

An Investigation Of The Relationship Between Counseling Self-efficacy And Counselor Wellness Among Counselor Education Students

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AN INVESTIGATION OF THE RELATIONSHIP BETWEEN COUNSELING SELF-EFFICACY AND COUNSELOR WELLNESS AMONG COUNSELOR EDUCATION STUDENTS

by

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

Recent research in counselor training has focused on the difficulties and challenges facing counseling practitioners that result in high stress, burnout, compassion fatigue, vicarious trauma, and counselor impairment. The American Counseling Association's (ACA) *Code of Ethics* has addressed the ethical issues inherent in counselor impairment. Further, the Council for Accreditation of Counseling and Related Educational Programs (CACREP) has focused on the development of counselors that will assist them in being resilient to workplace stressors. Wellness is a theoretically based construct that holds much promise for bolstering the resilience of pre-service counselors. In addition, counselor self-efficacy has been linked to greater advocacy for self and others, the use of higher order counseling skills, greater problem solving practice, and more self-regulated, ethical decision making. This study was designed to investigate the relationship between counselor self-efficacy and counselor wellness. A total of 88 participants completed both the Five Factor Wellness Evaluation of Lifestyle Inventory and the Counseling Self-Efficacy Scale. Demographic and descriptive statistics were included along with a Multiple Regression Analysis. Results did not indicate a statistically significant relationship. Potential limitations, implications for counselor educators, and future research directions were elucidated.

This dissertation is dedicated in honor and loving memory of my father, R.C. Childers.

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CHAPTER ONE: INTRODUCTION

Counseling professionals today face many challenges in working with a diverse range of clients. They must be culturally competent, proficient in assessment, able to choose effective techniques and strategies for client growth (Galassi & Akos, 2004), understand systems, provide advocacy (Amatea & Clark, 2005; Lambie & Williamson, 2004), be capable of demonstrating leadership (Littrell & Peterson, 2001), produce outcome data and responsive evaluation (Gysbers, 2004; Webb, Brigman, & Campbell, 2005). Further, counselors have to navigate managed care, balance large case loads, low job social status and pay (Bryant & Constantine, 2006), and they may even experience vicarious trauma from working with clients in extreme distress or crisis potentially resulting in compassion fatigue (Baggerly & Osborn, 2006). Additionally, professional school counseling literature provides many examples that support the current state of role ambiguity, role conflict, and the lack of a formal professional identity among school counseling practitioners (Amatea & Clark; Coll & Freeman, 1997; Butler & Constantine, 2005; Foster, Young, & Hermann, 2005; Lambie & Williamson). These factors contribute to occupational stress, which has been found to be negatively correlated with career satisfaction and career commitment, and positively correlated with burnout and attrition (Baggerly & Osborn; Culbreth, Scarborough, Banks-Johnson, & Solomon, 2005; Rayle, 2006).

Role conflict occurs when counselors must perform tasks or manage roles that are not within the prescribed or defined parameters of professional counseling (Bryant & Constantine, 2006; Butler & Constantine, 2005). Examples for school counselors include (a) serving as a substitute when teachers are absent, (b) being asked to do an inordinate amount of duty each day, (c) being relegated to clerical or administrative tasks to the exclusion of offering counseling

services, or (d) other ancillary services that may be provided by a paraprofessional (Baggerly & Osborn, 2006; Bryant & Constantine; Coll & Freeman; Galassi & Akos, 2004, Zalaquett, 2005). For mental health counselors role conflict may occur when they are (a) asked to deliver services to groups or populations with whom they lack expertise or feel incompetent, (b) manage caseloads too great to provide effective service, (c) are forced to provide diagnoses, and/or (d) are mandated to follow manualized treatment, regardless of client needs (Young & Lambie, 2007). Counselors may also have to make professional decisions that are in direct conflict with personal beliefs and values. Further, the disconnect between formal training and work place reality leaves many counselors feeling disillusioned and stressed (Akos & Scarborough, 2004; Culbreth et al, 2005; Studer, 2005; Young & Lambie).

Students may enter the field of counseling because of their perceptions regarding the nature of counseling. Incongruence between the individual's vocational interests and his or her actual job may result in dissatisfaction (Bryant & Constantine, 2006; Harris, Moritzen, Robitschek, Imhoff, & Lynch, 2001), lower performance and reduced retention (Harris et al.). When job responsibilities do not match counselor training and expectations, the result may be a reduction in professional identity (Akos & Scarborough, 2004) or decreased counseling self-efficacy—a lowered perception regarding one's capabilities to effectively help clients as a professional counselor (Baggerly & Osborn, 2006). In fact, Crutchfield and Borders (1997) suggested, "...counselors can become unsure of their abilities, even possibly becoming less skilled than they were upon receiving their counseling degrees" (p. 221).

Dealing daily with job related stress may leave the practitioner emotionally depleted, burned out (Butler & Constantine, 2005; Rayle, 2006; Crutchfield & Borders, 1997), and suffering from compassion fatigue (Baggerly & Osborn, 2006; Culbreth et al, 2005). These

stressors may decrease the counselor's ability to empathize with clients (Lambie, 2006). Further, the counselor may experience reduced effectiveness as an advocate for self and others. In addition, as counseling self-efficacy is lowered, so may be the counselor's career satisfaction and commitment to remaining in the counseling profession. The lower a counselor's self-efficacy, the less connected he or she may be to their identity as a counselor—and the greater potential for attrition (Baggerly & Osborn, 2006).

The counselor's ability to navigate role conflict, ambiguity, stress, and burnout may be bolstered through the resilience fostered by personal wellness and self-care strategies (Baggerly & Osborn, 2006; Bryant & Constantine, 2006; Butler & Constantine, 2005; Chandler, Bodenhamer-Davis, Holden, Evenson, & Bratton, 2001). Counselors entering the profession experience high levels of anxiety, in addition to the aforementioned work place stressors (Al-Darmaki, 2004). Wellness has been shown to mitigate stress, energize and vitalize counseling professionals (Littrell & Peterson, 2001), and is positively correlated with higher self-efficacy (Hattie, Myers, & Sweeney, 2004; Hermon & Hazler, 1999). This research study will investigate the potential and proposed relationship between counselor self-efficacy and counselor wellness among counseling graduate students.

Theoretical Background

Wellness

According to Street (1994), the term holistic wellness “defines an interdependent system of systems within the human being (e.g. physical, spiritual, intellectual) all of which interact with and affect each other” (p. 172). Holistic wellness has a long, rich history both in and out of counseling. Many counseling scholars and academics credit Adler with beginning the holistic

approach in counseling (Gladding, 2004). It is noteworthy to mention, however, that many cultures throughout history have subscribed to practices of holistic wellness including the ancestral and modern Native American cultures of the United States. For example, Garrett (1999) noted that in Cherokee culture, traditional wellness is both an internal balance of the harmonic interaction between the mind, body, and spirit, as well as systemic reciprocity with all living creatures.

Today, holistic wellness has re-emerged as a construct that is changing the way counselors view client well-being and practitioner self-care. Historical antecedents and philosophical roots surround this notion. Exploration of lifespan developmental prevention of disease and mental health concerns has prompted and necessitated the extension of the wellness concept to a paradigm for counselors to view clients. Holistic wellness is a comprehensive and theoretically grounded construct with a promising future for counselors. For the purposes of this dissertation the terms holistic wellness and wellness will be used interchangeably.

Adler (1923, 1928) proposed that individuals must be viewed as indivisible, holistic beings that are multi-faceted and are striving to resolve five primary life tasks: (a) society, (b) work, (c) love, (d) spirituality, and (e) coping with oneself. He conceded that facing our challenges and striving to maximize our potential in any of these five areas was risky business and took great courage (as cited in Gladding, 2004). Pursuant to Adler's theory others followed and developed further the philosophical discussion and understanding of the structure of well-being. Maslow (1954) suggested that humans strive to self-actualize, and he contended that persons who attain this higher order of being possessed specific characteristics. The following are descriptors Maslow believed constituted the formidable personable attributes of the self-actualized individual based on his own research: (a) realistic perception of reality, (b)

acceptance, (c) spontaneity, (d) problem solving, (e) solitude, (f) autonomy, (g) fresh appreciation, (h) peak experiences, (i) human kinship, (j) humility and respect, (k) interpersonal relationships, (l) ethics, (m) means and ends, (n) humor, (o) creativity, (p) resistance to enculturation, (q) imperfections, (r) values, and (s) resolution of dichotomies (Maslow). Thus, self-actualized persons are able to integrate these traits into their way of interacting with self and others.

With the advent of critical health concerns in the United States, more attention is being focused on wellness in counseling as a preventative strategy for working with clients. Wellness counseling promotes healthy development (Hartwig & Myers, 2003), emphasizes strengths, maximizes potential, and enhances coping skills (Harari, Waehler, & Rogers, 2005). Models of wellness for use with clients have been proposed in the literature. One such model was proposed by Myers, Sweeney, and Witmer (2000) and posited an illustrative conceptualization of wellness as a wheel including five spokes—all integrated and interlinked—that provide a combined picture of overall wellness. The wellness wheel spokes are (a) spirituality, (b) self-direction, (c) work and leisure, (d) friendship, and (e) love.

Spirituality

Spirituality was defined as the link one feels to the transcendent--something greater than oneself (Myers et al., 2000). Spirituality encompasses positive thoughts and optimism, both of which have been found to positively correlate with one's ability to cope with stress (Lightsey, 1996). Spiritual seekers may have more positive cognitions, empathize with others, reframe negative events, and effectively navigate stress. This may be crucial when considering stress produced by role difficulties and the high burnout faced by counselors (Myers et al., 2000).

Self-Direction

The second spoke of the wellness wheel is self-direction. This refers to an individual's ability to self-regulate, self-discipline, and direct his or her own actions in day to day activities (Myers et al., 2000). Encapsulated in this spoke are the elements of self-worth, self-esteem and self-concept as they refer to appraising one's own capabilities and values. The higher a person's self-esteem, the more ready he or she may be to face new challenges and potential failures without suffering loss of one's self in the process.

A person with high self-esteem may also have a greater sense of control over their environment and personal decision-making (higher internal locus of control). For example, an individual may perceive that their actions will directly influence outcomes; rather than viewing life as left to fate, destiny, or other external forces. Studies have shown that people with a high sense of control are better able to maintain an exercise regimen, eat healthier and make overall healthy lifestyle choices. They are also believed to have higher self-efficacy; that is the idea that they are capable of achieving a given task (Myers et al., 2000).

Work and Leisure

The third spoke of the wellness wheel in this model is that of work and leisure. Work should be an exciting blend of challenge and accomplishment that engages the worker. It serves many functions to the person and society—including financial contribution—while simultaneously providing a support system to the individual as well as tasks that are pleasing or enjoyable to partake in for mental stimulation (Myers et al., 2000). The function of being a pleasurable mental activity may be diminished if the workplace is too stressful, or if the individual feels that he or she is incompetent to complete the tasks at hand. Further dissolution

of emotional well-being and career satisfaction may occur if the individual's work is undervalued, there is a lack of clarity in work assignments, and a lack of control over assignments or the environment (Lambie, 2006). Conversely, work place social support appears to promote job satisfaction, lower turnover, and may potentially create greater counselor resiliency to stress and burnout (Harris et al, 2001; Lambie).

Friendship

Friendship and love are the other two wellness wheel spokes supported in the model by Myers and colleagues (2000). Having a positive social network and meaningful relationships with significant others allows an individual to have the support necessary to face challenges effectively. Friendship may also encourage leisure and other stress coping activities.

Love

Additionally, having healthy romantic relationships and intimate emotional connections with significant others also fosters resilience. Hendrick and Hendrick (2002) contend that love is central to and mandatory for the procurement of happiness. Further, healthy love relationships provide emotional intimacy and support as well as a safety network.

The Wellness Wheel Model proposed by Myers and colleagues (2000) was tested by Hattie, Myers, and Sweeney (2004) through an exploratory factor analysis. One total global functioning of wellness factor converged and five second order factors loaded, which were renamed as: Physical Self, Creative Self, Coping Self, Essential Self, and Social Self. In addition, 17 third order factors loaded onto these subscales. A structural equation model was constructed and a new counseling model, *The Indivisible Self Model*, was proposed. The indivisible self is the term used for the whole person, the global functioning individual and it is

comprised of the integrated components of the second order factors (specific wellness domains), each containing third order factors. The Physical Self includes exercise and nutrition. The Creative Self includes intelligence, control, emotion, humor, and work. The Coping Self contains leisure, stress, worth, and beliefs. The Essential Self includes essence, self care, gender identity, and cultural identity. The Social Self includes friends and love (Hattie et al.). Each of these domains will be described in greater detail in Chapter 2.

Wellness applies to both clients and counselors. Counselors entering the field experience high anxiety, stress, and are at risk of burnout and compassion fatigue (Butler & Constantine, 2005; Young & Lambie, 2007). Research has been conducted on the benefits of implementing wellness strategies with trainees (Chandler et al., 2000; Carroll, Gilroy, & Murra, 2003; Hermon & Hazler, 1999). Chandler and colleagues found that trainees who received biofeedback assisted relaxation training had reduced stress symptoms and enhanced well-being. Carroll and colleagues purported that counselor self-care may also increase counselor's ability to employ better ethical decision making processes. Hermon and Hazler also noted that generalized self-efficacy was increased for participants in their study who had greater self-regulation in regard to personal wellness strategies. The question of concern for this researcher is regarding the relationship of wellness and its factors to counseling self-efficacy. Hattie and colleagues (2004) specifically indicated that self-efficacy is one of the core components comprising sense of control (a third order factor under the second order factor of the Creative Self). If this link exists, it is possible that higher levels of counselor wellness may contribute to higher counseling self-efficacy, an important consideration in counselor education.

Self-Efficacy

Counselor educators have conducted research on the concept of counselor self-efficacy (CSE). Specifically, according to Sutton and Fall (1995) “self-efficacy beliefs are based on individual’s expectations that one possesses certain knowledge and skills, as well as the capability to take action required to overcome problems and to succeed under the stresses and pressures of life” (p. 332). Counseling self-efficacy was defined by Larson and Daniels (1998) as, “one’s beliefs or judgments about her or his capabilities to effectively counsel a client in the near future” (p.180). The term ‘capable to effectively counsel’ may mean different things including the counselor’s capability to (a) establish a therapeutic alliance with the client, (b) to confront and challenge the client, (c) to be emotionally present and available, or to (d) design effective interventions that are the impetus for client change.

Self-efficacy, or feelings of being capable in regard to given competencies, may significantly influence the type of career people choose and how they perform within the context of their career. People with similar aptitudes may perform disparately; in particular, it is ascertained that self-efficacy constitutes some degree of performance and achievement differences among persons of similar ability (Lent, Brown, & Hackett, 2002). Further, higher CSE is associated with choice of career, performance in career, and “persistence in the face of obstacles and disconfirming experiences” (Sullivan & Mahalik, 2000, p. 55). Lent and colleagues are credited with creating Social Cognitive Career Theory (SCCT) (as cited in Zunker, 2002). According to Social Cognitive Career Theory, people may over or under estimate their abilities based on information they have gathered and processed within social systems where they are immersed. These perceptions of capability to perform given tasks and to meet standards of competence may become the mediators of talent and effort—either inhibiting

the developing individual or promoting skill growth and attainment (Lent et al. as cited in Zunker).

There is a copious amount of research on CSE and it has been demonstrated to have a relationship with many other factors related to counseling. According to Al-Darmaki (2004), CSE is related to higher self-esteem, lower anxiety (both trait and state), stronger perceived problem-solving effectiveness, and the type of microskills chosen by counseling students in practicum. Barbee, Scherer, and Combs (2003) found that CSE had a significant positive correlation with pre-practicum service learning possibly due to the exposure to clients and clinical situations experienced by the trainees. Other researchers have found that regular supervision has increased CSE, and that there is a negative relationship between CSE and counselor anxiety (Leach & Stoltenberg, 1997). In addition, Barnes (2004) predicted that counselor trainees with higher CSE would perform at higher counseling skill level than trainees with lower CSE. Crutchfield and Borders (1997) found positive, though quite modest, positive gains in job satisfaction, CSE, and counseling effectiveness when field practitioners were given clinical peer supervision.

Lent, Hill, and Hoffman (2002) presupposed that trainees with higher CSE would have differential clinical functioning from their low CSE peers, specifically greater cognitive, behavioral, and affective responses when counseling clients. A review of the literature by Larson and Daniels (1998) revealed that higher CSE was correlated positively with counselor performance. Conversely, Leach and Stoltenberg (1997) indicated that counselor trainees who have high anxiety about working with specific populations—for example sexually abused clients—may have lower CSE. According to Urbani and colleagues (2002), increasing CSE and lowering anxiety is critical in order to improve clinical judgment and counseling performance.

Further, Fernando and Hulse-Killacky (2005) ascertained that supervision style impacts CSE, indicating that a varying style of clinical supervision that is sensitive to the needs of the supervisee is important. Thus, fostering educational environments that may support increased levels of counselor trainee CSE is essential.

Specific to professional school counselors (PSCs), Sutton and Fall (1995) investigated the relationship of CSE and school climate; they found that supportive administrators and school faculty were the strongest predictors of CSE. The support of school personnel was manifested by promoting the school counseling program and encouraging school counselors. The supportive climate may have also allowed the counselor to implement programs that are aligned with the American School Counselor Association (2005) supported model of the school counselor's role—prompting the congruence between counselor role expectation and role functioning, lowering role ambiguity and conflict.

A supportive environment was also identified as a significant variable in the Indivisible Self model proposed by Hattie and colleagues (2004). Specifically, the social self is the wellness domain that describes person-system support and connectivity. If a counselor is in a supportive, encouraging environment and is allowed to function congruent to expectations, then the counselor would likely have a higher level of social self wellness. Further, because the five self components of wellness are interrelated and reciprocally impactful, then wellness in the social domain may significantly improve overall wellness functioning.

Rationale for the Study

This study will examine two potentially related constructs: counselor self-efficacy and wellness (including the second order factors of wellness). If a relationship exists between these

two constructs, and they are both related to stress management and burnout reduction, then training programs should work to promote both of these in an effort to prepare counselors entering the field. Determining whether or not a significant relationship exists may be the first step to foster resilience of counselors through enhancing both of these developmental aspects.

Statement of the Problem

Based on the previously cited literature, increased counselor wellness and CSE appears to be important for both mental health and school counselors. Job related stressors such as role ambiguity, role conflict, and a non-solidified professional identity, may lead to low career satisfaction and poor job performance. Stress, burnout, and compassion fatigue may leave counselors feeling depleted, overwhelmed, underappreciated, and disconnected from their work and their constituents (Coll & Freeman, 1997; Crutchfield & Borders, 1997). Increased counselor wellness and CSE may bolster resilience to stressors for individuals entering the field of professional counseling.

The proposed investigation has three respective parts. The first, involves CSE; where the more efficacious counselors feel with their counseling skills, the more likely they are to effectively utilize higher level skills, advocate for themselves and others, and have greater job satisfaction and commitment. The second component is counselor wellness. This researcher is proposing that counselors, who are under considerable stress, need to employ self-care strategies. Further, students graduating from counselor preparation programs should have a viable self-care plan implemented prior to graduating from their program to better assist them in their school to workplace transition and adjustment. Third, if wellness and CSE are significantly and positively

related, then promoting wellness in students may improve their counseling self-efficacy, and thus, their effectiveness.

Research Question

Question 1: Is there a statistically significant relationship between counselor self-efficacy as measured by the Counseling Self-Efficacy Scale (Melchert et al., 1996) and counselor wellness as measured by the Five Factor Wellness Evaluation of Lifestyle (Myers & Sweeney, 2005)?

Hypothesis 1: There is a significant relationship between counseling self-efficacy and counselor wellness.

Null Hypothesis 1: There is no significant relationship between counseling self-efficacy and counselor wellness.

Definitions

Wellness—Wellness is defined as “...a holistic approach in which mind, body, and spirit are integrated in a purposeful manner with a goal of living life more fully. Wellness is more than the absence of disease, a state defined as ‘health’, and incorporates a concern for optimal functioning, or positive mental, physical, and spiritual health, and enthusiasm and zest for life” (Myers & Sweeney, 2005, p. 4).

Counseling Self-efficacy—Successful performance of counseling requires not only knowledge and skills, but also beliefs that one has the ability to perform counseling in a way that will produce particular client outcomes. Further, counseling self-efficacy is believed to be associated with training and experience (Melchert, Hays, Wiljanen, & Kolocek, 1996).

Masters Level Interns—For this study, participants will be students enrolled in internship at a Southeastern university in a counselor education program. Students in the counselor education

training program who are interning have completed the prerequisites for site based practice with group and individual supervision in a practica experience and have completed core course work. The core courses required for all counseling students prior to internship include: (a) Introduction to the Counseling Profession, (b) Theories of Counseling and Personality, (c) Techniques of Counseling, (d) Group Procedures and Theories in Counseling, (e) Ethical and Legal Issues, and (f) Practicum in Counseling. Additionally, mental health counseling students are also required to complete a Diagnosis and Treatment in Counseling course, and school counseling students must have taken Coordination of Comprehensive, Developmental Professional School Counseling Programs. Prior to entering internship, mental health and school counseling students receive live supervision while providing individual counseling through their counseling practicum course. Specifically, mental health students are required to accumulate 60 hours of direct client contact (3 hours per week) in practicum at the university's community counseling clinic; therefore, they must register and take two semesters of practicum. School counseling students are required to accumulate 40 hours of direct client contact which they complete in one semester of practicum. Both mental health and school counseling students must facilitate or co-lead small group counseling for a total of 6-10 hours.

Once in internship, differential requirements in client contact hours continue between mental health and school counseling students. Mental health counseling students must accumulate 900 clock hours (with a minimum of 360 direct client contact hours). School counseling students must accumulate 600 clock hours (with a minimum of 240 direct client contact hours). It is possible for school counseling interns to complete internship in one semester while the hour requirements for mental health counseling students necessitate two semesters of

internship. Individual counseling, group counseling, couples counseling, family counseling, career planning, and academic advisement all constitute direct client contact.

Methods

Participants

The sample to be used for this study will be Master's level internship students in both mental health and school counseling tracks at a southeastern university. The students will be participants in ongoing data collection on student characteristics and outcomes through the Masters level counselor education program. They are introduced to the instruments and purpose of the data collection for programmatic evaluation and research during their initial orientation to the Masters program. For this particular study, there will be a minimum of 70 participants, based on purposive sampling (Shadish, Cook, & Campbell, 2002). All data used by this researcher was pre-collected, de-identified data from a pre-existing database,

Instrumentation

The two instruments that will be used in this study are the Five Factor Wellness Inventory (5-Factor Wel) (Myers & Sweeney, 2005) and the Counseling Self Efficacy Scale (Melchert, Hays, Wilijanen & Kolocek, 1996). A description of each instrument follows.

The Counseling Self-Efficacy Scale (CSES)

The CSES was designed by Melchert and colleagues (1996), and is a Likert type scale containing 20 items. The items represent competencies believed to be critical to the counseling profession based on literature reviews about the skills and competencies needed to be an effective counselor (Fitzpatrick, 1999). The participant indicates through self-report their personal view of the degree to which they possess each competence in order from "Strongly

Disagree” to “Strongly Agree”. The results are tabulated for a total raw score and then divided by the number of items to produce an overall mean composite score for all items in the scale. The CSES has a test-retest reliability of .85 and a Cronbach alpha internal consistency of .93 (Barbee, Scherer, & Combs, 2003). The CSES was developed with content validity based on experts in the field and has been tested for convergent construct related validity with the Self Efficacy Inventory with a correlation of $r=.83$ (Melchert et al.). Further delineation regarding the CSES will be presented in Chapter 3.

The Five Factor Wellness Inventory (5F-Wel)

The 5F-Wel (Myers & Sweeney, 2005) includes three factor orders. The highest order includes one factor, the global wellness functioning--a combined composite representation of overall wellness functioning. There are five second order factors which encapsulate groups of third order factors. These five second order factors are the primary five wellness factors that are the basis for the name of the instrument. These five factors are categorized as interrelated and connected parts of the greater whole of the person and may be codified as selves of the whole including: the essential self, the social self, creative self, physical self, and coping self. Please see Table 1. for a breakdown of the third order factors contained within each second order factor (Myers & Sweeney).

Table 1. The 5F-Wel Second and Third Order Factors.

Second Order Factors	Third Order Factors
1. Essential Self	Culture Identity, Gender Identity, Self Care, Essence
2. Social Self	Love & Friends
3. Creative Self	Intelligence, Control, Emotion, Humor, and Work
4. Physical Self	Exercise & Nutrition
5. Coping Self	Leisure, Stress, Worth, Beliefs

The 5 F-Wel was developed using a structural equation model. Specifically, 103 items believed to be wellness related--based on theory--was administered to 3,043 participants and an exploratory factor analysis of the data was conducted. Three factor orders emerged and a restricted factor pattern was established based on confirmatory factor analysis (Hattie, Myers, & Sweeney, 2004). The goodness of fit index was .042 (chi square=8261, df=2533), which indicates an acceptable fit between the model and data. Alpha coefficients were provided for the second order factors as: (a) Total Wellness .94, (b) Creative Self -.93, (c) Coping Self, .92, (d) Social Self -.94, (e) Essential Self -.91, and (f) Physical Self .92. Multiple studies have been conducted that have supported evidence for convergent and divergent validity (Myers & Sweeney, 2005). All of the psychometric properties discussed here will be elaborated on further in Chapter 3.

Procedures

Participants will be informed about data collection procedures and consent will be gained during the orientation process upon entrance into the Masters program in counselor education. For the purpose of this study, the CSES and 5F-Wel will be distributed during the last week of internship for both mental health and school counseling students. Due to concerns of possible research bias, this researcher will not proctor any of the scale administration. Either internship instructors or the counselor education department Research Associate will administer the data collection instruments. A script will be provided to the scale administrator to read prior to distributing the instruments (see Appendix 1). Both instruments will be given with the directions to include no identifying information. A random number will be assigned to each participant and will be placed on both of the participant's instruments. There will be no time limit given for completing the scales and no restriction placed on the order of instrumentation. Participants who missed the instrument completion due to absence or illness may reschedule a make-up time where the research associate will administer at a scheduled make-up session.

Once instruments have been collected, the score sheets for the 5F-Wel will be sent for scoring to Jane Myers at University of North Carolina Greensboro (instrument co-author). The CSES will be scored by the Research Associate. All data will be put into excel formatted and downloaded into the Statistical Package for Social Science (SPSS, 2006), version 14.0 software to be analyzed.

Analysis

An *Ex Post Facto* analysis of data will be utilized. *Ex Post Facto* designs are often used to determine the degree of association between variables rather than looking at causality.

Therefore, they are different from an experimental design as there is no manipulation of variables but rather a description of relationships between variables (Shavelson, 1996). Specific to this study, since there are five subscales (second order factors) and one composite score (global wellness functioning) on the 5F-Wel, there may be different relationships between self-efficacy and the second order factors of the 5F-Wel. Therefore, the primary statistical analysis that will be employed will be hierarchical multiple regression analysis (MRA), “a statistical method for studying the relation between a dependent variable and two or more independent variables. The purpose for applying MRA might be prediction.” (Shavelson, p.528) A MRA may allow this researcher to determine if certain types of wellness have a predictive relationship with counseling self-efficacy and the effect sizes of these relationships.

Potential Limitations

A limitation to be considered here will be the small sample size. It will be difficult to generalize results from such a small number of participants, and increasing the risk of a Type II error. In addition, generalizing results will be difficult as the participants are students at one southeastern university and are therefore not representative of all graduate counseling students. Secondly, when using Likert type scales (which is the case for both instruments in this study—CSES and 5F-Wel), there is an increased likelihood of regression to the mean. Another potential limitation involving the CSES will be that it is face validated by experts, all three of which are licensed psychologists rather than counselors.

Implications for Counselor Educators

There will be numerous implications for counselor educators based on this research study. If these two constructs are significantly related, then it would be beneficial—given the expected

outcome of client effectiveness, counselor retention, resilience, and career satisfaction and commitment—to infuse experiences that increase both of these factors within the counselor education curriculum. These experiences may include service learning, job shadowing, and co-facilitation experiences for self-efficacy promotion. Further, counselor preparation programs may integrate wellness models and self-care plans to be implemented upon initial program entry. Also, evidence based practices may be applied to these measures in the form of documentation and growth experiences. Further, the Council for Accreditation of Counseling and Related Education Programs (CACREP) may want to consider a wellness standard for counselor education curriculum.

In addition, researchers may compare outcome measurements of school counseling interns' 5F-Wel and CSES scores with those of mental health interns to investigate if significant differences exist. Implications for longitudinal research may be determining if self-efficacy and wellness are predictors of retention within the profession for either school or mental health counselors.

Conclusion

The relationship between CSE and career satisfaction, commitment, and effectiveness has been demonstrated. Wellness has been indicated in stress and anxiety reduction, and as a potential mitigating factor for burnout and compassion fatigue. With projected shortages of school counselors (Baggerly & Osborn, 2006) and growing stress in the field for mental health counselors, the need to be equipped as a self-advocate and well individual upon entering the field is crucial. Being prepared as a counseling professional includes understanding and implementing wellness strategies to foster resilience. Further, CSE may also be higher for

counselors who are more well. While it is a plausible and logical conclusion that a significant relationship exists between counseling self-efficacy and wellness, it is proposed here that the next step will be to determine statistically if a significant relationship exists, the strength of the relationship (effect size), and how one factor may contribute to the other. Counselor educators need to prepare future counselors for this exciting and challenging field by equipping them with the skills necessary to be successful and healthy.

CHAPTER TWO: LITERATURE REVIEW

Introduction

The field of counseling has grown and changed dramatically within its first hundred years of inception. Emerging theories, a myriad of techniques, dedicated leaders, and unique characteristics have assisted in establishing the counseling profession as a powerful field in the helping arena. Counselors entering the field today may enjoy the many benefits of the ground work of pioneers that have cultivated the core foundation of an identity that unifies the profession. However, there is still much more potential growth and considerable difficulties facing counselors today. Current adversity and struggles for counseling practitioners include high stress, burnout, and compassion fatigue (Butler & Constantine, 2005; Young & Lambie, 2007). In addition, many counselors experience continuing role conflict and ambiguity based on the divergence of expectations held among constituents, stakeholders, and counselors themselves (Amatea & Clark, 2005; Borders & Drury, 1992; Bryant & Constantine, 2006; Butler & Constantine; Clark & Amatea, 2004; Coll & Freeman, 1997; Culbreth, Scarborough, Banks-Johnson, & Solomon, 2005; Foster, Young, & Herman, 2005; Ginter & Scalise, 1990; Lambie & Williamson, 2004; Rayle, 2006; Zalaquett, 2005; Young & Lambie).

Stress is a topic that has gained considerable attention. Iwasaki, Mactavish, and Kelly (2005) stated, “stress is a frequent topic in popular media, health and social service, and policy-making areas” (p. 81). Both school and mental health counselors face work related and institutional stress factors. Organizations have become more bureaucratic, there are greater service delivery demands with fewer allocated resources, and counselors often are excluded from policy-making procedures (Young & Lambie, 2007). In mental health settings, counselors face

increasing pressure to diagnose and provide manualized treatment as prescribed by Health Maintenance Organizations (HMOs) and other agencies invested in profitable health services (Young & Lambie).

In professional school counseling the dissolution between role expectations of the counselor and job realities are evidenced through documentation of counselors performing non-counseling duties such as test administration, exorbitant amounts of lunchroom duty, substitute teaching, scheduling, clerical responsibilities and more (Baggerly & Osborn, 2006; Bryant & Constantine, 2006; Butler & Constantine, 2005; Kameen, Robinson, & Rotter, 1985, Lambie & Williamson, 2004; Rayle, 2006; Zalaquett, 2005). These duties and responsibilities are often in philosophical conflict with the counselor training received by professional school counselors (Culbreth et al.; 2005). Like their mental health counterparts, school counselors are specifically trained in the delivery of individual and group counseling, consultation, collaboration, and coordination (Galassi & Akos, 2004). However, in addition to balancing many roles, counselors today are also required to gain a wide range of competencies for working with respectively different and varied client populations.

Counselors must learn to work in multiple contexts (Galassi & Akos, 2004); they have to be able to navigate systems, and to understand the systemic processes that impact clients. Counselors serve as a powerful voice for change through leadership (Littrell & Peterson, 2001), advocacy, and social justice. Further, they must be (a) diversity sensitive and competent; (b) able to effectively assess development (Galassi & Akos); (c) knowledgeable consumers of research; and (d) proficient at collecting, analyzing, and reporting client outcome data for evaluating counseling and programs (Borders & Drury, 1992; Gysbers, 2004; Webb, Brigman, & Campbell,

2005). While the scope of expectations for counselor skills is broadening, the stress that counselors experience also appears to be increasing.

Job related stress has been cited throughout the counseling literature (Rayle, 2006; Bryant & Constantine, 2006). While it has always been a concern for the helping profession, changes in the field of counseling and in the world in general continue to become more paramount as stressors to counseling professionals. The restrictions placed on mental health counselors by managed care in addition to increasing case loads are impetus for burnout (Young & Lambie, 2007). Moreover, many counseling jobs are perceived to have lower status and, consequently, lower pay (Bryant & Constantine, 2006) in spite of extensive education at the graduate level and clinical training. For professional school counselors (PSCs), stress is increased through the growing achievement gap, greater numbers of students with specific learning needs, high role ambiguity, role conflict, and inordinately large student to counselor ratios (Lindahl, 2000; Young & Lambie). For example, poor funding for the staffing of professional school counselors resulted in a counselor to student ratio of 966:1 in the state of California (American School Counselor Association, 2006). Global stressors have also impacted counseling professionals. Examples include terrorist attacks (specifically those of 9-11) (Zalaquett, 2005), the growing disparity in socioeconomic strata, the changing demographics of the U.S. population, and legal mandates or federal policy that influence the lives of clients and service delivery. Therefore, political, social, and ecosystems also increase the amount of stress experienced by counselors in and out of work.

Additionally, stress has been shown to impact job performance (Young & Lambie, 2007). In lieu of the stress of working with clients in traumatic or crisis based service, many counselors experience burnout and compassion fatigue. According to Baggerly and Osborn (2006), compassion fatigue may be thought of as a “disturbing preoccupation” (p. 203) with a client’s

crisis or trauma and thus causing great emotional distress to the counselor—potentially to the point of burnout. Burnout “is characterized by emotional fatigue, disengagement, irritability, and apathy resulting from the work environment” (Butler & Constantine, 2005, p. 55). The combined experience of compassion fatigue, job stress, and burnout may lead to greater attrition or lower career commitment of counselors due to job dissatisfaction (Coll & Freeman, 1997, Culbreth et al, 2005). Another antecedent of job dissatisfaction may be the lack of congruence between expectations for career and the actual reality of the work—misalignment of the counselor’s daily work from their intended vocational interest (Harris, Moritzen, Robitschek, Imhoff, & Lynch, 2001; Lambie & Williamson, 2004; Studer, 2005). Further, those counselors who are highly stressed and experiencing job dissatisfaction but choose to remain in the field may have resultant low job achievement and accomplishment (Baggerly & Osborn, 2006; Culbreth et al; Rayle, 2006).

Wellness may be critical to bolstering resilience to job related stress, and thereby preventing counselor burnout and/or impairment (Young & Lambie, 2007). Impairment may be so detrimental to counselor performance and client welfare that it is currently an ethical mandate that counselors recognize and address impairment. Specifically, the American Counseling Association’s (ACA) *Code of Ethics* (2005) states, “counselors are alert to the signs of impairment from their own physical, mental, or emotional problems and refrain from offering or providing professional services when such impairment is likely to harm a client or others (ACA ethical standard, C.2.g).

It is therefore imperative to identify the factors that lead to greater resiliency for mitigating the impact of these experiences, thereby promoting the healthy functioning, vitality, and retention of counselors. Two potential factors identified in the literature and to be described

in this review are the constructs known as counseling self-efficacy and counselor wellness (Bryant & Constantine, 2006; Butler & Constantine, 2005). A historical review of these constructs and their relationship will be provided.

Literature Review

Counselor Wellness

The concept of wellness does not come solely from a linear progression of theories isolated within their entirety. Rather, it is a juxtaposition of multiple theoretical perspectives, the amalgamation of which is supported in literature and research. Wellness has been studied in many cultures throughout history, even dating back to the Ancient Greeks. The Greek God of healing, Aesculapius, had two daughters: Panacea (the Goddess of cures) and Hygeia (the Goddess who guards physical health and is the protector of mental health). Hygeia was charged with the preservation of well-being and her name is the root of modern words related to this task—such as hygiene (www.wordquests.info.com; Hettler, 1984). Thus, there appears to be interest in the wellness concept from early recorded history, and it continues today.

Wellness as a counseling approach in the United States today has roots in philosophy. The precursor to wellness may be traced to William James, the philosopher who promoted the concept of “free will” in psychology. This was in stark contrast to the more deterministic view of psychologists of the 1870s who believed that human behavior could be predicted and controlled (Bankart, 1997). James argued that humans have the ability to choose freely and that they are capable of influencing their own fate. The concept was both liberating and captivating—the caveat to having free will and individual choice is that each person has responsibility for his or her consequential outcomes—be they positive or negative (Bankart).

Both of these concepts—free will and personal responsibility--lead us to the next theorist to greatly influence the wellness concept—Alfred Adler.

Adler (1928) believed that human beings have free will, and that the media and academic focus on biological traits and hereditary characteristics was confusing people about the degree to which they could be accountable for their behavior. He contended that while social, unconscious, and biological forces may help shape an individual's goals, the individual has personal choice, free will, and responsibility for actions chosen. The life goals he described encompassed and represented several aspects of the self, which Adler believed to be interrelated and integrated and are the basis for the name of his theory--often referred to as Individual Psychology (1923). Adler elaborated on the origins of these life goals, explaining that they were derived from an individual's feelings of inferiority (Adler, 1928).

Adler (1923, 1928) believed that most people suffer from inferiority complexes and, as a result each person strives to become superior. Overcoming obstacles in one's life is a central theme in Adlerian psychology, and he contended individuals must have great courage to face these challenges victoriously. Adler asserted that we are all striving to be our best; all people want to be self-actualizing. According to Ansbacher and Ansbacher (1956), in Adlerian theory, "There is one basic dynamic force behind all human activity, a striving from a felt minus situation towards a plus situation, from a feeling of inferiority towards superiority, perfection, totality" (p. 1). This is done through goals that the person establishes based on his or her projected ideal self. Adler ascertained that biology and socio-contextual factors influence the formation of these goals, but ultimately, they are the creation of the individual (Adler, 1923).

Adler himself poignantly described the notion of inferiority through a demonstration of its application in his own life. Adler was born a very sickly child; it was documented that he had

rickets that greatly restricted his physical movement (Bankart, 1997). One tenet of Adler's theory is that of the importance of a person's early recollections for revealing inferiority complex origins. Adler himself shared some of his earliest recollections where he indicated the foreshadowing of his passion for understanding the inferiority complex and the creation of individual goals. In the following quote, given in an interview, he elucidates his own awareness of his physical inferiority as the condition that instigated his creation of physical goals for himself:

One of my earliest recollections is of sitting on a bench bandaged up on account of rickets, with my healthy elder brother sitting opposite me. He could run, jump and move about quite effortlessly, while for me movement of any sort was a strain and an effort. Everyone went to great pains to help me, and my mother and father did all that was in their power to do. At the time of this recollection I must have been about two years old (in Bankart, 1997, p. 131, quoted from Bottome, 1939, p. 30).

Adler (1923) posited that the goals derived from our feelings of inferiority were so imperative to the constitution of behavior that he stated "we cannot think, feel, will, or act without the perception of some goal" (p. 3). He recognized the importance of goal formation in different life arenas including: spirituality, friendship, love, and work. The combination of these goals formulates an ideal self for the individual, one which, in all probability, is unattainable. Therefore, goals were fictional but serve as motivators and inspiration for personal action and behavior (Ansbacher & Ansbacher, 1956).

In addition, Adler (1923) emphasized the unity and wholeness of the self—meaning that all of these life goals were important as integrated aspects of the self. Life arenas have a reciprocal impact on each other, as well as the total functioning of the individual and striving for

the ultimate superiority: self-actualization. Following Adler's lead toward self-actualization, Maslow expanded the concept to a theory. Maslow concluded that human beings are autonomous, self-motivated, self-regulatory and are continually growing toward self-actualization (Maslow, 1971). He also subscribed to the notions of free will, free choice, personal responsibility, and striving for superiority which he called "dominance-feeling" (Lowry, 1973, p. 19). Maslow (1943) used the term healthy as practically synonymous with motivation to develop and self-actualize (Lowry; Hoffman, 1999). He further acknowledged the reciprocity of healthy individuals and their environments, stating, "Improving individual health is one approach to making a better world" (1968, p. 6).

Like Adler, Maslow (1991) asserted that unleashing one's full potential takes great courage. Specifically he stated, "The difference between the diminished individual, wistfully yearning toward full humanness but never quite daring to make it, versus the unleashed individual, growing well toward her destiny is simply the difference between fear and courage" (p. 120). Maslow also posited that contextual factors were necessary to foster self-actualization manifestation. These factors included having physiological, safety, and belonging needs met. He articulated the characteristics possessed by self-actualized persons (while simultaneously acknowledging that self-actualizing is rarely reached although all humans are capable of it and innately strive for it). The following is a list of characteristics that according to Maslow (1968) would be seen in the self-actualized person: (a) integration and unity of the whole person, (b) openness to experience, (c) feelings of zest in living, (d) responsibility, (e) wisdom, (f) honesty, (g) kindness, (h) ability to love, (i) firm sense of identity, and (j) confidence in one's stress management skills. Both Maslow and Adler made tremendous contributions to the understanding of healthy individuals and wellness approaches to clients.

In the 1970s, wellness took root in the medical community. Ardell (1986) published his first book on high level wellness in 1977 and reprinted a second edition 10 years later. The book expounds upon many holistic wellness concepts and is meant to be an alternative to an illness or medical model way of viewing medical patients (a philosophical approach echoed in the positive psychology movement away from diagnosis). His early conclusions about wellness were: (a) lifestyle awareness and intentionality are the most beneficial paths to being healthy and preventing illness or degenerative disease, (b) the positive effects of being healthy in one area of life will promote positive gains in other life areas, (c) a person can be well even in the midst of death or illness, and (d) every person can attain a high level of wellness. Further, Ardell described the mission, foundational guiding principles, and strategies of early Wellness Resource Centers (WRC) developed to promote healthy lifestyles in clients. In particular he stated:

The Wellness Resource Center staff works to help clients learn how to take charge of their own lives and to feel good about themselves. What happens is not medicine, as most of us think of medical services; it is an alternative approach wherein Travis and staff are facilitators and assistants to clients moving toward high level wellness. (p.11)

Ardell (1986) also described early assessment strategies for wellness including a wellness self-evaluation called the Wellness Inventory (as cited in Ardell, 1986—inventory author not identified). This 100 page workbook contained wellness checklists and psycho-educational information on optimal wellness. Questions on the checklist stressed a comprehensive range of wellness domains including: sleep patterns, personal care, home safety, nutritional awareness, physical activity, environmental awareness, emotional maturity, emotional expression, community involvement, creativity, parenting, and automobile safety. No information was

found by this researcher on how the Wellness Inventory assessment was scored or how the information was utilized for client intervention or client outcome comparisons.

Following a holistic program design, the four main dimensions targeted by WRCs for client wellness were (1) stress control, (2) self-responsibility, (3) nutrition, and (4) physical fitness. The dimensions of stress control included client creativity, ability to navigate stress, leisure, and methods employed by the client for stress reduction. The self-responsibility dimension was specifically designed with this objective, "...an effort is made to aid clients in understanding how they are responsible for the pressures and tensions in their lives" (Ardell, 1986, p. 15). The nutrition dimension was addressed through instruction about foods, vitamins, and minerals with an emphasis on balance. The physical fitness dimension was focused on endurance, flexibility, and strength (Ardell).

In his own discussion of holistic wellness, Ardell (1986) adds a fifth dimension to the list provided by the WRC—environmental sensitivity. According to Ardell, environmental sensitivity encompasses three aspects: (a) the physical, (b) the social, and (c) the personal. He described the physical as the landscape that surrounds an individual; the social as the economic, social and cultural climate; and the personal as "the extent to which your immediate surroundings either affirm or deny, facilitate or inhibit, your efforts to pursue high level wellness" (p. 163). While his book gives the practitioner a rationale for implementing wellness with clients, concrete strategies, techniques, and an exhaustive literature list for those seeking more information, he does not address client outcomes or evaluating programmatic success. We are left not knowing the degree of impact to which participants of WRC experienced wellness changes in their life. Further, it is unclear how wellness benefited the participants (i.e. less depression, greater gains in efficacy, reduction in illness, etc.). Lastly, Ardell himself

reconsidered his model and proposed some possible changes such as combining fitness and nutrition and adding an ethics, values, and purpose dimension as well as centering the dimensions around social norms and rules (Ardell).

Like the medical community, members of academia also began to incorporate concepts of wellness into practice in the 1970s. The University of Wisconsin at Stevens Point integrated a wellness philosophy into the mission of their Student Life Division and provided services for students designed to enhance six dimensions of functioning: (a) social, (b) occupational, (c) spiritual, (d) physical, (e) intellectual, and (f) emotional (Hettler, 1984). Hettler encapsulated the reasoning for a wellness approach in higher education by stating, “It seems ludicrous to prepare a student for a lifetime career in their area of interest and not prepare them for the responsibilities of maintaining their life” (p. 17). A holistic paradigm was also introduced in some counselor preparation programs around this time. For instance, J. Melvin Witmer decided to combine humanistic theory and health psychology in his scholarly teaching practice at Ohio University, creating a course called *Biofeedback and Self Control*. The class was a concerted effort by Witmer to introduce students to the power of the mind-body connection (Young & Lambie, 2007). Pursuant to this, Witmer would become one of the pioneers of the modern wellness movement in counseling.

Other counselors and psychologists chose a somewhat different approach and examined risk factors and resilience. In looking at developmental risk factors, Masten and Reed (2002) noted, “Resilience generally refers to a class of phenomena characterized by patterns of positive adaptation in the context of significant adversity or risk” (p.75). Factors found to increase resilience to risk and to predict adaptation in adverse context include self-worth, humor, spirituality, problem solving, positive relationships, self-regulatory behavior, and self-efficacy

(Masten & Reed). These resilience factors are foundational skills and competencies also noted throughout wellness literature; suggesting that these factors may be interrelated concepts. Specifically, wellness may in fact bolster resilience to job related stress—a risk factor in counselor impairment (Young & Lambie, 2007).

Wellness and holistic approaches have begun to emerge within many facets of counseling today. For example, Griffith (2004) promoted Internal Working Models for assessing client world view. This model hosted several elements related to client construction of meaning and subsequent behavior including: (a) client past experiences, (b) current context, (c) beliefs, (d) goals, (e) strategies, (f) actions, and (g) reactions. Particularly relevant to counselor wellness were the goals that were purported by Griffith. Griffith contended, similarly to Adler, that all humans have basic goals and that these are critical to and essential for motivating behavior. He further elaborated the four life arenas in which goal formation occurred (albeit most likely informally)—spirituality, socio-emotional, work/competency based pursuits, and physical well being. Again, the domains reflect a holistic conceptualization of the person—the balance of which is crucial to wellness.

Wellness in Counseling Today

More recently, there is a deliberate movement in the fields of medicine and counseling to adopt a holistic perspective and wellness paradigm (Wiedenfeld, O'Leary, Bandura, Brown, Levine, Raska, 1990). More than avoiding disease or experiencing an absence of illness, there is an emphasis on prevention and lifestyle choices that promote optimal functioning (Myers, Sweeney, & Witmer, 2000). This is done through taking personal responsibility and making positive choices (Parmer & Rogers, 1997).

Sweeney and Witmer (1991) further developed the concept of holistic wellness approaches in counseling. Then, Myers, Sweeney, and Witmer (2000) demonstrated a (WoW) model for treatment planning which they called the Wheel of Wellness Model. The conceptual framework of this model is illustrated within the name—a wheel of interrelated spokes (wellness domains)—all of which are integrated and reciprocally impactful. The authors chose five wellness domains, based on Adlerian theory, for the conceptual framework including: (a) love, (b) friendship, (c) spirituality, (d) work, and (e) self-direction. Love and friendship were the spokes that deal with social and relational wellness. Spirituality was the spoke concerned with personal transcendence and universal connection. Work was the wellness domain that specifically addresses career satisfaction and the ability to establish significant career support networks. Self-direction was the domain that encompasses the individual's ability to set goals and direct behavior to those ends including physical and nutritional health, self-esteem, realistic beliefs, humor, sense of control, emotional awareness and coping, problem solving/creativity, self-care, stress management, cultural identity and gender identity (Myers et al., 2000).

The Wheel of Wellness Model of counseling proposed by Myers and colleagues (2000) was theoretically grounded in a prevention focused, anti-pathological, developmental lifespan, strengths-based paradigm. The model was designed to assist counselors in holistically conceptualizing client wellness and pro-active, comprehensive intervention. The authors further suggested four steps for implementing the model within multiple contexts (i.e. individual counseling, group counseling, classrooms, training programs, etc.). The four steps were (1) introducing participants to the model, (2) assessment of current wellness functioning based on the model and its components, (3) deliberately designed interventions based on needs reflected in assessment, and (4) evaluation of client progress or ongoing needs. If needed per evaluation,

the counselor or educator would re-initiate the cycle until the projected goals of counseling were attained (Myers et al.).

Myers and colleagues (2000) also created an instrument for use in assessment in conjunction with their model. The instrument, The Wellness Evaluation of Lifestyle (WEL) (2000), was used to measure the five domains posited in the WoW Model. The Instrument was reportedly normed on a sample greater than 4,000 and had test-retest reliability between .90 and .96 for all scales (Myers et al, 2000).

However, Hattie, Myers, and Sweeney (2005), ran exploratory factor analysis on the WEL and discovered one composite overall factor for global wellness functioning, with five second order factors for wellness domain functioning. It is important to note that the factors that emerged in a structural equation model analysis of data were not the domain factors hypothesized in the original Wheel of Wellness Model. The five second order factors that emerged are listed in *Table 1* along with 17 third order factors.

Table 2. Second and Third order factors derived from exploratory factor analysis of the WEL based on the Wheel of Wellness model.

Second Order Factors	Third Order Factors
1. Essential Self	Culture Identity, Gender Identity, Self Care, Essence
2. Social Self	Love & Friends
3. Creative Self	Intelligence, Control, Emotion, Humor, and Work
4. Physical Self	Exercise & Nutrition
5. Coping Self	Leisure, Stress, Worth, Beliefs

Hattie and colleagues contend that the new model, the Indivisible Self, is constructed of interrelated domains. Please see Figure 1. To understand each of these domains, one needs to understand how the domains were defined and what they theoretically contribute to overall wellness. Elaboration associated with third order factors follows.

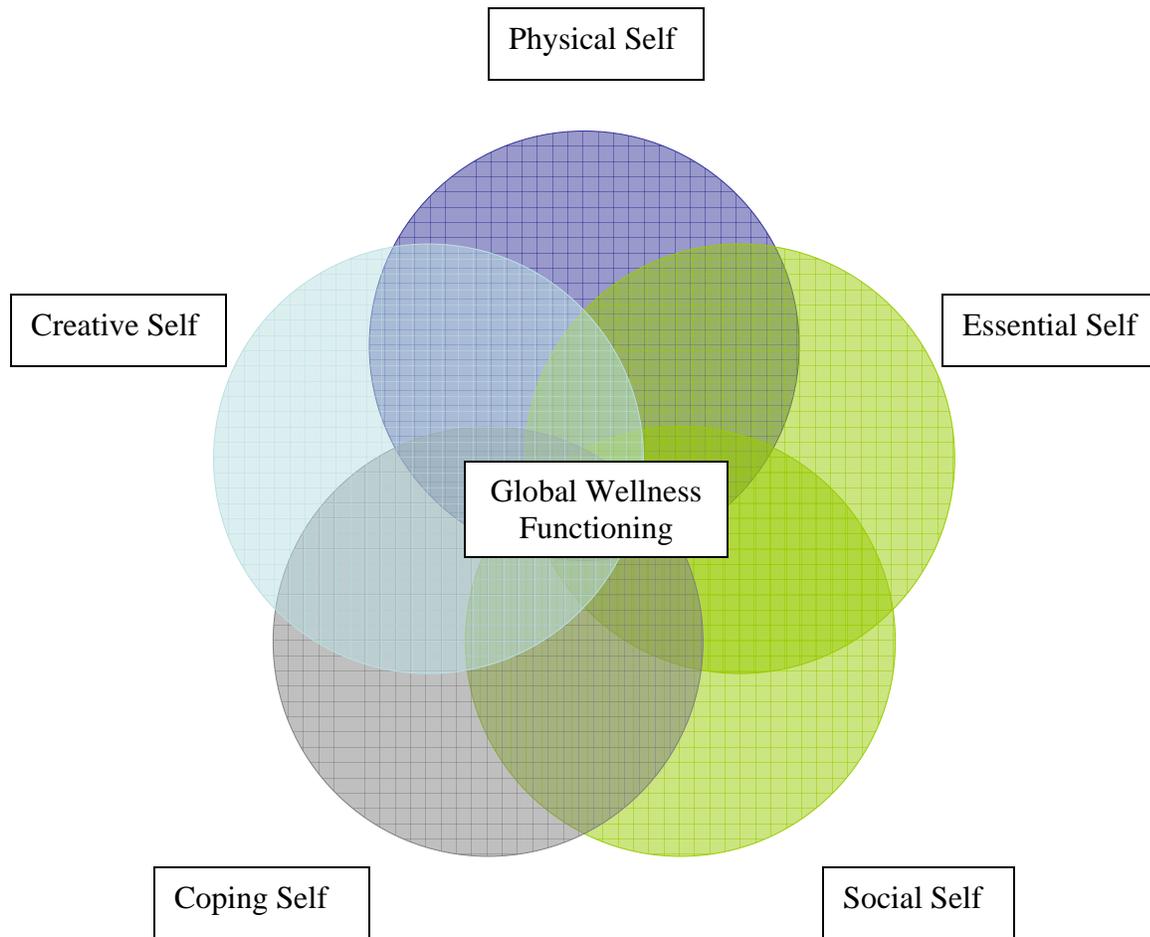


Figure 1. Venn Diagram of Indivisible Self Model

Physical Self

The U.S. Department of Health and Human Services summary health statistics for 2004 (Centers for Disease Control and Prevention, 2006) revealed that over 35% of U.S. adults are overweight, nearly 24 % are obese, and approximately 61% reported never participating in rigorous physical activity. In addition, 20% were smokers, and 47% were regular alcohol

drinkers. Further, over 215, 000 adults reported having migraines and or pain in the neck, back, face or jaw (p.31).

Bandura (2005) believed that a health model was more useful than an illness or disease model for promoting physical well-being. He wrote that mitigating health risks through healthy practices was necessary for decreasing the high cost of health care and the debilitation of disease. With pharmaceutical companies devising public marketing strategies and paying to advertise medicines and antidotes, the American public has become consumers of medical technologies, supplies, and interventions. He contended that it is far more cost efficient and beneficial to the individual's quality of life to develop preventative strategies for maintaining health, rather than attempting to repair illness (Bandura).

The third order factors of the physical self include exercise and nutrition. According to Sweeney and Witmer (1991), evidence exists that mood is greatly affected by regular and appropriate exercise. There appears to be a positive relationship wherein adherence to a stable and healthy exercise routine increases positive mental functioning and mood, contributing to overall wellness functioning.

Social Self

Fredrickson (2002) suggested that the meaning made of social situations was relevant for each individual, as it is personally constructed. She stated, "a social activity, for instance, can be construed as feeling connected to others and cared about..." (p. 130). Positive social connections--whether they are intimate and romantic, family ties, or mutual friendships--were characterized by acceptance, respect, reciprocity, and seeking to know and be known within the context of the relationship (Harvey, Pauwels, & Zickmund, 2002). Sweeney and Witmer (1991)

asserted that positive friendship requires self-disclosure, risk-taking, and personal responsibility. In addition, individual's with positive social relationships must have the ability to forgive transgressions. Forgiveness was associated with lower depression, less anxiety, decreased rumination on negative events, increased mental health and well-being (McCullough & Witvliet, 2002).

Another core trait of individuals with positive social abilities was gratitude. Gratitude has been a socially desirable trait across cultures and time, and may be characterized as, "a felt sense of wonder, thankfulness, and appreciation for life" (Emmons & Shelton, 2002, p. 460). Within relational context, gratitude promotes feelings of love and esteem, affirming the positive aspects of the relationship. Additionally, research has been conducted on romantic, or love based relationships. For example, Hendrick and Hendrick (2002) contend that love is central to and mandatory for the procurement of happiness.

Mattering has also been shown to be related to wellness. Mattering is defined by Rayle and Myers (2004) as "a sense of belonging in relation to others" (p. 81), or feelings of social importance. Rayle and Myers studied the relationship between (1) mattering, (2) ethnic identity, (3) acculturation, and (4) wellness. Of these constructs, mattering was the greatest predictor of wellness.

One further finding relating positive social life and wellness was based on a wellness group for older women. Ruffing-Rahal, and Wallace (2000), stated concerns that the elderly experience high-risk beyond physical ailments, including depression, isolation, increasing dependence on others, and grief and loss through death of members of their support network. Using an ecological model of well-being, the researchers developed a group with three core themes: (a) group ritual (activity), (b) group celebration (affirmation) and (c) group community

(synthesis). Group topics included safety, services for the elderly, medical treatment, coping with loss, nutrition, and well-being. Ruffing-Rahal and Wallace reported that the group has continued to meet and that the connection made by members is therapeutically improving their wellness and their lives.

Essential Self

Maslow (1968) stated that self-actualizing people have a “real self; a firm identity” (p. 157). Identity may encompass many facets including culture, ethnicity, gender, religion, core values, and more. These essential components of self may influence how an individual perceives the events of his or her life. Specifically, according to Sweeney and Witmer (1991), “We are affected, however, not so much by what happens as a result of circumstances or events, as by how we interpret and give meaning to what happens” (p. 530). Further, religion and spirituality were indicated as a key component of cultural identity and health according to Parmer and Rogers (1997). They identified specific reasons for this association stating:

Therefore, religion as an aspect of spirituality may influence one to examine health issues by (a) encouraging a healthy lifestyle, (b) prescribing healthy behaviors that prevent illness, (c) providing support systems when faced with stressful life events, and (d) fostering spiritual attitudes of faith that will sustain an individual in crisis (p. 60).

One example of the relationship between religion and health may be identified in Seventh Day Adventist doctrine (Parmer & Rogers, 1997). Practices that fostered the development of healthy habits were observed in the church community including abstaining from pork, smoking, alcohol, and encouragement to be vegetarian (Parmer & Rogers). Parmer and Rogers also identify race as linked to wellness by evidencing the life expectancies of African Americans to

Whites (69.2 years and 76 years respectively). Socioeconomics as a cultural variable may also contribute to wellness. Payne (1996) contended that resource allocation affects an individual's ability to afford healthier food and to gain exposure to life-enriching activities and educational events. Rayle and Myers (2004) found that ethnic identity was a significant predictor of wellness in minority youth.

In addition to the variable of cultural identity, gender identity strongly influences health living, too. Parmer and Rogers (1997) found that women placed more value than men on good habits to promote health and placed less confidence in medical care as a source of prevention. However, in a study of Black college students readiness to be physically active (Kelly, Lowing, & Kelly, 1998), only 32% of the women in the study were active compared to 57% of the men. In summary, the Essential Self is comprised of the characteristics that are the essence of the individual: culture, gender, and spirituality.

Coping Self

According to Bandura (1997), "people with high coping capacities have better control over disturbing thoughts" (p. 4), and are better able to reduce negative rumination by positively managing and regulating their thoughts and emotions. Coping by attempting to understand and acknowledge one's emotions during distressing events was found to be significantly linked to lower trait anxiety, lower depressive symptoms, and lower neuroticism in undergraduate women; additionally, coping through emotions was associated with positive adjustment (Stanton, Parsa, & Austenfeld, 2002). Other benefits of coping by appropriate emotional expression are habituation to a stressor allowing for a reappraisal of the stressor, and may facilitate regulation of

the environment. An example given was that expressed emotions may allow supportive friends or partners to understand and assist an individual in distress (Stanton et al., 2002).

Leisure is described by Iwasaki, Mactavish, and Mackay (2005) as “a self-protective coping device that may serve a variety of functions—buffering the effects of negative life events, providing a distraction from stress, or generating hope for the future” (p. 82). Leisure can be empowering, provide palliative relief, increase positive feelings including hope, and increase stress coping. Leisure activities vary among individuals and include rest, social time, physical activity, and more (Iwasaki et al).

Beliefs--another third order factor in coping--refer to an individual’s realistic interpretation of events. Specifically, according to Sweeney and Witmer (1991), “The greater the discrepancy between one’s private logic and reality, the greater the probability for inappropriate behavior in response to life events” (p. 531). Further, fixation on negative thoughts and negative beliefs may cause greater emotional distress and turmoil, possibly exacerbating reactions to stressful life events (Sweeney & Witmer).

Creative Self

Creativity is a valuable resource in today’s culture and is often rewarded--as evidenced by Nobel prizes, Pulitzers, Golden Globes, etc. (Simonton, 2002). However, this is not a newly appreciated asset but one with a rich history featured as far back as Roman mythology.

Simonton (2002) stated:

According to Roman mythology, each individual was born with a guardian spirit who watched out for the person’s fate and distinctive individuality. With time, the term was taken to indicate the person’s special talents or aptitudes. Although in the beginning

everybody could be said to 'have a genius', at least in the sense of possessing a unique capacity, the term eventually began to be confined to those whose gifts set them well apart from the average. The expression 'creative genius' thus unites two concepts with Greek and Roman roots pertaining to how the spiritual world permeates human affairs. Outstanding creativity was the gift of the gods or spirits, not a human act...With the increased secularization of European thought, however, the causal locus of creativity gradually moved away from the spiritual to the human world. Once this cultural shift took place, the phenomenon became the subject of psychological inquiry (p.190).

Creativity continues to attract attention today from educators, and cognitive and positive psychology researchers. The caveat to this line of research is that creativity is often difficult to define and measure. In more recent history, theorists such as Rogers (1954) and Maslow (1971) began to look at creativity as it applied to problem-solving and adaptation. Maslow believed that creativity promotes greater overall health, specifically stating, "anything that would help the person to move in the direction of greater psychological health or fuller humanness would amount to changing the whole person" (p. 74). He also alluded to the reciprocal nature of creativity in wellness by stating that with increased health, individuals were likely to be more creative.

Maslow (1971) further concluded that there were many ways to be creative and numerous variables involved in the development of creativity. Simonton (2002) viewed creativity similarly, and suggested that there are two types of creativity: everyday life or work enhancing creativity through problem solving, and creativity that alters or permanently influences culture and history. Simonton also contended that creative individuals display particular characteristics such as (a)

openness to different experiences, (b) playfulness, (c) nonconformity, (d) cognitive flexibility, and (e) imagination. Thus, creativity appears to be a multifaceted characteristic.

Within the framework of the Indivisible Self model of wellness, Hattie and colleagues (2004), found that the second order factor of creativity contained the third order factors of intelligence, control, emotions, humor, and work. Sweeney and Witmer (1991) noted that control is often referred to as competence, self-efficacy, or locus of control. The concept of control has gained attention in positive psychology because of its role in adaptive functioning. Specifically, Thompson (2002) indicated that “A person’s self-assessment of the ability to exert control is called perceived control--the judgment that one has the means to obtain desired outcomes and to avoid undesirable ones” (p. 203).

Control promotes hope, and a sense of competent mastery over oneself, even in the bleakest of circumstances. Viktor Frankl (1963) wrote about prisoners in Nazi concentration camps having no physical control over their surroundings but still maintaining control of their attitudes, beliefs, and ability to construct their own meanings and hope. In regard to wellness, Thompson (2002) stated that when people perceive that they have control, they are more likely to plan and implement action to reduce or avoid stress. Further, “control is beneficial because it is associated with positive emotions, leads to active problem solving, reduces anxiety in the face of stress, and buffers against negative physiological responses” (p. 204). Control is indicative of an individual’s choice about how to handle challenges and difficulties and what coping strategies to utilize in navigating such situations. It facilitates a person’s reliance on positive coping, such as using humor to alleviate stress.

Humor has also been identified as a third order factor under Creativity. Laughter and humor have been associated with healing for centuries in the medical community. Lefcourt

(2002) cited a surgeon named Henri de Mondeville from the 13th century who believed patients would recover more swiftly if they were happy, joyful, and laughing. In research on the benefits of humor, Lefcourt found that “higher scores on the various measures of humor related to less depression and irritability regardless of the frequency and intensity of life stressors” (p. 623). He further asserted that humor may be positively correlated with recovery from illness, dealing with mortality, coping, and even immune system functioning—which may be particularly critical since immune system functioning is suppressed during stressful or negative events, making the individual more susceptible to the ill-effects of such difficulties. According to Sweeney and Witmer (1991), humor “promotes physiological, psychological, and social change” (p. 533).

Likewise, emotions have been found to impact physical well-being. For example, negatively charged emotions prompt increased cardiovascular activity while positive emotions foster recovery from heightened cardio responses (Fredrickson, 2002). Further, Fredrickson hypothesized that, “if positive emotions broaden the scope of cognition and enable flexible and creative thinking, they also should facilitate coping with stress and adversity” (p. 126). Positive emotions increase an individual’s personal, internal resources for dealing with stressors.

Empirical Research on Counselor Wellness

The importance of a wellness paradigm was underscored by the ACA through the infusion of concepts such as the promotion of developmental factors that facilitate greater optimal potential for clients in the 1988 strategic plan (Myers, 1992). Further, the 1991 annual ACA convention theme was wellness (Myers). However, while there is vast support for and research on client wellness, limited research has been published on counselor wellness and counseling students’ wellness. In fact, according to Myers, Mobley, and Booth (2003) there is a paucity of information on how to effectively promote the personal development of counseling

students. In this section, the author will outline studies of wellness specifically related to counselors and counseling students.

Myers and colleagues (2003) conducted a study of 263 counseling graduate students including both doctoral and masters level. Doctoral students had greater wellness scores than masters students and masters students had greater scores than the general population based on the norm referenced WEL. Therefore, it was suggested that, “it is possible that wellness incorporates a developmental component for students and that the longer a student matriculates in a counseling program, the more wellness he or she may experience” (Myers et al., p. 272). However, these findings were contradictory to a dissertation study conducted by Roach (2004). Roach looked at the wellness of counseling students at the beginning, middle, and end of their program based on hours completed in CACREP accredited graduate counseling programs. The results indicated that no matter how long a student had been in the program, wellness was not differentiated. Thus, time in the program and matriculation did not appear to significantly increase wellness developmentally. However, it is important to note that a substantial limitation existed in Roach’s study. The data was not collected longitudinally, it was collected concurrently through cross-sectional sampling; and therefore the participants did not represent the growth and development over time of individuals in a counseling program, but rather represented wellness of student cohorts.

Another important study was conducted by Smith (2006) who examined the social desirability of graduate counseling students’ answers on the 5F-WEL. Smith administered both the 5F-WEL and the Marlowe-Crown Social Desirability Scale. She found that students did not appear to answer 5F-WEL questions in a manner to increase social desirability. In other words, the counseling students appeared to answer wellness questions honestly (Smith).

Wellness is clearly a construct that has received much attention and continues to be studied by counselors and other professionals. Wellness provides one means of assessing counseling students and has much potential and promise for counselor educators seeking to improve counselor preparation programs. However, little empirical research has been conducted on counselor wellness and on the impact of counselor training programs on the wellness of developing counselors (Myers et al., 2003). The current study seeks to decrease the literary paucity of counselor wellness research while also bringing greater attention to a potentially related construct: self-efficacy. Self-efficacy may be another construct that is critical for understanding counselor development and ongoing career success.

Counselor Self-Efficacy

It is ineffective to attempt to extrapolate and define self-efficacy without first describing basic tenets of social learning theory, which provides the supportive theoretical assumptions for this construct. Bandura (1977), the creator of social learning theory, proposed that reciprocal determinism exists between cognitive, behavioral, and environmental factors. He contended that the interactions of this trifecta, not just one facet, impact the individual as variant sources of influence, depending on circumstances and context. He further believed that the relationship between these factors was not a function of unidirectional operation, but rather, “interlocking determinants” (p. 10). Please see Figure 2.

The environment may foster and support individuals or may inhibit optimal growth and development. The individual’s behavior may reciprocally influence the environment through positive or negative impact. Further, characteristics of the individual (cognitive, affective, and physiological) also interact with the environment and behavior to shape circumstances (Bandura,

1977). Within this framework, it is the cognitive process characteristics of the individual that are paramount to understanding self-efficacy.

One additional basic tenet of social learning theory was understanding the person's cognitive influence on their environment and behavior is self-regulation. According to Bandura (1977), "By arranging environmental inducements, generating cognitive supports, and producing consequences for their own actions, people are able to exercise some measure of control over their own behavior" (p.13). To fully comprehend self-regulation, it is critical to conceptualize how it is generated and maintained. Self-regulation stems from the individual envisioning potential courses of action, judging his or her ability to produce the actions necessary for desired outcomes, and then goal-setting and taking action. Therefore, the self-regulatory function was dependent upon efficacy expectations, and this leads to a discussion of the self-efficacy construct.

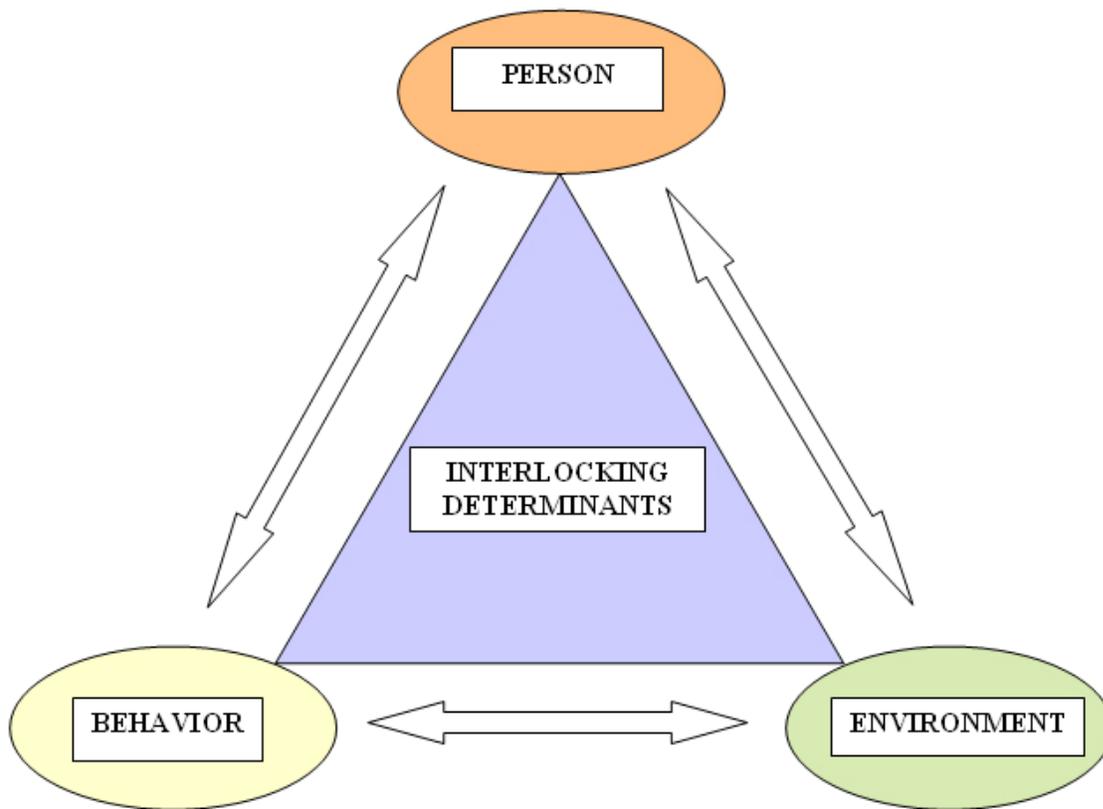


Figure 2. Behavior, Cognition, and Environment as Interlocking Determinants (Adapted from Bandura, 1977)

In order to regulate one's own behavior, the individual must be able to estimate outcome expectations for actions. As previously stated, this includes approximating consequences, the action required for any behavior, outcome expectancies, and an evaluation of one's abilities to successfully complete desired behavior (Bandura, 1977). An individual's efficacy expectation is "the conviction that one can successfully execute the behavior required to produce the outcomes", (Bandura, 1977, p. 79). Competent mastery of any given task requires the minimal skills necessary to perform the task and feelings of efficacy in one's ability to effectively apply skills (Bandura, 1986).

According to Bandura (1977), self-efficacy—a person’s determination about their ability to be successful—affects the degree of effort an individual will put forth in overcoming difficult or arduous circumstances. The more competent and capable a person believes he or she is, the more likely the individual is to undertake stressful situations. To illustrate this point, Bandura (1986) stated, “there is a marked difference between possessing sub-skills and being able to use them well under diverse circumstances. For this reason, different people with similar skills, or the same person on different occasions, may perform poorly, adequately, or extraordinarily” (p. 391). In general, people are unlikely to undertake tasks for which they believe they are incompetent (Bandura). However, they are willing to persevere through difficult tasks if they judge themselves to have the skills necessary to do so, and believe that they will eventually be successful.

Further, according to Bandura (1977), “perceived self-efficacy not only reduces anticipatory fears and inhibitions but, through expectations of eventual success, it affects coping efforts once they are initiated” (p. 80). This conceptualization about efficacy and coping through stress was expanded by Fernandez-Ballesteros, Diez-Nicolas, Capara, Barbaranelli, and Bandura (2002) when they suggested that, “unless people believe they can produce desired outcomes and forestall undesired ones through their actions, they have little incentive to act or to persevere in the face of difficulties” (p. 108). In that statement the authors imply that efficacy is an internal motivational source and lack of efficacy may result in resignation. Therefore, self-efficacy prompts the individual to navigate stress through pro-action, and to endure stress for greater quantities of time in order to achieve some goal or to perform some desired behavior.

According to Bandura (1977) there are four main sources of efficacy expectations: (a) performance accomplishments, (b) vicarious experience, (c) verbal persuasion, and (d) emotional

arousal. Bandura labeled these hierarchically based on each source's dependability as an influence on efficacy (Please see *Figure 3* for clarification). The strongest dependent contributor was performance accomplishments—shown in the figure as the base foundation. The other sources of efficacy expectations are placed respective to their reported degree of contribution, from greatest at the bottom to least at the top, according to Bandura.

Performance accomplishments (Bandura, 1977) were the most dependable source of efficacy expectation because they are based on the lived experience of the individual. The more success the individual experiences, the greater will be the efficacy for mastery of increasingly difficult competencies. The converse is also true, if the individual experiences repeated failure—thus producing lower efficacy expectations. Vicarious experience was the second most dependable producer of efficacy expectation. It was described by Bandura as “Seeing others perform threatening activities without adverse consequences can create expectations in observers that they too will eventually succeed if they intensify and persist in their efforts” (p. 81). There are two additional, and less dependent, sources of efficacy expectations: verbal persuasion and emotional arousal.

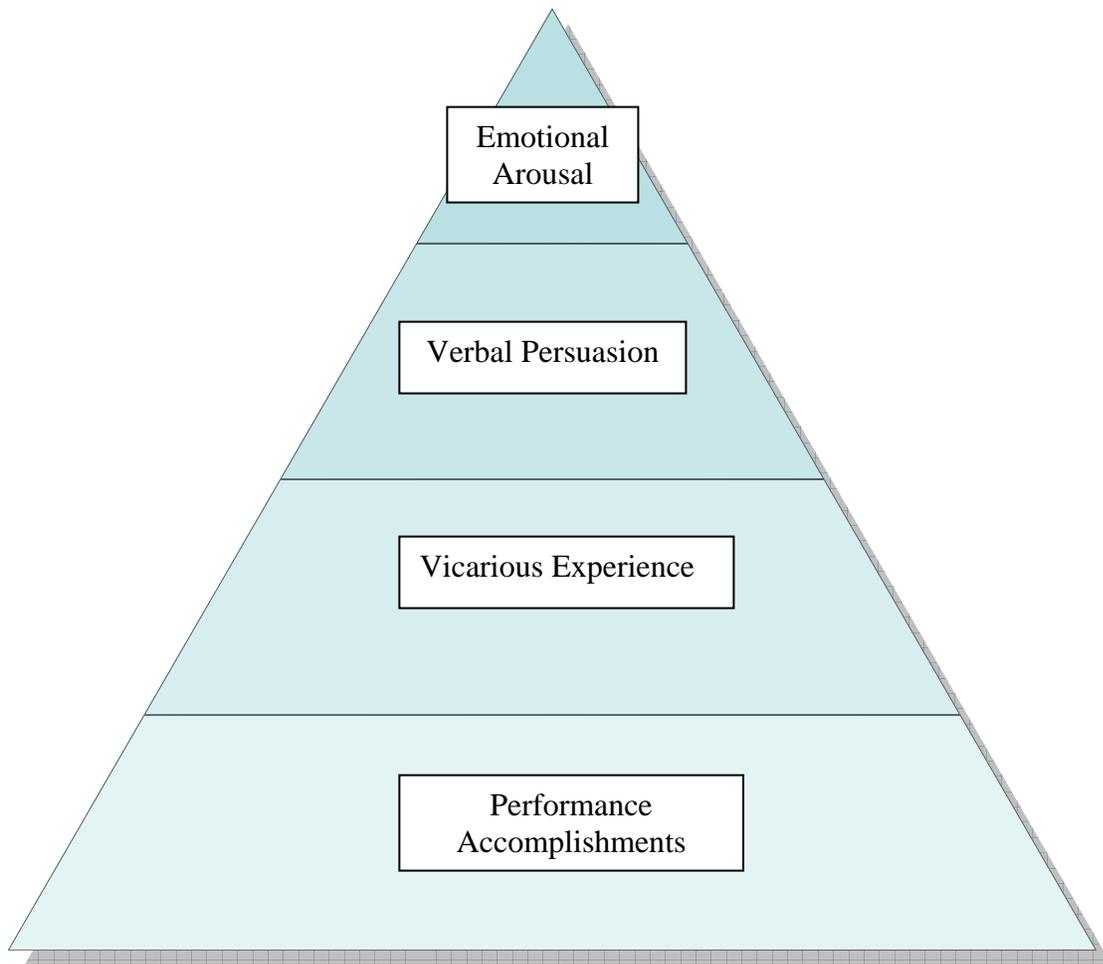


Figure 3. Graphical Depiction of the Hierarchy of Efficacy Expectation Sources (adapted from Bandura, 1977).

Verbal persuasion (Bandura, 1977) is verbal encouragement or prompting including exhortation and suggestion; it is the third most dependable source of efficacy expectancy. Bandura ascertained that this type of efficacy would be short-lived at best, especially if the individual experiences disconfirmation of competence. The last of the sources was emotional

arousal. Emotions are often perceived by individuals as critical information about the amount of stress they are capable of enduring. Fear, anxiety, and nervousness—normal emotions in new or stressful circumstances—are often misattributed to lack of ability by the individual. This negative labeling may spark a cyclical reaction according to Bandura, “because high arousal usually debilitates performance, individuals are more likely to expect success when they are not beset by aversive arousal than when they are tense, shaking, and viscerally agitated. Fear reactions generate further fear”, (p. 82). Emotional arousal may be relabeled to increase positive efficacy expectation.

Finally, Bandura (1977, 1986) contended that efficacy beliefs differ on three dimensions. The first is magnitude, based on the simplicity versus the complexity/difficulty of the task being considered by the individual. The second dimension is generality. Generality was the degree to which efficacy beliefs are specific to given tasks or if they are broad to other life arenas or competencies. The third dimension was strength. The stronger an efficacy belief, the less impact disconfirming circumstances have on the individual and the greater effort a person will exert to master challenges. Conversely, those with low self-efficacy discontinue or decline efforts if they are met with failure (Bandura, 1986). (*Figure 4.*)

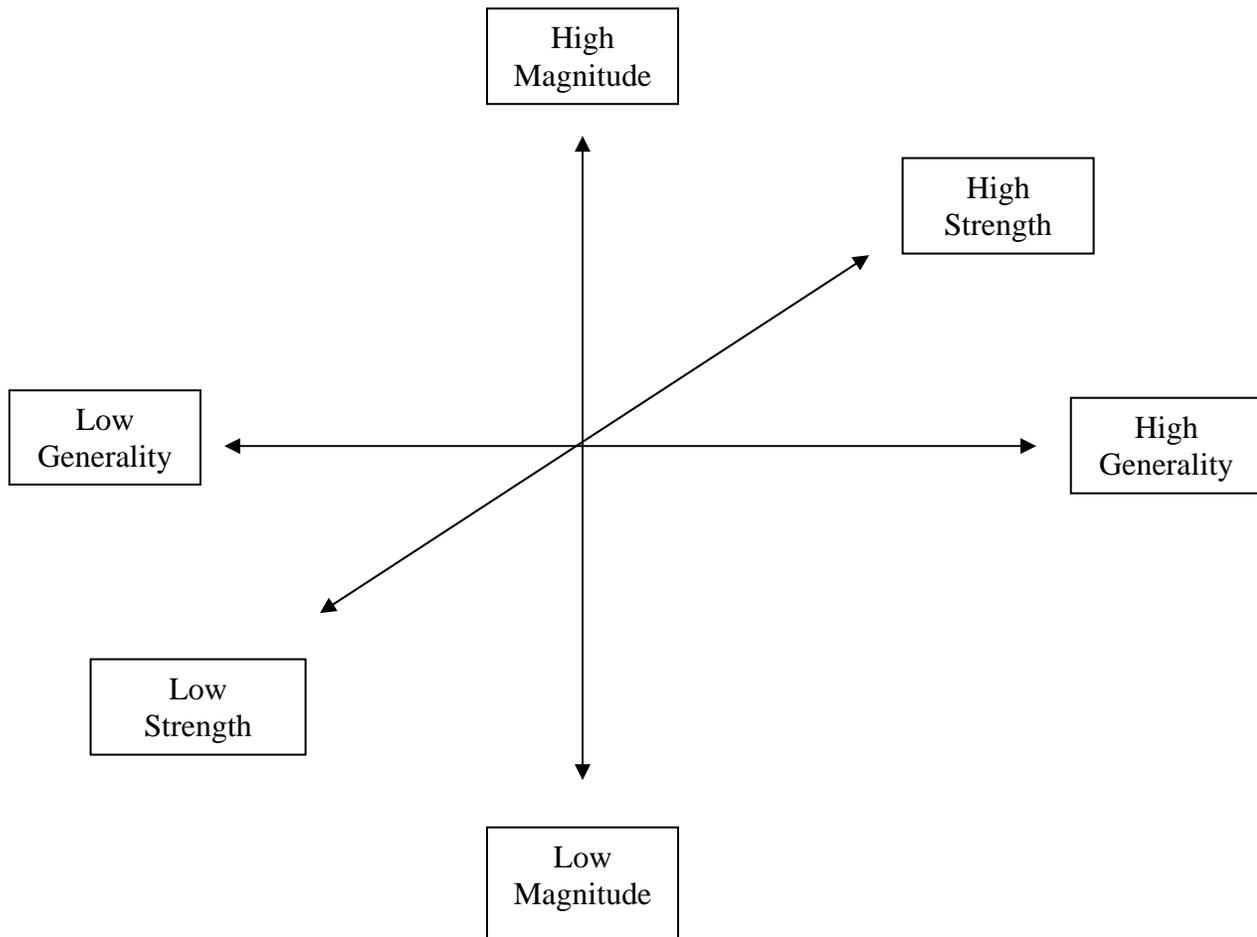


Figure 4. Three Dimensions of Efficacy Beliefs (Adapted from Bandura, 1977, 1986)

While self-efficacy may be the impetus for the bridge from cognition to action, it may also serve other purposes. According to Masten and Reed (2002), self-efficacy was a personal characteristic predictive of “good adaptation in the context of risk” (p. 82). They suggested that promoting self-efficacy may mitigate risk factors and improve resilience. Bandura, Barbaranelli, Caprara and Pastorelli (1996) stated that self-efficacy may impact individual development and adaptation. Maddux (2002) maintained that self-efficacy beliefs are critical for psychological adjustment and physical health, as well as competency based pursuit behavior—such as those

necessary for a successful work life. Maddux further asserted that self-efficacy beliefs develop over time through performance experience, and were influenced by others verbal persuasions, perceptions of success or failure, physiological arousal, fatigue and pain. Likewise, Bandura, Caprara, Barbaranelli, Gervino, and Pastorelli (2003) extended this explanation of the role of self-efficacy beliefs:

Perceived self-efficacy plays a pivotal role in this process of self-management because it affects actions not only directly but also through its impact on cognitive, motivational, decisional, and affective determinants. Beliefs of personal efficacy influence what self-regulative standards people adopt, whether they think in an enabling or debilitating manner, how much effort they invest in selected endeavors, how they persevere in the face of difficulties, how resilient they are to adversity, how vulnerable they are to stress and depression, and what types of choices they make at important decisional points that set the course of life paths. (p. 769)

Maddux (2002) enumerated the many benefits of self-efficacy. To begin with, strong self-efficacy beliefs promote and encourage exploration—a skill critical to one’s sense of agency. Low self-efficacy was a feature of depression, was associated with markedly increased anxiety, performance disruption, and further lowered self-efficacy (indicative of a negative cyclical spiral). Conversely, high self-efficacy

“influences the adoption of healthy behaviors, the cessation of unhealthy behaviors, and the maintenance of behavioral changes in the face of challenge and difficulty...In addition, researchers have shown that enhancing self-efficacy beliefs is crucial to successful change and maintenance of virtually every behavior crucial to health, including exercise, diet, stress management, safe sex, smoking cessation, overcoming

alcohol abuse, compliance with treatment and prevention regimens, and disease detection behaviors” (Maddux, 2002, p. 281).

Self-efficacy beliefs also were found to assist in self-regulation toward goal attainment by influencing the types of goals an individual chooses, more effective problem-solving, and better utilization of personal and cognitive resources, lower depression, and increasing coping strategies (Maddux, 2002; Fernandez et al., 2002). Bandura and colleagues (1996) stated, “the stronger the perceived self-efficacy, the higher the goal aspirations people adopt and the firmer is their commitment to them” (p. 1208). Other realms positive self-efficacy has impacted include academic functioning (Bandura et al., 1996), family functioning and satisfaction, positive affective and behavioral functioning (Bandura et al., 2003). With so many benefits, it is important to address the empirical basis for self-efficacy.

Empirical Research on Self-Efficacy

In a study of perceived personal and collective efficacy, Fernandez-Ballesteros and colleagues (2002) performed a mixed 4-way ANOVA to examine gender, age, socioeconomic status, and perceived efficacy. Interestingly, perceived collective efficacy was higher than individual self-efficacy, an important aspect when working as a team or a group in dealing with an obstacle. They also found that socioeconomic status was related to self-efficacy. Caprara, Pastorelli, Regalia, Scabini, and Bandura (2005) had similar findings of the relationship between low self-efficacy and low socio-economic status. The researchers hypothesized that this was due to marginalized groups experiencing life conditions indicative of low power and influence. This same trend was found for women, who may consider themselves to have less political influence and lower organizational status. Fitzpatrick (1999) reported similar results in counseling graduate students where the means on the self-efficacy scale were significantly different for men

and women (Men—Mean=4.3, Women—Mean=3.7), indicating that the female counseling students in the study evaluated their abilities lower than their male counterparts. However, this gender connection with self-efficacy may decrease over time as women begin entering higher levels of leadership, management, government, and become involved in legislative and political policy formation (Caprara et al., 2005).

In a study of efficacy, peer relationships and academic functioning among 279 children, Bandura and colleagues (1996) found that “children’s beliefs in their academic efficacy and aspirations are similarly accompanied by prosocialness, peer acceptance, low despondency, repudiation of moral disengagement, a low level of emotional and behavioral problems, and high scholastic achievement” (p. 1213). In addition, Bandura and colleagues also measured the parental efficacy for the group of parents whose children participated in this study. The researchers found that adults who have high parenting efficacy were better able to establish educational environments conducive to learning for their children both at home (by promoting educational endeavors), and within the school system through advocacy. This study established a link between self-efficacy (academic), social wellness (peer relationships and pro-social behaviors), and advocacy.

In a study of self-efficacy, coping, and immunological stress, (Wiedenfeld et al., 1990) subjects were chosen for participation that were experiencing extreme snake phobias. Subjects were pre-tested for coping self-efficacy and then were exposed to snakes. They were then given efficacy growth instruction based on structured mastery experiences and retested at a maximal efficacy level. Efficacy levels at both baseline and maximal growth differed by individuals due to extraneous variables and personal characteristics. The medical analysis used in this study was taken from baseline heart rate, saliva samples, and blood samples. The results of the study

indicated that when subjects were at the weaker (baseline) perceived self-efficacy, they experienced high heart rate, high blood pressure, and increased catecholamine secretion. The inverse was true for participants when tested at the maximal efficacy level after receiving only two hours of structured mastery instruction and experiences. One further interesting finding was that the stress produced in the mastery training experience actually had a positive effect on subjects, producing a higher level of lymphocyte and t-cell functioning indicative of an immunoenhancing response (Wiedenfeld et al). This study demonstrates the regulatory function of self-efficacy on physical stress coping.

The Relationship Between Self-Efficacy and Wellness

While this researcher found no empirical studies investigating the relationship between self-efficacy and wellness, both theory and literature suggest a significant relationship. Bandura (2005) wrote that self-efficacy was a requisite of self-regulatory behavior, the foundation of physical health. This is based on the assumption that health practices stem from one's belief in his or her ability to exercise control of overall personal well-being. Bandura (1986) also proposed that individual's attribution of their physical status to their own locus of control assisted in self-regulation based on perception of ability to change. An example he described was a scenario of people initiating an exercise regimen for the first time in a long while stating "those who read their fatigue, aches, and lowered stamina as signs of declining physical capacity are likely to curtail their activities more than those who regard such signs as the effects of sedentariness", (p. 408). Locus of control—a component of wellness according to Hattie and colleagues (2004) was core to both efficacy and self-regulatory behavior. Self-regulation was necessary for initiating and maintaining healthy behaviors and lifestyle habits such as exercise, nutritional intake, and stress management. It is also shown to mediate physiological coping of

stressors and threats (Wiedenfeld et al., 1990). In pain management studies, individuals received instruction designed to raise self efficacy such as pleasant imagery, attention diversion, and muscular self-relaxation. The results showed an increase in efficacy for dealing with pain and consequently increased individuals pain threshold and pain tolerance (Bandura, 1986).

Bandura (1986) noted numerous studies depicting the increased promotion of health (such as lower cholesterol, exercise and cardiovascular capacity, lower arterial plaque concentration) for individuals who had been trained for self-regulation through a self-management system model. In this model, Bandura described the process of teaching individuals how to establish goals, identify behaviors that would support the goals, and then regulate and monitor themselves in order to attain the health goals. The self-management trainees were then compared to individuals in control groups not receiving the intervention, but receiving medical care. He reported “the self-management system was more effective in reducing risk factors and increasing cardiovascular functioning than the standard medical care” (p. 249). He also ascertained that this regulatory functioning was impossible without the efficacy expectations of the individual underlying their ability to set goals and self-manage.

Wiedenfeld and colleagues (1990) explained that stressors impair the individual’s immune system over time, increasing the likelihood of illness, fatigue, or stress related disorders. In relation to self-efficacy and immune functioning enhancement versus compromise, they contended,

People who believe they can exercise control over potential threats do not conjure up apprehensive cognitions and are not stressed by them. But those who believe they cannot manage threats experience high levels of stress...After perceived coping self-efficacy is

strengthened to the maximal level, coping with the previously intimidating tasks no longer elicits differential physiological activation” (p.1084).

Bandura (1986) also concluded that individuals with low self-efficacy experience greater stress, despondency, depression, and anxiety, while those with high self-efficacy were more able to cope with stress and reduced displayed autonomic response.

Bandura (1986) further described the effects of perceived self-efficacy in relation to pain relief, especially for persons suffering from chronic pain. He contended that individuals with high self-efficacy use skills that they possess for pain amelioration, and because they believe they may cope with the pain they have a reduction in anticipatory reactions that exacerbate pain. Self-efficacy may further help with pain management as the individual becomes more focused on problem-solving and utilizing skills rather than focusing on discomfort (Bandura).

In a study of Black college students’ readiness to be physically active, Kelley and colleagues (1998) found that women and freshman were less likely to be physically active. The researchers suggested reasons for students to be physically inactive. They stated that low or no activity was the possible result of multiple factors, or a combination thereof, beginning with “one’s confidence in the ability to engage in regular physical activity, called self efficacy” (p. 62). Strategies indicated by the authors for increasing physical activity included increasing efficacy expectations for exercise (Kelley et al.).

Bandura and colleagues (1996) found that children’s academic self-efficacy had a significant positive relationship to pro-social behavior and positive peer relations—components of social wellness. Furthermore, Bandura and colleagues (2003) posited that self-efficacy fosters positive affective and behavioral functioning that enhances individual’s ability to connect with others and convey a welcoming attitude facilitative of positive relationships. This includes

the development of empathic self-efficacy described as an “active self-involvement in the emotional life of others” (p. 772). The relationship between social well-being and self-efficacy demonstrates that emotional self-regulation is tied to the ability to establish supportive relationships, a further mediator of stress.

Martin, Easton, Wilson, Takemoto, and Sullivan (2004), found that emotional intelligence (a third order factor under the second order factor of creativity), was a significant predictor of counseling self-efficacy in counseling graduate students. Emotional intelligence was described as being able to identify one’s own emotions, expressing emotions adaptively, and using emotions in effective problem solving. Emotional intelligence promotes interpersonal and intrapersonal understanding—skills inherently necessary to counselors (Martin et al.). Another interesting study by Fernandez-Ballesteros and colleagues (2002) linked self-efficacy to gender (a third order factor in the Indivisible Self Model) when they found that women have had historically lower self-efficacy. The study authors proposed that this may be due to females being afforded less political access historically. This is of particular importance in the counseling profession because the majority of counselors in training are female (Fernandez-Ballesteros et al.).

Literature Review Summary

Both wellness and self-efficacy are empirically and theoretically based constructs that have been demonstrated to impact the individual’s ability to mitigate stress factors. However, this author found no empirical evidence to support the relationship between these two constructs. While there appears to be a link based on relational components proposed in theory and in

literature, it is proposed here that research needs to be conducted that demonstrates this connection. Currently, this researcher has found no dissertations or research on this relationship.

CHAPTER THREE: METHODOLOGY

This chapter is divided into three primary sections. The first section outlines the study sample, data gathering procedures, instrumentation, data analysis stages, and research hypotheses. The second section presents ethical considerations made prior to this research study. The third and final section of this chapter will focus on potential limitations and challenges.

Study Sample

This study is designed to analyze data from an existing database. Therefore, human subjects violations were presumed to be of no risk because data was not gathered specifically for the purpose of this study. The data for this study came from 88 Masters level counseling students enrolled in a counselor education program at a southeastern university. As part of their admittance into the program, they participate in a programmatic orientation. At this orientation, consent is procured for assessment throughout the program—designated through a data collection matrix at allocated times during course work. Because the data is collected for the purpose of program evaluation, student participation in data collection is a mandatory requisite of admission into the program. The data is used to identify need based opportunities and strengths of the training program and do not correspond with individual student evaluation. The data is specifically used for program revision and improvement.

Data Gathering

The data is stored in a database for the program and is utilized for program evaluation. The data for this study was specified for collection at Internship (for all mental health and school counseling students) and the chosen instruments were the Counseling Self-Efficacy Scale

(CSES) (Melchert et al., 1996) and the Five Factor Wellness Evaluation of Lifestyle (5F-WEL) (Myers & Sweeney, 2005). The data was gathered by the College of Education's Research Associate (RA) for program evaluation, assessment, and data collection. The RA obtained entry into Internship classes via arrangement with course instructors. Data collection is operationally standardized through a research protocol. After entering the classroom the RA reads a script describing instructions for instrument completion (please see Appendix A).

Demographics were gathered through the program database, which links instrument responses/scores and student demographic information using a random number assignment. All identifying information (names, dates of birth, social security numbers) are excluded from the database. Demographics available to this researcher included employment status, gender, race, and age range. The instruments are either scored by the RA and doctoral students in the department (e.g. the CSES), or they are sent for scoring to the publisher of the specific instrument (e.g. the 5F-Wel) if that is required for interpretation.

Instrumentation

The Counseling Self-Efficacy Scale

The Counseling Self-Efficacy Scale (CSES), developed by Melchert, Hays, Wiljanen, and Kolocek (1996) was designed to measure counselors' feelings of competence in counseling knowledge and skills. The items reflect global skills used in counseling practice rather than specific competencies for particular theories or techniques. The instrument contains 20 items on a Likert-type scale, with responses to items holding a score of 1-5. Some of the items are negatively worded (to protect against acquiescent response bias in answering items), necessitating inverse coding for scoring purposes (Melchert et al). The range of raw scores on

this instrument vary from 20 (lowest score) to 100 (highest score) and the mean can either be based on the raw scores or on mean average scores for participants. Using the raw score means allows for greater variance in the data analysis procedures. Fitzpatrick (1999) studied counseling students' self-efficacy and their own evaluation of their performance. She reported that the CSES was used to measure students self-efficacy and that her mean results ($X = 4.0$) were within the same statistical range as those reported by Melchert et al (1996).

The CSES authors (Melchert et al., 1996) determined that .35 would be used as the criterion for item retention during instrument construction. All 20 of the items in the CSES met that criteria. Further, after the item analysis, the instrument's Cronbach alpha was .91.

According to Ary, Jacobs, and Razavieh (1996), content validation is the extent to which scores on an instrument are related to an external criterion variable believed to measure the behavior or characteristic in question. The CSES was content validated by three licensed psychologists who served as experts on this topic. Further, according to Ary and colleagues, convergent construct validation is the extent to which the measure of the characteristic in question is related to other measures presumed to be valid indicators of the same construct. The CSES was convergent construct validated through correlation of scores with the Self-Efficacy Inventory created by Friedlander and Snyder in 1983 (Melchert et al., 1996). The correlation between the two instruments was moderately high ($r = .83$).

In addition, Melchert and colleagues (1996) found that the CSES fit with models of counseling self-efficacy based on participant's experience. Projections about counselor development based on theory were found in the results of this study. However, there is very little empirical support for the psychometric properties of the CSES (Shanklin, 2003). Further, T. Melchert (personal communication, February 6, 2007) reported that no further studies have been

conducted to validate the instrument to his knowledge since the instrument was created in 1996, nor does he know of any studies currently utilizing the instrument. Nevertheless, the instrument is construct validated and theoretically grounded; thus, the CSES was chosen for use in this study.

The Five Factor Wellness Evaluation of Lifestyle

Of the four main domains of testing—Cognitive Ability, Personality/ Mental Health, Couples and Family, and Career or Vocational Interest—the Five Factor Wellness Inventory (5F-Wel) is basically a Mental Health Assessment. However, it is not like most mental health assessments in that it measures five interrelated domains that create an overall composite of individual wellness that include mind, body, spirit, social, and competency based pursuits. In addition, each domain contains multiple factors. Scoring for this assessment is done per domain (5 subscale scores) and then one overall composite score is given that indicates a construct of global wellness functioning (Myers & Sweeney, 2005).

The 5F-Wel is published by Mindgarden, Inc. and the authors are Myers and Sweeney (2005). There are multiple versions of the test that are meant to provide assessment based on developmental reading ability. These are categorized by reading ability at the third grade level or higher (elementary version—Form E), sixth grade reading level or higher (teenage version—Form T), and ninth grade reading level or higher (adult version—Form A) (Myers & Sweeney, 2005).

The 5F-Wel is based on two major Adlerian concepts: personal responsibility and a holistic approach to wellness. Adler believed in a growth model which stressed “taking responsibility, creating one’s own destiny, and finding meaning and goals to give life direction” (as cited in Corey, 2001, p.8). The researcher will look at each of these Adlerian concepts as they

apply to wellness. The first of these, personal responsibility, is the notion that individuals are responsible for their own well-being through self-direction and self-regulation. An underlying assumption of this principle is that the individual must have correct information and knowledge about what constitutes a healthy, balanced life. In addition, the individual must possess the cognitive faculties to pro-actively plan and engage in healthy behaviors that promote individual wellness (Myers & Sweeney, 2005).

The second principle, holism, posits that there is a connection between the mind-body-spirit and that all of these are interrelated and integrated. Therefore, lower functioning in one area will reduce overall global wellness of the individual. For example, a person who is not physically healthy may experience depression or lower self-concept. The idea of holism is that individuals have many systems working together and that all systems make significant and important contributions to overall well-being (Myers & Sweeney, 2005).

Another underlying assumption is that change and maturation may influence wellness. Myers and Sweeney (2005) developed versions of the 5F-WEL (elementary, teenage, and adult) to address lifespan developmental differences. In addition, the authors also address the issue of context as it impacts the developing individual's wellness; the contexts are described similarly to Bronfenbrenner's Ecosystemic concept. The proposed contextual variables include local, institutional, global, and chronometrical.

Lastly, the authors of the 5F-Wel promote wellness as a preventive measure for many physical, mental, emotional, and social problems. Further, personal wellness may have a mitigating effect when individuals face stress, relationship difficulties, illness, and life events beyond one's control. Indeed, it may actually foster resiliency by providing a buffer against negative external factors (Myers & Sweeney, 2005).

The Five Factors

Initial conceptualization of wellness as a wheel with five spokes—spirituality, self-direction, work/leisure, love, and friendship—was not supported when 103 factors were analyzed through factor analysis. However, 17 of the original 103 factors had discrete scale support. The only first order factor is the higher order wellness composite that incorporates all other factors. Subsequent to this are second order factors and third order factors. Specifically, five factors emerged as second order factors. A structural equation model was created using a restricted factor pattern and the second order factors were established. The second order factors comprise the five factors for which the instrument is named. The third order factors are grouped underneath each of the second order factors. We will look at each of the second order five factors individually and review the third order factors encapsulated within these second order domains. Please see Table 3.

Table 3. The 5F-Wel Second and Third Order Factors.

Second Order Factors	Third Order Factors
1. Essential Self	Cultural Identity, Gender Identity, Self Care, Essence
2. Social Self	Love & Friends
3. Creative Self	Intelligence, Control, Emotion, Humor, and Work
4. Physical Self	Exercise, Nutrition
5. Coping Self	Leisure, Stress, Worth, Beliefs

(Adapted from Myers & Sweeney, 2005)

The *Essential Self* is a term given to the category of factors that represent an individual's sense of meaning. It includes *essence, self-care, gender* and *cultural identity*. These third order factors create a sense of hopefulness, existential purpose, meaning, and reflect an individual's ability to define him or herself. Without these four factors, an individual may despair or feel hopeless and alienated from his or her own future and opportunities. Cultural and gender identity is having a level of knowledge and comfort with one's culture and gender and feeling supported within this identity. Self care is the ability to create and maintain healthy habits while also regulating any necessary changes for ongoing health and safety (i.e. avoiding substance abuse, seeking preventative medical care, getting rest) (Myers & Sweeney, 2005).

The *Social Self* includes the third order factors of *friendship* and *love*. The Social Self is the individual's ability to construct and maintain intimate and significant relationships with others. This includes the ability to appropriately disclose with others and to be open, real, and honest. The connections to others have been proven to increase the overall health of the individual through the provision of support and encouragement. These supports create a safe familial base for the individual, and it does not matter whether this family is biological or created through contacts established throughout the lifespan. Individual's who have not developed these strong relationships may suffer from alienation and isolation (Myers & Sweeney, 2005).

The *Creative Self* encompasses unique attributes and the qualities that an individual may possess within social interactions. It includes five third order factors: *thinking, emotions, control, positive humor, and work*. The third order factors of thinking and emotion are believed to be closely linked due to the reciprocal relationship between thoughts and emotions. Therefore, positive thoughts foster positive emotions. Control alludes to one's perception of his or her ability to influence events in life (internal versus external locus of control). Control encompasses an individual's beliefs about his or her own competence and ability to master tasks and achieve goals—and it is potentially related to self-efficacious behavior. The opposite of this is a person who believes that destiny determines fate and that he or she is powerless to determine what events transgress. Positive humor—or humor that does not emotionally or perceptually harm others—has been found to have healing physical effects and mental benefits. Work also appears to provide an essential stimulation and cognitive activity that increases a sense of generativity and the fullness of life--if it is enjoyed (Myers & Sweeney, 2005).

The *Physical Self* is the component of wellness that captures *exercise and nutrition* as third order factors. Physical well-being and health has been shown to negate the impact of stress

and to increase resilience to illness. Conversely, people with poor physical health habits are more susceptible to infection, illness, and difficulties caused by stress. Exercise includes maintaining a physical regimen that includes regular work outs and stretching. Nutrition includes maintaining a balanced diet and limiting unhealthy snacks; weight should be average, avoiding both under and overeating (Myers & Sweeney, 2005).

The *Coping Self* is a compilation of strategies utilized to deal with life challenges and stressful events. The four third order factors included in this self are *realistic beliefs, stress management, self-worth, and leisure*. Stress management is an individual's ability to locate resources (personal and external) to utilize in handling stressful circumstances or events. Self-worth indicates the value one assigns oneself. Leisure are the hobbies and activities that an individual enjoys outside of work tasks. Realistic beliefs are those thoughts which are within the parameters of reality and which exclude wishful thinking and unrealistic expectations for self or others (Myers & Sweeney, 2005).

Table 4. Number of items per scale for the 5F-Wel-Version A (adult form)

Factor	Number of Items
Creative Self	21
Thinking	4
Emotions	4
Control	4
Work	5
Positive Humor	4
Coping Self	19
Leisure	6
Stress Management	4
Self Worth	4
Realistic Beliefs	5
Social Self	8
Friendship	4
Love	4
Essential Self	15
Spirituality	5
Gender Identity	4
Cultural Identity	3
Self Care	3
Physical Self	10
Exercise	5
Nutrition	5
Total Wellness Items	73
Context Items (Local, Institutional, Global, Chronometrical)	Respective Item Quantities: 5,4,3,4 Total Context Items= 16
Validity Index (VI)	1
Total Items	90

(adapted from Myers & Sweeney, 2005)

Description of the Measure

The 5F-Wel may be used with anyone who is capable of reading at a 3rd grade level or higher. There are 3 versions of the 5F-Wel. These versions are the elementary, teenage, and adult forms. The 5F-Wel is a norm referenced instrument. However, several limitations exist based on the norm population. To begin with, the majority of participants are female and Caucasian. Additionally, of the males represented, a disproportionate number have either Masters or Doctoral degrees. Due to these limitations, the instrument authors encourage users of the 5F-Wel to “develop and use local norms for score interpretation” (Myers & Sweeney, 2005, p.23). Therefore, local tendencies and cultural specificity may change the norm for a given item or scale. The manual does provide minimum and maximum scores, ranges, mean and standard deviations for each scale on the 5F-Wel. While reliability and validity are reported, it is important to note that there are ongoing efforts to validate and increase item reliability for all factors.

Alpha coefficients are not available for the context scales because they have only been recently developed and constructed. However, the first, second, and third order factors all have been tested with a sample (N = 2,093). The alpha coefficients for the second order factors were reported by Hattie, Myers, and Sweeney (2004) were as follows: Creative Self (-.93), Coping Self (.92), Social Self (-.94), Essential Self (-.91), Physical Self (.90), and Total Wellness (.94). Test-retest is not available at this time for the 5F-WEL (Personal Communication with J. Myers, February 10, 2007).

Myers and Sweeney (2005) reported multiple studies of the relationship to constructs believed to be related to wellness including spirituality, acculturation, moral identity and social interest, academic self-concept, and more. They report that,

Both the first and second order factors have been found to discriminate among a variety of populations related to these variables. Differences in wellness have been found based on demographic indices such as age, gender, and ethnicity for both sets of factors...These studies provide evidence for the convergent and divergent validity of the 5F-Wel factors. (Myers & Sweeney, 2005, p. 20)

The 5F-Wel may be given individually or to groups, and average test taking time is about 10-20 minutes. Answers are given in the form of a 4 point Likert type scale and are placed on scannable scoring sheets which should be completed with a number 2 pencil. The answer sheets are mailed to instrument co-author, Jane Meyers, and scores are sent to the university research associate via a downloadable SPSS spreadsheet.

Scores are calculated by Myers when the user sends scannable sheets with answers for scoring. The scores are plotted in a profile and a numeric score that ranges from 25-100 is given, establishing a wide range of variance. Scores may be compared to the normed group mean and standard deviations. Because the scores are given in SPSS format, the information can be loaded and within and between group comparisons can be made. This may be particularly useful if a subgroup of individuals is used to look at specific group or local norms, allowing for interpretation of results within a given context (Myers & Sweeney, 2005).

As for the psychometric properties of the 5F-WEL, most of the information found from validation studies is research conducted by the instrument authors. This researcher was able to locate psychometrics from the *Mental Measurements Yearbook* (2007) test evaluation of the Wellness Evaluation of Lifestyle (2004) (WEL)—an earlier version of the currently refined 5F-WEL (2005). It is logical to infer that the psychometrics of the 5F-WEL are an improvement of the WEL's based on the attempts by the authors to validate the instrument. According to the

online *Mental Measurements Yearbook* (Burros Institute, 2004), scores of 80 or better on any subscales indicate moderate wellness for that scale. Internal consistencies were low and unreliable for the WEL and only one validity study had been conducted. Specifically the Mental Measurements Yearbook reports that

The only validity data presented on the WEL are based on 229 graduate counseling students who took the WEL and other instruments over a four-year period as part of courses in lifespan development and wellness' (manual, p. 12). It is not clear from the test manual which version of the WEL was employed in these studies. The validity data presented include correlations that a subset of WEL scales had with a self-report measure that also purportedly assesses components of wellness (i.e., the TestWell Scales). The authors reported that the WEL Total Wellness composite score correlated .77 with the TestWell composite score. Correlations among subscales identified as conceptually similar between the two measures tended to be more moderate (median $r = .50$). Also presented are correlations between certain WEL subscales and self-report devices that assess coping resources, psychosocial development, self-actualizing characteristics, locus of control, and death concerns. The theoretical rationale for using such measures to evaluate the construct validity of specific WEL subscales is either not provided or not often immediately apparent. For example, it is unclear why scores on measures of fear and anxiety associated with death, when correlated with the WEL Realistic Beliefs subscale (which is purported to assess 'ability to process information accurately, to perceive reality accurately, not as one might want or desire it to be,' manual, p. 5), would constitute a test of the WEL's validity. In sum, several factors make it difficult to evaluate whether these data are supportive of the WEL-S's validity: (a) the theoretical bases

underlying these validity analyses are unclear; (b) the construct validity data presented are selective construct validity data presented are selective, whereby correlations for only a subset of WEL subscales with one or more external measures are presented; (c) the correlations selected for presentation are often moderate at best; and (d) it is unclear as to which version of the WEL was used in these validity studies (Burros Institutes, via Ebscohost).

However, even with the inherent lack of psychometric soundness, the 5F-WEL may be the best measurement to date for wellness. This researcher found no other instrument as notably comprehensive and thorough as the 5F-WEL. It is also important to note that the changes between the WEL and 5F-WEL should have improved the psychometric properties of the more recent edition. In addition, the 5F-WEL appears to be theoretically grounded and the items contained in the instrument reflect the theoretical assumptions underlying the wellness construct.

Research Design

Data Analysis

The data analysis will be Multiple Regression Analysis (MRA). MRA is “a statistical method for studying the relation between a dependent variable and two or more independent variables” (Shavelson, 1996, p. 528). MRA is used for a number of reasons including: (a) for exploration of relationships between variables, (b) for predictive purposes, or (c) to test a theory (Shavelson). MRA is recognized by researchers for its flexibility, various techniques, adaptability, its provision of beta weights and effect sizes, and forms that promote both theory based models of analysis and exploratory analysis. The different forms of MRA are simultaneous, stepwise, and hierarchical (Hair, Black, Babin, Anderson, & Tatham, 2006;

Petrocelli, 2003). As a result of its varied utility, MRA has become increasingly popular and common in counseling research (Hoyt, Leirer, & Millington, 2006; Petrocelli; Hair et al.).

Of the differing types of MRA, the one used for this research analysis was hierarchical. The reasons for choosing this particular statistical design are as follows:

1. Hierarchical MRA is based on theoretical hypotheses (Petrocelli, 2003; Hoyt et al, 2006).
2. Hierarchical MRA allows the researcher to organize data entry prior to analysis in a manner that reflects prescribed hypothetical ordering of predictor variables (Petrocelli, 2003).
3. Changes in predictability for each subsequently added predictor variable during analysis is measured, such that the independent contribution to effect can be examined for each predictor variable (Petrocelli, 2003).

Hair and colleagues (2006) provided a systematic protocol for implementing MRA in research design through a decision-making model. The stages are (1) objectives of multiple regression analysis, (2) design, (3) model estimation, (4) diagnostic analysis, (5) interpretation, and (6) validation. In stage 1, this researcher chose the independent (predictor) variables and dependent (criterion) variable for this study. The independent variables were: (a) overall wellness, (b) coping wellness, (c) creative wellness, (d) physical wellness, (e) social wellness, and (f) essence wellness. The researcher then predicted—based on theory—the hierarchical representation by magnitude of predictability for the independent variables and wrote hypothesis statements for each in their assumed relative predictive importance, see Figure 5.

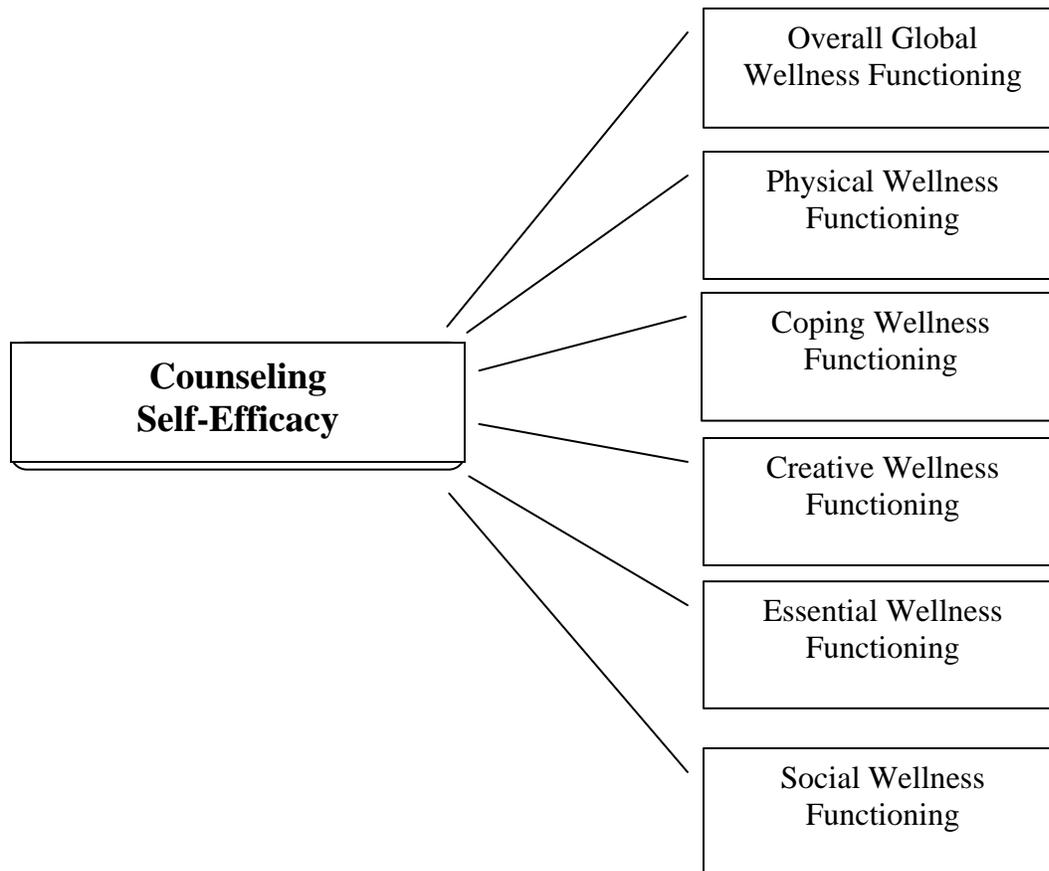


Figure 5. Model of Prediction Contribution by Magnitude of Overall Wellness and Subscales for Counseling Self-Efficacy as Measured by CSES and 5F-WEL

All of the independent variables were estimated to have positive directionality with the dependent variable. The following are the research hypotheses created in Stage 1:

Research Hypotheses

Hypothesis 1:

There is a significant relationship between counseling self-efficacy as measured by the CSES and overall global wellness functioning as measured by the 5F-WEL.

Null 1: There is no significant relationship between counseling self-efficacy as measured by the CSES and overall global wellness functioning as measured by the 5F-WEL.

Hypothesis 2:

There is a significant relationship between counseling self-efficacy as measured by the CSES and physical wellness functioning as measured by the respective subscale on the 5F-WEL.

Null 2: There is no significant relationship between counseling self-efficacy as measured by the CSES and physical wellness functioning as measured by the respective subscale on the 5F-WEL.

Hypothesis 3:

There is a significant relationship between counseling self-efficacy as measured by the CSES and coping wellness functioning as measured by the respective subscale of the 5F-WEL.

Null 3: There is no significant relationship between counseling self-efficacy as measured by the CSES and coping wellness functioning as measured by the respective subscale of the 5F-WEL.

Hypothesis 4:

There is a significant relationship between counseling self-efficacy as measured by the CSES and creative wellness functioning as measured by the respective subscale of the 5F-WEL.

Null 4: There is no significant relationship between counseling self-efficacy as measured by the CSES and creative wellness functioning as measured by the respective subscale of the 5F-WEL.

Hypothesis 5:

There is a significant relationship between counseling self-efficacy as measured by the CSES and essence wellness functioning as measured by the respective subscale of the 5F-WEL.

Null 5: There is no significant relationship between counseling self-efficacy as measured by the CSES and essence wellness functioning as measured by the respective subscale of the 5F-WEL.

Hypothesis 6:

There is a significant relationship between counseling self-efficacy as measured by the CSES and social wellness functioning as measured by the respective subscale of the 5F-WEL.

Null 6: There is no significant relationship between counseling self-efficacy as measured by the CSES and social wellness functioning as measured by the respective subscale of the 5F-WEL.

In Stage 2, research design, the researcher chooses a sample size and power level. Sample size is crucial for statistical power in significance testing and generalizability of results. In order for results to be generalized, the minimum number of observations to independent variables cannot fall below a ratio of 5:1, with a preferred ratio at 15 or 20: 1 (Hair et al, 2006). According to Shavelson (1996), the minimum sample size needed is 50 “and a general rule of thumb is that there should be at least about 10 times as many cases (subjects) as independent variables” (p. 536). Because this researcher was using an existing database, the quantity of data was predetermined by what had been collected through program evaluation data collection matrix. The number of available observations for this study was 88 with a calculated observation to independent variable ratio of 14:1. In this stage the researcher also defined the degrees of freedom for this analysis using the following formulaic expression from Hair and colleagues:

$$\text{Degrees of freedom (df)} = N - (\text{Number of independent variables} + 1)$$

In Stage 3, the researcher chose to test the assumptions inherent in the MRA by specifically looking at the data residuals or, “the difference between the observed and predicted values for the dependent variable”, (Hair et al., 2006, p. 205). This may be done through

residual plots where assumption violations may be evidenced through identified patterns. In order to take corrective action, it is necessary for the researcher to further assess the residual contribution of each independent variable while controlling the combined effects of all the independent variables through the use of partial regression plots.

In Stage 4, the researcher chose to use MRA for confirmatory specification (as an estimation technique) of the independent variables based on the projected model founded in theory. This required that the researcher have, “substantive knowledge of the research context and any theoretical foundation that allows for an objective and informed perspective as to the variables to be included as well as the expected signs and magnitude of their coefficients” (Hair et al., 2006, p. 206). After this, the significance level ($\alpha = .05$) for type I error was chosen and the researcher made influential observations to identify outliers in the data set that may impact regression results.

In Stage 5, the researcher evaluated the regression coefficients of the independent variables for their explanation of the dependent variable. Particular to the understanding of this issue is the assessment of multicollinearity—the degree of correlation among the independent variables used in the MRA. The problem of multicollinearity is the creation of shared variance between independent variables. The shared variance of the variables makes it difficult to determine the unique and relative contribution to the variance explained in the dependent variable measures by each independent variable (Hair et al., 2006). Therefore, the researcher will use semipartial correlation to control for the intercorrelations of independent variables to assess individual incremental predictive power.

Data obtained from the RA will be placed into SPSS version 14.0 (SPSS, 2006). In an effort to investigate the unique effects of each predictor variable (wellness domains) on the

criterion variable (self-efficacy), all will be placed in SPSS and regressed concurrently. This method of statistical control allows the researcher to hold constant all variables within the regression equation with the exemption of the specific predictor variable being examined (Hoyt et al., 2006). Therefore, the contribution of individual effects of predictor variables within the context of this sample may be ascertained.

Ethical Considerations

In order to conduct ethical research, the following safeguards were instituted:

1. The researcher reviewed the American Counseling Association's (ACA, 2005) *Code of Ethics* for research. The *ACA Code of Ethics* gives direction regarding ethical issues specific to counseling research. According to the ACA (2005) codes, "counselors plan, design, conduct and report research in a manner that is consistent with pertinent ethical principles, federal and state laws, host institutional regulations, and scientific standards governing research with human research participants" (G.1.a). All of the aforementioned criteria and standards were established in the design of this study.
2. The researcher submitted an Institutional Review Board (IRB) protocol application (#06-3977) for conducting the study with data from an existing source. The IRB Chair indicated that this study was exempt from review by the IRB (please see Appendix B.).
3. The researcher met with the dissertation committee (present at this meeting: E. H. Mike Robinson III, Glenn W. Lambie, B. Grant Hayes, and Shannon Ray—K. Dayle Jones was absent) and defended the proposal on July 18, 2006.

Committee approval was obtained and formal paperwork was filed through the College of Education at University of Central Florida.

4. A formal announcement of the intent to defend this dissertation was filed on February 12, 2007.
5. All of the data used in this study was devoid of identifying information, ensuring the confidentiality of participants in the program's data collection and program evaluation.

Limitations/Challenges

While MRA is strong in looking at the predictive relationship of multiple independent variables on a criterion (dependent) variable, there are some potentially confounding issues that must be addressed including: (a) multicollinearity; (b) measurement error; (c) specification error (Hair et al., 2006); (d) small sample size, increasing the likelihood of Type II error; and (e) violation of the independence of error terms. Also, both instruments' results are based on self-report data and therefore participants could have answered in ways they perceived to be socially desirable. In addition, the relationship being examined is correlational and this researcher could not control many extraneous variables, which include, but are not limited to, instruction and preparation based on student life experiences.

Methods Summary

The instruments used for this study were the CSES and 5F-WEL. Both of these instruments have Likert type items and are self-report. The current validity and reliability of each instrument was reported in this chapter. Participants, data collection, and hypotheses were outlined. The statistical design to be used and described herein is hierarchical MRA and a model

for factor loading was proposed by the author. Ethical considerations and limitations of this study were also addressed.

CHAPTER FOUR: FINDINGS

This chapter elucidates the findings of this study; specifically, an examination of the relationship between counselor self-efficacy and counselor wellness. The first section of this chapter will restate the proposed research question and provide particulars of the demographics of the study's sample including gender, cultural background, age, marital status, and employment status. The second section will provide descriptive statistics for the data set including the measures of central tendency for both instruments used, variability of scores, and standard deviations. The third section will restate the study hypotheses and results of the multiple regression analysis (MRA).

Research Question

This study was designed to explore the question: Is there a significant relationship between counselor self-efficacy and counselor wellness? In order to investigate the relationship of the two constructs, the researcher chose to use two instruments: one for counselor self-efficacy and one for counselor wellness. The two instruments chosen were the Counseling Self-Efficacy Scale (CSES) (Melchert et al., 1996) and the Five Factor Wellness Inventory (5F-WEL) (Myers & Sweeney, 2005). There were six hypotheses and six null hypotheses for this study.

Research Hypotheses

Hypothesis 1:

There is a significant relationship between counseling self-efficacy as measured by the CSES and overall global wellness functioning as measured by the 5F-WEL.

Null 1: There is no significant relationship between counseling self-efficacy as measured by the CSES and overall global wellness functioning as measured by the 5F-WEL.

Hypothesis 2:

There is a significant relationship between counseling self-efficacy as measured by the CSES and physical wellness functioning as measured by the respective subscale on the 5F-WEL.

Null 2: There is no significant relationship between counseling self-efficacy as measured by the CSES and physical wellness functioning as measured by the respective subscale on the 5F-WEL.

Hypothesis 3:

There is a significant relationship between counseling self-efficacy as measured by the CSES and coping wellness functioning as measured by the respective subscale of the 5F-WEL.

Null 3: There is no significant relationship between counseling self-efficacy as measured by the CSES and coping wellness functioning as measured by the respective subscale of the 5F-WEL.

Hypothesis 4:

There is a significant relationship between counseling self-efficacy as measured by the CSES and creative wellness functioning as measured by the respective subscale of the 5F-WEL.

Null 4: There is no significant relationship between counseling self-efficacy as measured by the CSES and creative wellness functioning as measured by the respective subscale of the 5F-WEL.

Hypothesis 5:

There is a significant relationship between counseling self-efficacy as measured by the CSES and essence wellness functioning as measured by the respective subscale of the 5F-WEL.

Null 5: There is no significant relationship between counseling self-efficacy as measured by the CSES and essence wellness functioning as measured by the respective subscale of the 5F-WEL.

Hypothesis 6:

There is a significant relationship between counseling self-efficacy as measured by the CSES and social wellness functioning as measured by the respective subscale of the 5F-WEL.

Null 6: There is no significant relationship between counseling self-efficacy as measured by the CSES and social wellness functioning as measured by the respective subscale of the 5F-WEL.

Sample Demographics

The participants in this study were mental health, marriage and family, school, and dual track counseling interns enrolled in a Southeastern university counselor education program. All students had completed the prerequisites to enroll in either part time or full time counseling internship. The data for this study was collected in the last two weeks of the semester for the Spring, Summer, and Fall of 2006. Students completed the instruments as part of an ongoing, systematic program evaluation and the data was de-identified by the counselor education program's research assistant before it was given to this researcher. This de-identification process assured that the data was confidential and the participants were anonymous to this researcher. Of the 91 potential participants, 88 completed both instruments and were included in this study (97% response rate).

Of the study participants, 77 were female and 11 were male (Table 5.). The marital status of the participants included married or with a partner 32 (34%), single 49 (52%), separated 1 (1%), divorced 4 (4%), and widowed 2 (2%) (See Table 6). The employment status of the study participants indicated that 43 were employed full time (46%), 23 were employed part time

(25%), and 22 were unemployed (23%), the other six percent were missing values (See Table 7).

The frequencies of the participants' cultural background revealed that three were Native American (3%), four were Asian-Pacific Islander (4%), 11 were Black (12%), 63 were Caucasian (67%), seven were Hispanic (7%), and six percent did not report cultural background (See Table 8.) The ages of the study participants ranged from 23 (lowest) to 56 (highest) with a mean age of 30.9 years old and a standard deviation of 8.3 years (See Table 9.).

Table 5. Gender Frequencies for Sample Population

GENDER				
	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	6	6.4	6.4	6.4
F	77	81.9	81.9	88.3
M	11	11.7	11.7	100.0
Total	94	100.0	100.0	

Table 6. Marital Status Frequencies for Sample Population

MARITAL STATUS					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	MARRIED-PARTNER	32	34.0	36.4	36.4
	SINGLE	49	52.1	55.7	92.0
	SEPARATED	1	1.1	1.1	93.2
	DIVORCED	4	4.3	4.5	97.7
	WIDOWED	2	2.1	2.3	100.0
	Total	88	93.6	100.0	
Missing	System	6	6.4		
Total		94	100.0		

Table 7. Employment Status Frequencies for Sample Population

EMPLOYMENT STATUS

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	FULL TIME	43	45.7	48.9	48.9
	PART TIME	23	24.5	26.1	75.0
	not working	22	23.4	25.0	100.0
	Total	88	93.6	100.0	
Missing	System	6	6.4		
Total		94	100.0		

Table 8. Cultural Background Frequencies for Sample Population

CULTURAL BACKGROUND 1

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	NATIVE AMERICAN INDIAN	3	3.2	3.4	3.4
	ASIAN-PAC ISLAND	4	4.3	4.5	8.0
	BLACK	11	11.7	12.5	20.5
	CAUCASIAN	63	67.0	71.6	92.0
	HISPANIC	7	7.4	8.0	100.0
	Total	88	93.6	100.0	
Missing	System	6	6.4		
Total		94	100.0		

Table 9. Age Frequencies for Sample Population

Statistics

age

N	Valid	88
	Missing	6
Mean		30.9091
Median		28.0000
Std. Deviation		8.30128
Variance		68.911
Range		33.00
Minimum		23.00
Maximum		56.00

Descriptive Statistics for Study Instruments

According to Shavelson (1996), descriptive statistics are “a set of concepts and methods used in organizing, summarizing, tabulating, depicting, and describing collections of data” (p. 8). The Counseling Self-Efficacy Scale (CSES) scores for this sample resulted in a minimum score of 20 and a maximum score of 99 (range of 79, $M = 36.05$, $SD = 16.92$) (See Table 10). A total of 88 participants also completed the Five Factor Wellness Inventory (5F-WEL). Scores were calculated for composite total wellness ($M = 82.93$, $SD = 7.51$), Creative Self Subscale ($M = 84.95$, $SD = 8.07$), Coping Self Subscale ($M = 79.31$, $SD = 8.19$), Social Self Subscale ($M = 92.79$, $SD = 9.9$), Essential Self Subscale ($M = 84.59$, $SD = 11.29$), and Physical Self Subscale ($M = 75.17$, $SD = 15.37$) (Table 11).

Table 10. Descriptive Statistics for the Counseling Self-Efficacy Scale

Descriptive Statistics							
	N	Minimum	Maximum	Mean	Std.	Kurtosis	
	Statistic	Statistic	Statistic	Statistic	Statistic	Statistic	Std. Error
CSES score at internship	91	20	99	36.05	16.920	8.388	.500
Valid N (listwise)	91						

Table 11. Descriptive Statistics for the 5F-WEL

		Statistics					
		TOTAL WELLNESS	CREATIVE SELF	COPING SELF	SOCIAL SELF	ESSENTIAL SELF	PHYSICAL SELF
N	Valid	88	88	88	88	88	88
	Missing	6	6	6	6	6	6
Mean		82.9264	84.9574	79.3137	92.7912	84.5881	75.1705
Std. Deviation		7.51212	8.07305	8.19094	9.89753	11.29268	15.37274
Variance		56.432	65.174	67.092	97.961	127.525	236.321

Because one for the underlying logical assumptions of MRA is that there is normal distribution of variables, frequency distributions were run for all scales. Overall, total wellness displayed a normal distribution with some exception (Figure 6). Both the Creative and Coping

CREATIVE SELF

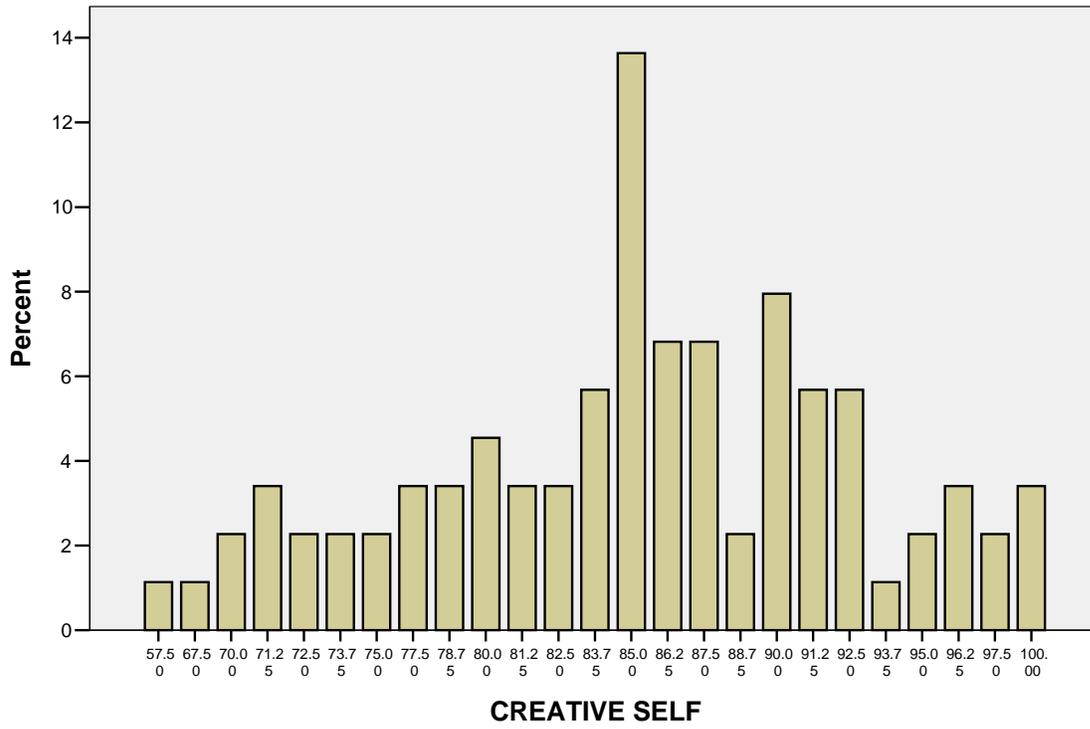


Figure 7. Distribution of Creative Self Scores for Study Sample

COPING SELF

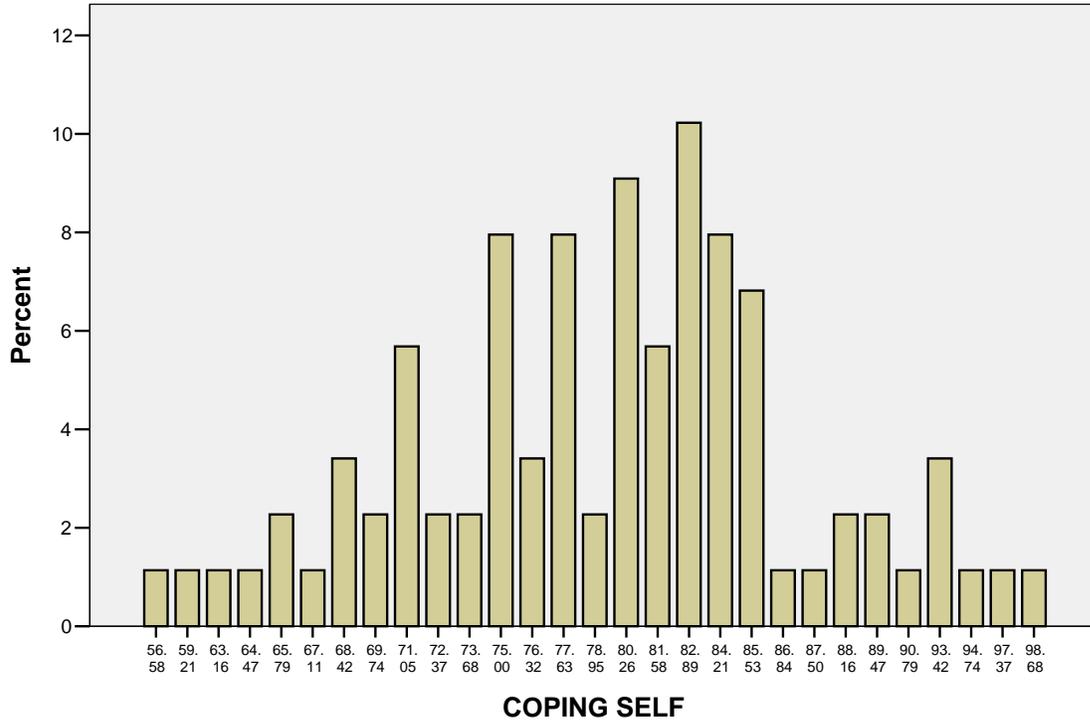


Figure 8. Distribution of Coping Self Scores for Study Sample

ESSENTIAL SELF

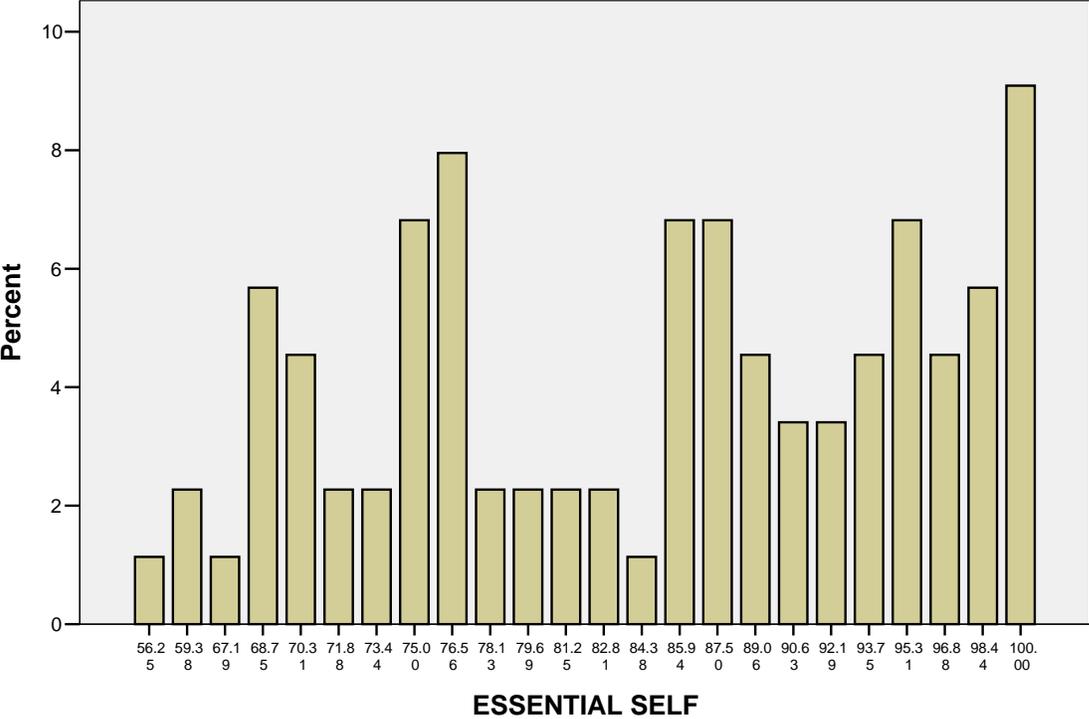


Figure 9. Distribution of Essential Self Scores for Study Sample

PHYSICAL SELF

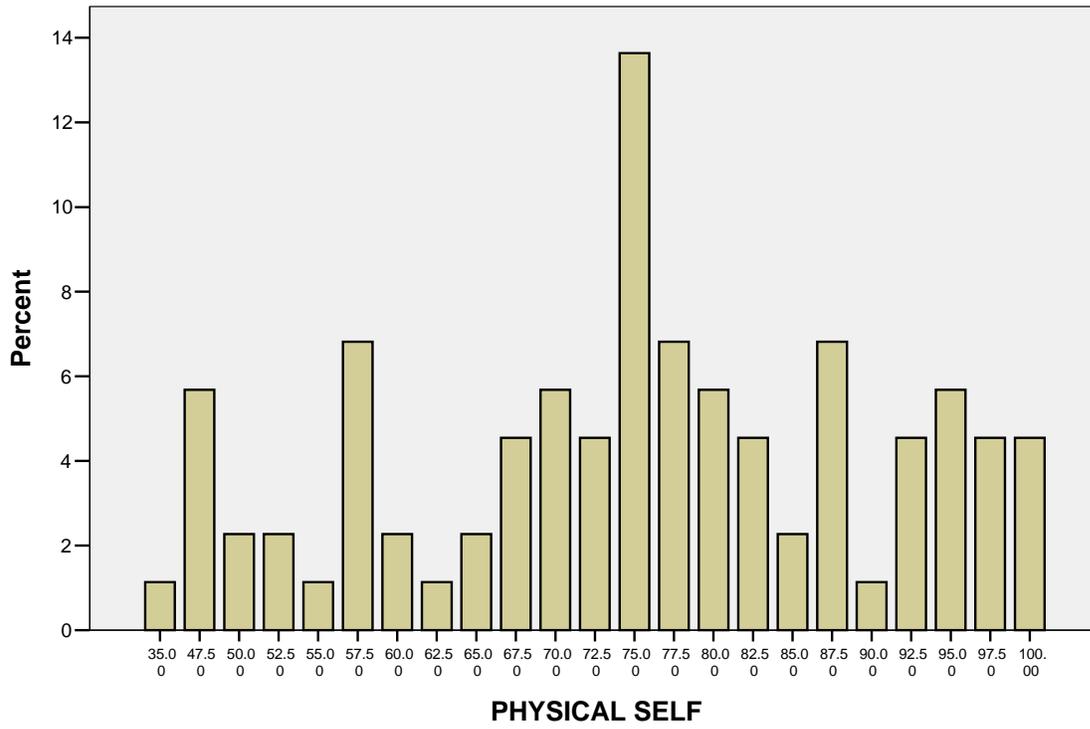


Figure 10. Distribution of Physical Self Scores for Study Sample

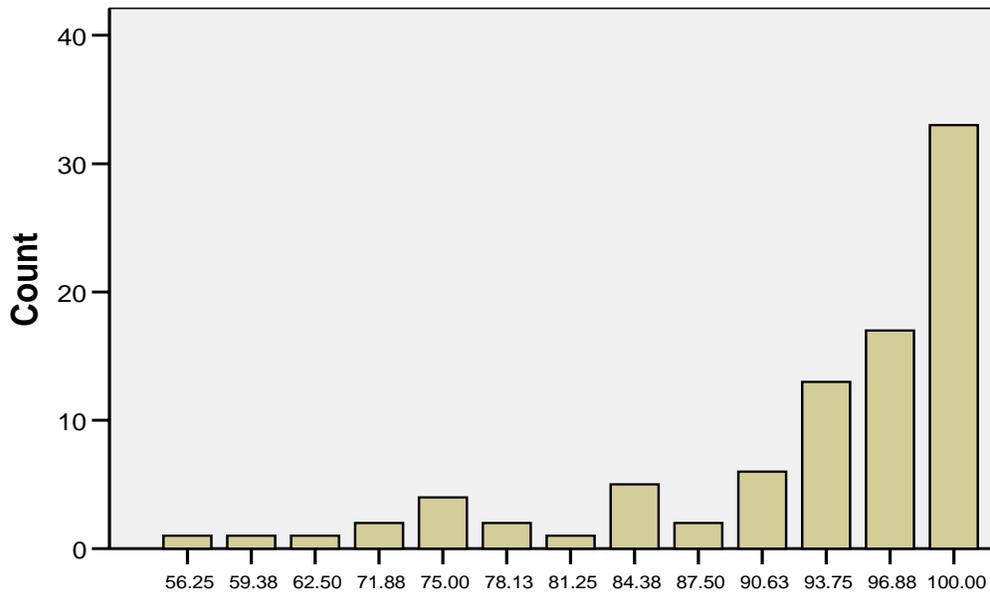


Figure 11. Distribution of Social Self Scores for Study Sample

Results of Multiple Regression Analysis

Scatterplots of each independent variable with the criterion variable were created to ensure that a linear relationship of interval data existed, per the underlying assumptions of MRA (Hair et al., 2006). A scatter plot is a representation of the relationship between two metric variables portraying the joint values of each observation in a two dimensional graph (Shavelson, 1996). The scatter plot for CSE and Total Wellness is pictured in Figure 13. The scatter plot for CSE and the Creativity Subscale of the 5F-WEL is pictured in Figure 14. The scatter plot for CSE and the Coping Self Subscale of the 5F-WEL is pictured in Figure 15. The scatter plot for CSE and Social Self Subscale of the 5F-WEL is pictured in Figure 16. The scatter plot for CSE and the Essential Self Subscale of the 5F-WEL is pictured in Figure 7. The scatter plot for CSE and the Physical Self Subscale of the 5F-WEL is pictured in Figure 18. All plots indicate linear relationships between the independent variables and the dependent variable and reflect that interval level data was collected.

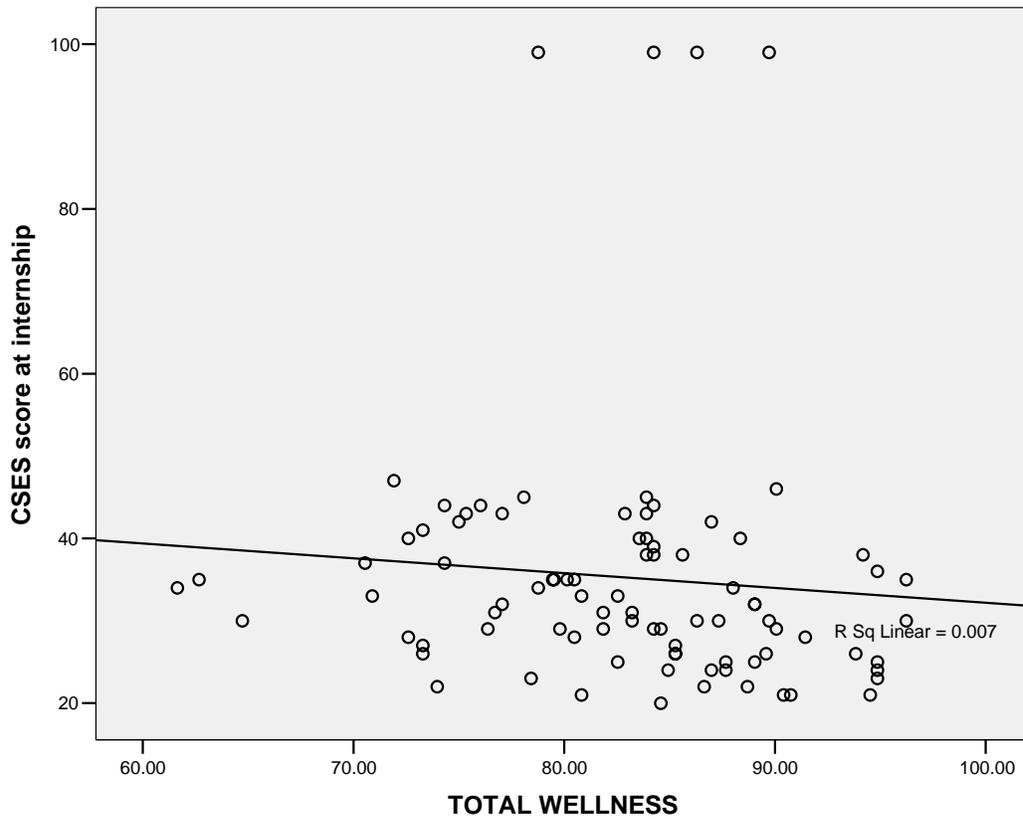


Figure 11. Scatter Plot for Counselor Self-Efficacy and Total Wellness

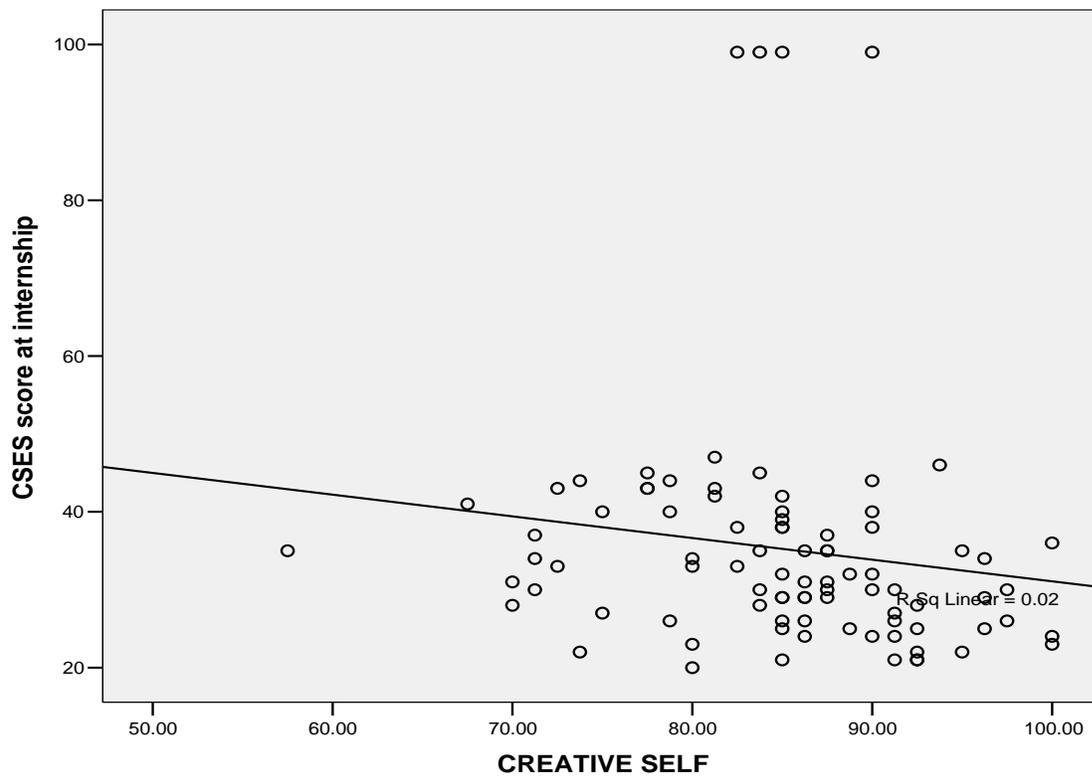


Figure 12. Scatter Plot for Counselor Self-Efficacy and Creative Self Subscale

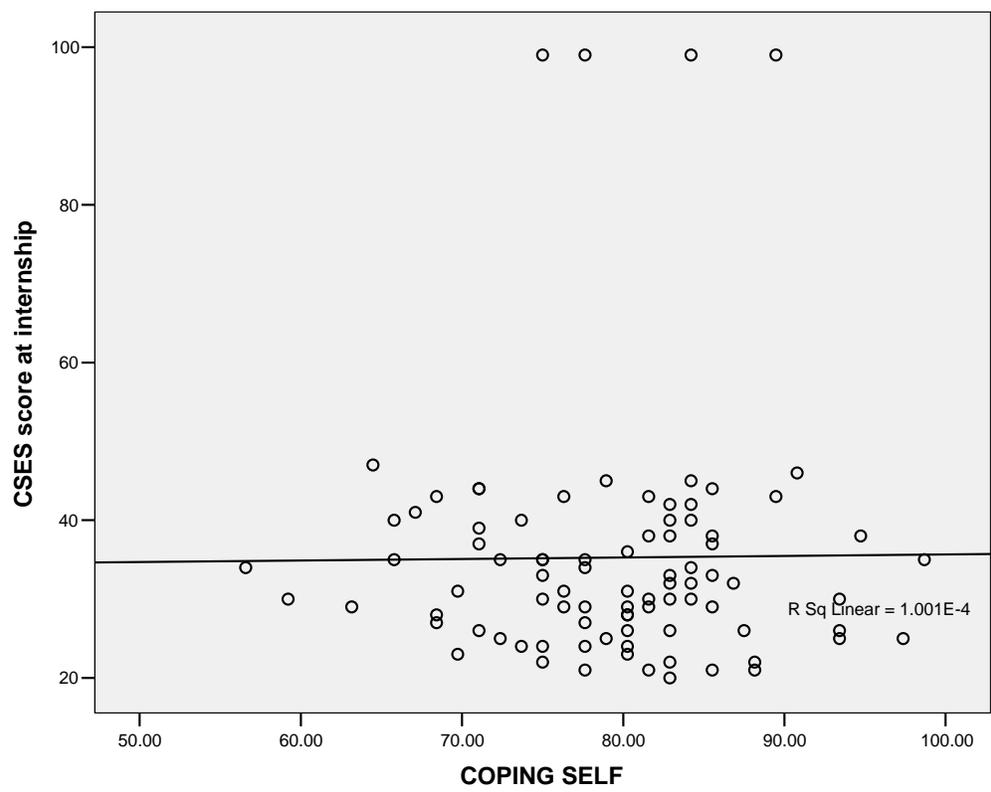


Figure 13. Scatter Plot for Counselor Self-Efficacy and Coping Self Subscale

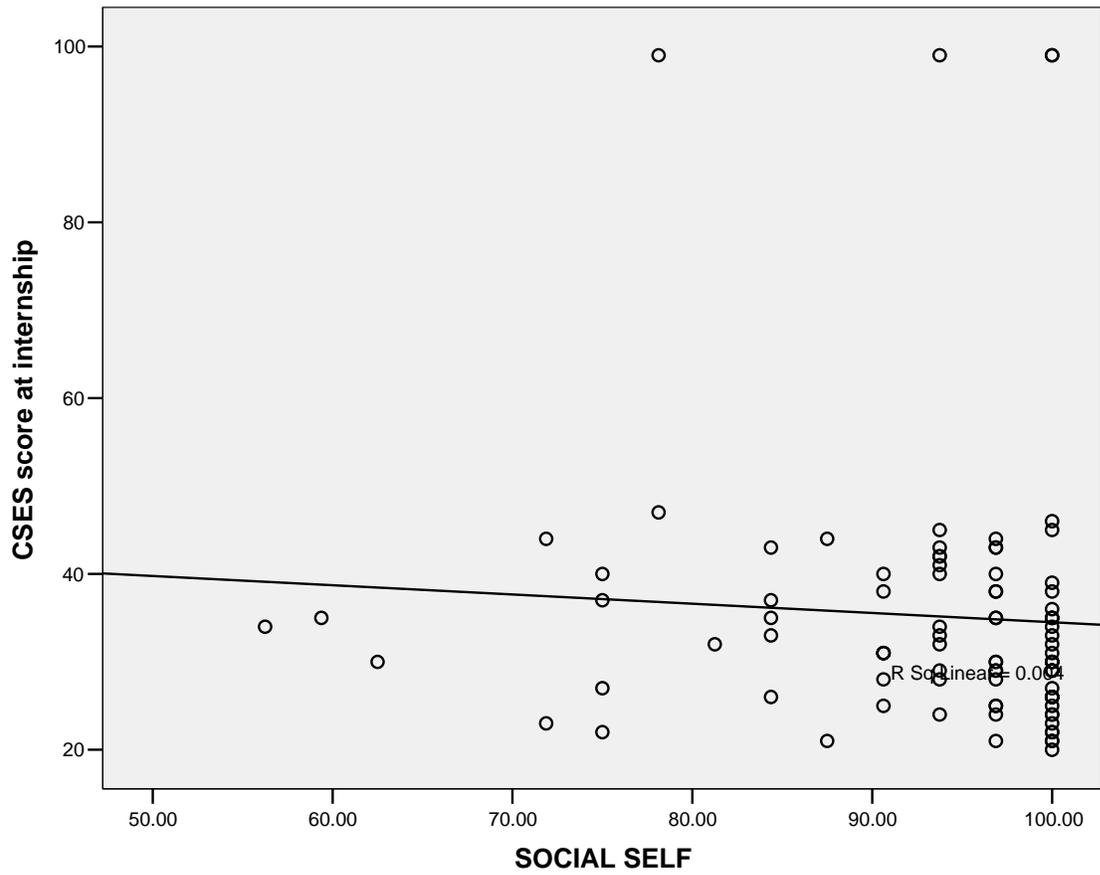
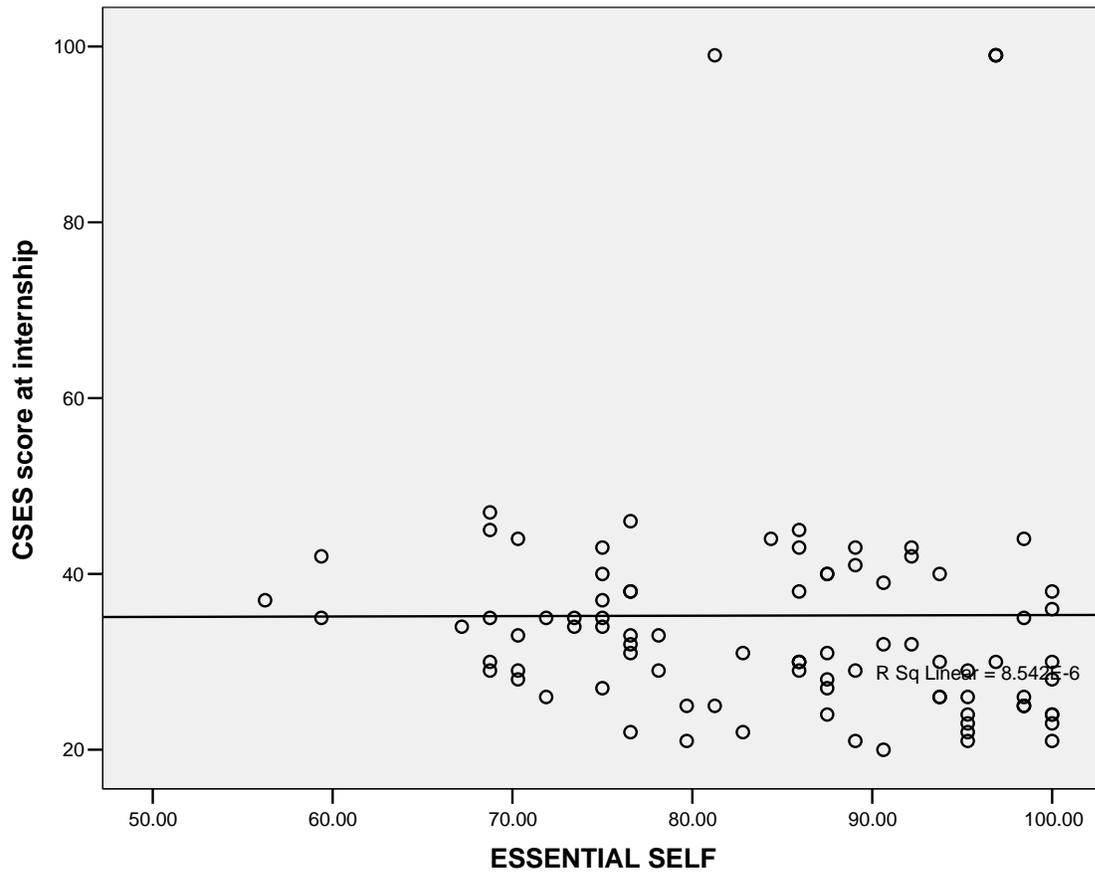


Figure 14. Scatter Plot for Counselor Self-Efficacy and Social Self Subscale



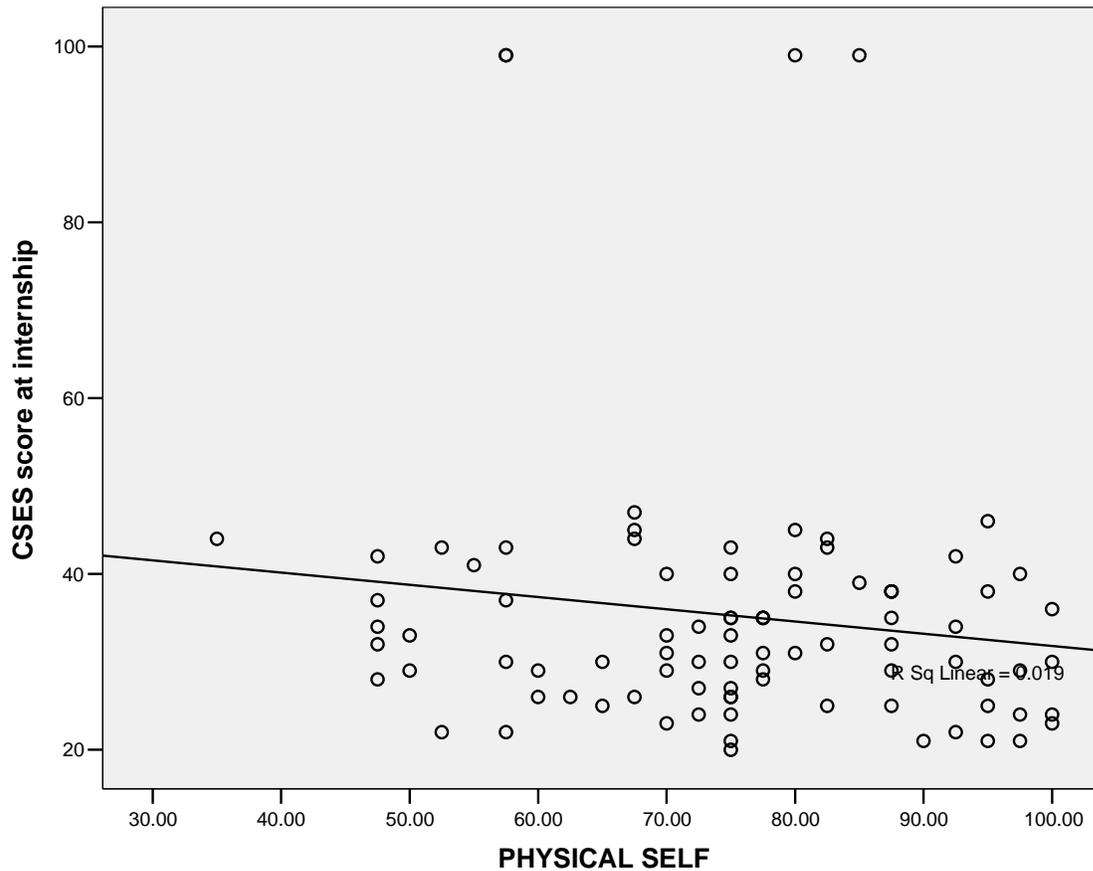


Figure 16. Scatter Plot for Counselor Self-Efficacy and Physical Self Subscale

In addition to demonstrating a linear relationship between variables, the scatter plots also allowed the researcher to evidence the existence of outliers. An outlier may be defined as an observation that has a substantial difference between the actual value for the dependent variable and the predicted value (Shavelson, 1996). As aforementioned, even with the appearance of outliers, all of the relationships between the variables were linear. In other words, the relationship between counseling self-efficacy scores and the 5FWEL total and subscale scores

was linear for this sample. A hierarchical MRA was run in SPSS (version 14.0, 2006). Overall, the linear composite of the independent variables entered into the regression equation predicted 5% of the variation in the dependent criterion F (df = 5, 82, F=.87, p=.508). All of the confidence intervals around each of the Beta weights included zero as a probable value, thus indicating that the results for the independent variables do not explain or predict the dependent variable (CSE) (See Table 12.).

Table 12. Multiple Regression Statistics

Model Summary									
Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics				
					R Square Change	F Change	df1	df2	Sig. F Change
1	.224 ^a	.050	-.008	15.767	.050	.866	5	82	.508

a. Predictors: (Constant), PHYSICAL SELF, ESSENTIAL SELF, SOCIAL SELF, COPING SELF, CREATIVE SELF

Table 13. Anova

ANOVA ^b						
Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	1076.277	5	215.255	.866	.508 ^a
	Residual	20384.712	82	248.594		
	Total	21460.989	87			

a. Predictors: (Constant), PHYSICAL SELF, ESSENTIAL SELF, SOCIAL SELF, COPING SELF, CREATIVE SELF

b. Dependent Variable: CSES score at internship

After analyzing the results of the MRA all of the null hypotheses for this study were accepted, specifically:

1. There was no significant relationship found between counseling self-efficacy as measured by the CSES and overall global wellness functioning as measured by the 5F-WEL.

2. There was no significant relationship found between counseling self-efficacy as measured by the CSES and Physical wellness functioning as measured by the respective subscale on the 5F-WEL.
3. There was no significant relationship found between counseling self-efficacy as measured by the CSES and coping wellness functioning as measured by the respective subscale on the 5F-WEL.
4. There was no significant relationship found between counseling self-efficacy as measured by the CSES and creative wellness functioning as measured by the respective subscale on the 5F-WEL.
5. There was no significant relationship found between counseling self-efficacy as measured by the CSES and essential wellness functioning as measured by the respective subscale on the 5F-WEL.
6. There was no significant relationship found between counseling self-efficacy as measured by the CSES and social wellness functioning as measured by the respective subscale on the 5F-WEL.

Summary

The purpose of this study was to investigate if a relationship exists between counselor self-efficacy and counselor wellness. Three violations of the underlying logical assumptions of Multiple Regression Analysis included normal distribution on the Essential Self and Social Self Subscales, the independence of error terms, and homoscedasticity. The results of the data were analyzed in this chapter, and yielded results that were not statistically significant for any of the independent variables of wellness and wellness subscales for the criterion variable, Counseling

Self-Efficacy. Chapter Five will include a discussion of the findings, limitations of this study, implications for counselor educators, and future research directions.

CHAPTER FIVE: IMPLICATIONS

This chapter summarizes an investigation of the relationship between counselor self-efficacy and counselor wellness. This chapter has three respective parts. The first section provides a discussion of results obtained in this study beginning with a review of the research hypotheses and an exploration of the results related to each. The second section outlines limitations of this particular study, and the third section specifies implications and future directions.

Discussion

Counseling self-efficacy was defined by Larson and Daniels (1998) as, “one’s beliefs or judgments about her or his capabilities to effectively counsel a client in the near future” (p.180). Counseling self-efficacy has been linked to the use of higher order counseling skills (Al-Damarki, 2004), lower anxiety in counseling sessions (Al-Damarki; Leach & Stoltenberg, 1997), greater clinical judgment (Urbani et al., 2002), and has been suggested to correlate positively with counselor performance (Larson & Daniels, 1998), counseling competence and effectiveness (Halverson, Miars, & Levneh, 2006). Wellness may be defined as more than avoiding disease or experiencing an absence of illness, there is an emphasis on prevention and lifestyle choices that promote optimal functioning (Myers, Sweeney, & Witmer, 2000). This is done through taking personal responsibility and making positive choices (Parmer & Rogers, 1997). Wellness applies to both clients and counselors. Counselors entering the field experience high anxiety, stress, and are at risk of burnout and compassion fatigue (Butler & Constantine, 2005; Young & Lambie, 2007). Research has been conducted on the benefits of implementing

wellness strategies with trainees (Carroll, Gilroy, & Murra, 2003; Chandler et al., 2000; Hermon & Hazler, 1999). Wellness has been shown to mitigate stress, energize and vitalize counseling professionals (Littrell & Peterson, 2001), and is suggested to correlate positively with higher self-efficacy (Hattie, Myers, & Sweeney, 2004; Hermon & Hazler, 1999).

The purpose of this study was to investigate, empirically, the relationship between counselor self-efficacy and counselor wellness. A hierarchical multiple regression analysis was used to analyze data gathered from 88 participants in a counselor education program's systematic program evaluation. The instruments used for the study were the Counseling Self-Efficacy Scale (CSES) (Melchert et al., 1996) and the Five Factor Wellness Evaluation of Lifestyle (5F-WEL) (Myers & Sweeney, 2005).

One interesting comparison to be made is the difference between CSES scores for this sample and those reported by Melchert and colleagues (1996). When looking at mean average comparisons (rather than raw score comparisons), this study sample had substantially different scores ($M = 1.8$, $SD = .85$) than participants in the study reported by Melchert and colleagues ($M = 3.82$, $SD = .40$). It is important to discern why the scores for counseling self-efficacy were substantially lower for this study's sample. Perhaps because the data was collected at the end of internship, random measurement error occurred. Specifically, according to Ary and colleagues (1996), participant error may occur when there are "fluctuations in motivation, interest, fatigue, physical condition, anxiety, and other mental and emotional factors affect the test results" (p. 276). Because the end of internship at the institution where this data was collected includes comprehensive portfolio presentations, final examinations, final graduation paperwork, etc.; there may have been less focus on the instruments taken by the participants. Also the length of the instrument, working 40 hour weeks in internship settings, and taking graduate courses may

have all affected the participant's investment in taking the instrument through fatigue. Another possibility was that the participants did not feel very efficacious. Being in internship may make students more aware of what knowledge they don't have and perhaps their limited scope of competence. In addition, impending graduation may invoke fears about having to be prepared as a practicing counselor.

As for the results of the 5FWEL, the scores for Total Wellness ($M = 82.93$), Creative Self ($M = 84.96$), Social Self ($M = 92.79$), and the Essential Self ($M = 84.59$), were all above the mean criterion for moderate wellness (80) according to Myers and Sweeney (2005). The elevated Social Self score echoes the findings for Love ($M = 92.12$) and Friendship ($M = 89.10$) from the earlier wellness instrument version, the WEL, when administered to entry level graduate students by Myers, Mobley, and Booth (2003). Perhaps counseling students have naturally good interpersonal skills and are more attune to connecting with others and maintaining social relationships. However, the Coping Self was slightly below ($M = 79.31$) and the Physical Self ($M = 75.17$) was the lowest scale for this sample, again, similar to the findings for Exercise ($M = 75.15$) and Nutrition ($M = 67.50$) in a study using the WEL by Myers and colleagues (2003). The low Physical Self scores may demonstrate the effects of stress that interns experience, and in addition, may also indicate an area where programs should be more intentional about increasing awareness of self care strategies. These findings also calibrate with the outcomes of focus groups conducted by this researcher wherein school counseling interns reported not eating healthy or exercising due to time constraints and stress during their time in a counselor education program. However, this is contradictory to Roach's (2004) findings that showed no difference in wellness between students entering, midway through, and leaving counselor training programs.

The current findings do not support a predictive relationship between counselor wellness and counselor self-efficacy with this population. Counselor self-efficacy was not predicted by counselor total wellness, creative self wellness, essential self wellness, coping self wellness, physical self wellness, and social self wellness. While there was no statistically significant relationship between each of the chosen factor structures for counselor wellness and counselor self-efficacy, there also exists the possibility that the limitations inherent to this study decreased the likelihood of finding a statistically significant relationship. These limitations will be outlined in the following section.

Limitations

This study had multiple limitations that may have impacted the results. One of the underlying assumptions made in order to test hypotheses statistically with Multiple Regression Analysis (MRA) is that of independence. Specifically, according to Shavelson (1996), it is the assumption that “the scores for any particular subject are independent of the scores of all other subjects” (p. 536). Violations of the independence of error term may have resulted in cases where students had more than one Internship course during the one year period of this data collection. For example, when students were registered in Internship class during both the Spring and Fall semesters. In addition, another student researcher was conducting a study involving wellness simultaneous to this study. Her study participants were at the same university and were asked to take the 5F-WEL during students’ practicum experience. If participants in her study took the instrument in the Spring of 2006, then it was possible that they had experienced three administrations of the 5F-WEL in the period of this study.

Other violations of the underlying assumptions of MRA included normal distributions and homoscedasticity, both of which were compromised in this sample. The abnormal distribution of 5F-WEL subscale scores occurred on three 2nd order factors in the sample (particularly physical self, essential self, and social self). Heteroscedasticity refers to unequal variances in the dependent variable for the possible combinations of the levels of the independent variables (Shavelson, 1996). Because unequal variance were found among the independent variables a violation of homoscedasticity occurred.

Beyond issues with the assumptions of the MRA, there were potentially multiple threats to this study's internal validity. In particular, these threats were maturation, history, and testing. According to Campbell and Stanley (1963) the threat of history refers to an event or events that occur between measurements. In this study, one event that changed is that in the summer of 2006, the professional school counseling students who had not yet entered practicum took a course on ethics and legal issues specific to school counselors. This may have affected (positively) their feelings of self-efficacy in specific regard to items that ask about legal and ethical issues on the CSES. In addition, some Internship instructors began requiring students to have holistic wellness plans, potentially impacting their knowledge and familiarity of wellness. Also, in the Fall of 2005, students were offered a wellness elective at the university where this study was conducted. Students who were enrolled in that course may have had a differential understanding of wellness or greater depth in application of wellness principles in their life. In addition, they 5F-WEL was administered to students in that course, potentially causing more of this study's participants to have a testing effect (internal validity issue).

According to Patten (2002) maturation occurs when subjects mature between a pretest and post test as an effect of development and not the specified treatment. This may have

occurred in this study in situations where students took internship more than once within the year long period of time that this data was collected. Testing is an internal validity threat wherein there is an effect from taking the same test more than once (Campbell & Stanley, 1963), this is potentially caused from the subject gaining familiarity with the instrument. In this study, due to the program evaluation's data collection matrix, all of the subjects had taken both the CSES and 5F-WEL twice, and some subjects may have taken both instruments up to four times due to overlap between this and a concurrently run study by another student researcher involving the wellness of practicum students.

In addition to internal validity threats, the external validity of this study is also questionable. According to Shavelson (1996), external validity of a study is, "the extent to which the findings of a particular study can be generalized to people or situations other than those observed in the study" (p. 20). This study may not be generalizable to the larger counseling population due to the small sample size. The small sample size also increases the risk of type II error. According to Brase and Brase (1991), a type II error occurs when the null hypothesis is accepted, when in actuality it is false. Further, because *ex post facto* research designs are meant to look at strength of association between variables after a treatment has been delivered, there are many extraneous variables that are not controlled for, or are unknown to the researcher, that may affect the results of the study (Shavelson, 1996). One other limitation was that both the CSES and 5F-WEL were self-report measures, this may have increased the risk of responses that are socially desirable.

Limitations of this study also included the lack of empirical support for the psychometric properties of the CSES. Further, there appeared to be some factors prohibiting sound data collection from the subjects as evidenced by multiple outliers in the sample. In six cases, the

subjects had answered every item on the 5F-WEL with the coded answer A. This appears to represent the possibility that some students are either disengaged from the data collection process, are unclear on the directions, or are simply frustrated with the length of the instrument. In addition, during the Spring and summer semesters of 2006, the CSES and 5F-WEL were collected the last night of Internship when many students may be fatigued from the semester, stressed about final examinations, and/ or anxious about presenting their culminating portfolios as required as a portion of the program's comprehensive examination for graduation.

Implications

While no significant relationships were found in this study, there are implications for counselor educators regarding the relationship between the constructs of counselor self-efficacy and counselor wellness. It is important that programs seeking to gather data for evaluation purposes choose instruments that are psychometrically sound and that best encapsulate and represent the construct being measured. For example, in this study the use of a different self-efficacy measure may have affected the result. Also, program evaluation may have greater accuracy if the instruments are only delivered to students one or twice during their program, since it is likely that repeated measurements increase the familiarity with instruments and weaken the internal validity of the data collection.

Because the relationship between counselor self-efficacy and counselor wellness is theoretically grounded and holds promise for bolstering resilience in the field, it warrants further investigation. The results of this study should not underscore the absence of a relationship, but rather should be taken as a challenge to explore the relationship with greater rigor and deliberate changes to the study design. For instance, using a greater sample size, better organization and

timing of test administration (such as delivering the instruments a month before the end of internship), and using a self-efficacy scale with sound psychometric properties. Additionally, test-retest reliability is important because it tests the consistency, or stability of an instrument administered at two or more points in time (Cherry, 2000). Because test-retest reliability was not established for the 5F-WEL it may be useful to design a study aimed at establishing whether or not there is significant test-retest reliability of that instrument.

It is also important to note that the 5F-WEL is still under construction and the authors continue to attempt to improve the instrument. For example, Myers, Luecht, and Sweeney (2004) have suggested that although the 5F-WEL was a psychometric improvement of the WEL, there are several reasons to consider revising it. The reasons included (a) the indivisible self model has not been statistically verified, (b) the 17 third order factor scales have been shown to be more highly correlated than originally thought, (c) greater demand for parsimony, or need for a shorter instrument, and (d) to increase simplicity of profiles for screening, assessment, diagnosis, and treatment (Myers et al., 2004).

In addition, this researcher applauds the efforts of any university to establish data gathering procedures for program evaluation with the express purpose of betterment of educational strategies. This researcher was informed that a consortium of multiple academic institutions is being formed that will constitute a database to share data collections and best practices in counselor education (personal communication with E.H. Robinson, III, October, 2006). To strengthen the potential findings in this proposition, it is recommended by this researcher that a panel review all instruments and a data collection matrix to establish sound collection by minimizing the effects of the aforementioned limitations. Further, it is important to continue to establish and refine protocol procedures for test delivery.

Future Directions

Future directions for this researcher include designing another study to further investigate these two constructs. The new proposed study would be with practitioners in the field (personal experience should be the greatest impact to self-efficacy according to literature). Another possibility is to look at the relationship of counselor wellness between mental health and school counselors, and counselor self-efficacy between mental health and school counselors. A further possibility is a mixed method design study of counselor wellness. In addition, this researcher would most likely use a different counseling self-efficacy instrument with greater psychometric soundness.

One interesting finding that occurred simultaneous to this study was found by Pollock (2007), whom also conducted research using the Counseling Self-Efficacy Scale. Her sample ($N = 124$) mean score was nearly 50 points ($M = 82.45$, $SD = 8.23$) higher than this researcher's sample mean ($N = 91$, $M = 36.05$, $SD = 16.92$) for the CSES. Pollock had also used graduate counseling students in her study most of whom were either in practicum or internship attending secular and faith based institutions. She was examining, and found, a significant relationship between counselor self-efficacy and counselor spirituality. It would be interesting to discern how the mean scores for her sample CSES distribution were substantially higher than the CSES mean scores from this sample. Additionally, it would be interesting to compare differences in the samples' training, education, and demographics that may have played a role.

Conclusions

Martin and colleagues (2004) indicated that counseling self-efficacy could be used for ongoing assessment in counselor training programs because increasing self-efficacy throughout

the program would empower students, provide a measure of training effectiveness, and to assist programs in individualizing training based on the emergent needs of students. Further, according to Halverson and colleagues (2006), individuals with greater self-efficacy demonstrate advanced empathy, assessment skills, and are better able to decide what therapeutic interventions to deliver in counseling sessions. Bandura (2005) wrote “progressive successes build belief in their ability to exercise control and bolster their staying power in the face of difficulties and setbacks” (p.250).

Given that counselors entering the profession face many challenges and difficulties, it seems sensible for programs to infuse pedagogical strategies aimed at raising counseling trainees’ efficacy expectancies. Counselor educators may design experiences in graduate training programs that are both challenging and attainable in order to accomplish this. According to Bandura (1997), individuals must have success through both easy and challenging tasks. Without difficulties and setbacks people do not have the adequate experience to have ongoing integrity of self-efficacious feelings and therefore, may be discouraged when faced with great adversity.

Modes of instruction based on self-efficacy sources in the development of efficacy expectations (Bandura, 1977) include infusion of performance accomplishments (participant modeling, performance desensitization, performance exposure, and self-instructed performance), vicarious experience (live and symbolic modeling), verbal persuasion (suggestion, exhortation, self-instruction, interpretive treatments), and emotional arousal (attribution, relaxation, feedback training, symbolic desensitization, symbolic exposure). Bandura (1986) also noted that when there is ambiguity about performance criteria then individuals are unable to judge their own efficacy due to lack of clarity about their ability to perform—thus lowering self efficacy.

According to Fitzpatrick (1999), “when one lacks relevant prior experience with the task at hand, efficacy appraisals become more sensitive to comparative information. This has been show to be particularly true when standards for success are ambiguous,” (p. 9). Counseling can be an ambiguous process and students need concrete and consistent feedback. Thus, there are many ways to easily implement an efficacy focus in the counseling curriculum.

Similarly, wellness may also easily integrated into counselor training programs. CACREP standards (2001) state that counselor education programs should promote and encourage the personal development of counseling students. According to Myers, Mobley, and Booth (2003) there is limited information on how to effectively assist students in personal development. Myers and colleagues (2003) further suggest that counselor education programs should assess student wellness and assist students in developing wellness strategies for the duration of their studies and career. Through the use of co-construction of self-care plans and holistically designed classroom instruction, students may be made more cognizant of their own current wellness functioning and their individual ideal wellness functioning. While some programs have devoted whole courses to the wellness paradigm and training, it is also easily integrated into multi-disciplinary coursework (e.g. assessment, testing and measurement, techniques, group counseling, etc.).

Indeed, the theoretical soundness of both counselor self-efficacy and wellness indicate that new professionals may greatly benefit from deliberate, planned exposure to both of these constructs in their training. While wellness may be linked to greater resiliency, physical well-being, reduced risk for burnout and impairment, self-efficacy is linked to higher counseling skills use, potentially better ethical decision making, and is proposed to correlate with one’s ability to advocate. In fact, according to Bandura (1986), “conditions combining high self-efficacy and

environmental unresponsiveness tend to generate resentment, protest, and *collective efforts to change existing practices*” (italics added)(p. 446). Bandura also insinuated that low self-efficacy may be linked to Seligman’s notion of learned helplessness—a negative cyclical reaction produced from the transaction between low self-efficacy and subsequent failure. Fernandez and colleagues (2002) stated, “Perceived collective efficacy is defined as a group’s shared belief in its conjoint capabilities to organize and execute the courses of action required to produce given levels of attainments. Unlike individual efficacy, collective efficacy involves interactive, coordinative, and synergetic social dynamics” (p. 108). Again, more impetus for inclusion in counselor training, as the need for counselors to serve as change agents and advocates within multiple systems continues to grow.

While the results of this study were not statistically significant, the imperative for inclusion of both of these constructs in counselor education remains theoretically sound. In addition, due to the limitations of this study, it is this researcher’s opinion that there is a possibility that the relationship between the two constructs does exist and warrants further investigation. If self-efficacy and wellness improve counselor resilience, career satisfaction, tendency to advocate for self and others, reduce the risk of burnout and impairment, and add to the pursuit of greater personal functioning, then the call for research on these two constructs continues for counselor educators and researchers.

**APPENDIX A: STANDARD INSTRUCTIONS TO BE READ WHEN
ADMINISTERING MASTER'S LEVEL PROGRAM EVALUATION
INSTRUMENTS**

Purpose: Hand out sign-off sheets, read it and explain it to them.

Instructions: Hand out one envelope and a pencil to each student attending orientation. Remind them NOT to open the envelope until instructed to do so. When everyone has an envelope, instruct them to take out the instruments and listen carefully to the following instructions:

Today you are going to be given four instruments to complete. There are no “right” or “wrong” answers. Although this is not a timed event, please do not spend too much time on any one item. Rather, read each item and select the response that best fits for you. For confidentiality and anonymity purposes, we are asking that you please do not write your name or any identifying information on any of the instruments. For program evaluation we are not necessarily interested in your individual responses, but rather we are assessing the group’s responses.

The first instrument is the Counseling Self Efficacy Scale. This instrument has twenty items. These items are on one sheet of paper; make sure you notice there are items on the front and back side of the paper. Please read each item and circle the answer that best fits for you—Strongly Agree, Agree, Uncertain, Disagree, or Strongly Disagree. If you wish to change an answer please erase the circle around the original item and circle the item that best fits for you.

The second instrument is the Robinson-Heintzelman Inventory. This instrument has 25 items. These items are also on one sheet of paper, so be sure to answer items on both sides of the paper. Circle the response that best fits for you (A, B, or C).

The third instrument is the Five-Factor Wel. Notice on the front of the instrument there are black lines through some of the instructions, except where it says, “sex” and “birthdate”. The test developers need your response to biological sex and birthdate for scoring purposes. Also notice that this instrument has a separate scoring sheet – a scantron sheet – which is placed directly behind the instrument. The numbers on the scantron sheet correspond with the numbers of the items on the instrument. Please bubble in the answer that best fits for you. If you would like to change an answer please erase the original answer, and mark your new choice.

The last instrument is the OQ-45.2. It has 45 items. Fill in the square of the response that best fits for you: Never, Rarely, Sometimes, Frequently, or Almost Always.

Remember, DO NOT write your name on any of the instruments in the packet. When you have completed all of the instruments, place them back in the envelope (you do not need to seal them), and come to the front of the room to turn in your envelope and pencil. Since program evaluation is mandatory, AFTER you turn in your envelope, please print your name next to your research code number so that I can verify that you have completed the instruments. This sheet will be kept confidential by me. All of the instrument responses in the envelopes are made anonymous. Now you may begin.

APPENDIX B. IRB EXEMPTION LETTER



Office of Research & Commercialization

December 20, 2006

Edward H. Robinson, III, Ph.D. &
Jennifer Curry
University of Central Florida
Child, Family & Community Sciences
ED 322N
Orlando, FL 32816-1250

Dear Dr. Robinson & Ms. Curry:

The University of Central Florida's Institutional Review Board (IRB) received your protocol IRB #06-3977 entitled, "The Relationship between Counselor Self-Efficacy and Counselor Wellness." The IRB Chair reviewed the study on 12/19/2006 and did not have any concerns with the proposed project. The Chair has indicated that under federal regulations (Category 4, research involving the collection or study of existing data, documents, records, if these sources are publicly available or if the information is recorded in such a manner that the subjects cannot be identified) this research is **exempt** from further review by our IRB, so an approval is not applicable and a renewal within one year is not required.

Please accept our best wishes for the success of your endeavors. Should you have any questions, please do not hesitate to call me at 407-823-2901.

Cordially,

A handwritten signature in cursive script that reads "Joanne Muratori".

Joanne Muratori
(FWA00000351 Exp. 5/13/07, IRB00001138)

Copies: IRB File

JM:jt

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