

Wellness Model of Supervision: A Preliminary Analysis

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A dissertation submitted to

The Graduate School of Education

Texas A&M University- Corpus Christi

In partial fulfillment to the requirements for the degree

Doctor of Philosophy

Graduate Program in Counselor Education & Supervision

29 April 2011

Wellness Model of Supervision: A Preliminary Analysis

A dissertation by

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ABSTRACT

This study compared the effectiveness of the Wellness Model of Supervision (WELMS; Lenz & Smith, 2010) against other models of supervision for developing the wellness constructs, total personal wellness, and helping skills among CITs. Participants in were 44 masters level Caucasian counseling students (9 men) completing their practicum and internship requirements in a CACREP accredited counseling program who were Caucasian ($N = 27$) Hispanic/ Latino ($N = 12$) and African American ($N = 5$) young adults ($M = 32$ years, $SD = 9.96$) of predominately heterosexual affectional orientation (96%). Pretest and Posttest measures of wellness construct, total wellness, and counseling skills were analyzed using a Split Plot Analysis of Variance. Results indicated that participants in the WELMS condition developed their personal construct of wellness and total wellness noticeably more when compared to participants receiving other models of supervision. Additionally, no differences in counseling skills development were noted between groups suggesting that the WELMS does not negate essential functions of supervisory and training practices. Implications for counselor development, meeting ethical requirements for self-care and monitoring, demonstrating student learning outcomes, and conducting empirical evaluations of supervisory practices are provided.

DEDICATION

To all the students before and after me who hope to make an impression on the lives of their students, peers, colleagues, and supervisors through the practices of empirically searching for the truth and personally questing for connection.



ACKNOWLEDGEMENTS

God has consistently blessed me with the gift of several people that have been very special to me and whom, without their support, it is unlikely that I would be a glimmer of the person I am today; many without whom the aspirations of this dissertation could have been achieved. Very briefly, I would like to thank and acknowledge each with the fore mention that this commentary will not adequately value the indelible mark you have left upon my life and those I have yet to meet.

My beautiful, compassionate, artistic, spontaneous and silly wife Rachel; we never missed a date night, a sunrise, or a chance to make light of our journey during the past three years. When considering returning to school, we agreed that we would give it our best, find our harmony and never forsake our love for each other despite the pressures and strain. We did it and I love you more for keeping your promises than I ever could explain so live the proof will be my charge.

To my mother, Kate. During my doctoral preparation I have been a workhorse. Along the way I have been asked: "Where do you get the energy?," "Have you always been like this?," and "Who told you to do this?" The answer has always been the same, "My Mom." Growing up with you was an amazing example of giving everything your fullest self. You always worked two jobs and always came home happy to see me and hopeful about our future. Children rarely do what their parents say and, more frequently, do what they see them doing; I learned much that I know about approaching life from watching you.

A very special thank you goes out to my friends and family, especially my cousins, for making sure that in the middle of this wild ride I never missed a Longhorns

game, an opportunity for a great concert, or a regenerative barbeque. In his original theory of optimal human functioning, Freud suggested that individuals were at their best when they were engaged in regular practices that encouraged them to work well and love well. I took care of the work; you helped greatly with the love. It is in my reflection through you all that I knew a great deal of who I am today.

My mentors have a great deal to do with all. Varunee Faii Sanganjanavanich you're the best. As a mentor and a colleague you have dominated and have not relented you support, humor and sharing of opportunities for growth. Dr. Rick Balkin, you were the unanticipated surprise of my doctoral development and instrumental in keeping me in great spirits about my potential to achieve in the field of counselor education and supervision. My boss, Dr. Marvarene Oliver, thank you does not describe the amount of gratitude that I have for knowing you. You embody a unique personal wellness that is both encouraging and inspiring. Additionally, had you and Dr. Kaye Nelson not supported me so diligently and graciously through evaluating game tape, we would not really know much about hypothesis three would we? It could be argued that all this started with a funky guitar player from the psychology department, Dr. Steve Seidel, you supported me then; you are supporting me now. I am grateful for our adventures in academe and your support of my very strange thesis about evolution and conquest strategies for dating. Finally, thank you to Dr. Robert Smith for always giving me the latitude to curiously peer around the next corner and encouraging the development of the Wellness Model of Supervision through which I have voice a resonate note of interest.

I would also like to extend an acknowledgement to Cohort 8, especially my boy John Buttermore Pope who was instrumental in the completion of this dissertation. We

were tiny, but mighty; challenged, but chipper. During our professional preparation we dared to speak and fared pretty well I think. Finally, a very sincere thank you to Jane E. Myers for her encouragement, guidance and support while developing and evaluating the WELMS and to Karen Eriksen for her support and guidance using the CSS.

To all, I wish you well.

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CHAPTER ONE

INTRODUCTION

Counselors and counselors in training (CITs) are frequently subjected to stress-producing factors that have the potential to deplete physical and mental resources and may jeopardize individual wellness. Individuals who have professionally identified with counseling may demonstrate greater wellness when compared to the general population (Myers, Mobley, & Booth, 2004). However, Roach and Young (2007) questioned whether counselor education programs have an impact in cultivating the wellness of CITs. While considering how this process works in action, Smith, Robinson, and Young (2007) detected that there is a negative association between the overall wellness of CITs and their exposure to psychological distress. The results of these authors' inquiries suggested that CITs may be impacted deleteriously by the psychological distress they encounter and that they may not be receiving the wellness interventions conducive to maintaining optimum functioning when exposed to stressors during their development and training.

The American Counseling Association (ACA) first formally recognized the importance of a developmental, wellness approach to the professional practice and identity of counselors (ACA, 1995). Since this initial proclamation, the ACA has continued to require counselors to “maintain and promote their emotional, physical, mental, and spiritual well-being” throughout their career development (ACA, 2005, p. 9). Echoing this contention the Council for the Accreditation of Counseling and Related Educational Programs (CACREP) has required counselor education programs to demonstrate wellness learning objectives in their curriculum, and stated that student

learning outcomes should be noted by graduates' proficient incorporation of these competencies in clinical practice (CACREP, 2009). Despite the suggestions emerging from scholars concerning successful infusion of wellness concepts within curriculum (Lenz, 2009; Witmer & Granello, 2005; Yager & Tober-Blank, 2007), few authors have made suggestions for the development and evaluation of student learning outcomes in clinical practice.

Supervision of CITs provides a professionally appropriate venue to evaluate a supervisee's wellbeing as well as their clinical skills. Perhaps a developmental, wellness approach to supervision will increase the availability of internal resources that a supervisee can provide to clients and thus safeguard them from the deleterious effects associated with exposure to psychological distress such as burnout and vicarious trauma. Lenz and Smith (2009) proposed one such model: The Wellness Model of Supervision (WELMS). This model was designed to facilitate traditional clinical aspects of counselor training while also developing the trainee's understanding and practical use of wellness concepts through education, assessment, planning of personal goals, and systematic evaluation of progress. One supposition underlying the WELMS is that supervision of CITs should occur in a context that maximizes the individual wellness of that trainee in a unique, diligent, sensitive, and ethically responsible manner. A further assumption of this model states that the efficacy of the supervision interventions can be measured quantitatively.

Statement of the Problem

Borders (2005) suggested that too often empirical research evaluating supervision models and techniques is underdeveloped or based on too small of a sample. This

paucity of empirical, evidence-based supervision paradigms is surprising considering that supervision models have historically resembled models of therapy, which have demanded evidence-based research. The problem under investigation is the lack of empirical research supporting counseling supervision models. Particularly, there is presently a lack of studies that investigate the Wellness Model of Supervision (Lenz & Smith, 2009).

Purpose of the Study

The purpose of the present investigation is to examine the efficacy of the WELMS paradigm when applied to CITs. This purpose is operationalized as follows: (a) When compared to other supervision models, is the WELMS more effective in facilitating the development of wellness constructs in CITs? (b) Does the WELMS positively influence the overall wellness of CITs when compared to other models of supervision as measured by the Five Factor Wellness Inventory (5F-WEL, Myers & Sweeney, 2005)? (c) Is there a difference in clinical skills development between the WELMS and a traditional model of supervision as measured by the Counseling Skills Scale (CSS, Erikson & McAuliffe, 2003)?

Statement of the Hypothesis

When establishing an intervention as evidence-based, investigators are charged with the task of demonstrating efficacy of one intervention when compared to either a control group or an alternative treatment. Therefore, to qualify the WELMS as an evidence-based intervention some necessary null hypotheses must be rejected. First, no difference will be demonstrated in the comprehensiveness of wellness definitions provided by CITs in the WELMS group when compared to those receiving a traditional supervision paradigm. Second, there will be no significant improvements for total

wellness between groups when comparing CITs receiving supervision using either the WELMS or other supervision paradigm. Finally, there will be no significant difference in the development of applied counseling skills when comparing CITs receiving clinical supervision using either the WELMS or a traditional model.

Significance of the Study

Although several authors have begun to develop an evidence base for counseling interventions such as solution-focused therapy and cognitive-behavioral treatments (Compton *et al.*, 2004; Howard & Kendall, 1996; Kazdin & Weisz, 1998; Kim, 2008; Lee, 1997; & Wilmshurst, 2002) little attention has been devoted to establishing a similar empirical basis for the practice of supervision within any orientation. In addition to providing empirical support for a model of counselor supervision, the present study also has the potential to demonstrate student learning outcomes for wellness variables in the clinical setting. Furthermore, the present investigation may assist other scientist-practitioners in evaluating other supervision models by providing an effective experimental design.

Population and Sample

Participants in the study will be Master's students who are (a) completing coursework in the Department of Counseling and Psychology Education during the Spring semester of 2010, and (b) completing their practicum and internship training experience at the Texas A&M University- Corpus Christi (TAMUCC) Counseling and Training Clinic as well as other sites in the community.

Participants will be assigned to one of two treatment conditions. Participants completing their practicum and internship requirements while at the TAMUCC Clinic

will represent the treatment condition and receive counseling supervision and skills development using the WELMS. Other CITs completing the practicum and internship requirements at other community based sites, but not at the Clinic will represent the alternative treatment group and receive supervision and training using other models of supervision such as administrative (Coleman, 2003; Kadushin, 1992), developmental (Stoltenberg, 1981; Stoltenberg, 1997) and facilitative (Pierce & Schauble, 1970) approaches. All demographic and identifying information for participants in the treatment group will be coded using 100's (i.e., 101-125) and those in the alternative treatment condition will be coded using 200's (i.e., 201-225). Because this is a within subjects design, a key that associates the individual's participant code with their identity will be stored in a securely locked file cabinet in the researcher's private facility. Following an initial baseline assessment, participants in the alternative treatment condition will be compared with participants in the WELMS condition.

Treatment

Participants in the treatment condition will receive clinical supervision using the WELMS paradigm. The WELMS (Lenz & Smith, 2009) is an approach to supervision that integrates wellness concepts into the supervisee development in relation to self and others. The WELMS is based on the Holistic Treatment Planning Model developed by Myers, Sweeney, and Witmer (2000). The WELMS has two unique qualities. First, this model emphasizes education, assessment, planning, and evaluation of supervisee wellness objectives believed to foster resilience to negative variables associated with the counseling practice. Second, the WELMS is a comprehensive and holistic perspective of clients and their issues. One goal of this model is that by using this holistic approach to

supervision, supervisees may learn about interviewing, assessment, treatment planning, case conceptualization, and evaluation in a holistic way.

Participants in the treatment condition will receive an orientation to the WELMS along with a rationale for the model. During this orientation, participants will complete an activity to define their personal definition of the wellness construct. Next, participants will complete a formal wellness assessment that will be scored and saved in SPSS and excel files using their assigned experimental code. Scores on this assessment yield 23 scores (total wellness, 5 second-order factors, and 16 third-order factors) that will be provided to the participants. Participants will use this information to self-select domains that they would like to develop during the semester as personal wellness objectives. Participants will complete a personal wellness plan to be evaluated and refined throughout semester on an individualized basis. Education on wellness models will be ongoing throughout participation.

Also, participants in the treatment condition will be rated on their clinical skills by their assigned practicum or internship instructor. These instructors will provide these evaluations to the researcher for coding and documentation. Evaluations will be based on the first and third tapes submitted for review in partial fulfillment of the course objectives.

Instrumentation

Five Factor Wellness Inventory. In the present study, the author will use the Five Factor Wellness Inventory to establish a baseline at the beginning of the semester and assess wellness development or maintenance at the conclusion of the semester (5F-WEL, Myers & Sweeney, 2005a). The 5F-WEL is an evidence-based tool “designed to

identify factors that are central to healthy living, and which represent domains of human functioning in which personality responsibility and choice will have positive effects on well being” (Myers & Sweeney, 2005a, p.1). The results of the 5F-WEL are intended to assist individuals in making choices for healthier living which may promote longevity and happiness. The 5F-WEL is based on The Indivisible Self: Evidence-Based Model of Wellness (IS-WEL, Myers & Sweeney, 2005b). In this model, the global construct of wellness is composed of 5 second-order factors (the Coping Self, Social Self, Creative Self, Essential Self, and the Physical Self) which are defined by 17 third-order factors subsumed under the second order factors in varying amounts. These factors have been postulated as integrated components affecting individual wellness in which change in one area is likely to affect general wellness, as well as the other domains in the model (Myers, *et al.*, 2000).

The adult version of the 5F-WEL is composed of 91 items, with between 4 and 6 items representing each third-order factor. The 5F-WEL boasts a normative sample of 3,343 individuals (1,173 males) of American Indian, African American, Asian American, Caucasian, and Hispanic ethnicities (Myers & Sweeney, 2005a). Five Factor-WEL items are 4 point Likert-type prompts in which the individual responds to positively worded prompts (e.g. I eat a healthy diet) on a continuum ranging from strongly disagree, disagree, agree, and strongly agree in which 1, 2, 3, and 4 points are contributed to the individuals score respectively (Myers & Sweeney, 2005a). The scores in the overall wellness, second-order, and third order domains range between 25 and 100 with varying means for males and females and between ethnic groups. These raw scores are calculated using linear transformation in which total points are divided by the number of items

within a scale and then multiplied by 25. The raw scores are then plotted with strengths and weakness being the focus of intervention protocols. This method has been regarded as a user friendly means for converting 5F-WEL data into meaningful representations for both practitioners and researchers.

Measurement limitations associated with the 5F-WEL are related to the reliability of third order factors, the degree to which the instrument account for scores between participants, and the appropriateness of a five factor model. For instance, DeMauro (2007) noted that while reliability evidence related to alpha coefficients for the 5F-WEL is robust for the general wellness (.94) and second order factors (.90 - .94) reliability becomes much more variable when examining the internal consistency of third-order factors. Additionally, while many successful applications of the 5F-WEL have been noted in empirical research studies within the counseling profession (Choate & Smith, 2005; Hartwig, 2003; Myers, Mobley, & Booth, 2003; Spurgeon & Myers, 2002), it has been suggested that a 4 factor structural model may provide a better instrument for exploring the relationships between wellness and other variables (Myers, Luecht, & Sweeney, 2004). Although preliminary factor analysis supported a 5 factor model (Hattie, Myers, Sweeney, 2004), these authors noted that the 5 factor model accounts for 32% of the variance in scores with a large proportion of test items that have similar coefficients across factors. This convolutes the process to place third-order variables (e.g. spirituality and ethnic identity) concretely into a second-order factor (e.g., Essential Self). While these psychometric limitations are present, the 5 F-WEL has continued to be regarded as a practical instrument for assisting individuals in developing wellness plans and creating positive changes in their lives (Myers, Luecht, & Sweeney, 2004).

Counseling Skills Scale. In addition to assessing counselor development using the 5F-WEL, the development of participant's clinical counseling skills will be assessed by independent raters using the Counseling Skills Scale (CSS, Eriksen & McAuliffe, 2003). The CSS is developed from analysis of preceding strategy checklists as well as feedback from experts in the field of counselor education and is designed to evaluate the "effectiveness of counseling skills performance" (Erikson & McAuliffe, 2003, p. 127). Ivey, Gluckstern-Packard, and Ivey, (2007) noted that the results of the CSS were intended to guide the development of CITs and identify the specific microskills that contributed to positive counseling interventions. When an evaluator is using this measure, an overall the trainee's score is composed of 22 skills grouped into 6 subcategories (Interest, Exploration, deepening, Change, Relationship, and Management) based on a real time viewing of a counseling interaction. These component skills have been postulated as representative of the standards for counseling skills and are reportedly grounded in contemporary research on effective counseling such as those investigated recently by some authors (Alberta & Wood, 2009; Trepal, Haberstroh, Duffey, & Evans, 2007).

The CSS is composed of 22 items, with between 1 and 5 items representing each subcategory. Reliability and construct validity for these items was based on a small sample of 29 individuals (17 males) of Caucasian, African-American, and Asian-American ethnicities (Eriksen & McAuliffe, 2003). CSS items are a 5-point Likert-type scale ranging from +2 *Highly developed* to -2 *Major adjustment needed*. Scores within each subcategory are totaled and divided by the number of items in that scale to calculate

an average score within the domain. Scoring of the CSS, like the 5F-WEL, is regarded as user friendly and provides immediate feedback to trainees, supervisors, and researchers.

Data Collection and Analysis

Wellness data for participants in both groups will be collected using a group format during the first (baseline) and twelfth (post-treatment) weeks of the Spring 2010 academic semester. Participants will begin by completing an informed consent statement describing the purposes and procedures of the study, the researchers contact information, and a statement of voluntary involvement. The researcher will emphasize that at any time, practicum and internship students can elect to decline clinical supervision using the WELMS in place of more traditional evaluation at no cost or penalty. No participants will be excluded from data collection due to any demographic information reported. Following completion of the informed consent statement, participants will complete a demographic questionnaire which will include their date of birth and initials for identifying purposes. This questionnaire will be function as the participants cover sheet within their personal participation file.

Participant wellness data is two-fold. First participants will be asked to respond to an open-ended prompt requiring them to describe their perception of “what wellness is” and “what are the activities that a well person engages in?” Responses to this prompt will be analyzed using word count as a dependent variable to measure the extensiveness of participant conceptualization of the wellness construct. Additionally, these responses will be analyzed using a frequency count of wellness variables that are included in the IS-WEL model to represent comprehensiveness. The IS-WEL model was chosen for its inclusive nature and relative acceptance in the professional counseling community. Two

independent raters will attend to these tasks and any disagreement concerning the protocol content will be ameliorated through discussion and reference to the literature in effort to create homogenous composites. A Split Plot Analysis of Variance (SPANOVA) procedure will be utilized to note significant relationships between the treatment versus alternative treatment groups for changes in content of wellness definitions as measured by a content frequency count over time.

In addition, participants will complete the 5F-WEL as part of the study requirements. The investigator will read participants the assessment directions orally and complete the practice example included in the instructions. Protocols will be entered into an SPSS file and confidentially scored by the test's author using the participant's 100 or 200 number to assure participant anonymity. The investigator will also use a SPANOVA procedure to detect significant differences between treatment versus the alternative treatment group for overall wellness over time.

Data related to counseling skills development will be collected in collaboration with department faculty. Participants will have their first and last counseling tapes for either practicum or internship scored by two independent raters trained in using the CSS. The training of these two raters has been documented and recognized by the inventories authors as cogent and representative of assessment standards for use. These independent raters will complete a trial use of the CSS with three randomly selected videos to establish inter-rater reliability. Discrepancies in rating will be discussed and negotiated until a satisfactory inter-rater reliability can be reached. Following, these raters will view participant counseling videos in 10-minute segments as recommended by the rating scale authors (Erikson & McAuliffe, 2003). An overall score and subcategory ratings will be

documented in SPSS files and analyzed using a strategy similar that utilized with scores on the 5F-WEL. A counseling skills develop quotient (CSDQ) will be calculated for each participant by subtracting the rating score for the participant's final tape minus the rating score for their first of the semester. A SPANOVA will be implemented to detect significant relationships between groups for development of counseling skills during the semester.

Finally, the relationship between level of wellness and a counselor in training's counseling skill development will be analyzed using a simple regression strategy. This analysis will investigate the relationship between participant wellness and ability to provide quality, developmentally appropriate counseling interventions.

Basic Assumptions

The researcher notes some poignant basic assumptions regarding evaluation of the WELMS and supervision in general. Foremost, the WELMS is regarded as more holistic supervision intervention than traditional strategies as it regards counseling as a part of the individual that affects the whole. In addition, it is assumed that the structured nature of the WELMS paradigm will require the supervisor to breathe life into the intervention when working with supervisees. Shulman (2005) suggested that more is caught than taught in supervision and that supervisees learn much about relating to clients through the relationship with their supervisor. Therefore, the investigator's contention is that during supervision, especially when applying the WELMS paradigm, supervisors should "lead by example" and that participation in wellness education, assessment, planning, and evaluation is essential to establishing a parallel process between supervisor and supervisee. In addition, the investigator will take care to provide feedback and evaluation

in a sensitive manner due to the personal nature of individual wellness and professional development.

Limitations

Limitations to the study are largely related to psychometric considerations related to the present research design. For instance, one threat to internal validity of the present design is related to participant selection. Due to contextual limitations the investigator was not able to randomly assign participants to treatment groups. Instead, participants were assigned to their treatment condition by virtue of whether they were completing internship and practicum requirements at the Clinic or not. Additionally, due to voluntary recruitment of participants to submit their session tapes for review matching may not be an option for the researcher. Another threat to internal validity is related to history effects. During the course of a semester, the potential exists for a number of circumstances to impact the development of counseling skills and personal wellness alike. Heppner, Wampold, and Kivlighan (2008) suggested that history effects are reduced when using at least two groups of participants such as a treatment and alternative treatment group. The investigator also regards attrition as another potential risk for the present study. During the pilot trial of this project which only evaluated participants in the WELMS condition, two members dropped out of the counseling program. If the total number of participants in the present study becomes too low to establish statistical significance, the investigator may elect to analyze alternative measures such as statistical power.

Finally, as previously noted, the items included in the 5F-WEL may be better accounted for using a 4 factor structural model rather than the existing one. In particular,

while the present instrument structure has accounted for 32% of variance, many of the test items do not fit concretely into just one second order factor. Additionally, the authors of the 5F-WEL have cited that scoring data based on normative information may increase the psychometric properties of the instrument. With these measurement limitations considered, the 5F-WEL is regarded as a practical tool for assisting in the development of participant's personal wellness plans while completing their practicum and internship experiences using the WELMS.

Definition of Terms

Clinic. The Texas A&M University- Corpus Christi Counseling and Training Clinic.

This facility is one training site for students in the Master's counseling program that provides training and supervision for CITs. The Clinic serves a community population free of charge.

Internship. A distinctly defined, post-practicum, supervised "capstone" clinical experience in which the student refines and enhances basic counseling or student development knowledge and skills, and integrates and authenticates professional knowledge and skills appropriate to his or her program and initial postgraduate professional placement (CACREP, 2009, p.60).

Practicum. "A distinctly defined, supervised clinical experience in which the student develops basic counseling skills and integrates professional knowledge. The practicum is completed prior to internship" (CACREP, 2009, p. 61).

Supervision. Practice of oversight provided to Master's level CIT's from either a doctoral student familiar with supervision models and practice or a more senior faculty member with similar education and greater degree of experience.

Furthermore, this relationship occurred during the longitudinal term of a site agreement contract and occurred in individual, triadic, and group formats. During this supervision, administrative, educational and supportive services were provided to CIT's in the form of tutorials and mentoring which included development of clinical skills, professional identity, and enhancing personal development. This relationship was evaluative and served as a means for gate keeping and assessing fitness to practice.

Wellness. A culturally defined state of being in which mind, body, and spirit are integrated in a way that enables a person to live a fulfilled life (CACREP, 2009, p. 62).

Wellness Model of Supervision (WELMS). A model of clinical supervision that integrates wellness variables into the education, assessment, planning, and evaluation of the supervisee and clients. Supervisees are overtly exposed to theories of wellness, formal and informal wellness assessments, formal personal wellness planning, and are evaluated on their progress toward personal goals and application of wellness concepts within case conceptualization and therapeutic tasks such as treatment planning. The WELMS follows the format and considerations presented by Lenz and Smith (2009).

Organization of Remaining Chapters

The remaining chapters will demonstrate how the WELMS compares to traditional models of supervision in terms of maintaining personal wellness and

improving the counseling skills of Master's level students in the helping profession. Chapter 2 will provide a developmental overview of supervision practice as related to counseling. This review will include supervision strategies that integrate useful theoretical concepts to meet a particular need, including wellness. Additionally, chapter 2 will provide a developmental overview of perspective on wellness and describe how wellness constructs are commonly used in the counseling profession. Following, chapter 3 will provide a detailed description of the method used by the researcher to investigate the foretold hypotheses. In chapter 4 the results of this investigation will be identified. Next a discussion of the study results including implications for the fields of counseling, counselor education, and supervision of clinical practice will be noted. Finally, chapter 6 will provide a manuscript reporting poignant results of the inquiry to be submitted to a professional journal at the time of dissertation approval.

CHAPTER TWO

REVIEW OF THE LITERATURE

The research questions presented in chapter one are based upon the literature and current issues regarding the relationship among counselor education and supervision, the recent emphasis on evidence-based practice within the helping profession, the construct of and student learning outcomes. Therefore, in the present chapter the goal is to provide the reader with the conceptual foundation necessary to evaluate the results of the present investigation. First, the reader will be provided with an overview of clinical supervision in the helping profession including an operation definition. Next, the historical development of supervision approaches which are reflected in the Wellness Model of Supervision (WELMS, Lenz & Smith, 2010) will be illustrated. Following, I will identify the development and contemporary expression of wellness within the helping professions and the importance of this construct to the field of counselor education and supervision. After a review of supervisory models that infuse wellness concepts when working with CITs (CITs), the WELMS will be described. Finally, a discussion regarding recent scholarship and measurement of supervisory practices and CIT development will be presented.

Supervision of Helping Professionals

Shulman (2005a) proposed the term “signature pedagogy” to describe educational practices prepare individuals for a particular profession in ways that are distinctive in that professional, is pervasive within the curriculum, and occurs across institutions. Later, Goodyear, Bunch, and Claiborn noted that “to the extent there is a signature pedagogy for the mental health profession, it must be supervision” (2005, p. 138). Although there is a consensus that the supervision of CITs and in professional practice is a prudent activity,

there remains a lack of uniformity among definitions largely related to mechanical semantics in construct delineation.

For instance, one of the first definitions of supervision is associated with the field of social work when the Russell Sage Foundation offered the first course in social work supervision in 1911 (Coleman, 2003). The trainings noted that supervision was intended to “enhance the clinical social worker’s professional skills, knowledge, and attitudes in order to achieve competency in providing quality patient care” by citing the administrative, educational, and supportive functions of supervisors as critical conduits for supervisee success (Coleman, 2003, p. 2). This author described administrative supervision attending to assuring that work objectives are being performed in a manner consistent with an agency’s policies and worker accountability. In addition to teaching clinical tasks, the educational functions of supervisors in this paradigm teach supervisees the knowledge, skills, and attitudes required to be successful when working with clients. Finally, the supportive aspect of supervision intends to create an environment in which the supervisee motivation can be enhanced and job related stress minimized thorough the process of mentoring and consultation.

Another widely accepted definition of supervision describes the activity as a “an intervention provided by a more senior member of a profession to a more junior member or members of that profession” (Bernard & Goodyear, 2009, p. 7). In the present case, the profession is clinical mental health counseling which includes professional activities such as assessment, diagnosis, providing therapeutic interventions, psychoeducation, crisis management, and advocacy as described by Gladding and Newsome (2010). These authors clarified that the supervisory relationship is characteristically evaluative and

hierarchical wherein the supervisor provides formal and informal feedback to supervisees. Additionally, supervision is a process that frequently occurs over time during master's level training and beyond during licensing. Finally, during this relationship, these authors have suggested that critical roles of the supervisor include facilitating development of the professional services provided by the supervisee through monitoring in addition to functioning as a gatekeeper for the helping profession.

Although Bernard and Goodyear (2009) have provided a definition that has been accepted across helping professions, the Council for Accreditation of Counseling and Related Educational Programs (CACREP) has proposed a succinct and sufficient definition of supervision in their standards as specifically related to the field of counselor education and supervision (Council for Accreditation of Counseling and Related Educational Programs, 2009). This definition of supervision described "a tutorial and mentoring form of instruction in which a supervisor monitors the student's activities in practicum and internship, and facilitates the associated learning and skill development experiences" (CACREP, 2009, p. 62). During this time, it is the supervisor's obligation to monitor and appraise the clinical work of their CIT while attending to the quality of services offered to clients during the student's training. This relationship is sanctioned to occur in individual, triadic, or group formats with proportions suggested to insure sufficient attention.

Several similarities between these definitions of supervision practice are noted. Foremost, all inherently feature the supervisor's oversight of a supervisee's work to assure quality of services provided to clients expressed within a hierarchical relationship. This may include evaluating assessments, monitoring interventions, and probing for

countertransference throughout a supervisees work with clients. In addition, all the descriptions connote a developmental process in which the supervisor functions as a guide. Activities subsumed under this role may include direction and encouragement during professional rites of passage such as completing graduate training or licensure requirements or involve other functions associated with professional identity such as affiliation and involvement with relevant specialty groups. Finally, the previously reviewed definitions have all included a gate keeping component in which the supervisor is responsible for assuring that the supervisee is meeting a particular standard related to agency, institutional, or professional standards.

From these established characterizations of activities and features that define a supervisory relationship (Bernard & Goodyear, 2009; CACREP, 2009; Coleman, 2003), I propose an operational definition of supervision to be referenced during the present investigation regarding the efficacy of the WELMS. As such supervision will here be regarded as the practice of oversight provided to Master's level CIT's from either a doctoral student familiar with supervision models and practice or a more senior faculty member with similar education and greater degree of experience. Furthermore, this relationship occurred during the longitudinal term of a site agreement contract and occurred in individual, triadic, and group formats. During this supervision, administrative, educational and supportive services were provided to CIT's in the form of tutorials and mentoring which included development of clinical skills, professional identity, and enhancing personal development. This relationship was evaluative and served as a means for gate keeping and assessing fitness to practice. The next section

will illustrate the development of clinical supervision practices as a professional activity within the helping profession.

Supervisory Constructs Relevant to the WELMS

Early accounts of clinical supervision connote the long standing belief that effective supervision supports effective practice. In this section I will identify the constructs relevant to clinical supervision implementing the WELMS as a professional practice standard. First, practical foundations will be reviewed in relation to the facilitative, developmental and behavioral strategies of supervision will be discussed. These theoretical dispositions are relevant to this discussion based upon their significant representation within the WELMS. Next, I will provide an overview of the emergence of wellness within the field of counseling and counselor education and identify its meaningful convergence with supervision. Following, I will discuss more recent developments in the last 25 years will be identified including the trend toward integrative supervision strategies in favor of pure models and measuring counselor development and potential relationship to student learning outcomes.

A Facilitative Approach to Supervision

Consistent with his theory of therapeutic personality change, Carl Rogers (1993) presented a model of facilitative supervision that modeled the necessary and sufficient conditions of empathy, genuineness, and unconditional positive regard for CITs. Through this process of relationship and warm acceptance, a stance of co-participation in the client's treatment is assumed that is intended to move the CIT toward competence and empowerment. Chambers and Long (1995) later noted that supervision, from a facilitative model, "should not be used as a tool to judge, criticize, condemn, and

commitment” (p. 312). These authors also suggested that valuation, empathy, congruence, and commitment as some definitive characteristics associated with a facilitative supervision approach (Chambers & Long, 1995).

In the context of supervision, valuation is the process which is mediated by both external and internal factors. Internal valuation is measured to the degree that a CIT perceives that their applied clinical experience is self-actualizing, important, credible, meaningful and humane. On the other hand, external valuation is measured to the degree that individuals that others who work with a CIT value their personal and professional growth such as peers, co-workers, faculty, and supervisors. Rogers (1993) noted that the acts of valuation that occurs within the supervisory relationship is closely related to unconditional positive regard and should empower the CIT to disclose aspects of their work without fear of being judged, disciplined or criticized.

In the same way that valuation is proposed to contribute to a CIT’s sense of acceptance, demonstrating empathy in the supervisory relationship conveys a sense of understanding from the CIT’s unique frame of reference. Rogers (1957) described empathy as a process in which one person views another’s internal world as if it were their without ever losing the “as if” quality (p. 243). Dean (1984) referred to empathy in a facilitative supervisory model as the lynchpin that joins client, CIT and supervisory in the therapeutic change relationship. From this author’s perspective, the use of empathy is especially powerful for the client experience when the CIT has already established an empathic bond with that client. Yegdich (1999) commented that not only can the supervisor detect the degree of empathy that the CIT is experiencing for the client in the

context of supervision, but that the quality of this relationship can be either influenced by the degree of empathy in the supervisory relationship either positively or negatively.

Chambers and Long (1995) also noted that the manner in which the supervisors demonstrate a genuine, congruent presentation of themselves can also impact the supervisory experience of CITs. If remaining consistent with the construct proposed by Rogers (1957) the congruent supervisor should be freely themselves and a paragon of wholeness when relating to CITs during supervision. Chambers and Long (1995) suggested that when this phenomenon is present, development of both supervisee and CIT insight and trust will follow.

The final definitive characteristic associated with a facilitative model of supervision is a mutual commitment to the supervisory approach and process. This is regarded largely by Chambers and Long (1995) as the act of stating consistent with the commitment to professional and personal development. It is supposed that when valuation, empathy, and congruence are met with a mutual commitment from both supervisor and CIT, an effective, nonauthoritarian relationship is established that promotes development of clients, CITs, and the supervisor through self discovery, self-directed living, learning, and problem solving.

A Developmental Approach to Supervision

A more overt discussion of CIT professional development within the context of the supervision context was originally presented by Stoltenberg and Delworth (1987) and later refined by Stoltenberg, McNeil, and Delworth (1998), who presented an Integrated Developmental Model (IDM) of growth during clinical training. Stoltenberg (1981) noted that most models of supervision at the time were constrained by a primary focus on

skill acquisition or adhering to theoretical trappings, and proposed that a developmental approach to understanding and meeting CIT needs may be useful. Recently, after reviewing a number of supervisory approaches, Bernard and Goodyear (2009) suggested that although other developmental models of CIT growth have been proposed, the IDM is perhaps the best known and most widely used due to descriptions of process and prescriptive variables. In the most recent model, the IDM has described CIT development as occurring across three levels and culminating in a final integrated level during which the structures of self-other awareness, motivation, and autonomy provide markers for growth.

As neophyte professionals, level 1 CITs generally have completed a great deal of coursework but have limited experience working with in the helping setting. As practicum and internship students, Stoltenberg (2001) noted that these CITs often demonstrate a high degree of both motivation and anxiety about providing the *right* or *best* way to work with their clients. Consequently, these CITs are often self-focused, self-conscious and nervous about developing skills while concurrently implementing them without the self-awareness of how this may be perceived by their clients. Level 1 CITs have also been described as dependant on their supervisor and faculty for overt and objective instruction and feedback. Because CITs are largely imitative in this stage, Stoltenberg (1981) commented that the optimal environment to foster change for CITs operating within this level is one that encourages autonomy, implements structure, explores the dynamics of the relationship between CIT and client, and reviews counseling practice in a supportive manner.

When CITs emerge into a level 2, usually some time near completion of degree requirements, it is assumed that the structure and support they have received from their supervisor has positively influenced their self-efficacy and confidence regarding the helping process. Bernard and Goodyear (2009) suggested that CITs at this developmental level struggle to manage vacillations in motivation due to the dichotomous experiences of confidence and confusion in their skills. Stoltenberg (1993) observed a characteristic dependency-autonomy conflict in this stage which can present as a resistance to supervisors or faculty members. Later, Stoltenberg (2001) noted that awareness has increased and that CITs in this stage can demonstrate empathic connecting to a greater degree, but struggle to manage enmeshment and over-identifying with clients. The recommended supervisory environment for CITs in this stage is one that provides latitude for decision making about counseling behaviors as the CIT should be able to identify their own strengths and weaknesses for themselves (Stoltenberg, 1981). Managing resistance through continued sensitivity and empathy is also a recommended feature of the supervisory environment.

Following resolution of the struggle between dependency and autonomy, CITs operating in level 3 are beginning to develop a more personalized approach to counseling regarding how they use and understand themselves through the therapeutic process. Bernard and Goodyear (2009) suggested that these CITs are characterized as being consistently motivated and not debilitated by doubts about personal effectiveness. Because these professionals are usually working as staff members or in a private practice, their solid belief in ability to make professional judgments and collegial relations with supervisors are evidence to their formidable autonomy. During this stage of development

individuals can be observed demonstrating an enhanced self-awareness regarding how they conceptualize issues and their clientele through a personal lens. Stoltenberg (1981) recommended that the optimal supervision environment for these professionals is one that treats the counselor as a peer, is autonomous with the counselor providing the structure, and that uses direct confrontation. As CITs continue to develop into an integrated professional (level 3i) across multiple domains (e.g. assessment, treatment planning, ethics, etc.), a master counselor emerges that demonstrates adequate self- and other awareness, is aware of strengths and limitations, and engages in collegial supervision as needed.

A Behavioral Approach to Supervision

Behavioral models of supervision use a specific and systematic approach when working with CITs. Bernard and Goodyear (2009) credited Wolpe, Knopp, and Garfield (1966) as pioneers for a model of supervision that is based on CIT demonstrating desirable behaviors through the process of shaping. At the fundamental premise of this approach, it is the role of the supervisor to provide opportunities and experiences targeted at increasing the CIT's demonstration of desirable therapeutic behaviors and extinguishing undesirable ones. Gray (1974) suggested that supervised practice of microskills use is essential to CIT development from a behavioral perspective. Although several authors have provided recommendations for behavioral approaches to counselor training and supervision (Agathon & Samuel-Lajeunesse, 1988; Callaghan, 2006; Gray, 1974; Wolpe, 1958), a recent offering by Vandenberghe (2009) has provided supervisors with a useful contemporary model implemented with practitioners of Functional Analytic Psychotherapy, a treatment modality based upon operant conditioning principles.

Vandenberghe's model (2009) conceptualized CIT development occurring across three supervisory contexts: introducing skills, overcoming difficulties, and shaping the therapeutic behavioral repertoire.

When applying the first context of *introducing skills*, the supervisor educates, models, and plans the CIT's use of therapeutic interventions and provides systematic evaluation and feedback following observations of client sessions. Skills and conceptual applications in this context that are successful are met with positive reinforcement contingencies; others that do not are met with feedback, instruction, modeling and planning. Within the second context of *overcoming difficulties* involves the supervisory actions required to "eliminate dysfunctional verbal control and avoidance patterns that compete with an adequate focus in-session" (Vandenberghe, 2009, p. 213). In this context confronting resistance is frequently done with cognitive therapy techniques of labeling distortions, arguing against negative beliefs, and restructuring irrational beliefs. A final context within which supervision occurs regards *shaping the CIT's therapeutic behavioral repertoire* in which contingencies are established between a presenting set of circumstances and a desired CIT behavior. Successive approximations and reinforcements schedules are the responsibility of supervisor in this context.

Boyd (1978) recommended that some necessary considerations remain true across all behavioral approaches to supervision which are embodied in the model presented by Vandenberghe (2009). All training implications considered, perhaps the most important component of the behavioral approach to supervision in relation to the WELMS is that desirable behaviors should be behaviorally defined and evaluated. Additionally, desirable behaviors, once identified, should be developed, applied and refined. Finally,

during training reinforcement should only be used thoughtfully to reinforce desired behaviors and the successive approximations toward a desired goal.

Wellness Within the Helping Professions

Since the passage of the American Counseling Association *Code of Ethics* (1995) counseling professionals have been required to embrace a developmental and wellness-oriented perspective towards professional development and practice. In response several scholars and practitioners have proposed theories of wellness and positive development (Myers & Sweeney, 2005a; Roscoe, 2009; Seligman & Csikszentmihalyi, 2000).

Although Myers and Sweeney (2005b) have provided a review of the modern development of the wellness construct, their review does not reflect contemporary developments submitted by authors such as Roscoe (2009) and excludes the implications within the counseling and counselor supervision settings. Therefore, I will briefly review the historical development of the wellness construct, provide an overview of holistic approaches within the counseling setting, and discuss the importance of personal and professional wellness within the field of counselor education and supervision.

Historical Development of the Wellness Construct

One of the earliest accounts of wellness and healing was attributed to Asclepius, the Greek god of healing and medicine, whose daughter Hygeia promoted the contention that illness can be prevented through education about healthy ways to live (Hart, 2000). Myers and Sweeney (2005) have credited this duo as initiating the wellness movement over 2,000 years ago and also added that developments since this time have been intermittent and usually consigned to the status of alternative medicine practices and other non-scientific methods of healing. Regardless, the mention of wellness

perspectives and attending to positive aspects of human functioning has a well documented history among philosophers and practitioners alike.

Aristotle is frequently credited as being the first to extensively write about a theory of wellness. In his work *The Nicomachean Ethics*, Aristotle presents an argument for a guiding practice to establish a sense of eudaemonia, or the happiness of one's spirit (Aristotle, book II). When presenting his argument, Aristotle recommended that individuals should strive to find the balance between excess and deficiency. He suggested that an individual is in a state of optimum wellness and flourishing when moderation and balance establish a *golden mean*. Aristotle further insisted that establishing the golden mean between excess and deficiency was not a process mediated by fortune, but instead required a person to exhibit a deliberate choice by noting "it is incumbent on us to control the character of our activities, since on the quality of these depends the quality of our dispositions" (Aristotle, Book II, p. 34). This initial theory of wellness, grounded in moderate and personal responsibility is evidenced today in cultural adages such as "everything in moderation" and "nothing in excess."

Over 2,000 years later, helping professionals begun extend take on the charge of Asclepius, Hygeia, and Aristotle in Western society and questioned the overt emphasis on the body alone and curing disease management as the goals of helping professionals. Myers (2009) credited Alfred Adler as the champion of the modern day wellness movement in western culture through recognition of the limitation to a medical model of treatment. Myers noted that Adler's Individual Psychology was the predecessor of what eventually evolved into the field of *positive psychology*. Alder's insistence on prevention and post hoc treatment contingent upon principles such as social interest to the

community, teleology of present actions to fulfilling self-directed goals, and the influence of relationships suggested a synergy between the lesser wholes of an individual's life into a greater one. Through this contention a more holistic perspective that considered work, friendship, love, spirituality and sense of coping with self as unifying principles of the integrated person was postulated (Sweeney, 2009).

Sometime after Adler, Dunn (1957, 1959) called to the helping community to become more health oriented stating that rather than the absence of disease. He added that medical professionals and psychiatrists had forgotten that an individual could not be separated into the biological, social, and mental aspects of themselves. Furthermore, Dunn (1959) incensed the helping profession for excluding the *spirit of man* from their treatment protocols noting a trend to dole out the responsibilities for treating an individual among professions. He noted,

“we have tended to subdivide the study of man into three major areas- the body, primarily the concern of the physician; the mind, largely the concern of the educator, psychiatrist and psychologist; and the spirit, entrusted to the custody of the religious preceptors. Similarly, we have been inclined to consign the development and maintenance of man's physical, social, and economic environment largely to economic and political leaders” (Dunn, 1959, p. 789).

This statement has remained a testament to the difficulties that helping professionals have faced in overcoming the challenges of the illness-oriented model of health and mental health care embraced by Western culture for hundreds of years.

Dunn's contention that individuals were more than the sum of their deficiencies and should not be artificially divided as such was embraced and proselytized during the

early 1980's by Bill Hettler (1984, 1986). Hettler (1984) proposed an expanded model of personal wellness that encompassed six aspects of the self which were integrated and complementary in persons demonstrating high levels of wellness and thriving: occupational, emotional, social, intellectual, physical, and spiritual. Hettler suggested that the tangible individual that helping professionals see is the manifestation of their status within these six dimensions of functioning. Furthermore, Hettler, like Aristotle, suggested that it is every individual's personal responsibility to pursue opportunities for thriving and that systemic organizations should provide relevant avenues to do so. Myers and Sweeney (2005b) noted that this proposal was not only well received by American society, but made substantial subsequent impact on health policy after being adopted by groups such as the YMCA, President Council on Physical Fitness and Sports, and the American Counseling Association. It may be argued that in relation to wellness within the educational setting Hettler's (1986) greatest contribution came when he challenged universities to promote the wellness of their students while preparing for transition to post-graduate life.

Contemporary wellness discussion generally has referenced the work of Jane Myers and her colleagues (Hattie, Myers, & Sweeney, 2004; Myers, 1992; Myers & Sweeney, 2005a; Myers, Sweeney, & Witmer, 1998). The work of these authors in developing an evidence based model of wellness has most recently been represented by the Indivisible Self model of wellness (ISWEL; Myers & Sweeney, 2005a). The IS-WEL model of wellness emerged from structural equation modeling procedures using a large data base of completed protocols (N=3,343) of the Wellness Evaluation of Lifestyle inventory (Hattie, Myers, & Sweeney, 2004). What emerged from the analysis was a

model of individuals as an integrated being in which changes in one aspect of their life affects their overall wellness. Responses to the inventory's items were clustered into five second-order factors of the self based on the essential life tasks originally cited by Adler and later explicated by Dreikurs and Mosak (1967; Mosak and Dreikurs, 1967): Creative Self, Coping Self, Social Self, Essential Self, and Physical Self, which contribute to an overall level of personal wellness (Hattie, Myers, & Sweeney, 2004, Myers & Sweeney, 2005a). These authors also identified 17 third-order variables that are subsumed within these domains (see figure 1). Because of the research base which has provided acceptable statistical support for this model and the ease with which the model can be described and implemented in educational and clinical settings, the IS-WEL model has been utilized by practitioners (see Granello, 2000; Myers & Sweeney, 2005b). In addition to the practical utility of the IS-WEL model when working with clients, the IS-WEL has been utilized in many empirical investigations related to counseling and psychology education (Choate & Smith, 2005; Hartwig & Myers, 2003; Spurgeon & Myers, 2002).

Most recently, Roscoe (2009) extensively reviewed the literature addressing the development of the wellness construct within the helping profession. Roscoe suggested that the five second-order factors included in the IS-WEL model (Myers & Sweeney, 2005) represented the contemporary state of wellness construct development, but added that environmental wellness variables such as pollution and conservation should be included in dialogue about assessment and theory. Roscoe also noted that the wellness is conceptualized as "a synergistic and multidimensional construct that is represented on a continuum, and not as an end state" (Roscoe, 2009, p. 222). Roscoe also highlighted the

importance of a defining, assessing, and evaluating the wellness construct within educational settings as a means to create momentum for professional practice and research.

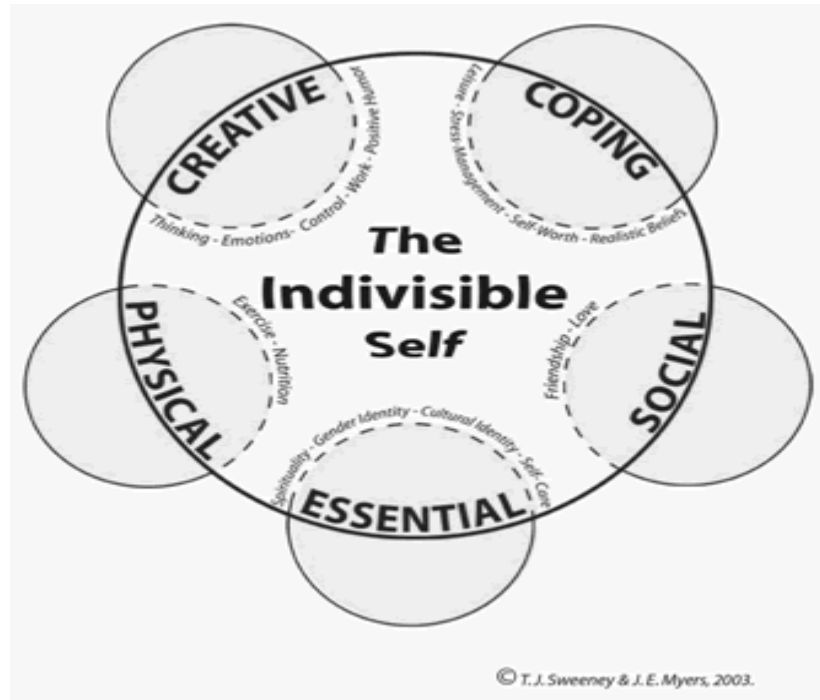
Contemporary Measurement of Wellness

Although Hettler and others have provided some useful assessments of personal wellness, the Five Factor Wellness Inventory (5F-WEL, Myers & Sweeney, 2005c) is an evidence-based tool “designed to identify factors that are central to healthy living, and which represent domains of human functioning in which personality responsibility and choice will have positive effects on well being” (Myers & Sweeney, 2005c, p.1). The results of the 5F-WEL are intended to assist individuals in making choices for healthier living which may promote longevity and happiness. The 5F-WEL is based on IS-WEL model (Myers & Sweeney, 2005a). In this model, the global construct of wellness is composed of 5 second-order factors (the Coping Self, Social Self, Creative Self, Essential Self, and the Physical Self) which are defined by 17 third-order factors subsumed under the second order factors in varying amounts (see Figure 1). These factors have been postulated as integrated components affecting individual wellness in which change in one area is likely to affect general wellness, as well as the other domains in the model (Myers, *et al.*, 2000).

The adult version of the 5F-WEL is composed of 91 items, with between 4 and 6 items representing each third-order factor. The 5F-WEL boasts a normative sample of 3,343 individuals (1,173 males) of American Indian, African American, Asian American, Caucasian, and Hispanic ethnicities (Myers & Sweeney, 2005a). Five Factor-WEL items

Figure 1.

Indivisible Self Model of Wellness (Myers & Sweeney, 2005a)



are 4 point Likert-type prompts in which the individual responds to positively worded prompts (e.g. I eat a healthy diet) on a continuum ranging from strongly disagree, disagree, agree, and strongly agree in which 1, 2, 3, and 4 points are contributed to the individuals score respectively (Myers & Sweeney, 2005c). The scores in the overall wellness, second-order, and third order domains range between 25 and 100 with varying means for males and females and between ethnic groups. These raw scores are calculated using linear transformation in which total points are divided by the number of items within a scale and then multiplied by 25. The raw scores are then plotted with strengths and weakness being the focus of intervention protocols. This method has been regarded as a user friendly means for converting 5F-WEL data into meaningful representations for both practitioners and researchers.

Measurement limitations associated with the 5F-WEL are related to the reliability of third order factors, the degree to which the instrument account for scores between participants, and the appropriateness of a 5 factor model. For instance, DeMauro (2007) noted that while reliability evidence related to alpha coefficients for the 5F-WEL is robust for the general wellness (.94) and second order factors (.90 - .94) reliability becomes much more variable when examining the internal consistency of third-order factors. Additionally, while many successful applications of the 5F-WEL have been noted in empirical research studies within the counseling profession (Choate & Smith, 2005; Hartwig, 2003; Myers, Mobley, & Booth, 2003; Spurgeon & Myers, 2002), it has been suggested that a 4 factor structural model may provide a better instrument for exploring the relationships between wellness and other variables (Myers, Luecht, & Sweeney, 2004). Although preliminary factor analysis supported a 5 factor model (Hattie, Myers, Sweeney, 2004), these authors noted that the 5 factor model accounts for 32% of the variance in scores with a large proportion of test items that have similar coefficients across factors. This convolutes the process to place third-order variables (e.g. spirituality and ethnic identity) concretely into a second-order factor (e.g., Essential Self). While these psychometric limitations are present, the 5 F-WEL has continued to be regarded as a practical instrument for assisting individuals in developing wellness plans and creating positive changes in their lives (Myers, Luecht, & Sweeney, 2004).

Importance of Wellness within Counselor Education and Supervision

The American Counseling Association has recognized importance of the counselor's wellness as related to the development of professional identity and responsibility to clients (ACA, 2005). Supported this contention, the Council for

Accreditation of Counseling and Related Educational Programs (CACREP, 2009) recently required counselor education programs to demonstrate student learning objectives for wellness in their curricula, and noted that graduates should be able to demonstrate proficient in implementing “self-care strategies appropriate to the counselor role” (Section II.G.1.d), “theories for facilitating optimal development and wellness over the life span” (Section II.G.3.h), and “an orientation to wellness and prevention as desired counseling goals” (Section II.G.5.a) (CACREP, 2009). Despite these prerequisites, there has remained a scarcity of supervision models that overtly emphasize the wellness of CITs and their clients. Therefore, I propose that the Wellness Model of Supervision (WELMS) presented and evaluated here may provide an appropriate contribution for counseling and other related educational programs at this time.

Counselors, CITs, and other mental health professionals are frequently subjected to stress-producing factors that have the potential to deplete physical and mental resources which may jeopardize individual wellness. Stoltenberg (1981) noted early that it is common for the tempo of graduate training and the demands placed on CITs to increase drastically in the absence of a corresponding readjustment and strengthening of the inner self. Researchers interested in the wellness of counselors have increasingly noted this trend. For instance, Myers, Mobley, and Booth (2003) suggested that initially graduate students that have professionally identified with counseling demonstrate greater wellness when compared to the general population. Unfortunately, Roach and Young (2007) suggested that counselor education programs have little impact in either sustaining or cultivating the wellness of these students. Smith, Robinson, and Young (2007) provided evidence for this contention and demonstrated that the overall wellness of CITs

was affected by their increased exposure to psychological distress associated with academic and practical training experiences. A recent national survey of post-graduate American counselors corroborated this contention and indicated that a substantial number of counselors are presently at risk for burnout, compassion fatigue and vicarious trauma (Lawson, 2007). The implications of Lawson's inquiry are dire when considering that burnout, compassion fatigue, and vicarious trauma are associated with deleterious outcomes for both counselor and client. The results of these researchers' inquiries suggested that CITs are not only at greater risk for psychological distress, but that associated impairments may carry over into their careers.

Numerous accounts identifying the potential of the supervisory role in assuaging the risk for vicarious trauma and compassion fatigue among helping professionals have been provided (Bober & Regehr, 2006; Harrison & Westwood, 2009; Hesse, 2002; Trippany, Kress, & Wilcoxon, 2004). These authors' contentions have been noted in both anecdotal statements and clinical lore which has implied that due to the characteristic nature of counseling referrals and interventions, individuals in this field are at risk for professional disenchantment and dissolution due to insufficient occupational, emotional, social, intellectual, physical, and spiritual maintenance. The accommodating potential for an emphasis on personal and professional wellness within the supervisory relationship may be realized as helping professionals concede that CITs may not be receiving the primary wellness interventions during their preparation that may be conducive to maintaining higher wellness functioning and resilience. Therefore, a model such as the WELMS which overtly integrates wellness variables and a holistic treatment

model approach to supervision may facilitate an environment that maximizes individual wellness in a unique, sensitive, organized and ethically responsible manner.

Trend Toward Integrative Models of Supervision

Although several models of supervision have claimed to be comprehensive in nature (Chambers & Long, 1995; Stoltenberg, McNeil, & Delworth, 1998; Vandenberghe, 2009), some practitioners have begun to implement integrated approaches to supervision across theoretical contexts to meet the needs of CITs. Haynes, Corey and Moulton (2003) argued that practical use of integrated models of supervision appeared to be intuitive considering that many practitioners use integrated approaches when working with clients. These models incorporate more than one theory or technique to provide the developmental experiences required for CITs to achieve when confronted with a diverse set of clientele and workplace issues. Nelson, Johnson, and Thorngren (2000) noted: “the integrated approach provides a practical tool for conceptualizing and implementing the supervision process. Supervisors will find flexibility in the roles they assume with supervisees, and supervisees will benefit from a model that considers their own developing processes and differing needs” (p. 42). Of particular interest to the investigation of the WELMS are previous models that have infused wellness concepts, albeit inherently by virtue of their fundamental assumptions.

Supervision Models that Infuse Wellness Concepts

There have been a burgeoning number of clinical supervision models presented over the past two decades. Although several models claim to be comprehensive in nature most are identified by a particular dimension or theory as: developmental, cognitive behavioral, and solution-focused. Many models however define themselves as

integrative. Lenz and Smith (2010) noted that most integrative models infuse some aspects of wellness.

Developmental models of supervision have often implicitly attended to wellness variables. For example, the previously discussed the Integrated Developmental Model (IDM) proposed by Stoltenberg and Delworth (1987), emphasized four levels of development across eight counselor functioning domains. In addition to an emphasis on the supervisee's cognitive development, wellness concepts of self and other awareness, coping, motivation, and autonomy are examined. This integrative supervision model considers cultural differences and has recently been presented from an evidence-based perspective (Stoltenberg & McNeill, 2009). Bernard's Discrimination Model of Clinical Supervision is another example of an integrative model (Bernard & Goodyear, 2009). The foundation of this model involves the supervisory roles of teacher, counselor, or consultant during the course of supervision. Skill building is emphasized as related to process, conceptualization, and personal development. Concepts of wellness are discretely infused in this model by the supervisor through the skill building domains and personalization of practice during supervision. Both of these models implicitly attend to wellness domains such as work, thinking, realistic beliefs and self-worth as identified in the IS-WEL model (Myers & Sweeney, 2005a).

Foy and Breunlin (1995) described integrative supervision from a metaframeworks perspective which also encompasses second and third order wellness domains as described by Myers and Sweeney (2005a). This model of integrative supervision is grounded in the following principles: everything is relevant, the theory used in supervision must be relevant to the problem at hand, constraints are most

relevant, and constraints are manifested in the actions, meaning, and emotion, existing within the biopsychosocial system of the individual. Constraints are categorized as organization, sequences, development, mind, culture, and gender. In this integrative supervision approach the relationship between the supervisor and counselor is considered to be the vehicle to determining and developing CIT personal wellness. The special attention given to variables such as cultural identity, gender identity, emotions and meaning are consistent with descriptions of self postulated in the IS-WEL model.

Finally, the Integrative Couple Therapy Model (ICT) proposed by Smith (2001) established the foundation for the Integrative/Contextual Supervision Model (I/C-SM). This approach emphasized the relationship between the supervisor and therapist for facilitating the development of CITs across many domains. The I/C-SM regards context (setting and culture of therapy), personal characteristics of the supervisor, supervisee, and clients, the relationship skill level of the supervisor, supervisee, and clients, and relevant theories and techniques as critical variables which affect the outcome of training experiences. Perhaps most accommodating for integration of wellness variables is the flexible framework that emphasizes facilitative, cognitive-behavioral, and psychoeducational processes during supervision which are conducive to educational, assessment, planning and evaluation practices implemented using the WELMS.

The above integrative supervision models have infused wellness over the course of supervision implicitly. However, none of the illustrated models has as a cornerstone value the professional and personal wellness development of the CIT. Without such a model it may be a dawdling road to meeting the student learning outcomes required by *CACREP Standards* (CACREP, 2009) and the professional identity noted in the ACA

Code of Ethics (ACA, 2005). Therefore, because wellness is regarded as a vital educational and professional factor for counseling professional, the need for wellness as the lynchpin within a supervision model is apparent. Lenz and Smith (2010) proposed that the WELMS is one such model.

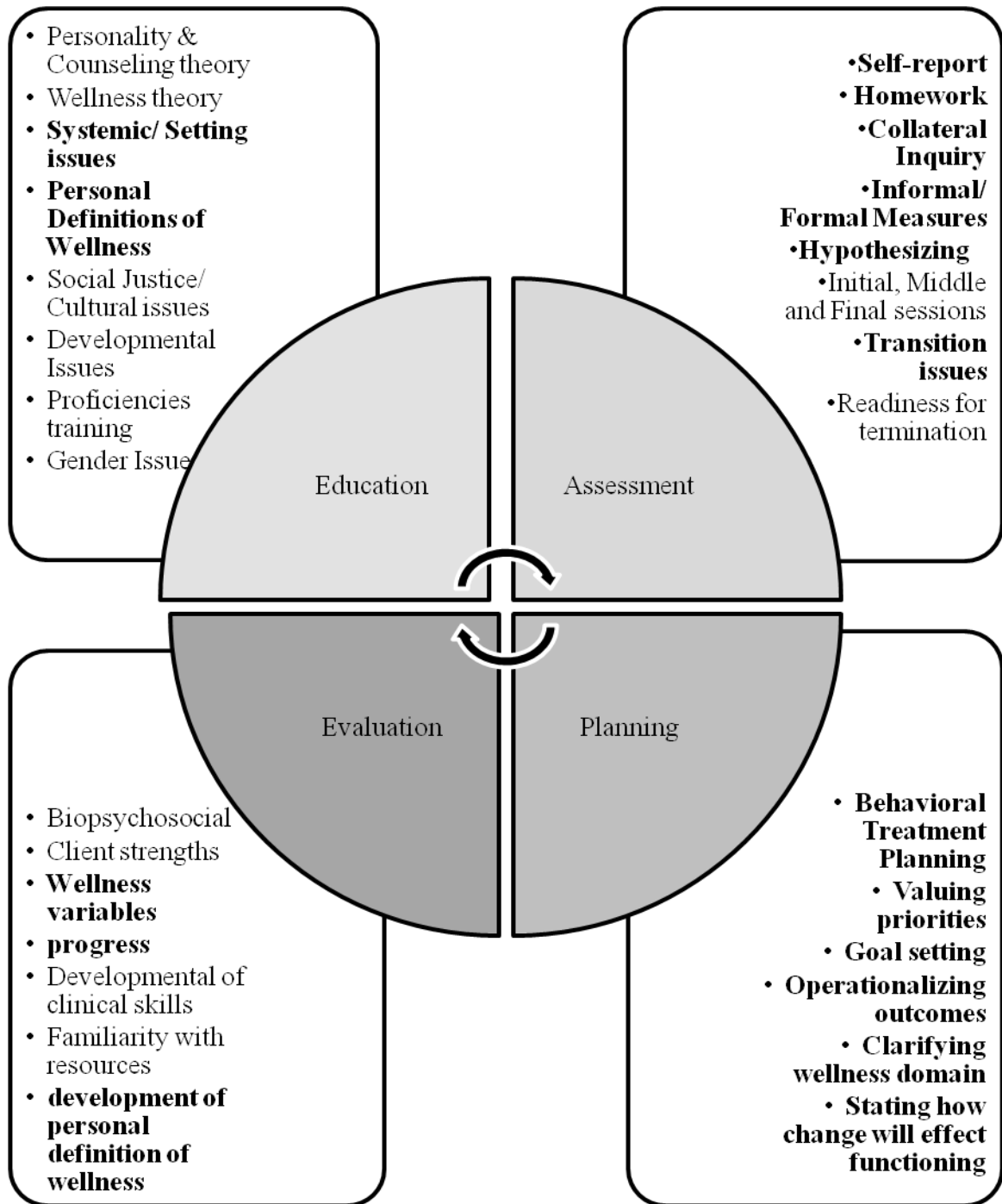
Wellness Model of Supervision

Myers and colleagues (Myers & Sweeney, 2005; Myers, Sweeney, & Granello, 2000; Granello, 2000) have illustrated a holistic, wellness-based approach of client care that was implemented for CIT development. They proposed that personal wellness development relies on the following: education about wellness concepts, self-assessment, planning of goals, and systematic evaluation of progress. As noted in the review of supervision approaches that have influenced the process assumptions of the WELMS, clinical models are frequently the basis of models for supervision. Therefore, these fundamental elements of education, assessment, planning, and evaluation have provided the basis for the WELMS when supervising counselors, CITs, mental health case managers, and other related professionals (Figure 2).

Education. As noted in Figure 2, a fundamental understanding about personal and formal theories of wellness is at the core of the WELMS model. During this educational process supervisees are encouraged to explore and continually refine their own personal definitions of wellness. This process begins during the initial session where the supervisor queries the supervisee's personal definition of wellness. Alternatively, this assignment can be provided as homework for the CIT. Periodically, CITs are encouraged to discuss their dynamic conception of wellness in relation to personal and professional experiences.

Figure 2.

Content and process when using the Wellness Model of Supervision



Through this process the supervisor attempts to help the CIT think about wellness actively and discover as sense of personal meaning of the construct as they engage in their training and how this client cases may be conceptualized using this lens. It is hoped that with supportive encouragement and guidance from their supervisor, wellness education relevant to the CIT's experiences may be associated with enduring expansion and ownership of their schema about the construct.

Additionally, the role of the supervisor is to educate CITs about formal models of wellness available in the literature. This orientation begins with an introduction to healthy living and positive, strengths-based perspectives. A wide range of theories of wellness (e.g., Hettler, 1980; Myers & Sweeney, 2005a; & Roscoe, 2009) are introduced to CITs who are encouraged to talk about the concepts included in these models that resonate with them. The supervisor provides the CIT with information about the models using a variety of resources ranging from scholarly publications to internet resources. As homework assignments, the supervisor encourages the CIT to conduct their own inquiries, become familiar with the numerous models available and adopt one that makes sense to them. Relevant aspects of domains of wellness in relation to client cases are discussed in an effort to reinforce CIT learning about holistic perspectives. The educational aspect of this model provides a platform from which the supervisor can model the psychoeducational function of counseling interventions for the CIT, a process that can also be discussed.

Assessment. Appraisal of wellness (Figure 2) is another cornerstone of the WELMS. The purpose of regular self-assessment in the WELMS is twofold: 1) Form a professional perspective, assessment provides a training experience for CITs to develop

their skills with appraisal and interpretation in an experiential format, and 2) CITs obtain a more defined and objective measurement of their personal level of wellness. This process can occur informally and formally both during and/ or between supervision sessions. Assessment practices are ongoing starting in the initial session and lasting the duration of the supervisory relationship. The assessment of the CIT's wellness often begins subjectively and becomes more objective over time. During this process the supervisor's role is that of evaluator, educator, and guide. Lenz and Smith (2010) noted that genuine CIT participation during the assessment process is facilitated to a greater degree when the fear of judgment is assuaged and rapport is established between supervisor and CIT.

One method of informal assessment is dialoguing between supervisor and supervisee. Myers et al. (2000) suggested that an informal assessment of wellness can begin with general conversations or informal interviews. Supervisors can implement a number of flexible formats for informal assessment including the paper and pencil strategy discussed by Myers and Sweeney (2005) or a card sort task such as that discussed by Roscoe (2006). Although informal assessments are quick, relatively inexpensive to produce and readily interpreted, they do not lend themselves to rigorous evaluation practices such as those available through quantitative methods.

For a more quantitative assessment of wellness functioning, some have proposed the use of scaling questions rating both global and specific wellness domains on a scale of 1 (low) to 10 (high) (Myers et al., 2000; Myers & Sweeney, 2005a). Lenz and Smith noted that this strategy is complimentary to strengths-based perspectives of intervention including solution-focused techniques. For instance, CITs can provide ratings of their

subjective level of wellness, their personal satisfaction with that rating, and the desired level of a particular wellness variable using the 10-point scale format. From this data, the CIT can begin to view their strengths and areas for growth from a new, measurable perspective. One advantage of implementing this scaling assessment is that constructive objectivity is parsimoniously created between the supervisor and CIT.

In addition to informal assessments, there are a number of formal wellness appraisals available for use by supervisors and supervisees via the internet and more traditional scholarly resources. Myers and Sweeney (2005b) provided links to a number of free wellness assessments such as the LiveWell (Hettler, 2007), available at www.hettler.com that can be easily accessed and utilized. Although these assessments are brief and user friendly, the majority of them lack the sufficient validity and reliability necessary for rigorous research regarding supervision outcomes. The Five Factor Wellness Inventory (5F-WEL; Myers & Sweeney, 2005c) on the other hand, is an evidence-based tool “designed to identify factors that are central to healthy living” with acceptable psychometric properties (Myers & Sweeney, 2005c, p. 1). The results of the 5F-WEL were intended to support individuals while making plans for living a healthier, fuller life. Myers and Sweeney (2005c) used the IS-WEL as the organizing theory underlying the 5F-WEL (Myers & Sweeney, 2005c).

Lenz and Smith (2010) recommended using discretion when deciding to whether deciding to implement informal or formal assessments due to financial and CIT developmental variables. To safeguard against sensitivity, it is recommended that although the supervisor guides the supervisee through the assessment findings to begin a dialogue about initial impressions, the CIT should direct the dialogue regarding

impressions of data. Also, it may be helpful to dialogue the ways in which the supervisee perceives this domain to be affecting their life. Following a review of assessment results and the CIT reports a personal understanding of what the data means to them and how these factors influence their personal lives and their work with their clients, the planning of personal wellness interventions can begin.

Planning. Consistent with the model presented by Myers and Sweeney (2000, 2005), Lenz and Smith (2010) recommended that personal wellness planning begin with the CIT self-selecting one or two areas for improvement. It was recommended that supervisors discourage CITs developing goals for multiple of all domains to avoid being overwhelmed and engaging in a task that is insurmountable task. Because wellness has been regarded as a multifaceted and integrated construct (Dunn, 1967; Hettler, 1984; Myers & Sweeney, 2005; Roscoe, 2009) it has been proposed that change in one domain will likely increase an individual's overall wellness. Strategies to assist the CIT in begin transforming assessment data into personal planning includes prioritizing domains, examining the likelihood of completing the behavioral tasks associated with desired outcomes, and examining the large deviations between extreme scores.

After the CIT identifies the wellness domain that they would like to change, the supervisor guides the supervisee in developing a personal wellness plan. During this process, the supervisor can implement a number of supervision strategies to identify resistance, negative thinking, irrational conceptualizations, and exceptions to the deficits, while still demonstrating a supportive, authentic, and respectful regard for the supervisee. The supervisor's during personal wellness planning is that of facilitator in helping the supervisee in developing a personal wellness plan rather than an authority on how the

supervisee should be living. The planning process culminates when the CIT has completed a written developmental plan with the supervisor that addresses five objectives: 1.) defining the wellness domain to be enhanced using a definition that makes sense to them, 2.) a rating of the CIT's present degree of satisfaction with self in this domain on a scale of 1-10, 3.) writing a narrative prospecting how desired changes in this domain may affect self and work with clients, 4.) identifying interventions including objectives, behavioral terminology, including people involved and resources to be used, and finally, 5.) documenting how they know that progress has been made toward their goal. In addition to providing a objective, behavioral plan, this activity is also intended to be used as an example of constructive and nonjudgmental treatment planning with clients.

Evaluation. A well organized and strategic personal wellness plan provides a useful tool for evaluation of CIT progress toward goals analogous to treatment reviews conducted with their clients. Lenz and Smith (2010) suggested that periodic evaluation and reflection of CIT progress toward wellness objectives should include dialogue about how successes and barriers have influenced the CIT's sense of self both personally and professionally. Supervisors encouraged supervisees' to use a wellness journal to track a transformation of their personal and professional achievements associated with the WELMS. Informal evaluations can occur periodically with supervisors who are encouraged to provide prudent, supportive guidance. As discussed previously, more formal evaluations can be mediated through the resources available at www.nationalwellness.org, www.wellnessinventory.net, www.hettler.com, or using the 5F-WEL. To avoid practice effects and the Hawthorne effect, Lenz and Smith (2010)

recommended that formal assessments be used judiciously. Lenz and Smith also noted that visual representations of change can enhance the discussion about changes over time. Typically, CIT gains are acknowledged using a number of strategies including encouraging statements, certificates, supportive letters, and commemorations.

Fundamental Assumptions

Lenz and Smith (2010) initially noted four primary assumptions inherent within the process structure of the WELMS: modeling ongoing wellness development and a holistic perspective for supervisees, a reliance on continual assessment, planning and evaluation, CIT-selected domains for development in a facilitative context, and the use of personal processes as a training tool for skills that may benefit clients. Since then, an additional assumption has been proposed by the first author: exposure to the developmental, wellness approach to case conceptualization and intervention in supervision positively influences CIT practice via the sociobiological variables associated with cognitive schema priming as described by social psychologists such as Bargh (2006), Martin, Fink, Laine, and Ayala (2004), and Wheeler, DeMarree, and Petty (2007). The following is a brief overview of these assumptions.

The functional importance of the supervisor educating, modeling and practicing personal wellness development and holistic case conceptualization with CITs was captured by Shulman (2005b) who stated that “more is caught than taught” in supervision (p. 24). This contention suggested that supervisees are likely to do what they see their supervisor do rather than what they tell them to do. The mantra behind this argument is adequately noted in the aphorism “be the change you want to see in the world” which has been attached to several movements in the counseling profession, including wellness.

Lenz and Smith suggested that the supervisor's personal and professional commitment to wellness development in themselves as well as supervisees and clients is closely related to the parallel process that occurs in any supervisory relationship (Russell, Crimmings, & Lent, 1984).

Due to the complex nature of CIT development and the supervisory relationship, leading by example alone is not enough to establish an environment that values consistency with commitment to change. Therefore, another assumption of the WELMS is that continual assessment and evaluation of supervisees' wellness is an imperative, yet sensitive activity. As previously noted, supervisors should incrementally monitor the development and progress of each CIT's wellness objectives using behavioral-oriented outcomes and assessments appropriate to CIT developmental level and access to resources. Subsequently, discussion and modification of CIT goals should be discussed collaboratively. Lenz and Smith referenced guidelines proposed by Heckman-Stone (2003) who noted that supervisees tend to prefer "clear expectations, constructive evaluations, regular direct observation, positive feedback, encouragement to perform, self-evaluation, formal evaluation, and discussion" when engaging in the professional development process (p. 24). In addition, short and long term goals should be markers for measurable objectives that signify progress and ensure continuity.

A third assumption of the WELMS is that attending to the CIT's personal and professional development of wellness-related concepts in supervision should be facilitated in an environment that exhibits the core conditions of empathy, genuineness, and unconditional positive regard as described by Rogers (1957, 1993). These characteristics are associated with establishing a working alliance was recommended by

Lenz and Smith (2010) to encourage a non-critical supervisory climate. This approach is not only intended to limit personal judgments, but also may encourage the CIT to find their own expression of the process.

As noted by Yegdich (1999), supervision is not therapy and to assure that client issues are attended to, Lenz and Smith (2010) recommended that attending to wellness principles of supervisees should not encompass the majority of the supervision objectives. When using the WELMS, these authors recommended that an orientation to supervision be implemented to educate CITs on the model and expectations for supervision in general. Typically, attention to CIT personal wellness objectives will not represent more than 20- 40% of the supervisory hour. Traditional client management supervision strategies such as case conceptualization, diagnostic concerns, ethical issues, professional development, establishing helping relationships, treatment planning, hypothesizing and suggesting interventions comprise the remainder of the session. The content relevant to each phase of supervision and associations with the CIT developmental process is represented in Figure 2 with the items in bold representing wellness concepts that have been infused into clinical supervision. Furthermore, as illustrated by the linear sequence in Figure 2, wellness education, assessment, planning, and evaluation is initially a linear process with each stage providing the necessary foundation for the next. From that point on the supervision domains and process become integrated in nature with all facets of the supervision process informing the others.

The most recent assumption regarding the WELMS model regards the manner through which CITs schemas develop and are expressed via the WELMS process.

Priming is the process by which an individual exposure to a recent event or phenomenon

increases the activation of associated schemas (Akert, Aronson, & Wilson, 2005). Bargh (2006) recently reviewed the extensive literature on the substantial effects that activating stimuli can have on nonconscious subsequent behavior including the expression of stereotypes, biases and emotional expression. It is supposed that the WELMS mediates CIT conceptualizing and expression of the holistic, wellness oriented model through activating this schema prior to discussing client-related issues such as presenting issues, resiliency factors, and treatment approaches. The strategy of *priming* CITs to view their professional and personal development from a holistic, wellness perspective during supervision as a means to have them approach clients in a similar manner appears to be indicated given Bargh's (2006) suggestion that even complex conceptual structures can emerge in a behavioral repertoire following repeated interaction and negotiation with a particular phenomenon in the environment. In addition to discussions associated with wellness education, assessment, planning, and evaluation, it is common practice when using the WELMS to have media such as screen savers, posters and pictures depicting positive wellness concepts in the supervisory environment.

Recent Research and Scholarship in Supervision

Within the last decade the standard of the scientist-practitioner paradigm has been associated with an increased number of research and scholarship in the field of counselor supervision. Despite this increase in scholarly activity, an overwhelming majority of these articles have not implemented empirical quantitative strategies to assess the development of CITs. I will provide a review the recent growth of commentary regarding quantitative evaluations of supervisory practices published within the peer-reviewed journals published by the American Counseling Association.

Borders (2006) provided a five year review of articles within ACA journals addressing supervision practices published between the years of 1999 and 2004. This snapshot of publications noted that approximately 36% of the articles addressing counselor supervision practices were quantitative empirical studies with the majority being conceptual works (55%). Although nearly one third may seem like a noteworthy proportion of the articles published, in her analysis Borders defined quantitative studies as experimental studies, descriptive studies, *ex post facto* studies, and survey data. When describing the common themes associated with conceptual manuscripts, Borders noted that instructive case illustration highlighting multicultural and relational practices were most frequent. From this analysis a number of poignant caveats may be extracted. Foremost, a majority of the articles classified as quantitative were large surveys and lacked any manipulation of variables associated with process and outcome. This observation suggests that counselor educators and supervisors have either been primarily interested in exploring relationships or are in contexts that have limited access to strategies within the supervisory relationship. Furthermore, the review provided by Borders does not provide any indication of the frequency of either experimental or quasi-experimental studies subsumed under the category of empirical research. However, given the contemporary emphasis on evidence-based practices, at the time, Borders' review appears to substantiate claims citing a deficit of rigorous studies that "enhance supervision practice and refine supervisor training" (p. 108).

While reviewing supervision articles published in peer-reviewed psychology journals during the same time frame, Goodyear, Bunch, and Claiborn (2005) noted a similar trend detected by Borders (2006). Goodyear, et al. (2005) identified 49 articles in

across 11 popular psychology journals (e.g. *Professional Psychology: Research and Practice*) that directly addressed the topic of supervision practice. Their findings included corroborated a trend toward conceptual products (46%) in favor of quantitative evaluations of supervisory practices (24%). Unlike the review produced by Borders (2006), Goodyear, et al. (2005) did identify a single quantitative study evaluating the effectiveness of supervision practices (Norrie, Eggleston, & Ringer, 2003). Similar to the articles surveyed in the counseling literature, the literature promulgated by the psychology profession also lacks studies that can make claims regarding cause and effect relationships between variables in supervision and outcomes.

The reviews provided by Borders (2006) and Goodyear, et al. (2005) have illustrated a number of trends that are related to the investigation of the WELMS. Foremost, although several conceptual and illustrative articles have been proposed such as that by Lenz and Smith (2010), few have followed up proposals with empirical quantitative studies that identify whether or not these models are effective in meeting the desired outcome. Secondly, an increase in rigorous and quantitative investigations of supervisory practices may increase the accountability and credibility of both supervisors and counseling professionals. Finally, an increase in quantitative empirical methods for reviewing supervisory strategies may provide templates and examples for burgeoning scientist-practitioners to replicate or modify regardless of whether these models are demonstrated as successful in promoting counselor development.

Measuring Counselor Development

Counselor educators and supervisors have a critical role in both promoting CIT development and initiating gate keeping protocols for students that are harmful to self or

others in the professional setting. Although graduate students have generally performed well academically and were admitted to their programs following academic rites of passage, several authors have noted the inconclusive ability of predicting counselor development and performance when working with clients based solely upon assessments such as aptitude tests (Eriksen & McAuliffe, 2006), academic achievement indices (Roberts, Bordin, Christianson, & Lopez, 2005), or other fundamental characteristics such as race or nationality (Bikos & Uruk, 2005).

Sheppard, Britton and Kress (2008) recently commented that the measurement of counselor development is a daunting task. In particular Sheppard, et al. cited the ambiguous nature of *counseling competence* as the primary barrier preventing stable and general acceptance of assessment reliability and validity. These authors noted that, in general, “competence-related instruments that demonstrate positive psychometric properties focus on in-session skills and do not address the full array of attributes that define competence” such as out of session tasks. Sheppard et al. continued to note that in the face of a nonconsensus regarding what proficient CITs look like, counselor educator and supervisors evaluate supervisees using their subjective version of a broad and general definition of competence.

Gonsalvez and McLeod (2008) recently suggested that assessments of counselor development may not only be useful for determining whether a CIT is progressing adequately, but also to assess the effectiveness of supervisory strategies. From an empirical perspective, if two models of supervision were compared against one another, the model that contributed to CIT development at a greater degree may be identified as more effective in facilitating counselor development. One assessment of interest for the

measurement of CIT development using the WELMS is the *Counseling Skills Scale* (CSS, Eriksen & McAuliffe, 2003).

The CSS was developed from an analysis of strategy checklists, feedback from a sampled group of experts in the field of counselor education, and is designed to evaluate the “effectiveness of counseling skills performance” (Erikson & McAuliffe, 2003, p. 127). Ivey, Gluckstern-Packard, and Ivey, (2007) noted that the results of the CSS were intended to guide the development of CITs and identify the specific microskills that contributed to positive counseling interventions. When an evaluator is using this measure, an overall the trainee’s score is composed of 22 skills grouped into 6 subcategories (Interest, Exploration, Deepening, Change, Relationship, and Management) based on a real time viewing of a counseling interaction. These component skills have been presented as representative of the standard for counseling skills and are reportedly grounded in contemporary research on effective counseling such as those investigated recently by some authors (Alberta & Wood, 2009; Trepal, Haberstroh, Duffey, & Evans, 2007).

The CSS is composed of 22 items, with between 1 and 5 items representing each subcategory. The initial reliability and construct validity measures for these items are based on a small sample of 29 individuals (17 males) of Caucasian, African-American, and Asian-American ethnicities (Eriksen & McAuliffe, 2003). CSS items are a 5-point Likert-type scale ranging from +2 *Highly developed* to -2 *Major adjustment needed*. Scores within each subcategory are totaled and divided by the number of items in that scale to calculate an average score within the domain. Scoring of the CSS is regarded as

user friendly for persons who have completed the preparatory training course and provides immediate feedback to trainees, supervisors, and researchers.

Although several authors (Eriksen & McAuliffe, 2006; Gonsalvez & McLeod, 2008; Sheppard, et al., 2008) have suggested that measuring CIT development is presently an imperfect practice, nonetheless scientist practitioners cannot wait for perfect measures to surface before evaluating supervisory practices. The CSS presented and developed by Eriksen and McAuliffe (2003) has provided one assessment that may be implemented to not only assess CIT development, but also to evaluate the efficacy of supervisory modalities.

Conclusions

As the signature pedagogy of the helping professions, historical developments regarding supervision of applied experiences have resulted in a valued practice. This oversight provided to Master's level CITs from either a doctoral student familiar with supervision models and practice or a more senior faculty member with similar education and greater degree of experience is crucial in fostering the development of clinical skills, professional identity, and enhancing personal development. In addition to the practice of supervision, the construct of wellness has also pervaded the helping profession, albeit intermittently in terms of scholarly expansion.

The WELMS has been proposed as an integrative model that CACREP accredited programs may implement to maintain and cultivate the personal and professional wellness of CITs during their applied practical experiences. Although the WELMS is reflective of the supervisory values embraced by the facilitative, developmental, and behavioral traditions, it is the overt infusion of wellness concepts and values that

establishes it as unique in contemporary practice. By virtue of the behavioral nature the model, the WELMS is a preferred candidate for measurement and comparison to other modalities.

Investigation of the WELMS using the 5F-WEL and CSS may concurrently provide an assessment of CIT proficiency as well as a statement regarding the efficacy of the model. Whether or not the WELMS emerges from a quantitative, empirical evaluation as effective or not, limitations and outcomes may provide a template for future scientist-practitioners to move beyond survey research in the field of counselor education and supervision in to a realm where complex phenomenon are evaluated despite the use of imperfect measurements.

CHAPTER 3

METHODOLOGY

Purpose of the Study

The purpose of the present investigation is to examine the efficacy of the WELMS paradigm when applied to CITs. First, the present investigation evaluated the WELMS paradigm against other supervision as an effective means for developing the conceptual representation of wellness among counseling students. Second, this study compared the effectiveness of the WELMS as a contributing factor to the overall wellness of CITs when compared to other models of supervision as measured by the Five Factor Wellness Inventory (5F-WEL; Myers & Sweeney, 2005c). Finally, the present study investigated the degree to which participating in the WELMS paradigm was associated with clinical skills development when compared to CITs receiving other models of supervision as measured by the Counseling Skills Scale (CSS; Erikson & McAuliffe, 2003).

Research Questions

This study was designed to answer the following questions:

1. When compared to other supervision models, is the WELMS more effective in facilitating the development of wellness constructs in CITs?
2. Does the WELMS positively influence the overall wellness of CITs when compared to other models of supervision as measured by the Five Factor Wellness Inventory (5F-WEL; Myers & Sweeney, 2005c)?

3. Is there a difference in clinical skills development between the WELMS and other models of supervision as measured by the Counseling Skills Scale (CSS; Erikson & McAuliffe, 2003)?

Design

Participants

Participants in study were 44 master's-level counseling students (9 men) completing their practicum and internship requirements in a CACREP accredited counseling department were solicited to participate in the investigation. Participants who completed the study were predominately Caucasian ($N = 27$, 61%). Five individuals identified themselves as African American (11%) and 12 others identified themselves as Hispanic/ Latino (27%). Participants were mostly young adults with a mean age of 32 years ($SD = 9.96$) who identified themselves as either single (62%), married (31%), or divorced (7%). Forty two participants (95%) identified themselves as heterosexual persons; two participants (4%) identified themselves as lesbian.

Instrumentation

Five Factor Wellness Inventory. With permission from the instrument's authors, in this study the Five Factor Wellness Inventory was used to establish a baseline at the beginning of the semester and assess wellness development or maintenance at the conclusion of the semester (5F-WEL, Myers & Sweeney, 2005a). The 5F-WEL is an evidence-based tool "designed to identify factors that are central to healthy living, and which represent domains of human functioning in which personality responsibility and choice will have positive effects on well being" (Myers & Sweeney, 2005a, p.1). The results of the 5F-WEL are intended to assist individuals in making choices for healthier

living, which may promote longevity and happiness. The 5F-WEL is based on The Indivisible Self: Evidence-Based Model of Wellness (IS-WEL, Myers & Sweeney, 2005b). In this model, the global construct of wellness is composed of 5 second-order factors (the Coping Self, Social Self, Creative Self, Essential Self, and the Physical Self) which are defined by 17 third-order factors subsumed under the second order factors in varying amounts. These factors have been postulated as integrated components affecting individual wellness in which change in one area is likely to affect general wellness, as well as the other domains in the model (Myers, et al., 2000).

The adult version of the 5F-WEL is composed of 91 items, with between four and six items representing each third-order factor. The 5F-WEL boasts a normative sample of 3,343 individuals (1,173 males) of American Indian, African American, Asian American, Caucasian, and Hispanic ethnicities (Myers & Sweeney, 2005a). Five Factor-WEL items are four point Likert-type prompts in which the individual responds to positively worded prompts (e.g. I eat a healthy diet) on a continuum ranging from strongly disagree, disagree, agree, and strongly agree in which 1, 2, 3, and 4 points are contributed to the individuals score respectively (Myers & Sweeney, 2005a). The scores in the overall wellness, second-order, and third order domains range between 25 and 100 with varying means for males and females and between ethnic groups. These raw scores are calculated using linear transformation in which total points are divided by the number of items within a scale and then multiplied by 25. The raw scores are then plotted with strengths and weaknesses being the focus of intervention protocols. This method has been regarded as a user-friendly means for converting 5F-WEL data into meaningful representations for both practitioners and researchers.

Measurement limitations associated with the 5F-WEL are related to the reliability of third order factors, the degree to which the instrument account for scores between participants, and the appropriateness of a 5 factor model. For instance, DeMauro (2007) noted that while reliability evidence related to alpha coefficients for the 5F-WEL is robust for the general wellness (.94) and second order factors (.90 - .94) reliability becomes variable when examining the internal consistency of third-order factors.

While many successful applications of the 5F-WEL have been noted in empirical research studies within the counseling profession (Choate & Smith, 2005; Hartwig, 2003; Myers, Mobley, & Booth, 2003; Spurgeon & Myers, 2002), it has been suggested that a four factor structural model may provide a better instrument for exploring the relationships between wellness and other variables (Myers, Luecht, & Sweeney, 2004). Although preliminary factor analysis supported a five-factor model (Hattie, Myers, Sweeney, 2004), these authors noted that the five-factor model accounts for 32% of the variance in scores with a large proportion of test items that have similar coefficients across factors. This convolutes the process to place third-order variables (e.g., spirituality and ethnic identity) concretely into a second-order factor (e.g., Essential Self). While these psychometric limitations are indicated, the 5 F-WEL has continued to be regarded as a practical instrument for assisting individuals in developing wellness plans and creating positive changes in their lives (Myers, Luecht, & Sweeney, 2004).

Counseling Skills Scale. With permission from the instrument's authors, the development of participant's clinical counseling skills will be assessed by to independent raters using the Counseling Skills Scale (CSS; Eriksen & McAuliffe, 2003). The CSS was developed from analysis of strategy checklists as well as feedback from experts in

the field of counselor education and is designed to evaluate the “effectiveness of counseling skills performance” (Eriksen & McAuliffe, 2003, p. 127). Ivey, Gluckstern-Packard, and Ivey, (2007) noted that the results of the CSS were intended to guide the development of CITs and identify the specific microskills that contributed to positive counseling interventions. The CSS is composed of 22 skills grouped into six subcategories (Interest, Exploration, Deepening, Change, Relationship, and Management) based on a real time viewing of a counseling interaction. These component skills have been postulated as representative of the standards for counseling skills and are reportedly grounded in contemporary research on effective counseling such as those investigated recently by some authors (Alberta & Wood, 2009; Trepal, Haberstroh, Duffey, & Evans, 2007).

The CSS is composed of 22 items, with between one and five items representing each subcategory. Reliability and construct validity for these items was based on a small sample of 29 individuals (17 men) of Caucasian, African American, and Asian American ethnicities (Eriksen & McAuliffe, 2003). CSS items are a 5-point Likert-type scale ranging from +2 *Highly developed* to -2 *Major adjustment needed*. Scores within each subcategory are totaled and divided by the number of items in that scale to calculate an average score within the domain. Scoring of the CSS, like the 5F-WEL, is regarded as user friendly and provides immediate feedback to trainees, supervisors, and researchers.

Procedures

The present study implemented a quasi-experimental, within-subjects design with a between factors effect to assess the effectiveness of the WELMS when compared to other supervision models for developing complexity of wellness definitions, total

personal wellness, and counseling skills. After receiving approval from the university's Institutional Review Board, students enrolled in practicum and internship coursework in a CACREP accredited counseling program in partial fulfillment toward their degree requirements were recruited for the study during the third week of classes.

The researcher recruited participants in university practicum and internship courses. Students were informed that a doctoral student was interested in investigating how the different approaches to the supervision of CIT applied training experience may influence personal concepts of wellness, total wellness as measured by the 5F-WEL, and development of counseling skills. Students were informed that their participation would require a pretest and posttest measure of these domains, was voluntary, confidential and not required by course objectives. Furthermore, students were informed that non-participation would not affect their course standing and that the instructor would be unaware of student participation throughout the study. At this time, students were provided with time to consider their involvement and ask questions about the purpose and process of the study.

Following this recruitment proposal, the researcher provided the participants with a protocol (see Appendix) comprised of an informed consent release, demographic questionnaire, open-ended prompt requesting a personal definition of wellness, and the 5F-WEL (Myers and Sweeney, 2005c). All participants were required to provide a study code to assure anonymity and matching of protocols during data analysis. This code was comprised of participants' last initial and their birth date (MM/DD/YEAR). Student that self-identified as completing their practicum and internship requirements at the Texas A&M University- Corpus Christi Counseling and Training Clinic were assigned to the

WELMS condition; those completing practicum and internship at other sites in the community were assigned to the other supervision models condition. Participants completed this paper and pencil protocol once during the third week of classes (pretest) and again 10 weeks later (posttest).

After completing the posttest measure of the experimental protocol, participants were solicited to submit their first and final practicum or internship session tapes for evaluation and scoring. These evaluations were used to assess the development of participants' counseling skills over the course of one semester. Participants were given the option of submitting tapes at the time of solicitation or before the end of semester. Participants were provided a sealable manila envelope and asked to label tapes as "first" or "last," indicate whether they completed practicum or internship at TAMUCC Counseling and Training Clinic, and provide their assigned participant code. All tapes were stored in the Practicum and Internship Coordinator's office in a secure, double-locked cabinet.

Data Analysis

Hypothesis 1

To evaluate the null hypothesis that there is no statistical difference between the comprehensiveness of wellness definitions provided by CIT's in the WELMS group when compared to those who receive other supervision paradigms a content analysis of was conducted. The participants' personal definitions of wellness were analyzed for elements of wellness described in the Indivisible Self Model of Wellness (IS-WEL; Myers & Sweeney, 2005a; 2005b; 2005c). The experimenter used frequency count as a dependant variable to determine the degree of complexity of an individual's wellness

constructs both pretest and posttest. Several researchers have implemented a similar content analysis to yield information regarding the degree to which a construct is represented in the social sciences (Bartholome, Tewksbury, & Bruzzone, 2000; Gonzales & Meyer, 2001; Lenz, 2007; Winn & Rubin, 2001). Rejection of this null hypothesis would indicate that one supervision approach was more effective when compared to the other for developing the complexity of personal wellness definitions among participants.

Two independent raters were provided with a visual model of the IS-WEL model and definitions of total wellness, five second-order wellness variables (i.e., Social Self, Creative Self, Physical Self, Essential Self, and Coping Self), and 17 third order wellness variables (i.e., Love, Friendships, Thinking, Emotions, Control, Work, Positive Humor, Exercise, Nutrition, Spirituality, Gender Identity, Cultural Identity, Self-Care, Leisure, Stress-Management, Self-Worth, and Realistic Beliefs). After reviewing and discussing model extensively, each rater independently counted the number of wellness variables present in the participant's description of wellness for pretest and posttest measures and documented the frequency on a spreadsheet next to their unique participant code. The raters independently evaluated participant responses during two rounds of coding using this blind method. The raters had no knowledge of whether the participant protocol being scored was affiliated with either the WELMS or other supervision models group. During the second round of coding the raters reviewed the response ratings and discussed discrepancies (N= 3 of 64) to reach an agreement regarding any incongruity between the ratings in effort to establish an unequivocal interrater reliability for the scoring of participant responses.

All participant scores were entered into Statistical Package for the Social Sciences (SPSS) files. A Split Plot Analysis of Variance (SPANOVA) was conducted to determine the effect of the independent variable (supervision type) had on the dependant variable (amount of wellness variables in participant definitions).

Hypothesis 2

To evaluate the null hypothesis that there is no significant improvement for total wellness between groups when comparing CIT's who receive either the WELMS or other supervision paradigms scores on the 5F-WEL were compared between groups. Participants' total wellness scores as measured by the 5F-WEL were used as the dependant variable. Rejection of this null hypothesis would suggest that one supervision approach was more effective when compared to the other for developing the total wellness of participants while engaging in the applied practicum and internship training experience.

Participants' ratings to pretest and posttest items were entered into a Microsoft Excel document. Each protocol was reviewed after being entered to increase fidelity of data entry practices and safeguard for errors in data entry. Following the protocol of the instrument's authors, participant ratings were converted from letter ratings (i.e., A= Strongly Agree, B= Agree, C= Disagree, D= Strongly Disagree) to numerical ratings (i.e., A=1, B=2, C=3, D=4) and sent to the instrument's authors for scoring. Data was returned to the investigator in an SPSS file with each participant's pretest and posttest total, second order, and third-order wellness scores. A SPANOVA was conducted to determine the effect of the independent variable (supervision type) had on the dependant variable (overall wellness).

Hypothesis 3

To evaluate the null hypothesis that there is no significant difference in the development of applied counseling skills when comparing CITs who receive supervision from either the WELMS or other paradigm, pretest and posttest ratings on the CSS were compared between groups. Rejection of this null hypothesis would suggest that one supervision approach was more effective when compared to the other for developing the counseling skills of participants while engaging in the applied practicum and internship training experience.

To assess development of counseling skills during the applied training experience, practicum and internship courses are required to submit three audio or videotapes of live counseling with clients. Two raters evaluated the participants' first and third counseling tapes submitted as part of the course requirements for their practicum and internship courses. Following review of the first and third counseling tapes the two raters evaluated the CIT's performance using the Counseling Skills Scale (Eriksen & McAuliffe, 2003). Both of the independent raters have received training from the instruments first author and regularly practice using the CSS with CIT's. The CIT's first tape was utilized in this study as a pretest measure of counseling skills development and the final tape was regarded as a posttest measure. Each tape received an over CSS score which was documented on the CIT's rating form.

All participant scores were entered into Statistical Package for the Social Sciences (SPSS) files. SPANOVA was conducted to determine the effect of the independent variable (supervision type) had on the dependant variable (total score on the CSS).

Summary

This study implemented a quasi-experimental, within-subjects design with a between factors effect to evaluate the effectiveness of the WELMS when compared to other supervision models for developing complexity of wellness definitions, total personal wellness, and counseling skills with practicum and internship students at TAMUCC. During pretest and posttest measures, participants provided personal definitions of wellness, completed a formal wellness inventory, and submitted tapes of counseling sessions to be compared between groups. The independent variable in this study was supervision type and had two levels (WELMS and Other Supervision) and three dependant variables (degree of complexity of an individual's wellness constructs; total wellness; counseling skills development).

The data analysis strategy implemented three separate SPANOVA protocols to evaluate three separate null hypotheses. Specifically, these hypotheses were: 1) no difference will be demonstrated in the comprehensiveness of wellness definitions provided by CITs in the WELMS group when compared to those receiving other supervision models; 2) there will be no significant improvements for total wellness between groups when comparing CITs receiving supervision using either the WELMS or other supervision paradigm; 3) there will be no significant difference in the development of applied counseling skills when comparing CITs receiving clinical supervision using either the WELMS or other models. It is proposed that if these null hypotheses are rejected, a statement may be inferred regarding the effectiveness of the WELMS as a training modality for practicum and internship students.

CHAPTER 4

RESULTS

Participants were involved in a program to determine whether there are differences in the development of wellness as a personal construct, personal wellness as measured by the 5F-WEL, and counseling skills between individuals receiving wither the WELMS or other supervision models. Forty seven participants were recruited and completed practicum or internship training while participating in the study as members of the treatment group (N=16) or the alternative treatment group (N=16). An a priori power analysis was conducted to determine appropriate sample size. Given a moderate effect size, a sample of 34 was necessary to establish sufficient power for the research design. In the absence of this sample size a sensitivity analysis was implemented to determine if the *F* value was large enough to document a meaningful difference between both groups.

Preliminary Data Analysis

A preliminary analysis of the data for this study was conducted to increase the likelihood that statistical testing reflected accurate relationships between the independent and dependent variables. Although the data for assessing the development of participants' personal wellness constructs and development of counseling skills development did not appear to contain any significant outliers, one participant's scores were removed from the WELMS condition when assessing development of personal wellness during applied training experience. The data from this participant's 5F-WEL demonstrated extreme scores and increased the overall error for this group without significantly reducing the mean score of the WELMS group. The differences in this data are not below in Table 1.

Table 1

Differences in pretest and posttest scores for the WELMS group following elimination of outlier group.

| | Treatment Condition | M | SD | N |
|--------------------------|---------------------|-------|------|----|
| Pretest with outlier | WELMS | 80.52 | 5.48 | 16 |
| Pretest without outlier | WELMS | 79.86 | 4.97 | 15 |
| Posttest with outlier | WELMS | 82.12 | 6.06 | 16 |
| Posttest without outlier | WELMS | 82.46 | 6.11 | 15 |

Development of a Personal Wellness Construct

A split plot analysis of variance (SPANOVA) was conducted between the WELMS and other supervision models groups across pretest and posttest. An alpha level of .05 was utilized. Assumptions for normality were not met in the posttest condition for other supervision models ($p = .006$) and homogeneity of variances (Box's $M = 15.3$, $p = .003$) were not met. However, the number of participants in each group was equal suggesting a robust sample. Descriptive statistics for the dependant variables across the supervision groups are in presented Table 2.

Table 2

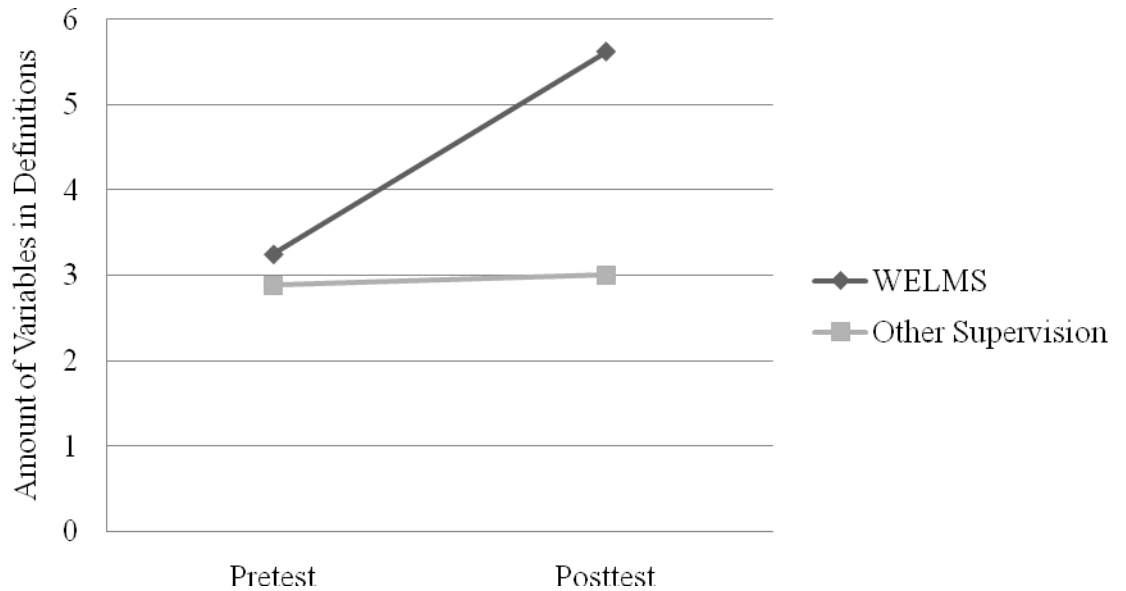
Descriptive Statistics for Amount of Wellness Variables Present in Participant's Personal Construct of Wellness as Measured by Written Definitions

| | Treatment Condition | M | SD | N |
|--------------------|---------------------|------|------|----|
| Pretest Construct | WELMS | 3.25 | 1.12 | 16 |
| | Other Supervision | 2.88 | 1.36 | 16 |
| Posttest Construct | WELMS | 5.62 | 2.27 | 16 |
| | Other Supervision | 3 | 0.88 | 16 |

Before receiving either the WELMS or other models of supervision, both groups exhibited similar complexity of their personal wellness construct ($M = 3.25$; $SD = 1.12$ and $M = 2.88$; $SD = 1.36$ respectively). However, following the implementation of a supervision model, the SPANOVA detected a statistically significant interaction within participants ability develop a more complex personal definition of wellness and supervision type from pretest to posttest, $F(1, 30) = 14.21$, $p < .01$, $\eta_p^2 = .32$ indicative of a large effect size (Table 3). This finding represented in Figure 1 suggested that participants in the WELMS group improved the amount of wellness variables represented in their personal definitions of wellness significantly more than those receiving clinical supervision using other models from pretest to posttest.

Figure 3

Interaction Effect between Group and Time for the Amount of Variables in Participant's Personal Definition of Wellness



Additionally, there was a statistically significant effect observed between groups $F(1,30) = 11.77, p < .01, \eta_p^2 = .28$ indicative of a moderate to large effect size (Table 3). Although scores of participants in the other supervision models condition decreased slightly, this change was not statistically significant. These findings indicated that participants in the WELMS condition increased the complexity of their personal wellness construct as measured by the amount of wellness variables included in their personal definitions of wellness on average ($M = 5.63$) when compared to participants in the other supervision models condition ($M = 3$).

Table 3

Tests of Between and Within Subjects Effects for Amount of Wellness Variables Present in Participant's Personal Construct of Wellness as Measured by Written Definitions

| | F | Sig. | η_p^2 |
|---------------------------------|-------|------|------------|
| Between Subjects Effects | | | |
| Group | .30 | .58 | 0.10 |
| Within Subjects Effects | | | |
| Time*Supervision Type | 14.21 | <.01 | 0.32 |

A sensitivity analysis for sample size of 32 indicated that a critical F value of a least 4.18 was necessary to demonstrate a moderate effect when one was present. The F value for the both between subjects and within subjects effects ($F = 11.77$ and $F = 14.21$ respectively) met this criteria suggesting that the results of this SPANOVA can be regarded as sufficient measure of the treatment effect.

Development of Personal Wellness during Applied Training Experience

A SPANOVA was also conducted between the WELMS and other supervision models groups across pretest and posttest following the removal of an outlier from the WELMS condition. An alpha level of .05 was utilized. Assumptions for normality ($p > .01$) and homogeneity of variances (Box's $M = 1.17$, $p = .77$) were met. Descriptive statistics for the dependent variables across the supervision groups are presented in Table4.

Table 4

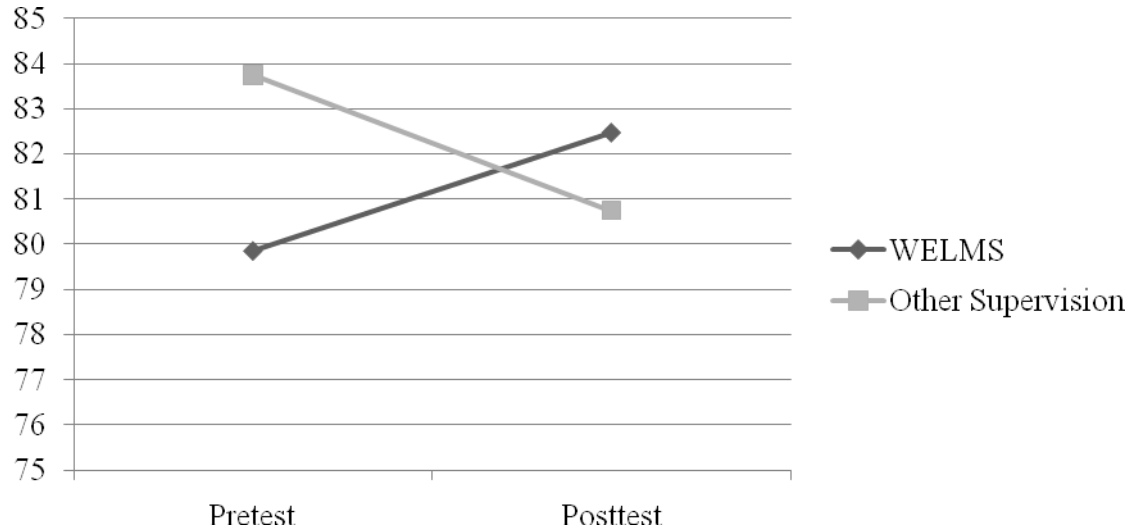
Descriptive Statistics for Participant's Total Wellness as Measured by the Five Factor Wellness Inventory (Myers & Sweeney, 2005).

| | Treatment Condition | M | SD | N |
|-------------------|---------------------|-------|------|----|
| Pretest Wellness | WELMS | 79.86 | 4.97 | 15 |
| | Other Supervision | 83.75 | 5.55 | 16 |
| Posttest Wellness | WELMS | 82.46 | 6.11 | 15 |
| | Other Supervision | 80.75 | 6.45 | 16 |

Before receiving either the WELMS or other models of supervision, both groups exhibited similar levels of personal wellness ($M = 79.86$; $SD = 4.97$ and $M = 83.75$; $SD = 6.11$ respectively). Following the implementation of a supervision model, there was a statistically significant interaction for participants' development of personal wellness from pretest to posttest, $F(1, 29) = 5.65$, $p = .02$, $\eta_p^2 = .16$ indicative of a medium effect size (Table 5). This finding represented in Figure 2 suggests that participants in the WELMS group improved the amount of total wellness from pretest to posttest when compared to those receiving clinical supervision using other models.

Figure 4

Interaction Effect between Group and Time for the Amount of Participants' Total Wellness as Measured by the Five Factor Wellness Inventory (Myers & Sweeney, 2005).



Further analysis of SPANOVA results indicates that there was not a statistically significant effect observed between groups $F(1,29) = .40, p = .53, \eta_p^2 = .01$ indicative of a minimal effect size (Table 5). Although participants in the WELMS condition increased their scores on average and those in the other supervision models condition scores decreased slightly, this change was not statistically significant.

Table 5

Tests of Between and Within Subjects Effects for Participants' Total Wellness as Measured by the Five Factor Wellness Inventory (Myers & Sweeney, 2005).

| | F | Sig. | η_p^2 |
|---------------------------------|------|------|------------|
| Between Subjects Effects | | | |
| Group | .40 | .53 | 0.01 |
| Within Subjects Effects | | | |
| Time*Supervision Type | 5.65 | .02 | 0.16 |

A sensitivity analysis for sample size of 32 indicated that a critical F value of a least 4.18 was necessary to demonstrate a moderate effect when one was present. The F value for the both between subjects and within subjects effects ($F = .30$ and $F = 3.42$ respectively) did not meet this criteria.

Development of Counseling Skills

A SPANOVA was conducted between the WELMS and other supervision models groups to assess whether participation in the WELMS was deleterious for the development of counseling skills during the course of a semester. An alpha level of .05 was utilized. Assumptions for normality ($p > .01$) and homogeneity of variances (Box's $M = .40, p = .95$) were met. Descriptive statistics for the dependent variables across the supervision groups are presented in Table 6.

Table 6

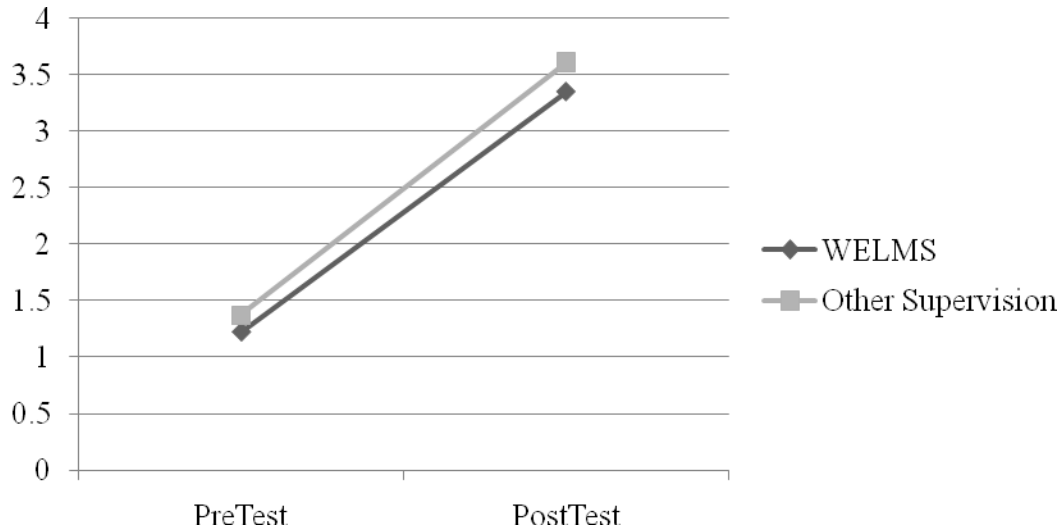
Descriptive Statistics for Participant's Counseling Skills Development as Measured by the Counseling Skills Scale (Eriksen & McAuliffe, 2003).

| | Treatment Condition | M | SD | N |
|----------------------------|---------------------|------|------|----|
| Pretest Counseling Skills | WELMS | 1.22 | 3.34 | 12 |
| | Other Supervision | 1.37 | 3.17 | 8 |
| Posttest Counseling Skills | WELMS | 3.35 | 3.75 | 12 |
| | Other Supervision | 3.61 | 3.98 | 8 |

Before receiving either the WELMS or other models of supervision, both groups exhibited similar levels of counseling skills development as measured by the CSS ($M = 1.22$; $SD = 3.34$ and $M = 1.37$; $SD = 3.17$ respectively). Following the implementation of a supervision model, there was no statistically significant interaction for participants' counseling skills development from pretest to posttest, $F(1, 18) = .006$, $p = .94$, $\eta_p^2 < .01$ indicative of a minimal effect size (Table 7). This finding represented in Figure 5 suggests that participants in the WELMS group improved their counseling skills from pretest to posttest at a similar level when compared to those receiving clinical supervision using other models.

Figure 5

Development of Participants' Counseling Skills as Measured by the Counseling Skills Scale (Eriksen & McAuliffe, 2003).



Further analysis of SPANOVA results indicates that there was not a statistically significant effect observed between groups $F(1,18) = .02, p = .88, \eta_p^2 < .01$ indicative of an extremely minimal effect size (Table 7). These results illustrate that participants in the WELMS condition increased their scores on the CSS during the semester similar to participants in the other supervision models condition indicating that engagement in the WELMS did not impede the development of their counseling skills.

Table 7

Tests of Between and Within Subjects Effects for Participants' Counseling Skills Development as Measured by the Counseling Skills Scale (Eriksen & McAuliffe, 2003).

| | F | Sig. | η_p^2 |
|---------------------------------|-------|------|------------|
| <u>Between Subjects Effects</u> | | | |
| Group | .02 | .88 | < .01 |
| <u>Within Subjects Effects</u> | | | |
| Time*Supervision Type | < .01 | .94 | < .01 |

Summary of Results

The results of this investigation provide several conclusions regarding the effectiveness of the WELMS for increasing the complexity of wellness constructs, sustaining or improving total wellness, and developing counseling skills when compared to other models of supervision. First, the results from a SPANOVA indicated a significant interaction between participants ability to develop a more complex personal definition of wellness and supervision type from pretest to posttest. The findings support the rejection of the null hypothesis that there is no difference between supervision modalities for increasing CIT conceptualization of wellness. Second, the results of a SPANOVA detected a statistically significant interaction for participants' development of personal wellness from pretest to posttest. The finding also supports the rejection of the null hypothesis that there is no difference between supervision modalities for increasing CIT wellness while engaging in clinical supervision. Finally, a SPANOVA to assess

differences in the development of counseling skills over the course of a semester found no statistically significant interaction for participants' counseling skills development from pretest to posttest. This supports the retention of the null hypothesis that there is no difference between supervision modalities for developing the counseling skills of CITs.

CHAPTER 5

SUMMARY, DISCUSSION, CONCLUSIONS

Introduction

Counselors and CITs are frequently subjected to stress-producing factors that have a deleterious effect on their physical and mental resources which ultimately jeopardizes personal wellness. Myers and colleagues (2004) noted that individuals who professionally identify with counseling demonstrate greater wellness when compared to the general population; however, other researchers have questioned whether counselor education programs have a meaningful impact in cultivating the wellness of CITs during their professional preparation (Roach & Young, 2007). While considering how this process works in action, Smith, Robinson, and Young (2007) noted that there is a negative association between the overall wellness of CITs and their exposure to psychological distress. These authors suggested that CITs are impacted harmfully by the psychological distress they encounter during the training process and that they are not receiving the personalized wellness interventions conducive to maintaining or improving optimum functioning.

Despite the recommendations of some scholars for overtly integrating wellness variables into counselor education curriculum, (Lenz, 2009; Witmer & Granello, 2005; Yager & Tober-Blank, 2007), there is little evidence to suggest that this trend has not persisted. In response, Lenz and Smith (2010) developed the WELMS to place accountability for the development of personal wellness and counseling skills concurrently in the context of clinical supervision. This supervision modality described in Chapter 2 overtly attends to CIT wellness and clinical skill development through four

distinct processes of education, assessment, planning, and evaluation similar to the Holistic Model for Treatment Planning described by Myers and colleagues (2000). The present investigation was designed to evaluate the effectiveness of the WELMS when compared to other supervision models using a quasi-experimental design. This investigation was guided by the following research questions:

1. When compared to other supervision models, is the WELMS more effective in facilitating the development of wellness constructs in CITs?
2. Does the WELMS positively influence the overall wellness of CITs when compared to other models of supervision as measured by the 5F-WEL?
3. Is there a difference in clinical skills development between the WELMS and other models of supervision as measured by the CSS?

In an effort to begin developing empirical support for the WELMS as an efficacious intervention, some necessary null hypotheses were proposed:

1. No difference will be demonstrated in the comprehensiveness of wellness definitions provided by CITs in the WELMS group when compared to those who receive other supervision models.
2. No significant improvements for total wellness between groups will be noted when comparing CITs who receive supervision from either the WELMS or other supervision models.
3. No significant difference in the development of counseling skills will be detected when comparing CITs who receive supervision from either the WELMS or other supervision models.

To establish support for the efficacy of the WELMS, it was necessary in this investigation to reject the first to null hypotheses and retain the third one. This outcome would provide evidence that the WELMS was an effective means for developing CIT understanding of wellness as a construct and developing personal wellness while keeping counseling skills development in a range similar to that of their peers in the other supervision models condition.

Discussion

The study implemented a quasi-experimental, within-subjects design with a between factors effect to assess the effectiveness of the WELMS when compared to other supervision models. This comparison aims to examine the complexity of wellness definition development, total personal wellness, and counseling skills. The results of this investigation provides evidence supporting the use of the WELMS as an intervention for promoting CIT wellness and counseling skills development concurrently within the context of clinical supervision. Furthermore, the findings support the practice of operationalizing the desired outcomes associated with supervision modalities and implementing empirical strategies to verify their utility. From the findings of this investigation, a number of poignant caveats emerged that provide support for the WELMS as a useful supervisory intervention in a counselor education program.

Although both groups were able to describe a personal definition of wellness during pretest measurements, the WELMS was more effective when compared to other models of the supervision for developing the comprehensiveness and complexity of CIT's personal wellness definitions over time. As a result, the null hypothesis that no difference would be noted between groups for developing complexity of CITs' wellness

definitions over time is rejected. This suggests that exposure to the education, assessment, planning and evaluation processes of personal wellness are associated with increased learning and retention of components of wellness that are associated with the helping profession. Myers and colleagues (2000) noted that education and developing a personal definition of wellness was a critical first step for individuals to personalize their milieu and see their individual journey as a process rather outcome-oriented.

In addition to being statistically significant, the practical significance of this finding is evident in the assumption that a CIT with a more holistic, comprehensive perspective of their client has a more differentiated schema for understanding clinical issues than one that does not. In addition to better understanding client issues through an expanded schema of wellness and optimal human functioning, CITs may also be able to conceptualize their experiences during the training process from a more holistic perspective. Optimally, the goal of conceptual development of the wellness construct with CITs over time is promising for a shift away from a medical, disease-based model of working with clients, to one which accounts for a number of client variables.

The results reported in this study also support the contention that the WELMS is a more effective means than other models of supervision for maintaining and developing CIT wellness during the course of an academic semester as measured by the 5F-WEL. At the beginning of the semester, CITs in the other supervision models groups reported a higher level of total wellness compared to CITs in the WELMS condition ($M = 83.75$; $M = 79.86$ respectively). At the end of the academic semester, CITs receiving other models of supervision reported a decrease of total wellness on average when compared to those receiving the WELMS ($M = 80.75$; $M = 82.46$). Given this change in scores over time, it

is prudent to reject the null hypothesis that there is no difference between treatment modalities in maintaining or promoting CIT wellness during the applied training experience. This preliminary finding supports the contention that if counselor education programs implemented the WELMS during the practicum and internship experiences, they will increase the likelihood that students will be more resilient to variables associated with burnout and vicarious trauma.

Although a decrease of three points by CITs receiving other models of supervision and increase of 2.6 by those receiving the WELMS may not appear to be practically significant, when prospecting a persisting trend over time the implications for CIT resiliency development are compounded. Following a large national survey of counselors, Lawson (2007) suggested that regardless of setting, engagement in career sustaining behaviors is closely associated with counselor wellness. By intentionally engaging in wellness practices through active education, planning, assessment and evaluation, CITs have demonstrated the ability to make improvements over time in their wellbeing despite facing the challenges associated with practicum and internship.

Finally, the results of this investigation support the supposition that the content and processes inherent in the WELMS do not take negate the counseling skills development of CITs as measured by the CSS. Participants in both groups demonstrated similar pretest and posttest scores following reviews of their practicum and internship tapes. Given these results, the null hypothesis is retained the implicating the WELMS as an effective tool for counseling skills development. From a practical standpoint, this initial finding dispels the dispute that attending to CIT wellness and teaching clinical skills through the lens of holistic practices abstracts attention to the development of

counseling skills. Therefore, in addition to increasing the comprehensiveness of CIT understanding about wellness in self and others, while improving personal wellness, CITs learn traditional helping skills to the same degree as their peers.

Implications for Practice

The results of this study have several implications of the present study for meeting accomplishing the training tasks expected of counselor supervisors, engendering practices that meet ACA ethical requirements for self-care, fulfilling CACREP standards for CIT training, and using empirical research methodology to assess effectiveness of counseling interventions. Bernard and Goodyear (2009) noted that supervision has two central purposes: to foster the professional development of CITs and to ensure client welfare through adequate service delivery and monitoring. From a holistic perspective, the separation between personal and professional growth is an artificial one; that is, it is unlikely that an individual would experience development in their professional competence without contemporaneously experiencing personal growth. When the counselor is actively striving toward self-development, increased awareness of others from a holistic perspective and supported in their professional development, they will be more emotionally, cognitively and spiritually available for their clients. As a consequence of this active development and increased availability of self, the optimum capacity to promote the client's welfare is promoted.

The ACA has provided clear expectations for self-care and monitoring practices in its *Code of Ethics* (2005). For instance, ACA requires counselors to “engage in self-care activities to maintain and promote their emotional, physical, mental, and spiritual well-being to best meet their professional responsibilities” (ACA 2005, Section C; p. 9).

In addition, ACA requires that “counselors assist colleagues or supervisors in recognizing their own professional impairment and provide consultation and assistance when warranted with colleagues or supervisors showing signs of impairment and intervene as appropriate to prevent imminent harm to clients” (ACA, 2005, C.2.g, p. 9-10). Through the use of the WELMS, CITs are exposed to the primary wellness interventions that support engagement in these professional behaviors and familiarity with a comprehensive model to reference. It is proposed that with repeated exposure and practice defining wellness and engaging in systematic review of self and clients from a holistic perspective, these professional requirements are more likely to be legitimately addressed. This proposition is critical given the findings by Larson (2007) in which 48.58% of practicing counselors surveyed ($n = 389$) indicated that they were presently practicing in the range between stressed and impaired on the wellness continuum. With regular implementation of the WELMS during the training experience, it is possible to decrease this percentage over time. Therefore, if the WELMS is successful in the long-term for promoting personal and professional wellness, this study may have detected a valuable inroad for promoting wellness in the counselor education profession.

Like the ACA, counselor educators have a commitment to foster an understanding and engagement in wellness and holistic practices throughout CITs curricular experiences. For instance CACREP (2009) mandates that counselor education programs foster an understanding of self-care strategies appropriate to the counselor role (Section II, G.1.d), engage students in supported behaviors that promote optimal wellness and growth of the human spirit, mind, or body (Section II, G.2.e), provide education about theories for facilitating optimal development and wellness over the life span (Section II,

G.3.h), and instill wellness and prevention as desired counseling goals (Section II, G.5.a). Until now, overt strategies for attending to these requirements have been predominantly presented in coursework preparation, but only minimally exhibited within the supervisory context (Lenz & Smith, 2010). The WELMS provides one strategy for counselor educators and supervisors to facilitate continuity of course content during the applied skills development experience when it may be needed the most. In addition, the WELMS provides counselor educators and supervisors a framework to actively meet these CACREP requirements and tangible student learning outcomes.

Finally, this investigation has promising implications for the practice for developing operational definitions of abstract constructs such as wellness and counseling skills development and conducting empirical investigations to demonstrate efficacy of supervisory practices. As noted by the reviews of literature conducted by Borders (2005) and Goodyear (2005), the predominate professional product in counselor supervision is a theoretical article rather than empirical investigations. At best, the academic community frequently relies on a single-case illustration to demonstrate supervisory outcomes. In the case of the WELMS, the quantifiable nature of wellness constructs and counseling skills development, in conjunction with opportunities for implementing reliable and valid assessment practices, provides a promising model for researcher to use in their studies. As funding streams become increasingly constricted and professional organizations move toward evidence-based practice, it is unlikely that supervision practices will not be subjected rigorous scrutiny as well.

Limitations

A number of limitations to this project's design, process, and results related to bias, internal threats to validity, measurement, sample characteristics and attribution inferences are evident. Foremost, participants' scores on the 5F-WEL may have been influenced by participant reactance associated with repeated measurement of the same dependant variable over time. Participants in the WELMS condition, knowing that they have been participating in a model of supervision designed to emphasize wellness development, may have provided responses that confirm the utility of this model. This is an especially noteworthy consideration given that the 5F-WEL has a great deal of face validity for items. Although it is possible that while completing the second administration of the 5F-WEL participants in the WELMS condition may have depicted themselves as more well, the statistical assumptions in the data analysis of these results do not support this contention.

The fidelity of the present study would also be increased by implementing practices to randomly assign participants to either the WELMS or other supervision models conditions. By increasing the likelihood that each participant has to be assigned to a supervision condition, cause and effect relationships may be generalized more easily to the population of CITs. Although random sampling procedures are preferred in experimental research practices, Newton and Rudestam (1999) noted that social sciences research commonly implements nonprobability sampling by virtue of the hypotheses being tested and convenience of research participants.

Another consideration that would strengthen this study is related to imprecision of measures. For instance, the 5F-WEL has several limitations for measuring total wellness. Hattie and colleagues (2004) noted that the five factor model implemented to calculate

total wellness using the 5F-WEL accounts for only 32% of the variance within the scores recorded by the normative sample. In addition, the normative sample for the 5F-WEL ($N = 2,093$) is predominately comprised of female university students. Although there is a clear need for additional measures of total wellness, for the present study this assessment appears to be a reasonable choice given that the sample consisted predominately of female university students. In addition to variables related to the psychometric properties of the 5F-WEL, the CSS is a subjectively scored instrument which may compromise the validity of the instrument. Whereas, two raters collaborated to identify a rating for each participant's present level of counseling skills development, it is possible that another pair of raters may have provided different ratings. Both raters in this study completed training to use the CSS facilitated and supervised by the instruments authors; however, interrater reliability cannot be assured.

Perhaps the most glaring limitation to the present study is related to variable sample sizes for testing each hypothesis due to difficulties with tapes. When testing hypotheses one and two, it was possible to conduct a sensitivity analysis to determine if the F values (14.21 and 5.65 respectively) were large enough to detect a difference between groups if one existed. This was not the case for hypothesis three in which a null was retained but unable to be confirmed by such statistical procedures. Future investigations may benefit from implementing more proximal and immediate review of CIT tapes to reduce the likelihood of damage and corruption during the storage process.

Finally, although this investigation has provided evidence about what has happened in the context of CIT development when comparing the WELMS to other models of supervision, it is uncertain how it has happened. From the findings, it is

unclear what particular aspects of the WELMS are most associated with positive changes and which are perceived as less of a contribution to CIT development. This is a major limitation of quantitative research endeavors and attempts to understand the occurrence of non-objective change. Additionally, from the results of this investigation, it is unsure whether the trend toward increased wellness and counseling skills development recorded may have persisted for participants in the WELMS group beyond the experimental term. Furthermore, it is unclear what CIT traits and characteristics are associated with maximum responsiveness to the WELMS. This information may contribute to more effective selection and screening of CITs for which the WELMS is suitable for clinical application.

Directions for Future Research

The present research study has detected several strengths associated with the WELMS; however, future investigators can implement an array of research methodologies that will be useful in clarifying several undiscovered aspects of the WELMS. The suggestions are intended to evolve the evidence base for the WELMS as a useful clinical approach and elucidate what aspects of this model are salient for creating positive change. For instance, Chambless and colleagues (1998) proposed that a minimum of two between group design experiments demonstrating efficacy of an intervention when compared to a control group or alternative treatment are required to establish evidentiary validity. Therefore, at least one confirmatory large number study ($N \geq 34$), using the same design, needs to be conducted and evaluated to begin making claims about the empirical legitimacy of the WELMS as a supervisory intervention supported by empirical evidence. Future research would be considered more robust if the

population sample is drawn from another site with similar fundamental characteristics (Chambless, et al., 1998). In this case, researchers should solicit a participant pool from another CACREP Counselor Education program when conducting a confirmatory investigation.

In addition to large number designs, researchers can further investigate the legitimacy of the WELMS using single subject research designs (SSRDs). Several authors have proposed that SSRDs are a valuable means for evaluating the efficacy of practices in counseling (Foster, 2010), counselor education (Ray, Minton, Schottelkorb, & Brown, 2010), counseling supervision (Lenz, Oliver, & Nelson, 2011), and higher education settings (O'Neill, McDonnell, Billingsley, & Jenson, 2011). Chambliss, et al. (1998) noted that, in the absence of adequate large number experimental designs, scientist-practitioners can implement large ($N > 9$) or small ($N > 3$) series' of SSRDs to establish strong and modest evidence bases respectively for an intervention. Single subject research designs that implement strong experimental controls for internal and external validity will prove an invaluable supplement for establishing causal relationships between the use of the WELMS and the desired process-related outcomes.

Researchers are also encouraged to implement qualitative research designs to glean the themes, patterns, concepts, insights and understandings that are associated with completing professional preparation requirements using the WELMS. Patton (2002) suggested that through analysis of open-ended interviews, direct observations and written documents such as journals, researchers can capture the lived experience of individuals within a specific context. Just as the results of this quantitative evaluation have indicated *what* has happened when CITs participate in the WELMS, completion of qualitative

inquiries will assist in identifying questions regarding *how* and *why* the WELMS is effective.

In case of large number, SSRDs, and qualitative investigations longitudinal studies are encouraged to detect whether the trends and perceptions of wellness construct, personal wellness and counseling skills development persist over time. Follow up studies would provide insight regarding the depth of learning among CITs as they transition from students to professionals and efficacy of the WELMS intervention over time. While conducting these follow up studies, future researchers are encouraged to implement additional strategies for assessing the wellness construct, personal wellness and counseling skills development. Researchers may also be interested in investigating the relationship between personal traits and student characteristics using these varied methodological approaches.

Conclusion

This quasi-experimental research study investigated the effectiveness of the WELMS and other models of supervision for developing the comprehensiveness of a personal wellness construct, total wellness, and counseling skills among CITs. The results indicated that participants in the WELMS condition developed more comprehensive personal definitions of wellness and increased total wellness significantly more when compared to those receiving other models of supervision. In addition, CITs receiving the WELMS did not demonstrate a deficit in their counseling skills development that was associated with participation with this supervision modality.

The implications of this study's results provide a contribution to the literature related to evidence-based practices in the supervision of counseling professionals. In

addition to being a useful clinical tool, the results of this study support the use of the WELMS for increasing engagement in practices for self-care and monitoring endorsed by the ACA (2005) and meeting student learning outcomes in CACREP programs. Furthermore, this study has provided a model for future researchers to design empirical analyses of supervisory practices and suggestions for future research that may contribute to the body of scholarly information in the field of counselor education and supervision. In conclusion, as the demands placed on counselors, educators and CITs increases, the WELMS provides a strategy for attending to personal and professional development during the training process that provides a hopeful outlook for fostering resiliency among CITs.

References

- Agathon, M., & Samuel-Lajeunesse, B. (1988). Teaching behavioral assessment and therapy to French psychiatric students. *Journal of Behavioral Therapy and Experimental Psychiatry, 19*, 27-30. doi:10.1016/0005-7916(88)90007-9
- Akert, R. M., Aronson, E., & Wilson, T. D. (2005). *Social Psychology* (5th Edition). Upper Saddle River, NJ: Prentice Hall
- Alberta, A. J., & Wood, A. H. (2009). A practical skills model for effectively engaging clients in multicultural settings. *The Counseling Psychologist, 37*, 564-579. doi:10.1177/0011000008326231
- American Counseling Association (1995). *ACA Code of Ethics*. Alexandria, VA: Author
- American Counseling Association (2005). *ACA Code of Ethics*. Alexandria, VA: Author
- Bargh J. A. (2006). What have we been priming all these years? On the development, mechanisms, and ecology of nonconscious social behavior. *European Journal of Social Psychology, 36*, 147–168.
- Bartholome, A., Tewksbury, R., & Bruzzone, A. (2000). “I want a man”: Patterns of attraction in all-male personal ads. *The Journal of Men’s Studies, 8*, 309-321. doi:10.3149/jms.0803.309
- Bernard, J.M., & Goodyear, R.K. (2009). *Fundamentals of clinical supervision*. Upper Saddle River, NJ: Pearson.
- Bikos, L. H., & Uruk, A. C. (2005). Counseling outcome as a function of counselor nationality for American expatriate clients. *International Journal for the Advancement of Counselling, 27*, 523-539. doi:10.1007/s10447-005-8489-9
- Bober, T., & Regehr, C. (2006). Strategies for reducing secondary or vicarious trauma:

do they work? *Brief Treatment and Crisis Intervention*, 6, 1-9.

doi:10.1093/brief-treatment/mhj001

Borders, L. D. (2005). Snapshot of clinical supervision in counseling and counselor education: A five-year review. *The Clinical Supervisor*, 24, 69-113.

doi:10.1300/J001v24n01_05

Callaghan, G. M. (2006). Functional analytic psychotherapy and supervision.

International Journal of Behavioral and Consultation Therapy, 2, 416-431.

Chambers, M., & Long, A. (1995). Supportive clinical supervision: a crucible for personal and professional change. *Journal of Psychiatric Mental Health Nursing*, 2, 311-316.

Chambless, D. L., Baker, M. J., Baucom, D. H., Beutler, L. E., Calhoun, K. S., Crits-Christoph, P., ... Woody, S. R. (1998). Update on empirically validated therapies, II. *The Clinical Psychologist*, 51, 3-16.

Choate, L. H., & Smith, S. L. (2003). Enhancing development in 1st-year college student success courses: A holistic approach. *Journal of Humanistic Counseling, Education, and Development*, 42, 178-193.

Coleman, M. (2003). Supervision and the clinical social worker. *Clinical Social Work*, 3(2), 1-4. Retrieved from www.socialworkers.org/practice/clinical/csw0703b.pdf

Compton, S. M., March, J. S., Brent, D., Albano, A. M., Weersing, R., & Curry, J. (2004). Cognitive-Behavioral Psychotherapy for Anxiety and Depressive Disorders in Children and Adolescents: An Evidence-Based Medicine Review. *Journal of the American Academy of Child & Adolescent Psychiatry*, 43, 930-959.

Council for Accreditation of Counseling and Related Educational Programs (2009). 2009

Standards. Retrieved from http://www.cacrep.org/2009_standards.html.

Dean, R. G. (1984). The role of empathy in supervision. *Clinical Social Work Journal*, *12*, 129-139. doi:10.1007/BF00755663

DeMauro, G. E. (2007). Five Factor Wellness Inventory. In Geisinger, K. F., Spies, R. A, Carlson, J. F., & Plake, B. S. (Eds.), *The Seventeenth Mental Measurements Yearbook*, (pp. 328-330). Lincoln, NE: The Buros Institute of Mental Measurements.

Dunn, H. L. (1957). Points of attack for raising the levels of wellness. *Journal of the National Medical Association*, *49*, 225-235.

Dunn, H. L. (1959). High-level wellness for man and society. *American Journal of Public Health*, *49*, 786-792. doi:10.2105/AJPH.49.6.786

Dreikurs, R., & Mosal, H. H. (1967). The tasks of life: II. The fourth life task. *Individual Psychologist*, *4*(2), 51-56.

Eriksen, K. P., & McAuliffe, G. J. (2003). The Counseling Skills Scale: A measure of counselor competence. *Counselor Education & Supervision*, *43*, 120-133.

Eriksen, K. P., & McAuliffe, G. J. (2006). Constructive development and counselor competence. *Counselor Education and Supervision*, *45*, 180-192.

Foster, L. (2010). A best kept secret: Single-subject research design in counseling. *Counseling Outcome Research and Evaluation*, *1*, 30-39.

doi:10.1177/2150137810387130

Foy, C. W., & Breunlin, D. C. (1995). Integrative supervision: A metaframeworks perspective. In R. H. Mikesell, D. D. Lusteran, & S. H. McDaniel (Eds.), *Integrating family therapy: Handbook of family psychology and systems theory*

(pp. 387-394). Washington, DC: American Psychological Association.

Gladding, S. T., & Newsome, D. W. (2010). *Clinical Mental Health Counseling in Community and Agency Settings*. (3rd ed.). Upper Saddle River, NJ: Pearson.

Gonzales, M., & Meyer, S. (1993). Your mother will like me: Self presentation in the personal ads of heterosexual and homosexual men and women. *Personality and Social Psychology Bulletin*, *19*, 131-142. doi:10.1177/0146167293192001

Goodyear, R. K, Bunch, K., & Claiborn, C. D. (2005). Current supervision scholarship in psychology: A five year review. *The Clinical Supervisor*, *24*(1), 137-147. doi:10.1300/Joo1v24n01_07

Granello, P. (2000). Integrating wellness work into mental health private practice. *Journal of Psychotherapy in Independent Practice*, *1*, 3-16.

Gray, J. J. (1974). Methods of training psychiatric residents in behavioral therapy. *Journal of Behavioral Therapy and Experimental Psychiatry*, *5*, 19-25. doi:10.1016/0005-7916(74)90008-1

Harrison, R. L., & Westwood, J. (2009). Preventing vicarious traumatization of mental health therapists: Identifying protective practices. *Psychotherapy Theory, Research, Practice, Training*, *46*, 203-219.

Hart, G. D. (2000). *Asclepius: The God of Medicine*. London, UK: Royal Society of Medicine Press.

Hartwig, H., & Myers, J. E. (2003). A different approach: Applying a wellness paradigm to adolescent female delinquents and offenders. *Journal of Mental Health Counseling*, *25*, 57-75.

Hattie, J. A., Myers, J. E., & Sweeney, T. J. (2004). A factor structure of wellness:

- Theory, assessment, analysis, practice. *Journal of Counseling & Development*, 82, 354-364.
- Haynes, R., Corey, G., & Moulton, P. (2003). *Clinical supervision in the helping professions: A practical guide*. Pacific Grove, CA: Brooks/Cole.
- Heckman-Stone, C. (2003). Trainee preferences for feedback and evaluation in clinical supervision. *The Clinical Supervisor*, 22, 21-33. doi:10.1300/J001v22n01_03
- Heppner, P.P., Wampold, B.E., & Kivlighan, D.M. (2008). *Research Design in Counseling* (3rd ed.). Belmont, CA: Thompson Brooks/ Cole.
- Hesse, A. (2002) Secondary trauma: How working with trauma survivors affects therapists. *Clinical Social Work Journal*, 30, 293–309.
doi:10.1023/A:1016049632545
- Hettler, B. (1986). Strategies for wellness and recreation program development. *New Directions for Student Services*, 34, 19-32. doi:10.1002/ss.37119863404
- Hettler, W. (1984). Wellness: Encouraging a lifetime pursuit of excellence. *Health Values: Achieving High Level Wellness*, 8, 13-17.
- Howard, B., & Kendall, P.C. (1996). Cognitive-behavioral family therapy for anxiety-disordered children: A multiple baseline evaluation. *Cognitive Therapy and Research*, 20, 423-444.
- Ivey, A. E., Gluckstern-Packard, N., & Ivey, M. B. (2007). *Basic attending skills* (4th ed.). Hanover, MA: Microtraining Associates
- Kadushin, A. (1992) *Supervision in Social Work* (3rd ed.), New York, NY: Columbia University Press.
- Kazdin, A. E., Weisz, J. (1998). Identifying and developing empirically supported child

- and adolescent treatments, *Journal of Consulting and Clinical Psychology*, 66, 100-110.
- Kim, J. S. (2008). Examining the effectiveness of solution-focused brief therapy: A meta analysis. *Research on Social Work Practice*, 18, 107-116.
doi:10.1177/1049731507307807
- Lawson, G. (2007). Counselor wellness and impairment: A national survey. *Journal of Humanistic Counseling, Education and Development*, 46, 20-34.
- Lee, M. Y. (1997) A study of solution-focused brief family therapy: outcomes and issues. *American Journal of Family Therapy*, 25, 3-17.
- Lenz, A. S. (2007). "Emotional Conquest Strategies in Written Communication: An application for online dating" (M.A. Thesis, Texas A&M University- Corpus Christi, 2007).
- Lenz, A. S. (2009, October). *Counseling for wellness: Working out the kinks in a new education paradigm*. Poster presented at Association for Counselor Education and Supervision Conference, San Diego, CA.
- Lenz, A. S., & Smith, R. L. (2010). Integrating wellness concepts within a clinical supervision model. *The Clinical Supervisor*, 29, 228-245.
doi:10.1080/07325223.2010.518511
- Lenz, A. S., Oliver, M., & Nelson, K. (in press). In-person and computer-mediated distance group supervision: A case study. *VISTAS 2011*.
- Martin, N., Fink, R., Laine, M., & Ayala, J. (2004). Immediate and short-term effects of contextual priming on word retrieval in aphasia. *Aphasiology*, 18, 867 – 898.

- Mosak, H. H., & Dreikurs, R. (1967). The life task: III. The fifth life task. *Individual Psychologist*, 5(1), 16-22.
- Myers, J. E. (1992). Wellness, prevention, development: The cornerstone of the profession. *Journal of Counseling & Development*, 71, 136–139.
- Myers, J. E. (2009). Wellness through social interest. In T. J. Sweeney (Ed.), *Adlerian Counseling and Psychotherapy* (5th ed.), (33-44). New York, NY: Routledge.
- Myers, J. E., Luecht, 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, 194-208.
- Myers, J. E., Mobley, A. K., & Booth, C. S. (2003). Wellness of counseling students: Practicing what we preach. *Counselor Education & Supervision*, 42, 264-274.
- Myers, J. E., & Sweeney, T. J. (2005a). The indivisible self: An evidence-based model of wellness (reprint). *The Journal of Individual Psychology*, 61, 269-279.
- Myers, J. E., & Sweeney, T. J. (Eds.). (2005b). *Counseling for wellness: Theory, research and practice*, Alexandria, VA: American Counseling Association.
- Myers, J. E., & Sweeney, T. J. (2005c). *Manual for the Five Factor Wellness Inventory*. Palo Alto, CA: MindGarden.
- Myers, J. E., Sweeney, T. J., & Witmer, J. M. (1998). *The Wellness Evaluation of Lifestyle*. Greensboro, NC: Authors.
- Myers, J. E., Sweeney, T. J., & Witmer, J. M. (2000). The Wheel of Wellness: A holistic model for treatment planning. *Journal of Counseling & Development*, 78, 251-266.

- Nelson, M. D., Johnson, P., & Thorngren, J. M. (2000). An integrated approach for supervising mental health counseling interns. *Journal of Mental Health Counseling, 22*, 45-58.
- Newton, R. R., & Rudestam, K. E. (1999). *Your statistical consultant*. Thousand Oaks, CA: Sage Publications.
- O'Neill, R. E., McDonnell, J. J., Billingsley, F. F., & Jenson, W. R. (2011). *Single case research designs in educational and community settings*. Upper Saddle River, NJ: Pearson.
- Patton, M. Q. (2002). *Qualitative research & evaluation methods* (3rd ed.). Thousand Oaks, CA: Sage Publications.
- Pierce, R.M., & Schauble, R.G. (1970). Graduate training of facilitative counselors: The effects of individual supervision. *Journal of Counseling Psychology, 17*, 210-215.
doi:10.1037/h0029221
- Ray, D. C., Minton, C. A., Schottelkorb, A. A., & Brown, A. G. (2010). Single-case design in child counseling research: Implications for counselor education. *Counselor Education & Supervision, 49*, 193-208.
- Roach, L. F. & Young, M. E. (2007). Do counselor education programs promote wellness? *Counselor Education and Supervision, 47*, 29-45.
- Roberts, M. C., Borden, K. A., Christiansen, M. D., & Lopez, S. J. (2005). Fostering a culture shift: Assessment of competence in the education and careers of professional psychologists. *Professional Psychology: Research and Practice, 36*, 355–361.

- Rogers, C. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology, 21*, 95-103. doi:10.1037/h0045357
- Rogers, C. (1993). *On becoming a person*, London, England: Constable.
- Roscoe, L. J. (2006). *Assessing the Utility of the Wellness Card Sort*. Poster presented at the Annual Convention of the Western Psychological Association, Palm Springs, CA.
- Roscoe, L. J. (2009). Wellness: A review of theory and measurement for counselors. *Journal of Counseling & Development, 87*, 216-224.
- Russell, R., Crimmings, A., & Lent, R. (1984). Counselor training and supervision: Theory and research. In S. Brown and R. Lent (Eds.), *Handbook of Counseling Psychology* (pp. 625-681). New York, NY: Wiley.
- Seligman, M., & Csikszentmihalyi, M. (2000). Positive psychology: An introduction. *The American Psychologist, 55*, 5-14. doi:10.1037/0003-066X.55.1.5
- Sheppard, J. B., Britton, P. J., & Kress, V. (2008). Reliability and validity of the professional counseling performance evaluation. *Australian Journal of Guidance & Counselling, 18*, 219-232.
- Shulman, L. (2005a). The Signature Pedagogies of the Professions of Law, Medicine, Engineering, and the Clergy: Potential Lessons for the Education of Teachers. Paper presented at the Math Science Partnerships (MSP) Workshop: "Teacher Education for Effective Teaching and Learning" Hosted by the National Research Council's Center for Education. Irvine, CA. Retrieved from taylorprograms.org/images/Shulman_Signature_Pedagogies.pdf

- Shulman, L. (2005b). The Clinical Supervisor-Practitioner Working Alliance: A Parallel Process. *The Clinical Supervisor*, 24, 23-47. doi:10.1300/J001v24n01_03
- Smith, H. L., Robinson III, E. H., & Young, M. E. (2007). The relationship among wellness, psychological distress, and social desirability of entering master's level counselor trainees. *Counselor Education & Supervision*, 47, 96-109.
- Smith, R.A., & Davis, S.F. (2001) *The psychologist as detective: An introduction to conducting research in psychology* (2nd ed.). Upper Saddle River, NJ: Prentice Hall.
- Smith, R. L. (2001) Integrative couple therapy: Beyond theory and practice. In L. Sperry (Ed.), *Integrative and biopsychosocial therapy: Maximizing treatment outcomes with individuals and couples* (pp. 43-66). Alexandria, VA: American Counseling Association.
- Spurgeon, S. L., & Myers, L. E. (2004). Relationships among racial identity, college type, and wellness. *Journal of Black Studies*, 1, 1-17.
doi:10.1177/0021934708315153
- Stoltenberg, C. D. (1981). Approaching supervision from a developmental perspective: The counselor complexity model. *Journal of Counseling Psychology*, 28, 59-65.
doi:10.1037/0022-0167.28.1.59
- Stoltenberg, C. D. (1997). The integrated developmental model of supervision: Supervision across levels. *Psychotherapy in Private Practice*, 16, 59-69.
doi:10.1300/J294v16n02
- Stoltenberg, C. D., & Delworth, U. (1987). *Developmental supervision: A training model for counselors and psychotherapists*. San Francisco, CA: Jossey-Bass Publishers.

- Stoltenberg, C. D. & McNeill, B. W. (2009). *IDM supervision: An integrative developmental model for supervising counselors and therapists*. New York, NY: Routledge.
- Stoltenberg, C. D., McNeil, B. W., & Delworth, U. (1998). *IDM: An integrated developmental model for supervising counselors and therapists*. San Francisco, CA: Jossey-Bass Publishers.
- Sweeney, T. J. (2009). *Adlerian Counseling and Psychotherapy*. (5th ed.). New York, NY: Routledge.
- Trepal, H., Haberstroh, S., Duffey, T., & Evans, M. (2007). Considerations and strategies for teaching online counseling skills: Establishing relationships in cyberspace. *Counselor Education and Supervision, 46*, 266-279.
- Trippany, R. L., Kress, V. E., & Wilcoxon, S. A. (2004). Preventing vicarious trauma: What counselors should know when working with trauma survivors. *Journal of Counseling & Development, 82*, 31-37.
- Vandenberghe, L. (2009). Keeping the focus on clinical relevant behavior: Supervision for functional analytic psychotherapy. *International Journal of Behavioral and Consultation Therapy, 5*, 209-221.
- Wheeler S. C., DeMarree, K. G., & Petty, R. E. (2007). Understanding the role of the self in prime to behavior effects: The active-self account. *Personality and Social Psychology Review, 11*, 234–261. doi:10.1177/1088868307302223
- Wilmshurst, L. A. (2002) Treatment programs for youth with emotional and behavioural disorders: an outcome study of two alternate approaches. *Mental Health Services Research, 4*, 85-96.

- Winn, L. L., & Rubin, D. L. (2001). Enacting gender identity in written discourse: Responding to gender role bidding in personal ads. *Journal of Language and Social Psychology, 20*, 393-418. doi:10.1177/0261927X01020004001
- Witmer, J. M., & Granello, P. F. (2005). Wellness in counselor education and supervision. In J. E. Myers & T. J. Sweeney (Eds.), *Counseling for Wellness: Theory, research, and practice* (pp. 261-272). Alexandria, VA: American Counseling Association.
- Wolpe, J. (1958). *Psychotherapy by reciprocal inhibition*. Stanford, CA: Stanford University Press.
- Wolpe, J., Knopp, W., & Garfield Z. (1966). Post-graduate training in behavioral therapy. *Exerta Medica International Congress Series, No. 150*. Proceedings of the IV World Congress of Psychiatry, Madrid, Spain.
- Yager, G. G., Tovar-Blank, Z. G. (2007). Wellness and Counselor Education. *Journal of Humanistic Counseling, Education & Development, 46*, 142-153.
- Yegdich, T. (1999). Lost in the crucible of supportive supervision: Supervision is not therapy. *Journal of Advancement in Nursing, 29*, 1265-1275. doi:10.1046/j.1365-2648.1999.01012.x

APPENDIX A**Preliminary Questionnaire**

- 1.) What is your last initial (example: L. for Alan Lenz) ____ .
- 2.) What is your birthday (month/ day/ year)? _____/_____/_____
- 3.) Gender:
 - a. Female
 - b. MaleIf female, are you pregnant? Yes No
- 4.) What is your current job occupation and title?
- 5.) How many hours a week do you work? _____
- 6.) How many hours a night do you usually sleep?
 - a. Less than 4
 - b. Between 4 and 6
 - c. Between 6 and 8
 - d. More than 8
- 7.) Growing up was personal wellness emphasized in your family?
 - a. Yes
 - b. No
- 8.) Growing up has your ethnic culture promoted personal wellness?
 - c. Yes
 - d. No
- 9.) Are you a practicum student or internship student this semester?
 - e. Practicum
 - f. Internship I
 - g. Internship 2
- 10.) Will you be completing practicum or internship hours at the TAMUCC Counseling & Training Clinic this semester?
 - a. Yes
 - b. No

Your Definition of Wellness

Wellness is an interesting and sometimes ambiguous concept. Please provide your personal definition of what wellness is below.

5F- Wellness Inventory

Mark only one answer for each item using this scale:

| | |
|---------------------------------|-----------------------------------------|
| Answer Strongly Agree | if it is true for you most of the time. |
| Answer Agree | if it is true for you some of the time. |
| Answer Disagree | if it is mostly not true for you. |
| Answer Strongly Disagree | if it is never true for you. |

| | | | |
|-----------------------|--------------|-----------------|--------------------------|
| Strongly Agree | Agree | Disagree | Strongly Disagree |
| A | B | C | D |

1. I engage in a leisure activity in which I lose myself and feel like time stands still. ____
2. I am satisfied with how I cope with stress. ____
3. I eat a healthy amount of vitamins, minerals, and fiber each day. ____
4. I often see humor even when doing a serious task. ____
5. I am satisfied with the quality and quantity of foods in my diet. ____
6. Being a male/female is a source of satisfaction and pride to me. ____
7. When I have a problem, I study my choices and possible outcomes before acting. ____
8. I do not drink alcohol or drink less than two drinks per day. ____
9. I get some form of exercise for 20 minutes at least three times a week. ____
10. I value myself as a unique person. ____
11. I have friends who would do most anything for me if I were in need. ____
12. I feel like I need to keep other people happy. ____
13. I can express both my good and bad feelings appropriately. ____
14. I eat a healthy diet. ____
15. I do not use tobacco. ____
16. My cultural background enhances the quality of my life. ____
17. I have a lot of control over conditions affecting the work or schoolwork I do. ____

| Strongly Agree | Agree | Disagree | Strongly Disagree |
|-----------------------|--------------|-----------------|--------------------------|
| A | B | C | D |

18. I am able to manage my stress. ____
19. I use a seat belt when riding in a car. ____
20. I can take charge and manage a situation when it is appropriate. ____
21. I can laugh at myself. ____
22. Being male/female has a positive affect on my life. ____
23. My free time activities are an important part of my life. ____
24. My work or schoolwork allows me to use my abilities and skills. ____
25. I have friends and/or relatives who would provide help for me if I were in need. ____
26. I have at least one close relationship that is secure and lasting. ____
27. I seek ways to stimulate my thinking and increase my learning. ____
28. I am often unhappy because my expectations are not met. ____
29. I look forward to the work or schoolwork I do each day. ____
30. I usually achieve the goals I set for myself. ____
31. I have sources of support with respect to my race, color, or culture. ____
32. I can find creative solutions to hard problems. ____
33. I think I am an active person. ____
34. I take part in leisure activities that satisfy me. ____
35. Prayer or spiritual study is a regular part of my life. ____
36. I accept how I look even though I am not perfect. ____
37. I take part in organized religious or spiritual practices. ____
38. I am usually aware of how I feel about things. ____

39. I jump to conclusions that affect me negatively, and that turn out to be untrue. ____

| Strongly Agree | Agree | Disagree | Strongly Disagree |
|-----------------------|--------------|-----------------|--------------------------|
| A | B | C | D |

40. I can show my feelings anytime. ____

41. I make time for leisure activities that I enjoy. ____

42. Others say I have a good sense of humor. ____

43. I make it a point to seek the views of others in a variety of ways. ____

44. I believe that I am a worthwhile person. ____

45. I feel support from others for being a male/female. ____

46. It is important for me to be liked or loved by everyone I meet. ____

47. I have at least one person who is interested in my growth and well being. ____

48. I am good at using my imagination, knowledge, and skills to solve problems. ____

49. I can start and keep relationships that are satisfying to me. ____

50. I can cope with the thoughts that cause me stress. ____

51. I have spiritual beliefs that guide me in my daily life. ____

52. I have at least one person with whom I am close emotionally. ____

53. I am physically active most of the time. ____

54. I use humor to gain new insights on the problems in my life. ____

55. I can put my work or schoolwork aside for leisure without feeling guilty. ____

56. I have to do all things well in order to feel worthwhile. ____

57. I feel a positive identity with others of my gender. ____

58. I am appreciated by those around me at work or school. ____

59. I plan ahead to achieve the goals in my life. ____

60. I like myself even through I am not perfect. ____

61. I am satisfied with my free time activities. ____

| | | | |
|-----------------------|--------------|-----------------|--------------------------|
| Strongly Agree | Agree | Disagree | Strongly Disagree |
| A | B | C | D |

62. I do some form of stretching activity at least three times a week. ____

63. I eat at least three meals a day including breakfast. ____

64. I do not use illegal drugs. ____

65. I believe in God or a spiritual being greater than myself. ____

66. I can experience a full range of emotions, both positive and negative. ____

67. I am able to relax when I need to do so to relieve my stress. ____

68. I eat fruits, vegetables, and whole grains daily. ____

69. My spiritual growth is essential to me. ____

70. When I need information, I have friends whom I can ask for help. ____

71. I am proud of my cultural heritage. ____

72. I like to be physically fit. ____

73. I have at least one person in whom I can confide my thoughts and feelings. ____

74. I am satisfied with my life. ____

75. I have enough money to do the things I need to do. ____

76. I feel safe in my home. ____

77. I feel safe in my workplace or school. ____

78. I feel safe in my neighborhood. ____

79. I feel safe in my daily life. ____

80. I am afraid that I or my family will be hurt by terrorists. ____

81. I am optimistic about the future. ____

82. My government helps me be more well. ____

83. My education has helped me be more well. ____

| | | | |
|-----------------------|--------------|-----------------|--------------------------|
| Strongly Agree | Agree | Disagree | Strongly Disagree |
| A | B | C | D |

84. My religion helps my well being. ____

85. I know I can get a suitable job when I need one. ____

86. I watch TV less than two hours each day. ____

87. World peace is important to my well being. ____

88. Other cultures add to my well being. ____

89. I look forward to growing older. ____

90. I like to plan the changes in my life. ____

91. Changes in life are normal. ____

92. What is your current marital status?

A. married/partnered D. divorced

B. single E. widowed

C. separated

93. What is your current employment status?

A. employed full time D. retired, working part time

B. employed part time E. not working

C. retired, not working

94. Are you currently a student?

A. yes, in high school

D. yes, taking courses for fun degree

B. yes, working on undergraduate E. no, not currently a student

C. yes, working on graduate degree

95. What is the highest level of education you have completed?

A. less than high school D. Bachelor's Degree

B. high school graduate E. Advanced Degree

C. trade/technical school/A.A. Degree

96. If you have an advanced degree, please specify your highest degree.

A. Master's degree C. Professional degree (DDS, JD, MD)

B. Specialist degree D. Doctorate degree (Ph.D., Ed.D.)

97. What is your biological sex?

A. Male B. Female

98. Are you biracial?

A. Yes B. No

99. What is the primary cultural background with which you most closely identify?

A. Native American D. Caucasian

B. Asian or Pacific Islander E. Hispanic/Latino/Latina

C. African American

100. What is your sexual/ affectional orientation?

A. gay C. bisexual

B. lesbian D. heterosexual

Appendix B**COUNSELING SKILLS SCALE - Modified**

Student Name _____ Theoretical Orientation _____

Review by Audio _____ Video _____ Faculty Name _____

Please first rate the student's microskills as -2, -1, 0, +1, or +2 according to the scale below. Then summarize each grouping of skills by averaging its individual microskills scores. Place that average in the blank following the grouping heading.

NOTE: If a skill is not performed but does not seem necessary, then assign it an "NN" and average only those skills performed into mean grouping scores. If a skill is not performed but should have been, then give it a score of -1 and average it with the rest of the skills performed under that super-heading.

- +2 *Highly developed: helpful, well-timed, and consistently well-performed*
- +1 *Well developed: helpful and well-timed when performed, but not consistently smooth*
- 0 *Developing skills: somewhat helpful but too many missed opportunities*
- 1 *Continue practice: not helpful or well-timed, or no skill existent when it should be*
- 2 *Major adjustment needed: not at all helpful or well-timed, potentially harmful*
- NN *Not performed, but not necessary; (an)other skill(s) within this "grouping" used to effectively meet this grouping's goals*

I. SHOWS INTEREST AND ENCOURAGEMENT

Group Score _____

- | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|
| <p>1. Body Language and Appearance – Maintains open, relaxed, confident posture with appropriate eye contact. Forward lean, comfortable position shows interest. Uses head nods and body gestures to encourage client talk. Maintains professional dress.</p> | -2 -1 0 +1 +2 NN |
| <p>2. Minimal Encouragers -- Repeats key words and phrases. Uses prompts (uh huh, okay, right, yes) to let client know s/he is heard.</p> | -2 -1 0 +1 +2 NN |
| <p>3. Vocal Tone – Uses vocal tone that matches the sense of the session and session goals. Vocal tone varies. Vocal tone communicates caring and connection with the client.</p> | -2 -1 0 +1 +2 NN |
| <p>4. Evoking and Punctuating Client Strengths – Session grounded in appreciation of and belief in client and in client strengths and abilities.</p> | -2 -1 0 +1 +2 NN |

- +2 *Highly developed: helpful, well-timed, and consistently well-performed*
- +1 *Well developed: helpful and well-timed when performed, but not consistently smooth*
- 0 *Developing skills: somewhat helpful but too many missed opportunities*
- 1 *Continue practice: not helpful or well-timed, or no skill existent when it should be*
- 2 *Major adjustment needed: not at all helpful or well-timed, potentially harmful*
- NN *Not performed, but not necessary; (an)other skill(s) within this "grouping" used to effectively meet this grouping's goals*

5. Appropriate use of silence – communicates caring, provides time for client to process, paces session. -2 -1 0 +1 +2 NN

II. ENCOURAGES EXPLORATION Group Score _____

6. Questioning -- Asks open-ended questions that encourage the client to continue talking and to provide information. Uses when needed and when Theoretically consistent. Uses closed questions judiciously. Does not overuse questions. -2 -1 0 +1 +2 NN

7. Requesting Concrete and Specific Examples -- Asks for concrete and specific instances when clients provide vague generalities. ("Give me an example of how you might feel or behave when facing _____.") -2 -1 0 +1 +2 NN

8. Paraphrasing (reflection of content) -- Engages in brief, accurate, and clear rephrasing of what the client has expressed. -2 -1 0 +1 +2 NN

9. Summarizing -- Makes statements at key moments in the session that capture the overall sense of what the client has been expressing. -2 -1 0 +1 +2 NN

III. DEEPENS THE SESSION Group Score _____

10. Reflecting Feeling -- States succinctly the feeling and the content of the problem faced by the client ("You feel _____ when _____.") -2 -1 0 +1 +2 NN

11. Using Immediacy – Reflects here-and-now session experiences of the client or the counselor by recognizing feelings and behaviors, expressed verbally or nonverbally, of the client or the counselor. Can be related to the counselor-client relationship. ("As we talk about _____ problem, I sense you are feeling _____ about me." "I notice that you smile as you are talking about your father's death. How is that for you?") -2 -1 0 +1 +2 NN

- +2 *Highly developed: helpful, well-timed, and consistently well-performed*
- +1 *Well developed: helpful and well-timed when performed, but not consistently smooth*
- 0 *Developing skills: somewhat helpful but too many missed opportunities*
- 1 *Continue practice: not helpful or well-timed, or no skill existent when it should be*
- 2 *Major adjustment needed: not at all helpful or well-timed, potentially harmful*
- NN *Not performed, but not necessary; (an)other skill(s) within this "grouping" used to effectively meet this grouping's goals*

12. Observing Themes and Patterns -- Identifies more overarching patterns of client acting, thinking, or behaving that may be related to a problem. ("In _____ situations, you regularly do _____ [or think _____ or feel _____] which seems to lead to _____ which causes you problems.") -2 -1 0 +1 +2 NN

13. Challenging/Pointing out Discrepancies -- Expresses observations of discrepancies. These may be between verbal or nonverbal thoughts, feelings, and behaviors. ("You expect yourself to do _____ when facing the problem of _____, but you do _____ instead. What do you make of this?") -2 -1 0 +1 +2 NN

14. Reflecting Meaning and Values – Reflects the unexpressed meaning or belief/value system that is behind the words the client is saying. ("You feel strongly about making choices based on your belief that _____.") -2 -1 0 +1 +2 NN

IV. ENCOURAGES CHANGE Group Score _____

15. Determining Goals and Desired Outcomes -- Collaboratively determines outcomes toward which the counseling process will aim. Helps client set goals congruent with client's values. -2 -1 0 +1 +2 NN

16. Using Strategies for Creating Change – Uses theoretically-consistent and intentional intervention strategies to help client move forward toward treatment goals (such as using guided imagery, looking at dysfunctional thoughts, behavioral strategies, search for exceptions or past successes). -2 -1 0 +1 +2 NN

17. Considering Alternatives and their Consequences -- Helps the client review possible options and the value of each over the long term. ("One option would be _____, and that would mean _____. Another option would be....") -2 -1 0 +1 +2 NN

- +2 *Highly developed: helpful, well-timed, and consistently well-performed*
- +1 *Well developed: helpful and well-timed when performed, but not consistently smooth*
- 0 *Developing skills: somewhat helpful but too many missed opportunities*
- 1 *Continue practice: not helpful or well-timed, or no skill existent when it should be*
- 2 *Major adjustment needed: not at all helpful or well-timed, potentially harmful*
- NN *Not performed, but not necessary; (an)other skill(s) within this "grouping" used to effectively meet this grouping's goals*

18. Planning Action and Anticipating Possible Obstacles --

-2 -1 0 +1 +2 NN

Reaches agreement about actions to take between sessions, who is responsible for them, and when they will be done. Helps client to list what obstacles might interfere and decide how to handle them. ("So, you will do _____ by _____ date. What could prevent you from accomplishing your plan?")

V. DEVELOPS THERAPEUTIC RELATIONSHIP

Score _____

19. Consistently engages in caring manner with client, particularly by demonstrating such core conditions as genuineness and authenticity, warmth and acceptance, respect and positive regard, and empathy.

-2 -1 0 +1 +2 NN

VI. MANAGES THE SESSION

Score _____

20. Opens session smoothly and warmly greets client. Begins work on counseling issues in a timely way. Structures session, directing client naturally through opening, exploration, deeper understanding, creating change, and closing; focuses client on essence of issues at a level deep enough to facilitate movement. Smoothly and warmly ends the session, in a timely way, planning for future sessions or for termination.

-2 -1 0 +1 +2 NN

TOTAL CSS SCORE (add grouping averages): _____

Instructor Comments:

Modification of model by Eriksen, K., & McAuliffe, G. (2003). A measure of counselor competence. *Counselor Education & Supervision*, 43, 120-133.