

The Effect of a Wellness Intervention on the Total Wellness of
Counseling Practicum Graduate Students

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Abstract

This study examined the effect of a wellness intervention on the total wellness of master's-level graduate students in counseling practicum. It was posited that participation in a wellness intervention would result in observable increases in student total wellness. Using a quasi-experimental, single-group pretest-posttest design with quota sampling, a sample size of 30 practicum students was recruited. Participants were administered the 5F-Wel Inventory to assess baseline wellness, and participated in a wellness intervention, which was followed up with a posttest administration of the 5F-Wel (Myers & Sweeney, 2005d). Data analysis involved using analysis of covariance (ANCOVA). The results of these analyses indicated there was a statistically significant difference in participants' Total Wellness and wellness factors scores, supporting the research hypothesis that participation in a wellness intervention increases student wellness as indicated by 5F-Wel posttest scores. Implications for clinical supervision, counseling education, as well as areas for future research are offered.

Myers, Sweeney, and Witmer (2000) comprehensively define wellness as a means of living that is oriented toward optimal health and wellbeing, the purposeful integration of body, mind, and spirit with the goal of living life more fully within all spheres of functioning, including social, personal, and environmental. Accordingly, wellness, personal growth, and professional development are fundamental aspects in the theory and practice of the counseling profession (Corey, Corey, & Callanan, 2011; Hattie, Myers, & Sweeney, 2004; Hendricks, Bradley, Brogan, & Brogan, 2009; Lawson & Venart, 2005). As such, counseling graduate programs have made efforts to incorporate an emphasis on wellness as a component of self-awareness and professional development in recent years (Frame & Stevens-Smith, 1995; Forrest, Elman, Gizara, & Vacha-Haase, 1999). Professional organizations and associations such as the American Counseling Association (ACA), the Association for Counselor Education and Supervision (ACES), and the Council for the Accreditation of Counseling and Related Education Programs (CACREP) individually and collectively outline the significance of personal growth: the ACA Code of Ethics (2005) addresses personal growth under Supervision, Training, and Teaching, emphasizing "training components that encourage self-growth or self-disclosure as part of the training process" (Section F.7.a.4, p. 15); and the CACREP 2009 Standards suggests "strategies for facilitating optimum development and wellness across the lifespan" (Section II.3.h., p. 11). While there is significant research in areas regarding the concept of wellness, wellness models, factors that contribute to wellness, and the importance of wellness to clients seeking counseling services as well as for counseling professionals to prevent or address professional impairment (Cummins, Massey, & Jones, 2007; Elman & Forrest, 2007; Myers &

Sweeney, 2005a; Roscoe, 2009), there appears to be a paucity of research specifically examining wellness in graduate counseling students and counselors-in-training. This is the foundation for the significance and purpose of this research study.

Wellness as a Component of Counselor Education

Self-care and wellness are concerns of counseling professionals as well as the clients whom they serve, and balancing the multifaceted dimensions of wellness is challenging even for the most experienced, proficient, and prominent counseling providers. Carl Rogers (1995; as cited in Cummins, Massey, & Jones, 2007, p. 80) described the challenge to balance self-care and client care: "I have always been better at caring for and looking after others than I have in caring for myself". Lack of self-care and wellness can make professionals vulnerable to increased anxiety (Bemak, Epps, & Keys, 1999; Prieto, 1998), distress (Cummins et al., 2007; Sherman & Thelen, 1998), compassion fatigue (Figley, 1995, 2002), burnout (Lee, Cho, Kissinger, & Ogle, 2010; Maslach, 2003), and ultimately impairment (Elman & Forrest, 2007; Forrest et al., 1999). Lawson, Venart, Hazler, and Kottler (2007) proposed that rather than simply focusing on pathology (i.e. burnout and impairment) or "all-or-nothing" labeling (i.e. "well" or "impaired"), that the counseling profession conceptualize wellness as fluid with specific reference points along a continuum of well, stressed, distressed, and impaired. Ideally, education, prevention, intervention, and rehabilitation efforts should be developed and adapted accordingly. At the heart of this study is the issue of impaired counseling professionals and counselors-in-training, the impact of impairment on the counseling profession, and how wellness education can serve to remediate contributory factors.

Historically, research exploring the wellness of counselors indicates conservative estimates of more than 6,000 counselors currently practicing in the United States with some type of mental, psychological, or emotional distress (Kottler & Hazler, 1996; Sheffield, 1998). Lawson and Venart (2005) reported a survey of 770 practicing counselors regarding wellness and impairment and noted that 63.5% of respondents have known a counselor whom they would consider impaired; in those cases, 54.3% of supervisors and 64.2% of colleagues were aware of the impairment, and 73.7% did not receive therapeutic intervention. Lawson et al. (2007) concluded that though most counselors have been aware of other counselors who were impaired, the general consensus is that little was done to help due to a lack of response, lack of support, and most importantly, a lack of resources or information for how best to identify or remediate impaired or at-risk professionals.

What makes this literature relevant to this study is the general consensus of researchers that anxiety, distress, and impairment can occur at any time during professional development, including graduate education and early counselor training (Sherman & Thelen, 1998). Prieto (1998) and Bemak et al. (1999) indicated that students may be more vulnerable to increased anxiety; this may be particularly so as they enter the clinical practicum phase of their educational and professional development, which introduces new stressors unique to the transition from student to counselor-in-training. As stressors contribute to increased anxiety and distress, Sherman and Thelen (1998) noted a subsequent decline in therapeutic effectiveness; this is what Elman and Forrest (2007) call trainee impairment.

Though wellness has been explored in numerous studies over the course of three decades, a review of the research reveals a gap in the literature regarding wellness in counseling students. Counseling students face distinct stressors related to their education, professional development, and training (Degges-White & Myers, 2006; Myers & Degges-White, 2007; Perepiczka, 2009), and these stressors may result in increased anxiety, distress, and trainee impairment (Bemak et al., 1999; Prieto, 1998; Sherman & Thelen, 1998), which may further contribute to decreased fitness to practice and therapeutic efficacy, as well as professional deficiencies (Elman & Forrest, 2007; Lee, Cho, Kissinger & Ogle, 2010). The researchers assert that increased stressors and compromised wellness may be particularly prominent as students enter the clinical practicum phase of their educational and professional development, which introduces new stressors unique to the transition from student to counselor-in-training as they begin to manage multiple roles and demands.

Research Questions and Hypotheses

Understanding the impact of a wellness intervention on personal wellness of graduate students involved in clinical practicum was the focus guiding this research study. Specifically, the following research questions were posed:

- 1) Research Question 1 (RQ1): After controlling for the Total Wellness pretest scores, is there a significant difference in participants' Total Wellness posttest scores based on a wellness intervention?
- 2) Research Question 2 (RQ2): Is there a difference in students' total wellness as indicated by wellness factor scale scores (Creative Self, Coping Self, Social Self, Essential Self, and Physical Self) on the pretest and posttest administrations of the Five Factor Wellness Inventory (5F-Wei) (Myers & Sweeney, 2005d)?

The research hypothesis for RQ1 was that participation in a wellness intervention would increase reported student total wellness, with significant differences observed across the specified five wellness factors of the Creative, Coping, Social, Essential, and Physical Selves (RQ2).

Method

Participants

The study was implemented over the course of 30 weeks, spanning the fall and spring semesters. Participants were identified and selected from the roster of graduate students in a master's program in counseling at a large southeastern U.S. metropolitan city and were recruited utilizing convenience sampling, a sampling technique in which participants are obtained from a readily available source, and typically involves obtaining volunteer participants (Jackson, 2009). Potential participants met the study's established inclusionary criteria, which targeted students enrolled in a master's level graduate program who were entering the clinical practicum phase of their education and training. Potential participants were precluded from sample selection based on any or all of the following exclusionary criteria: a) students not eligible for, registered, or enrolled in master's counseling practicum; and b) students who have completed practicum phase of their graduate program. Such students were outside of the specified scope of this study.

After seeking Institutional Review Board (IRB) certification, the Principal Investigator (PI) sent a letter to the co-directors of the training office detailing the study and seeking permission to contact seminar instructors regarding recruitment of students. Seminar instructors

were provided with an overview of the study. The researchers secured permission to recruit participants from both the co-directors of the training office and the seminar instructors. A total of 123 master's students were identified as potential participants and invited to participate in the study; from this population, 73 students volunteered to participate in the study to comprise the initial study sample. Of the 73 participants who initially enrolled in the study, 34 participants received the intervention (wellness workshop), and 30 participants completed all study requirements. The primary reason for attrition, as noted by the researchers, involved inability to commit to participation in the wellness intervention, a requirement for study participation.

Table 1
Participant Sample Information

| | Population (<i>N</i>) | Initial Sample | Final Sample (<i>n</i>) | Average Attrition Rate |
|-------------|----------------------------|-------------------|------------------------------|---------------------------|
| Fall 2011 | 69 | 33 | 12 | 58% |
| Spring 2012 | 54 | 40 | 18 | 33% |
| Total | 123 | 73 | 30 | 46% |

Instrumentation

Demographic questionnaire.

The researchers collected demographic information from study participants to use for data analysis using a specific study-generated questionnaire. The questionnaire collected the following information: gender, age, race/ethnicity, marital status, religious affiliation, occupational history/work status, and educational status.

The Five Factor Wellness Inventory (5F-Wel)

The Five Factor Wellness Inventory (5F-Wel), developed by Myers and Sweeney (2005a, 2005b, 2005d) is a 98-item, self-report assessment designed as an instrument of measure based on the Indivisible Self Wellness (IS-Wel) Model. Responses are recorded using a 4-point Likert rating scale, based on the following options: strongly agree, agree, disagree, and strongly disagree. The 5F-Wel assesses personal wellness based on holistic characteristics, with 73 of its items yielding a composite total wellness score based on five factors with 17 corresponding secondary sub-factors, delineated as follows: Creative Self (Thinking, Emotions, Control, Work, Positive Humor); Coping Self (Leisure, Stress Management, Self-Worth, Realistic Beliefs); Social Self (Friendship and Love); Essential Self (Spirituality, Gender Identity, Cultural Identity, Self-Care); and Physical Self (Nutrition and Exercise). This study utilized the A Version of the 5F-Wel. Permission to use the 5F-Wel-A was obtained by the author.

Regarding reliability, alpha coefficients for the 5F-Wel-A were: Total Wellness - .98, Creative Self - .96 (related context scales ranging from .79 to .88), Coping Self - .89 (related context scales ranging from .58 to .91), Social Self - .96 (related context scales ranging from .92 to .95), Essential Self - .95 (related context scales ranging from .89 to .92), and Physical Self - .90 (related context scales ranging from .87 to .89). Hattie et al. (2004) examined the construct validity of the 5F-Wel based on a comparison of it to similar measures (e.g. Testwell, Coping Responses Inventory, Measures of Psychosocial Development, Inventory of Self Actualizing Characteristics, and Developmental Counseling and Therapy); reported correlations range from .28 to .74, and are indicative of the construct validity of the 5F-Wel as a measure of wellness.

Procedures

Pretest. During Weeks 1-3 of counseling practicum, the PI attended the first 30 minutes of seminar classes introduced the purpose of the study and requested voluntary student participation. Study packets were given to students who agreed to participate; each packet was labeled with a study-generated ID to protect participants' anonymity and consisted of the following: a) the informed consent (a copy of the document was provided for the student's records); b) the demographic questionnaire; c) the pretest 5F-Wel; and d) an invitation to participate in the wellness intervention with specific listed dates for attendance. A copy of the wellness intervention agenda was provided, and a return slip with the selected attendance date was to be returned to the researchers in the completed packet). The PI offered brief instructions regarding the completion of the packets, and PI was present in the room only to answer subsequent questions if needed. Once the packets were completed, the researchers collected them. Upon completion of this phase, study participants were given a letter (also contained in the initial study packet) denoting the second phase of their study involvement—administration of the treatment, the wellness intervention. The completed 5F-Wel instruments were sent to Dr. Myers for scoring as per the instructions specified in the permission to use the 5F-Wel Inventory; in addition to the scoring of the 5F-Wel Inventory, an individualized personal wellness profile for each participant was returned by Dr. Myers to the researchers. The wellness profiles were integral to the wellness intervention.

Wellness Intervention

After the identification of study participants as well as the establishment of the proposed sample and initial data collection of 5F-Wel (Myers & Sweeney, 2005b, 2005d) pretest scores, participants were invited to attend and participate in the wellness intervention. A series of four wellness seminars and workshops were held over the course of Weeks 4-6 of the practicum period. Participants selected their date to attend one of the seminars during initial data collection. The intervention was a three-hour workshop conducted by the PI, and designed based on the Five Factor Wellness (5F-Wel) and Habit Change Workbook (Myers & Sweeney, 2005b), a supplement to the 5F-Wel Inventory. During the seminar, the PI defined wellness, and educated participants on "The Indivisible Self: An Evidenced-Based Model of Wellness (IS-Wel)" (Myers & Sweeney, 2005a; Sweeney & Myers, 2005); a copy of the seminar and workshop outline, agenda, and goals and objectives can be provided upon request. The researchers reviewed with participants their pretest 5F-Wel scores and the preliminary wellness profile, and facilitated participants' understanding of how to develop their wellness plan as well as identify specific ways to implement their individual wellness plans. At the conclusion of the intervention, each participant developed a personal wellness plan to implement during Weeks 7-12 of the study.

Posttest Administration

The posttest administration of the 5F-Wel occurred during Week 13-15 of the students' counseling practicum. During Week 12, the PI sent a reminder letter to all seminar instructors of the final data collection phase. The PI attended seminar classes during Week 13-15 to distribute the final study packet, which contained the posttest 5F-Wel Inventory. Once packets were completed, they were either directly returned to the researchers or deposited in the secured drop-box. This concluded participants' commitment to the study.

Throughout the entire study, participants were monitored for potential deleterious effects of participation. The researchers assessed for the manifestation of potential risks and harm to participants utilizing direct inquiry and participant self-report. It was anticipated that such potential risks were minimal, but might have included participants becoming aware of stressors or issues that may be negatively impacting their physical, emotional, or mental wellness. If participants were to report or were observed to experience any adverse reactions, a referral for free counseling was offered; services were available to participants through the Student Assistance Program provided by The Wellness Corporation. No such negative effects related to study participation were reported or observed. Participants were able to voluntarily withdraw from the study at any time; participants who withdrew from the study were noted under Participant Attrition. Only data collected from participants who completed all phases of the study—pretest, wellness intervention, and posttest—were included in data analysis.

Data Analysis

The primary means to analyze participant responses involved inputting data into IBM SPSS Statistics, Version 19. All participants were assigned individual study identification (study ID), and it was this ID that was assigned to participant response data in SPSS. Descriptive statistics such as measures of central tendency (i.e. mean, median, and mode), distribution, and dispersion (i.e. range, standard deviation) were used to analyze demographic data. In order to answer the posited research questions (RQ1 and RQ2), ANCOVA was used to analyze data from the pre- and posttests to determine if there was a significant difference in these scores and if this difference could be attributed to the wellness intervention, with 5F-Wel Total Wellness pretest scores as the covariate.

Results

Demographic Information

The sample was comprised of participants from diverse racial and ethnic backgrounds, including Caucasian (27.3%), African American (63.6%), Hispanic/Latino (3%), and Asian (3%) ethnicities. Regarding gender, the sample was composed of 24 female (80%) and 6 male (20%) participants. The age range of participants was 20-60 years old; the mean (*M*) age range of participants was 35-39 years old. Regarding education, because all participants were enrolled in a graduate degree program, all of them held at least a bachelor's degree; however 20% of participants also had previously earned a master's degree. All participants were enrolled in school on full-time status. Additionally, 60% of the participants were employed either full-time (40%), or part-time (20%); 40% of participants were unemployed or not working. Regarding relationship status, 50% of the participants were single/never married, 36.7% were married or partnered, and 13.3% were separated or divorced.

To address the research questions, the data collected was analyzed using ANCOVA, with the pretest scores as the covariate. ANCOVA was employed as the measure of data analysis as opposed to repeated measures ANOVA, because the researchers wanted to analyze the impact of the wellness intervention after controlling for pretest scores. ANCOVA allowed for a comparison of participants' pretest and posttest Total Wellness scores as obtained by the two administrations of the 5F-Wel Inventory to determine if differences in the scores were observed,

and if those observed differences could be attributed to the wellness intervention, controlling for preexisting differences and error variances. Descriptive statistics of participant pre- and posttest 5F-Wel Total Wellness (TW) scores are as follows: Pretest TW $\bar{x} = 77.67$, $SD = 6.54$; Posttest TW $\bar{x} = 78.52$, $SD = 9.14$. Additionally, Table 2 presents descriptive statistics for the wellness factors scale scores; observable increases in participant mean scores were noted for all wellness factor scales.

Table 2
Descriptive Statistics for Participant 5F-Wel Wellness Factors Scores

| | Mean | Median | Mode | SD |
|-----------------|-------|--------|--------------------|-------|
| Creative Self | | | | |
| Pretest Scores | 78.33 | 76.50 | 70.00 | 8.49 |
| Posttest Scores | 78.96 | 78.75 | 73.75 | 10.29 |
| Coping Self | | | | |
| Pretest Scores | 75.20 | 76.00 | 76.00 | 9.20 |
| Posttest Scores | 76.01 | 75.00 | 73.68 ^a | 9.80 |
| Social Self | | | | |
| Pretest Scores | 88.87 | 92.00 | 100.00 | 10.10 |
| Posttest Scores | 88.44 | 90.63 | 93.75 | 12.87 |
| Essential Self | | | | |
| Pretest Scores | 83.20 | 84.50 | 70.00 ^a | 8.28 |
| Posttest Scores | 82.71 | 83.60 | 82.81 ^a | 12.87 |
| Physical Self | | | | |
| Pretest Scores | 62.30 | 62.00 | 52.00 | 15.34 |
| Posttest Scores | 67.60 | 66.50 | 55.00 | 16.47 |

a. Multiple modes exist. The smallest value is shown

An ANCOVA was conducted to compare student wellness based on the 5F-Wel Total Wellness scores after participating in a wellness intervention. The dependent variable was participants' 5F-Wel posttest Total Wellness scores after the intervention; the independent variable was the wellness intervention. The covariate was participant 5F-Wel pretest Total Wellness scores prior to receiving the wellness intervention. The level of statistical significance or alpha (α) was set at 0.05. After adjusting for the pretest scores, there was a statistically significant difference in the participants' Total Wellness scores after the wellness intervention as measured by the posttest administration of the 5F-Wel, with $F(1, 28) = 9.742$, $p < .004$. Additionally, effect size is indicated by partial eta squared (R^2), which is reported as .258, and is consistent with a medium association; these results are presented in Table 3.

Table 3

*ANCOVA: Tests of Between-Subjects Effects, Dependent Variable:
 Posttest Total Wellness*

| Source | Type III Sum of Squares | df | Mean Square | F | Sig. | Partial Eta Squared |
|------------------|-------------------------|----|-------------|-------|------|---------------------|
| Corrected Model | 624.682 ^a | 1 | 624.682 | 9.742 | .004 | .258 |
| Intercept | 111.897 | 1 | 111.897 | 1.745 | .197 | .059 |
| PreTotalWellness | 624.682 | 1 | 624.682 | 9.742 | .004 | .258 |

Note. a. R Squared = .258 (Adjusted R Squared = .232), b. Computed using alpha = .05

For RQ2, the data collected were analyzed using ANCOVA, which allowed for a comparison of participants' pretest and posttest scores as obtained by the two administrations of the 5F-Wel Inventory to determine if differences in the scores were observed, and if those observed differences can be attributed to the wellness intervention, controlling for preexisting differences and error variances. The five factors of wellness as defined by Myers and Sweeney's (2005a, 2005d) Indivisible Self Model of Wellness, specifically the Creative, Coping, Social, Essential, and Physical Selves, served as the basis for the ANCOVA.

An ANCOVA was conducted to compare student wellness based on the 5F-Wel wellness factors scale scores for The Creative Self, The Coping Self, The Social Self, The Essential Self, and The Physical Self, after participating in a wellness intervention. The dependent variable was participants' 5F-Wel posttest scores after the intervention; the independent variable was the wellness intervention. The covariate was participant 5F-Wel pretest scores prior to receiving the treatment (wellness intervention). The level of statistical significance or alpha (α) was set at 0.05, which is standard in social science research. After adjusting for the pretest scores, there was a statistically significant difference in the participant wellness factor scale scores (Creative Self, Coping Self, Social Self, Essential Self, and Physical Self) after the wellness intervention as measured by the posttest administration of the 5F-Wel: for the Creative Self wellness factor, $F(1, 28) = 26.275, p < .000, R^2 = .484$; for the Coping Self wellness factor, $F(1, 28) = 11.700, p < .002, R^2 = .295$; for the Social Self wellness factor, $F(1, 28) = 7.065, p < .013, R^2 = .201$; for the Essential Self wellness factor, $F(1, 28) = 13.645, p < .001, R^2 = .328$; and for the Physical Self wellness factor, $F(1, 28) = 51.600, p < .000, R^2 = .648$. For each wellness factor, statistically significant differences were observed; with medium to large effect size strength of variability in pre- and posttest mean wellness factor scores. Table 4 summarizes the ANCOVA data analysis findings as discussed.

Table 4
 ANCOVA: Tests of Between-Subjects Effects, Dependent Variable: Creative, Coping,
 Social, Essential, and Physical Self Scores

| Source | Type III Sum of Squares | <i>df</i> | Mean Square | <i>F</i> | Sig. | Partial <i>R</i> ² |
|------------------------|-------------------------------|-----------|----------------|----------|------|----------------------------------|
| Pretest Creative Self | 1487.23 | 1, 28 | 1487.23 | 26.28 | .000 | .484 |
| Pretest Coping Self | 821.15 | 1, 28 | 821.15 | 11.70 | .002 | .295 |
| Pretest Social Self | 984.36 | 1, 28 | 984.36 | 7.06 | .013 | .201 |
| Pretest Essential Self | 1574.10 | 1, 28 | 1574.10 | 13.64 | .001 | .328 |
| Pretest Physical Self | 5100.83 | 1, 28 | 5100.83 | 51.60 | .000 | .648 |

Note. a. R Squared = .258 (Adjusted R Squared = .232), b. Computed using alpha = .05

Discussion

With regard to the study’s purpose, it was hypothesized that participation in a wellness intervention would increase total wellness scores. Findings of ANCOVA support a medium to high effect size of the statistical difference in participants’ posttest scores after the wellness intervention when participant’s pretest scores were the covariate; it is asserted that an observed difference in participants’ posttest Total Wellness scores is as the result of the wellness intervention. This outcome appears to be consistent with findings reported by Roach and Young (2007), specifically, “results of the ANOVA indicated that there were statistically significant differences between mean scores on Total Wellness based on a wellness course offering, $F(1, 198) = 7.245, p = .008$ ” (p. 37), however, effect size was not discussed. In this study, ANCOVA findings yielded a significant value of .004, and the observed statistical significance has medium strength, as noted by a partial eta squared value of .258. These findings appear to be indicative of the value of wellness courses and strategies for promoting wellness in students at best.

One difference between this study and that conducted by Roach and Young (2007) was the significantly smaller sample size; the sample size for this study was 30 participants; Roach and Young’s sample size was 204. In this study, attrition was a significant factor regarding sample size; approximately 46% of participants who initially began the study voluntarily withdrew prior to receiving the intervention. This was a factor that should be considered as a potential limitation, and also an issue to note in future research efforts.

Research Question 2 investigated differences in students’ total wellness as indicated by total wellness and wellness factor scores on the pre- and posttest administrations of the 5F-Wel. It was hypothesized that observable changes between pretest and posttest would be noted in participants’ Total Wellness, wellness factors, or “Selves” and subscale scores, and that these changes would be attributable to a wellness intervention. Findings of the ANCOVA support a statistical difference in participants’ pretest and posttest wellness factors scale scores, with a medium to high effect size and strength of association supporting the research hypothesis. The differences in the pre- and posttest scores of the Physical Self are statistically significant, and

appear consistent with participants' expressed goal to improve specific aspects of their wellness as noted in their personal wellness plans created as a part of the wellness intervention. Succinctly, participants who set out to improve their physical wellness over the course of the study appear to have been successful in that effort. The findings for Research Questions 1 and 2 seem to support an infusion of a wellness curriculum into existing counseling education programs as well as potential student interest in such. Such findings are consistent with similar responses reported in existing literature on wellness in counselor education programs (Perepiczka, 2009; Roach, 2005).

Limitations

Possible attrition factors include the time commitment required to complete the study, which was approximately four hours. As previously discussed, attrition greatly reduced the final sample size. Having a smaller sample size reduces the power of statistical analyses such as *t*-tests and ANOVA, and smaller samples increase the potential risk of a Type II error (Jackson, 2009). Lastly, time as a limitation may have been mitigated if the study had spanned the duration of students' practicum and internship, which is approximately ten months rather the 3-month period of practicum only. Though attempts were made to reduce the amount of contact between the researchers and the participants and to limit the focus of all contact to the purpose of the research study, it is possible that this may have increased the risk of a Type I error (Jackson, 2009).

An additional limitation is gender. The study sample is comprised of 30 participants, and is disproportionately female (80%). This may be consistent with current trends indicating that counseling is a female-dominated profession (Mobley, 2004). Research regarding gender differences and wellness offers split opinions. Generally speaking, research regarding gender differences in Total Wellness notes no differences in wellness between men and women (Ryff & Keyes, 1995; Diener, Suh, Lucas, & Smith, 1999; Myers, Mobley, & Booth, 2003; Myers & Mobley, 2004). From a psychological perspective, women are twice as likely to experience depression as are men (Berger, 2011). Furthermore, Diener et al. (1999) reviewed three decades of literature examining happiness and subjective wellbeing. It noted that though men and women had consistent Total Wellness scores and no discernible differences exist, women are more likely to report higher perceptions of wellness than men. Examining gender difference can be the focus of future research efforts.

Implications for Counseling Education

Well counselors are more likely to produce well clients (Witmer & Young, 1996). If one supports this assertion, then it seems prudent to adopt a wellness philosophy as not only a standard of practice, but as a foundational aspect of counselor education and professional training. Suggestions for how to create a counselor education program emphasizing wellness and prevention are a proposal of Witmer and Young (1996), and include a) discussing counselors' legal and ethical responsibilities to prevent impairment—mentioned in this section; b) planning opportunities for students to enhance their personal growth and development throughout their program; c) requiring counseling and other experiential personal growth activities; d) education that focuses on knowledge, skills, and strategies for coping with stress, distress, impairment, and burnout; and e) formative and summative assessments for students to assess vulnerabilities in conjunction with faculty and supervisor assessment for impairment. Additionally, El-Ghoroury, Galper, Sawaqdeh, and Bufka (2012) emphasized graduate

programs' unique and "strong position to promote students' wellbeing at a wide level" (p. 131); such efforts could involve simple strategies such as incorporating wellness strategies into printed materials (i.e. department handbooks and student guides), as well as discussions of wellness and self-care in academic curriculum and professional training and development. Williams-Nickelson (2006) as cited by El-Ghoroury et al. (2012) offers examples of wellness efforts in education such as educating students in how to self-monitor their stress levels and how to develop a personal wellness and self-care plan, and suggests that these strategies should be taught in students' first year, creating a wellness and coping foundation.

Further support is presented by Witmer and Granello (2005) suggesting three models to incorporate wellness into counselor education and training; each model offers a different level of adaptation. The first is a course-specific model such as a wellness class offered over the course of an academic term, which involves a relatively simple integration. A second approach is an "infusion" model, which weaves wellness objectives and assignments into existing curricula and course work, and is a more intermediary integration of wellness. The third and most comprehensive model involves a full integration of wellness into all curricular aspects of counselor education, specifically "a wellness philosophy would be incorporated into every facet of the program from faculty participation, student admissions, and course work, to co-curricular activities and field work experiences" (p. 268). Such a holistic wellness model would include "opportunities for mental, emotional, social, physical, vocational, and spiritual experiences that enhance wellbeing" (p. 271).

The wellness seminar and workshop used as the intervention in this study could be adapted to meet any of the objectives of the afore-mentioned wellness-based education models. A two-day wellness course could be created expanding on the outlined goals, objectives, and agenda, or an entire semester class could be developed based on the existing objectives, and resources such as the Five Factor Wellness and Habit Change Workbook (Myers & Sweeney, 2005c), or texts such as Myers and Sweeney's (2005a) *Counseling For Wellness: Theory, Research, and Practice*. Additionally, adapting aspects of the Five Factor Wellness and Habit Change Workbook into existing curriculum would allow for the creation of course-specific assignments that could promote student wellness in every class. This would also be in keeping with the spirit and intent of CACREP 2009 Standards that suggest "strategies for facilitating optimum development and wellness across the lifespan" (Section II.3.h., p. 11). Lastly, a wellness education curriculum infused with aspects of the Indivisible Self Model of Wellness (Myers & Sweeney, 2005d) could address the holistic aspects of wellness listed by Witmer and Granello (2005).

Recommendations

A principal recommendation for the utility of this study is the inclusion of a wellness intervention as an educational component of master's students' training. Ideally, wellness can be an integral part of counselor education and training; a body of research champions this philosophy (Hensley, Smith, & Waller-Thompson, 2003; Myers, Mobley, & Booth, 2003; Myers & Sweeney, 2008; Roach & Young, 2007; Sheffield, 1998; Yager & Tovar-Blank, 2007). However, at minimum, a one-day wellness seminar can be offered to students prior to the beginning of their practicum and/or internship requirement. Formative and summative

assessments of wellness can be incorporated at specific intervals or “check points” during this practical training period. This can involve re-administrations of a wellness assessment, a meeting with the academic advisor or seminar instructor to review the student’s wellness plan, as a separate planned meeting or as a part of student on-site or seminar supervision. Another option for implementing a wellness intervention is to incorporate it into the practicum and internship seminar course curriculum. A pre-test assessment can be introduced during the first weeks, and a wellness plan can be incorporated as an element of the seminar. Specific wellness and self-care activities can be infused into the seminar course outline and syllabus. Thus students can begin to learn the practical skills they need to care for themselves in addition to their future clients. An ounce of prevention is worth more than a pound of cure related to counselor distress, impairment, and professional burnout.

One possibility for future research is a replication of this study. Replication efforts should seek to increase the sample size, to a minimum of 50 participants, which would counter one of the identified research limitations. It is anticipated that this increase in the sample should allow for sufficient comparison of observable and statistically relevant differences. Potential variations of this study are cross-sectional, or longitudinal, with multiple post-intervention assessments to assess wellness across the entire span of a student’s graduate program.

Additionally, future research efforts can consider a qualitative methodology. One possible approach is to examine student’s perception of their wellness during the practicum and/or internship. A phenomenological research design will allow for the capturing of the lived experiences of student’s during this critical time of their educational and professional development. Also, a grounded theory design allows for the development of a wellness theory or model specific to counseling graduate students and the counseling education curriculum. One of the principle issues regarding wellness in counseling education is that while wellness has been adequately defined as a construct with solid theory, varying models, and established research, the counseling profession lacks a uniformed definition of impairment or a universally-implemented, comprehensive remediation or rehabilitative plan to address impaired professionals (Frame & Stevens-Smith, 1995; Kottler & Hazler, 1996; Sheffield, 1998; White & Franzoni, 1990). One plan to mitigate impairment is preventive education. Future research efforts can examine the short-term and long-term effects of wellness interventions as a part of counseling education and training on wellness in counseling professionals and the potential for influencing the manifestation of impairment in practitioners.

In closing, counselor educators, clinical supervisors, and counseling professionals have a fiduciary responsibility to the clients who receive services, the students who have enrolled in counseling programs with aspirations to serve the community, and to the counseling profession as a whole. It is not sufficient to teach students how to care for others and not to at least necessitate self-care as a personal and educational requirement for professional development. Adopting a wellness-based teaching paradigm and educational philosophy and incorporating specific wellness interventions are viable alternatives.

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