

Electronic Theses and Dissertations, 2004-2019

2007

The Relationship Between Master's Level Counseling Practicum Students' Wellness And Client Outcomes

Elizabeth O'Brien
University of Central Florida

 Part of the [Counselor Education Commons](#), and the [Education Commons](#)
Find similar works at: <https://stars.library.ucf.edu/etd>
University of Central Florida Libraries <http://library.ucf.edu>

This Doctoral Dissertation (Open Access) is brought to you for free and open access by STARS. It has been accepted for inclusion in Electronic Theses and Dissertations, 2004-2019 by an authorized administrator of STARS. For more information, please contact STARS@ucf.edu.

STARS Citation

O'Brien, Elizabeth, "The Relationship Between Master's Level Counseling Practicum Students' Wellness And Client Outcomes" (2007). *Electronic Theses and Dissertations, 2004-2019*. 3284.
<https://stars.library.ucf.edu/etd/3284>

THE RELATIONSHIP BETWEEN MASTER'S LEVEL COUNSELING PRACTICUM
STUDENTS' WELLNESS AND CLIENT OUTCOMES

by

ELIZABETH R. O'BRIEN
B. A. University of South Carolina, 1999
Ed. S. University of South Carolina, 2002

A dissertation submitted in partial fulfillment of the requirements
for the degree of Doctor of Philosophy
in the Department of Child, Family, and Community Sciences
in the College of Education
at the University of Central Florida
Orlando, Florida

Spring Term
2007

Major Professor: Edward H. Robinson III

© 2007 Elizabeth R. O'Brien

ABSTRACT

Client outcome research focuses primarily on three specific aspects of therapy: therapist technique, client behaviors and therapeutic interaction. The term “therapeutic interaction” focuses on the relationship between the counselor and the client, and is often ignored in client outcome research. Counselor specific contributions to the therapeutic process are called therapist characteristics may be an innovative way to assess how counselors’ impact clients’ outcomes in counseling. For the purposes of this study administering the Five Factor Wellness Evaluation of Lifestyle and the Outcome Questionnaire to master’s level student counselors assessed therapist characteristics. The Outcome Questionnaire was administered to clients at a community-counseling clinic at two points and a delta score was calculated to create the variable “client outcome.”

In order to test the research hypotheses, 70 master’s level counseling students completed both the Five Factor Wellness Evaluation of Lifestyle and the Outcome Questionnaire. These scores were then matched with master’s level counseling students’ client delta scores, which created the dependent variable. The results of the multiple regression analysis indicated no statistically significant relationship; therefore the null hypotheses were accepted as the constructs student counselor wellness and client outcomes were not related. Results of the study were summarized and discussed, limitations of the study were explored and recommendations for future research were proposed.

I dedicate this dissertation to the three people that have loved and supported me
throughout this difficult process:
my parents, Hans and Carolyn O'Brien,
& my fiancé, Kyle Oden.
Thank you all so very much!

ACKNOWLEDGMENTS

First, I would like to thank the members of my dissertation committee: Edward H. Robinson III, Mark Young, Shannon Ray, Stephen Sivo, and Grant Hayes. You have given me so many opportunities, more than I probably know about. Thank you all for the meetings, the edits, and the support.

I would also like to thank the members of my cohort, especially Jen Curry and Lorie Welsh, who were always willing to listen, talk, and laugh. I cannot tell you how much I appreciate your capacity for love and caring. To Sandy, Wendy, Emeric, and Nicola, you taught me how invaluable differences in individuals can be. Thank you for being my first professional colleagues, I wish you all the very best.

To my former office mate, Heather Smith, thank you for the good advice and help.

To the members of my cuddle group: Sarah Main, Mimi Meriwether, and Crissy Roddy. You ladies are the best friends a girl could ask for and I am forever grateful that we met that summer-my love to you all.

To the crew at Lexington Mental Health: Beth Durant, Beth Hook, Kara Pechersky, Dave Perault, David Michael, and Wanda Nunn. First of all, thank you for giving me the opportunity to learn and develop my counseling skills, learning how to keep a sense of humor while in a profession that can be so difficult, and for supporting me even when my path diverged. We know what we've been through...I thank you being my friends.

Josh Gold and Margaret Burggraf, thank you for teaching me how to be a marriage and family counselor. In the war between my heart and my head, I think my heart is winning—sorry Dr. Gold.

And finally, to Stephen Rogers, I miss you very much, but I still feel you guiding my path in ways that I can't explain. Thank you for giving me the chance to get to know the real you before you left us.

TABLE OF CONTENTS

LIST OF TABLES.....	ix
LIST OF ABBREVIATIONS.....	x
CHAPTER ONE: INTRODUCTION.....	1
Literature Review.....	1
Impairment.....	3
The Purpose of the Study.....	4
Question.....	5
Hypotheses.....	5
Definition of terms.....	6
Methods.....	6
Data Analysis.....	7
Instruments.....	8
Limitations.....	9
Summary.....	11
CHAPTER TWO: LITERATURE REVIEW.....	12
Client Outcome Research.....	12
Meta-Analysis.....	14
Common Factors.....	17
Therapeutic Alliance.....	20
Wellness.....	25
Impairment.....	26
Wellness.....	29
Summary.....	34
CHAPTER THREE: METHODOLOGY.....	36
Participants.....	36
Student Counselors.....	36
Client Participants.....	37
Materials.....	38
The Five Factor Wellness Evaluation of Lifestyle.....	38
Reliability.....	39
Validity.....	39
The Outcome Questionnaire-45.2.....	40
Reliability.....	41
Validity.....	42
Research Design.....	42
Procedures.....	42
Data Analysis.....	43
Statistical Analysis.....	44
Summary.....	45
CHAPTER FOUR: FINDINGS.....	46
Question.....	46
Sample Demographics.....	46

Descriptive Statistics.....	48
Five-Factor Wellness Evaluation of Lifestyle	48
OQ.45.2.....	49
Multiple Regression.....	50
ANOVA	51
Factor Analysis	51
Hypotheses.....	52
Summary	52
CHAPTER FIVE: DISCUSSION.....	53
Discussion	53
Limitations	54
Implications of Findings and Future Research	58
Conclusion	60
APPENDIX A: IRB LETTER	62
APPENDIX B: PERMISSION TO USE ASSESSMENTS	64
APPENDIX C: INFORMED CONSENT.....	70
REFERENCES	73

LIST OF TABLES

Table 1: Participants' Gender	47
Table 2: Participants' Track Identification	47
Table 3: Number of Times Participants Enrolled in Practicum.....	47
Table 4: Participants' Cultural Background	48
Table 5: Participants' Marital Status.....	48
Table 6: 5F-WEL Descriptive Statistics	49
Table 7: OQ.45.2 Descriptive Statistics.....	50
Table 8: Multiple Regression Analysis.....	51

LIST OF ABBREVIATIONS

ACA	American Counseling Association
ACES	Association for Counselor Education and Supervision
CACREP	Council for Accreditation of Counseling and Related Educational Programs
5F-WEL	Five Factor Wellness Inventory
OQ.45.2	Outcome Questionnaire 45.2

CHAPTER ONE: INTRODUCTION

Research examining client outcomes usually focus on one of three processes of therapy: therapist technique, client behaviors, or therapeutic interaction (Lambert & Hill, 1994). Therapeutic interaction, which is often equated with Rogers' notion of therapeutic alliance, focuses on the relationship between client and counselor. In most studies of successful outcome, counselors' techniques and client behaviors are the primary focus of research (Wampold, 2001). However, this maybe an incomplete picture of what makes counselors successful with their clients. Studies have shown that the person of the therapist is deeply embedded in the counseling process. However research has primarily concentrated on counselors' relationship attitudes and static characteristics (Lambert, 1989). Holistic wellness is an alternative measurement of individual functioning that could offer insight to counselors' therapeutic interactions. The wellness paradigm conceptualizes the individual in terms of physical, psychological, and spiritual health (Myers & Sweeney, 2005). This study will attempt to examine these therapist specific variables that may influence client outcomes in counseling.

Literature Review

Client outcome research quantifies client progress by using an assessment to measure symptoms, and then examines changes in scores over time. Research studies of client outcomes admit that a major contributor to clients' healing or deterioration can be attributed to the individual therapist (Blatt, Sanislow, Zuroff, & Pilkonis, 1996; Garfield, 1994; Lambert & Bergin, 1994; Lambert & Okiishi, 1997). Yet researchers remain unclear as to what it is about counselors that make them either successful or unsuccessful. Wampold

(2001) stated that, “The essence of therapy is embodied in the therapist; and clearly the person of the therapist is a critical factor in the success of therapy,” (p. 201). Wampold offers no clear-cut answers on how to measure the ‘essence’ of therapy; however, authors of client outcome studies have often concluded that the personhood of the counselor should be included under the broad category of common factors (Weinberger, 1995). The term common factors refers to those general factors that are not confined to a specific therapeutic theory, rather they are found in every treatment modality (Frank, 1973; Young, 1992).

One way to create an operational definition of counselor essence is to examine individual wellness. In psychology, holistic wellness was born from the ideas of Maslow and Adler. Maslow (1968) proposed the idea of self-actualization, which is defined as the act of improving individual health via physical, psychological, and social avenues. Initially called ‘holistic-dynamic’ psychology, Maslow created a picture of what healthy and resilient individuals do to thrive. Essentially, he created one of the first proactive and preventative forms of mental health care.

Adler (1956) examined the nature of man, the integration of the person, and the importance of understanding an individual as the sum of his parts. However, in Adler’s case, he was promoting the treatment of mind and body, as he found each to be reciprocal to determining the individual’s conceptualization of the world, and the purpose for which the individual lives his life. In this ideal of wellness, Adler’s five specific life tasks are integrated to form the whole developmental process of the individual over the lifespan: spirituality, self-regulation, work, love, and friendship. Out of this idea, Sweeney and Witmer (1991) created the wheel of wellness paradigm, which offers a more cohesive model for individual functioning. Examining counselors in terms of wellness is important because it gives a

holistic point of view and incorporates mind, body, and spiritual into systemic picture of overall functioning (Myers & Sweeney, 2005).

Impairment

While these ideas of integration and holistic treatment are useful for clients and client outcomes, there is no precedent for examining counselors' efficacy in the same manner (Sheffield, 1998). It is interesting that counselors should be expected to examine holistically, yet it seems that counselors own efficacy is often fragmented and dissected (Witmer & Young, 1996). Illustrations of this idea can be found in ethics codes and research regarding counselor impairment.

The American Counseling Association (ACA) Code of Ethics and Standards of Practice (2005) clearly states that counselors must "...refrain from offering or accepting professional services when their physical, mental, or emotional problems are likely to harm a client or others," (Section C.2.g.). In literature regarding mental health professionals, the term impairment is often used to delineate professional problems. Impairment is defined in a threefold manner: inability and/or unwillingness to acquire and integrate professional standards into one's repertoire of professional behavior; an inability to acquire professional skills in order to reach an acceptable level of competency; an inability to control personal stress, psychological dysfunction, or excessive emotional reaction that interfere with the professional's functioning (Lamb, Presser, Pfof, Baum, Jackson, & Jarvis, 1987). These ideas bring into focus what it is to be a non-functioning counselor, but it is more difficult to ascertain what it means to be an effective counselor and highly functioning individual at the same time.

Witmer and Young (1996) stated, “‘well’ counselors are more likely to produce ‘well’ clients.” This statement employs the idea of isomorphism; the idea that the therapeutic relationship is composed of inter-locking layers and structural similarities between the counselor’s life and the client’s outcomes (Haley, 1976; Bernard & Goodyear, 2002). Hill (2004) argued that this isomorphic relationship is a compelling reason for counselor educators to promote wellness in counseling students, which fulfills not only counselor educators’ responsibility to their students, but also their ethical obligation to beginning counselors’ clients.

Counselor education programs, professional codes of ethics, and literature specifically related to counselors and counselors-in-training discuss the importance of wellness (ACA, 2005; Association for Counselor Education and Supervision [ACES], 1995; Witmer & Young, 1996). Ethical codes clearly stipulate that if a counselor or counselor-in-training is impaired, that actions should be taken to protect clients and counselors from harm. However, the definition of impairment has not been fully articulated, nor there is no empirical evidence to support this proviso.

The Purpose of the Study

Research regarding counselor interventions and successful client outcomes has primarily focused on a search for effective therapies, rather than effective providers of therapeutic interventions (Task Force, 1995). Although therapeutic interventions are deemed successful or unsuccessful, the counselor specific contributions to the therapeutic relationship are often ignored or relegated under the heading of common curative factors (Steering Committee, 2002). As discussed previously, the counselor specific contributions to therapy

and the therapeutic relationship remain difficult to identify. Leaders in the field of counseling have thought that wellness is a characteristic of effective counselors, but there is little current research to support this. Examining counselors in terms of wellness is an attempt to further understand the possible relationship between the health of the counselor and the effectiveness of counseling.

The purpose of this study is to investigate whether or not there is a clear empirical link between counselor wellness and client outcomes. Although research in psychiatry, psychology, and counseling allude to the link between these two ideas, there is no evidentiary link illustrated in research literature (Wampold, 2001). Therefore this study will attempt to establish a beginning to this line of inquiry.

Question

What is the relationship between master's level counseling students' wellness and client outcomes?

Hypotheses

1. Ho = There is no relationship between master's level counseling students' wellness as measured by the Five-Factor WEL (5F-WEL) and client outcomes as measured by the Outcome Questionnaire (OQ.45.2).
2. Ho = There is no relationship between master's level counseling students' wellness as measured by the OQ.45.2 and client outcomes as measured by the OQ.45.2.

Definition of terms

Master's level counseling students. Participants will be master's level counseling students who are currently enrolled in their practicum experience at a large university in the southeast. Students may be enrolled in their first, second, or third semester of practicum, which is a pre-internship experience near the end of their training.

Wellness. Wellness is defined as the interrelated wholeness of the mind, body, and spirit (Witmer & Sweeney, 1992). An individual is considered well when he or she strives for optimal functioning within the paradigms of mind, body and spirit, which is contrary to the more commonly held belief that wellness is simply the absence of pathology or illness (Myers & Sweeney, 2005). In this study, Wellness is defined as the scores on the 5F-WEL Inventory.

Client Outcomes. Client outcomes are quantified measures of client progress, which is defined as an alleviation of symptoms or distress (Wampold, 2001). Specific assessment tools are employed to measure client progress, such as self-report measures, which generate data regarding the client's overall improvement or decline. In this study, the OQ.45.2 will be used to measure client progress.

Methods

This *ex post facto* correlational study investigated the question of whether there is a relationship between counselor wellness and client outcomes (Campbell & Stanley, 1963). Participants will be chosen by purposive sampling methods. This allows the researcher to deliberately select a sample whose characteristics will match the characteristics in the population (Shadish, Campbell, & Cook, 2002). In this study, the researcher will examine

wellness of counseling students at a community counseling clinic, which has established procedures for collecting client outcome data. By employing purposive sampling methods, the results of this analysis may be generalized to other counseling students.

Faculty members who teach the practicum course at an on-site community clinic in a large university in the southeast will be contacted for permission to enter his or her class to obtain access to the students. All practicum students in the 2006 school year will be given information about the study and asked to participate. Those students who are willing to participate will be asked to complete a consent form, a brief information form, the OQ.45, and the 5F-WEL. The forms and instruments will be administered on-site and collected by the researcher upon completion.

Clients who participate in counseling at the on-site counseling clinic must be 18 years of age or older, and are required to sign a 'Client Information and Consent to Treatment' form. This form includes clients' consent to allow assessment data to be utilized in research, so long as the data is coded in such a way that no identifying information is available to researchers. Clients also complete the OQ.45 upon admission and at four week intervals during the course of treatment. A Research Associate, employed by the university and who is responsible for procuring and disseminating coded client outcome data to institutional review board (IRB) approved researchers will collate the data. For this project, the research associate will provide client OQ.45 scores.

Data Analysis

Multiple regression analysis will be used to determine the nature of the relationship between counselors' wellness and client outcomes. With regard to this study, the independent

variables are counselor wellness as measured by the OQ.45 and the 5F-WEL. The dependent variable is client outcome, as measured by the OQ.45. This type of analysis was chosen because it helps to determine the relative importance of each independent variable in the prediction of the dependent variable, allows the nature of the relationship between the independent variables and the dependent variables to be assessed, and examines the relationships among the independent variables with regard to the dependent variable (Hair, Black, Babin, Anderson, & Tatham, 2006). The analysis of data will be completed in the Statistical Package for the Social Sciences (SPSS).

Detecting a significance level in multiple regression is dependent upon the sample size. Because it is anticipated that the relationship between the independent and dependent variables will be strong, and purposive sampling methods are being employed for data collection, it is allowable to have a smaller sample size (Hair, et al, 2006). It is anticipated that the sample size will be between 50-100 participants, and that the regression analysis will not include more than two variables, therefore the power of the analysis should not be greatly diminished.

Instruments

Two instruments will be used in this study: the OQ.45 and the 5F-WEL. The OQ.45 is a self-report measure of patient progress on three specific aspects of daily life: subjective discomfort, interpersonal relationships, and social role performance (Lambert, Morton, Hatfield, Harmon, Hamilton, Reid, Shimokawa, Christopherson, & Burlingame, 2004). These three aspects of patient progress make up the subscales of the instrument, and create an overall score of distress for the client. This 45-item measure was designed to be appropriate

for baseline screening of clients, to be used to monitor client progress, and was specifically designed to be administered frequently yet remain sensitive to changes in client functioning. In this study, the researcher will utilize the total score on the OQ.45 as the measure of client distress. A decrease in this score is considered to be progress.

The 5F-WEL is based on research conducted on the paradigm of wellness and the five major life tasks as reported by Sweeney and Witmer (1991). This 73-item instrument measures wellness in first, second, and third order factors. The first factor is an overall score of wellness, the second order factors include five specific constructs: the essential self, the social self, the creative self, the physical self, and the coping self. There are 17 third order factors that are subsets of the second order factors. In this study, the first order factor will be analyzed to determine a relationship between counselor wellness and client outcome. Second order factors will be analyzed if a relationship between wellness and outcomes is established.

Limitations

It is anticipated that there will be limitations to this study with regard to reliability, validity and data analysis. Reliability refers to the stability of scores over multiple measurement attempts. Data collected in this study will come from counselor and client participants over the spring, summer, and fall 2006 semesters. During treatment, adult clients are given the OQ.45 before they begin treatment, and then every four weeks as they participate in counseling. The OQ.45's overall score has been found reliable for repeated administration to college counseling center clients (Vermeersch, Whipple, Lambert, Hawkins, Burchfield, & Okiishi, 2004). However test-retest reliability of the OQ.45's subscales are not as sensitive, and will not be used in this study.

The OQ.45's concurrent validity has been examined with respective assessment counterparts, such as the Beck Depression inventory, the Symptom Checklist 90 R, etc. (Lambert, et al, 2004). A Pearson product correlation on the total score of the OQ.45 revealed that concurrent validity of the measure with regard to the criterion measures was deemed acceptable; therefore there is a degree of confidence that this assessment measures the construct for which it was designed. Because the 5F-WEL is one of the first measures of its kind, it is not as certain that it is comparable with other measures. There is limited construct validity data on the 5F-WEL. However there is some indication that the instrument is able to discriminate among different demographic indices, such as age, gender, and ethnicity (Myers & Sweeney, 2005).

Finally, limitations with regard to data analysis include type II error and heteroscedacity of the variables, and the independence of cases. Due to the fact that it is anticipated that the sample size of this study will be relatively small ($n < 100$), there is a chance that the power of the multiple regression will be lessened. Which could result in a type II error, that is not detecting a correlation when in fact one does exist (Hair, et al, 2006).

Heteroscedacity is the degree to which the variance of the dependent variable is concentrated in only a limited range of the independent values, instead of the complete range of independent values (Hair, et al, 2006). Because the 5F-WEL's second order factors are likely to be related to each other, it may be difficult to determine which second order factors contribute most to client outcomes.

The master's level counselors will be given the OQ.45 and the 5F-WEL in the last three weeks of their practicum experience. Students may participate in the data collection in more than one semester; however their data will be treated as independent cases. Treating

participants' multiple assessment scores as individual cases will violate the independence of the error terms. That is, it cannot be assumed that each predicted value is independent and not related to any other prediction (Hair, et al, 2006).

Summary

Traditionally, client outcome research has focused on therapist techniques or client behaviors instead of therapeutic interaction. However, therapeutic interaction, specifically the therapeutic alliance has been proven significant in improving clients' functioning. Although the 'essence' or personhood of the therapist is considered significant, these terms remain difficult to operationalize. Examining counselors' in terms of wellness may be one way to define these significant characteristics.

This study focuses on a research project that may establish a link between counselor wellness and client outcomes. Counseling students in their pre-internship practicum experience at a large university in the southeast will be asked to participate in this *ex post facto* correlational study. Two instruments, the 5F-WEL and the OQ.45 will be administered to counseling students who consent to participate. Participants' clients will also take the OQ.45 as they participate in counseling. Participants' assessment scores and participants' clients' scores will be entered into SPSS and a multiple regression analysis will be conducted. The following chapter will review literature pertaining to outcome research, common therapeutic factors and current wellness literature.

CHAPTER TWO: LITERATURE REVIEW

The purpose of this study is to examine the relationship between counselor wellness and client outcomes. An examination of the literature has shown that there is some link between client outcomes and the therapist's personality or "essence." In order to understand the reasons for the present study, the following review examines the current research methodology used to identify client outcomes, discusses common factors in psychotherapy and the therapeutic alliance, and looks at research on counselor impairment and the concept of wellness.

Client Outcome Research

In 1952, Hans Eysenck wrote an article that sparked a great controversy in psychotherapy research. He examined two studies that discussed treatment interventions and how they affected client outcome. Client outcome is the quantified measure of clients' change in symptoms over time. In his review of two studies comparing recovery in psychologically distressed clients who had no psychotherapy versus distressed clients who had been in psychotherapy, he found that clients who participated in therapy had a recovery rate relatively equal to the no treatment group. Hence, Eysenck concluded that the effectiveness of psychotherapy was unproven. His article began a long-term effort among researchers to determine if psychotherapy was effective (Eysenck, 1952).

Interestingly, what emerged from this debate was not only the evidence for psychotherapy's efficacy, but also a critical examination of how client outcome research studies should be compared and analyzed. Smith, Glass, and Miller (1980) cited specific errors that had taken place in Eysenck's and subsequent reviews of client outcome research

supporting the effectiveness of psychotherapy. The errors were: *ex post facto* exclusion of studies based on reviewer judgment, comparing studies without using a common statistical metric, threats to internal validity, and utilizing studies that inherently supported researcher bias (p. 22).

Ex post facto exclusion of studies means that an author utilized some outcome studies, while neglecting to use others in a given research review. However, this strategy presumes that the researcher has some sense of objectivity and distance from the issue being studied. Determining the efficacy of psychotherapy was a high stakes debate for many, and it is difficult to imagine that a researcher on either side of this debate would include an outcome study that does not appear to support his or her side. Moreover, most researchers' examining psychotherapy's efficacy did not include their methodology for excluding a study (Smith et al, 1980).

The second issue in research reviews was utilizing statistical significance as the common metric to compare studies. Yielding a statistically significant result is tied to a study's sample size. When comparing studies of unequal sample size, the larger sample sizes have a greater chance of showing statistically significant results than smaller sample sized studies. Therefore, it would be easy for a reviewer to find studies with larger sample sizes that would skew data in a desirable direction and support the preferred position (Smith et al, 1980).

Third, there is the question of internal validity. Internal validity is defined as, "the extent to which the intervention, rather than extraneous influences, be considered to account for the results, changes or group differences," (Kazdin, 1994, p. 22). Threats to internal validity can include: historical events, maturation and/or attrition of subjects, repeated

testing, related factors that create changes over time and create group differences, and regression towards the mean. Campbell and Stanley (1963) cite randomized assignment of participants to treatment or control group as an effective way to ensure internal validity (p. 23). Unfortunately, reviews on literature of psychotherapy's effectiveness did not take into account the differing levels of internal validity, such as participant assignment to treatment groups, when comparing reviews, thereby making the conclusions drawn from these studies invalid (Smith, et al, 1980, p 14).

Finally, research reviewers had a tendency to utilize studies that supported their particular side of the psychotherapy effectiveness debate. Considering the degree to which reviewers were already skewing results to support their position, results from Eynseck's 1952 review, and subsequent reviews until about 1980 should be reviewed with caution. In an effort to mitigate the bias in systematic reviews of therapeutic research, Smith and colleagues created a revolutionary new way to examine and review studies. It was a sophisticated statistical technique called meta-analysis.

Meta-Analysis

In the *Benefits of Psychotherapy*, Smith and colleagues (1980) attempted to answer the question, "Is psychotherapy effective?" However, what also emerged from this work is a methodology that allows research reviewers to examine heterogeneous studies and utilize specific steps to make them more homogenous and comparable. These steps are: defining population, sampling and search procedures, classifying studies, and analyzing the data to create a common metric. In the paragraphs below, the steps that Smith and colleagues (1980) took to resolve these methodological issues are described.

Defining population, sample, and search procedures are imperative to understanding a study because this information allows readers to determine if a study was conducted in a rigorous and methodical way. Defining the population in individual terms of illness, age, and gender, allows a researcher to determine if characteristics among treatment and control groups were relatively equal, thereby assessing the level of internal validity. Reporting sampling procedure helps the reader to understand how the search for relevant research studies was conducted, and if efforts were made to include all available studies. Finally, reporting search procedures demonstrates that reviewers have searched in relevant and well-known databases and journals, such as *Psychological Abstracts* or the *Journal of Counseling Psychology*.

Classifying studies allows the researcher to, “investigate the relationship between the effect produced by the therapy in a study and other features of the study, such as the characteristics of the clients, the therapy, the outcomes, as well as the technical features of the study itself,” (Smith et al, 1980, p. 59). In effect, the authors devised a coding system that allowed studies to be categorized in such a way that logical comparisons between studies could be made. Their classification included such variables as: client diagnosis, client-therapist similarity, therapy modality, therapist experience, and outcome measurement. Although this is not an exhaustive list, it does give an idea of how studies can be differentiated. Interestingly, Smith and colleagues also created a coding system that rated internal validity of studies. Ratings ranged from high, medium or poor internal validity depending on the assignment of subjects to treatment groups and the extent of experimental mortality in a study (Smith, et al, 1980, p. 63).

Finally, the authors created a common metric to compare studies based on the magnitude of their effect rather than if the treatment was statistically significant. Magnitude of effect, or effect size, is “the mean difference between the treated and control subjects divided by the standard deviation of the control group,” (Smith, et al, 1980, p. 68). Utilizing the mean difference allows researchers to compare studies that may use different instruments to measure outcomes. It is also important to note that at the time of the first meta-analysis, the Statistical Package for the Social Sciences (SPSS) was newly available and for the first time, allowed statisticians to analyze large amounts of data using computers instead of hand calculations (which also have greater potential for computational error). Ultimately, Smith and colleagues found that the average effect size of psychotherapy was 0.85. Meaning that an individual engaged psychotherapy would be better off than eighty percent of people who had not engaged in therapy (Smith et al, 1980, p. 124). In the years since Smith and colleagues’ meta-analysis of client outcome research, other researchers have conducted similar meta-analyses to examine the efficacy of psychotherapy. Reviews have converged and it has been determined that overall, psychotherapy is effective and beneficial to clients (Wampold, 2001). In fact, psychotherapeutic research has replicated Smith and colleagues findings that participants who are placed in treatment experience greater alleviation of symptoms and distress than participants who are placed in control groups with no treatment (Wampold, 2001).

The ability to categorize outcome data has lead to researchers demarcating outcome research into three distinctive clusters: examining client outcomes with regard to therapist techniques, client behaviors, and therapeutic interaction/process (Lambert & Hill, 2004). Therapist techniques are the theoretical orientation and skills that therapists use to effect

change in clients. Client behaviors are the symptoms, behaviors, and global functioning that change over the course of client treatment. Finally, therapeutic interaction/process are the relationship factors between the therapist and client that create a positive environment for client change. Particularly important in therapeutic interaction/process research and client outcomes is the existence of the common therapeutic factors or curative factors that seem to account for therapeutic effectiveness regardless of theoretical orientation.

Common Factors

Rosenzweig (1936) initially stated that common factors in psychotherapy and counseling are defined as those implicit factors that cut across schools of therapeutic thought. He stated that although schools tend to adhere to the idea that it is the unique therapeutic intervention that created change in the individual, he offered a compelling argument that it was the commonalities between all of these therapies that were the healing mechanism for clients. In 1940, Goodwin Watson hosted a conference in which prominent figures of psychotherapy, such as Saul Rosenzweig, Alexandra Adler, and Carl Rogers, came to a consensus as to the “true” common factors. They determined that it was the support, interpretation, insight, behavior change, a good therapeutic relationship, and certain therapist characteristics that were the salient features of successful therapy (Sollod, 1981). With the exception of Jerome Frank’s work on “non-specific” factors, research on these common components was not as prevalent until the 1980’s. Since that time, leaders in the field of psychotherapy have debated the true nature of the common factors, with research focused primarily on ascertaining the elements that truly unite the therapeutic experience and creating

more efficacious treatments based on these components (Garfield, 1973; Gitelson, 1962; Grencavage & Norcross, 1990).

Although there is some truth to the idea that there are common factors in all therapies, they are not necessarily present in the same degree in every school of thought (Weinberger, 1995). For example, although the psychodynamic approach stipulates that the therapeutic relationship is necessary for the individual to engage in psychotherapy, it does not emphasize the relationship as a central component to treatment in the way that the humanistic approach does (Rogers, 1990). This issue has led to something of a “buffet effect” with different schools choosing to acknowledge and study those factors they perceive as relevant to their treatment, while leaving some factors out of research endeavors altogether (Weinberger, 1995).

Grencavage and Norcross’ (1990) meta-analysis of fifty publications on common factors shared in diverse therapeutic approaches emphasized that researchers’ determinations of important components in therapy are somewhat ambiguous. Their examination of professional books, peer reviewed articles, special journal sections, and chapters in edited books, revealed that dependent upon the researchers’ theoretical orientation, the number of common factors included in a given work could range from one to twenty. Ultimately the following commonalities in therapeutic interventions emerged from their analysis: (1) therapeutic alliance, (2) opportunity for catharsis, (3) acquisition and practice of new behaviors, (4) clients’ positive expectancies, (5) beneficial therapist qualities, and (6) providing a rationale for change processes. Although these commonalities were determined to be most prominent, Grencavage and Norcross admitted that there was still a great deal of variance in authors’ definitions of each component.

Interestingly, there is mounting evidence that the common factors, especially the therapeutic relationship, are vital to therapeutic success (Lambert, 2005; Lambert & Okiishi, 1997; Wampold, 2001). Grissom (1996) conducted a meta-analysis that compared 46 previously conducted meta-analyses to determine the superior outcome of therapy, placebo, and control treatment comparison studies. Treatment was categorized into three groups: therapy - the participant engaged in some form of specific factors therapy; placebo – the participant engaged in a seemingly credible therapeutic intervention that utilized non-specific (common) factors; or control – the participant was monitored and told to “wait and see.” Although it was determined that specific therapeutic intervention yielded the greatest positive outcome for participants, placebo intervention was the second greatest determinant of positive outcomes (Grissom, 1996). Although these results are not necessarily surprising, the analysis also revealed that the placebo treatment did have a moderate effect size ($ES = .48$), meaning that placebo, or common factors, was effective for roughly half of the population to which it was administered to. Effect sizes for placebo of .44 had been found in earlier meta-analyses conducted over a smaller sampling of outcome research (Lambert, Weber, & Sykes, 1993; Lipsey & Wilson, 1993). Interestingly, while the effect size for therapy versus placebo was larger ($ES = .58$), it was not as dramatically different as one might expect (Grissom, 1996). This could lead to the conclusion that although common factors are not singularly responsible for client success, they are an important ingredient in client treatment.

Strupp and Hadley (1979) gave voice to the concerns of many who are uneasy about the level of success that is attributed to common factors. Specifically, concerns center on the idea that successful outcomes are associated predominantly with the therapeutic relationship (Butler & Strupp, 1986; Strupp, 1995). Researchers argue that if the relationship were the

only “necessary and sufficient” component of psychotherapy, then there is little need for different therapeutic approaches or specific training to become a successful therapist (Frank, 1973; Rogers, 1990; Strupp & Hadley, 1979). Regardless of the debate, it is clear that the therapeutic relationship, or alliance, plays an important part in treatment.

Therapeutic Alliance

The therapeutic alliance was first alluded to by Freud (1912) to explain the detrimental effects that transference could have on the process of analysis. Transference is defined as clients’ unconscious shifting of feelings and fantasies from past relationships onto their analyst (Corey, 2001). Transference interference was further explained as the ego’s mechanism to instinctively repel and repress the relationship between the analyst and patient (Sterba, 1934). The importance of transference is not only that it leads researchers to the therapeutic alliance; it is the first mention of the significance that occurs when analyst and patient experience a meeting of the minds. Freud (1912) articulated this idea by stating, “the first aim of treatment is to attach the person of the patient to the person of the therapist,” (p. 139). Theorist of psychoanalytic practice furthered Freud’s ideas to include the positive aspects of forming a healthy relationship between therapist and patient, deeming it a “therapeutic alliance,” (Bibring, 1937; Sterba, 1934; Zetzel, 1956). The alliance between two individuals engaged in the therapeutic process was thought to be a necessary and facilitative requirement to engage the client in purposeful work (Greenson, 1965).

The idea of alliance between therapist and client was not without its detractors. Brenner (1979) reexamined earlier works on alliance and deemed it “neither correct nor useful to distinguish between transference and therapeutic alliance.” His interpretation of

Freud's meaning of transference held that its existence in therapeutic process was fodder for further analysis. Moreover, alliance could not be distinguished as a separate entity from transference, as these phenomenon are inextricably linked (Brenner, 1979). Although some psychotherapists may have warmed up to the idea of the importance of the relationship, there are still those who refer to its importance as "an overplayed hand..." that is relied upon too heavily without the benefit of theoretical underpinnings (Brady, Davidson, Dewald, Egan, Fadiman, Frank, Gill, Hoffman, Kepler, Lazarus, Raimy, Rotter, & Strupp 1980).

In contrast to Brenner's outcry, there were still theorists who believed that the relationship was not only necessary, it was the impetus for client change (Strong, 1969). Although theorists are consistent in their belief that the relationship is important, the definition of relationship varies a great deal (Gaston, 1990). Examples of how the definition of therapeutic alliance has taken divergent paths can be seen in the psychodynamic school and the client-centered approach. Psychodynamic theorists' idea of the therapeutic alliance has grown to include the following elements: tasks, goals, and bonds (Kleinke, 1994). Whereas, the client-centered approach delineates the following concepts as central to the therapeutic alliance: the patient's affective relationship with the therapist, the patient's capacity to work purposefully in therapy, and the therapist's empathic understanding and involvement (Gaston, 1990).

Although the psychotherapeutic approach and client-centered approach are defined slightly differently, they are essentially based on the therapist's ability to make the client feel heard and empowered within sessions (Gaston, 1990; Kleinke, 1994). Rogers (1992) took the importance of the alliance a step further with his assertion that the relationship was one of the definitive variables that could bring about meaningful change in the individual. Empirically,

there is evidence to suggest that this relationship is indeed powerful (Horvath & Symonds, 1991; Ricks, 1974). To this end, there is a movement in the field of outcome research to foster a greater understanding of what works in a therapeutic alliance, and to make practitioners more aware of how consistently and substantially this alliance contributes to therapeutic success (Task Force, 1995).

Perhaps the most dramatically presented study of therapist effects on client outcomes is Ricks' 1974 study. Ricks conducted a longitudinal study comparing the results of two therapists, whom he labeled the "supershrink" and the "pseudoshrink." Both therapists were working with severely disturbed adolescent boys. While the supershrink was deeply involved in treating his patients, the pseudoshrink treated them with a detached diffidence. The results of these practitioners' work was astounding. While the supershrink's patients were highly functioning, with only 27% becoming schizophrenic in adulthood, 87% of the pseudoshrink's clients were diagnosed as schizophrenic in later life (Ricks, 1974). Much of this difference was attributed to the relationship that the patients reported having with their therapist. The supershrink's clients felt that he was generally warmer, involved, and devoted to their wellbeing whereas clients' perceptions of the pseudoshrink reported his reserved manner, fearfulness in working with difficult cases, and his lack of empowerment and instillation of hope in his clients (Ricks, 1974).

While the Ricks study is persuasive, it is weakened by its examination of only two therapists. In the last thirty years since the Ricks study, there has been a greater push to examine therapeutic success in terms of theoretical approaches rather than individual therapist effects (Okiishi, Lambert, Nielsen, & Ogles, 2003). Obviously, it is difficult to gather a large sample of individual therapists with client outcome data for analysis and

classify them as either “super” or “pseudo.” Second, the therapeutic relationship is presented statistically in most outcome studies as “therapist effect,” a variable that can be interpreted as not significant in statistical analysis. This occurs most often because of the low sample size of therapists in a given study (Crits-Christoph & Mintz, 1991). Therapist effect can have a great deal of affect in client outcomes in real-world practice, but because it is not statistically significant in research studies, it may be ignored or overlooked as important.

In an effort to discover the actual effects of the individual therapist, Horvath and Symonds (1991) conducted a meta-analysis examining the relationship between working alliance and client outcomes. Their examination of twenty-four studies revealed that the working alliance was the most predictive measure of successful client outcomes. Interestingly, it was also the client’s perception of a positive alliance that was most predictive of positive outcome, rather than therapists’ or third party assessments. Furthermore, the working alliance was not specifically linked to the theoretical orientation of the clinician or the length of treatment. These findings confirm that therapists have a great deal of influence on their clients’ success, regardless of their theoretical orientation.

At the same time a parallel line of inquiry in working alliance research was a meta-analysis conducted on outcome studies related to therapist efficacy that could account for therapist differences. The primary focus of this study was to determine how variability in therapist outcomes could be lessened to create more successful therapeutic interventions, and in turn, higher client outcomes. An examination of fifteen studies found that using treatment manuals and experienced therapists decreased therapist effects (Crits-Cristoph, Baranackie, Kurcias, Beck, Carroll, Perry, Luborsky, McLellan, Woody, Thompson, Gallagher, & Zitrin, 1991). The researchers’ suggestions focused primarily on manualizing therapeutic

interventions to create more successful outcomes, rather than examining variables that could improve an individual counselor's relationship building skills.

In spite of this, other research has continued to focus on those traits that make individual counselors successful. Lambert (1989) described the impact that a counselor's process style and static traits have on clients. Process style is the therapeutic style, techniques, and relationship attitudes that are unique to each counselor. Examples of process can be seen in counselor's rate of speech, use of silence, and level of empathy. The counselor's gender, personality type, values, and personal adjustment are more static traits. Although process style can be refined over time, static traits are not as likely to change. In his literature review of therapeutic process and outcome research, Lambert (1989) highlighted literature that supported the belief that individual therapist effect was important. Moreover, he compiled a list of traits and characteristics that may account for therapist affects, furthering the line of inquiry.

Lafferty, Beutler, and Crago (1989) conducted a study on therapist efficacy to indicate the process styles and static traits that affect clients the most. They found that therapist's relationship skills, such as empathy, regard, and congruence, showed the greatest differentiation between more and less successful therapists. Interestingly, their study also determined that more successful therapists place higher value on having an intellectual and reflective lifestyle than a monetarily prosperous or exciting lifestyle. The researchers interpreted these results to mean that successful therapists may be more intrinsically motivated to help others, while less successful therapists may be more extrinsically motivated by monetary gain.

Although the aforementioned studies suggest some traits that make a therapist successful, there are still more aspects of therapist personality that need to be defined. Early in literature regarding common factors and the therapeutic alliance, Rosenzweig (1936) stated:

Very closely related to such implicit factors is the indefinable effect of the therapist's personality. Though long recognized, this effect still presents an unsolved problem. Even the personal qualities of the good therapist elude description for, while the words *stimulating*, *inspiring*, and so on suggest themselves, they are far from adequate. For all this, observers seem intuitively to sense the characteristics of the good therapist time and again in particular instances, sometimes being so impressed as almost to believe that the personality of the therapist would be sufficient in itself, apart from everything else. To account for the cure of many a patient by a sort of catalytic effect.

However, researchers are still struggling to create an operational definition of therapist characteristics that are imperative to creating a successful working alliance. Lambert (1989) stated that these characteristics had a “mystical quality,” and would remain elusive until research focused solely on individual therapists' effects. Examining counselors' wellness may be one way to define these traits. In the next section, we examine the concept of wellness which may be an important characteristic of the effective counselor.

Wellness

The Greek god of medicine and healing, Aesculapius, had two daughters: Panacea and Hygiea. Aesculapius' daughters represented aspects of his gifts in different ways, Panacea was the goddess of healing and cures, and her sister Hygiea was the goddess of welfare and prevention of disease (Wikipedia.com). It is from these mythological beings that modern medicine has derived its approaches to health care: reactive and proactive. Reactive health care looks to cure the ills of individuals, while proactive health care attempts to

prevent disease and illness before it occurs. Often, individuals are not treated and cared for unless they are ill. Mental health care treats individuals in a similar way; treatment is generally dispensed only when illness is detected.

Moreover, counselors' functioning is also assessed in a reactionary manner. Counselors are termed "impaired" when their functioning is not optimal. Unfortunately, this practice does not define what an optimal functioning individual should look like, what Witmer (1985) refers to as a "well individual." Examining a counselor in terms of wellness may be a more proactive way to assess individual functioning and encourage healthy lifestyle practices. The following section explores counselor impairment and the development of the wellness paradigm in counseling.

Impairment

Professional health care providers who are unable to perform their duties categorized in three ways: (a) incompetent professional, (b) unethical professional, and (c) impaired professional (Lamb, et al, 1987; Stadler, Willing, Eberhage, & Ward, 1988). An incompetent professional is one who either lacks professional training or is unwilling to continue skill development beyond initial training. Unethical professionals are those who are unwilling to conform to specific guidelines and laws laid out in professional organizations or licensure boards. And finally, an impaired professional is one who is unable to competently give effective care to others. Impaired professionals are not considered to be malicious or willful in their neglect of clients, whereas incompetent or unethical professionals may engage in their behaviors willingly (Stadler et al, 1988). This review of the literature will focus specifically on professionals who are deemed impaired.

Impaired professionals, specifically counselors, are often overlooked or ignored by their professional peers (Olsheski & Leech, 1996). Reasons for these oversights can range from counselors' isolation, an unclear definition of true impairment, or fear of ostracism by other professionals. However counselors and counselor educators have certain obligations that compel them to intervene if they are aware of a floundering colleague. First, all counselors are bound by the ethical obligation of nonmaleficence, "first, do no harm." Secondly, counselors who are impaired may either be of little benefit or harmful to their clients. There is empirical evidence supporting the idea that counselors have the power to influence clients, and impairment could negatively affect counselors' ability to help alleviate clients' symptoms (Frame & Stevens-Smith, 1995). Third, ethical codes of the American Counseling Association (ACA) and the Association for Counselor Education and Supervision (ACES) both state that professional counselors and counselor educators are obligated to report any type of impairment that would interfere with counselors or counselors-in-training performance. Finally, legal consequences of counselor impairment can include malpractice lawsuits and liability of supervisors, training institutions, and job sites (Frame & Stevens-Smith, 1995).

Causes of impairment can include burnout, depression, emotional disturbance, drug and alcohol abuse, sexual involvement with clients, overwork, and emotional contagion (Emerson & Markos, 1996). Kottler (1993) described burnout as an inevitable consequence of counseling that is marked by a lack of willingness or joy in engaging in work activities. Depression can be defined as ongoing feelings of extreme sadness or loneliness (Sue, Sue, & Sue, 2000). A personal tragedy or sudden life change may illicit an emotional disturbance in an individual, leading to feelings of stress and anxiety. Drug and alcohol abuse can cause

impairment in counselors' judgment, severe health problems, and may lead to engaging in other unethical activities (McCrary, 1989). Sexual involvement is generally considered a serious violation of clients' rights. However, due to the prevalence of sexual misconduct cases before ethics and licensure boards, violations could be interpreted as symptoms of impairment (Emerson & Markos, 1996). Overwork is marked by enmeshment with clients and the work environment, as well as counselors' inability to recognize that their high expectations of their skills is causing elevated levels of personal stress. Finally, emotional contagion is a more understated form of impairment, in which counselors begin to internalize their severely disturbed clients' pathology (Guy & Liaboe, 1986).

Empirically, there are studies to suggest that counselors-in-training are already experiencing symptoms of impairment and some action needs to be taken. For example, a study on counselor impairment and dismissal revealed three specific reasons for student attrition: (1) academic performance, (2) emotional impairment, or (3) ethical violations (Bradley & Post, 1991). Although emotional impairment was the second most prevalent reason for dismissal, the researchers did state that identification of impairment is more subjective and more difficult to prove and/or justify than academic dismissal. The researchers also noted that some impaired counselors-in-training remain undetected.

Gaubatz & Vera (2002) examined gate-keeping procedures in counselor training programs. Their survey of counseling faculty found that instructors judged that 10.4 % of counseling students in their programs were psychologically or interpersonally incompetent. More disturbing was that respondents also reported that these students were dismissed or remediated only fifty percent of the time. Lack of support from administration and

subjectivity of determining impairment were again reasons cited for lack of dismissal (Gaubatz & Vera, 2002).

Protocols for handling counselor impairment are often borrowed from other professions, such as social work or medicine. Sheffield (1998) proposed an intervention procedure for impaired counselors based on the North Carolina physicians health program's existing plan. Although it is imperative that the counseling profession creates more definitive interventions for impaired counselors, reactionary interventions are not enough. Instead, counseling professionals and counselor educators must strive to inoculate and mitigate impairment by adopting a preventative model, such as promoting counselor wellness.

Wellness

The wellness movement originated from medical practitioners concerns that individuals relied too heavily on medical intervention and not enough on preventative self-care (Ardell, 1986, p. 3). In the journal *Health Values*, Hettler (1984) defined wellness as, "an active process through which individuals become aware of and make choices toward a more successful existence," (p. 13). Within the medical paradigm, Hettler developed a model of wellness that included six specific dimensions: intellectual, emotional, physical, social, occupational, and spiritual health (Savolaine & Granello, 2002).

In a similar vein, the counseling field has attempted to carve out a professional identity that promotes proactive care and is wellness oriented (D'Andrea, 1988; Myers, Sweeney, & White, 2002). However, there have been some stumbling blocks along the road. McAuliffe and Eriksen (1999) cited possible reasons, including dominant culture's need for independent functioning without asking for help and medical funds that are channeled to

medical interventions focused on pathology. Despite these hindrances, there are still those in the counseling profession who continue to focus on wellness.

The wheel of wellness and prevention model, conceptualized by Sweeney and Witmer (1991), was developed as an intervention focused specifically on holistic wellness. This notion of wellness was derived from Adler's concept of reciprocity, which states that there is a synergistic relationship between the mind, body, and environment (Adler, 1956 p. 189). Adler also determined that social interest is one of the foremost human drives. Social interest is defined as, "the innate aptitude through which the individual becomes responsive to reality, which is the social situation," (p 133). More directly, an individual is an integration of many parts, and is motivated to interact with others in human society.

In their original work, Sweeney and Witmer (1991) reiterated Adler's contention that we are all confronted with five life tasks: spirituality, self-regulation, work, friendship, and love. Spirituality is the individual's interpretation of his or her purpose in life, or how he or she fits into the greater picture. Self-regulation is the individual's ability to balance his or her internal thoughts, cognitions, and emotions with the external stimuli the world provides. Sweeney and Witmer (1991) conceptualized spirituality as the center of the individual, because life meaning and purpose can have tremendous impact on intra-psychic functioning, behaviors, physical health and social functioning (Savolaine & Granello, 2002). Self-regulation, or the ability to restrain oneself and engage in self-analysis, functions as the semi-permeable barrier between the individual's inner world and the external world (Witmer, 1985).

The last three life-tasks are more representative of the outer world. Work encompasses not only job, but also the responsibilities of having a family, volunteering,

engaging in education, and other leisure activities. Friendship and love are very similar in that relationships are formulated on the basic idea of positive regard for others and a sense of caring and responsibility. Love is marked by a more intense experience of emotions, intimacy, and sharing, but both are important to individual's wellbeing.

After their original position paper on wellness, Witmer and Sweeney (1992) proposed more expansive ideas regarding the wheel of wellness and prevention model. Although the spirit of the five life tasks remained intact, the authors were much more deliberate in their discussion of the external forces that affect an individual's wellness. External forces were defined as societal institutions that influence an individual's daily existence: family, religion, education, community, media, government, and business/industry. All of the aforementioned entities were discussed as having potential benefits and risks to individual's wellness both micro-systemically and macro-systemically. The authors posited that family, religion, and education would likely affect the individual's living patterns in their everyday life; while communities, media, and government had power to influence policy making that promoted a healthy and proactive lifestyle.

In light of the model, Myers, Sweeney, and Witmer (2000) developed an intervention method for introducing wellness in counseling. The intervention modality consists of four phases: introduction to the wheel of wellness model and prevention (including life-span development), assessment of the individual's current functioning based on the model, interventions that enhance function and wellness, and evaluation and follow-up. More emphasis was placed on the importance of life-span development, since wellness needs evolve over time. For example, a study comparing older and younger adults found that

younger adults had greater social support but were less likely to engage in self-care activities (Granello, 2001).

The Wellness Evaluation of Lifestyle (WEL) is an instrument developed by Myers, Sweeney, and Witmer (1996) to assess individual functioning and wellbeing. The instrument was constructed to reflect the tenets of the wheel of wellness model. In 2004, Hattie, Myers, and Sweeney published an article regarding a statistical analysis that had been conducted on the WEL to ascertain its validity. The exploratory and confirmatory factor analyses on the WEL revealed that both the wellness model and instrument needed to be reordered to incorporate the statistical findings (Hattie et al, 2004). The results of these analyses are two-fold: an evidenced-based model of wellness and the development of a more parsimonious assessment of individual wellness and functioning.

The Indivisible Self emerged as the new, evidence-based model of wellness (Myers & Sweeney, 2005). Included in this new model was the first order factor of the indivisible self and the second order factors: essential self, creative self, coping self, social self, and physical self. The indivisible self is composed of the five second order factors and harkens back to Adler's original notion of holistic integration of the individual. The second order factors incorporate the original life tasks proposed in the wheel of wellness model to some degree, but there are subtle differences. Essential self incorporates the individual's sense of purpose and meaning, as well as his or her identity as an individual. The creative self incorporates the ideas of self-regulation, but also includes aspects of humor and creativity. The coping self includes stress management, leisure, self-worth, and realistic beliefs, which allow an individual to respond to life events and mitigate the negative effects that can occur as a result. The original components of love and friendship are included in the social self, which

are important to enhancing quality of life. Finally, the physical self encompasses aspects of exercise and nutrition.

In order to assess the new model of wellness, the researchers developed a new form of the instrument which they called the five-factor WEL (5F-WEL). The new version is significantly shorter than the WEL and reflects the new model's second order factors (Myers & Sweeney, 2005). Additionally, Myers, Luecht, and Sweeney (2004) have continued to analyze data collected on the 5F-WEL to determine its effectiveness in measuring indivisible wellness. The researchers are also beginning to develop a newer measure, the four-factor WEL (4F-WEL) in hopes of creating a more efficient measurement of holistic wellness. Regardless of the newer measure, there is currently no other measure that can assess wellness in the same way that the 5F-WEL does (Hattie, et al, 2004).

The importance of wellness research is that it offers therapists and researchers the opportunity to examine an individual's functioning in a holistic manner. The 5F-WEL's unique ability to assess so many areas of wellness functioning make it valuable not only to clients, but also in helping to guide the field of counseling. Specifically, it could be a new way to examine the individual characteristics of a therapist that make him or her better able to form a positive working alliance with clients. Since a positive working alliance is thought to be one of the best ways to create effective change in an individual (Rogers, 1992), this change could be measured by utilizing clients' outcome scores in relationship to individual counselor wellness.

Summary

In the mid nineteen-fifties Hans Eysenck began the debate as to whether or not psychotherapy truly affected client outcomes. Over the next thirty years researchers began examining Eysenck's claim and furthered his lines of inquiry. Ultimately, what emerged from this flurry of research was a revolutionary new way to analyze outcome research: the meta-analysis. Originally developed by Smith and colleagues (1980), the meta-analysis allowed scholars to systematically review outcome research, convert statistical results into a common metric, and determine what types of therapeutic interventions affected client outcomes.

Eventually, outcome research developed into three distinctive areas of interests: therapist techniques, client behaviors, and therapeutic interaction/process. Therapeutic interaction research in particular holds that there are certain common factors that are curative to clients, regardless of the therapist's theoretical orientation. All schools of psychotherapy ascribe to the belief that common factors exist, but each school is different in how much success in outcome they attribute to these factors (Weinberger, 1995).

The therapeutic alliance is one of the common factors that are of great importance to psychotherapists and researchers alike (Gaston, 1990). Freud stated that, "the first aim of treatment is to attach the person of the patient to the person of the therapist," (1912, p. 139). Although other theorists have debated the level of attachment that Freud implied, it is clear that the relationship between the counselor and client is of utmost importance to the overall success of the client.

However, in the therapeutic alliance, the question becomes how much of the person of the therapist will affect the person of the client. Hamilton asserted that within the therapy

the client must, “attempt to reorganize himself against the screen of the caseworker’s personality,” (Rogers, 1938). This leaves a question of whether or not the personality of the counselor is indeed an appropriate screen for the client’s “reorganization.”

In the field of counseling, a counselor is termed “impaired” if he or she is not functioning at an optimal level, and is therefore not a healthy “screen.” This reactionary view of mental health is not conducive to promoting a healthy lifestyle in an individual. Instead, the field of counseling needs to move towards a wellness paradigm, which conceptualizes individuals in terms of their overall functioning and continuous efforts towards better quality of life (Hill, 2004). For the purposes of this study, the wellness of counselors-in-training will be assessed, and a statistical analysis will be run to determine if there is a positive relationship between a counselor’s wellness and his or her clients’ positive outcomes.

CHAPTER THREE: METHODOLOGY

The purpose of this study is to examine the relationship between counselor wellness and client outcomes. The following chapter explores the methodology that was used to conduct this study. Discussion will center on participant selection, materials used, research design, and procedures.

Participants

Student Counselors

Student participants were selected via purposive sampling methods, from a Council for the Accreditation of Counselor Education and Related Programs (CACREP) accredited counseling program in a large university in the southeastern United States.

Potential participants were identified by their enrollment in a practicum course required by their program of study. The practicum experience allows student counselors to begin practicing counseling skills with actual clients in a community counseling clinic. Students at this particular institution must declare a track, or area of counseling interest, such as mental health, marriage and family, or school counseling. Individuals in the mental health or marriage and family track were required to enroll in two practicum classes, while those in school counseling were required to enroll in one practicum experience. Students may also be enrolled in an extra practicum class if their program deems it necessary for remediation, or if the student feels a need for more training prior to internship off campus.

Two instruments were administered to student participants during the spring, summer and fall semesters of 2006. Students were asked to participate in data collection during the

last two weeks of a given semester. As stated previously, depending on students' counseling track, some participants may have been enrolled in the practicum experience at two points during the 2006 school year. Students were recruited for participation in each semester, regardless of whether or not they had participated in the study previously. Assessments collected from the same students at two different points during the study will be treated as independent cases. Still, it must be noted that multiple collections will result in threats to internal validity. These threats could include: history, maturation, and testing. In an effort to control for some of these threats, assessments were chosen for their high levels of reliability. In addition, a script was utilized during instrument administration to standardize some of the testing effects that may have taken place. The script was as follows:

My project is entitled 'The Relationship between counselors' wellness and client outcomes. I am examining the link between counselors' overall functioning and how this correlates with clients' alleviation of symptoms.

To participate in this project, you will need to read and sign the informed consent, the instruction sheet, the OQ.45 and the 5F-WEL. All information will be kept confidential by coding assessments with your PID. All paperwork will be kept in a locked office, in a locked file cabinet on the UCF campus.

The Research Associate is responsible for gaining access to your clients' OQ.45 scores through the clinic. Clients consent to these scores being used in research by signing the 'Consent to Treatment' form before beginning services. Clients' scores are filed under your PID, making client participation in this project anonymous.

Thank you for your participation.

Client Participants

Client participants were selected based on the fact that they had been previously assigned to the student counselors selected for this study. Unlike the student counselor participants, the client participants were given assessments during their course of treatment.

Therefore, data utilized for clients' outcomes was collected concurrently during this study and there was no interaction between client participants and the researcher.

Materials

The Five Factor Wellness Evaluation of Lifestyle

The 5F-WEL is based on the wheel of wellness and prevention, a developmental construct that examines the individual from holistic and global perspective (Sweeney & Witmer, 1991). Initially derived from the work of Adler, the wheel of wellness attempts to conceptualize the individual in terms of specific life tasks: spirituality, self-regulation, work, friendship, and love (Sweeney & Witmer, 1992). At its inception, the wheel of wellness paradigm made it possible for counselors to conceptualize the profound interaction that pieces of the individual have on the person as a whole, or as Adler (1956) discussed "...the reciprocal action of the mind and body, for both of them are parts of the whole with which we are concerned," (p 225).

With these ideas in mind, the Wellness Evaluation of Lifestyle (WEL) was developed as a means to measure the construct of wellness. Initially, the components of the instrument were based directly from the wheel of wellness model, however through factor analysis it was determined that assumptions made regarding the appropriate demarcation of components were not supported through statistical analysis (Hattie, Myers, & Sweeney, 2004). Therefore, an exploratory factor analysis was utilized to determine the appropriate groupings of the components. It was determined that there is a distinctive order to the factors of wellness. The first order factor is described as overall "Wellness," the second order factors (or subscales) are referred to as "Essential Self," "Social Self," "Creative Self," "Physical Self," and

“Coping Self.” There are also 17 third order factors that contribute to the overall wellness score. In its third iteration of the original assessment, the 5F-WEL contains 73 questions that purport to measure the “indivisible self,” or the sum of a person’s wellbeing (Myers & Sweeney, 2005).

Reliability

Myers and Sweeney (2005) report the psychometric properties of the 5F-WEL in the instrument’s manual. Cronbach’s alpha coefficients based on a sample of 2,093 individuals were reported for first and second order factors of the 5F-WEL-A showed high internal consistency: total wellness (.90), creative self (.92), coping self (.85), social self (.85), essential self (.88), and physical self (.88). A recent research study conducted at the University of Central Florida utilizing the 5F-WEL yielded comparable Cronbach’s alpha coefficients (Smith, 2006).

The authors do not report any alternate forms reliability for the 5F-WEL-T or the 5F-WEL-E (Teenage and Elementary versions of the assessment, respectively). Myers and Sweeney do not report any measures of test-retest reliability. Knowing test-retest reliability is important, as it would help researchers to ascertain whether or not this measure is sensitive to changes over time.

Validity

Structural equation modeling was utilized to determine the higher order factors of the 5F-WEL; however, examining the validity of the instrument regarding convergent evidence is not reported in the instrument’s manual. This is more than likely because there are few, if any, comparable extant measures of wellness. However, the authors give a list of studies that

have explored the construct related validity of the instrument in relationship to specific contexts such as: ethnic identity, academic self-concept, mattering, and life satisfaction. Studies pertaining to wellness differences based on demographic variables such as age, gender and ethnicity are also provided in the manual.

In assessing the criterion-related validity of the 5F-WEL, the authors determined that there was a high correlation between the variables of life satisfaction and total wellness scores (.38) Because it was determined that life satisfaction was a greater predictor of wellness than happiness (.30) or health (.30), an item regarding overall life satisfaction was added to the assessment to increase the predictive validity of the instrument.

The norm group for the 5F-WEL-Adult (5F-WEL-A) was comprised of 1,899 adult volunteers recruited through university classes, professional workshops, and through research projects. Scores on the 5-FWEL can range between 25 and 100. Means of the normative sample were reported in the manual as follows: total wellness ($M = 76.22$, $sd = 12.51$), creative self ($M = 77.80$, $sd = 12.99$), coping self ($M = 72.36$, $sd = 10.63$), social self ($M = 84.06$, $sd = 17.82$), essential self ($M = 78.90$, $sd = 16.15$), and physical self ($M = 70.98$, $sd = 17.00$). Norms were also available for third order factors, demographic variables, and other versions of the 5F-WEL (such as 5F-WEL-Teen).

The Outcome Questionnaire-45.2

The Outcome Questionnaire-45.2 (OQ-45) is a forty-five-item instrument designed to assess client progress in therapy. Based on Lambert's (2004) three fundamental aspects of client functioning, the instrument yields four scores: TOTAL DISTRESS score, SUBJECTIVE DISTRESS scale score, INTERPERSONAL RELATIONSHIP scale score,

and SOCIAL ROLE PERFORMANCE scale score. The SUBJECTIVE DISTRESS subscale measures symptoms of anxiety and depression, as these two are among the most prevalent symptom groups in the United States population. The INTERPERSONAL RELATIONSHIP scale measures the satisfaction and problems that occur in individual's relationships. Finally, the SOCIAL ROLE PERFORMANCE scale assesses the client's report of conflict and dissatisfaction in performing certain life tasks, such as employment, family life, and leisure time.

The OQ-45 can be administered to adults with at least a fifth grade reading level. The instrument takes between five and fifteen minutes to complete, and can be hand-scored in about ten minutes. Scores either meeting or exceeding the cutoff scores for each scale are based on normative samples and are considered areas of clinical interest. Cut-off scores can be calculated for the TOTAL DISTRESS score (63), SUBJECTIVE DISTRESS subscale (36), INTERPERSONAL RELATIONSHIPS subscale (15), and the SOCIAL ROLE PERFORMANCE subscale (12).

Reliability

According to the instrument's manual (Lambert et al, 2004), the reliability of the OQ-45 was assessed using a sample of students from a large university setting. A Cronbach's alpha was used to test the internal consistency of the instrument, which was found to be significant at the .01 level. A Pearson product correlation coefficient was calculated to determine the test-retest reliability and was also found to be significant at the .01 level. The internal consistency value for the total score was .93, and the test-retest value for the total score was .84.

Validity

According to the manual (Lambert et al, 2004), concurrent validity was estimated by calculating a Pearson's product-moment correlation coefficient between the OQ-45 and the Symptom Checklist 90 Revised (SCL-90R). The OQ-45's total score and subscale scores were compared to its counterpart, the SCL-90 Revised which also measures individual's reports of distress, social role difficulty, and interpersonal relationships. Both the OQ-45 and the SCL-90R's concurrent validity were found to be significant at the .01 level. The construct validity was calculated, and researchers found medium to small effect sizes for the total distress score (.50), and subscales of symptoms distress (.50), interpersonal relations (.31), and social role (.42) (Vermeersch, Whipple, Lambert, Hawkins, Burchfield, & Okiishi, 2004).

Research Design

This *ex post facto*, correlational design was used in this study to examine the occurrence of the variables in their natural state. The main purpose of this study was to establish the nature of the relationships between the variables, and thereby clarify the existence of a phenomenon (Fraenkel & Wallen, 2006). This kind of correlation strengthens the credibility of the hypothesis, and is a relatively inexpensive approach to provide credibility before more extensive experimentation (Campbell & Stanley, 1963, p. 64).

Procedures

Prior to beginning the project, the researcher followed and obtained the approval of the Institutional Review Board (IRB) required to conduct research using human participants. The IRB approval letter, protocol # 06-3349, is included in Appendix A. The researcher

obtained the licenses for each instrument used, and compiled instruments into coded packets for test administration (Appendix B). Faculty members who taught the practicum course at the institution were contacted, and gave their verbal permission to enter their class and administer instruments to the student participants (Appendix C).

Student participants were given the 5F-WEL and the OQ-45. The 5F-WEL was coded with a number given to the researcher by the instrument distributor, and was sent off for computer scoring via the United States Postal Service. 5F-WEL scores were returned to the researcher via email in the Statistical Package for the Social Sciences (SPSS). The student participants' OQ-45 was coded with the same number, and hand-scored by the researcher. The OQ-45 scores were then entered into the Statistical Package for the Social Sciences 14.0 (SPSS) by the researcher.

The university's research associate at the community counseling clinic collected the client data. The clients' scores were maintained on an onsite database, and are stored under the student participants' student identification number. The researcher gave the research associate a list of the student participants' student identification numbers. The research associate then compiled the OQ-45 scores of each students' clients over the course of treatment during that semester. The scores were downloaded into SPSS and an electronic copy was given to the researcher.

Data Analysis

After the data was collected, it was entered into SPSS version 14.0, and several analyses were conducted to determine the nature of the relationships between the variables. A multiple regression analysis was used to determine the nature of the relationships between

student counselor's wellness and client outcomes. Variables used to measure student counselor wellness were total wellness (x), creative self (x), coping self (x), social self (x), essential self (x), and physical self, and total distress score (y). The variable used to measure client outcomes was a change in total distress scores ($z - z = z$). A factor analysis was used to determine which factors of wellness contributed most to the change in clients' outcome scores. Finally, analysis of variance (ANOVA) was used to examine the differences among groups based on the student counselors' specialization.

Statistical Analysis

Multiple Regression analysis was chosen as an appropriate way to assess the degree and characteristics of the relationship between the dependent and independent variables. Examining the data through this statistical procedure allows the researcher to examine the magnitude, sign and statistical significance of the regression coefficient for each independent variable (Hair et al, 2006).

Factor Analysis is an interdependence technique in which the primary purpose is to define the underlying structure among the variables in the analysis (Hair et al, 2006, p. 104). In this case, the variables of student counselor wellness were simultaneously considered maximize individual variables explanation of the entire variable set. The researcher used statistical analysis to determine how each second order wellness variable contributed to participants' overall wellness in this sample.

ANOVA is a statistical technique used to determine if the means of two sample groups differ significantly in a given population. In this case, an ANOVA was used to examine the difference between groups of people with regard to the independent variables to determine if

there was a significant difference to the dependent variable. The researcher utilized ANOVA to determine if there was a significant difference between client outcomes based on student counselors' specialization.

Summary

Participants were selected for this study using purposive sampling methods. Student participants were selected because they were enrolled in a CACREP accredited counselor training program at a large university in the southeast. Client participants were selected because they were enrolled in counseling sessions with the student participants.

Student participants' wellness and psychological functioning were measured using the 5F-WEL and the OQ.45. Client participants' functioning was measured by the OQ.45. Changes in client functioning was derived by using a difference score that was calculated by subtracting clients' initial OQ.45 score (given before treatment took place) from a subsequent OQ.45 score (given during the course of treatment).

This *ex post facto* correlational research design was used because it allowed the researcher to examine the variables in their natural state and without manipulation. After the data from the assessments was collected, the researcher entered results into SPSS. The data was analyzed using multiple regression, factor analysis and ANOVA. Results of the analyses will be discussed in the next chapter.

CHAPTER FOUR: FINDINGS

The purpose of this study is to examine the relationship between counselor wellness and client outcomes. The following chapter begins by reiterating the study's question and hypotheses, reports a demographic description of study participants, descriptive statistics, and results of data analysis. Finally, the study's hypotheses will be reexamined in light of the results of the statistical analysis.

Question

The research question was formulated as follows: what is the relationship between master's level counseling students' wellness and client outcomes? Based on this question the following hypotheses were developed:

Null Hypothesis 1: There is no relationship between master's level counseling students' wellness as measured by the Five-Factor WEL (5F-WEL) and client outcomes as measured by the Outcome Questionnaire (OQ.45.2).

Null Hypothesis 2: There is no relationship between master's level counseling students' wellness as measured by the OQ.45.2 and client outcomes as measured by the OQ.45.2.

Sample Demographics

Students were recruited from a master's level counseling practicum course at a large university in the southeast. Over three semesters, 110 students were identified as potential participants. Of these 110 potential participants, 70 chose to participate. Of these participants, six were male and 64 were female (Table 1). The average age of the participants was 29.89

with a standard deviation of 6.7 years, and a range of 23 to 53. Students were also asked to identify their course track as well as how many times they have enrolled in the practicum course. With regard to tracks, four participants were enrolled in dual track (emphasis in both mental health and school counseling), 49 were enrolled in mental health track, and 17 were enrolled in school counseling track (Table 2). As to the question of how many times students have been enrolled in the practicum course, 47 participants had enrolled only once, 21 had enrolled twice, and two participants had enrolled in the practicum course three times (Table 3).

Table 1: Participants' Gender

GENDER					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	MALE	6	8.6	8.6	8.6
	FEMALE	64	91.4	91.4	100.0
	Total	70	100.0	100.0	

Table 2: Participants' Track Identification

TRACK					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	DT	4	5.7	5.7	5.7
	MH	49	70.0	70.0	75.7
	SC	17	24.3	24.3	100.0
	Total	70	100.0	100.0	

Table 3: Number of Times Participants Enrolled in Practicum

PracLvl					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	47	67.1	67.1	67.1
	2	21	30.0	30.0	97.1
	3	2	2.9	2.9	100.0
	Total	70	100.0	100.0	

All participants responded to the question regarding cultural background. Two were Asian/Pacific Islander, 10 were Black, 47 were Caucasian, and 11 were Hispanic (Table 4). Finally, all participants responded to the question about marital status. Of the 70 participants, 28 were married or partnered, 38 were single, one was separated, two were divorced, and one was widowed (Table 5).

Table 4: Participants' Cultural Background

CULTURAL BACKGROUND 1					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	ASIAN-PAC ISLAND	2	2.9	2.9	2.9
	BLACK	10	14.3	14.3	17.1
	CAUCASIAN	47	67.1	67.1	84.3
	HISPANIC	11	15.7	15.7	100.0
	Total	70	100.0	100.0	

Table 5: Participants' Marital Status

MARITAL STATUS					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	MARRIED-PARTNER	28	40.0	40.0	40.0
	SINGLE	38	54.3	54.3	94.3
	SEPARATED	1	1.4	1.4	95.7
	DIVORCED	2	2.9	2.9	98.6
	WIDOWED	1	1.4	1.4	100.0
	Total	70	100.0	100.0	

Descriptive Statistics

Five-Factor Wellness Evaluation of Lifestyle

Student participants in this study reported high levels of Total Wellness when compared to means reported by Myers, Mobley and Booth (2003). This study's sample of

student participants' mean Total Wellness scores ($M = 83.65$, $sd = 8.22$) were slightly higher than those reported by Myers and colleagues ($M = 78.25$, $sd = 7.3$). Mean scores for this sample's second order wellness factors were as follows: Coping Self ($M = 98.61$, $sd = 9.35$); Creative Self ($M = 85.39$, $sd = 9.51$); Essential Self ($M = 87.25$, $sd = 10.44$); Social Self ($M = 93.58$, $sd = 9.48$); and Physical Self ($M = 75.64$, $sd = 15.32$) (Table 6). These mean scores were also similar to those reported for student counselors by Myers, Mobley, and Booth (2003).

Table 6: 5F-WEL Descriptive Statistics

Descriptive Statistics							
	N	Range	Minimum	Maximum	Mean	Std. Deviation	Variance
JTOTWEL	70	37.33	59.93	97.26	83.6541	8.22226	67.606
COPING_SELF	70	49.93	48.68	98.61	78.6392	9.35183	87.457
CREATIVE_SELF	70	50.00	50.00	100.00	85.3929	9.51863	90.604
ESSENTIAL_SELF	70	42.19	57.81	100.00	87.2549	10.44506	109.099
PHYSICAL_SELF	70	60.00	40.00	100.00	75.6429	15.32667	234.907
SOCIAL_SELF	70	43.75	56.25	100.00	93.5848	9.48450	89.956
Valid N (listwise)	70						

OQ.45.2

In the present study the average student participant's OQ.45.2 TOTAL DISTRESS had a reported mean of 31.82 with a standard deviation of 19.14. These results are slightly lower than normative data reported by Lambert and colleagues (2004), whose sample of 235 undergraduate college students yielded OQ.45.2 TOTAL DISTRESS scores that were higher than this sample ($M = 42.15$, $SD = 16.61$).

Table 7: OQ.45.2 Descriptive Statistics

Descriptive Statistics							
	N	Range	Minimum	Maximum	Mean	Std. Deviation	Variance
OQ_SS	70	79.00	6.00	85.00	31.8286	18.14033	329.072
Valid N (listwise)	70						

Multiple Regression

In order to investigate the nature of the relationship between master's level student counselors' wellness and client outcomes, the researcher chose to examine three variables. The independent variables were measured using the Total Wellness score for the 5F-WEL and the OQ.45.2 TOTAL DISTRESS score, to ascertain student counselors' wellness. The dependent variable, client outcome, was generated by using a client's OQ.45.2 TOTAL DISTRESS score that was taken before counseling began and subtracting it from the same client's OQ.45.2 TOTAL DISTRESS score taken at least four weeks after counseling had begun. The number created is referred to as a delta score. Overall, the linear composite of the independent variables entered into the regression procedure predicted 3.2 % of the variation in the dependent criterion $F(2, 53) = .878, p = .422$. All of the confidence intervals around each of the b weights included a zero as a probable value. This suggests that the results for each of the independent variables probably do not explain or predict the dependent variable. (Table 8)

Table 8: Multiple Regression Analysis

Model Summary ^b									
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	.179 ^a	.032	-.004	16.92167	.032	.878	2	53	.422

a. Predictors: (Constant), OQ_SS, jTOTWEL

b. Dependent Variable: OQ_CL1

ANOVA ^b						
Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	502.812	2	251.406	.878	.422 ^a
	Residual	15176.171	53	286.343		
	Total	15678.982	55			

a. Predictors: (Constant), OQ_SS, jTOTWEL

b. Dependent Variable: OQ_CL1

ANOVA

In order to run an ANOVA, the groups of interest must have at least twenty viable cases for analysis (Hair, et al, 2006). Although there were 49 cases in the mental health track, there were only 17 cases in the school counseling and four cases dual counseling track. Based on the fewer cases in the two of the three groups, it was determined that no ANOVA be conducted.

Factor Analysis

The purpose of conducting a factor analysis was to determine which second order 5F-WEL factors contributed most to client participants' positive outcomes. Based on the lack of significant findings in the multiple regression analysis, it was determined that there was no further analysis be conducted.

Hypotheses

Null Hypothesis 1: There is no relationship between master's level counseling students' wellness as measured by the Five-Factor WEL (5F-WEL) and client outcomes as measured by the Outcome Questionnaire (OQ.45.2). Null hypothesis one was accepted.

Null Hypothesis 2: There is no relationship between master's level counseling students' wellness as measured by the OQ.45.2 and client outcomes as measured by the OQ.45.2. Null hypothesis two was accepted.

Summary

The purpose of this study was to determine if there is a relationship between master's level counseling students' wellness and client outcomes. Data from this study yielded results that were not statistically significant. Due to the results from data analysis, the null hypotheses were accepted. A discussion of these results, implications of findings, and directions for future research will be discussed in the following chapter.

CHAPTER FIVE: DISCUSSION

The purpose of this study was to examine the relationship between counselor wellness and client outcomes. The previous chapter reported the results of statistical analysis of this study. The following chapter will include a discussion of these results, implications of findings, and directions for future research.

Discussion

Ethical codes and research literature in counseling clearly state that counselors should be ‘well’ in order to successfully work with clients (ACA, 2005; ACES, 1995). Unfortunately, research literature has historically concentrated on defining an impaired counselor and how he or she can cause harm to clients (Stadler et al, 1988) rather than attempting to define characteristics that make a counselor ‘well’ and fully functional (Witmer, 1985). Although there is theoretical literature that suggests that ‘well’ counselors can help clients more successfully than ‘un-well’ counselors (Hill, 2005; Rosenzweig, 1936) there is little empirical research to support this idea.

The purpose of this study was to examine the relationship between counselor wellness and client outcomes, and create an empirical link between counselor wellness and client outcomes. This was attempted by collecting data from master’s level student counselors and clients in a community-counseling clinic. For the purposes of the study, the independent variables were counselor wellness, as measured by the 5F-WEL and the OQ.45.2. The dependent variable was client outcome, which was found by using an OQ.45.2 measure of client functioning before beginning counseling and subtracting an OQ.45.2 score after the client had been in counseling for at least four weeks, creating a delta score.

The multiple regression analysis of the independent variables counselor wellness and distress and the dependent variable client outcomes yielded no statistically significant relationship. Ultimately, the null hypotheses were accepted, meaning that there is no relationship between the independent variables of student counselors' wellness and overall distress and the dependent variable client outcome. While conducting this study, the researcher made several observations, which could be interpreted as limitations that affected the statistical results. A discussion of these limitations, including (a) sample population, (b) data collection, (c) instrument selection, (d) threats to internal validity, and (e) threats to external validity follows.

Limitations

It was anticipated that the sample size for this study would be approximately 80 student counselors. Although 70 students did participate, only 58 cases were viable for statistical analysis. This occurred because client OQ.45 delta scores could only be collected and linked to 58 student counselors. One of the requirements for successfully conducting a multiple regression analysis is to have a minimum of 20 cases for each independent variable (Hair et al, 2006). If the sample size is low, a Type II error could occur. A type II error occurs when a statistical analysis yields a result that is not significant, when in fact the results may be significant. In this case, although there was a ratio of 20 cases to each independent variable, the low sample size could also have resulted in a Type II error, the risk of which could have been reduced if the sample size were to have been larger.

Another issue is that the sample used for this study had a larger population of students in mental health track versus school counselor track. While completing the counseling

program, students are required to declare a track (or major) in counseling. Students can either be enrolled in the mental health counseling track, school counseling track, or dual track, which allows them to become both mental health and school counselors. Both the mental health counseling track and the dual track require that students participate in the practicum class twice, while school counseling students only enroll once. In essence, students in the mental health track may have been exposed to the assessments at two points during this study. With regard to the statistical analysis, this may have resulted in a violation of the independence of error terms and may have also resulted in a threat to the internal validity of the study.

The second issue that may have affected the analysis was the process of gathering clients' OQ.45.2 scores. The database procedure used to collect the data was to enter an output command in the software that reports an individual client's OQ.45.2 scores over the entire time that he or she was in treatment. While this report did give dates that the assessment was administered, it did not identify which counselor had treated the client. In order to gather this information, the research associate had to go into the individual client's report to determine the treating counselor, which were not always accurately recorded in the software. Due to the research constraints mandated by the Institutional Review Board, the researcher was not able to personally gain access to the OQ.45.2 client database. In an attempt to preserve the study, the researcher had to match the time frame that the student counselor may have treated a client to match the client's delta OQ.45.2 score to the student counselor's 5F-WEL and OQ.45.2 score. Although the researcher made every effort to control for error, this process may have resulted in clients' overall OQ.45.2 delta score being attributed to the incorrect student counselor.

Another issue concerns social desirability. Smith (2006) found an inverse relationship between master's level counseling students OQ.45.2 scores and the Marlow-Crowne assessment for social desirability. This study implied that master's level counseling students may "fake good" on the OQ.45 in order to appear less disturbed than they really are. This could explain why the mean OQ.45 scores of the student counselors were lower than the mean reported in the OQ.45.2 testing manual (Lambert et al, 2004).

Internal validity threats in this study included: history, maturation, and testing (Campbell & Stanley, 1963). History refers to an event that occurs between the measurement administrations. In this case, in August 2006 there was a personnel change in the clinic coordinator position may have had some affect on both the student counselors and clients. The new clinic coordinator made some organizational changes to the clinic, including: (1) streamlining the documentation process for clients, (2) the timeframe in which phone calls were returned to clients, and (3) how student workers were required to organize and maintain the facility. The level of interest and active participation in improving clinic conditions was a marked difference from the previous clinic coordinator, and this may have had an effect on both practicum students and clients.

Maturation is a phenomenon that occurs over the passage of time, including growing older and gaining experience. In this case, some student counselors were enrolled in the practicum setting more than once, and aspects of their personal wellness and overall distress may have changed over the course of two or three semesters. Likewise, clients may have experienced a maturation effect while participating in counseling sessions.

Finally, testing refers to "the effects of taking a test upon the scores of a second testing," (Campbell & Stanley, 1963, p. 5). Clients who were included in this study were

given the OQ.45.2 at least two times, and their familiarity with the instrument may have had an impact with how they answered subsequent administrations. Also during the course of this study, student counselors, specifically mental health and dual track, may have participated in this study twice, and taken the OQ.45.2 and the 5F-WEL at least two times. Testing concerns can be addressed by examining the test-retest reliability of the instruments. The test-retest reliability value for the OQ.45.2's TOTAL DISTRESS score was .84. This value was calculated using a Pearson's Product correlation and was significant at the .01 alpha level (Lambert et al, 2004). However, test-retest reliability scores for the 5F-WEL were not reported by the instrument's authors and have not been found in subsequent research literature (Myers & Sweeney, 2005; Personal Communication with J. Myers, February 10, 2007). Therefore, internal validity may not have been affected by the OQ.45.2, but the 5F-WEL may not be appropriate if multiple administrations are required.

External validity attempts to answer the question, "is this study generalizable to other populations?" (Campbell & Stanley, 1963). Although this study was conducted a large university and examined a specific phenomenon with a chosen sample, caution should be used in when generalizing these results to other populations because of the research design used. The nature of *ex post facto* research design is to examine specific constructs of a phenomenon after it has occurred (Campbell & Stanley, 1963). Therefore, the researcher does not attempt to control the environment studied, which could result in extraneous variables that could not accounted for, which may not occur if the study was conducted at another site.

Implications of Findings and Future Research

Although the discussion of this study brought to light the limitations of this research, there are still implications that can be drawn. The following section will discuss these implications along with directions for future research including (a) data collection and instrument selection (b) sample population, and (c) assessing the relationship between counselor wellness and client outcomes

First, although there were issues with procuring the OQ.45.2 data, it is clear that once the procedure for collecting assessment scores is standardized, there will be a rich source of client outcome data for future research. Because the student participants were familiar with the OQ.45.2, it may be advantageous for future researchers at this institution to use a less familiar instrument to obtain information about students' global functioning and distress. Finally, because there are no current test-retest reliability scores for the 5F-WEL, it may be beneficial to conduct a study to obtain this information.

It is apparent that students who are enrolled in these particular counseling courses are exposed to a variety of assessments at multiple points in their master's program. Which could imply that student counselors in this sample were very familiar with these assessments and adept recognizing weaknesses in test design. This could be corrected by minimizing administration of assessments and re-evaluating the instruments that are being used. Furthermore, diversifying instruments selected for administration to students could also be helpful. For example, using the Symptom Checklist Revised instead of the OQ.45.2 would still allow researchers to measure levels of symptom distress, but would be an instrument less familiar to students.

Finally, although the 5F-WEL and OQ.45 were shown to be psychometrically sound instruments, it could be helpful to add other instruments to this line of research. For example, future studies may want to include other means of assessing client outcomes, such as goal attainment or rates of client relapse. Another way to obtain a broader view of clients' experience in counseling would be to include an assessment measuring clients' perception of the counseling process. For example, there is some evidence to suggest that clients' perception of their counselors is a more accurate assessment of success in counseling than examining outcome alone (McKay, Dowd, & Rollin, 1982). Therefore, future studies may be improved if client outcomes were measured in a more dynamic manner.

The study's sample was limited to students enrolled in a CACREP accredited counseling program at a large university in the southeast. However, this could be considered an incomplete look at counselors' characteristics and their impact on client outcomes. Broadening the research to include other counselor populations could be done in multiple ways. Future research could examine student counselors who are enrolled in other counseling specializations, such as rehabilitation counseling or pastoral counseling, students who are enrolled in CACREP accredited programs and non-CACREP accredited programs, or professional counselors who are currently practicing.

This study's sample included far more students enrolled in the mental health track than the school-counseling track. In order to examine the possible differences between mental health and school counselors, future studies should attempt to include more equal groups of counselors. This is important because certain statistical analyses, such as ANOVA, require relatively equal groups in order to correctly analyze mean differences in data.

One of the goals of this study was to identify the construct that could encapsulate the concept “counselor characteristics,” which is defined as the personal qualities of a counselor that facilitates his or her success with clients. The supposition was that the wellness construct could have been one way to define these counselor characteristics. At this time, the results of the analysis do not support this idea. However, it may be beneficial to continue this line of research. As mentioned previously, there are ways to improve the current study, such as broadening the sample population and changing some of the assessments used with the participants, which could in turn help to increase the statistical analyses that could be conducted. Ultimately, theory supports the idea that the constructs counselor wellness and client outcomes are related; therefore future research should be conducted to find some empirical evidence to support these ideals.

Conclusion

The purpose of this study was to attempt to establish an empirical link between master’s level student counselor wellness and client outcomes. The independent variables were counselor wellness, as measured by the 5F-WEL and the OQ.45.2. The dependent variable was client outcome, which was measured by creating a delta score of clients’ initial OQ.45.2 score minus a subsequent OQ.45.2 score. Ultimately, the multiple regression analysis yielded no significant relationship between the constructs of student counselor wellness and client outcomes, which resulted in an acceptance of the null hypotheses.

Upon examining the results of this study, the researcher explored limitations that may have affected the study as well as implications for future research. Limitations of this study included threats to internal validity, threats to external validity, sample size, instrument

selection, and data collection issues. However, out of these limitations came several ways in which this study could be improved and replicated in the future. First, a protocol could be developed for data collection, so that the database that the researcher used is more user-friendly and accurate. Secondly, the instruments used could be diversified, so as ascertain a more holistic view of clients' experiences in counseling. Moreover, the sample population could be diversified so that different statistical analyses could be used with data collected.

Finally, the results of this study do not support the idea that there is a link between counselor wellness and client outcomes. However, professional literature in counseling and psychology and professional ethics codes of counseling theoretically support the idea that there is a link between the wellness of a counselor and the improved outcomes of clients as a result. Although this study did not provide empirical support for this connection, there is reason to believe that these two constructs are somehow linked.

APPENDIX A: IRB LETTER



Office of Research & Commercialization

April 4, 2006

Elizabeth O'Brien
10227 Blanchard Park Trail
Orlando, FL 32817

Dear Ms. O'Brien:

With reference to your protocol #06-3349 entitled, "**The Relationship of Wellness and Social Desirability of Master's Level Counseling Students and Client Psychological Distress Outcomes**," I am enclosing for your records the approved, expedited document of the UCFIRB Form you had submitted to our office. **This study was approved on 3/30/06. The expiration date will be 3/29/07.** Should there be a need to extend this study, a Continuing Review form must be submitted to the IRB Office for review by the Chairman or full IRB at least one month prior to the expiration date. This is the responsibility of the investigator. **Please notify the IRB office when you have completed this research study.**

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

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

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

Cordially,

Barbara Ward
Barbara Ward, CIM
UCF IRB Coordinator
(FWA00000351 Exp. 5/13/07, IRB00001138)

Copies: IRB File
Edward H. Robinson III, Ph.D.

BW:jm

APPENDIX B: PERMISSION TO USE ASSESSMENTS

PERMISSION TO USE THE 5F-WEL

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

1. I will send you:

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

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

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

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

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

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

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

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

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

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

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

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

Jane Myers, Ph.D., LPC

OQ®-PAPER & PENCIL PRODUCT BINDING LICENSE AGREEMENT
(20050501 Mail or Fax Form)

1. Licensee. If the OQ® Measures, LLC (Hereafter "OQ® Measures") or its designee has approved of the Application of the Applicant by the act of returning to the Applicant correspondence indicating this fact, then the Applicant is the "Licensee" under this License Agreement.
2. OQ®-Product. "OQ® Product" means the paper and pencil version of the health care protocol, outcome screening, progress tracking or outcome prognostic measure, and work of authorship for which the Applicant is applying for on the accompanying "OQ® - PRODUCT LICENSE APPLICATION & ORDER FORM."
3. License. Subject to the terms and conditions of this Agreement, OQ® Measures grants to the Licensee a license to use, copy and distribute the specific OQ® product accompanying an Administration & Scoring Manual, but only in connection with Licensee's bona fide health care practice (the "License") as the Applicant has applied for and been approved for. This Administration & Scoring Manual may NOT be duplicated. Student licenses expire upon issuing of the student's first terminal degree or five years after the issue of the Student License, whichever comes first. The Licensee is granted a license only to the specific OQ® Product being applied for on the Application & Order Form.
4. Modifications. Licensee may not modify, translate into other languages or change the content, wording or organization of OQ® product or create any derivative work based on OQ® Product. Licensee may put the OQ® Product into other written, non-electronic, non-computerized, non-automated formats, provided that the content, wording and organization are not modified or changed.
5. Copies, Notices and Credits. Any and all copies of the OQ® Product made by Licensee must include the copyright notice, trademarks, and other notices and credits in the OQ® Product. Such notices may not be deleted, omitted, obscured or changed by Licensee.
6. Use, Distribution and Charges. The OQ® Product may only be used and distributed by Licensee in connection with Licensee's stated bona fide health care practice and may not be used or distributed for any other purpose. Without limiting the generality of the foregoing, Licensee may not distribute copies of the OQ® Product beyond the scope of the applied for license or to other persons for use by other persons. Such other persons should apply to OQ® Measures for a license to use the OQ® Product. Licensee may not charge any client, patient, organization or other entity for use of the OQ® Product.

7. Responsibility. BEFORE USING OR RELYING UPON THE QQ® PRODUCT IT IS THE RESPONSIBILITY OF LICENSEE TO ASCERTAIN THE SUITABILITY OF THE QQ® PRODUCT FOR ANY AND ALL USES MADE BY LICENSEE. THE QQ® PRODUCT IS NOT A DIAGNOSTIC TOOL AND SHOULD NOT BE USED AS SUCH. THE QQ® PRODUCT IS NOT A SUBSTITUTE FOR AN INDEPENDENT MEDICAL OR OTHER APPROPRIATE PROFESSIONAL EVALUATION. ANY AND ALL USE OF AND RELIANCE ON THE QQ® PRODUCT BY LICENSEE IS AT LICENSEE'S SOLE RISK AND IS LICENSEE'S SOLE RESPONSIBILITY. LICENSEE SHALL INDEMNIFY QQ® MEASURES AND ITS OFFICERS, DIRECTORS, EMPLOYEES, AND REPRESENTATIVES, AND THE AUTHORS OF THE QQ® PRODUCT AGAINST, AND HOLD THEM HARMLESS FROM, ANY AND ALL CLAIMS AND LAW SUITS ARISING FROM OR RELATING TO ANY USE OF OR RELIANCE ON THE QQ® PRODUCT PROVIDED BY QQ® MEASURES TO LICENSEE. THIS OBLIGATION TO INDEMNIFY AND HOLD HARMLESS INCLUDES A PROMISE TO PAY ANY AND ALL JUDGMENTS, DAMAGES, ATTORNEYS' FEES, COSTS AND EXPENSES ARISING FROM ANY SUCH CLAIM OR LAW SUIT.

8. Disclaimer. LICENSEE ACCEPTS THE QQ® PRODUCT "AS IS" WITHOUT WARRANTY OF ANY KIND. QQ® MEASURES DISCLAIMS ANY AND ALL IMPLIED WARRANTIES, INCLUDING IMPLIED WARRANTIES OF MERCHANTABILITY, FITNESS FOR A PARTICULAR PURPOSE, AND NONINFRINGEMENT. QQ® MEASURES DOES NOT WARRANT THAT THE QQ® PRODUCT IS WITHOUT ERROR OR DEFECT. QQ® MEASURES SHALL NOT BE LIABLE FOR ANY CONSEQUENTIAL, INDIRECT, SPECIAL, INCIDENTAL OR PUNITIVE DAMAGES. THE AGGREGATE LIABILITY OF QQ® MEASURES FOR ANY AND ALL CAUSES OF ACTION (INCLUDING THOSE BASED ON CONTRACT, WARRANTY, TORT, NEGLIGENCE, STRICT LIABILITY, FRAUD, MALPRACTICE, OR OTHERWISE) SHALL NOT EXCEED THE FEE PAID BY LICENSEE TO QQ® MEASURES. THIS LICENSE AGREEMENT, AND SECTIONS 7 AND 8 IN PARTICULAR, DEFINES A MUTUALLY AGREED UPON ALLOCATION OF RISK. THE FEE REFLECTS SUCH ALLOCATION OF RISK.

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

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

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

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

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

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

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

APPENDIX C: INFORMED CONSENT

May 5, 2006

Dear Participant:

I am a graduate student at the University of Central Florida. I am conducting a study this semester, entitled The Relationship of Wellness of Master's Level Counseling Students and Client Psychological Distress Outcomes. The purpose of this research is to measure how student counselors' psychological health is related to their clients' distress outcomes. The researchers intend to use the data collected to contribute to a pilot study for dissertation, as well as to contribute to the body of knowledge regarding the link between counselors' psychological wellness and clients' alleviation of distress. Participants' confidentiality is guaranteed.

You will be asked to complete three inventories during the semester. The inventories are: the Five Factor Wel Inventory Form A, the Personal Reaction Inventory, and the Outcome Questionnaire. These assessments will be administered during the course meeting time and will take about 25 minutes to complete.

You are being invited because you have been identified as a registered student in this class. Please be aware that you are not required to participate in this study and you may discontinue your participation in this study at any time without penalty. You may also omit any questions you prefer not to answer.

Your identity will be kept confidential. Your responses will be analyzed and reported confidentially to protect your privacy. Records will be kept in a locked filing cabinet in the investigator's locked UCF campus office.

There are minimal risks and no direct benefits; no compensation will be awarded. The anticipated minimal risk is a possible heightened awareness of your own wellness. If you feel that you need to discuss some issue regarding your wellness, please speak with the researcher and/or she can refer you to an area counselor for further consultation on this matter. You are free to withdraw your consent to participate and may discontinue your participation in the study at any time without consequence. This research study has been reviewed and approved by the UCF Institutional Review Board. If you have any questions about this research project, please contact the researcher or my faculty supervisor:

Elizabeth R. O'Brien, University of Central Florida (UCF)
College of Education, Suite 115c; Orlando, Florida 32816-1250
Telephone: (321) 246-0409

Edward H. Robinson III, University of Central Florida (UCF)
College of Education, P. O. Box 161250; Orlando, Florida 32816-1250
Telephone: (407) 823- 3819

May 5, 2006

Information regarding your rights as a research volunteer may be obtained from:
Barbara Ward, Institutional Review Board (IRB) University of Central Florida (UCF)
12443 Research Parkway, Suite 302; Orlando, Florida 32826-3252
Telephone: (407) 823-2901

If you decide to participate in this research study, please sign and return this copy of the consent form.

A second copy is provided for your records.

Sincerely, _____ (researcher signature)

_____ (printed)

Principal Investigator signature: _____, Ph.D., Professor, College of Education

Project title: The your project name here project at the University of Central Florida

___ I have read the procedure described above. I have read the "Informed Consent to Participate" and agree to allow the researchers to use the information I provide for related presentations and publications.

___ I voluntarily agree to participate and state that I am over 18 years of age.

___ I voluntarily agree to allow the researchers to use excerpts of my narrative work anonymously, for the purposes of reporting this research and informing future pedagogy.

_____ / _____

Participant

Date

REFERENCES

- Adler, A. (1956). *The individual psychology of Alfred Adler*. H. L. Ansbacher & R. R. Ansbacher (Eds.) New York: Basic Books.
- American Counseling Association. (2005). *ACA Code of Ethics*. Alexandria: VA: American Counseling Association.
- Ardell, D. B. (1986). *High Level Wellness*. Berkley, California: Ten Speed Press.\
- Asclepius. (n. d.). Retrieved July 31, 2006, from <http://en.wikipedia.org/wiki/Aesculapuis>
- Association for Counselor Education & Supervision. (1995). *Ethical guidelines for counseling supervisors*. Counselor Education & Supervision, 34, 270.
- Bernard, J. M., & Goodyear, R. K. (2004). *Fundamentals of clinical supervision* (3rd ed.). New York: Pearson, Allyn & Bacon.
- Bibring, E. (1937). Therapeutic results of psychoanalysis. *International Journal of Psycho-analysis*, 18, 170-189.
- Blatt, S. J., Sanislow, C. A., Zuroff, D. C., & Pilkonis, P. A. (1996). Characteristics of effective therapists: Further analyses of data for the national institute of mental health treatment of depression collaborative research program. *Journal of Consulting and Clinical Psychology*, 64 (6), 1276-1284.
- Bradley, J., & Post, P. (1991). Impaired students: Do we eliminate them from counselor education programs? *Counselor Education & Supervision*, 31 (2), 60-67.

- Brady, J. P., Davison, G. C., Dewarld, P. A., Egan, G., Fadiman, J., Frank, J. D., Gill, M. M., Hoffman, I., Kempler, W., Lazarus, A. A., Raimy, V., Rotter, J. B., & Strupp, H. H. (1980). Some views on effective principles of psychotherapy. *Cognitive Therapy and Research*, 4, 269-306.
- Brenner, C. (1979). Working alliance, therapeutic alliance, and transference. *Journal of the American Psychoanalytic Association*, 27, 136-158.
- Butler, S. F., & Strupp, H. H. (1986). "Specific" and "nonspecific" factors in psychotherapy: A problematic paradigm for psychotherapy research. *Psychotherapy*, 23, 30-40.
- Campbell, T. D., & Stanley, J. C. (1963). *Experimental and quasi-experimental designs for research*. Boston: Houghton Mifflin Company.
- Crits-Christoph, P., Baranackie, K., Durcias, J. S., Beck, A. T., Carroll, K., Perry, K., Luborsky, L., McLellan, A. T., Woody, G. E., Thompson, L., Gallagher, D., & Zitrin, C. (1991). Meta-analysis of therapist effects in psychotherapy outcome studies. *Psychotherapy Research*, 1 (2), 81-91.
- Crits-Christoph, P., & Mintz, J. (1991). Implications of therapist effects for the design and analysis of comparative studies of psychotherapies. *Journal of consulting and Clinical Psychology*, 59 (1), 20-26.
- Corey, G. (2001). *Theory and practice of counseling and psychotherapy* (6th ed.). Belmont, CA: Brooks/Cole.
- D'Andrea, M. (1988). The counselor as pacer: A model for revitalizations of the counseling profession. In R. Hayes & R. Aubrey (Eds.) *New directions for counseling and human development* (pp. 22-44). Denver, Colorado: Love.

- Emerson, S., Markos, P. A. (1996). Signs and symptoms of the impaired counselor. *Journal of Humanistic Education & Development*, 34 (3), 28-37.
- Eysenck, H. J. (1952). The effects of psychotherapy: An evaluation. *Journal of Consulting Psychology*, 16, 319-324.
- Frame, M. W., & Stevens-Smith, P. (1995). Out of harm's way: Enhancing monitoring and dismissal processes in counselor education programs. *Counselor Education and Supervision*, 35 (2), 25-34.
- Frank, J. D. (1973). *Persuasion & Healing*. Baltimore: The Johns Hopkins University Press.
- Freud, S. (1912). *Papers on technique*. In J. Strachey (Ed. and Trans.), *The standard edition of the complete psychological work of Sigmund Freud* (Vol. 11, pp. 139-151). London: Hogarth Press.
- Garfield, S. L. (1973). What are the therapeutic variables in psychotherapy? *Psychotherapy and Psychosomatics*, 24, 372-378.
- Garfield, S. L. (1994). Research in client variables in psychotherapy. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (4th ed. pp. 190-228). New York: Wiley.
- Gaston, L. (1990). The concept of the alliance and its role in psychotherapy: Theoretical and empirical considerations. *Psychotherapy*, 27 (2), 143-153.
- Gaubatz, M. D., & Vera, E. M. (2002). Do formalized gatekeeping procedures increase programs' follow-up with deficient trainees? *Counselor Education & Supervision*, 41, 294-305.

- Gitelson, M. (1962). The curative factor in psycho-analysis. *International Journal of Psycho-Analysis*, 43, 194-234.
- Granello, P. F. (2001). A comparison of wellness and social support networks in different age groups. *Adultspan*, 3 (1), 12-22.
- Greenson, R. R. (1965). The working alliance and the transference neuroses. *Psychoanalysis Quarterly*, 34, 155-181.
- Grencavage, L. M., & Norcross, J. C. (1990). Where are the commonalities among the therapeutic common factors? *Professional Psychology: Research and Practice*, 21 (5), 372-378.
- Grissom, R. J. (1996). The magical number .7 +/- .2: Meta-meta-analysis of the probability of superior outcome in comparisons involving therapy, placebo, and control. *Journal of Consulting and Clinical Psychology* 64 (5), 973-982
- Guy, J. D., & Liaboe, G. P. (1986). Personal therapy for the experience psychotherapist: A discussion of its usefulness and utilization. *The Clinical Psychologist*, 39, 20-23.
- Hair, J. F., Black, W. C., Babin, B. J., Anderson, R. E., & Tatham, R. L. (2006). *Multivariate data analysis*. Upper Saddle River, New Jersey: Prentice Hall.
- Hattie, J. A., Myers, J. E., & Sweeney, T. J. (2004). A factor structure of wellness: Theory, assessment, analysis and practice. *Journal of Counseling & Development*, 82 (3), 354-364.
- Haley, J. (1976). *Problem solving therapy*. San Francisco: Jossey-Bass.
- Hettler, B. (1984). Wellness: Encouraging a lifetime pursuit of excellence. *Health Values: Achieving High Level Wellness*, 8 (4), 13-17.

- Hill, N. R. (2004). The challenges experienced by pretenured faculty members in counselor education: A wellness perspective. *Counselor Education & Supervision, 44* (2), 135-146.
- Horvath, A. O., & Symonds, B. D. (1991). Relation between working alliance and outcome in psychotherapy: A meta-analysis. *Journal of Counseling Psychology, 38* (2), 139-149.
- Kadzin, A. E. (1994). Methodology, design, and evaluation in psychotherapy research. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (4th ed.) (pp. 19-71). New York: Wiley.
- Kleinke, C. L. (1994). Common principles of psychotherapy. Brooks/Cole Publishing Company: Pacific Grove, CA.
- Kottler, J. (1993). On being a therapist. San Francisco, CA: Jossey-Bass.
- Lafferty, P., Beutler, L., & Crago, M. (1989). Differences between more and less effective psychotherapies: A study of select therapist variables. *Journal of Consulting and Clinical Psychology, 57* (1), 76-80.
- Lamb, D. H., Presser, N. R., Pfost, K. S., Baum, M. C., Jackson, V. R., & Jarvis, P. A. (1987). Confronting professional impairment during the internship: Identification, due process, and remediation. *Professional Psychology: Research and Practice, 18* (6), 597-603.
- Lambert, M. J. (1989). The individual therapist's contribution to psychotherapy process and outcome. *Clinical Psychology Review, 9*, 469-485.

- Lambert, M. J. (2005). Early response in psychotherapy: Further evidence for the importance of common factors rather than “placebo effects.” *Journal of Clinical Psychology*, 61 (7), 855-869.
- Lambert, M. J., & Bergin, A. E. (1994). The effectiveness of psychotherapy. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (4th ed.) (pp. 143-189). New York: Wiley.
- Lambert, M. J., & Hill, C. E. (1994). Assessing psychotherapy outcomes and processes. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (4th ed.) (pp. 72-113). New York: Wiley.
- Lambert, M. J., Morton, J. J., Hatfield, D., Harmon, C., Hamilton, S., Reid, R. C., Shimokawa, K., Christopherson, C., & Burlingame, G. M. (2004). *Administration and scoring manual for the OQ-45.2*. Salt Lake City, UT: American Professional Credentialing Services LLC.
- Lambert, M. J., & Okiishi, J. C. (1997). The effects of the individual psychotherapist and implications for future research. *Clinical Psychology: Research and Practice*, 4, 66-75.
- Lambert, M. J., Weber, F. D., & Sykes, J. D. (1993). Psychotherapy versus placebo. *Poster presented at the 83rd Annual Meeting of the Western Psychological Association*, Phoenix, AZ.
- Lipsey, M. W., & Wilson, D. B. (1993). The efficacy of psychological , educational, and behavioral treatment: Confirmation form meta-analysis. *American Psychologist*, 48, 1181-1209.

- Maslow, A. H. (1968). *Toward a psychology of being*. New York: Van Nostrand Reinhold.
- McAuliffe, G. J., & Eriksen, K. P. (1999). Toward a constructivist and developmental identity for the counseling profession: The context-phase-stage-style model. *Journal of Counseling & Development*, 77(3), 267-280.
- McCrary, B. (1989). The distressed or impaired professional: From retribution to rehabilitation. *Journal of Drug Issues*, 19 (3), 337-349.
- McKay, J. K., Dowd, E. T., & Rollin, S. A. (1982). Clients' characteristics as mediating variables in perception of counselors' social influence. *Perceptual and Motor Skills*, 54 (2), 523-526.
- Myers, J. E., Leucht, R. M., & Sweeney, T. J., (2004). The factor structure of wellness: Reexamining theoretical and empirical models underlying the wellness evaluation of lifestyle (WEL) and the five-factor wel. *Measurement and Evaluation in Counseling and Development*, 36 (1), 194-208.
- Myers, J. E., & Sweeney, T. J. (2005). *Manual for the five factor wellness inventory*. Greensboro, NC: Authors.
- Myers, J. E., & Sweeney, T. J. (2005). The indivisible self: An evidence-based model of wellness. *The Journal of Individual Psychology*, 61 (3), 269-278.
- Myers, J. E., Sweeney, T. J., & White, V. E. (2002). Advocacy for counseling and counselors: A professional imperative. *Journal of Counseling & Development*, 80 (4), 394-402.
- Myers, J. E., Sweeney, T. J., & Witmer, J. M. (1996). *The wellness evaluation of lifestyle*. Palo Alto, CA: MindGarden.

- Myers, J. E., Sweeney, T. J., & Witmer, J. M. (2000). The wheel of wellness counseling for wellness: A holistic model for treatment planning. *Journal of Counseling & Development, 78*, 251-266.
- Okiishi, J., Lambert, M. J., Nielsen, S. L., & Ogles, B. M. (2003). Waiting for supershrink: An empirical analysis of therapist effects. *Clinical Psychology and Psychotherapy, 10*, 361-373.
- Olsheski, J., & Leech, L. L. (1996). Programmatic interventions and treatment of impaired professionals. *Journal of Humanistic Education & Development, 34* (3), 128-141.
- Ricks, D. F. (1974). Supershrink: Methods of a therapist judged successful on the basis of adult outcomes of adolescent patients. In D. F. Ricks, M. Roff, & A. Thomas (Eds.), *Life history research in psychopathology*. Minneapolis: University of Minnesota Press.
- Rogers, C. R. (1992). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting and Clinical Psychology, 60* (6), 827-832.
- Rosenzweig, S. (1936). Some implicit common factors in diverse methods of psychotherapy. *American Journal of Orthopsychiatry, 6*, 412-415.
- Savolaine, J., & Granello, P. F. (2002). The function of meaning and purpose for individual wellness. *Journal of Humanistic Counseling, Education and Development, 41*, 178-189
- Shadish, W. R., Cook, T. D., & Campbell, D. T. (2002). *Experimental and quasi-experimental designs for generalized causal inference*. Boston: Houghton Mifflin Company.

- Sheffield, D. S. (1998). Counselor impairment: Moving toward a concise definition and protocol. *Journal of Humanistic Education & Development*, 37 (2), 96-105.
- Smith, M. L., Glass, G. V., & Miller, T. I. (1980). *The benefits of psychotherapy*. Baltimore, MD: The Johns Hopkins University Press.
- Sollod, B. (1981). Goodwin Watson's 1940 conference. *American Psychologist*, 36, 1546-1547.
- SPSS Inc. (2006). Statistical Package for the Social Sciences (Version 14.0) [Computer Software]. Chicago, IL: SPSS Inc.
- Stadler, H. A., Willing, K. L., Eberhage, M. G., & Ward, W. H. (1988). Impairment: Implications for the counseling profession. *Journal of Counseling and Development*, 66, 258-260.
- Sterba, R. (1934). The fate of the ego in analytic therapy. *The International Journal of Psycho-analysis*, 15, 117-126.
- Steering Committee. (2001). Empirically supported therapy relationships: Conclusions and recommendations of the Division 29 Task Force. *Psychotherapy: Theory, Research, Practice, & Training*, 38 (4), 495-497.
- Strong, S. R. (1968). Counseling: An interpersonal influence process. *Journal of Counseling Psychology*, 15, 215-224.
- Strupp, H. H. (1995). The psychotherapist's skills revisited. *Clinical Psychology: Science and Practice*, 2 (1), 70-74.
- Strupp, H. H. & Hadley, S. W. (1979). Specific versus nonspecific factors in psychotherapy: A controlled study of outcome. *Archives of General Psychiatry*, 36, 1125-1136.

- Sweeney, T. J., & Witmer, J. M. (1991). Beyond social interest: Striving toward optimum health and wellness. *Individual Psychology*, 47 (4), 527-540.
- Task Force, (1995). Training in and dissemination of empirically-validated psychological treatments. *The Clinical Psychologist*, 48, 3-23.
- Vermeersch, D. A., Whipple, J. L., Lambert, M. J., Hawkins, E. J., Burchfield, C. M, & Okiishi, J. C. (2004). Outcome questionnaire: Is it sensitive to changes in counseling center clients? *Journal of Counseling Psychology*, 51 (1), 38-49.
- Wampold, B. E. (2001). *The great psychotherapy debate: Models, methods, and findings*. Mahwah, New Jersey: Lawrence Erlbaum Associates, Publishers.
- Weinberger, J. (1995). Common factors aren't so common: The common factors dilemma. *Clinical Psychology: Science and Practice*, 2 (1), 45-69.
- Witmer, J. M., & Sweeney, T. J. (1992). A holistic model for wellness and prevention over the life span. *Journal of Counseling & Development*, 71, 140-148.
- Witmer, J. M., & Young, M. E. (1996). Preventing counselor impairment: A wellness approach. *Journal of Humanistic Education & Development*, 34 (3), 141-155.
- Young, M. E. (1992). *Counseling methods and techniques: An eclectic approach*. New York: Macmillan
- Zetzel, E. R. (1956). Current concepts of transference. *International Journal of Psychoanalysis*, 37, 369-375.