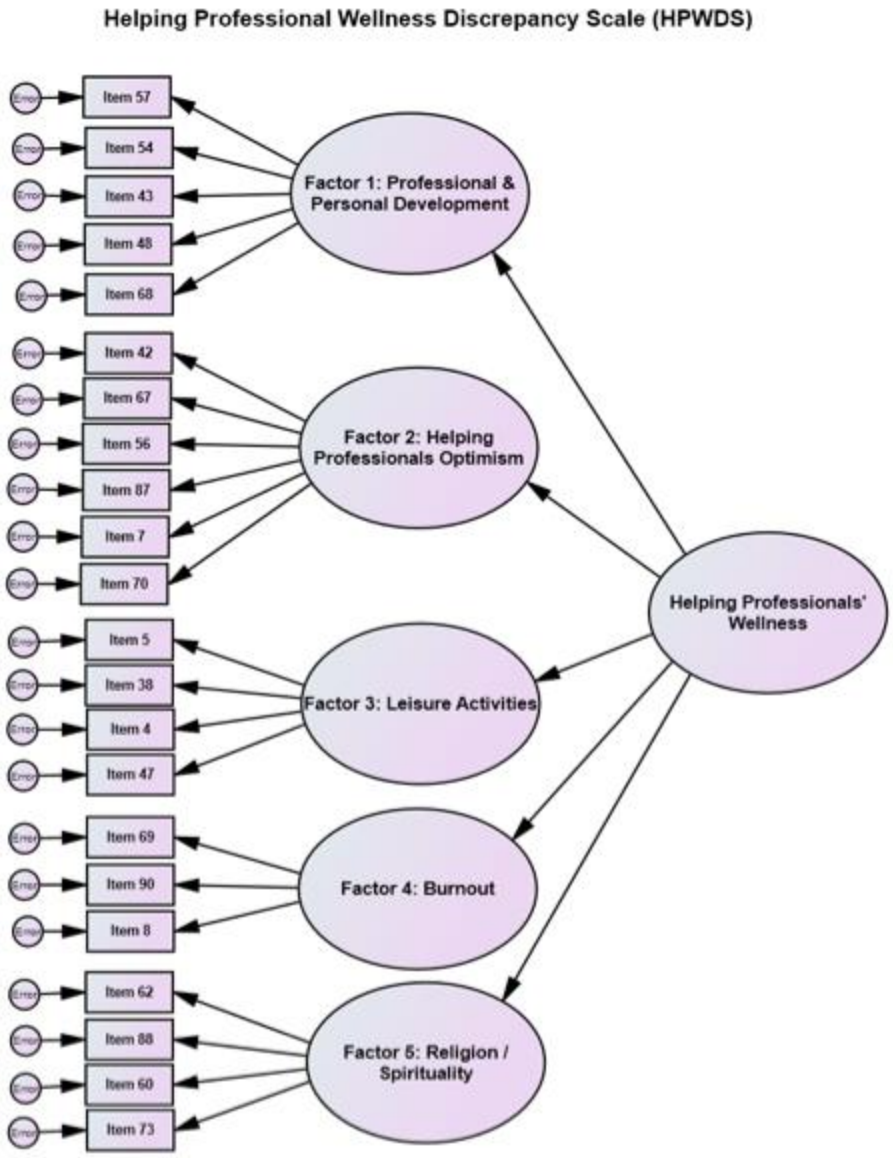
Scoring

Each item on the HPWDS is a statement regarding a dimension of wellness or unwellness. Respondents answer according to a 5-point verbal frequency scale reflecting the extent to which they engage in a behavior, experience, or feeling during a week. Responses range from: 0 – 2 times, 3 – 5 times, 6 – 8 times, 9 – 11 times,

and 12 or more times per week. Participants respond to items based on the question "how often do you" engage in the activities or experience the feelings per week *and* "how often do you want to" engage in the activities or experience the feelings per week.

To score the HPWDS, the perceived wellness values (i.e., denoted by the question "how often do you") are subtracted form the aspirational wellness values (i.e., denoted by the question "how often do you want to") on the HPWDS instrument. Then, the absolute value of the number is taken. For example, if an individual scores a 5 on the aspirational portion and a 2 on the perceived portion, the discrepancy would be a 3. Discrepancy scores show individuals' differences between their perceived levels of wellness and their aspirational levels of wellness on the 22 items on the HPWDS.

Five Factor HPWDS Path Diagram



Sample of the HPWDS

Helping Professional Wellness Discrepancy Scale (HPWDS) Please review the following items and report (circle) how often you ***do*** and how often you ***want to*** engage in the activities or experience the feelings per week.	**How often do you?**					**How often do you want to?**				
	0 – 2 times	3 – 5 times	6 – 8 times	9 – 11 times	12 or more times	0 – 2 times	3 – 5 times	6 – 8 times	9 – 11 times	12 or more times
1. Partake in activities to further your knowledge as a helping professional	1	2	3	4	5	1	2	3	4	5
2. Feel like you are making a difference as a helping professional	1	2	3	4	5	1	2	3	4	5
3. Immerse yourself in leisure activity/activities with which you participate	1	2	3	4	5	1	2	3	4	5
4. Have religious or spiritual beliefs that you feel are sustaining	1	2	3	4	5	1	2	3	4	5
5. Experience exhaustion because of your work as a helping professional	1	2	3	4	5	1	2	3	4	5
6. Partake in activities to further your knowledge in an area of your choice	1	2	3	4	5	1	2	3	4	5
7. Believe that your contributions as a helping professional matter	1	2	3	4	5	1	2	3	4	5
8. Engage in free-time/leisure activity (i.e., time spent away from work or chores)	1	2	3	4	5	1	2	3	4	5
9. Engage in prayer (e.g., praying)	1	2	3	4	5	1	2	3	4	5
10. Believe that your contributions as a helping professional matter	1	2	3	4	5	1	2	3	4	5
11. Take the initiative to learn about new research in the helping professions	1	2	3	4	5	1	2	3	4	5
12. Experience optimism about client's futures	1	2	3	4	5	1	2	3	4	5
13. Partake in enjoyable activities (i.e., things you enjoy doing)	1	2	3	4	5	1	2	3	4	5

Please Continue On The Next Page...

Helping Professional Wellness Discrepancy Scale (HPWDS) Please review the following items and report (circle) how often you ***do*** and how often you ***want to*** engage in the activities or experience the feelings per week.	**How often do you?**					**How often do you want to?**				
	0 – 2 times	**3 – 5 times**	**6 – 8 times**	**9 – 11 times**	**12 or more times**	**0 – 2 times**	**3 – 5 times**	**6 – 8 times**	**9 – 11 times**	**12 or more times**
	↓	↓	↓	↓	↓	↓	↓	↓	↓	↓
14. Experience satisfaction with your spiritual or religious activity	1	2	3	4	5	1	2	3	4	5
15. Experience optimism about client's futures	1	2	3	4	5	1	2	3	4	5
16. Engage in activities to advance your knowledge (e.g., reading, writing)	1	2	3	4	5	1	2	3	4	5
17. Experience satisfaction in your life	1	2	3	4	5	1	2	3	4	5
18. Find time to relax	1	2	3	4	5	1	2	3	4	5
19. Meditate with a focus on a higher power or spiritual entity	1	2	3	4	5	1	2	3	4	5
20. Take time to advance your professional development (i.e., attend conferences or seminars)	1	2	3	4	5	1	2	3	4	5
21. Experience happiness	1	2	3	4	5	1	2	3	4	5
22. Experience optimism about your future	1	2	3	4	5	1	2	3	4	5

Thank you for taking this Questionnaire!!!

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