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An Investigation of the Relationship among Wellness and Academic Factors of Counseling Self-Efficacy of Counselors-In-Training

Rosanne Nunnery

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AN INVESTIGATION OF THE RELATIONSHIP AMONG WELLNESS AND
ACADEMIC FACTORS OF COUNSELING SELF-EFFICACY
OF COUNSELORS-IN-TRAINING

By

Rosanne Nunnery

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AN INVESTIGATION OF THE RELATIONSHIP AMONG WELLNESS AND ACADEMIC FACTORS OF COUNSELING SELF-EFFICACY OF COUNSELORS-IN-TRAINING

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What a counselor-in-training believes about his or her ability directly impacts his/her persistence and ability to perform a task successfully. Evidence shows a link between academic factors and counselor self-efficacy with trainees who perform better academically being more confident in their ability to counsel. In addition, there is a strong probability that part of a trainee’s belief system and subsequent behavior choices are connected with his or her total wellness. Having a higher self-efficacy can improve counselor competence and give insight into the gatekeeping process. Because there is limited research to address academic factors and total wellness of counseling self-efficacy (CSE) of counselors-in-training (CIT), this study concentrates on the gap in the educational and counseling literature. This research documents the extent to which these variables can contribute to the prediction of CSE of CIT.

Specifically, academic factors, wellness and CSE of CIT were assessed across randomly selected CACREP accredited master’s-level counseling programs. Liaisons were contacted, provided a description of the study, and invited to ask any questions
related to their students’ involvement in the study. Those who agreed to allow participation in their program were asked to forward an email introducing the study and requesting participation to counseling practicum and internship students at their institution. In the email, potential participants were provided with directions for accessing and completing the survey, contact information for the researcher, and approximate deadline for completion. Each participant was asked to complete a consent form, a demographic questionnaire, the 5F-Wel, and the Counselor Activity Self Efficacy Scale.

There were 2 hypotheses considered in this study. First, a significant relationship will exist between academic factors and the CSE of CIT. This hypothesis was not supported. A significant relationship will exist between the total wellness score and the CSE of CIT. Regression analysis revealed that the complete model including all 5 predictor variables did not significantly predict CSE of CIT. This model accounted for only 6 % of the variance of CSE of CIT. Thus, this hypothesis was not supported. These findings indicate the need for additional research to examine which factors contribute to the CSE of CIT.
DEDICATION

I have always believed that God had a special purpose for me. It took many years along different paths to truly realize that I was right where I needed to be as a counselor, educator, wife, and mother. This dissertation was a part of validating that calling and was the culmination of many years of hard work, following my instincts, and listening to supporters and mentors along the way. I started this educational journey uncertain of what may happen but sure that it would be a learning process both spiritually and emotionally.

I dedicate this dissertation to my wonderful family. Particularly to my understanding, supportive, and patient husband, Barrett, who has put up with these many years of research, studying, and stress. God truly blessed me with bringing you into my life. There is no doubt that without his love and dedication as a husband and father, this dissertation would not be possible. To our precious son John Alex, who brings laughter and joy to my life and studied right along with me. To our new addition, Lillian, you remind me that life is unpredictable and that love is unconditional. I must also thank my terrific in-laws, Bill and MerylLee Nunnery who have helped emotionally, financially and have given me their fullest support.

Finally, I dedicate this dissertation to my unpredictable life. I am so glad that I have lived out of love rather than fear. Fear debilitates but love invigorates. Thank you for those who have been willing to walk beside me through all of the twists and turns of my life.
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CHAPTER I
INTRODUCTION

Individuals choose to enter the field of counseling for a variety of reasons. Prior to admittance into a counseling program, students are screened and evaluated using various criteria based upon the university admittance requirement. These criteria range from Graduate Record Examination Scores, grade point average, recommendation letters, and interviews (Ericksen & McAuliffe, 2006; Hosford, Johnson, & Atkinson, 1984; Kencel, Hezlett, & Ones, 2001; Market & Monke, 1990; McKee, Harris, & Swanson, 1979). This places the faculty in a role as gatekeeper ensuring that a student is suitable for a counseling program. After admittance, these trainees interact with faculty, students, and clientele to increase their knowledge of counseling skills and improve competence which is standardized by the accreditation body in which the program is regulated (Council for Accreditation and Related Educational Programs [CACREP], 2009).

Reinforcing competence within the training process is important because competent counselors-in-training (CIT) are more likely to become competent counseling professionals. With more competence, there is greater likelihood that clients will benefit from the clinical services being offered by the profession (Kerl, Garcia, McCullough, & Maxwell, 2002). Although competency principles are outlined in the American Counseling Association Code of Ethics (2005), it can be further promoted by examining
counseling self-efficacy (CSE). Self-efficacy is a key element in the perceived positive achievement outcomes of individuals. Self-efficacy is an individual’s personal perception about their ability to be successful at a particular task (Bandura 1977). Having high CSE reinforces that a student is more confident in theory, interventions and strategies that impact clients.

The level of wellness in CIT can influence the development of CSE and their overall clinical outcome performance. Although self report measures completed by counseling students indicated higher wellness levels than the general population, approximately five percent of students have been shown to have some form of psychological impairment (Gaubetz & Vera, 2002; Smith, Robinson, & Young, 2007). CIT who are unwell as a result of their distress may have difficulty focusing on the issues of their client due to their own distress, impacting their confidence and competence in effectively working with clients. This research study will explain the role of gatekeeping as a means to promote competence and self-efficacy and investigate the potential and proposed relationship between CSE and wellness of CIT.

The American Counseling Association (ACA) and the CACREP accountability standards for training programs reinforce the need for increased competence for counselors (ACA, 2005; CACREP, 2009). Despite the efforts of these organizations to inform counselors of the risks and consequences of impairment, there has been little research about which factors may contribute to impairment. Evidence of impairment encompasses many different forms including personal burnout, depression, anxiety, poor stress responses, and traumatization. Previous research by Kottler and Hazler (1996) estimated that over 6,000 counselors have some form of emotional or mental impairment
that may compromise the services they offer. It is important that counseling professionals learn to recognize signs of counselor impairment because potential harm can come to clients if it were to go unaddressed (Emerson & Markos, 1996).

Harm to clients can happen for many reasons from emotionally impaired counselors with personal issues to counselors who practice beyond their skill level. In both cases the counselor’s actions can compromise and reduce the quality of counseling the client receives (Sheffield, 1998). This reduction in quality of care is of paramount importance for clients who place their trust in a professional counselor to direct their treatment. Incompetence and poor skill training are wrong because there are ethics that govern all helping professionals (ACA, 2005). To ensure that counselors maintain appropriate conduct, a code of ethics assists with reinforcing what is appropriate behavior for counselors, CIT, and counseling supervisors’ professional conduct.

The American Counseling Association (ACA, 2005) Code of Ethics specifically outlines the importance of counselors maintaining competence and boundaries in their practice by seeking out appropriate training, having supervised experience, expanding self-awareness and personal development. These standards are important for clients who seek help with various issues and expect that the professional they seek is trained, qualified, and promoting him or herself in an honest manner. When counselors act in an incompetent manner, they risk harming their clients as well as their professional reputation and the reputation of the counseling profession. Training to prevent impairment begins at the onset of counselors’ professional training, during supervision, and onto their own self-monitoring during their professional practice.
From the beginning of their professional training, CIT are initially under the responsibility of the academic program to which they were accepted. While enrolled, counselor educators are responsible for teaching skills, reviewing clinical progress, supervising students’ clinical experiences, and evaluating the performance of counselor trainees (Watkins, 1997). In addition, counselor educators are required to evaluate, monitor, and possibly endorse the CIT who have been under their instruction. There should be periodic evaluation and accountability measures in place to recognize any impairment of CIT that are impaired in any way (ACA, 2005; National Board for Certified Counselors, 2009). When examining the ACA Code of Ethics regarding supervision, counselor educators are required to conduct assessments of all their students while enrolled in a training program. The ethical code encompasses multiple factors such as academic performance, personal qualities, readiness to be in practice, personal development, competence, and ability to make timely referrals (ACA, 2005; Brady & Post, 1991; Emerson & Markos, 1996; Foster & McAdams II, 2009; Hensley, Smith, & Thompson, 2003; Lamadue & Duffy, 1999; Russel, DuPree, Beggs, & Peterson 2007). Trainee competence is the specific responsibility of supervisors and faculty to monitor and police the behavioral outcomes of CIT. According to Tang and colleagues (2004), “training counselors to be good practitioners is a primary mission of most graduate counselor education programs” (p.1).

Since endorsement is the final end for CIT completing their program of study, there is a great deal of pressure on counselor educators to practice appropriate assessment in monitoring and evaluating CIT and to not endorse those who are not competent nor mentally capable of serving clients. When professors and supervisors are placed in the
position to decide the fate of CIT, they are taking on the role of a gatekeeper (Brear, Dorrian, & Luscri, 2008).

The term gatekeeping is widely used across paradigms and is defined differently depending upon the context in which it is discussed. Fundamentally, the definition should include the concept of responsibility. When examining the concept of counselor gatekeeping, it refers broadly to counselors, supervisees, and educators taking the responsibility to intervene when necessary (Brear et al., 2008).

Effective gatekeeping functions to promote student equity, fulfill the educational and ethical responsibilities of the educator, guard the integrity of training programs, ensure the quality of graduates, enhance the status of the profession, maintain societal sanction, and protect the interests of the community, particularly potential clients (Brear et al., 2008, p.94).

Gatekeeping involves identifying impairment and protecting the profession by implementing appropriate strategies and assessment tools to evaluate student suitability for the profession. This includes three broad elements: the gatekeeper and the student, a defined framework and criteria for evaluation, and protection of the profession by examining students during the training process (Brear et al., 2008).

Within the academic setting, the gatekeeper establishes the criteria for a suitable student which includes examining skill, personal qualities and overall behavior of the student. As Spruill and Benshoff (1996) noted, “counseling supervisors promote professionalism by modeling professional approaches to ethics, respectful treatment of and discussion about clients, and other aspects of professional counseling practice”
Significant components of the evaluation process include examining impairment, diminished professional functioning, and unethical behavior. Examining impairment may involve supervisors having a watchful eye for decreased functioning. However, it is more feasible to have an assessment tool and procedure in place for all students so that no one individual is singled out. Diminished professional functioning could be regulated by supervisors throughout the practicum and internship process. This is possible by the evaluation of CIT skills both by review of trainees counseling sessions and by supervisors sitting in on sessions. In addition, unethical behavior can be evaluated by using the ACA code of ethics guidelines (2005) as a benchmark. With built-in measures, students who are impaired will have the opportunity to have consultation, remediation, or endorsement depending upon the CIT performance. There is no set defined methodological framework present to measure impairment across multiple helping professions. One method of intervention is through the implementation of a uniform gatekeeping evaluative tool during the training process (Brear et al., 2008).

Gatekeeping is an important tool for ensuring that counselor competence exists. Counselor competency is not only an ethical requirement as a standard of practice but also a fundamental principle in ensuring that counselors are maintaining a level of effectiveness to practice in the profession (ACA, 2005). Gatekeeping is not only important for the profession as a whole but for those who follow the CACREP standards (CACREP, 2009). Counseling programs can reinforce competency through their written standards and policies. Also, most programs assert that CIT competency is a reflection of the attended program whether accredited or not because there is an expectation that students are prepared to practice. Related literature regarding competency asserts that
students are evaluated with a consistent yet standardized evaluation with appropriate documentation (Forrest & Elman, 1999; Wheeler, 2000). There must be clear expectations for what counselors-in-training are required to do as well as a formalized evaluation method for assessing CIT that is communicated clearly (Hanna & Smith, 1998). There is an additional need to have ongoing assessment of trainees’ personal and professional ability which assists with intervening with students who have difficulty with personal struggles that may impact their potential.

Highlighting the importance of competent practice, the ACA code of ethics indicates that counselor consultation, continuing education, self monitoring of effectiveness, adhering to ethical standards, and acknowledging when there is impairment are essential tasks to which counselors must attend. In addition, counselors are encouraged to continually monitor their physical, emotional, and mental wellbeing and both seek help from a professional as needed and terminating services to clients if there is a threat of harm (ACA, 2005). It is likely that this monitoring of self and counselor skills will help promote counselor self-efficacy and promote wellbeing. These personal struggles are exhibited by their beliefs and personal actions when directly working with clients. Beutler, Machado, and Neufeldt (1994) “identified counseling self-efficacy as one of three stable and reliable characteristics that could be used for selecting and training counselors” (Urbani et al., 2002, p.92).

**Self-Efficacy**

In 1986, Bandura presented the construct of self-efficacy in his social cognitive learning theory. The construct referred to a set of personal cognitive performance
appraisals linked to specific behaviors. In his conceptualization, it was hypothesized that an individual’s personal self-efficacy will naturally influence how they interact with other people. In other words, an individual’s thinking patterns about his or her outcome performance (personal self-efficacy) will be evident in the behaviors he or she exhibits in daily interactions with others. This behavioral response can have a domino effect as these responses to thinking patterns influence others. This may include their verbal exchanges including how messages are given and received. In his theory of self-efficacy, Bandura delineates four categories that contribute to an individual having high or low self-efficacy. These categories include: performance enhancement, vicarious learning, verbal persuasion, and emotional arousal (Bandura, 1982).

Performance enhancement involves learning a skill or behavior and performing that skill or behavior successfully. An individual will rely on past experiences to gauge success in a task. For example, an individual would have high self-efficacy related to a science course because he or she has done well in every science course taken before. A student will be tested on his or her ability to successfully perform the task learned such as that learned in a science class.

Vicarious learning involves observing a successful model of behavior and being able to successfully perform the behavior. Since an individual is observing someone equal to or below him or her in ability, there is a belief that if she can do the task, then so can I.

Verbal persuasion involves receiving motivational statements or gestures of encouragement from others. This is what is often seen as “cheerleaders” whose purpose it is to encourage and motivate a team for positive success.
Finally, emotional arousal includes the performance anxiety that influences one’s ability to complete a task. When an individual is placed in a role as performer, the stress will cause feelings of anxiety to develop which motivate the individual to “rise to the occasion” and successfully complete the task at hand. A major portion of the self-efficacy research has focused on exploring the impact of these sources on the development of efficacy beliefs.

An examination of the self-efficacy literature indicates that for those seeking to measure individual perceptions of ability, the selection of a specific self-efficacy measure that closely matches the desired task performance criteria is often a better predictor of performance outcomes than a more general self-efficacy measure (DeTure, 2004). As a result, self-efficacy research has broadened in scope over the past few decades to include a wide variety of investigations of ability perceptions across several domains. Included in this body of research are studies of CSE among CIT.

**Counseling Self-Efficacy**

In 1998, Larson presented the social cognitive model of counselor training (SCMCT) as an extension to Bandura’s 1986 social cognitive theory. This model describes how the CIT environment and trainee personal agency factors can influence a counselor’s learning and overall performance in counseling. A consistent finding is that CSE is a trait that is integral to successful training outcomes. If a counselor has high self efficacy, he or she is less likely to be anxious and more likely to feel competent in his or her performance (Beutler et al., 1994; Larson & Daniels, 1998). Overall improvement in a counselor’s level of CSE can happen by implementing specific skills and improving
competence (Urbani et al., 2002). The following research examines the factors that influence the CSE of CIT, variables correlated with the CSE of CIT, and predictive factors of CSE of CIT.

Research has been conducted in terms of counselors or CIT and self-efficacy. The research ranges from identifying factors that influence self-efficacy (Poidevant, Loesch, & Wittmer, 1991), exploring the relationship between anxiety and self-efficacy (Barbee, Scherer, & Combs, 2003; Larson et al., 1992), examining models to promote self-efficacy in training (Barnes, 2004), and counselor-in-training perception of self-efficacy (Tang et al., 2004). Additional studies examined mindfulness (Greason & Cashwell, 2009) and emotional intelligence in relation to self-efficacy (Easton, Martin, & Wilson, 2008). As a result of the findings of these studies, training interventions have been designed specifically to help improve CSE in regard to personal competence and CIT beliefs regarding ability to perform effectively. Interventions are centered on coursework which may include assigned readings and classroom discussions. Other interventions may be implemented at the practicum or internship level to involve hands on learning experiences, modeling by supervisors or other trainees, and encouraging the use of self-reflection and development (Easton et al., 2008; Larson & Daniels, 1998). These interventions provide opportunities for trainees to explore their insecurities, build their level of knowledge through specific activities, and provide visual representation of expected behaviors as modeled by supervisors. Self-efficacy is improved as trainees increase their skill level and are provided feedback regarding needed improvements and overall ability.
Although there has been a link between specific academic factors and counselor self-efficacy, there is a need to look beyond academic factors to help further explain what impacts the CSE of CIT. This is important because although academic factors such as grade point average and classroom performance may contribute to counselors-in-training self-efficacy, the holistic nature of an individual is not considered. Since having a strong self-efficacy will influence outcome performance, it is important to look at the complete picture to break down influential components. One additional factor that can be explored is counselors-in-training overall perceptions of wellness.

Counselor Wellness

Wellness has been defined many different ways across various professions. One way to define it specific to the field of counseling was given by Myers, Sweeney, and Witmer (2000). They reinforced focusing on a life that encompasses a lifestyle of health and wellbeing that integrates the body, mind, and spirit (Myers et al., 2000). The focus on wellness is not new to the counseling profession. A resolution issued in the early 1990s titled, *The Counseling Profession as Advocates for Optimum Health and Wellness*, was adopted by the American Counseling Association to infuse wellness into the counseling paradigm (Myers & Sweeney, 2008). The adoption of this resolution made the concept, formation, and implementation of wellness programs of paramount importance and as an ethical guideline within the helping profession. This resolution advocates for the formation of specific counseling policies and procedures to promote health and wellness. This would not only pertain to practicing counselors and the clients they serve but to trainees whose wellness and health are essential for promoting the wellness of clients. If
we want CIT to have optimal functioning, then there needs to be an appropriate model to examine wellness.

It is important to strengthen wellness programs in counselor education programs and to implement strategies to promote wellness programs because counselor educators, CIT, and clients are interconnected and impact one another (Hill, 2004). Wellness training and wellness models can be reviewed and implemented as a means of promoting wellness. One such model developed by Myers, Sweeney and Witmer (2000), the Wheel of Wellness (WoW), can be used as one tool to examine and improve self-efficacy. It can help supervisees create tangible programs to assist with self-efficacy improvement. The purpose of the WoW was twofold. First, it served as a tool to assist with client assessment and the selection of appropriate interventions (Myers & Sweeney, 2005b). The second purpose was to assist counselor educators as a comprehensive intervention that could assist counselor educators as a comprehensive intervention that could assist trainees with understanding their level of wellness and incorporating means to improve it (Myers et al., 2000). The model is illustrated as a wheel that contains interrelated spokes that include a series of reciprocal wellness domains based on basic principles of Adlerian Individual Psychology. Encouraging the implementation of a wellness model, may help to decrease stress and increase self-efficacy to help improve the overall wellbeing of the trainees and clients (Myers, Mobley, & Booth, 2003; Smith, Robinson III, & Young, 2007; Vries & Valadez, 2005; Wilkerson, 2006).

Although research indicates the importance of wellness and ways to promote it; this research will specifically examine deficient areas of self-efficacy, academic factors and wellness to target areas of needed expansion of programs in the trainee setting. Part
of the methods discussed in literature includes assessing students’ academic ability, personal characteristics, and clinical skills (Brear et al., 1999). Not only is the use of wellness training methods an important component that can influence self-efficacy but wellness factors are fundamental in understanding personal characteristics that enhance self-efficacy. Knowing trainees areas of wellness deficiency, programs can target specific interventions to promote wellness in students within the classroom, department, and campus wide. When there is intentional effort to promote wellness within CIT, there is likelihood that overall counseling self-efficacy will improve (Curry, 2007).

Most of the early models of wellness were derived from medical science and were grounded in theories from physical health sciences (Dunn, 1961). The first mental health models designed specifically for counseling included the first model by Sweeney and Witmer (1991) which was WoW. This model was utilized and researched for the purpose of creating a standalone model that was validated by research. Overtime, there was a need to expand upon the WoW creating the Indivisible Self Model of Wellness (IS-WEL). This model involves the single higher order factor of wellness and the second order factors of creative self, coping self, social self, essential self, and physical self with 17 third order factors. The corresponding third order factors are subcategories that make up each of the individual 5 second order factors. Both second and third order factors are correlated within the context of local, institutional, global, and chronometrical factors (Myers & Sweeney, 2005b). Conducting an assessment of wellness may help determine trainees’ level of wellness, identify problematic areas that need work, and help to contribute to CIT level of self efficacy.
Statement of the Problem

What a counselor-in-training believes about his or her ability directly impacts his/her persistence and ability to perform a task successfully. Evidence shows a link between academic factors and CSE with trainees who perform better academically being more confident in their abilities to counsel. In addition, there is a strong probability that part of a trainee’s belief system and subsequent behavior choices are connected with his or her total wellness. As noted earlier, in previous literature increased counselor wellness and CSE are important for perspective counselors.

Although there has been research conducted to examine self-efficacy in relation to wellness (Curry, 2007) there has been no examination of which factors, academic or wellness, have the highest likelihood to predict the CSE of CIT. Faculty members are responsible for the students who are accepted into the counseling program and for implementing coursework that can help promote CIT self-efficacy. Since researchers are unclear regarding the exact factors that contribute to self-efficacy, further investigation is needed. Examining the additional component of wellness may assist faculty in developing programs that successfully strengthen students’ self-efficacy in their ability to effectively counsel clients.

Purpose of the Study

The purpose of this study was to explore the variables that contribute to the CSE beliefs of CIT. This study examines the amount of influence student wellness factors have on the variance of the CSE of CIT above and beyond what academic factors contribute. The effect of wellness and academic predictor variables on CIT self-efficacy
across randomly selected CACREP programs was explored and analyzed. The researcher hypothesized that the CIT with more hours of clinical supervision, clinical experience, and a higher GPA will have a higher rate of CSE. Also, those CIT with a higher total wellness score will have a higher rate of self-efficacy. More specifically, the following research questions were answered:

Research Question 1: What are the number of courses and credits completed, number of supervised practicum or internship hours completed, number of hours of clinical experience (outside practicum and internship), current GPA in their respective counseling programs, levels of wellness, and counselor self-efficacy among counselor education students?

Research Question 2: What is the relationship among number of credits completed, number of supervised field experience hours, clinical experience, program GPA, wellness, and counseling self efficacy of CIT?

Research Question 3: To what extent can the variance in CSE of CIT be accounted for by the four academic factors and perceived student wellness?

In addition, the following hypotheses were tested:

Research Hypothesis 1: A significant relationship at the .05 alpha level will exist among the academic factors, wellness, and CSE of CIT.

Research Hypothesis 2: The regression model will result in an overall model in which five predictors (the four academic factors and wellness) significantly predict CSE of CIT at the .05 alpha level.
Definition of Key Terms

Counselors-in-training (CIT): These are individuals who had some formal admittance into their representative counselor education program (CACREP, 2009).

Wellness: For the purpose of this study, wellness was defined from a counselor perspective as “a way of life oriented toward optimal health and well-being in which the body, mind, and spirit are integrated by the individual to live more fully” (Myers et al., 2000, p. 252).

Academic Predictors: number of courses or credits completed, number of supervised (practicum or internship) hours, GPA in counseling program, number of hours of clinical experience (outside of practicum or internship).

Self-Efficacy: Self-efficacy is an individual’s perceived judgment of their own capability of performing a specific task. As a result, it shapes how a person will behave in a particular environment (Bandura, 1982).

Counselor Self-Efficacy (CSE): According to Larson and Daniels (1998) counselor self-efficacy is defined as “one’s beliefs or judgments about her or his capabilities to effectively counsel a client in the near future.” (p.180). This belief is based upon his or her own subjective assessment of competence to counsel.

Summary

By measuring wellness and academic factors, this research will provide evidence for the amount of variance these factors contribute to CIT self-efficacy and give insight for possible areas of improvement with counseling programs. If specific components can be evaluated to predict elements that may improve a counselor’s perception of
performance, then counselor education programs can adjust philosophies and
instructional approaches within their programs. In addition, counseling trainees will gain
added insight into their level of functioning and recognize areas of needed personal and
professional growth.
CHAPTER II
LITERATURE REVIEW

Introduction

The importance of professional counseling competence, boundaries, appropriate training, supervised experience, and the expansion of self awareness and personal development have been emphasized across professional organizations and licensure boards in the field of counseling for decades (Association for Counselor Education and Supervision, 1995; ACA, 2005; CACREP, 2009). When appropriate standards and safeguards are in place, counselors are clearly aware of the expectations for practice and there is a presumption that they will perform accordingly. These standards, in large part, are based on the ACA Code of Ethics which outlines the use of counselor consultation, continuing education, self monitoring of effectiveness, adherence to ethical standards, and acknowledgement of the need for help when personal problems arise (ACA, 2005). Since practicing counselors are required to adhere to such standards of self care and client care, it stands to reason that there should be a relatively low number of incompetent counselors seeing clients. Unfortunately, this is not always the case.

For many counselors, the recognition of the importance to practice in an ethical manner begins during the counselor training program. Counselor training programs provide a valuable service in preparing counselors to work with a diverse client
population. Professors and supervisors are required not only to follow the standards established for credentialing in their jurisdiction, but also are responsible for teaching, reviewing clinical skill development, supervising the clinical experience, and evaluating performance (CACREP, 2009; Watkins, 1997). In so doing, supervisors and counselor educators are better equipped to evaluate, monitor, and endorse CIT. To ensure effectiveness, part of this process must include the use of a periodic evaluation of the trainees and a method of accountability for endorsing CIT (ACA, 2005; NBCC, 2009). Among the areas commonly assessed are trainees’ academic performance, personal qualities, readiness for practice, personal development, competence, and professional responsibility (ACA, 2005). Through this evaluative process, counselor educators and supervisors take on the role of gatekeeper. As a gatekeeper, trainers are required to take on the responsibility of regulating the progress of students in their care. This process typically begins at admittance and follows throughout the training process to graduation.

**Stages of the Gatekeeping Process**

The first stage of the gatekeeper process begins when the student is admitted into a program. Each program has their own admission procedures and requirements to ensure the admittance of quality students. However, researchers have found that admission procedures are often based on a limited number of criteria ranging from the Graduate Record Examination (GRE) scores, undergraduate grade point average, letters of recommendation, to applicant interviews to examine the suitability for the respective program. These criteria are individually and collaboratively used as means to determine program success (Eriksen, & McAuliffe, 2006; Hosford, Johnson, & Atkinson, 1984;
Kuncel, Hezlett, & Ones, 2001; Markert & Monke, 1990; McKee, Harris, & Swanson, 1979). Although these criteria are utilized as screeners, there is always the possibility that a student may look successful on paper and be able to conduct an interview successfully yet not be able to competently perform in their respective field of study.

The second stage of the gatekeeper process deals with the interaction with students during their training program. As part of the gatekeeping role in this stage, counselor educators and supervisors are responsible for monitoring the wellness of counselors and CIT. (ACA, 2005; Association for Counselor Education and Supervision, 1993; CACREP, 2009; Myers, 1992). When counselors take care of themselves there is a positive correlation with being able to better meet the needs of clients. Variables often linked with lack of wellness in counselors or those in training include burnout, compassion fatigue, and vicarious traumatization (Cummins, Massey, & Jones, 2007, Lawson, 2007; Vries & Valadez, 2006). This is important because “wellness as a unifying philosophy in counselor education may be a way to prevent impairment and burnout in students and professionals” (Roach & Young, 2007, p. 29).

Smith et al. (2007) found that although graduate students rated their wellness levels higher than the average population, there are a large percentage of masters’ level students who indicate having psychological distress similar to that reported in the clinical population that helping professionals serve. Counselors who are unwell may have difficulty focusing on the issues of the client due to their own distress. As a result, counselors may not have much confidence in their ability to help others because of their own perception of their inability to help themselves. One possible way to promote efficacy may be through improving wellness. The level of wellness in CIT can influence
the development of CSE and subsequently their overall clinical performance (Smith et al., 2007). With increased CSE, counselors may increase their level of competence with clientele.

Promoting wellness in counselor education training makes intuitive sense. Wellness or lack thereof, may contribute to the personal appraisal a trainee has in performing a task. This personal appraisal, also known as self-efficacy, refers to one’s perceptions regarding their overall ability to perform a specific action. A general understanding of self-efficacy was established by Bandura (1977) when he referred to self-efficacy as an individual’s personal determination about their ability to be successful at a particular task. He further presented the construct of self-efficacy as a set of personal cognitive performance appraisals that are linked to specific behaviors (Bandura, 1982). As a result, self-efficacy is indicated through the behaviors that an individual exhibits in his or her daily interactions with others. In turn, this behavioral response will create a domino effect as these encounters influence environmental choices and impact other people. For example, if a boss does not have confidence in his or her ability to lead others, it will be exhibited through lack of leadership skills and will influence the outcome of the individuals under him or her.

Self-efficacy may influence the choice of and performance in a particular career. Even if two individuals are similar in regard to aptitude, the performance and overall achievement of an individual will differ based upon their level of self-efficacy (Lent, Brown, & Hackett, 2000). Since self-efficacy is a key element in positive achievement outcomes in general, it also is important in other domains such as counseling performance. When a practicing counselor is self-efficacious, he or she is more confident
with theory, interventions, and strategies to help the client. This confidence may help to improve the outcome of performance within the counseling relationship and reinforce the competence of the practitioner. With more competence, clientele will be positively impacted through the skills implemented by the practitioner.

Larson (1998) expanded upon the concept of self-efficacy within the counseling arena by examining how the counselor-in-training environment and personal characteristics can influence the trainee’s learning and performance. Larson and Daniels (1998) defined counseling self-efficacy as “one’s beliefs or judgments about her or his capabilities to effectively counsel a client in the near future” (p.180). CSE is a trait that is important to help determine trainee success. The higher an individual’s perceived CSE, the lower the level of anxiety and personal belief regarding competence. Higher CSE increases positive outcomes for the agency and the clientele being served. Identifying factors that contribute to self-efficacy would foster competence, thereby; increasing self-efficacy (Beutler et al., 1994; Larson & Daniels, 1998).

Therefore, it is important to identify the factors that may contribute to greater CSE of CIT. This literature review will examine counselor competence, CSE, and counselor wellness. A review of these components both individually and holistically was conducted to help the researcher understand how the reinforcement of wellness can help influence trainees’ perception of performance and how counselor education programs are a good platform for implementing effective strategies to promote self-efficacy.
Counselor Competence

To gain an understanding regarding the possible factors that contribute to CSE, it is important to examine what makes a counselor competent. Within the gatekeeping literature, Brear et al. (2008) found fourteen studies in which researchers looked specifically at CIT suitability for working with clients. There were similar basic factors found within the studies. For example, academic and nonacademic factors such as evaluation of clinical skill level and personal problems both of an intrapersonal and interpersonal nature. These elements can hinder or increase suitability when working with clients. Getting a grasp on both academic and personal issues can increase competence (Brear et al., 2008). Not only are there personal factors to be considered in regard to competence, there are also requirements set forth by accrediting bodies.

The Association for Counselor Educators and Supervisors (ACES) and the CACREP have specific guidelines regarding monitoring, assessing and giving an overall evaluation of supervisees including CIT. However, there are no specific guidelines regarding how competence should be taught or evaluated across programs (Hensley et al., 2003). Furthermore, Greggo and Becker (2010) found that the evaluation of competencies as a counselor-in-training continues to be vague and in further need of evaluation. The literature review on competence suggests a need to evaluate clinical performance although there is no one guideline regarding implementation. CACREP standards require counselor educators to evaluate students’ academic performance, clinical skills, and personal behavior throughout the training process. However, there are challenges to this process as supervisors must take into account the legal obligations and institutional requirements when evaluating clinical competence (Kerl, Garcia,
McCullough, & Maxwell, 2002). Part of the challenge includes the establishment of an evaluation process of counselor competence for students in the program, the reluctance of faculty in dismissing incompetent students, and the legal issues that emerge when dismissing deficient students (Kerl et al., 2002). One way to address these challenges is to examine what has shown to be effective in promoting counseling competence.

Procedural methods are important for evaluating present and future competence. With the use of an evaluative means to assess counselors, some researchers have devised systematic programs or methods to review student progress, competence, and problematic behavioral performance. Evaluation makes the gatekeeping process more uniform and systematic across CIT programs. Initial methods involved incorporating the use of uniform gatekeeping policies to review and retain students. This is a sound way to govern counselor trainees’ skill level and emotional soundness because it can help promote competence and self-efficacy when a model is implemented effectively. Promotion of these skills can be attained by reviewing various evaluation methods that have been implemented across CIT programs.

One evaluation method encourages a holistic approach that promotes a trainee personally and professionally. The Frame and Stevens-Smith (1995) model expressed four reasons to specifically oversee student progress. These included: ethical standards, the impact of a therapist on a client, monitoring of counselor trainees development by a supervisor, and the possibility for malpractice due to client injury. They incorporate a three step process involving the use of the personal characteristics evaluation form. This form is given at midterm and the end of the semester. Low scores by one faculty on the first evaluation leads to remediation, low scores by two faculty requires a meeting with
an advisor, and low scores from three or more faculty requires a meeting with faculty and advisor regarding the possibility of continuing in the program (Frame & Stevens-Smith, 1995).

Another evaluation method used to promote competence with trainees that increases outcome performance was devised by Wilkerson (2006). His method encouraged the use of a therapeutic process model which is typically used in working with clients and applied it to trainees. Wilkerson’s model involves five components: informed consent, intake and assessment, evaluation, treatment planning, and termination. The informed consent process involves having an established policy and procedure manual that specifically outlines program requirements containing the risks and benefits of the counseling program. The intake and assessment component occurs as a student is admitted into the program. Information is gathered from students with a screener for applicants to assess their readiness for the counseling program. The evaluation component is designed to determine a student’s learning needs from the beginning of their counseling training and is monitored throughout the program until completion. A treatment planning process is in place to enhance student growth, development, and performance. This is done through instituted programs within the counseling program with documentation of student need and attendance. The final component involves termination with graduation or dismissal from the program due to lack of change or progress. This would not surprise the student since explanation of the program expectations were explained throughout the program (Wilkerson, 2006).

An alternative model which incorporates the importance of due process was developed by Baldo and Softas-Nall (1997) based upon policies developed from the
division of professional Psychology at the University of Northern Colorado. Their approach places the responsibility of gatekeeping on the entire faculty of a program. Students receive a written plan of remediation which the student must sign acknowledging that they received feedback from the faculty. The student can present his or her case to the faculty. The plan details clear action steps that are explained to the students, faculty, and administration. Support is necessary at all levels in order for the counselor educator plans to function appropriately.

One way to address the challenge of deciding which competency model to use is to examine the research outcomes found regarding counselor competence. In a 1999 study, Bradley and Fiorini evaluated the status of practicum training in CACREP programs across the United States to specifically look at the program status and competence of its students. Trainees should be competent in their ability to perform because it affects the overall quality of services that they provide to their clients. The researchers asked faculty respondents to indicate which counseling competencies students should acquire in their training to successfully complete the practicum (Bradley & Fiorini, 1999). The respondents indicated that trainees should be capable of recognizing and effectively correcting their counseling limitations, effectively work with diverse clientele, facilitate group counseling, and effectively demonstrate their readiness for employment as a counselor. These competencies could be taught by infusing multicultural skills training into their curriculum, implementing skill based training, requiring demonstration of emotional stability, and appropriate examination of trainees’ ability to facilitate counseling groups resulted in a more positive practicum experience
(Bradley & Fiorini, 1999). These skills reinforced the importance of having specific academic standards maintained to ensure competence.

Another way substantive due process is used is through the use of an effective evaluative tool such as the Professional Counseling Performance Evaluation Form (PCPE) developed by the faculty at Southwest Texas State University (Kerl et al., 2002). Ethical codes that already existed in Texas were used as a framework for some of the questions on the PCPE. This evaluative tool can be used in all classes and noted on syllabi as a means to evaluate unethical, irresponsible, or unprofessional behavior. If there is failure in the PCPE by students, then each faculty can acknowledge that the standards are not being met and a referral to the faculty review committee (FRC) can be made. This will help ensure a suitable gatekeeping procedure and reduce graduating incompetent CIT. Students are informed of this method in the beginning of their graduate coursework so they are aware of the expectations of competence (Kerl et al., 2002; Lumadue, & Duffey, 1999). This method creates a framework from which other programs can model their own standard of practice. With the implementation of a specific model or evaluative tool, there is more regulation of competence, increased support for a gatekeepers evaluation, and greater likelihood of self-efficacy enhancement.

Having an understanding that programs are working to establish a means to promote competence is a step to assist with the gatekeeping when there is impairment. Knowing that some form of evaluation and remediation may be necessary to ensure competence to practice, there remains hesitancy among faculty to remediate due to complications with student and organizational rights and fear of lawsuits (Gaubetz & Vera, 2002). This also may be due in part to faculty avoiding the personal and
professional distress experienced by them after dismissing a student from a program (Foster & McAdams III, 2009). Although there are mixed perceptions about the review process in training programs by students, if there are clear and precise methods that are established in an open and concrete manner, there will be trust established between faculty and students regarding program expectations (Foster & McAdams III, 2009). This can be done through egalitarian communication between faculty and staff not only from the top-down but from the bottom-up through open discourse regarding programmatic expectations which is often found through academic advising and evaluation and the clinical supervision process (Choate & Granello, 2006; Foster & McAdams III, 2009; McAdams, Foster, & Ward, 2007).

Having measures in place such as gatekeeping procedures and competency models influence the rate of graduation and ultimately the number of competent practitioners serving clients. Although there are built in program requirements, there is a likelihood that some incompetence may occur. According to Gaubetz and Vera (2002), between 4 to 5 percent of counselors-in-training have a psychological impairment. They and other researchers found that students in their study reported lower levels of competence of fellow students than did faculty. In fact, students report twice as many fellow students as being incompetent or impaired as opposed to faculty. This may result in some students feeling as if problematic students are ignored or feeling resentment toward impaired students who do not meet program expectations yet their inadequacy is being ignored by faculty (Gaubetz & Vera, 2002; Oliver et al., 2004). This research reinforces the need for a built in evaluative tool to measure competence.
Olkin and Gaughin (1991), found that most of the problems in supervisees were identified through academic coursework, then by practicum and clinical coursework, and finally by faculty referrals and routine student evaluations. According to Foster and McAdams III (2009),

the development of an orientation toward competent professional performance should be a behavior addressed regularly during their clinical instruction and supervision experiences. Therefore, “clinical faculty members must be especially equipped to evaluate and support the personal and professional fitness for practice of their supervisees. (p.279)

As a result, there has been open discourse about the importance of a systematic method of admitting, evaluating, remediating, and dismissing students. Various approaches have been outlined to effectively measure competence or lack thereof. Unfortunately, there are no specific programmatic ideas outlined that will examine how to promote the development of counselor-in-training competence. A systematic method is important because competency and self-efficacy may be collaborative in nature. If CIT meet specific competency standards in their respective programs, there is a greater likelihood that they will have a higher level of self-efficacy prior to leaving the program and upon beginning their clinical practice. Having a systematic approach with specific programmatic ideas incorporated throughout a counseling training program may enhance the CSE of CIT by increasing skill level and experience, and by providing direction for ways to improve ability. Part of understanding the connection between competence and self-efficacy is by clearly understanding the terms.
**Self-Efficacy**

Bandura (1977) presented the construct of self-efficacy as a set of personal cognitive performance appraisals linked to specific behaviors he categorized under social cognitive theory. Self-efficacy is an individual’s perceived judgment of their own capability of performing a specific task. Self-efficacy shapes the environmental choices individuals make and how they behave within that environment (Bandura, 1977). An individual will gravitate toward an environment where they perceive a higher likelihood of success. This may include working in a corporate environment where an individual has a specific job he or she is trained to do, completing the job, and getting positive feedback for a job well done. Self-efficacy is a means by which individuals can integrate their existing cognitive, social, and behavioral skills in completing a particular task in a specific environment. When individuals believe they are capable of performing a task successfully it will be demonstrated by their behavioral response in social situations in which they are required to perform said task. Self-efficacy has an impact on motivation, behavior and wellbeing (Bandura, 1982). It influences how goals, tasks, or obstacles are accomplished (Bandura, 1977; 1982). To get a broader understanding of self-efficacy, it is important to explore the tenets of social cognitive theory.

**Social Cognitive Theory**

Bandura’s Social cognitive theory (1986) assumes that an individual’s personal self-efficacy will naturally influence how they interact with other people. In his research, Bandura noted that an individual’s cognitive appraisal regarding his or her capabilities is more fundamental to increasing efficacy than the outcome expectations whether rewarded
or punished. He indicated that self-efficacy contains three fundamental dimensions that influence personal self-efficacy: magnitude, generality, and strength. Magnitude involves an individual’s perception of a task as being difficult; generality is how broadly an experience of failure or success is interpreted and strength indicates how strongly ingrained one’s self-efficacy beliefs are (1986). The social cognitive theory contains four categories that contribute to an individual having high or low self-efficacy which includes: performance enhancement, vicarious learning, verbal persuasion, and emotional arousal (Bandura, 1977; 1986). Each of these predictors is an influential element in promoting or demoting self-efficacy because self-efficacy is linked to performance feedback. According to Schunk & Zimmerman (2007):

Learners obtain information to appraise their self-efficacy from their actual performances, vicarious (modeled) experiences, forms of persuasion, and physiological reactions. One’s own performances offer reliable guides for assessing self-efficacy. In general, successes raise self-efficacy and failures lower it, although an occasional failure = success after many successes = failures may not have much effect. (p. 9)

An explanation of the four categories of social cognitive theory will help give understanding regarding the components of self-efficacy.

**Performance Enhancement**

Performance enhancement or performance attainment happens when an individual completes a task successfully over and over again. Once a skill is performed whether it is deemed successful or unsuccessful, the individual has a perception of how
well it was completed and will attach that same perception to his or her future ability to
perform it (Bandura, 1986). For example, an individual would have high self-efficacy
related to a science course because he or she has done well in every science course
previously taken.

**Vicarious Learning**

Vicarious learning involves observing a successful model of behavior and being
able to successfully perform the behavior. Since an individual is observing someone
equal to or below him or her in ability, there is a belief that if she/he can do this task, then
so can I. The influence of modeling is important to the learning process of individuals as
they watch, perform, and have success overtime (Bandura, 1986). For example, a new
retail employee learning how to use the cash register from a fellow employee would be
more likely to successfully run the cash register.

**Verbal Persuasion**

Verbal persuasion involves receiving motivational statements or gestures of
encouragement by others (Bandura, 1986). These individuals are seen as “cheerleaders”
whose purpose it is to encourage and motivate a team for positive success. Also, verbal
persuasion is evident when students are encouraged, prompted, or motivated by teachers
that they are capable of performing a task or having a positive outcome. Therefore, the
students begin to believe that a task is possible. The outcome of success then reinforces
the continuation of success in that activity. For example, when coaches encourage
athletes’ performance, they are more likely to try harder and to work to achieve the positive outcome of winning the game.

**Emotional Arousal**

Emotional arousal includes the performance anxiety that influences one’s ability to complete a task. When an individual is placed in a role as performer, the stress will cause feelings of anxiety to develop (Bandura, 1977). This anxiety assists with motivating the individual to perform the task and once the task is successfully completed, the emotional arousal will decline. For example, if a student notices less anxiety than usual while taking tests, he or she may interpret that they are more skillful which can promote self-efficacy. If an individual possesses strong self-efficacy beliefs, then they have a higher likelihood of establishing higher goals, and have an overall greater commitment, motivation and perseverance with achieving the goals (Bandura, 1995). The components that make up self-efficacy also contribute to the definition.

**Overview of Current Literature and Research**

Using Bandura’s model as a general base for understanding the concept of self-efficacy, various researchers explored how self-efficacy could relate to particular fields of study. One research team indicated how cognitive ability relates to self-efficacy where individuals with high cognitive ability have more positive experiences and knowledge which leads to personal productivity. As a result, an individual with high self-efficacy will be more perseverant with a task, will complete it, and feel successful (Phillips &
Gully, 1997). Additional researchers examined individual’s perception of performance in relation to academic outcomes.

**Research in Academic Settings**

Lane and Lane (2001) surveyed 76 postgraduate students to predict effectiveness of self-efficacy in a post graduate setting. The participants completed a self-efficacy measure that assessed skills needed to effectively complete their course. Thirteen weeks later, they were re-evaluated to see if they accurately predicted their projected performance outcome using the end of the semester grades. Overall, the self-efficacy to cope with the intellectual demands of the program predicted over eleven percent of the variance in performance after a lapse of thirteen weeks. Lane and Lane (2001) believe that this provided support of the importance of self-efficacy as a predictor of outcome performance.

In another study, Bandura’s (1977) model was linked by examining the influence of self-efficacy on the motivation and writing outcomes of students. A research synthesis of writing and self efficacy was examined across two decades. The synthesis examined the relationship between writing self-efficacy, other motivational constructs in writing, and writing outcomes. Pajares (2003) found that writing outcomes were influenced by self-efficacy beliefs. Although Pajares (2003) found that personal self-efficacy does influence human motivation, additional support should be provided by teachers, schools, and other adult role models. These support individuals can influence students’ level of motivation, behavior, and outcome performance in writing (Pajares). This outcome encourages a collaborative effort between student and teacher to boost academic efficacy.
To further examine efficacy in academia, Lane, Lane, and Kyprianou (2004) examined business students in the United Kingdom in regard to their self-efficacy and self-esteem and the impact these variables have on academic performance for 205 postgraduate management students (Lane et al., 2004). The researchers believed that self-efficacy could be utilized as an avenue to increase performance. They hypothesized that this was possible by identifying and operationally defining the sources of self-efficacy and finding possible correlates of self-efficacy. These foci were measured by examining competence and performance. Using correlation and multiple regression analyses, correlations between self-efficacy and positive perceptions of academic achievement and self-esteem were noted (Lane et al., 2004). Self-efficacy was found to be a mediating factor in the relationship between performance accomplishments and academic performance. Their findings supported the idea that self-efficacy is developed by the cognitive appraisal of previous performance (Bandura, 1997). Expanding upon social cognitive theory to include counseling helps reinforce how self-efficacy is impactful across professions.

**Research on Self-Efficacy and Counseling**

In 1998 Larson presented the SCMCT as an extension to Bandura’s 1986 social cognitive theory. It was developed because the domain of counseling and counselor training was not addressed in Bandura’s extensive research on social cognitive theory. This model describes how the counselor-in-training environment and trainee personal agency factors can influence a counselor’s learning and overall performance in counseling. It helps explain ways by which supervisors can train counselors to be
efficacious with their clients as well as encouraging a link between knowing and doing. “CSE beliefs, based on SCT, would be hypothesized to affect counseling actions through the mediating influences of other self-generated processes including affective processes, motivational processes, and other cognitive processes (Larson, 1998, p. 227).” CSE is a trait that is important for the outcome of training success. If a counselor has high self efficacy, he or she is less likely to be anxious and more likely to feel competent in performance (Beutler et al., 1994; Larson & Daniels, 1998). Overall improvement in a counselor’s level of self-efficacy can happen by implementing specific skills and improving competence (Urbani et al., 2002). Part of improving competence involves examining influential factors of counselor self-efficacy and interventions to improve efficacy.

CSE also has been related to SCT constructs including stable counselor variables, personal agency variables, counselor performance and the supervision/work environment (Larson & Daniels, 1998). Within these constructs there is a relationship to CSE in the 14 studies reviewed. Personal agency variables such as outcome expectancies, affective arousal, and self evaluation were examined across 11 studies showing a relationship to CSE (Larson & Daniels, 1998). Among these studies, Larson and Daniels (1998) found that interventions seem to increase CSE. Included among these interventions are: practicum training, role play, modeling, and positive performance feedback.

Lack of CSE may be linked to the implementation of skills, amount of experience, and interaction by supervisors. When examining the performance of entry level trainees, Stoltenberg, McNeil and Delworth (1998) found that trainees experience an increase in anxiety due to their overall lack of counseling skills and self-efficacy along with concern
regarding negative feedback from clients and supervisors. With more experience, anxiety can decrease and level of perception of competence and skill can improve (Stoltenberg et al, 1998).

Not only do entry level trainees exhibit increased self-efficacy due to an increase in skill training, there is evidence that feedback influences efficacy. Research was conducted on the influence of performance feedback on counseling self-efficacy and anxiety with graduate level trainees (Daniels & Larson, 2001). This was done by examining both positive and negative performance feedback on self-efficacy and anxiety through the use of a mock counseling session. The results revealed that positive feedback increased counseling self-efficacy and decreased anxiety, whereas; a negative evaluation increases anxiety along with a negative evaluation. This outcome implies that a supervisor can help increase a trainee’s self-efficacy by focusing on specific techniques, giving positive feedback, and providing suggestions for improvement in skill (Daniels & Larson, 2001; Howard, 2008).

Some programs are incorporating service-learning in their pre-practicum programs because it offers students the opportunity to get valuable hands-on counseling experience in the field. Larson and Daniels (1998) found that learning experiences such as these influence counselor self-efficacy. When CIT have additional opportunities to learn and practice skills, there may be an impact on self-efficacy. The importance of service learning was the research focus of Barbee, Scherer, and Combs (2003). They examined the responses of students trained under a service-learning method in regard to self-efficacy and anxiety. Utilizing the Counselor-Self-Efficacy Scale and the State-Trait-Anxiety Inventory, the researchers found that pre-practicum service-learning has a
positive relationship with CSE and a negative association with student anxiety compared with those not trained using pre-practicum service learning. However, students’ level of previous experience and training accounted for more variance in self-efficacy. This infers that exposure to learning in the field contributes to perceptions of ability to successfully complete the task and reduces stress (Barbee, Scherer, & Combs, 2003). Part of the increasing skill level and outcome performance is ongoing supervision.

Part of the academic environment for CIT involves the requirement for supervision of counseling hours. The examination of counselor performance by supervisors is linked with CSE but only in limited capacity due to lack of research (Larson & Daniels, 1998). However, perception of the supervision experience influences efficacy. There is a difference between the perceived or objective environment when examining the supervisor, counselor, or client’s perspective when comparing it with the actual events. Counselors often relate their level of self-efficacy to their perception of how the supervisory environment was which may or may not be equivalent to the supervisor’s evaluation of the same experience or environment (Barnes, 2004; Larson & Daniels, 1998). This is important since self-efficacy has been noted to be influenced by vicarious learning and verbal persuasion which is often modeled by supervisors (Bandura, 1977; 1982). With CSE being important in regard to perceived outcome performance and overall competence, it is important to have a broad overview of CSE research.

Larson and Daniels (1998) reviewed thirty-two studies from 1982 until 1998 regarding self-efficacy beliefs and counseling. One area reviewed was the research that contributed to the predictive value of CSE. Seven studies between 1982 and 1988 were
found that contributed to the most variance in CSE. These included previous levels of CSE, anxiety, perceptions of fraudulence, counselor characteristics, positive feedback, and perceptions of the environment. In addition, CSE along with anxiety and counselor coursework were found to be significant factors that contribute to counselor performance (Larson & Daniels, 1998).

Other researchers narrowed the focus on a specific counseling skill or programs as a means to promote CSE. Levitt (2001) found that teaching and emphasizing active listening of trainees with their clients can directly impact CSE thereby increasing effectiveness. Greason and Cashwell (2009) encouraged the focus of mastery experiences where individuals get first-hand experience with a skill to help promote CSE. To be successful at this, they argue that counselors should have the ability to be mindful, empathetic, and sustain attention in session (Greason & Cashwell). Mastery of specific skills can promote efficacy and overall outcome performance and can be accomplished through skill-based learning. Knowing that specific skills influence CSE, personal characteristics are impactful as well.

Martin, Easton, Wilson, Takemoto, and Sullivan (2004) surveyed 140 counseling students and practicing counselors regarding their emotional intelligence and self-efficacy. Martin and colleagues (2004) found that counselors have higher levels of emotional intelligence than other career populations. Counselors with higher levels of perceived emotional intelligence have a relationship with perceived CSE. The predictive relationship between emotional intelligence and counseling efficacy can help establish a framework to incorporate training of emotional intelligence within counseling programs.
Expanding on their 2004 research, Easton, Martin, and Wilson (2008) sought to examine these constructs further by testing whether emotional intelligence and counselor self-efficacy would increase with additional training and experience over time. This was done by comparing 66 counseling students and 74 practicing professional counselors’ perceived emotional intelligence and counselor self-efficacy. The results supported the findings of 2004 and revealed the importance of counselors identifying their own emotions and skills related to CSE with professional counselors exhibiting higher self-efficacy than counselor trainees (Easton, Martin, & Wilson, 2008).

**Research Studies on Self-Efficacy and Counselors-in-Training**

As indicated in the above self-efficacy literature, multiple variables have been examined to help explain the amount of variance in counseling self-efficacy. The research ranges from identifying factors that influence self-efficacy (Poidevant, Loesch, & Wittmer, 1991), the relationship between anxiety and self-efficacy (Barbee, Scherer, & Combs, 2003; Larson et al., 1992; Leach & Stoltenberg, 1997), examining models to promote self-efficacy in training (Barnes, 2004), counselor-in-training perceptions of self-efficacy (Tang et al., 2004).

With the various forms of research completed on self-efficacy, different variables have been examined to help explain the correlates and variability in CSE of CIT. Research has been conducted examining contributing factors, promotion of, and maintenance of self-efficacy. Poidevant, Loesch, and Wittmer (1991) found that psychology and counselor trainees exhibited high levels of self-efficacy in regard to professional activities such as counseling, supervision, and training. More current
research by Tang et al. (2004), examined specific factors to determine trainees’ relationship to self-efficacy of 116 counselor education students. These factors include: age of the counselor, work experience, number of courses taken, and total number of internship hours. When they looked specifically at the six selected counselor education programs in the Midwest from three CACREP and three non-CACREP programs, there was no difference in total self-efficacy but students from CACREP programs did report less anxiety associated with self-efficacy. Students with more coursework completed exhibited greater self-efficacy (Tang et al., 2004). This was supported by Poidevant, Loesch, and Wittmer (1991) who found that psychology and counselor trainees exhibited high levels of self-efficacy in regard to professional activities such as counseling, supervision, and training. The primary factor contributing to variation in CSE of CIT was the number of training hours and prior related work experience. Students with more coursework completed exhibited greater self-efficacy (Tang et al., 2004). Other methods that promote specific skills training have been examined to assist with promoting CIT efficacy.

The effectiveness of the skilled counselor training model (SCTM) with counselors-in-training was examined to assess the effectiveness of the specific skills taught in the program on overall self-efficacy (Urbani et al., 2002). The SCTM program focuses on three stages of counseling: exploring, understanding and acting. Their research focused on pretesting to assess counseling skills before the training and a post test after learning and implementing the SCTM program. A total of 53 students were in the experimental group with 9 students in the control group. The results revealed that CIT perceptions of their skill level was higher for those in the experimental group receiving
the program training as opposed to those who did not (Urbani et al., 2002). This suggests that more training can increase competence and belief regarding performance because of skill level improvement, thereby increasing self-efficacy.

Barnes (2004) discusses two approaches to apply self-efficacy with CIT that can help improve skill level. The first is the self-efficacy enhancement approach. He encourages the enhancement of Bandura’s four sources of efficacy (vicarious learning, performance enhancement, verbal persuasion and emotional arousal). Trainees are assisted with increasing their awareness of what is occurring in counseling and teaching trainees’ skills to handle self-efficacy enhancement. The second approach suggested by Barnes is the context approach. This approach examines trainees’ self-regulation through supervision interaction and feedback. It involves the supervisor teaching the social-cognitive model, focusing on factors that influence development, and helping trainees process and reflect the counseling environment. This is an ongoing process throughout supervision although there are mixed results regarding the mutual influence (Barnes, 2004). Environment is also an important factor when examining school CIT self-efficacy.

When examining the relationship between school climate and CSE, Sutton and Fall (1995) explored how the school environment including faculty relationships, counselor role, and demographic variables affects the self-efficacy of school counselors. Results revealed that school counselor self-efficacy is negatively affected by an unsupportive school climate but can be improved by supportive colleagues, by administrative staff, and when the role of the school counselor is clearly defined. This implies that school counselor programs should train trainees in how to create a collaborative school climate for counselors (Sutton & Fall, 1995). Since the trainee
program environment and practicing site influence self-efficacy, the type of accredited program may also influence outcome performance.

Tang et al. (2004), examined three CACREP and three non CACREP accredited programs in regard to whether accreditation status impacted students’ self-efficacy. The study examined whether age, prior work experience, number of courses taken, and number of internship hours have a positive relationship with counseling self-efficacy of 116 participants enrolled in six Midwestern counselor education programs in the United States. Participants were administered the Self-Efficacy Inventory and a demographic questionnaire. The data was grouped according to CACREP accreditation and was controlled for specific demographic variables (age, prior work experience, number of courses taken, and number of internship hours). The multivariate analysis of variance revealed no difference in self-efficacy between CACREP and non CACREP accredited programs in regard to amount of course work, hours of internship, and prior work experience. The most variation in CSE was evident when specifically looking at the number of training hours and prior work related work experience which may be connected to CACREP accredited programs that require 60 semester credits.

Along with this study, there have been training interventions specifically designed to help improve CSE in regard to personal competence and counselor’s-in-training beliefs regarding ability to effectively perform. They are centered on coursework which may include assigned readings and classroom discussions. Other interventions may be at the practicum or internship level which involves hands-on learning experiences, modeling by supervisors or other trainees, and encouraging the use of self-reflection and development.
(Larson & Daniels, 1998; Easton et al., 2008). Training to improve self-efficacy is typically influenced by supervisors as they are required to prepare CIT to practice.

**Counselors-in-Training and Supervision**

An additional way to influence self-efficacy is by evaluating the impact of supervisors on supervisees. One study examined whether supervisory styles used with master’s level counseling students would impact self-efficacy. Fernando and Hulse-Kilacky (2005) proposed reviewing the interaction between supervisor and supervisee. The authors specifically looked at three styles: attractive style, interpersonally sensitive style, and task-oriented style. Using a multiple regression analysis, the researchers found that 13% of the variance of self-efficacy could be explained by the three supervisory styles with the task-oriented style being the most statistically significant contribution. Overall, the researchers indicate that supervision style can impact self-efficacy. Self-efficacy is improved when supervisors utilize the task-oriented style of supervision. It is important that supervisors adjust their style to what is appropriate for each supervisee (Fernando & Hulse-Kilacky, 2005). Just as style of supervision is important for the increase in CIT self-efficacy, so is the amount of clinical supervision received.

Part of training and supervision is to help develop counseling skills and to increase trainees’ confidence in their ability to perform (Bernard & Goodyear, 1998, Loganbill, Hardy, & Delworth, 1982). According to Cashwell and Dooley (2001), “counselors who receive inadequate, little or no clinical supervision after completion of their training may experience a decline in the level of their counseling performance” (p.40). They argue that supervision can either benefit or hinder the level of efficacy for
CIT. Less supervision has been shown to decrease helpful verbal counseling responses and other counseling skills. Utilizing the Counselor Self Estimate Inventory and demographic questionnaire, the results indicated that counselors receiving clinical supervision possessed higher levels of counselor self-efficacy (Cashwell & Dooley, 2001).

As stated in Constantine (2001),

…effective supervision may represent an important means by which supervisees develop counseling self-efficacy because of its potential for providing supervisees with a) knowledge about critical counseling tasks, b) opportunities to develop skills through structured practice, c) support and encouragement regarding counseling skills, and d) help with managing anxiety and other types of affect. (p.82)

There is an additional likelihood that individuals with a higher self-efficacy will be better equipped to work with challenging and diverse clients and that supervision feedback is imperative to help increase trainees perception of performance (Constantine, 2001).

**Gaps in the Research Literature**

Although the examination of the above mentioned variables is important to the existing self-efficacy literature, they do not fully explain the total variance accounted for by the CSE of CIT. In other words, each factor adds additional weight to the importance of studying counseling self-efficacy and provides some evidence to what may contribute to enhancing it within trainees. The contributing factors examined vary across studies from individual factors, institutional requirements, supervision exposure, and training
requirements. Giving the weight that Bandura (1977) placed upon self-efficacy being an individual factor that is influenced more by an individual’s cognitive appraisal versus outside expectations, it is important to explore the possibility of another construct that may contribute to the existing constructs mentioned in previous literature, wellness. An individual’s level of total wellness may be directly linked to high or low self-efficacy because of the connection between the physical, coping, emotional, essential, and creative parts of self that wellness theory promotes. Current research approaches have focused on CSE in regard to specific variables from various methodological approaches but little research has specifically looked at wellness as a contributing factor for lower or higher perceived self-efficacy in trainees.

From the review of research on self-efficacy and wellness, two empirical studies were found that suggested that the examination of the relationship between wellness in relation to counseling self-efficacy. Smith et al. (2007) in their research on wellness, psychological distress, and social desirability examined 240 master’s-level counseling students from nine counseling programs testing the Five Factor Wellness with its relationship to psychological distress and social desirability. Their primary goal was to determine if counselor education students’ response to wellness and distress were connected to their personal perception of social desirability. The social desirability scale seeks to examine if the respondents will answer honestly or answer in a way that makes them appear more favorable. Using Pearson product moment correlations, partial correlations, one-sample t tests, and analysis of variance, a strong relationship was found between psychological distress and social desirability with no relationship between wellness and social desirability. There was a relationship between psychological distress
and lower levels of wellness although the counseling students did have higher levels of wellness than the average population. With these findings, they suggested that further research be conducted on the CSE of CIT in relation to wellness due to their finding of increase distress in this population. This research approach was limited because it did not specifically examine already existing academic variables that influence self-efficacy nor does it implement the use of a self-efficacy scale better aligned to examine CIT skills that contribute to the CSE of trainees versus only examining practicing counselors’ perceived self-efficacy.

Another empirical study, conducted by Curry (2007), specifically investigated the relationship between counseling self-efficacy and wellness among counselor education students. Using an existing data base of 88 master’s level counseling students who were given the 5F-Wel and the Counselor Self-Efficacy Scale, she examined the relationship between counseling self-efficacy and wellness using hierarchical multiple regression analysis. She hypothesized that there would be a significant relationship between CSE and counselor wellness. The results revealed that there was not a significant relationship between counselor wellness and self-efficacy. The study showed limitations due to the author’s utilization of only one institution with an existing data set, and the use of the Counselor Self-Efficacy Scale which does not specifically examine specific skill attainment areas for trainees (Curry, 2007). Further review of wellness literature can help to explain the importance of the components in relation to self-efficacy and competence.
Historical Views of Wellness

Wellness as a counseling approach in the United States is rooted in philosophy. It is argued that William James, who reinforced the concept of free will in the field of psychology, sparked the concept of wellness within the mental health field (Bankart, 1997). Through his writings, James argued that humans have the ability to make personal choices which can subsequently influence the outcome of their lives. This makes individuals responsible for their own consequences (Bankart). His ideas preceded the works of another influential thinker regarding wellness, Adler.

In the 1920’s, Adler began discussing how individuals strive to become superior due to their personal feelings of inferiority. As part of his psychology movement, Adler (1954) endorsed the ability to overcome obstacles and face adversity with the goal of becoming self-actualized. He not only encouraged the implementation of goal setting in different life domains, he also focused on the unity and wholeness of self to achieve these goals. He believed that goals were derived from personal feelings of inferiority which are directly linked to behavioral outcomes in that no individual will think, feel, or act without it being in relation to a goal. Adler postulated that these goals were formed in various life domains which included: spirituality, friendship, love, and work (1954). Having goals that motivate the self, he emphasized the importance of unity and wholeness of self because the life domains specifically impact each other to influence the functioning of an individual. Most of the early models of wellness were derived from medical science and were grounded in the physical sciences (Ardell, 1986; Myers & Sweeney, 2005). Knowing this, there was a need to expand beyond just the physical aspects of wellness to also include the mental aspects of wellness.
Attempts to systematically define wellness were originally connected with the World Health Organization’s (WHO, 1967) definition of wellness. The WHO examined the physical, mental, and social wellbeing of individuals not just the disease free concept. The goal was to focus on optimal health. Over time, other theorists worked to develop a theoretical framework for wellness where an individual has the power to contribute to his or her perception, practice of, and growth of wellness (Maslow, 1968). Maslow (1968) discussed the importance of individuals reaching their full potential with the ultimate goal of becoming self-actualized. Working toward self-actualization can lead to a higher sense of perceived wellness. The following traits help characterize a self-actualized person: the integration and unity of the whole person, openness to experience, feelings of zest for life, being responsible, having wisdom, being honest, exhibiting kindness, loving others, a solid sense of identity, and personal confidence in one’s stress management skills (Maslow, 1968).

Additionally, the understanding of wellness was influenced by the work of Dunn. In 1961, Dunn helped to develop and define the construct of wellness in relation to personal fitness, personal responsibility, and environmental factors (Warner, 1984). Beginning as a physician focused on patient wellness and optimal health, Dunn (1977) thought of wellness as a positive state not just the negative state of illness. If one looks beyond being well as the mere absence of illness, then there is a greater focus on looking at wellness from a perspective of health and strength that is multifaceted. His desire was that individuals would pursue optimal wellness from a physical and psychological perspective (Ardell, 2005). Dunn’s original conceptualization viewed wellness as “an integrated method of functioning, which is oriented toward maximizing the potential of
which the individual is capable. It requires that the individual maintain a continuum of balance and purposeful direction within the environment where he is functioning” (Dunn, 1977, p.4). This conceptualization reinforced the importance of maintaining a healthy balance both physically and psychologically in an individual’s life. Individuals are responsible for making healthy decisions which includes being aware of the environment of which they are a part and how that influences personal decisions (Dunn, 1977).

Encouraging an understanding of wellness led to the development of models that could be followed.

One of the first Wellness models was developed by Hettler in 1984 and it has become the foundation for many subsequent models. While this model focused primarily on physical health, it served as a catalyst that started the wellness movement popular today which has resulted in models that are much more evidence-based and holistic in nature (Myers et al., 2000; Myers & Sweeney, 2005a, 2008; Sweeney & Witmer, 1991).

As a physician, Hettler’s work developed out of his desire to promote personal and professional growth in his patients. His hexagonal model focused on six dimensions of healthy functioning which included: physical, emotional, social, intellectual, occupational, and spiritual (Hattie et al., 2004). These six components were devised out of his idea that they all work together to create a healthy balance of self in relation to the environment. His work was devised out of his own study and interest in the concept of well living. With the passage of time, the counseling world was influenced to promote physical and mental health from a wellness perspective.

In 1989, a resolution titled *The Counseling Profession as Advocates for Optimum Health and Wellness* was adopted by the American Counseling Association to infuse
wellness into the counseling profession (Myers & Sweeney, 1991). This resolution encouraged the conceptualization, formation, and implementation of wellness programs as an important focus in the mental health field and helped establish an ethical guideline for practitioners as part of the decision making process when working with clients to devise treatment plans. If we want CIT to have optimal functioning, then there needs to be an appropriate model to examine wellness. Subsequently, an intentional effort to promote wellness and personal health has become a fundamental part of becoming an effective counselor (Myers & Sweeney, 2005a; Yeager & Tovar-Blank, 2007).

With this resolution, counselor educators began creating a programmatic paradigm shift toward a more holistic model of wellness that encompassed specific life tasks which originally included: spirituality, self-regulation, work, friendship, and love. It reinforced the importance that wellness and illness are relational because they are needed to define each other. This was successful because it reinforced the need to examine wellness as a unifying force within individuals that influences their ability to cope (Witmer & Sweeney, 1992; Myers et al., 2000). As a result of this shift, counseling curricula are now more focused on appropriate assessments to assist with wellness theory while working with clients. This focus has reinforced the need to educate trainees for themselves and clients regarding the components of wellness, and has now become a part of the CACREP accreditation requirements within curriculum (CACREP, 2009; Roscoe, 2009). This can be accomplished through targeting counselor programs who train counselors on theories and practice that will ultimately influence the counselors role with clients (Myers et al., 2003; Smith et al., 2007; Vries & Valadez, 2005; Wilkerson, 2006). For the purpose of this study, wellness was defined from a counselor perspective as “a
way of life oriented toward optimal health and well-being in which the body, mind, and spirit are integrated by the individual to live more fully” (Myers et al., 2000, p. 252). The theoretical change in the understanding and concept of wellness over time helps support a definition of wellness which encourages a holistic perspective.

**Wheel of Wellness Model**

Originally, Sweeney and Witmer (1991) expanded upon the concept of holistic wellness through a comprehensive review of wellness literature. They examined contemporary research across paradigms with Adlerian psychology as their primary construct. Sweeney and Witmer (1991) found that the research reinforced the focus of the originally presented life tasks as outlined by Adler and they expanded upon it to reinforce their own model. This review led to the development of the WoW model (Myers et al., 2000). The model is illustrated as a wheel that contains interrelated spokes that include a series of reciprocal wellness domains based on basic principles of Adlerian Individual Psychology. These principles were condensed into a set of five basic wellness domains, each represented by a spoke in the wheel. The original model included domains of the three basic life tasks proposed by Adler (1954) of work/leisure, friendship, and love with the additional domains of self and spirit added by Witmer and Sweeney (2000) after examining experimental and applied research across different areas of psychology.

The work/leisure spoke includes career satisfaction with a belief that work is useful to the community and self. This domain also captures the essence of leisure which involves engaging in pleasurable activities on a regular basis. The love and friendship spokes deals with social and relational wellness. The spirituality spoke includes work and
self direction describe as spokes on the wheel. These were further explained as the love and friendship spokes dealing with social and relational wellness and examines the way that a person’s basic social needs are met through interaction with others. The self-direction spoke includes the means by which one can direct and control his or her life goals across physical, emotional, and psychological domains. It looks specifically at an individual’s sense of worth, sense of control, realistic beliefs, personal awareness and coping, and creative problem solving ability. The spirituality spoke includes personal transcendence and finding purpose in life (Myers et al., 2000).

The purpose of the WoW was twofold. First, it served as a tool to assist with client assessment and the selection of appropriate interventions (Myers & Sweeney, 2005b). The second purpose was to assist counselor educators as a comprehensive intervention that could assist trainees with understanding their level of wellness and incorporating means to improve it (Myers et al., 2000). A suggestion of how to incorporate the model includes the following: introduction of the WoW to students, assessment of students’ current level of wellness, incorporating the WoW components through specific interventions, and evaluating and following-up with the interventions including changing the interventions if needed (Myers, et al., 2000).

Although the WoW model was an evidence-based model that created a framework for conceptualizing and measuring wellness, theoretical models typically expand and change as more empirical testing and validation is completed. The Indivisible Self model of wellness (IS-WEL) was developed out of research based on the WoW model. After analyzing the data gathered from more than a decade of research, the IS-WEL was developed. The data indicated that the hypothesized circumplex model where
spirituality was the core and the most important component of wellness was not supported by the data. While a factor structure that prelicated the original WoW model could not be found, the factor loadings did encourage further examination of the structure of wellness (Hattie et al., 2004; Myers & Sweeney, 2005b).

**Indivisible Self Model of Wellness**

Using exploratory factor analysis over seven years of research data, Hattie, Myers, and Sweeney (2004) discovered that there was an overall composite factor of global wellness functioning that emerged with five second order factors of wellness and seventeen third order factors. The new model, called IS-WEL, is an empirically-based model whose components interact and will contribute to change in other areas both positively or negatively (Myers et al., 1998; Myers & Sweeney, 2005b). At the center of the IS-Wel model is the indivisible self or total wellness which is defined as the single higher order factor. The second order factors emerged from the authors’ understanding of the indivisible self. These factors were labeled: Creative Self, Coping Self, Social Self, Essential Self, and Physical Self (Myers, & Sweeney, 2005b). (See Figure 2.1).
Figure 2.1  Venn Diagram of Indivisible Self Model
Table 2.1 Definitions of the Components of the Indivisible Self Model

<table>
<thead>
<tr>
<th>Factor</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Single Higher Order Factor</td>
<td>The Sum of all items on the Five Factor Wellness Inventory (5F-Wel); a measure of one’s general well-being or total wellness</td>
</tr>
<tr>
<td>Corresponding Second-Order Factors and Third Order Factors</td>
<td></td>
</tr>
<tr>
<td>Creative Self: thinking, emotions, control, work, and positive humor.</td>
<td>This includes the what qualities that each individual forms to make a unique place among others within our social interactions within the world</td>
</tr>
<tr>
<td>Coping Self: leisure, stress management, self-worth, realistic beliefs</td>
<td>This is the combination of qualities that regulates an individual’s response to life events and ways to move beyond having negative effects from the events.</td>
</tr>
<tr>
<td>Social Self: friendship and love.</td>
<td>This includes an individual’s social support network.</td>
</tr>
<tr>
<td>Essential Self: spirituality, gender identity, cultural identity, and self-care.</td>
<td>It is one’s essential meaning making process in relation to human life, self, and others in the world.</td>
</tr>
<tr>
<td>Physical Self: nutrition and exercise</td>
<td>Those elements that comprise our physical aspects of development and overall functioning.</td>
</tr>
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Within the framework of the IS-Wel model of wellness, the second order factor of creative self contained the third order factors of intelligence, control, emotions, humor, and work. An individual’s creativity is expressed in the third order domains as individuals striving to find their unique place in the universe (Adler, 1954). The second order factor of coping self contains the third order factors of leisure, stress, worth, and beliefs. The coping self, according to Myers and Sweeney (2005a), “is composed of elements that regulate our response to life events and provides a means for transcending their negative effects” (p. 34). The second order factor of social self contains the third
order factors of love and friendship. There is evidence to support that having close relationships enhances life and is a positive predictor of overall mental health (Myers & Sweeney, 2005a). The second order factor of essential self includes the third order factors of spirituality, gender identity, cultural identity, and self-care. One aspect of this second order factor involves an individual making sense out of their interconnected relationship to life, self, and others in the world. The second order factor of physical self includes the third order factors of exercise and nutrition. This involves the biological and physiological process that encourages the ongoing process of maintaining an optimal level of physical activity and health nutrition along with self-care that reinforces the maintenance of appropriate lifestyle choices (Myers & Sweeney, 2005a). A description of each of these scales appears in Table 2.1. Understanding the components of wellness, in particular the IS-WEL model reinforces the importance of not only studying wellness but finding ways to promote it.

Overview of Current Literature and Research

Research Studies on Wellness in General Population

Infusing wellness into the general population is one area of research focus in the current literature. Roscoe (2009), in her review of wellness theory, noted that theorists have failed to agree on the construct of wellness over time and proposes a comprehensive definition of wellness. She noted that researchers have had several common elements in their theories and constructs of wellness since the resolution of the World Health Organization including: social wellness, emotional wellness, physical wellness, spiritual
wellness, psychological wellness, occupational wellness, and environmental wellness (Adams, et al, 1997; Crose et al., 1992; Durlak, 2000; Hettler, 1980; Leafgren, 1990; Renger et al., 2000;). Each one of these attempts at conceptualizing wellness further supports the need for a more integrated approach to viewing wellness. This includes understanding the wellness within individuals as encompassing a more complete whole that is made up of many individual parts.

Professional helpers are attempting to take an active role in the promotion of wellness with their clients. The goal is to move an individual from complacency with self to a greater understanding of self and a sense of wellbeing. According to Britzman and Henkin (1992)

The reorientation and reduction stages of therapy can provide an opportunity to reveal how one’s particular style of life impacts not only the presenting problem(s) but also the resulting wellness related choices. Unhealthy attitudes and apperceptions can be challenged in a caring fashion, and individuals can be encouraged to develop alternative, more functional attitudes. As a result, promotion toward wellness can occur in a concomitment manner with other life-style issues and may help empower an individual to overcome discouraged feelings. (p.198)

The research on wellness is important for all clients being served by mental health personnel. There is a need for wellness counseling as individuals are faced with the rising cost of health care, an increase in life expectancy, and life stressors. A wellness approach is a proactive approach to promote a holistic and healthy lifestyle that can impact overall
health care problems (Fetter & Koch, 2009). To do this, wellness counseling can be implemented through the use of the Indivisible Model of Wellness (Sweeney, & Witmer, 1991) and implementation of counseling skills and techniques. Counselors can implement steps to promote wellness by first defining wellness and explaining the wellness model to clients. Then, a formal assessment can be conducted through the use of the Five Factor Wellness Inventory (5F-Wel; Sweeney & Witmer, 1991). Finally, counselors and clients can work together to develop a specific wellness plan (Fetter & Koch, 2009). Having a plan can help develop a baseline for progress so evaluations can be measured over time (Granello, 2000).

**Research Studies on Wellness in Students**

Part of promoting wellness within individuals includes infusing the concepts within a previously established institutional framework whether it is through the academic arena, athletics, or military. In colleges, students are facing multiple difficulties from financial struggles, maintenance of academic standing, and balancing social, familial, and school life within the college environment. As universities become more aware of the struggles students face on campuses, counselors are often called upon to work with students through counseling interventions or advisors to help students improve their problem solving and coping skills. To improve the success of first year college students, Choate and Smith (2003) believe that the integration of the WoW model (Myers, Sweeney, & Witmer, 2000) may improve overall development. This model was taught in a one-semester success course for freshmen students. Meeting once a week, the students were taught the wellness model and at the end of the semester were given the
WEL instrument to measure their level of wellness. The results revealed an overall increase in the total Wel scores and targeted areas. (Choate & Smith, 2003).

Wellness evaluation and promotion is imperative to promote personal and professional competence in venues where training takes place. When specifically examining the wellness of athletes and non-athletes, the research results revealed that athletes had lower levels of wellness than non-athletes. This supports the infusing of a wellness program within college campus especially since research has shown that athletes on college campuses typically have high demands placed upon them and have difficulty balancing their multiple roles including their athletic, academic, and interpersonal demands (Watson & Kissinger, 2007).

Similar results have been found within military academic settings. The military cadets are placed in highly stressful situations where they are forced to balance expectations both military and secular (Gold & Friedman, 2000). This level of stress can impact one’s sense of mattering and may hinder overall wellness. As a result, Myers and Bechtel (2004) gave freshman first semester cadets’ assessments to specifically measure perceived stress, general mattering, and wellness. The results indicated that cadets reported higher levels of wellness in the areas of physical wellness, love and friendship, and a greater sense of humor than the general population of civilians. However, cadets rated work wellness lower and perceived their environment to be more stressful than their civilian counterparts (Myers & Bechtel, 2004). The implementation of wellness interventions within this setting may prove to help these cadets decrease their level of stress and maintain their positive wellness components. This reinforces the significance
that wellness can play within a university setting where training occurs whether with individuals focusing on a military career or pursuing careers in the mental health field.

**Research Studies with Counseling Practitioners**

While counselors seek to promote wellness within their clients, and researchers study wellness, it is equally important for counselors to assess, understand, promote, and maintain their own personal wellness. If counselors expect to serve the public in a competent manner, they must maintain their own level of self-care which can be achieved through optimal wellness. Many researchers have assessed, discussed, and reinforced the need for CIT to evaluate their wellness and promote their own level of wellness. Multiple studies on wellness with helping professionals reveal a link to personal variables which has consistently been shown to affect clinical work (Guy, Poelstra, & Stark, 1989; Pope & Tabachnick, 1994). Burnout is a consistent problem that helping professionals face and is linked to counselor wellness because it is characterized by symptoms of emotional fatigue, disconnection from self, and lack of feeling useful (Maslach, Jackson, & Leiter, 1996; Skovholt, 2001). Burnout does not occur in a vacuum, rather it is connected to influential environmental factors such as lack of peer and supervisory support, inability to control environmental situations, and a large caseload that is not conducive to optimal practice (Cummins, Massey, & Jones, 2007; Maslach, 2003). Additional variables linked with wellness include vicarious traumatization due to working with traumatized clients (Figley, 2002; Pearlman & Saakvitne, 1995) as well as work related variables such as job satisfaction and increased caseloads (Walsh & Walsh, 2002).
Compassion fatigue is another variable of concern for counselors with personal unresolved stressors related to working with individuals with chronic illness. Figley (2002) examined compassion fatigue as a form of burnout and how it needs to be effectively managed in psychotherapists. He devised a model to effectively help psychotherapists manage the promotion of self-care versus the care of others. First, clinicians with compassion fatigue need to understand what it is. Next, therapists must be desensitized to the stressors through therapeutic means by exposing the therapist to the stressor in small doses paired with relaxation. The final component of decreasing compassion fatigue is by expanding a therapist’s social network and support (Figley, 2002). Although this research did not specifically use the term wellness, it did encourage some form of systematic way to assist with decreasing burnout and possible impairment which can also be accomplished by evaluating a trainee for their level of wellness and implementing ways to increase it.

After reviewing multiple studies, Lawson (2007) found that more than half of all mental health professionals seek out counseling at some point in their careers. However, results of the research on counseling students and wellness revealed that counseling students reported a higher wellness score than an adult norm group. Although there was no indication that being a student in a counseling program influenced their level of wellness, there was a difference between counseling students and students in other programs (Myers, Mobley, & Booth, 2003).

In a study examining the wellness and impairment among American Counseling Association members, Lawson (2007) worked to identify what factors contribute to counselor wellness. One thousand American Counseling Association Members were
randomly selected from the membership roll and were given three assessments: The Career-Sustaining Behaviors Questionnaire, the Professional Quality of Life Scale-Third Addition, and a demographic questionnaire. With over 501 respondents, the author wanted to examine wellness and impairment among American Counseling Association members and to specifically examine what characteristics and skills contribute to counselor wellness. Overall, the respondents reported being satisfied with their jobs and reported themselves as well although they reported the wellness of colleagues lower. The respondents indicated stress associated with larger caseloads that include clients who exhibit many intense psychological problems from suicidal ideation to histories of trauma. The examination of the impact of compassion fatigue, burnout, and vicarious traumatization revealed that upwards of 14% of counselors have had their wellness challenged. This has an overall impact on the quality of services clients receive. These results teach counselors that they should maintain their personal wellness, maintain an objective perspective regarding the work they do, value the profession and clients, maintain healthy life balance, and focus on the spiritual components of self (Lawson, 2007).

When specifically examining the combination of counseling wellness and self-efficacy, there is limited research. However, Curry (2007) conducted a hierarchical multiple regression analysis to analyze 88 participants in a counselor education program in regard to counselors-in-training self-efficacy and wellness. The results indicated no predictive value between counselor wellness and counselor self-efficacy. When examining self-efficacy and wellness individually, there were interesting findings. Counselor graduate students reported less self-efficacy while reporting more wellness in
the areas of total wellness, creative self, social self, and the essential self as explained by the five factor wellness (Myers & Sweeney, 2005; Curry, 2007). As part of the research limitations, Curry (2007) suggests the usage of a broader sample, the use of an additional self-efficacy instrument, and further examination of the relationship between CIT and self-efficacy because of the influence wellness has on counseling performance outcomes. Curry’s (2007) conclusions encouraged more research on wellness and self-efficacy.

Summary

This literature review was designed to give a thorough overview of specific definitions of counselor competence, self-efficacy, and counselor wellness and to examine specific research literature on these constructs. The reviewed literature examined the importance of counselor competence and the role supervisors have on promoting competence. With the gatekeeping responsibilities on supervisors to promote trainees, the need to increase self-efficacy was supported. As a way to promote competence and CSE in CIT, the components of wellness and the implementation of a wellness model have proven to be important. The overall research supports a need for counselors and CIT to be self-efficacious and to promote wellness through self care measures.
CHAPTER III
METHODOLOGY

The goal of this research is to more accurately explain and predict which constructs (academic factors or wellness) or combination of these constructs has the greatest predictive value of CSE of CIT. This study examined the amount of influence student wellness had on the variance of the CSE of CIT above and beyond what academic factors contributed. The effect of wellness and academic predictor variables on CIT self-efficacy across randomly selected CACREP was explored and analyzed. This chapter is divided into five subsections: (a) general research design, (b) characteristics of the participants, (c) procedures for data collection (d) psychometric properties of each instrument, and (e) statistical/data analyses employed.

Research Design

The proposed study is designed to determine the relationship among various academic factors, wellness, and CSE of CIT enrolled in randomly selected master level counseling training programs accredited by CACREP. A research study that addresses these issues is needed to identify possible predictor variables that might explain observed variance in the self-efficacy of counselors preparing to graduate and work with various clientele.
For the purposes of this study, five predictor variables were examined as they relate to the
criterion variable. The criterion variable for this study, counselor self-efficacy, was
measured by the Counselor Activity Self Efficacy Scale (CASES; Lent, Hill, & Hoffman,
2003). The predictor variables assessed in this study were total wellness (Myers &
Sweeney, 2005c) and a series of academic factors including: number of courses/credits
completed, number of supervised practicum/internship hours, hours of clinical
experience, and current grade point average. The goal was to explain which of the
predictor variables (5F Wel global scale and a series of academic factors assessed using a
demographic questionnaire) or combination of both, more accurately predicted CSE of
CIT as measured by the CASES.

Participants
The number of participants comprising the sample was based on best practice
guidelines for determining acceptable sample sizes in a research study. When selecting an
appropriate sample size, Tabachnick and Fidell (2007) warn researchers against including
too many cases. They argued that when the number of cases increases, the risk of
obtaining significance from any variance also increases. As a result, it is often times more
appropriate to measure a smaller number of cases with a greater likelihood to reveal
significance (Hair, Black, Babin, Anderson, & Tatham, 2006). To determine the sample
size required for a multiple regression analysis, Tabachnick and Fidell encourage the
examination of several factors including power, alpha level, number of predictors, and
effect sizes. According to these authors, when testing independent variables, sample size
can be determined through use of the following formula: \( N \geq 104 + m \), where \( m \) = the
number of independent variables used in the study. According to this guideline, the present study required a minimum of 109 participants to test individual predictors. This is an adequate sample size since the programs were randomly selected and the size of each CACREP program varied according to geographic location, type of school, and number of students in the selected program.

**Population/Sample**

The target population for this study was master’s level CIT in CACREP accredited counseling programs across the United States. As of May 2010, there were 574 CACREP accredited counseling programs nationwide. Using a random number generator in which each program has an equal likelihood of being selected to participate in the study, a representative sample was chosen. Every program was given a number from 1 to 574. Participants were selected based upon their CACREP counseling program being randomly chosen from the database of 574 accredited programs. One out of every four programs was selected from the 574 CACREP programs. Subjects were drawn from various states such as New York, New Jersey, Oregon, Maryland, Ohio, California, Colorado, Florida, and Alabama. A courtesy letter was sent to the CACREP liaison or contact person for each randomly selected program requesting their willingness to forward the research instruments to the faculty member directly responsible for the coordination of the internship and practicum classes. All students in the selected program who were enrolled in their practicum or internship courses were given the opportunity to participate. Final subjects were those that consented to voluntarily participate in the study. Program liaisons were not required to indicate if their program would participate;
however, if a program liaison made contact with the researcher indicating no desire to participate another program was randomly selected to replace it. A reminder email was sent out two weeks prior to the completion deadline to the selected program liaisons.

To reduce the threats to external validity, only students who had reached the practicum and internship stage of their program were invited to participate. This specific subset of students will already have acquired basic counseling skills and met the requirements in the counseling program to begin their practicum or internship field experiences. Having a targeted population reduces the risk of interaction and reaction effects. Isolating the student sample to those who were within the field experience also helps maintain uniformity. Therefore, utilizing a specific population of master’s level practicum and internship students established a baseline of minimum competency. It is anticipated that this will help standardize the sample.

**Procedure for Data Collection**

Prior to beginning the study, formal approval was obtained from the Mississippi State University Institutional Review Board (IRB). In addition, appropriate permission and/or required consent for use of each instrument were obtained from the original authors or copyright holders. Next, program chairs or liaisons from randomly selected CACREP accredited master’s-level counseling programs were contacted, provided a description of the study, and invited to ask any questions related to their students’ involvement in the study. Those who agreed to allow participation in their program were asked to forward an email introducing the study and requesting participation to counseling practicum and internship students at their institution. In the email, potential
participants were provided with directions for accessing and completing the survey, contact information for the researcher, and approximate deadline for completion. Each participant was asked to complete a consent form, a demographic questionnaire, the 5F-Wel, and the Counselor Activity Self Efficacy Scale. It was estimated that participants would spend approximately 45 minutes completing all instruments in this study. Data from returned surveys were stored in the database of Survey Monkey, the proprietor of the site hosting the survey. This data collection method was chosen to assist in the distribution and collection of data across a broad research area.

**Instrumentation**

A total of six variables were examined in this study: wellness, a series of academic factors (the number of courses/credits completed, the number of supervised practicum and internship hours completed, the number of hours of clinical experience outside practicum and internship and the student’s current GPA in the counseling program) and counseling self-efficacy. The primary predictor variable of wellness was measured by examining the total score on the 5F-Wel which, according to Myers and Sweeney (2005b), is indicative of one’s general well being. The academic factors were examined using the demographic questionnaire which collected information regarding number of courses and credits completed, number of supervised practicum or internship hours completed, number of hours of clinical experience (outside practicum and internship), and current GPA in their respective counseling program.
Five Factor Wellness Evaluation of Lifestyle

The 5F-Wel is an evidence-based tool that was developed using a factor analysis of the data gathered using the Wellness Evaluation of Lifestyle (WEL) (Myers, Luecht, & Sweeney, 2004; Myers & Sweeney, 2005b). Like the original WEL instrument, the 5F-Wel is designed to assess specific characteristics of wellness derived from Adlerian counseling theory (Sweeny & Witmer, 1991). The 5F-Wel includes 100 items that measures a higher order wellness factor, five second order factors (creative self, coping self, social self, essential self and physical self) and 17 third order factors (thinking, emotions, control, work, positive humor, leisure, stress management, self-worth, realistic beliefs, friendship, love, spirituality, gender identity, cultural identity, self-care, nutrition, and exercise). Additional contextual variables (local, institutional, global, and chronometrical) also are examined. Responses are made using a 4 point Likert scale that includes response options ranging from 1 (strongly disagree) to 4 (strongly agree). Sample questions include: I like myself in spite of my imperfections, I am an active person, I can reduce my stress by thinking positive thoughts, and I have sources of support with respect to my race, color, or culture (Myers & Sweeney, 2004). Scores on each factor are converted to a common metric to allow for ease of comparison. Each scale ranges from 1 to 100, with higher scores being indicative of a higher degree of wellness in that specific area. Only the total wellness score will be used for this study because it encompasses a total score for all of the five factors of wellness to indicate the respondents’ total level of wellness or optimal functioning. Connolly and Myers (2003) in their regression analysis of wellness, mattering, and job satisfaction, specifically
examined the Total Wellness score because it summed all the individual scores for the individual items providing a measure of holistic wellness.

As cited in the 5F-Wel manual (Myers & Sweeney, 2004), multiple researchers have examined wellness in various contexts which supports the validity and norm sample results of the instrument. The research supporting the validity of the 5F-Wel spans several years and has examined several variables in relation to the scores on the 5F-Wel. Instrument reliability was established with over three thousand participants who completed the Wellness Evaluation of Lifestyle with 73 specific items specifically targeting the components of the 5F-Wel. The alpha coefficient for the Total Wellness scale was .94 (DeMauro, & Lonborg, 2005).

**Demographic Questionnaire Examining Academic Factors**

The demographic questionnaire is an author developed instrument designed to examine academic factors that may contribute to the amount of variance accounted for by the CSE of CIT. The questions were designed to gather information related to each participant’s academic background and counselor education status. The following questions were included in the questionnaire:

1. How many courses/credits have you completed in the counselor education program?
2. How many supervised practicum or internship hours have you completed?
3. How many hours of clinical experience (outside practicum and internship) have you had?
4. What is your current GPA in your counseling program?
In addition to the questions related to academic performance, several demographic questions were asked to better understand the makeup of the sample participants in this study. These questions asked participants to self-report their age, gender, and ethnicity (Myers & Sweeney, 2004).

The Counselor Activity Self Efficacy Scales (CASES)

The CASES (Lent et al., 2003) is an instrument designed to measure a counselor’s perceived capability as a counselor in three broad areas: performing basic helping skills, managing session tasks and the ability to negotiate challenging counseling situations and presenting issues. The CASES is a 41 item instrument which covers three sub-domains of counseling self-efficacy. Under the first domain, helping skill self-efficacy, there is an examination of exploration stage skills, insight stage skills, and action stage skills. In the instructions for the helping skill self-efficacy items, participants are asked to indicate how confident they are in their ability to use each of the following helping skills effectively over the next week. Examples of these items includes: attending (orient yourself physically toward the client), listening (capture and understand the messages that clients communicate), and restatements (repeat or rephrase what the client has said, in a way that is succinct, concrete, and clear). Under the second domain, session management self-efficacy, there is a focus of capturing counselors’ perceived ability to integrate specific helping skills within a variety of different situations. In the instructions for the session management self-efficacy, participants are asked to indicate how confident they are in their ability to do the following tasks such as “keep sessions „on track’ and focused,” “respond with the best helping skill, depending on what your client needs at a
given moment”, and help your client explore his or her thoughts, feelings, and actions.”

Under the third domain, counseling challenges self-efficacy, counselors are presented with counseling situations that are challenging and they are asked to rate their level of confidence in working through these challenges. In the instructions for the counseling challenges self-efficacy, participants are asked to indicate how confident they are in their ability to work effectively, over the next week, with each of the following client types, issues or scenarios. Examples include individuals who are “clinically depressed, have been sexually abused, or are suicidal.”

For the self-efficacy items, participants were asked to rate their confidence in their ability to perform a task or manage situations based upon a 10-point Likert scale from no confidence (0) to complete confidence (9; Lent et al., 2003). Higher scores indicate stronger confidence in one’s counseling ability. A factor analysis utilizing the data from 345 participants was conducted. Eigenvalue, scree plots, percentage of variance, and overall interpretable criteria were used as part of the factor analysis to determine the number of factors to retain. Using factor loading, the authors’ chose to retain items that yielded a factor loading above .50 and showed a difference of greater than .10 between the factor on which they loaded most highly and with other factors. This was chosen so that there was an appropriate balance between cross-loadings and identification of similar factors. This process resulted in a three factor structure with 48 out of the initial 59 items being retained.

The internal reliability estimates for the individual scales ranged from .79 (Exploration Skills) to .94 (Session Management and Client Distress) which supported internal consistency. The alpha coefficient for CASES total score is .97. Intercorrelations
among the CASES scales ranged from .44 to .72. Test-retest reliability of the CASES supported the internal consistency in the original sample with stable correlations. Only the total CASES score will be used for this study because it encompasses a total score for all of the three domains of self-efficacy to indicate the respondents’ total level of counselor activity self-efficacy. Mitchell (2008) in his research examining the predictive relationship between supervision and clinician self-efficacy in behavioral health utilized the CASES total score as a measure of CSE.

**Statistical/Data Analysis**

Data were analyzed using the sixteenth version of the Statistical Package for the Social Sciences (SPSS, 2006). Descriptive statistics and internal reliability coefficients were computed (where applicable) for each variable in the study. Additionally, hierarchical regression analysis were used to examine the variables of Total Wellness, Total Self-Efficacy Score, and the four Academic Factors (number of courses/credits completed, number of supervised practicum/internship hours, hours of clinical experience, and current grade point average).

**Hierarchical Regression**

The primary purpose of multiple regression is to help develop an equation that can be utilized for predicting values on a dependent/criterion variable (DV) utilizing the independent/predictive variables (IVs). Regression utilizes the correlation between the DV and IVs to make this prediction. The correlation will tell the researcher how much
variation in the DV is contained within the IVs. Hierarchical regression analysis provides a way of examining differences across populations.

In this method, the researcher chooses the order in which variables will be entered into the data analysis. Each independent variable is evaluated regarding what it adds to the predictive value of the dependent variable (Mertler & Vannatta, 2005). For this study, hierarchical regression analysis was used to examine how much variance wellness contributes to counseling self-efficacy above and beyond what academic factors noted in previous research have been shown to contribute.
CHAPTER IV
RESULTS

The purpose of this study was to explore specific variables that may contribute to the CSE beliefs of CIT. Understanding how academic factors and wellness play a role in CSE may empower the gatekeepers of the profession to develop protocol to promote self-efficacy for successful outcomes of the students being trained. More specifically, the aim of this study was to determine whether CIT counseling self-efficacy can be predicted by observing the global factor of wellness identified in the Indivisible Self Model of Wellness above and beyond what academic factors contribute to the variance in CIT counseling self-efficacy.

The following research questions were explored:

Research Question 1: What are the number of courses and credits completed, number of supervised practicum or internship hours completed, number of hours of clinical experience (outside practicum and internship), current GPA in their respective counseling programs, levels of wellness, and counselor self-efficacy among counselor education students?

Research Question 2: What is the relationship among number of credits completed, number of supervised field experience hours, clinical experience, program GPA, wellness, and counseling self-efficacy of CSE?
Research Question 3: To what extent can the variance in CSE of CIT be accounted for by the four academic factors and perceived student wellness? In addition, the following hypotheses were tested:

Research Hypothesis 1: A significant relationship at the .05 alpha level will exist among the academic factors, wellness, and CSE of CIT.

Research Hypothesis 2: The regression model will result in an overall model in which five predictors (the four academic factors and wellness) significantly predict CSE of CIT at the .05 alpha level.

Descriptive Data

Demographics and Frequencies

A total of 139 CIT completed the consent form and started the surveys. Of the 139, CIT 109 completed the assessments. The final sample included 17 males (15.6%) and 92 females (84.4%). The participants’ ages ranged from 22 to 62 with a mean of age 32 ($SD =10.40$). Racial distribution was as follows: 90 (82.6%) Caucasian participants, 10 (9.2%) African-American participants, 6 (5.5%) Hispanic participants, and 3 (2.8%) Asian/Pacific Islander participants. Six participants marked biracial status on the wellness inventory, while 103 indicated non-biracial status.

When asked about employment status, 27 (24.8%) participants reported working full-time, 56 (51.4%) work part-time, 1 (0.9%) retired, and 25 (22.9%) participants identified themselves as not currently employed. When examining level of education and pursued degree, 72 (66.7%) participants have a bachelor’s degree and 35 (32.4%) have an
advanced degree with 9 (4.5%) participants currently pursuing a graduate degree with the additional sample not indicating their pursued degree.

Looking specifically at sexual orientation, 94 (87.0%) identified as heterosexual, 5 (4.6%) as gay, 2 (1.9%) as lesbian, and 7 (6.5%) as bisexual. An examination of marital status revealed varied responses. Fifty-two participants (47.7%) indicated being married/partnered, 48 (44.0%) identified as single, 7 (6.4%) as divorced, 2 (1.8%) as widowed, and none as separated. Table 4.1 presents the results of the frequencies and percentages for these demographic variables.
Table 4.1  Frequencies and Percentages of Responses to Demographic Variables

<table>
<thead>
<tr>
<th>Demographic Variable</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Race</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caucasian</td>
<td>90</td>
<td>82.6%</td>
</tr>
<tr>
<td>Hispanic/Latino/Latin</td>
<td>6</td>
<td>5.5%</td>
</tr>
<tr>
<td>African American</td>
<td>10</td>
<td>9.2%</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>3</td>
<td>2.8%</td>
</tr>
<tr>
<td>Native American</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Bi-racial Status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>6</td>
<td>5.5%</td>
</tr>
<tr>
<td>No</td>
<td>103</td>
<td>94.5%</td>
</tr>
<tr>
<td>Employment Status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full-time</td>
<td>27</td>
<td>24.8%</td>
</tr>
<tr>
<td>Part-time</td>
<td>56</td>
<td>51.4%</td>
</tr>
<tr>
<td>Retired</td>
<td>1</td>
<td>0.9%</td>
</tr>
<tr>
<td>Not Working</td>
<td>25</td>
<td>22.9%</td>
</tr>
<tr>
<td>Level of Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trade/Technical/AA</td>
<td>1</td>
<td>0.9%</td>
</tr>
<tr>
<td>Bachelor’s Degree</td>
<td>72</td>
<td>66.7%</td>
</tr>
<tr>
<td>Advanced Degree</td>
<td>35</td>
<td>32.4%</td>
</tr>
<tr>
<td>Sexual Orientation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gay</td>
<td>5</td>
<td>4.6%</td>
</tr>
<tr>
<td>Lesbian</td>
<td>2</td>
<td>1.9%</td>
</tr>
<tr>
<td>Bisexual</td>
<td>7</td>
<td>6.5%</td>
</tr>
<tr>
<td>Heterosexual</td>
<td>94</td>
<td>87.0%</td>
</tr>
<tr>
<td>Marital Status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married/partnered</td>
<td>52</td>
<td>47.7%</td>
</tr>
<tr>
<td>Single</td>
<td>48</td>
<td>44.0%</td>
</tr>
<tr>
<td>Separated</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Divorced</td>
<td>7</td>
<td>6.4%</td>
</tr>
<tr>
<td>Widowed</td>
<td>2</td>
<td>1.8%</td>
</tr>
</tbody>
</table>

*Note: n = 109*

**Descriptives and Predictor (Independent) Variables**

Table 4.2 reports the mean (M), standard deviation (SD), minimum range, and maximum range for each of the predictor variables. The first block of variables
contains four academic factors which measures overall counseling experience including
number of credits/courses completed, number of practicum and internship hours
completed, total hours of clinical experience outside of practicum and internship and
grade point average (GPA). Data collected from 109 subjects was examined. The mean
for number of credits/courses completed was $M = 33.41$ ($SD = 25.53$). The mean for
number of supervised practicum and internship hours completed was $M = 271.18$ ($SD =
549.6$), mean for total hours of clinical experience outside of practicum/internship was
$M = 769.04$ ($SD = 1958.2$), and current grade point average $M = 3.49$ ($SD = 1.15$). In this
study, the scores varied. The large standard deviations for supervised practicum and
internship hours can be accounted for by the variation in responses from the sample since
the questions were open-ended. For the number of supervised practicum and internship
hours, they ranged from 0 to 3500 with 39 individuals (35%) with the highest scores. For
the number of clinical hours, the scores ranged from 0 to 10,500. The majority of the
sample, seven-six (69.7%), reported no clinical hours. For the number of credit hours
completed, the scores ranged from 0 to 130 hours. For GPA, the scores ranged from
unknown to a 4.00 GPA. The highest frequencies were indicated by 13 individuals
(11.9%) indicating a GPA of 3.8 with by 33 individuals (33%) indicating a 4.0 average.

The other independent variable is the higher-order factor of the Indivisible
Self Model of Wellness is total wellness (Myers & Sweeney, 2005b). The variable of
Wellness measured the total score across the five domains of wellness (coping self,
creative self, physical self, essential self, and coping self) with higher scores indicating a
greater level of wellness. Scores on the wellness variables may range from 25 to 100, and
minimum and maximum ranges for this study are indicated in Table 2.3. The variable
Total Wellness $M = 76.69$ ($SD = 12.84$) is composed of elements of all seventeen individual third order factors of wellness giving an overall score of how well the participants perceive themselves to be. The scores ranged from 32.19 to 95.21.

Table 4.2 Descriptive Statistics for Independent (Predictor) Variables

<table>
<thead>
<tr>
<th>Independent Variables</th>
<th>Range Minimum</th>
<th>Range Maximum</th>
<th>Mean</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Courses/Credits completed</td>
<td>0</td>
<td>130</td>
<td>33.41</td>
<td>25.53</td>
</tr>
<tr>
<td>Supervised Hours</td>
<td>0</td>
<td>3,500</td>
<td>271.18</td>
<td>549.60</td>
</tr>
<tr>
<td>Hours of Clinical Experience(outside Practicum/Internship)</td>
<td>0</td>
<td>10,500</td>
<td>769.04</td>
<td>1958.2</td>
</tr>
<tr>
<td>Current GPA</td>
<td>0</td>
<td>4.00</td>
<td>3.49</td>
<td>1.15</td>
</tr>
<tr>
<td>Total Wellness Score</td>
<td>32.19</td>
<td>95.21</td>
<td>76.68</td>
<td>12.84</td>
</tr>
</tbody>
</table>

*Note: N =109*

Descriptives and Criterion (Dependent) Variable

The dependent variable Counselor Activity Self Efficacy Scales (CASES) is an indication of a participant’s perceived ability to perform as a counselor when faced with specific problem situations in four domains (performing basic helping skills, managing session tasks and the ability to negotiate challenging counseling situations and presenting issues) and scores may range from 0 to 9. As reported in Table 4.3, the mean for the CASES total score variable was $M = 7.33$ ($SD = 1.29$). In this study, scores ranged from 3.63 to 9.61.
Table 4.3  Descriptives for Dependent (Criterion) Variable

<table>
<thead>
<tr>
<th>Dependent Variable</th>
<th>Range Minimum</th>
<th>Range Maximum</th>
<th>Mean</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>CASES</td>
<td>3.63</td>
<td>9.61</td>
<td>7.33</td>
<td>1.3</td>
</tr>
</tbody>
</table>

*Note: N = 109,*

Reliability Analyses

To examine the reliability of the instruments used in this study for this sample, Cronbach’s alpha coefficients (Hair et al., 2006) were calculated to evaluate the internal consistency of each instrument scale. Table 4.4 presents the results of these analyses, which includes the reliability coefficients computed for each of the study variables and the original normed alpha coefficients for the instruments reported by the authors.

Table 4.4  Cronbach’s Alpha Coefficients for Academic Factors, Total Wellness, and Total CASES

<table>
<thead>
<tr>
<th>Variable</th>
<th>Full Sample Study</th>
<th>Sample Study Alpha (α)</th>
<th>Original Form Alpha (α)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Wellness</td>
<td></td>
<td>.90</td>
<td>.90</td>
</tr>
<tr>
<td>Total CASES</td>
<td></td>
<td>.97</td>
<td>.97</td>
</tr>
</tbody>
</table>

*Note: α = Cronbach’s alpha coefficients; CASES = Counselor Activity Self-Efficacy Scales.*

Testing of Research Hypotheses

Hypothesis One

Hypothesis One suggests that a significant relationship at the .05 alpha level would exist among the variable of academic factors, wellness, and the CSE of CIT.
Research supports the relationship of academic factors such as amount of training hours and prior work experience in relation to CSE (Poidevant, Loesch, & Wittmer, 1991; Urbani et al., 2002). Curry (2007) encouraged further research examining wellness in relation to counseling self-efficacy with a larger sample which this research was designed. To test this hypothesis, Pearson product-moment correlations were computed and a correlation matrix constructed to evaluate the relationship among variables. As indicated by Table 4.5, significant relationships exist between four of the factors. The number of courses completed is correlated with hours of clinical experience, \( r = .334, p < .01; \) supervised hours \( r = .463, p < .01 \) and GPA \( r = .324, p < .01 \). This is likely since they are all academic variables measuring similar constructs. Supervised hours are correlated with hours of clinical experience, \( r = .355, p < .01 \); which are linked because they are academic variables explaining hours of training or preparation. There were no significant correlations between CASES and Wellness, \( r = .153, p < .01 \); or between CASES and all other academic variables. As a result, hypothesis one was partially supported.
Table 4.5  Correlations Among Dependent (Criterion) and Independent (Predictor) Variables

<table>
<thead>
<tr>
<th>Variable</th>
<th>CASES</th>
<th>Total Wellness</th>
<th>CrsCompl</th>
<th>SupHrs</th>
<th>HrsClinical</th>
<th>GPA</th>
</tr>
</thead>
<tbody>
<tr>
<td>CASES Total</td>
<td>1.000</td>
<td>1.000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Wellness</td>
<td>.153</td>
<td>1.000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wellness</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CrsComp</td>
<td>.053</td>
<td>.057</td>
<td>1.000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SupHrs</td>
<td>-.141</td>
<td>.004</td>
<td>.47**</td>
<td>1.000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HrsClinical</td>
<td>-0.63</td>
<td>.164</td>
<td>.33**</td>
<td>.36**</td>
<td>1.000</td>
<td></td>
</tr>
<tr>
<td>GPA</td>
<td>.030</td>
<td>-.088</td>
<td>.32**</td>
<td>.109</td>
<td>.090</td>
<td>1.000</td>
</tr>
</tbody>
</table>

Note:  SupHrs = number of supervised practicum/internship hours, CrsComp = number of courses/credits completed, and HrsClinical = Hours of clinical experience outside of the practicum/internship ** p < .01

Hypothesis Two

Hypothesis two suggests that the regression model will result in an overall model in which five predictors (the four academic factors and wellness) significantly predict counselor self efficacy of CIT. To test this hypothesis, a standard multiple regression analysis was conducted to see how well all five predictor variables predicted CSE. Prior to data analysis, missing data were assessed for each entry on all study instruments prior to creating variables. Seven values were missing on the wellness instrument, two values were missing on the CASES, and three participants left GPA blank and one individual did not respond to the number of hours of clinical experience. The missing values on the wellness instrument were replaced using the mean substitution method for all valid responses for those particular questions. Assumptions were tested by examining normal probability plots of residuals, scatter diagrams of residual versus predicted residuals, and the Shapiro–Wilk’s statistical test for normality. The plots, diagrams, and test indicate some non-normal distributions. Tolerance statistics and the variance inflation factor for
each predictor were examined for multicollinearity. In this study, there were tolerance values below 0.1 but no VIF values above 10; therefore, there were assumption violations. Outliers were identified by calculating the Mahalanobis distance in a preliminary regression procedure. Seven outliers were identified, which accounts for 6% of the total sample. Since this is a regression analysis, it is important to keep these outliers included in the data to help explain what these low scores tell us about the variables being examined. In addition, due to the study’s variables being continuous in nature, some problems identified with homoscedasticity and multicollinearity would be expected because the variables are open ended with no set range of distribution. Furthermore, having moderate violations of linearity and homoscedasticity may weaken the regression model but it does not invalidate the results and can be overlooked especially with larger sample sizes (Mertler & Vannatta, 2005).

A standard multiple regression analysis was then conducted to determine which independent variables (academic factors and total wellness) were significant predictors of CSE of CIT. The regression analysis revealed that the complete model including all five predictor variables did not significantly predict the CSE of CIT $F(5, 104) = 1.56, p < .05$. $R^2$ for the model was .073, and adjusted $R^2$ was .026. This model accounts for 7% of the variance in the CSE of CIT. Table 4.6 displays the unstandardized regression coefficients (B), intercept, and standardized regression coefficients ($\beta$) for each variable. In terms of individual relationships between the independent variables and the CSE of CIT and the independent variables, they did not predict a significant portion of the variance. Total Wellness ($t = 6.42$), CrsComplete ($t = 1.29$), SupHrs ($t = -1.68$), HrsClinical ($t = -1.73$),
and GPA \((t = .24)\). Figure 4.1 provides a graphic representation of the regression analysis. Based on the data, Hypothesis two was not supported.

Table 4.6  Summary of Regression Analysis for Variables Predicting CSE of CIT

<table>
<thead>
<tr>
<th>Variable</th>
<th>B</th>
<th>SE B</th>
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*Note: \(N = 109\)*

Figure 4.1  Hypothesized Model: Total Wellness, Number of Courses completed, number of Supervised Hours, Number of Clinical Hours, and GPA on the Counseling Self-Efficacy of Counselors-in-training.
CHAPTER V
CONCLUSIONS

In this final chapter, the study results are summarized, a review of the findings from the statistical analyses of the data is presented, limitations are identified, and recommendations for future research are included. In addition, counseling implications and practical suggestions concerning the issues that have been raised in this study are stated. Conclusions are then made about the outcome of the research.

Summary of the Study

The purpose of this study is to explore the variables that contribute to the CSE beliefs of CIT. This study examines the amount of influence student wellness factors have on the variance of the CSE of CIT above and beyond what academic factors contribute. More specifically, the aim of this study was to investigate empirically the relationship among various academic factors, wellness, and CSE of CIT enrolled in randomly selected master level counseling training programs accredited by the Council for the Accreditation of Counseling and Related Educational Programs (CACREP). What a counselor-in-training believes about his or her ability directly impacts his/her persistence and ability to perform a task successfully. Evidence shows a link between academic factors and CSE with trainees who perform better academically being more confident in their abilities to counsel. In addition, there is a strong probability that part of
a trainee’s belief system and subsequent behavior choice are connected with his or her total wellness. A research study that addresses these issues is needed to identify possible predictor variables that might explain observed variance in the self-efficacy of counselors preparing to graduate and work with various clientele.

For the purposes of this study, five predictor variables were examined as they relate to the criterion variable. The criterion variable for this study, CSE, was measured by the CASES (Lent, Hill, & Hoffman, 2003). The predictor variables that were assessed in this study were total wellness, measured using the 5F-Wel (Myers and Sweeney, 2005c), and a collection of academic factors (number of courses/credits completed, number of supervised practicum/internship hours, hours of clinical experience, and current grade point average). The goal was to explain which of the predictor variables (5F Wel global scale and a series of academic factors assessed using a demographic questionnaire) or combination of both, more accurately predicted CSE of CIT as measured by the CASES. Study participants were asked to complete a consent form, a demographic questionnaire, the 5F-Wel, and the Counselor Activity Self Efficacy Scales. It was estimated that participants would spend approximately 45 minutes completing all instruments in this study. Data from returned surveys was stored on the Survey Monkey database. This data collection method was chosen to assist in the distribution and collection of data across a broad research area. The study was designed to protect students from any intentional physical, psychological, or social risks with responses being kept confidential and anonymous. Correlations and hierarchical multiple regression were conducted and the results reported in this study.
Description of Sample

The usable sample consisted of 109 CIT from randomly selected CACREP programs across the United States whose liaison agreed to distribute the link to the surveys. With regard to racial distribution of the participants, 9.2% (n = 10) were African American, 5.5% (n = 6) were Hispanic, 82.6% (n = 90) were Caucasian and 2.7% (n = 3) did not identify. The gender distribution was proportionate to what is typically seen in the counseling profession with 15.6% (n = 17) of the participants being male and 84.4% (n = 92) being female.

Description of Study Variables

The independent (predictor) variables of academic variables (number of courses/credits completed, the number of supervised practicum and internship hours completed, the number of hours of clinical experience outside practicum and internship and the student’s current GPA), were examined using a demographic questionnaire. The mean score of courses/credits completed was $M=33.41$ ($SD=25.53$), the mean number of supervised practicum and internship hours completed was $M=27.18$ ($SD=549.6$), the mean number of hours of clinical experience was $M=769.04$ ($SD=1958.04$), and the mean GPA was $M=3.49$ ($SD=1.15$). Due to these variables being examined as part of the demographic questionnaire, there were no normed comparisons to be made. However, Tang et al. (2004) found in their examination of age, prior work experience, number of courses taken, and number of internship hours that these variables all have a positive relationship with counseling self-efficacy. The most variation in CSE was evident when specifically looking at the number of training hours and prior work related experience.
The mean averages were as follows: internship hours $M = 239.00$ $(SD = 1.49)$, work experience $M = 2.19$ $(SD = 3.29)$, and clinical hours worked $M = 1.93$ $(SD = 1.04)$. The CSE mean score for this study was $M = 5.70$ $(SD = 1.78)$.

The other independent (predictor) variable, *Total wellness* which encompasses a total score for all of the five factors of wellness (coping self, creative self, physical self essential self, and social self; Myers & Sweeney, 2005b), indicated the respondents’ total level of wellness or optimal functioning. The respondents total wellness mean score was $M = 76.68$ $(SD = 12.84)$ compared to the mean score for the norm group for total wellness of $M = 76.22$ $(SD = 12.51$; Myers and Sweeney, 2004). These results are quite similar when examining the normed group and sample for this study. When comparing related statistics for the 5F Wel, Roach and Young (2007) reported above average total wellness scores for counselor education students within their respective programs when examining 204 counseling students from universities across the south eastern United States. The scores were similar whether the students were at the beginning ($M = 80.44$, $SD = 7.55$), midpoint ($M = 81.57$, $SD = 7.64$), or ending ($M = 80.71$, $SD = 7.05$) of their counselor education program (Roach & Young, 2007). These high scores are not surprising since research by Myers et al (2003) concluded that there were significantly higher levels of wellness found among counselor education students than the average population (2003).

The dependent (criterion) variable CASES is an indication of a participant’s score for perception of CSE. The mean for this scale was $6.05$ $(SD = 1.16)$ with higher scores indicating greater counseling self-efficacy. When presenting comparative statistics for the CASES, Lakeisha Lanae Harris (2007) examined the factors that influence the
CSE of rehabilitation counselors using the CASES total score and subscale scores. The mean for CASES total score was 7.00 ($SD = 1.56$) which was slightly higher than indicated in this study. However, the sample consisted of 63 CIT as compared to 109 for this sample.

**Analysis of Research Hypotheses**

**Research Hypothesis One**

Hypothesis one suggested that a significant relationship at the .05 alpha level would exist between the variables of academic factors, wellness, and the CSE of CIT. A correlation matrix was constructed to test the relationship between these variables. A relationship between the variables was suggested in the literature based on findings the number of internship hours, work experience, total coursework, and clinical course work hours influenced counseling self-efficacy (Tang et al., 2004). A significant positive relationship existed among the academic variables of number of courses/credits completed, number of clinical hours completed, CIT GPA and number of supervised hours completed. The significant correlation was likely because all of these variables intertwine as they represent elements of academic requirements. This may be because respondents were in their practicum/internship phase of their program and would have more supervised hours completed at the time of the study. Also, it is assumed that to maintain enrollment in the program, respondents would have to maintain their GPA and would differ based upon the number of courses/credits completed.
In addition, a negative relationship existed between number of supervised hours completed, number of clinical hours completed, and the total CASES score. Although these findings are not significant, they suggest that the amount of experiences CIT have with clients whether supervised or unsupervised does not impact the CSE of CIT. Further analysis indicated a negative relationship between total wellness and CIT grade point average. Although insignificant, this finding suggests that the total wellness of this sample was not impacted by the student’s grade point average within the counseling program. These results suggest that academic factors, although important for the overall outcome of CIT, may not offer additional insight into the variation of CSE of CIT.

**Research Hypothesis Two**

Hypothesis two suggested that the regression model will result in an overall model in which five predictors (the four academic factors and wellness) significantly predict counselor self efficacy of CIT. A standard multiple regression analysis employing the forced entry method was used to determine the amount of variance in CASES accounted for by the predictor variables. The overall model accounted for only 7 % of the variance in the CSE of CIT. This overall percentage was not statistically significant ($R^2 = .073$, $F (5,104),= p <. 05$), thus hypothesis two was not supported.

The analysis indicated that the variables of total wellness, number of courses/credits completed, number of supervised hours within practicum/internship, number of clinical hours, and counseling program GPA did not predict a significant portion of the variance in CSE of CIT. The current findings do not support a predictive relationship between counselor total wellness, academic factors, and CSE of CIT.
Jennifer Curry (2007) in her research found similar results when examining the predictive relationship between counselor wellness and counselor self-efficacy. Although she utilized a convenient sample in her research and this study was across a broad spectrum of universities, parallel results indicate that some other element should be considered as an influencing factor of CSE. One possibility is that the limitations in this study may have contributed to the insignificance found within the correlations and regression analysis. The following section discusses the limitations noted.

**Limitations**

The results of this study must be understood within the context of the limitation inherent in the design and implementation of the study. Limitations exist that relate to sampling and instrumentation and are addressed in order to promote a better analysis of future studies in this area of research.

**Instrumentation**

First, the instruments used in this study were all self-report measures that depended on accurate information from an adult population namely counselors-in-training. There is a tendency for participants to self-report socially desirable answers especially when personal reputation may be taken into consideration when answering the questions (Hayes et al., 1999). However, the researcher was very careful to emphasize to the participants that there were no right or wrong answers. In addition, every reasonable measure was taken to protect the confidentiality of all study participants, thereby empowering the participants to be truthful.
Secondly, even though the CASES were validated by a limited number of studies, the alpha coefficient for the sample and norm group were almost identical reinforcing the reliability of the measure. However, the lack of empirical support for the psychometric properties of the CASES is a limitation. The other assessment used in the study, the 5-F Wel was validated by multiple researchers. The 5F-Wel had an exact total wellness alpha coefficient as this research sample, .90, which reinforces that the participants’ answers were reflective of that of the original sample. However, the 5F-Wel continues to be improved upon by the developers. The demographic questions were not pre-tested, were open-ended, and did not have a comparative sample to be drawn from; therefore, this created a limitation for this study.

**Sampling**

In interpreting the data, the use of CACREP versus non-CACREP programs was decided. Although this provided a random sampling of 574 programs, it limits the outcome of the results to programs accredited by this council. Adding in non-CACREP programs could provide a larger sample in which to interpret the data and could provide a comparative analysis. Although sent out to over one hundred randomly selected CACREP, only the minimum sample was acquired. In addition, this research may have targeted those individuals who perceived themselves as “well” and had the time and opportunity to complete the survey. Utilizing and online host site may have limited the sample. Paper and pencil distribution may have enhanced participation of students and broadened the student sample base.
**Recommendation for Future Research**

Additional research is needed to substantiate and broaden the current findings relative to the relationship among wellness, academic factors, and CSE of CIT. Future directions for this researcher include designing another study to further investigate these constructs. A new proposed study would be to examine wellness and CSE of CIT at the entry of their training program and then at the ending of their practicum/internship to account for the impact of their coursework and clinical experience. Another possibility is to examine personality type and CSE of practicing counselors and/or CIT to determine if specific personality characteristics help to predict higher or lower levels of self-efficacy.

Since counselors typically have higher rates of wellness than the general population, additional research could be done comparing the wellness levels of practicing counselors in private practice with those employed in community mental health settings. It would be interesting to discern the difference in their levels of wellness and to specifically look at number of clients seen per week, amount of time off, production pressure, and overall feeling of client improvement. These factors might possibly be contributing factors to counselor total wellness.

**Implications for Counseling**

While no significant correlations or relationships found in this study, there are implications for counselor educators regarding the relationship between the constructs of counseling self-efficacy, academic factors, and wellness. First, since academics are a part of entry requirement, for graduation, and as a measure of success, it would be important to reconsider how much weight is given to academic variables in measuring performance.
as a practicing counselor. With no correlation between academic variables and self-efficacy, counselor educators should consider alternative means to evaluate success.

Second, when programs are seeking to gather data on outcome performance, they should consider a self-efficacy instrument that is psychometrically sound and measures what it is intended to measure. Finally, with no correlation between self-efficacy and wellness, it is important that counseling educators reevaluate additional factors that may influence counselor self-efficacy of CIT and help to promote them within the counseling program.

Since wellness programs are being implemented across counseling programs, the goal is to improve overall mental, physical, and psychological wellbeing but it does not necessarily conclude that it will improve efficacy. Although the results indicate an absence of a relationship, it is important to challenge the relationship by examining research design. For instance, further research could be done examining programs with and without counselor wellness programs, looking at CACREP versus non CACREP programs, and considering the reliability of the wellness instrument being used. According to Myers et al. (2004), the 5F-Wel made improvements of the original WEL but revisions were being considered. In the 5F-Wel, the indivisible self model was not statistically verified, the third order factor scales were more highly correlated than originally thought which influenced this researcher’s use of the total wellness score, and desire to shorten and simplify the instrument (Myers et al., 2004).

There is a desire for counselor educators to not only promote counselor wellness and high academic standards but to ensure that CIT are competent to practice (ACA, 2005). As part of this competence, researchers can use their experience and judgment to guide them in determining the most adequate means to promote this. Promotion of these
factors cannot be adequately done without identifying the most influential components that contribute to counselor wellness, academic rigor, and counseling self-efficacy.

**Conclusions**

This study adds to the literature on the relationship among wellness, academic factors, and CSE of CIT. Although no significant relationship was found, these variables represented 7% of the variance in CSE of CIT. This finding has implications for the approach counselor educators take in developing wellness programs and with promoting counseling self-efficacy. Ruling out which factors do not contribute to CSE of CIT, helps to examine other possible indicators.

Multiple variables have been examined to help explain the amount of variance in CSE. The research ranges from identifying factors that influence self-efficacy (Poidevant et al., 1991), anxiety and self-efficacy (Barbee et al., 2003; Larson et al., 1992), examining models to promote self-efficacy in training (Barnes, 2004), and counselor-in-training perception of self-efficacy (Tang et al., 2004). This is important because counseling self-efficacy could be evaluated as part of the assessment process in counselor training programs to promote student empowerment, to help establish effective training programs to promote emotional intelligence and to enhance clinical experience (Martin et al., 2004). If CIT meet specific competency standards in their respective programs, there is a greater likelihood that they will have a higher level of self-efficacy prior to leaving the program and upon beginning their clinical practice.

Counseling competency standards should be established by the respective programs to raise self-efficacy of trainees and therefore promote competence. Since
counselor educators and supervisees are the gatekeepers of the profession, self-efficacy should be promoted within their respective educational settings. Bandura (1977) established a framework to infuse self-efficacy concepts through enhancing performance, vicarious learning experiences, verbal persuasion, and as a means to promote emotional arousal. With these learning expectations in place, trainees are better able to judge their own performance which helps to promote self-efficacy.

The ACA code of ethics (2005) and CACREP (2009) not only require the promotion of competent practice but reinforce the promotion of personal development and wellness. There is limited information regarding how to effectively implement strategies to promote personal development with students (Myers et al., 2003). As a result, Myers et al. (2003) encouraged the assessment of wellness with CIT and the implementation of wellness strategies. Furthermore, Gibson, Dollarhide, and Moss (2010) encouraged the implementation of specific of transformational tasks to assist with professional identity development. This includes the CIT’s ability to develop a definition of counseling, encouraging personal growth, and enhancing personal development. Gibson and colleagues encourage this progression by self evaluation, self motivation, and through getting connected within a counseling community (2010). Through the implementation of effective strategies within the classroom and practicum/internship setting, student current wellness could be evaluated and enhanced through a program specifically designed to do so. This can be done through a multidisciplinary approach to wellness, personal identity, and professional identity development across the training process.
Although the results were not significant according to the research questions posed, this research provides valuable information to counselor educators and counselor trainers regarding wellness in relation to competence and CSE. Wellness has been identified as a key factor in understanding what makes a human being maintain daily functioning. This is important because human beings are complex creatures that are impacted by the environmental stressors of life. There is an interconnection between how an individual responds to life events which interplay between the physical, emotional, and mental wellness of an individual. One can naturally affect the other either creating a positive or a negative reaction to whatever event is occurring. As a result, an individual defines their response to these events as either coping well or unwell. This makes it difficult to create a clear definition of wellness that can completely encompass everyone’s individual experience. Knowing this, it is important that wellness be a factor to consider when working with individuals who choose to work toward a career in counseling.

Although the construct of wellness is individualized and subjective, it is important that counselor educators and trainers foster the promotion of wellness in trainees. Just as academic history is important as an assessment tool to predict success as a counselor, it is important to consider wellness because of the possibility of impairment. This could be done through personal interviews and mentorship between a student and faculty to evaluate trainees’ perception of wellness at the entry of the program then reevaluate trainees at the practicum and internship to assess their personal level of growth. The training period in between can be utilized to foster a relationship with the CIT that promotes individual growth with personal counseling skills, self-reflection,
appropriate counseling referrals for the student, and identifying factors that may contribute to burnout or possible impairment. By adequately addressing these throughout the training process, there will be an open forum to discuss wellness, compassion fatigue, and other problems related to living well.

As a trainee feels well, productive, and supported as a counseling student, this may promote an environment that reinforces confidence in the student to effectively perform as a practicing student and subsequent professional in counseling. This cyclical relationship will directly impact the relationship between students, faculty, and the client whom is impacted by the services the student is providing.

CSE is an important factor when considering a CIT’s ability to function as a competent and professional counselor. Although this research does not specifically indicate a significant relationship between academic factors, total wellness, and self-efficacy; it does not discount the importance that academic performance and wellness play within counselor education programs. With professional competence as a required ethical consideration, wellness initiatives may be a factor that could contribute to reducing impairment. Further exploration of factors that influence CSE may help to determine what additional constructs should be implemented within counselor education programs.
REFERENCES


APPENDIX A

FACULTY EMAIL SOLICITATION
Dear CACREP Representative,

I would like to request your assistance in recruiting participants for a research project I am currently conducting. The project aims to explore the influence of wellness and academic factors on the counseling self-efficacy of counselors-in-training. It is my goal that this type of explanatory research will assist researchers in recognizing possible predictor variables to explain observed variations in the factors that contribute to counseling self-efficacy. Your institution’s program was one of several CACREP-accredited programs randomly selected for inclusion in this research project.

Prospective participants who consent to being included in this study will be asked to complete an online survey which includes a brief demographic questionnaire, the Five Factor Wellness, and the Counseling Activity Self-Efficacy Scales. Participation should take no longer than 20 minutes, and all responses will remain anonymous.

Would you be willing to help? If so, I ask that you please forward the attached announcement describing the study to prospective participants in your graduate programs. Participants must be currently enrolled in a graduate counselor education training program, working toward their masters, specialist, or doctoral degree, and currently enrolled in their practicum or internship. Should you decide to assist in participant recruitment I ask that you please email me to let me know you have distributed the research announcement to your students. This will assist me in defining the parameters of my sample. If you have any questions regarding this project you can contact me directly at 601.479.8735 or you can contact the Mississippi State University Regulatory Compliance Office at 662.325.3994.

Thank you for your assistance. Your time and effort are greatly appreciated.

Rosanne Nunnery
APPENDIX B

STUDENT EMAIL SOLICITATION
I would like to invite you to participate in a Web-based research project entitled: “The Relationship among Academic Factors, Wellness, and Counseling Self Efficacy of Counselors-in-Training.” The project aims to explore the influence of wellness and academic factors on the counseling self-efficacy of counselors-in-training. It is my goal that this type of explanatory research will assist researchers and counselor educators in recognizing possible predictor variables that might explain observed variations in counseling self-efficacy.

Participants who consent to being included in this study will be asked to complete an online survey which includes a brief demographic questionnaire, the Five Factor Wellness, and the Counseling Activity Self-Efficacy Scales. Participation should take no longer than 45 minutes, and all responses will remain anonymous. To maintain your anonymity, you will not be asked to include any identifying information (e.g., name, student identification number, net id) at any point throughout the survey process.

Please note that the decision to participate in this research study is completely voluntary. Your refusal to participate will involve no penalty or loss of benefits to which you otherwise would be entitled, and you may skip any item or discontinue your participation at any time without penalty or loss of benefits.

If you should have any questions about this particular research project, please feel free to contact the project’s principle investigator, Rosanne Nunnery directly at 601-479-8735. For additional information regarding your general rights as a research subject, please feel free to contact the Mississippi State University (MSU) Regulatory Compliance Office at 662-325-5220.

Click on the link below to begin.

http://www.surveymonkey.com/s/MKVYM8P
APPENDIX C
INFORMED CONSENT
INFORMED CONSENT

Please read the following important information before continuing on to the surveys.

Thank you for your interest in my research titled “The Relationship among Academic Factors, Wellness and Counseling Self Efficacy of counselors-in-training.” My name is Rosanne Nunnery and I am a doctoral student in the Counselor Education program at Mississippi State University. The purpose of this research is to determine the relationship among various academic factors, wellness, and counseling self-efficacy of counselors-in-training enrolled at randomly selected master level counseling training programs accredited by the Council for the Accreditation of Counseling and Related Educational Programs (CACREP). A research study that addresses these issues is needed to identify possible predictor variables to explain the counseling self efficacy of counselors preparing to graduate and work with various clientele. This type of explanatory research is important for assisting researchers in recognizing possible predictor variables to explain observed variations in the factors that contribute to counseling self-efficacy. In addition, this study will serve as Rosanne Nunnery’s dissertation for her doctoral degree from Mississippi State. Please understand that your participation in this study is completely voluntary. Your refusal to participate will involve no penalty or loss of benefits to which you may otherwise be entitled. Should you choose to participate, you will be asked to answer a few demographic questions and complete an online version of the Counselor Activity Self-Efficacy Scales (CASES) and the Five Factor of Wellness (5-F Wel). The CASES is a 41-item self-report measure designed to assess counseling self-efficacy. You will be asked to rate, using a 9-point Likert scale, the degree to which each statement reflects your own confidence of how you would perform in a counseling situation or clientele given your current level of training and expertise. If for any reason you choose not to answer a question simply skip the item and move on to the next. The 5F-Wel is a 101-item self-report measure designed to assess counselor wellness. You will be asked to rate, using a 4-point Likert scale, the degree to which you agree with the statement presented. Completing the demographic section, the CASES, and the 5F-Wel should take approximately 45 minutes. There are no risks (physical, psychological, or social) associated with this study, and you are reminded that you are free to discontinue your participation at any time without penalty or loss of benefits. Should however an individual experience any uncomfortable feelings as a result of his or her participation in this study he/she will be encouraged to discuss these feelings with his/her on campus counseling center, counselor educator advisor, or the CACREP liaison responsible for distributing the email. In addition, please note that the anonymity of your responses will be maintained throughout the duration of this research project. At no point will you be asked to include any personally identifying information. Your responses will be combined with those of students from a number of randomly selected counselor training programs nationwide and reported in aggregate form. Only the researchers (Rosanne Nunnery and Joshua Watson) will have access to the completed surveys. The original copies of the completed surveys will be securely kept in Rosanne Nunnery’s password protect Survey Monkey account until the research is completed. At that time the digital data will be stored on a secure, password protected external hard drive maintained by Rosanne Nunnery. While all attempts will be made to protect confidentiality, participants should be advised that these records will be held by a state entity and therefore are subject to disclosure if required by law. If you should have any questions about this research project, please feel free to contact me at 601-479-8735 or by email at rn19@msstate.edu. To inquire about additional information regarding your rights as a research subject, please contact the Mississippi State University Regulatory Compliance Office at 662-325-3994.

To continue please indicate your consent below.

I have read the above informed consent and agree to participate in this research project.
APPENDIX D

5F WEL PERMISSION
Permission to Use the 5F-Wel

The authors of the 5F-Wel will give our permission for your use of the instrument in your dissertation or other research. We will provide information and scoring services, per the following procedures:

1. The Specimen Set for the 5F-Wel includes the Manual, One Instrument, an NCS response sheet if you plan to use paper-and-pencil administration, and a Brief Interpretive Report. The cost for this is $30. The cost is $25 if you will accept pdf files and plan electronic scoring (in which case we will not mail any documents or provide bubble sheets). You can copy the 5F-Wel as needed for your population; the cost of scoring is $1 per person, prepaid. Alternately, you may have your participants complete the inventory online. The scoring cost is the same.

2. You will need to specify the nature of your population. We will then assign you a three digit key code which must be written and bubbled in on all of your forms or included in your electronic data set. This code will comprise the first three numbers for each id, so your cases will be numbered, assuming your code is 799, as 799001, 799002, 799003, etc.

3. As a pilot, please complete one 5F-Wel bubble sheet and mail it to me, or complete an SPSS or Excel file in an agreed-upon format for testing. This is to verify that all instructions are followed and all data requested are provided. We will provide the initial file. You will need to assure that all of your participants provide all of the requested data. (If using the on-line version, filling out the form once is also necessary, with a code to be provided based on the nature of the population).

4. When you have collected all of your data, if you are using bubble sheets, review your bubble sheets/data form and edit them as necessary for demographic items and missing data. Then, put them all in the same order (one edge of the page is cut so they can be matched, all right side up and facing forward). If you are using on-line administration, you must add "age" as a variable.

5. We will have the data scanned, which takes anywhere from one day to two weeks, depending on when it arrives. We are on a semester system and scanning of midterms and finals takes priority. No scanning services are available during university breaks and holidays. Electronic files may be scored more quickly.

6. The data will be scored using SPSS for windows. Our preference is to e-mail the data file to you. It can also be sent on a disk, but you will have to provide the disk and pay postage. The data file will contain all of the demographic information, item responses, and subscale scores for your participants. It will include raw scores and J-scores for the 5F-Wel factors.

7. We will provide a syntax file to assist you in interpreting the variables in the data set. We will not provide you with the scoring protocol - that is, we will not tell you which items score on which subscales.

8. The manual for the 5F-Wel includes all of the psychometric data you will need for your research proposal.

9. Your data will be included in our data set for development of the 5F-Wel. Individual data will not be used in any form, and we will not conduct research solely on your data set. We expect you to maintain informed consent forms for all participants.

10. Under no circumstances do these permissions include the right to include item and scale information in published documents resulting from your study. The 5F-Wel is proprietary and any such publication of information is a violation of U.S. copyright laws and professional ethical codes of conduct. Please let me know if there is anything else we can do to assist you in your research.

Jane Myers
APPENDIX E

CASES PERMISSION LETTER
Dear Colleague:

Thanks for your interest in the CASES scales, a copy of which can be found on the following pages. Part I are the Helping Skills self-efficacy scales; Part II = Session Management self-efficacy; Part III = Counseling Challenges self-efficacy. Item content for specific scales and scoring information can be found in Lent, Hill, and Hoffman (2003, *Journal of Counseling Psychology, 50*, 97-108).

You are welcomed to use the CASES. If you do so, we would appreciate hearing about your research findings or clinical/supervision experiences with them. They were designed primarily for research purposes, but they may prove useful in the supervision context as well. Bear in mind that they should still be considered as “under construction,” psychometrically speaking. While our initial findings were promising, further study of the factor structure, reliability, and validity of the scales is certainly warranted.

If you intend to use them in a training or supervision context, please remember that their intent is to tap students’ perceptions of their own counseling capabilities – they should not be seen as objective measures of how well students are functioning in counseling. As self-report measures, they could also be affected by self-presentation biases, especially if students feel that their self-efficacy ratings could influence their supervisor’s or course instructor’s evaluations of them (e.g., in determining course grades).

With these important caveats in mind, we think the CASES could be used profitably in a collaborative, developmental way with students – for instance, in helping them to think about their current strengths and growing edges, and in focusing them (and supervisors) on particular skill areas that warrant further development. A comparison of student’s self-ratings with the supervisor’s ratings could be a very useful discussion tool, as could a pre-post assessment of the student’s self-ratings (but, once again, not for evaluative purposes).

One last thing: the rating scale for the CASES uses a scannable font type called “OMR bubbles.” To use this font, you will need to load the attached font file onto your computer. Otherwise, you can convert the current rating format into a more conventional option (e.g., “circle the number that best reflects your response to each question”).

Good luck in your research and supervision work!

Bob Lent
APPENDIX F

CASES INSTRUMENT NOT COPYRIGHTED
**General Instructions:** The following questionnaire consists of three parts. Each part asks about your beliefs about your ability to perform various counselor behaviors or to deal with particular issues in counseling. We are looking for your honest, candid responses that reflect your beliefs about your current capabilities, rather than how you would like to be seen or how you might look in the future. There are no right or wrong answers to the following questions. Using a dark pen or pencil, please fill in the number that best reflects your response to each question.

**Part I. Instructions:** Please indicate how confident you are in your ability to use each of the following helping skills **effectively**, over the next week, in counseling most clients.

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**How confident are you that you could use these general skills effectively with most clients over the next week?**

1. **Attending** (orient yourself physically toward the client).
2. **Listening** (capture and understand the messages that clients communicate).
3. **Restatements** (repeat or rephrase what the client has said, in a way that is succinct, concrete, and clear).
4. **Open questions** (ask questions that help clients to clarify or explore their thoughts or feelings).
5. **Reflection of feelings** (repeat or rephrase the client’s statements with an emphasis on his or her feelings).
6. **Self-disclosure for exploration** (reveal personal information about your history, credentials, or feelings).
7. **Intentional silence** (use silence to allow clients to get in touch with their thoughts or feelings).
8. **Challenges** (point out discrepancies, contradictions, defenses, or irrational beliefs of which the client is unaware or that he or she is unwilling or unable to change).
9. **Interpretations** (make statements that go beyond what the client has overtly stated and that give the client a new way of seeing his or her behavior, thoughts, or feelings).
10. **Self-disclosures for insight** (disclose past experiences in which you gained some personal insight).
11. **Immediacy** (disclose immediate feelings you have about the client, the therapeutic relationship, or yourself in relation to the client).
12. **Information-giving** (teach or provide the client with data, opinions, facts, resources, or answers to questions).
13. **Direct guidance** (give the client suggestions, directives, or advice that imply actions for the client to take).
Part I (cont’d)

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How confident are you that you could use these general skills effectively with most clients over the next week?

14. **Role play and behavior rehearsal** (assist the client to role-play or rehearse behaviors in-session).
15. **Homework** (develop and prescribe therapeutic assignments for clients to try out between sessions).

Part II. Instructions: Please indicate how confident you are in your ability to do each of the following tasks effectively, over the next week, in counseling most clients.

1. Keep sessions “on track” and focused.
2. Respond with the best helping skill, depending on what your client needs at a given moment.
3. Help your client to explore his or her thoughts, feelings, and actions.
4. Help your client to talk about his or her concerns at a “deep” level.
5. Know what to do or say next after your client talks.
6. Help your client to set realistic counseling goals.
7. Help your client to understand his or her thoughts, feelings, and actions.
8. Build a clear conceptualization of your client and his or her counseling issues.
9. Remain aware of your intentions (i.e., the purposes of your interventions) during sessions.
10. Help your client to decide what actions to take regarding his or her problems.
Part III. **Instructions:** Please indicate how confident you are in your ability to work effectively, over the next week, with each of the following client types, issues, or scenarios. (By “work effectively,” we are referring to your ability to develop successful treatment plans, to come up with polished in-session responses, to maintain your poise during difficult interactions and, ultimately, to help the client to resolve his or her issues.)

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How confident are you that you could work effectively over the next week with a client who ...

1. …is clinically depressed.
2. … has been sexually abused.
3. …is suicidal.
4. … has experienced a recent traumatic life event (e.g., physical or psychological injury or abuse).
5. … is extremely anxious.
6. … shows signs of severely disturbed thinking.
7. … you find sexually attractive.
8. … is dealing with issues that you personally find difficult to handle.
9. … has core values or beliefs that conflict with your own (e.g., regarding religion, gender roles).
10. … differs from you in a major way or ways (e.g., race, ethnicity, gender, age, social class).
11. … is not “psychologically-minded” or introspective.
12. … is sexually attracted to you.
13. …you have negative reactions toward (e.g., boredom, annoyance).
14. … is at an impasse in therapy
15. … wants more from you than you are willing to give (e.g., in terms of frequency of contacts or problem-solving prescriptions).
16. … demonstrates manipulative behaviors in-session.
APPENDIX G

IRB APPROVAL LETTER
August 19, 2010

Rosanne Nurney
P.O. Box 1325
Meridian, MS 39302

RE: IRB Study #10-204: The Relationship among Academic Factors, Wellness and Counseling
Self Efficacy of counselors-in-training

Dear Ms. Nurney:

The above referenced project was reviewed and approved via administrative review on 8/19/2010 in accordance with 45 CFR 46.101(b)(2). Continuing review is not necessary for this project. However, any modification to the project must be reviewed and approved by the IRB prior to implementation. Any failure to adhere to the approved protocol could result in suspension or termination of your project. The IRB reserves the right, at anytime during the project period, to observe you and the additional researchers on this project.

Please note that the MSU IRB is in the process of seeking accreditation for our human subjects protection program. As a result of these efforts, you will likely notice many changes in the IRB’s policies and procedures in the coming months. These changes will be posted online at http://www.orc.msstate.edu/human/aahp.php. The first of these changes is the implementation of an approval stamp for consent forms. The approval stamp will assist in ensuring the IRB approved version of the consent form is used in the actual conduct of research.

Please refer to your IRB number (#10-204) when contacting our office regarding this application.

Thank you for your cooperation and good luck to you in conducting this research project. If you have questions or concerns, please contact me at cwilliams@research.msstate.edu or call 662-325-5220.

Sincerely,

Christine Williams
IRB Compliance Administrator

cc: Joshua Watson
APPENDIX H

PERMISSION FOR THE REPRINT OF DEFINITIONS OF THE COMPONENTS OF
THE INDIVISIBLE SELF MODEL
On Sun, Oct 24, 2010 at 6:27 PM, <barobehere@comcast.net> wrote:

Dr. Myers,

I hope you are well. I am still in the data collection phase of my dissertation and it is a slow process. It is definitely a test of patience. I am editing, and re-editing, and re-editing right now. I know that you were not granting permission to use the Wheel of Wellness image in research. However, I am inquiring about using an adapted version of table 4.1 from page 33 from the Myers and Sweeney text *Counseling for Wellness: Theory, Research, and Practice*. I believe it will help to clarify what I am discussing in my writing regarding the Indivisible Self. If not, I understand. Please see below. Thank you.

HI Roseann:

Dr. Sweeney and I do not object to the table, though much or maybe all of it is verbatim. In that case, it is more appropriate to say "reprinted with permission".

Best wishes.

Jane Myers

On Mon, Oct 25, 2010 at 11:03 PM, <barobehere@comcast.net> wrote:

Dr. Myers,

I appreciate that you are checking with Dr. Sweeney for me. I look forward to hearing from you.

Rosanne