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Counselor Educators' Wellness Levels' Impact on How They Promote Wellness

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To the Graduate Council:

I am submitting herewith a dissertation written by Rachael Camille Marshall entitled "Counselor Educators' Wellness Levels' Impact on How They Promote Wellness." I have examined the final electronic copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, with a major in Counselor Education.

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Counselor Educators' Wellness Levels' Impact on How They Promote Wellness

A Dissertation Presented for the
Doctor of Philosophy
Degree
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Rachael Camille Marshall
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Dedication

This work is dedicated to my family. From government cheese and sharecroppers, cornbread and gardens, waitresses and matriarchs; I stand on the shoulders of all those that came before me. Those that held me in tired arms, so I can see just over a new horizon, and taught me how to continue the tradition of holding others.

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"The Answer to the Great Question... Of Life, the Universe and Everything... Is... Forty-two,'
said Deep Thought, with infinite majesty and calm."
—Douglas Adams, The Hitchhiker's Guide to the Galaxy

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climbed, and every failure as an adventure to be explored. I am who I am because of each of you and how you have loved me. Thank you!

"Let's think the unthinkable, let's do the undoable. Let us prepare to grapple with the ineffable itself, and see if we may not eff it up after all."
— *Douglas Adams, Dirk Gently's Holistic Detective Agency*

Abstract

If wellness facilitates the "optimal state of health and well-being that each individual is capable of achieving" (Myers et al., 2000, p. 252), then counselor wellness is of great significance in research, counselor training, and practice. Counselors-in-training (CITs) need opportunities to develop awareness, knowledge, and skills to improve personal wellness in order to practice ethically and reduce levels of impairment. Counselor educators (CEs) have a responsibility to assess, evaluate, and promote personal growth for counselor trainees. Because of the isomorphic relationship between both counselor and client, and CIT and CEs, questions persist as to how counselor wellness is promoted and maintained. If well counselors produce well clients then well CEs produce well CITs. Therefore, this quantitative study focused on wellness and mindful present moment awareness in CEs and how these variables impact wellness promotion behaviors. The results of the analyses concluded that wellness is associated with wellness promotion, though not directly aligned with each wellness and wellness promotion subscale. Positive relationships were found between each of these three variables in correlation; however, mindful present moment awareness did not have a predictive relationship with wellness promotion behaviors. Furthermore, the creative self wellness scores are predictive for overall wellness promotion behaviors. The connections to wellness theory provide further evidence for continued work on CE wellness to support the development of future counselors. Caution should be used with addressing the predictive relationship of the variables and future research should focus on the variables that impact wellness promotion. Further research into the understanding of wellness and wellness promotion should focus on the factors that contribute to wellness and

classroom philosophy. Finally, CEs should work to practice awareness to maintain their

wellness, and question how they incorporate wellness into CIT training.

Keywords: Wellness, 5F-WEL, Mindfulness, MAAS, Wellness Promotion Behaviors,

     Counselor Educators

Preface

You are not the reps you do on the elliptical machine or the amount of water you drink.

Which seems easy to distinguish until you start to measure yourself by all the ways in which you don't measure up.

And self-care becomes a burden

And wellness becomes a mirage

And we quickly forget how we used to measure our worth before we held a yard stick to our "self-care time"

We stopped feeling good for completing tasks, and creating time in our schedules. And started bearing grudges against the bubble bath we never take, or the book that is collecting dust.

We stopped thinking about the bills we paid that create home and shelter. We stopped appreciating when we say no, instead we sit with the guilt, and push ourselves to engage, engage, engage- in compensation. We started only knowing rest in our sleep, but not in our hurried dreams.

We forget that each breath is different, and that each moment ours.

We forget that self-care is not always glamorous or spontaneous. It is present in the mundane and even painful.

It's there when you hike that extra mile, with burning lungs and tired feet. It's there when you turn a mirror on the things about yourself that need to be faced. When you make the choice to do that deep harrowing work we watch our own clients do, and it's there when you notice...one... breath.

And how that one breath is nothing like the next

Table of Contents

List of Tables

Chapter 1: Introduction

Wellness is "a way of life oriented toward optimal health and well-being, in which body, mind, and spirit are integrated by the individual to live life more fully within the human and natural community" (Myers, Sweeney, & Witmer, 2000, p252). Wellness is the foundation of counseling, which focuses on strengths rather than illness or pathology (Lawson & Myers, 2011). Wellness explores the biopsychosocial, spiritual, environmental, and cultural aspects of human development (Lawson, 2007; Myers & Sweeney, 2008; Witmer & Young, 1996). In practice, wellness in counseling focuses on work with client development (Myers & Sweeney, 2008) and counselor ethics (Shillingford, Trice-Black, & Butler, 2013; Witmer & Young, 1996). For counselors, wellness rests on the opposite side of the continuum to counselor impairment (Lawson, 2007). Therefore, all practicing counselors fall on this continuum between well and impaired (Hill, 2004; Lawson, 2007; Myers et al., 2016).

If wellness facilitates the "optimal state of health and well-being that each individual is capable of achieving" (Myers et al., 2000, p. 252), then counselor wellness is of great significance in research, counselor training, and practice (Lawson, Venart, Hazler, & Kottler, 2007). Counselors-in-training (CITs) need opportunities to develop awareness, knowledge, and skills to improve personal wellness in order to practice ethically and reduce levels of impairment. However, the very nature of counseling leaves counselors vulnerable to stress, and too much stress can lead to impairment (Cummins, Massey, & Jones, 2007). Therefore, it is important that counselor educators (CE) teach wellness to future counselors for impairment prevention (Myers, Trepal, Ivers, & Wester, 2016).

Counselor Educators and Wellness

Counselor educators have a responsibility to assess, evaluate, and promote personal

growth for counselor trainees (CACREP, 2015). CEs work in many different roles such as a

counselor, teacher, supervisor, mentor, researcher, and community leader, incurring many

stressors like counselors in practice and merging with those also present in academia and higher

education administration (Myers et al., 2016). The few studies exploring CEs self-perceived

wellness found relatively high levels of wellness, which steadily decrease as life stressors

increase (Shillingford, Trice-Black, & Butler, 2013; Wester et al. 2009). Myers et al. (2016)

identified stressors impacting CEs wellness, specifically time, personal and professional

congruence, and professional supports. CEs are models for their CITs who will one day work as

licensed counselors, responsible for maintaining and modeling wellness. If well counselors

produce well clients (Myers et al., 2016; Witmer & Young, 1996) then, well CEs produce well

CITs (Hill, 2004).

Modeling behavior is another way of teaching and imparting positive habits for future

work (Hill, 2004). According to Lambert and Lawson (2011), professional counselors can

experience impairment through burnout, compassion fatigue, and vicarious traumatization when

working with clients. Lambert and Lawson (2011) also found that increasing personalization and

awareness within counselor education programs helps create a nurturing environment for

individual wellness practice and habit formation. When CITs have space to investigate

personalized self-care strategies from empirically based interventions, wellness becomes a

process and practice, instilling CITs with a sense of responsibly and validation for their own

wellness (Lambert & Lawson, 2011). This space for exploration helps CITs develop a wellness

philosophy (Roach & Young 2007; Yager & Tovar-Blank, 2007) and create a personal definition of wellness to practice after graduation. Personal wellness definitions influence practice, encourage future wellness habits, and increase wellness. CEs can help CITs explore stressors and improve wellness by giving sufficient space for exploration and awareness, modeling wellness practice, and teaching wellness or self-care strategies.

Wellness Theory

Wellness has been defined in many ways in the field of counseling (Roach & Young, 2007). Myers (1991) defined wellness as "the maximizing of human potential through positive lifestyle choices" (p. 1). Myers, Sweeney, and Witmer (2000) then created the Wheel of Wellness as a model for understanding wellness across the lifespan. The definition of wellness in the Wheel of Wellness links to theoretical foundations in Alder's social interest and striving for mastery, Maslow's striving for self-actualization, growth, and excellence, and research on characteristics of healthy people (Myers et al., 2000). The latest revision is entitled the Indivisible Self: An Evidence-Based Model of Wellness (IS-WEL; Myers, Luecht, & Sweeney, 2004). This comprehensive wellness model came from cross-disciplinary studies to explore health, quality of life, and longevity (Myers & Sweeney, 2008).

In an effort to view an individual client as a whole person, the Indivisible Self was born from the Wheel of Wellness (Sweeney & Witmer, 2000), to conceptualize the complexity of human development (Hattie et al., 2004). Therefore, the Indivisible Self uses systemic considerations (local, institutional, global, and chronometrical) to explore five domains (essential self, creative self, coping self, social self, and physical self) (Myers & Sweeney, 2004). Each of these five domains are then divided into subcomponents, including thinking, emotions, control,

3

work, positive humor, leisure, stress management, self-worth, realistic beliefs, friendship, love, spirituality, gender identity, cultural identity, self-care, nutrition, and exercise (Myers & Sweeney, 2004). The 5F-WEL assessment measures these complex pieces to identify life tasks for healthy functioning and practice (Hattie et al., 2004).

Wellness practices include being emotionally, mentally, and physically stable, and having the ability to recognize coping methods (Wester, Trepal, & Myers, 2009). According to the ACA's Taskforce on Counselor Wellness and Impairment (Lawson & Venart, 2005), counselor wellness is directly related to the self-evaluation of impairment, compassion fatigue, vicarious traumatization, and burnout. CEs have a responsibility to 1) educate all counselors to prevent impairment, 2) secure quality resources, interventions, and treatment for impaired counselors, and 3) advocate within the ACA and at the state and national levels to address the broader issues surrounding impairment as well as the specific needs of those who are impaired (ACA, 2015).

Wellness must be nurtured to prevent impairment; therefore, counselors must use awareness to appraise their health and burnout throughout their careers (Myers & Sweeney, 2005a). Wellness is both a process and a choice that counselors, CEs, and CITs must engage in to maintain and prevent impairment and burnout. Schaufeli, Maslach, and Marek (1993) described burnout as a process parallel to the wellness development process, therefore, burnout can be corrected before symptoms lead to impairment such as depression or substance abuse. CEs need to teach empirically grounded techniques and strategies to engage in the wellness process (Wolf, Thompson, & Smith-Adcock, 2012). The Indivisible Self Model of Wellness (Hattie, Myers, & Sweeney, 2004), provides a common language for CEs to explore their own wellness and how they nurture wellness with CITs.

Shapiro, Brown, and Biegel (2007) concluded that psychological impairment affects a significant proportion of mental health professionals during their careers. These counselors are responsible for maintaining their own wellness and self-care (ACA, 2017). Impairment and burnout among the counselor population is a high concern, as Wardle and Maryorga (2016) found that in a sample of 94 counselors, 85% had some degree of indication for burnout. Due to these high levels of impairment it is essential to not only focus on the wellness of clients, but also the wellness of counselors as this affects clients.

Wellness and Burnout

Burnout is emotional exhaustion that prevents empathy and therapeutic presence with clients (Lee & Asforth, 1990; Stephens, 2016). Impairment and burnout may present as unprofessional behaviors such as showing up late, missing or canceling appointments, not responding to client's needs, and damaging the therapeutic relationship (Falender, Collins, & Shafranske, 2009). Because 30% of change in counseling stems from the therapeutic relationship (Asay & Lambert, 1999), counselor impairment can significantly hinder client progress by damaging the relationship. Impairment negatively affects clinical work; therefore, it is the counselor's ethical responsibility to engage in ways to promote personal wellness (Richards, Campenni, & Muse-Burke, 2010). The high burnout rate among counselors brings into focus CEs responsibility to promote wellness in their CITs.

If well counselors produce well clients (Myers et al., 2016; Witmer & Young, 1996), then it is postulated that well CEs produce well CITs (Hill, 2004). CEs have stressors of their own, such as job satisfaction, tenure reviews, intentions to leave academic work, time pressures, work life balance, teaching load, managing household responsibilities, and working with professional

regulations (Hendel & Horn, 2008; Myers et al., 2016). CEs experience multiple demands and time constraints that may be compounded by unrealistic expectations and little feedback or recognition (Hill, 2004). The struggle to balance these multiple demands impact wellness in both professional and personal development (Hendel & Horn, 2008; Hill, 2004). CEs also need to protect against impairment specific to their clinical and academic responsibilities; however, little is known about how CE's personal health and wellness affect how they promote wellness in students.

Promoting Wellness

Kaplan and Gladding (2011) stated that the counseling profession, and specifically CEs, should encourage evidenced-based, ethical practices for CITs. Wellness levels affect how counselors work with clients; however, in both our accrediting body (CACREP) and our ethical code (ACA), little information exists about specific strategies to maintain wellness (Kaplan et al., 2014). The CACREP (2017) website indicates there are 1,204 accredited programs with matriculating CITs being held to CACREP standards, but provides no specific criteria on how to promote wellness for CITs in a profession prone to stress and impairment. Wellness is presented as a directive, with no strategic plan.

Counseling programs, both CACREP and non-CACREP accredited, produce large numbers of counselors with the expectation that they can engage ethically in self-care practices to maintain wellness; however, CACREP (2016) offers no standards in curriculum to address wellness for CITs. CACREP (2016) mentions "self-care strategies appropriate to the counselor's role" under professional counseling orientation and ethical practice (p. 8), but without specific strategies, criteria, or necessity for evaluation. CACREP (2016) standards mention the word

wellness three times in relation to ethically and culturally addressing wellness across the lifespan, its role in addiction recovery, and fostering family wellness; all specifically relating to understanding future client wellness. Clients' wellness is affected by counselors, CITs, and CEs, and they must take precautions to maintain wellness. While wellness is shown to be important for clients, and therefore, for CITs, CEs do not have empirically validated standards or criteria for teaching, promoting, or evaluating wellness. This information gap also creates learning environments that do not have direct strategies to promote wellness for CITs. Mindfulness is one example of a self-care strategy that programs are using to promote wellness.

Mindfulness

Counseling programs are highlighting mindfulness as a wellness technique for CITs and for use with clients (Fulton & Cashwell, 2015; Testa & Sangganjanavanich, 2016). Recent studies also suggest that those in the counseling profession are more likely to engage in mindfulness practices (Baer, 2003; Daniel, Borders, & Willse, 2015). Mindfulness, with its emphasis on attentive observation, awareness, and acceptance, is not only used in programs to aid in CIT's wellness, but also in counselor development such as promoting multicultural competencies (Ivers, Johnson, Clarke, Newsome, & Berry, 2016), tolerating ambiguity (Bohecker, Vereen, Wells, & Wathen, 2016), and increasing empathy (Block-Lerner, Adair, Plumb, Rhatigan, & Orsillo, 2007; Greason & Cashwell, 2009; Raab, 2014; Shapiro, Brown, & Biegel, 2007). There are a variety of wellness activities counseling programs use for CIT's wellness; however, mindfulness has links to domains from the Indivisible Self (Wolf et al., 2014). Mindfulness is defined as present moment awareness (Baer, 2003). Present moment awareness helps individuals more wholly experience physical (physical self), emotional and

mental (creative self), attitudinal (coping self), and interpersonal (social self) processes (Roach & Young, 2007; Wolf et al., 2014). Given the recent focus on mindfulness in the counseling literature (Shapiro, Carlson, Astin, & Freedman, 2006), it important to pay particular attention to mindfulness as a way to promote wellness.

Mindfulness practice promotes present moment awareness, which increases wellness (Lenz et al., 2012). Mindfulness is a state of high awareness of the present moment, acknowledging and accepting it, without getting stuck in thoughts or in emotional reactions; i.e. mindfulness is present moment awareness (Baer, 2003; Shapiro et al., 2006). Mindfulness helps people remove themselves from unhealthy cognitions and increase recognition of thoughts, emotions, and maladaptive ways of responding to stress (Shapiro, Astin, Bishop, & Cordova, 2005). Using mindfulness practices during supervision can increase awareness of CITs' wellness and impact future wellness practices in professionals (Christopher et al., 2011). When counselors are well and have higher present moment awareness they function more competently and model effective behaviors (Witmer & Young, 1996).

CEs are tasked with teaching CITs to be effective and ethical counselors by modeling and promoting wellness; mindfulness may be one of the ways to accomplish this task. Mindfulness helps individuals become more aware of their own thought processes, creating space for personalizing their experiences with wellness and self-evaluation by stimulating the middle prefrontal brain associated with self-observation and metacognition (Davis & Hayes, 2011). Counselors and CITs can better understand their own wellness and impairment through mindfulness promoting competent functioning in CEs.

Statement of the Problem

Counselor educators (CEs) play an integral role in supporting wellness development for CITs, but little research exists exploring counselor educators' general wellness, mindfulness, and how the wellness levels of counselor educators impact how they promote wellness in CITs (Myers et al., 2016; Wester et al., 2009). Counselor educators (CE) must work to educate students on wellness and overall well-being through promoting self-care strategies and understanding risk factors for impairment to evaluate and promote personal growth for CITs (CACREP, 2016). Wellness is important to counselor development, as counselors who are well work more efficiently, attend to clients' wellness, and enhance the therapeutic relationship (Lambert & Lawson, 2011). Clinicians are ethically required to work to prevent impairment and harm to clients, and CITs must abide by the same requirements (ACA, 2015). Therefore, CEs working to help students develop professionally and personally as counselors have a responsibility as educators, mentors, supervisors, and gatekeepers for CITs developing into counselors (Wester et al., 2009). Part of counselors' development is the responsibility to practice ethically by working to maintain wellness (ACA, 2014). CEs take multiple roles in laying the foundation for counselor development and wellness strategies; however, a research gap exists exploring the wellness of CEs, mindfulness, and the impact on their multiple roles.

Purpose of the Study

The purpose of this study is to explore the relationship between levels of wellness, levels of mindfulness, and how wellness is taught by counselor educators (CEs). Specifically, this quantitative study focused on wellness and mindful present moment awareness in CEs and how these variables impact promotion behaviors. The effects of self-care and wellness promotion as

constructs will be grounded in Wellness Theory, which outlines wellness choices based on five general factors: (a) creative self, (b) coping self, (c) social self, (d) essential self, and (e) physical self that influence overall wellness (Hattie et al., 2004; Myers & Sweeney, 2005b). The specific research questions guiding this study are:

RQ1: What are the average levels of wellness, mindful present moment awareness, and wellness promotion behaviors in CEs? Are there differences by demographic variables (i.e., institution type, tenure track, teaching format, age, years of experience, or mindfulness practices)?

RQ2: What strategies do CEs use to promote wellness behaviors?

RQ3: Are wellness promotion behaviors associated with level of wellness and mindful present moment awareness?

RQ4: Do level of personal wellness, mindful present moment awareness, and demographic variables (gender, CACREP-accreditation) predict level of wellness promotion behaviors in CEs?

Significance of the Study

The results from this study can influence how CEs teach wellness, tend to their own wellness, and how mindfulness relates to CEs wellness. This study is significant because it will explore the effects of wellness on CEs and how they promote wellness to counselors-in-training (CITs). The aim of this study is to highlight the ways CEs contribute to CITs wellness development. This could ultimately provide a framework for better preparation for future counselors to prevent burnout or impairment. Knowing the relationship between wellness and how CEs promote wellness will help identify ways to effectively teach and evaluate wellness.

Definition of Terms

Wellness is defined as a continued process of making choices that maximize human potential (Myers 1991).

Impairment is when counselors' health negatively impacts counselor's professional functioning negatively, which hinders client care or poses the potential for harm to the client (Lawson & Venart, 2005) Specific forms of impairment include:

> *Burnout* is emotional exhaustion that prevents empathy and therapeutic presents with clients (Lee & Asforth, 1990; Stephens, 2016).

> *Vicarious traumatization* is the process of connecting with clients' pain, impacting counselors' empathy and health (Saakvitne, Pearlman & Staff of TSI/CAAP, 1996).

> *Compassion fatigue* is a feeling of deep sympathy and sorrow for another who is suffering, accompanied by a strong desire to alleviate the pain or remove its cause (Figley 1995).

Wellness Theory outlines wellness choices based on five general domains: (a) creative self, (b) coping self, (c) social self, (d) essential self, and (e) physical self that influence overall wellness (Hattie et al., 2004; Myers & Sweeney, 2005).

Wheel of Wellness is defined by Myers, Sweeney, and Witmer (2000) as a model for understanding wellness across the lifespan.

The Indivisible Self (IS-WEL) conceptualizes wellness into five general domains with subcomponents: the essential self; the creative self; the coping self; the social self; and the physical self (Myers & Sweeney, 2004).

Mindfulness is present moment awareness (Baer, 2003); acknowledging and accepting the

11

moment, without getting stuck in thoughts or in emotional reactions (Shapiro et al., 2006).

Mindfulness practice is a self-care strategy to increase present moment awareness, encourage acceptance, and decrease judgement (Shapiro et al., 2006).

Counselor Educators (CEs) are instructors for future counselors and are responsible for assessing, evaluating, and promoting personal and professional growth for counselor trainees (CACREP, 2016).

CACREP accredited refers to the guidelines for Counselor Education Programs set forth by the Council for Accreditation of Counseling and Related Educational Programs (CACREP, 2016)

Delimitations of the Study

Due to the number of counseling programs across the United States, for the purpose of this study, participants will be recruited from programs that are both CACREP-accredited and non-CACREP accredited to view the varied spectrum of wellness, mindfulness, and wellness promotion in those preparing counselors for practice. In this study, wellness is defined through the Indivisible Self model (IS-WEL) because it brings a holistic definition of wellness, and has a direct connection to counseling practice. Another delimitation is the decision explore the perspective of counselor educators (CEs) with at least one year of experience in a program with mental health counseling, school counseling, marriage and family counseling, rehabilitation counseling, community counseling, and/or professional counseling and abiding by the ACA code of ethics. Therefore, the participant must have a PhD or EdD in Counselor Education and must teach in the above approved counseling programs. I decided this criteria would be important to get a well-rounded picture of how programs prepare CITs for future ethical counseling practice.

Limitations

There are several limitation to this study. The first limitation is a smaller than predicted sample size. The initial calculations called for a sample of 150 for a multiple linear regression; however, with a moderate effect size (.3) and an alpha of .05, 118 is an appropriate size for other statistical calculations with less than six factors. The sample could be stronger with 150. Recruitment could have impacted sample size, as all participants were contacted by email rather than person-to-person contact. There may also be a nonresponse bias. Therefore, the sample is limited to CEs with access to email, who regularly check email, and do not treat enmass emails as spam. The length of the scales (30-45 min) also potentially influenced participants not completing the surveys. While 125 finished the 5F-WEL, MAAS, and WPS, only 118 finished the demographic sections limiting demographic variation.

In addition, the sample size and length of the survey could have impacted the variability in the sample for some demographics. The CE population is largely Caucasian women which prevented variation in the sample. While I specifically sought to find schools across the United States in a variety of counseling programs, the sample is also largely from the Southern region. The sample also mainly consisted of CACREP accredited programs so there could be no distinction made between CACREP and non CACREP accredited programs, or by differences in gender, race, region, or tenure status due to minimal variations in these demographics.

Also, all responses are self-report and therefore subject to participant biases. Therefore, caution is advised as participants are subject to fatigue, impression management, memory, and cultural limitations in self-report (Podsakoff, MacKenzie, Lee, & Podaskoff, 2003). Specifically, this study looked at wellness promotion behaviors CEs used, but not the impact on CITs.

Therefore, all wellness promotion behaviors are not explored as impactful to wellness development, but instead their importance to CEs.

It is important to note that the Wellness Promotion Survey (WPS), was designed for this study; however, it is the first time it is being used and has no normative data. From the initial 48 items, only 27 remained strongly loaded; therefore data from the initial 48 items were not in final results. This could lead to a lack of information on wellness promotion behaviors specific to spiritual growth, cultural exploration, and social justice work. Also, the incorporation of a sixth factor –based on question wording and connecting across factors– made it harder to find connections between hypothesized factors. Caution should be taken in exploring the coursework factor in relation to other forms of wellness promotion. However, this also produces questions for future work on the development of the WPS as outlined in the next section.

Organization of the Study

This study is presented in five chapters. The first chapter serves as an introduction to the study, as well as an overview of the importance of the wellness, mindfulness, the theoretical framework used, and CEs as the population. The purpose of the study is addressed, and key terms are defined in this chapter. Chapter two serves as a literature review of the main constructs of the study: wellness, mindfulness, and counselor educators (CEs). Chapter three serves as a report of the methodology to be used in the study. The method, procedure, instrumentation, data collection, and analysis are addressed as well as information for the survey pilot. Chapter four outlines results of each analyses; beginning with exploratory factor analysis for the WPS, then proceeding to descriptive statistics, correlations, and multiple regressions. Finally, Chapter five

provides context, discussion, limitations and implications for future research and counselor

educators.

Chapter 2: Literature Review

The purpose of this study was to explore the relationship between levels of wellness, levels of mindfulness, and how wellness is taught by counselor educators (CEs). Specifically, this quantitative study focused on wellness and mindfulness in CEs and how this impacts promotion of CITs' wellness in counselor training programs. This chapter reviews the literature relevant to the current study. The first section gives a brief introduction of Counselor Educators. The next section outlines Wellness, including history, connection to counseling practice, current research, and impairment. The next sections describe methods of measuring wellness, the development of the Wheel of Wellness, Indivisible Self Model, and assessments (WEL and 5F-WEL). The next section reviews Wellness promotion and CEs wellness. The next section reviews literature related to Mindfulness, how it relates to wellness, and its use in counseling and counselor education programs. In each section, the constructs will be explored with their connection to Counselor Educators as a population. The last section concludes with gaps in the literature and the purpose of the study.

Counselor Educators (CEs)

Counselor Educators (CEs) are instructors for future counselors and are responsible for assessing, evaluating, and promoting personal and professional growth for counselor trainees (CACREP, 2016). CEs are trained for professional counseling, supervising, teaching, research, and leadership (Sears & Davis, 2003) and are evaluated on their ability to engage in scholarship, teaching, and service (Borders et al., 2011). CEs go through doctoral-level training after completing their Master's in counseling, with varying levels of counseling experience. Many counseling programs are now accredited through Council for Accreditation of Counseling

and Related Educational Programs (CACREP, 2016), which provides guidelines for training, evaluation, and development for counselors-in-training (CITs) and Counselor Educators (CEs). Standards influence how CEs promote CITs professional identity development. CEs have a responsibility to aid in CITs professional identity development (Gibson, Dollarhide, Leach, & Moss, 2015).

Counseling professionals also have a responsibility to support a wellness paradigm in their work with clients, other counselors, and CITs. In 2011, Mellin, Hunt, and Nichols conducted a qualitative investigation with 238 counselors about professional identity. Counselors in this study viewed their professional identity as based in holistic, developmental, preventative, and wellness based work with clients. ACA (2014) mandates that counselors should monitor themselves for their own physical, mental, or emotional impairment (Standard, C.2.g.). Counselors also need to monitor others for signs of impairment and "refrain from offering or providing professional services when such impairment is likely to harm a client or others" (ACA, 2014, F.5.b.). CE's are therefore responsible for practicing, modeling, and evaluating wellness for themselves and other practitioners.

Because of the isomorphic relationship between both counselor and client, and CIT and CEs, questions persist as to how counselor wellness is promoted and maintained. CACREP (2015) outlines curriculum requirements for CITs. Specifically, CACREP (2015) supports a wellness orientation and focuses on prevention for counselors' professional and personal development. Counselors are expected to promote wellness, optimal functioning, and growth in clients (Section II.2.e.). Therefore, it is important that counselors are aware of their placement on the continuum of *impaired* and *well*. This awareness is imperative for counseling practice, CITs

development, and CE responsibilities, as it is unethical to operate while personally or professional impaired. However, CEs are called to promote wellness with no strategic plan for implementation. Some training programs require students to devise personal philosophies of wellness (Roach & Young, 2007; Yager & Tovar-Blank, 2007) while others infuse wellness into supervision (Blount, Taylor, Lambie, & Anwell 2016; Lenz, Sangganjanavanich, Balkin, Oliver, & Smith, 2012), and many conceptual pieces focus on wellness promotion in general (Barden, Conley, & Young, 2015; Cummins, Massey, & Jones, 2007; Foster, 2010; Hendricks, Bradley, Brogan, & Brogan, 2009). However, there is not a structured outline for wellness promotions in CACREP standards or CE practice. Therefore, before exploring the ways CEs can promote wellness we must first define wellness and its relation to counseling.

Wellness

The concept of wellness dates back to Aristotle, who described it as refraining from excess, and Descartes, who connected wellness to the duality of mind and body (Myers & Sweeney, 2008). Wellness merges Eastern and Western ideas of health. Eastern models primarily focus on preventative care and movement to restore balance, while Western models focus on repair and fixing as a reaction to illness (Otani, 2003). Currently, Merriam Webster defines wellness as "the quality or state of being in good health especially as an actively sought goal that promotes wellness" (Wellness, n.d.).

The concept of wellness also spans multiple professional disciplines with their own separate definitions. Physician Halber Dunn (1961) described well-being as more than just the absence of illness but instead existing along a continuum. Hettler (1984) defined wellness as "an active process, through which people become aware of, and make choices toward, a more

successful existence" (p.14). Hettler's work primarily relates to business and community organizations (Myers & Sweeney, 2005). In the nursing profession, Pender, Murdaugh, and Parsons (2006) argued for a multidimensional definition of wellness that includes biopsychosocial, spiritual, environmental, and cultural factors. Myers and Sweeney (2008) merged definitions to define wellness for the counseling profession as "strengths-based strategies for assessing clients, conceptualizing issues developmentally, and planning interventions to remediate dysfunction and optimize growth" (p. 482). Wellness is a foundational element for the counseling profession. Wellness is conceptualized as a paradigm for counseling and provides strength-based strategies for ethical practice that promotes the values of the counseling profession.

Wellness and the Counseling Profession

The counseling profession is rooted in wellness; specifically, in its focus on prevention and dedication to development across the lifespan (Kaplan & Gladding, 2011). Counseling grew out of the guidance movement in education from the work of Jesse B. Davis. Davis recognized the need for guidance because of the social and vocational issues during the Industrial Revolution (Sweeney, 2001). The Industrial Revolution was a period in U.S. history between 1820-1840 in which the production of goods moved from home businesses to machine-aided production factories, initiating the rise of new business, labor unions, and an expanding world of work (Aubrey, 1977). Davis used guidance activities to facilitate student exploration and development of self within the world of work, believing these services in education could address some of the social concerns of the time (Aubrey, 1977; Capuzzi & Gross, 2013). While Davis was working in education, Frank Parsons worked within the community.

Frank Parsons is referenced as the father of the Modern Guidance movement (Aubrey, 1977; Capuzzi & Gross, 2013). He worked with community youth to identify potential vocations, focusing on individual growth and development (Aubrey, 1977; Sweeney, 2001). Parsons believed that by increasing knowledge of self and the world of work, individuals could discover occupational fit (Aubrey, 1977). In contrast to the medical model of the day, Davis and Parsons focused on the potential and strengths within individuals to help them achieve goals (Sweeney, 2001; Stephens, 2016). The counseling profession was thus born from wellness and working towards human potential.

In contrast to the wellness model used in counseling, the medical model has a deep history in health sciences and is still prevalent in today's society and posits individual's problems as the result of pathology (Remley & Herlihy, 2007). Walz, Gazda, and Shertzer (1991) outlined ways in which the field of counseling can create plans to grow, paving the way for the 20/20 Vision of Counseling, and a consensus definition of the profession. "Counseling is a professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals" (Kaplan, Tarvydas, & Gladding, 2014, p. 366). Today, counselors use the wellness model as a philosophical underpinning to conceptualize problems faced by individuals as normal and natural results of human development (Lawson & Myers, 2011). Myers, Sweeney, and Witmer (2000) merged definitions from Halber Dunn and Hettler to define wellness for counselors:

"a way of life oriented toward optimal health and well-being, in which body, mind, and spirit are integrated by the individual to live life more fully within the human and natural community. Ideally, the optimal state of health and well-being that each individual is

capable of achieving" (p. 252).

The importance of the wellness model to the counseling profession spurred a plethora of research dedicated to client wellness and development (Myers & Sweeney, 2005a; 2008; Myers et al., 2000). The counseling profession thus developed, with its own national organization (American Counseling Association), ethical code (ACA, 2014), and accreditation standards for training counselors (Council for Accreditation of Counseling and Related Educational Programs, [CACREP], 2016). However, if wellness is a philosophical understanding that all humans strive for optimal health and well-being, it begs the question of how counselors' wellness impacts counseling work.

Counselor Wellness

Counseling is rooted in wellness philosophy focusing specifically on prevention and a developmental perspective (Myers et al., 2000). Counselors conceptualize clients' problems as the normal result of the natural lifespan; therefore, it is necessary for counselors to be aware of their own wellness. Wellness is included in the ACA Ethical Code (2014); notably, the need for counselors to "engage in self-care activities to maintain and promote their own emotional, physical, mental, and spiritual well-being to best meet their professional responsibilities" (Section C, p. 8). Witmer and Young (1996) stated, "well counselors are more likely to produce well clients" (p. 151) and, unwell counselors could do harm to clients and damage the counseling relationship.

Impairment. Impairment is opposite wellness on the continuum. Impairment occurs when counselors' health significantly impacts a counselor's professional functioning, posing potential to harm the client and hindering client care (Lawson & Venart, 2005). There are three

specific types of impairment: (1) Burnout, defined as emotional exhaustion that prevents empathy and therapeutic presence with clients (Lee & Asforth, 1990; Stephens, 2016); (2) Compassion fatigue, a feeling of deep sympathy and sorrow for another who is suffering, accompanied by a strong desire to alleviate the pain or remove its cause (Figley 1995); and (3) Vicarious traumatization, the process of connecting to the pain clients experience, and the resulting empathy with that pain impacts health (ACA, 2017; Saakvitne, Pearlman, & Staff of TSI/CAAP, 1996). Counselors and CITs face impairment due to the stressful nature of counseling work and expectations of the counseling profession (Yu, Lee, & Nesbit, 2008).

Impairment is regarded as a professional problem in counseling as impaired counselors risk harming clients (Young & Lambie, 2007). Burnout, specifically, affects counselors' physical and mental health, and contributes to depression, anxiety, and fatigue (Testa & Sangganjanavanich, 2016). Counselors experiencing burnout may demonstrate pessimism, cynicism, or indifference towards their clients (Gündüz, 2012). Wardle and Mayorga (2016) used a survey to explore burnout rates for counselors. Though they had a small sample size (N=35), they found that 85.7 % of respondents showed some degree of burnout. Specifically, they found that burnout was either something counselors should be aware of and paying attention to, or they were overtly demonstrating burnout, threatening their physical and mental well-being. These findings are similar to a study by Hughes and Kleist (2005) who used grounded theory to explore four first-semester counselor educator doctoral students. These students cited stress, isolation, and academic program requirements that contributed to burnout, highlighting the need for counseling programs to nurture wellness in students. Burnout is just one outcome from impairment.

Related to burnout, compassion fatigue impacts counselor ability to empathize with clients. Figley (1995) described compassion fatigue as the inability to hold others' suffering. According to Figley, compassion fatigue hinders empathy and restricts emotional energy essential for developing the therapeutic alliance. Therefore, when counselors work with clients that experience traumatic or stressful issues, they respond with extreme sympathy, prompting a lack of proper boundaries. Lax boundaries can be compounded by personal and professional life stressors which directly impact empathy with clients, resulting compassion fatigue.

Adams, Boscarino, and Figley (2009) explored the relationship between compassion fatigue and psychological distress with social workers. The social workers in the sample were living in New York City following the September 11th, 2001 terrorist attacks on the World Trade Center. Is found that compassion fatigue directly related to psychological stress. They also found that environmental stressors impacted both personal and professional well-being. Alkema, Linton, and Davies (2008) also explored compassion fatigue within a specific environment. Is explored the self-care, compassion fatigue, and burnout levels of hospice professionals, directly relating impairment to the working environment. Of the 37 hospice care professionals, they found a negative correlation between self-care and compassion fatigue; therefore, the more self-care present the less compassion fatigue the hospice care professional experienced (Alkema et al., 2008). This study illustrated that compassion fatigue can be influenced by wellness promotion strategies such as self-care.

Much like compassion fatigue, counselors experiencing vicarious traumatization also experience a lack of empathy, but demonstrate symptomology of post-traumatic stress disorder as well (Thompson, Amatea, & Thompson, 2014). As symptoms increase, counselor

effectiveness decreases, increasing the potential for counselors to do harm to clients. Hodgkinson and Shepherd (1994) explored social workers' experiences in dealing with catastrophic events, such as natural or man-made disasters. Is found that social workers responding to these events showed high levels of cognitive disturbances such as intrusive unpleasant thoughts and depressive symptoms. Is also found a high correlation between trauma work and elevated trauma symptoms (Hodgkinson & Shepherd, 1994). This study illustrated the need for wellness as those in the helping profession assist others after trauma and catastrophic events.

The severity of vicarious traumatization is directly related to the type of work in which counselors or healthcare workers are engaged. For example, Pearlman and Saakvitne (1995) found counselors working with sexual assault survivors experienced feelings of stigmatization, isolation, feeling of loss of personal safety, lower self-efficacy, and a lack of capacity for intimacy. Canfield (2005) found that vicarious traumatization can cause symptoms akin to Post-Traumatic Stress Disorder: nightmares, anger, and sadness related to clients' experiences. The ways in vicarious trauma impacts functioning also impacts the way counselor view themselves, others, and their surrounding systems, illustrating that vicarious trauma can cause harmful changes in how counselors relate with others and negatively affect professional and personal relationships. The counseling relationship is pivotal to the counseling process by definition, and all types of impairment negatively affect this relationship. Impairment and wellness are therefore ethical issues.

While wellness is required to practice ethically, a large number of counseling professionals experience impairment. Puig et al. (2012) sampled 139 mental health professionals to compare their job burnout and personal wellness. Puig et al. (2012) used the Five Factor

Wellness Inventory (5F-WEL; Myers & Sweeney, 2004) and the Counselor Burnout Inventory (Lee et al., 2007). They found significant correlations between the five factors of burnout and the five factors of wellness. Specifically, the Exhaustion burnout subscale predicted the Physical Self wellness subscale, the Incompetence burnout subscale negatively correlated to the Essential Self, Social Self, Creative Self, and Coping Self wellness subscales, the Devaluating Client burnout subscale related to Thinking and Creative Self wellness subscales, and the Deterioration in Personal Life burnout subscale was negatively correlated to the Coping Self wellness subscale. Although the study had a small sample size, these professionals varied in professional identification by connection to the American Counseling Association (ACA), American Association for Marriage and Family Therapy (AAMFT), and the American Psychological Association (APA). The correlational design of this study cannot pinpoint cause and effect between wellness and burnout. However, this study illustrates the connection between counselor impairment and wellness, and the importance of continued vigilance for counseling practitioners.

Section Summary

The very nature of counseling is stressful and provokes anxiety; the relationship built into the definition of counseling creates more opportunities for counselors to become unwell than to maintain wellness. However, counselors are not only expected to take care of their own wellness and that of their clients, but also monitor the wellness of other clinicians. Counselors who suspect they are experiencing burnout or impairment must seek counseling, consultation, or supervision (ACA, 2016).

Lawson and Myers (2011) stated that "the fact that impaired counselors are more likely to harm has been established; similarly, well counselors are more likely to help clients become

better" (p. 163). Counselor wellness and counselor impairment rest on a continuum opposite each other and have specific effects on counselors' work. Counselor impairment occurs when counselors focus on clients' problems and ignore or minimize their own needs for self-care (Lawson, Venart, Hazler, & Kottler, 2007). In order to practice ethically, counselors must be prepared to monitor their own wellness and impairment. There are assessments to measure wellness in order for counseling professionals to better understand their own wellness, and their next steps. The next section will explore ways to measure wellness.

Measuring Wellness

There are numerous models of wellness across disciplines, but this section will focus on wellness as it is applied in the counseling profession. Myers (1991) explored the wellness-oriented paradigm for counseling that focuses on strengths as a direct response to the illness-oriented approach of the medical model. Wellness is therefore a foundational piece of the counseling profession, and helps guide interventions and philosophy (Myers, 1991). Wellness theory explores the wellness of humans, whether they be clients, counselors, counselors-in-training (CITs), or counselor educators (CEs). Wellness evolved from being a model for counseling philosophy to be a necessity for consideration in ethical practice.

Wellness as a theory has evolved from theoretical foundations in Adler's theory of social interest and striving for mastery, Maslow's striving for self-actualization, growth, and excellence, and research on characteristics of healthy people (Myers et al., 2000). The measurement of wellness demonstrates a series of adaptations and changes that mirror our understanding of this construct. Chronologically, the Wheel of Wellness (WoW; Sweeney & Witmer, 1991; Witmer & Sweeney, 1992) became the foundation for the Indivisible Self Model

(IS-WEL; Myers & Sweeney, 2005). It is necessary to use theory to bring a unifying definition of wellness and assessments to 1) evaluate the definitions of wellness and 2) evaluate wellness in to people. The development of assessments allows professionals to evaluate wellness, and propose ways to strengthen wellness. First, from the WoW, the Wellness Evaluation of Lifestyles or WEL inventory (Myers et al., 1996) was developed. As the WEL evolved through multiple incarnations, it then became the empirical basis for the IS-WEL, culminating in its current incarnation as the Five Factor Wellness Inventory or the 5F-WEL (Myers et al., 2005). The section below will outline the history and development of these wellness models specific to the counseling profession.

The Wheel of Wellness

The Wheel of Wellness (WoW) is a model for understanding wellness across the lifespan (Myers, Sweeney, & Witmer, 2000) and is the first theoretical model of wellness based in counseling theory. The WoW was developed through extensive literature reviews from multiple disciplines to identify characteristics that correlated with healthy living, quality of life, and longevity (Myers & Sweeney, 2004). WoW evolved from Alfred Adler's work (Adler, 1933). Specifically, Adler described the complexity of human development and outlined the five life tasks for individual's growth: (a) work, (b) friendship, (c) love, (d) self, and (e) spirit. Adler identified three constructs that explore a holistic understanding of human development: socio, teleo, and analytic (Adler, 1933). Socio is the desire to connect, teleo presupposes that individuals are goal-oriented, and every behavior has a purpose. Analytic is the idea that human behavior is rooted in the unconscious (Sweeney, 1998). These became part of the basics for the WoW.

Maslow (1970) studied characteristics of healthy people and stated that self-actualization, growth, and excellence are each a universal human tendency. WoW developed from personality, social, clinical, health, and developmental psychology and has applications in stress management, behavioral medicine, psychoneuroimmunology, ecology, and contextualism (Myers et al., 2000). The original Wheel proposed the five life tasks outlined in Adlerian theory. The Wheel of Wellness organized individual wellness into a circular wheel structure with a center, spokes, and outer rims that incorporate all five of these life tasks; with spirituality in the center (Myers, Sweeney, & Witmer, 2000).

The original Wheel was organized with seven subtasks or spokes representing self-regulation or life tasks. These components were (a) sense of worth, (b) sense of control, (c) realistic beliefs, (d) spontaneous and emotional response, (e) intellectual stimulation, problem solving, and creativity, (f) sense of humor, and (g) physical fitness and nutrition. The tasks of friendship, work, and love were the rims of the wheel. Witmer et al. (1998) chose the circular model to illustrate the connection between the components of the Wheel. Therefore, changing one component of the WoW impacts the other components. These five life tasks were evaluated through a factor analysis of the Wellness Evaluation of Lifestyle Inventory (WEL; Myers et al., 1995; Witmer, Sweeney, & Myers, 1993; Hattie et al., 1999). The WEL came from the 17 dismantled constructs of the Wheel of Wellness. The WEL was examined with large datasets and moved through three variations to become the 5F-WEL after further factor analysis and structural equation modeling (Myers, 2003). The initial WEL inventory (Myers et al., 1996) used the Wheel of Wellness to examine individual wellness characteristics; however, this model did not recognize leisure and work as separate constructs.

The next iteration of the WEL was developed over 10 years through seven different studies to field test items (Myers, 2003). Items on the WEL were tested for convergent and divergent validity by comparing 229 CITs with scores on comparable scales such as the Coping Resources Inventory (Hammer & Marting, 1987) and Testwel (National Wellness Institute, 1983). An overall diverse sample of 2, 295 adults found that similar constructs had high correlations, demonstrating construct validity, and different constructs had lower correlations, illustrating discriminant validity (Myers, 2003). The WEL was then revised as the WEL-S in which work was divided into work and leisure, and self-regulation was renamed self-direction, with 12 subtasks.

Myers and Sweeney (2005) therefore, revised the Wheel of Wellness to include 12 subtasks of self-direction. The 12 subtasks included: (a) sense of humor, (b) problem solving and creativity, (c) self-care, (d) stress management, (e) sense of control, (f) sense of worth, (g) nutrition, (h) exercise, (i) realistic beliefs, (j) emotional awareness and coping, (k) gender identity, and (l) cultural identity. Work, friendship, and love remained the rims of the wheel. However, (a) business/industry, (b) media, (c) government, (d) community, (e) family, (f) religion, and (g) education were added to surround the wheel as influencing life forces (Witmer, Sweeney, & Myers, 1998). Therefore, this model outlined how these tasks interacted with outer systems and life happenings. For example, family, community, religion, education, government, media, and business/industry could all impact wellness. Also, global events such as natural disasters (i.e. earthquakes, floods) and human-made hazards (i.e. war, oppression) impact these life tasks (Myers et al., 2000). Time, therefore, affects wellness as healthy functioning occurring at one point in life affects future development and functioning.

The WEL-S was the inventory used to explore quality of life and happiness; however, it was cited as the WEL in most articles. During this time, Hermon and Hazler (1999) used the WEL with a sample of 155 undergraduate students to explore the relationship between well-being and quality of life. They found the six components of the WEL to be positively correlated to happiness. Powers, Myers, Tingle, and Powers (2004) used the WEL to study perceived stress in couples with a spouse in medical school. They used a sample of 83 couples' responses. Researchers found that medical residents scored similar to doctoral students in counselor education, but scored lower in realistic beliefs. Overall results indicated that the realistic beliefs combined with high spousal wellness scores demonstrated that while respondents were high achieving, they did not recognize their success compared to the general population. This study began the interest into stress in higher education environments and the effects on students' wellness, development, and success.

Myers, Mobley, and Booth (2003) used five years of responses to the WEL to explore the wellness levels of 263 graduate students in a counseling program. Is found that master's students had higher levels of overall wellness than the norm group, and doctoral students scored significantly higher. However, this only included initial results from first year students and did not explore their progression through the program. Time and contextual factors were important to understanding wellness development and not just present moment wellness.

The Wheel of Wellness was assessed again using the WEL-S (Myers et al.,1995; Witmer, Sweeney, & Myers, 1993), and while the instrument was found valid and reliable, the Wheel of Wellness was not supported (Hattie et al., 2004). From the sample of more than 3,000 people, Hattie et al. (2004) found that the model needed to be revised. While the Wheel of Wellness

rested on foundational and multidiscipline research on wellness, it did not group components in the hypothesized order, leading to the next iteration of wellness– The Indivisible Self Model. From the initial WEL, to the WEL-S and finally to the WEL-J which was renamed the Five Factor Wellness Inventory (5F-WEL) the formation of the IS-WEL is an empirically grounded model of understanding wellness (Myers et al., 2005). The 5F-WEL was the basis for the development of the Indivisible Self Model. Table 2.1 illustrates a chronological development of the wellness models and assessments.

The Indivisible Self Model

While the Wheel of Wellness was a substantial foundation for future concepts, the structure needed to be redefined. Hattie et al. (2004) assessed 3,993 individuals, finding support for the reliability and construct, convergent, and discriminate validity of the WEL, but not for the organization of the Wheel of Wellness. Seventeen of the factors of the Wheel of Wellness were identified through factor analysis, but these factors did not group into the hypothesized subtasks. The new grouping resulted in five second-order factors: (a) Creative Self, (b) Coping Self, (c) Social Self, (d) Essential Self, and (e) Physical Self. Each second-order factor is made of unique elements, creating distinctive individual interpretations.

The Indivisible Self added contextual variables to illustrate how individuals are influenced by the world around them. These variables are: (a) local contexts– family, school, community, (b) institutional contexts– policy, laws, or governments, (c) global contexts –culture, politics, and environmental impact, and (d) chronometrical contexts –ways in which individuals change across the lifespan (Myers & Sweeney, 2004). The IS-WEL addresses wellness for an individual's internal and external world, encompassing a holistic understanding of wellness.

Table 2.1
Overview of wellness scale development.

Scale	Model	Tasks	Subtasks	Assessment	Contextual factors
WEL	Wheel of Wellness	5: • Work • Friendship • Love • Spirituality • Self-regulation	8-self-regulation • sense of worth • sense of control • realistic beliefs • spontaneous & emotional response, • intellectual stimulation, • problem solving, & creativity, • sense of humor • physical fitness & nutrition.	123 items 15 scales	
WEL-S	Wheel of Wellness	6: • Work • Leisure • Friendship • Love • Spirituality • Self-direction Divided work and leisure	12-self-direction • sense of worth • sense of control • realistic-beliefs • emotional awareness & management • problem solving & creativity • sense of humor • nutrition • exercise • self-care • stress management • gender identity • cultural identity	120 items 17 scales	Life Forces surround the Wheel: • business/industry • media • government • community • family • religion • education surrounded the wheel
WEL-J /5F-WEL	Indivisible Self Model	5 Second-order factors: • Creative Self • Coping Self • Social Self • Essential Self • Physical Self	Third-order tasks: Creative Self • thinking, emotions, control, work, & positive humor Coping Self • leisure, stress management, self-worth, & realistic beliefs. Social Self • love & friendship Essential Self • spirituality, gender identity, cultural identity, & self-care Physical Self • nutrition & exercise	73 items 5 second-order scales 17 third-order scales	Local (safety) • Family • Neighborhood • Community Institutional (policies & laws) • Education • Religion • Government • Business/industry Global (world events) • Politics • Culture • Global events • Environment • Media • Community Chronometrical (lifespan) • Perpetual • Positive • Purposeful

The Creative Self is a combination of attributes which are unique and impact social interaction (Adler, 1954). It has five components: thinking, emotions, control, work, and positive humor. The Creative Self is based in clinical experience and research on how emotional experiences tend to influence cognitive responses (Myers et al., 2004). Therefore, positive expectations impact emotions, behavior, and perceptions of anticipated outcomes which effect physical and mental functioning. Increasing the ability to think clearly, view the world accurately, and respond appropriately to different situations, which will decrease stress and therefore increase wellness (Myers et al., 2004).

The Coping Self is comprised of four components: leisure, stress management, self-worth, and realistic beliefs (Myers et al., 2004). The Coping Self supports how individuals deal with life events, with irrational beliefs as the sources of frustrations and disappointments (Myers et al., 2004). Different levels of self-worth can be successfully managed by learning to manage stress and cope with life's changes (Myers et al., 2004). Leisure is essential to wellness; for example, learning to become totally absorbed in an activity in which times stands still helps individuals cope with stress (Csikszentmihalyi, 1990). The Coping Self is comprised of elements to regulate responses to life events and surpass negative effects. Moorhead, Gill, Minton, and Myers (2012) gathered the wellness levels of 115 CITs to explore forgiveness in relation to wellness. Quantitative measures showed that students less likely to forgive held lower scores on the Coping Self factor. These results demonstrate the many ways CITs wellness is tested and stretched during counselor training, and how CEs can help CITs gain awareness of hazards to wellness.

The Social Self includes two components, love and friendship, and relates to the desire

for connectedness (Myers et al., 2004). According to Myers et al. (2004), friendship and love are part of a continuum and not clearly distinguishable. Friendship and intimate relationships represent social connectedness or support and, therefore, enhance the quality and length of individual's lives; while isolation, alienation, and separation from others are associated with poor health conditions. Social support has been identified as a strong positive predictor of mental health over the lifespan (Cohen & Syme, 1985).

The Essential Self supports how individuals make meaning and consists of four components: spirituality, gender identity, cultural identity, and self-care (Myers et al., 2004). Adler (1933) viewed spirituality, not religiosity, as a central component to holistic wellness with positive benefits for quality of life and longevity (Mansager, 2000). Gender and cultural identity are conceptualized as the lens through which individuals can view life experiences. Life experiences affect the meaning-making process when exploring the relationship to life, self, and others (Myers et al., 2004). Self-care refers to "proactive efforts to live long and live well" (Myers et al., 2004, p. 237). Lacking self-care promotes a general disregard for well-being and avoidance of health promoting habits, reflected in the loss of meaning and purposeful life.

Finally, the Physical Self is a biological facet of the individual and is comprised of two components: nutrition and exercise (Myers & Sweeney, 2004, 2005b). The Physical Self and its components are widely promoted, and research is compelling regarding the importance of exercise and nutrition with longevity (Warburton, Nicol, & Bredin, 2006; Lee, & Paffenbarger Jr, 2000; Caspersen, Powell, & Christenson, 1985). From the evaluation and research on the Wheel of Wellness, the Indivisible Self Model was created to better understand wellness and wellness promotion (IS-WEL; Myers & Sweeney, 2004, 2005b).

The IS-WEL model has statistical support from the use of the Five Factor Wellness Inventory (5F-Wel; Myers & Sweeney, 2004). Unlike the Wheel of Wellness that was hypothetical, the IS-WEL is built from empirical research on how the factors interact (Sweeney, 2005; Hattie et al., 2004). This model has been used in multiple research projects over the past 27 years with studies to explore wellness in different populations including practicing counselors, CITs, and CEs.

Section Summary

For the purpose of this study, wellness is defined as a continued process of making choices that maximize human potential (Myers, 1991); specifically, mental, emotional, social, physical, vocational, and spiritual well-being to promote personal and professional growth (Witmer & Young,1996). Wellness rests opposite impairment on the continuum and is necessary for counselors' and clients' safety. The counseling profession rests on tenets of wellness and understanding healthy development, but we lack unified discussions of wellness as well as empirically based interventions to promote wellness (Wolf, Thompson, & Smith-Adcock, 2012). The need to further explore client and counselor wellness led to the development of the Wellness theories including the Wheel of Wellness, the Indivisible Self Model (IS-WEL), and methods of evaluation, WEL, and 5F-WEL.

The 5F-WEL has also been validated in different languages such as Korean (Jang, Lee, Puig, & Lee, 2012), different education levels including adolescents and children, and for diverse populations (Myers & Sweeney, 2005b; Spurgeon & Myers, 2010). The IS-WEL, along with the 5F-WEL, is based in research on characteristics of healthy people, considered strength-based, grounded in theory, and orientated for choice in wellness behaviors (Myers et al., 2004). The IS-

WEL is a model of wellness developed from the counseling profession and well suited to investigate the wellness of CEs. Hill (2004) stated counselor education programs need to address and promote individual wellness among students and faculty. She made specific recommendations for CEs to promote wellness at the individual, collegial, systemic, and departmental levels. The next section will explore how CEs promote wellness.

CEs Promoting Wellness

CEs are in a unique position to both model and teach wellness to promote career sustaining habits in CITs. In a sample of 501 American Counseling Association members, Lawson (2007) explored career sustaining variables for wellness in the workplaces. He found the five highest-ranking variables assessed for career-sustaining behaviors or wellness in the workplace were: "(a) maintain sense of humor, (b) spend time with partner/family, (c) maintaining balance between professional and personal lives, (d) maintain self-awareness, and (e) maintain sense of control over work responsibilities" (Lawson, 2007, p. 28). There are a few studies exploring interventions to promote wellness, but the majority of interventions are introduced through conceptual articles. Myers, Mobley, and Booth (2003) assessed the wellness of 263 first year master's and doctoral students, and noted that entry level students demonstrated high wellness ratings. They suggested that the counseling field attracts people that are more willing to incorporate wellness practices, matching professional and personal values. However, they also noted that counselor training programs should incorporate wellness from the very beginning of their training program to set wellness as a foundation for development. Wellness can be infused into program, curriculum, and classwork.

Wolf, Thompson, Thompson, and Smith-Adcock (2014) explored the wellness levels of 38 master's level counseling students that took part in a semester-long, student led, wellness program. The program was comprised of 14 optional wellness workshops throughout the semester, encouraging reflection and goal creation. This mixed method study used the 5F-WEL for pre- and post-test and qualitative feedback gathered after the program to gain insights into the CITs experiences. Initial quantitative results illustrated significant changes in overall wellness scores, which increased in post-test measures. Additionally, four of the five subscales increased significantly– Creative Self, Coping Self, Essential Self, and Physical Self. The qualitative interviews illustrated that participants cited themes of a willingness to change, self-awareness, connection to spirituality, and a wish to maintain balance (Wolf et al., 2014). Limitations for this study included a small sample size, comprised of mostly Caucasian female students that volunteered to be part of the program. Also, while the results illustrated an overall increase in wellness as measured by the 5F-WEL, and more awareness as seen in qualitative interviews, Is did not compare to students outside of the wellness program. Therefore, they were unable to comment on the influence of the program on wellness. However, they do model a way to use the 5F-WEL to promote wellness in a counseling program as each student received their results increasing awareness. Other research and conceptual pieces highlighted using assessment to help CITs better understand their own wellness.

Roach and Young (2007) conducted research with 204 CITs from three CACREP accredited universities. The CITs were divided into three test groups based on their level in the programs. They were then given the 5F-WEL. Roach and Young (2007) found that while most students scored high on concepts of wellness overall, there was not a statistically significant

difference between the three groups. However, the authors also used open-ended questions asking students about the presence of wellness instruction in their programs and, if present, how this instruction integrated into the program curriculum. Student answers ranged from having a specific course to address wellness within clients and within themselves to the concept of wellness synthesized into the CACREP required curriculum courses. Is reported that CITs wellness may influence the quality of service they provide to clients (Roach & Young, 2007). They also noted that students who felt supported had higher levels of wellness. Therefore, while wellness is emphasized in counseling curriculum and students are exposed to wellness concepts, they lacked effective implementation strategies and student progress evaluation. Because of the cross-section nature of the research design, students were compared from three different points in their training and therefore no statements could be made about causes for their development. However, other studies explored wellness from the view of supervisors instead of students.

Blount, Taylor, Lambie, and Anwell (2016) conducted a phenomenological study to investigate six clinical supervisors' perceptions of their supervisees' wellness. Supervisors' experiences were divided into five themes: (a) intentionality, (b) self-care, (c) humanness, (d) support, and (e) wellness. Is cited that wellness is not only important to the counseling profession (Myers & Sweeney, 2004), but also that wellness is necessary to support supervisors' and supervisees' overall growth. The supervisors interviewed in this study specifically cited the need for CEs to be more intentional in their inclusion of wellness and its impact on the therapeutic relationship. They outlined the need for CITs to have a developed wellness plan, coursework, and mindset based on the foundational elements of wellness (Blount et al., 2016). Therefore, it is essential to aid in the overall wellness of supervisees to nurture development. Caution should be

used in with the qualitative results from this study as results were not meant to be generalizable, but instead help to understand how these supervisors viewed their supervisees' wellness needs.

Lenz, Sangganjanavanich, Balkin, Oliver, and Smith (2012) investigated the use of a wellness oriented approach to supervision. Is used a quasi-experimental design to explore the Wellness Model of Supervision (WELMS), and used the 5F-WEL and the Counseling Skills Scale (CSS; Eriksen & McAuliffe, 2003) as pre- and post-tests. While the comparative analysis of the WELMS and alternative models of supervision did not illustrate significant support for higher wellness scores, it did provide initial support for the WELMS as an effective supervisory intervention (Lenz et al., 2012). The WELMS scored very similarly on promoting wellness definitions, total wellness, and counseling skills to alternative models of supervision. Although this study highlighted WELMS as an effective supervision model, the findings are based on a small sample size (N=24) that lacks diversity. The WELMS needs more evidence and evaluation before being put in practice. My research study will gather more evidence for different way of wellness promotion. Other studies looked specifically at Wellness development when using the WELMS with CITs.

Meany-Walen, Davis-Gage, and Lindo (2016) explored the WELMS of four practicum students using a single case-study design. Researchers used the 5F-WEL as a weekly measure for participants taking part in WELMS. Results yielded that the changes from baseline increased during the intervention for all four participants, however, wellness levels after the intervention indicated that only two of the four participants reported continued increases in wellness. Meany-Walen et al. (2016) indicated that outside professional and personal issues contributed to the participants' stress. There is a continued need to find interventions that contribute to increased

wellness during and after implementation to for CITs. While CITs and CEs recognize the ethical necessity of wellness and wellness practices, there are more conceptual pieces exploring wellness in the classroom than empirical findings on wellness promotion.

Some training programs require students to devise personal philosophies of wellness before their first clinical practicum experiences (Roach & Young 2007; Yager & Tovar-Blank, 2007). Yager and Tovar-Blank (2007) provided suggestions on how to incorporate wellness instruction and model wellness and self-care behaviors for students in their programs. They outlined 10 different ways for CEs to connect CITs with wellness in the classroom. For example, wellness needs to be specifically related to the counseling curriculum and can be introduced through the informed consent process for CITs as they enter the program. In addition, CEs should consider themselves models for wellness during their interactions with students. New CITs are used to a model for teaching that emphasizes content over self-understanding; however, if CEs associate self-growth with learning goals for counselor development they can work to shift the academic culture towards self-awareness and self-care (Yager & Tovar-Blank, 2007). Counselors are expected to change and grow continuously and therefore, need to integrate self-awareness and growth with their own wellness.

CEs will need to be conscious of their own wellness and learn effective ways to promote wellness in themselves and CITs. There are inherent difficulties and discomforts in life and development, and CEs can help CITs explore how wellness levels can confront these discomforts and change naturally. CEs help CITs understand wellness and wellness promotion strategies. Counseling is an altruistic profession in which some counselors may ignore their own needs, to instead focus on their clients (Figley, 2002). Counselors must then make a conscious choice to

engage in wellness, and CE's need to help develop that understanding. Counselors continue to look at strengths and lifelong development of clients, CEs can teach this philosophy and encourage CITs to find this in themselves as well. The authors encourage CEs to implement these ideas in the classroom with the use of stories from their professional and personal life.

In another conceptual article, Cummin, Massey, and Jones (2007) suggested using assessments as a starting point for promoting and maintaining counselor wellness. They highlighted the Wellness Evaluation of Lifestyle Inventory (WEL; Myers & Sweeney, 2005) as an assessment as well as: the F.A.M.I.L.Y. Self-Care Assessment Inventory (Eckstein, 2001), the Professional Quality of Life Scale (Stamm, 2002), and the Stress Reaction Inventory (Yassen, 1995). They also encouraged counselors to create a wellness plan which includes promoting caring relationships, personal therapy, mentorship, and using assessments to monitor wellness changes (Cummin et al., 2007). Cummin et al. (2007) presented the initial measure of wellness (WEL) as a potential starting assessment. The 5F-WEL would be the most recent incarnation of the WEL and factors from the Indivisible Self Model have been used to outline wellness promotion in conceptual articles about wellness.

Venart, Vassos, and Pitcher-Heft (2007) also explored the literature to find ways to help counselors when they feel stressed. They rested their interventions on strategies to improve physical, emotional, cognitive, and interpersonal wellness. For physical wellness, they encouraged counselors to monitor and calm the body, address nutritional needs, and follow dietary guidelines. For emotional wellness, the authors suggested turning inward to notice emotions, finding ways to express emotions, and practicing self-refection and self-awareness. Cognitive wellness can be maintained through awareness of self-esteem, autonomy, and

competence. Celebrating personal accomplishments, continuing life-long learning, and involvement in something greater than the self are also important to maintain cognitive wellness. The authors also explored connection to others in relation to wellness. Venart et al. (2007) also asserted that interpersonal self-wellness or maintaining relationships is important to overall wellness. This concept links to Myers and Sweeney (2005), who also stated that social support was a strong predictor of mental health across the life span. They also recommend personal therapy, consultations, peer support groups, and supervision to help maintain interpersonal wellness. The authors outlined specific practices both in and outside of the classroom to help promote wellness in CITs.

Wolf, Thompson, and Smith-Adcock (2012) described how CEs can infuse wellness in counseling programs using the IS-WEL as a theoretical framework. The authors suggested CEs presenting as models for wellness, integrating wellness into the curriculum, and encouraging co-curricular wellness activities. They also highlighted how each component of the WEL can be incorporated into curricular and co-curricular activities. For example, Wolf et al. (2012) encouraged CEs to promote exercise, art, and external counseling for CITs to promote physical self, essential self, and coping self. They suggested that coursework should create space for reflection and expression of experiences, self, and wellness. CEs that integrate wellness experiences into the classroom give CITs a specific time and place regardless of their available financial and physical resources. Wolf et al. (2012) were able to add suggestions for promoting wellness in CITs, infusing wellness into counseling programs.

Foster (2010) suggested that wellness for CITs needed to be added to the curriculum, expanding the role of CEs to wellness promoters. Foster (2010) explored this concept through

the Wellness Cube Model (WCM) which incorporated a) counseling coursework, b) wellness factors as defined by the IS-WEL, c) content assignments and experiential exercises, and d) Adlerian principles. Therefore, Foster (2010) stated that since wellness is a foundation for counseling practice it can be included in counseling coursework, connected to professional organizations and campus honors societies– notably Chi Sigma Iota as a counseling honors society with direct links to CEs. First, second, and third order factors of the IS-WEL can then be organized into class experiences, discussions, and readings. This will make class assignments and exercises ways to explore and nurture wellness factors in CITs. Foster (2010) gave examples of experiential exercises such as journaling, informal self-assessments, community service projects, and group discussion (small, large, and online).

The WCM has no empirical research for the development at this time. However, Foster, Steen, O'Ryan, and Nelson (2016) explored how Adlerian life tasks (love, friendship, work, coping with self, and spirituality) predict stress in CITs. Foster et al. (2016) used a sample of 183 entry-level master's students to find if the 5F-WEL second order factors predicted stress levels as measured by the Beck Anxiety Inventory (BAI; Beck & Steer, 1993). Is found that anxiety had significant negative relationships with four of the five life tasks – love was the only life task that did not demonstrate the hypothesized relationship. Limitations for this study included a lack of standardized test administration as some of the schools administered their test to CITs in class and others during orientation. It also should be noted that no online programs were tested. Wellness is a standard of practice in the counseling professional and therefore, it is also socially desirable to demonstrate higher levels of wellness and so this could skew the results of the measures. However, this study does have direct implication for CEs such as: increasing support

through faculty advisors, infusing wellness into coursework, and decreasing isolation through social events.

Those drawn to the counseling field and attending counselor training programs score higher on wellness measures (Myers et al., 2003; Roach & Young, 2007). However, CEs and CITs experience stress and demands that are inherent in counselor training and practice. Research indicates that it would be helpful to create classroom spaces to promote wellness and awareness. CEs are expected to promote wellness through modeling, teaching, and supervision. Therefore, CEs need to monitor their own wellness in order to function effectively. The next section will explore the wellness of CEs.

CEs Wellness

While wellness and wellness theory hold deep roots in the counseling profession, there is little research exploring the wellness levels of CEs. CEs are not only responsible for educating, evaluating, and creating programming for CITs, but also maintaining their own wellness as counseling professionals (ACA, 2014). Hill (2004) stated if well counselors produce well clients then well CEs produce well CITs. Hill (2004) outlined this as an isomorphic relationship, defined as an inter-relational repetition of patterns (Koltz, Odegard, Feit, Provost, & Smith, 2012). CEs model values and ethical principles of the counseling profession for CITs. For example, if CEs do not acknowledge their own lack of sleep after a conference, they model the pattern of behavior of ignoring needs and their own wellness. Therefore, CE wellness is also an important construct to explore as they experience stress from their roles as counselors, supervisors, educators, leaders, gatekeepers, and academics.

CEs levels of stress and wellness are important to consider in relation to work stress. Wester, Trepal and Myers (2009) used the IS-WEL to gain initial wellness levels and Perceived Stress Scale (PSS; Cohen, Kamarck, & Mermelstein, 1994) to explore perceived stress levels for 180 CE respondents. Wester et al. (2009) found that CEs wellness scores were higher than the norm sample from Myers and Sweeney's (2005) earlier study. They also found that as the PSS scores increased, 5F-WEL scores decreased, illustrating that CEs are aware of their own wellness and stress. Wellness was also explored across demographic information and illustrated that tenure-seeking professors were significantly lower in Coping Self than full professors. Participants demonstrated lower scores in the realistic beliefs factor of the Coping Self (Wester et al., 2009). Realistic beliefs about self contribute to better ability for CEs to maintain self-care and cope with multiple job demands. Therefore, this study illustrates that academia presents another layer of occupational strain for CEs.

Academic stressors include time pressures, work-life balance, teaching load, physical health, student interactions, faculty meetings, and dealing with paperwork (Hendel & Horn, 2008). Myers, Trepal, Ivers, and Wester (2016) used a phenomenological design to find deeper meaning from the IS-WEL results from Wester et al. (2009) study mentioned above. Eleven CEs were interviewed about their wellness practices and stressors. Themes included: a) time, specifically, leisure, flexibility, and balance, b) congruence illustrating the aspects of life, work, and family that contributes to wellness and c) professional supports, specifically, department chair, family/partner, and mentoring. Findings were consistent with themes found in higher education research, demonstrating the need for CEs to not only be aware of stressors associated with counseling work, but also academic environments.

Relatedly, Shillingford, Trice-Black, and Butler (2013) explored the wellness of minority female CEs through qualitative methods. Eight CEs were interviewed, and eight themes were found: attraction to the field of counselor education, challenges resulting from minority female counselor educator status, feelings of personal success, wellness practices beneficial to professional and personal success, motivation to excel, setting boundaries, and developing a strong professional identity. Specifically, this study found that while each CE cited self-care as important, they also indicated they did not have the time for practice. Other researchers in higher education (Daughhetee, Puleo, & Thrower, 2010; Ponjuan, Conley, & Trower, 2011) and counselor education (Bradley & Holcomb-McCoy, 2004) found that minority educators experienced significant challenges connected to racism and lack of support systems or mentors. Most studies use a largely Caucasian CE sample to explore wellness and occupational stress. Shillingford et al. (2013) demonstrated that ecological systems and systems of oppression also play a role in CE wellness. The lack of research exploring diverse population indicate a need to explore wellness in diverse CITs and CEs.

Another population with little wellness insights are Counselor Educators in training or doctoral students. Perepiczka and Balkin (2010) explored the wellness of 173 counselor education doctoral students. They specifically used the IS-WEL as the theoretical basis for the study and each participant was asked to complete the 5F-WEL and demographic information. This study offered initial exploration in the CE doctoral student population, finding that total wellness scores were higher than average population levels, but demographic information demonstrated no statistical significance in relation to wellness. However, much like the tenure-seeking professors from Wester et al. (2009), CE doctoral students had lower scores in Coping

Self, specifically in the Realistic Beliefs factor. Much like their CE counterparts, these unrealistic beliefs can lead to overcommitting themselves and unrealistic expectations, which could illustrate the isomorphic relationship in action.

Section Summary

The wellness model provides a common language to discuss developmental and wellness-based clinical interventions for CITs and CEs. The Indivisible Self wellness model (IS-WEL) fits well within most of the core counseling courses and CEs can use assignments and evaluations in their course material to help promote CIT wellness. The wellness model allows CITs to complete a wellness inventory (5F-WEL) and find deficient areas early in their training programs. Hattie, Myers, and Sweeney (2004) suggested that since inventories such as the IS-WEL address dimensions of wellness, CITs and CEs can generate individualized wellness plans. They also suggested programs find ways to offer wellness activities for students that extend beyond the classroom, such as workshops or support groups, to provide options for students to care for themselves in professional and personal development. Some programs are offering mindfulness as classroom activities, interventions, and practice (Leppma & Young, 2016; Christopher, Christopher, Dunnagan, & Schure, 2006). The needs for CITs to understand wellness and practice awareness has led to many studies exploring mindfulness in CIT development.

Mindfulness

Mindfulness has roots in Eastern meditation practices (Bodhi, 2000). The word mindfulness comes from the Prakrit language, originally called "sati", which means having awareness, attention, and remembering (Bodhi, 2000). The long history of mindfulness created

multiple competing definitions; however, in autumn of 2004, a contingency of mindfulness researchers met to agree on a working definition (Bishop et al., 2004). Is' discussion outlined a two-part definition dividing mindfulness into awareness and attitude. The two components outline mindfulness as (a) self-regulation of attention−awareness and (b) orientation of experience− attitude. For the purpose of this study, mindfulness will be explored as a trait, encompassing the first component−awareness.

Mindfulness practice is a self-care strategy to increase present moment awareness, encourage acceptance, and decrease judgement (Shapiro et al., 2006). Mindfulness in this study is therefore understood as a trait, which can be influenced by mindfulness practice. Mindfulness practice can refer to regular practice, dedicating a period of time to engage in breath awareness, bodily awareness, meditation, and/or mindful movement such as gentle yoga (Kabat-Zinn, 1990). Mindfulness practices can be introduced through mindfulness interventions. Mindfulness interventions refer to programs in which individuals are taught mindfulness practices.

Kabat-Zinn (2000) stated that mindfulness practice may be helpful for people in Western society and pushed for Western researchers and clinicians to introduce mindfulness practice into mental health treatment programs as a means to increase wellness. The initial and most frequently cited type of mindfulness intervention is the mindfulness-based stress reduction (MBSR) program (Kabat-Zinn, 1990). MBSR was developed for populations with a wide range of stress-related disorders and chronic pain. The program takes 8-10 weeks and introduces participants to a range of mindfulness practices, including: meditation skills, group discussions, and homework. The purpose of this program was to investigate empirical connections between mindfulness and well-being, and to teach participants to increase awareness of thoughts, feelings,

and body sensations. (Kabat-Zinn, 2003). A surge of mindfulness based research exists, looking specifically at how to measure mindfulness and any ties to well-being (Davis & Hayes, 2011).

Measuring Mindfulness: Mindful Attention Awareness Scale

The Mindful Attention Awareness Scale measures the awareness component of mindfulness; specifically, it "assesses individual differences in the frequency of mindful states" (MAAS; Brown & Ryan, 2003, p. 824). The MAAS uses 15 items to measure core characteristic of mindfulness specifically, a receptive state of mind in which attention observes what is taking place, this state of mind is informed by a sensitive awareness of what is occurring in the present. The MAAS defines acceptance as a construct under awareness (Brown & Ryan, 2003). The MAAS focuses on awareness of what is occurring in the present rather than the acceptance, trust, empathy, gratitude, or compassion which are associated with the second component of mindfulness (Shapiro & Schwartz, 1999). The MAAS explores "present-centered attention-awareness" as the foundational starting point for mindfulness (Brown & Ryan, 2003, p. 824).

The MAAS began with 184 items, and was reduced to 55 after expert feedback (Brown & Ryan, 2003). The first 55 items were then pilot tested with 313 undergraduates. After exploratory factors analysis only items that loaded on the factor of awareness were kept (Brown & Ryan, 2003). A confirmatory factor analysis with 327 university students and cross validated with 239 adults brought the final MAAS down to 15 items. All scale items significantly related to awareness (Brown & Ryan, 2003).

The 15 item MAAS was initially validated by Brown and Ryan (2003). Is used a sample of active Zen meditation practitioners and non-meditators. The two groups matched in demographic variables, and the MAAS assessed mindfulness as a trait. Nineteen Zen meditators

scored significantly higher on the MAAS than the non-meditators (Brown & Ryan, 2003). They also found that the more year's meditators practiced, the higher the mindfulness scores, illustrating a positive correlation between Mindful awareness and mindful practice. Brown and Ryan (2003) established criterion validity by comparing MAAS scores with scores from well-validated surveys related to self-esteem, anxiety, depression, and life satisfaction.

Brown and Ryan (2003) found that the MAAS correlated in the expected manner to neuroticism, which has been consistently related to lower psychological well-being in past research, depression, anxiety, and pleasant and unpleasant tone. Participants that scored higher on self-esteem also scored higher on the MAAS, and self-actualization scores were also associated with higher mindfulness scores. In relation to physical well-being, participants that reported less health visits also scored higher on the MAAS. However, Hopkins Symptom Checklist Somatization scale of physical health was inversely related to the MAAS. Is contribute this to the somatization affect. However, this study illustrated that mindfulness as defined by awareness and measured by the MAAS has connections to increased well-being.

The links between well-being and mindfulness encouraged more research and practice for mindfulness to be used to promote wellness. Shapiro et al. (2007) used the MAAS scale with 54 master's level counseling students. The mindfulness intervention group participated in an eight-week MBSR class and the control group participated in a research methods and psychological theory class. The intervention group and control group filled out pre-and posttest MAAS scales. The intervention group reported significant declines in stress, negative affect, rumination, and anxiety. They also experienced increases in positive affect and self-compassion. The study had a small sample size and mostly self-identified as Caucasian. However, both between and within

50

group comparisons indicated that the mindfulness intervention promoted greater sense of awareness (Shapiro et al., 2007). This study illustrates that mindfulness promotes present moment awareness, which increases wellness (Lenz et al., 2012).

Mindfulness and Wellness

Mindfulness enhances wellness by increasing the quality of moment-to-moment experiences. Mindfulness encourages openness, curiosity, and acceptance of the present moment, without avoiding or suppressing emotions (Salzberg, 2011). Therefore, emotions are seen as less threatening and moments are no longer loaded with emotion or judgment, but accepted as a necessary part of being human (Salzberg, 2011). Kabat-Zinn (1990), stated "the very first and most important step in breaking free from a lifetime of stress reactivity is to be mindful of what is actually happening while it is happening" (p. 264). Thus, the higher awareness of the moment influences wellness.

Mindfulness connects with higher levels of self-esteem (Rasmussen & Pidgeon, 2011; Pepping, O'Donovan, & Davis, 2013), empathy (Block-Lerner et al., 2007; Dekeyser, Raes, Leijssen, Leysen, & Dewulf, 2008; Greason & Cashwell, 2009; Raab, 2014; Shapiro et al., 2007), positive affect (Waters et al., 2009), psychological functioning (Cho, Heiby, McCracken, Lee, & Moon, 2010), emotional regulation (Feldman, Hayes, Kumar, Greeson, & Laurenceau, 2007), and an overall sense of well-being (Sauer, Walach, & Kohls, 2011). Baer et al. (2006) suggested that mindful individuals demonstrated greater emotional regulation because of increased awareness and acceptance of emotions. The ability to regulate emotions is positively correlated with long-term emotional well-being (Greeson, 2009). Mindfulness relates to the Indivisible Self Model of wellness by helping increase awareness of physical (physical self),

emotional and mental (creative self), attitudinal (coping self), and interpersonal processes (social self) (Roach & Young, 2007; Wolf et al., 2014). Specifically, mindful meditation can be used in an intervention to combat clinical issues such as stress, depression, and anxiety by increasing awareness.

Mindfulness has found a home for clinical application in the counseling field, with numerous links to well-being and wellness. Specifically, McGarrigle and Walsh (2011) explored stress, awareness, and self-car in human service workers. They used the Perceived Stress Scale (PSS; Cohen, Kamarck, & Mermelstein, 1994) and the MAAS to explore eight-weeks of contemplative practice with 12 human service workers. Paired t-tests suggested that mindfulness significantly decreased stress and increased awareness. Then, researchers used thematic analysis to investigate same 12 human service workers' journals and focus groups. They found that time, permission, and place were necessary considerations for continued practice. McGarrigle & Walsh (2011) found that awareness of stress and understanding stress was necessary in order to begin self-care and the foundation for wellness. This illustrated the need for specific strategies to implement wellness.

Other studies explored how mindful meditation impacts depression. Ramel, Goldin, Carmona, and McQuaid (2004) explored mindfulness meditation and its effects on depression and cognitive processing. The researchers assessed 23 participants before and after an eight-week MBSR program. Participants completed an extensive battery of questionnaires. While 22% of participants reported a change in their psychotropic medication or psychotherapy treatment between the two assessments, these changes were not found to be significant. They found that participants in the MBSR program had significantly less rumination compared to initial scores

and to the control group. Reductions in ruminative tendencies were found across three methods of analysis: within subject repeated measures ANOVA, multiple regression, and between-subject analyses. Even after controlling for intake levels of rumination as well as changes in regression, analysis illustrated that the more mindfulness meditation practiced, the less rumination was reported in posttest. Ramel et al. (2004) found that participants in the eight-week MBSR training had significantly less reflective rumination compared to initial rumination scores, and the control group which matched age, gender, and initial depressive symptoms. However, the small non-random sample restricts generalizability and statistical power. The significant changes in rumination relate to coping and emotional regulation; which is necessary to maintain wellness.

Depression and anxiety were also explored by Hofman, Sawyer, Witt, and Oh (2010). They completed a meta-analysis of 29 studies to support the efficiency of mindfulness-based therapy for reducing anxiety and depression. In these studies, MBSR and mindfulness-based cognitive therapy created the majority of the analysis. Clinical populations had larger pre- and post-test effect sizes than the nonclinical population, which had moderate effect sizes. Nineteen studies detected mindfulness interventions effectiveness for long-term follow-ups on depression and anxiety symptoms. Hofman et al. (2010) concluded that mindfulness-based therapy can be used effectively with clinical populations as it can alter cognitive and affective process underlying clinical issues and promoting wellness. Is found further evidence to support that open awareness is valuable to changing behaviors to be more consistent with needs– increasing wellness and coping (Coping Self). Healthcare professionals use mindfulness, mindfulness practices, and mindful interventions to increase wellness in clients, but healthcare professionals can also use mindfulness to prevent impairment for their own work.

Shapiro, Astin, Bishop, and Cordove (2005) explored quality of life and stress reduction in healthcare professionals. They used a randomized controlled pilot study with professionals such as: physicians, nurses, social workers, physical therapists, and psychologists. A group of 38 health care professionals were divided randomly into the MBSR group (n=18) or the control group (n=20). Is found the eight-week MBSR intervention was effective for increasing quality of life and reducing stress in healthcare professionals, by increasing awareness (Shapiro et al., 2005). A limitation was a small sample size, and of the 18 participants in the randomized mindfulness group, eight did not complete the intervention. Two of the individuals in the control group did not complete the study. However, this study did highlight mindfulness as a self-care strategy for health professionals.

The link between mindfulness and well-being is not direct as the definition of wellness and well-being is very diverse. However, key factors such as emotional regulation, physical health, psychological health, and cognitive ability are related to mindfulness; specifically, the increase in moment-to-moment awareness. Counselors are mental health professionals working in stress-inducing environments and mindfulness is one way to promote counselor wellness. The next section will outline Studies on mindfulness and counselor wellness.

Mindfulness to Promote Counselor Wellness

When counselors are well and have higher present moment awareness, they function more competently and model effective behaviors (Witmer & Young, 1996). Testa and Sangganjanavanich (2016) examined 380 counseling interns' levels of burnout, emotional intelligence, and mindfulness. All participants were from CACREP accredited programs and between the ages of 22-68. Participants took a variety of surveys related to the constructs being

measured. Testa and Sangganjanavanich (2016) found that as mindfulness increased, burnout decreased. As mindfulness and emotional intelligence scores increased, there were significant decreases in burnout. Of the Five-Facet Mindfulness Questionnaire, the acting with awareness facet of mindfulness was significantly negatively correlated with exhaustion and depersonalization subscales on the burnout survey. This study suggests that present moment awareness is helpful for counseling interns when tending to wellness.

Christopher et al. (2011) explored the long-term impact of mindfulness practices with master's level counseling students. In this qualitative study, researchers interviewed 16 former students whom had been practicing counseling for four years after matriculation. Is conducted semi-structured interviews and used content analysis to identify themes. All participants learned mindfulness in their master's program and found that it influenced their awareness and understanding of self-care. Specifically, nine participants experienced difficult emotions during their mindfulness practice and reported going to counseling, thus illustrating that mindfulness increases counselors' ability to maintain awareness of their own wellness and needs. Limitations for this study included that participants volunteered to participate and could be subject to self-selection bias. All participants were Caucasian and came from a rural Western university. Most participants were female. However, results were consistent with similar qualitative studies citing increased awareness and well-being with the practice of mindfulness with other populations (Chrisman, Christopher, & Lichtenstein, 2009; Christopher et al., 2006; Schure et al., 2008).

Newsome, Christopher, Dahlen, and Christopher (2006) found similar results when they explored the experiences of a course developed to provide students with self-care opportunities and mindfulness practices to reduce burnout. Eleven CITs were divided into focus groups.

Participants reported changes in stress levels and enhanced clinical training. However, the qualitative results of this study were meant to be not generalizable, instead it is important to gather information on the phenonom and it is necessary to note that mindfulness was not the only practice taught in the course. The students stated that time, opportunity, and space to promote wellness was necessary for CITs to explore wellness, and that mindfulness is one option to help promote ethical practice by maintaining wellness (Newsome et al., 2006).

Mindfulness appears to impact possible facets of wellness from the Indivisible Self Model of Wellness and in other known impactors on well-being. Mindfulness and mindfulness practices are ways to promote wellness. Counseling programs can use mindfulness to build on the tradition of wellness in counseling and encourage wellness in future counselors. Specifically, CEs can use wellness promotion strategies such as mindfulness to prepare future counselors. However, there is little information on how mindfulness impacts CEs in their duties as counselors, supervisors, teachers, and academics.

Mindfulness for CEs

CEs have a responsibility to promote wellness for CITs (CACREP, 2016). Few studies have explored CEs use of mindfulness, and impacts on teaching. Jennings, Snowberg, Coccia, and Greenberg (2011) explored mindful experiences of K-12 teachers. Jennings et al. (2011) developed the Cultivating Awareness and Resilience in Education (CARE) program, to combat stress and increase teaching performance. This quantitative pilot study measured the pretest and posttest experiences of 74 school teachers. Eighty-eight percent of the participants cited that the program should be provided for all teachers. Researchers found that teachers scored higher on scales testing well-being, efficacy, and mindfulness, and lower on burnout/time-pressure scales

after the program. While responses from teachers highlighted success from the mindfulness program, there was not a control group as this study was quasi-experimental with no follow up or longitudinal investigation.

Dougherty (2016) explored the lived experiences of 10 CEs that do daily mindfulness practices in the classroom. I recorded telephone interview sessions and thematic analysis to find eight themes: (1) mindfulness practices, (2) contemplative practices and the experience of educators, (3) interconnectivity, (4) treatment outcomes, (5) therapeutic presence, relational empathy, (6) awareness and acceptance, (7) self-care, and (8) critiques. Noting that CEs with daily mindfulness classroom practice explored their own awareness and acceptance of their "physical, emotional, spiritual, and interpersonal experiences as essential to their mindfulness practice" (Dougherty, 2016, p. 139). They also cited mindfulness in the classroom to promote self-care and wellness for CEs and their students. However, there were no measures of wellness specifically to illustrate the students' experiences in the classroom. Several participants highlighted that students reported that mindfulness supported their wellness, which connects with other research (Christopher et al. 2011; Greason & Cashwell, 2009; Grossenbacher & Parkin, 2006; Rothaupt & Morgan, 2007). Dougherty (2016) also suggested that if CEs want to use mindfulness to promote wellness in their classroom, they must also cultivate a mindfulness practice for themselves.

Section Summary

Mindfulness research continues to grow in research and exploration in clinical counseling work, and in self-care for those working the human services. Mindfulness and mindfulness practices are ways to promote wellness. Mindfulness relates to facets of wellness from the

Indivisible Self Model of Wellness and in other known impactors on well-being. Counseling programs can use mindfulness to build on the tradition of wellness in counseling and encourage wellness in future counselors. However, there is little research exploring the mindfulness of CEs, and the impact on clinical and academic responsibilities.

Summary of the Literature

Counselor Educators have a responsibility to promote wellness in their CITs; however, there is little information exploring the connection between CE's wellness and how CEs promote wellness (Myers et al., 2016; Wester et al., 2009). Most articles that address ways of promoting wellness are conceptual articles. According to the CACREP (2016) standards, CEs must work to educate students on wellness and overall well-being through promoting self-care strategies and understanding risk factors for impairment to evaluate and promote personal growth for CITs. Counselors who are well attend to clients' wellness and enhance the therapeutic relationship (Lambert & Lawson, 2011). Clinicians are ethically required to work to prevent impairment and harm to clients, and CITs must abide by the same requirements (ACA, 2015). Therefore, CEs working as educators, mentors, supervisors, and gatekeepers have a responsibility to help students understand wellness as it contributes to their role as counselors (Wester et al., 2009). CEs take multiple roles in laying the foundation for counselor development and wellness strategies; however, a research gap exists exploring the wellness of CEs, mindfulness, and the impact on their multiple roles.

This chapter provided a review of the literature pertaining to CEs, wellness and its development in the counseling profession, measures of wellness, and mindfulness. The purpose of this study is to explore the relationship between levels of wellness, levels of mindfulness, and

how wellness is taught by counselor educators (CEs). Specifically, this quantitative study will focus on wellness and mindfulness in CEs and how this impacts promotion of CITs' wellness in counselor training programs. The next chapter will address the methodology of the current study.

Chapter 3: Method

This chapter provides a detailed description of the methodology that was used to complete this study. The initial section restates the research questions with hypothesis, followed by participant selection, instrumentation including the development of a survey to measure wellness promotion, and procedure. The final section includes data analysis for each research question.

Research Questions and Hypothesis

1. *What are the average levels of wellness, mindful present moment awareness, and wellness promotion behaviors in CEs? Are there differences by demographic variables (i.e., institution type, tenure track, teaching format, age, years of experience, or mindfulness practices)*

   H11: Based on past research, I hypothesize that CEs will have higher scores on wellness (5-FWEL) and mindfulness (MAAS) as compared to the general population. Also, based on previous work with the 5F-WEL, wellness promotion behaviors (WPS) will show lower levels in the essential self questions specifically based in spirituality. The 5F-WEL and the MAAS have normative data for the population which will be used in the analysis. I also hypothesizes that demographic variables will correlate with the other constructs. Specifically, participants with more years of CE experience will have higher levels of wellness, mindful present moment awareness, and wellness promotion behaviors.

2. *What strategies do CEs use to promote wellness in their students?*

   H12: I hypothesizes that CEs will use more wellness promotion behaviors categorized in the creative self as it can be easily infused into coursework (Yager & Tovar-Blank, 2007;

Wolf et al., 2012).

3. *Are wellness promotion behaviors associated with level of wellness and mindful present moment awareness?*

   H13: I hypothesize that higher levels of wellness (5F-WEL) and mindful present moment awareness (MAAS) will positively correlate with higher wellness promotion behaviors (WPS).

4. *Do levels of personal wellness, mindful present moment awareness, and demographic variables (gender, CACREP-accreditation) predict level of wellness promotion in CITs?*

   H14: I hypothesize that higher levels of wellness (5F-WEL) and mindful present moment awareness (MAAS) will be predictive of higher wellness promotion behaviors (WPS). I also predict that levels of wellness (5F-WEL) and mindful present moment awareness (MAAS) will predict higher levels in subscale wellness promotion behaviors. I also hypothesizes that gender and CACREP-accreditation will be significant factors in predicting levels of wellness promotion.

Participants

Potential participants for the study included Counselor Educators (CEs), specifically those with degrees in Counselor Education. Participants working as CEs in both CACREP and non-CACREP accredited programs were invited to participate. Programs could be seeking accreditation, or non-accredited based on factors of timing, standards, and program goals; however, if their program was teaching mental health counseling, school counseling, marriage and family counseling, rehabilitation counseling, community counseling, and/or professional counseling and/or abiding by the ACA code of ethics, they were considered as acceptable

participants for the study. CEs in these environments were necessary to answer the research questions as they are connected to CIT development. Participants needed to have at least one year of faculty experience working at a University; specific length of work experience as faculty was gathered in demographic data.

Participants were invited to take the surveys through e-mail, CESNET-L (a professional counseling listserv), NFIN-L (a new faculty list serve), the Chi Sigma Iota International Honors Society listserv, the regional ACES listservs, and word of mouth recruiting methods. The total number of eligible participants who fully competed the surveys were 118 (N=118). A power analysis with a sample of 118 had an alpha of .05 and moderate effect size (0.2) for a linear regression analysis. There were seven additional participants who completed all but the demographic information on the survey (n= 125), and their responses were used to expand on the understanding of the WPS for exploratory factor analysis (EFA). There were 20 additional participants that only completed up to 34% of the survey and were not included in data analysis. Response rate cannot be determined because the sampling method relied on referral from initial contact people and listservs.

Ages of participants ranged from 27-72 years old with an average of 48 years old. Of the 118 participants, 74.6% identified as women, 24.6% identified as men, and one participant marked prefer not to answer. The predominate race/ethnicity of participants was Caucasian at 78.6%, followed by African American at 9.3%, Asian American/Pacific Islander at 2.6%, and Hispanic/Latin at 2.6%. One participant was Native American, one participant marked both African American and Caucasian and one participant marked Native American and Caucasian. Participants were from mainly CACREP-accredited Universities at 76.3%, 12.7% in progress,

and 11% not accredited.

Inclusion and Exclusion Criteria

As previously stated, the participants of this study were Counselor Educators or those working in counseling programs (specifically, mental health counseling, school counseling, marriage and family counseling, rehabilitation counseling, community counseling, and/or professional counseling and/or abiding by the ACA code of ethics) with one year of experience. Therefore, the participant must have a PhD or EdDs in Counselor Education (or closely related field) and must teach in the above approved counseling programs. The only exclusion criteria will be participants that do not train future counselors and/or have less than one year of teaching experience.

<div align="center">

Instrumentation

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This study used three inventories in addition to demographic questions. After participants accept the informed consent on the first page of the survey, they saw a screening question asking how long they have worked as a Counselor Educator. The next section will be the Five Factor Wellness Inventory (5F-WEL), followed by the Mindful Attention Awareness Scale (MAAS), then Wellness Promotion Survey (WPS), and followed by brief demographic questions. The 5F-WEL is most effective when put first in a battery of surveys (Myers & Sweeney, 2014). I researched, created, and piloted the WPS.

Five Factor Wellness Inventory (5F-WEL)

The 5F-WEL for Adults (5F-WEL-A) was developed through structural equation modeling analysis from its predecessor inventory, the Wellness Evaluation of Lifestyle (WEL; Hattie et al., 2004; Myers et al., 1998). The 5F-WEL was created from the restricted factor

63

pattern identified from the initial 132 items on the WEL; therefore, by loading items only on their respected scales, which created five clear second-order factors for a unifying scale of wellness. The goodness of fit index (RMSEA) was .042 (chi square=8261, df=2533) indicating acceptable fit of model to data (Myers & Sweeney, 2014). Third order factors were grouped under the five second order factors: Creative Self (the third order factors of Thinking, Control, Positive Humor, Work, and Emotions), Coping Self (Realistic Beliefs, Leisure, Stress Management and Self Worth), Social Self (Friendship and Love; the Essential Self includes Spirituality), Essential Self (Spirituality, Self-Care, Gender, and Cultural Identity), and Physical Self (Physical Self includes Exercise and Nutrition). Coefficient alpha scores for the 5F-Wel scales range from .60 to .94, representing moderate to high scale reliability (Myers et al., 2014). Exploratory and confirmatory factory analyses support the development of each of the scales (Myers, 2004; Myers et al., 2014). The Cronbach's alpha for the current study was .93 indicating high internal consistency for the 5F-WEL's reliability; the Cronbach's alpha for each subscale was: coping .86, creative .86, essential .73, social .57, and physical .82.

Each item on the 5F-WEL is a statement in which participants respond on a four point Likert scale (strongly agree to strongly disagree). Items include statements such as, "I am satisfied with how I cope with stress" or "My cultural background enhances my quality of life." The final edition of the 5F-WEL has 74 items and takes 10-20 minutes to complete. Each scale is converted to a score that ranges from 20-100 by dividing by the mean score for each scale by the number of items, and multiplying by 25 (Hattie et al., 2004). Each of the five factors receive a score in addition to an overall wellness score. In a sample of 4,494, normative information for the 5F-WEL includes the overall scores- M = 71.63, SD = 15.87 and subscales (Table 3.1).

Table 3.1

5F-WEL Normative Data

Scales	Mean	Standard Deviation
Total Wellness	71.63	15.87
Creative Self	73.18	16.15
Coping Self	68.73	12.73
Social Self	77.35	23.56
Essential Self	73.38	20.07
Physical Self	66.58	18.13

Mindful Attention Awareness Scale (MAAS)

The MAAS is a 15-item scale designed to measure mindfulness, specifically a state of mind in which attention is informed by awareness of only what is occurring at the present moment without judgement or influence from cognitive functions. Therefore, it focuses on thoughts that are not filtered through cognitive appraisal, evaluation, memories, beliefs, biases, and judgement (Brown & Ryan, 2003). The MAAS has strong psychometric properties with undergraduate, community, and nationally sampled adults, and cancer populations (Brown & Ryan, 2003; Carlson & Brown, 2005). The MAAS was tested in relation to well-being indicators. Brown and Ryan (2003) compared with measures to find negative correlation to expected measures of self-esteem, optimism, anxiety, pleasant affective, life satisfaction, and self-actualization. Researchers also found positive correlations to neuroticism and depressive symptoms. They also explored physical well-being through the Hopkins Symptom Checklist Somatization scale (Derogatis, Lipman, Rickels, Uhlenhuth, & Covi, 1974), and a self-report of medical health visit frequency over the past 21 days. In relation to physical well-being, participants that reported less health visits also scored higher on the MAAS. However, Hopkins

Symptom Checklist Somatization scale of physical health was inversely related to the MAAS, which they contributed to the somatization affect. However, this study illustrated that mindfulness as defined by awareness and measured by the MAAS has connections to increased well-being. Internal consistency level ranged from .80 to .90 (Cronbach's alpha), and the MAAS demonstrated high test-retest reliability, discriminate, convergent, known-groups, and criterion validity (Brown & Ryan, 2003). The MAAS takes five minutes or less to complete. Items are phrased as statements and participants respond to each with a six point Likert scale. The MAAS include items such as, "I find it difficult to stay focused on what is happening in the present moment" and "I rush through activities without being really attentive to them." The normative information for community adults is a M = 4.20, SD = .69, in four independent samples of 436. The normative information for 14 independent samples of college students (N = 2,277) with a M = 3.83, SD = .70 (Brown & Ryan, 2003; Carlson & Brown, 2005). The Cronbach's alpha for the current study was .911 indicating high internal consistency for the reliability of the MAAS.

Wellness Promotion Survey (WPS)

After a thorough literature review, no surveys that examined how CEs promote wellness in their students could be located; therefore, I set out to create a survey to serve this purpose. The development of the Wellness Promotion Survey (WPS) was divided into five steps: 1) identifying and defining theory and constructs through literature review, 2) selecting the survey format, 3) creating a pool of potential items related to constructs, 4) submitting to panel of expert reviews for content validity, and 5) pilot testing for feedback and exploratory factor analysis (Colton & Covert, 2007).

The first step of survey creation was an extensive review of the literature as it related to

66

the scope of this survey. During the review of literature, direct relations were found between the 5F-WEL, the foundational pieces of the counseling profession, and the purpose of the survey. The 5F-WEL and its constructs were used as guides in the creation of the new survey. The major purpose of WPS is to measure the behaviors of CEs; specifically, how CEs promote wellness in their students.

The survey is a self-reported quantitative measure grounded in the Indivisible Self Model of Wellness (IS-WEL). A literature review is essential to understanding how the survey can be meaningful and questions can be well understood (Fowler, 2014). The IS-WEL divides wellness into five factors of wellness: Creative Self, Coping Self, Essential Self, Social Self, and Physical Self (Myers et al., 2004). The 5F-WEL assessment measures these complex pieces to identify life tasks for healthy functioning and practice (Hattie et al., 2004). The IS-WEL is an empirically grounded model of understanding wellness formed in the values of the counseling profession (Myers et al., 2005). Therefore, the IS-WEL is an excellent match for the theoretical grounding of the new survey.

The initial pool of survey items was guided by careful review of existing literature on wellness assessments and conceptual articles on how CEs could promote wellness in their students. Each item was then grouped into one of the five factors of wellness outlined by the 5F-WEL, and then intentionally written to reflect a behavior CEs may do to promote that factor. These factors contribute to an overall wellness understanding, and therefore, each factor needs representative items. Based on the information gathered from the literature review and review of wellness assessments, a pool of 202 potential stems were identified and created, each with a connection to one of the five factors. Crocker and Algina's (1986) guidelines for writing items

were followed; specifically, using present tense language, limiting double negatives, limiting indefinite qualifiers (e.g., merely, seldom), considering the reading level of participants, asking about only one construct at a time (i.e. not double barreled questions), and when possible using no more than 20 words in a statement. From these initial items grouped into each category, statements were condensed when repeated and rephrased to a statement of action by CEs. Twelve items were designed to survey Coping Self, twelve items for Creative Self, 19 items for Essential Self, nine for Social Self, and eight for Physical Self; totaling 60 items in the initial draft. Two open-ended questions were also created, "Of all these different behaviors what do you see as the most important and why?" And "Are there any other wellness promotion strategies you use in the classroom not listed above? Please explain."

The survey was formatted to solicit how often CEs engaged in wellness promoting behaviors. Qualitative questions then gauge how CEs viewed the importance of the wellness promoting behaviors, and if there are any wellness promotion behaviors they use that are not listed. Since the primary focus of the survey is to identify the behaviors promoted from each of the five wellness constructs, a Likert-type scale was created. CEs self-report how often on a Likert scale, "*1-Never, 2- Somewhat Never, 3- Sometimes, 4- Fairly Often, 5-Very Often, 6-Always*" they exhibit specific wellness promotion behaviors. The Likert scale is preferred over dichotomous measures when a more nuanced answer is reflective of actual behaviors; therefore, respondents are not forced to choose one or the other (Clark & Watson, 1995). Each question lists categories from negative or low to positive or high as this increases validity of psychometric properties (Colton & Covert, 2007).

Content validity is the degree to which a specific measure reflects a particular intended

construct. Content validity will be assessed through expert reviews. Three expert reviewers were be invited to provide feedback on the content of the items. The pool of potential reviewers included experts in counselor wellness, counselor education, and survey development. Reviewers were chosen because they are considered leaders in the field researching counselor wellness and work as counselor educators. Each reviewer received an invitation to evaluate the survey (Appendix A).   Changes were made to the statements and responses based on the information provided by the expert reviewers. Reviewers were asked to consider: a. Does each item clearly relate to a wellness subscale? b. Is each item correctly connected to its wellness subscale? c. Are any of the items unclear or confusing? d. Does the survey seem to be missing any important components of wellness promotion behaviors? e. Do you have any other feedback regarding the WPS? In addition to these content experts, student researchers in a measurement class will also provide feedback on the survey. Of the three reviewers, two were counselor educators, contributing as experts in wellness, with master's degrees ranging from community counseling, mental health counseling, school counseling, and marital, couple, and family counseling, and doctoral degrees in the Counselor Education. The other expert reviewer has a degree in formal measurement and experience in survey development. From the initial feedback from the expert reviewers the initial 60 questions were reworded and condensed to 48 questions.

After the expert review, the 48 item WPS went to pilot testing for face validity. In this pilot, 9 counselor educators were asked to complete the WPS and respond to questions about clarity and length. These volunteers were selected via personal contacts, and their results were not used in the final dissertation study. Pilot test reviewers were asked: a. How was the clarity of the directions? b. How was the clarity of each item? c. Were any items confusing? If yes, please

list. d. How was the length of the survey? e. How long did it take you to complete the survey? f. Do you have any other feedback regarding the WPS? Feedback from the pilot test was tabulated to find which items in the second draft from expert feedback needed revision.

Demographic Questions

A demographic questionnaire was included at the end of the study. This questionnaire asked participants to indicate their age, gender identity, race/ethnicity, faculty position, tenure status, CACREP accreditation status, CACREP content areas each teaches, Association for Counselor Education and Supervision (ACES) regional membership, number of years working as a paid Counselor Educator, institution type, and teaching format. Age range was a fill in the blank option. Options for gender identity included: man, woman, transgender female, transgender male, gender variant/non-conforming, other please specify, or prefer not to answer. Ethnicity categories included: African American/Black, Native American, Asian, Caucasian/White, Pacific Islander, Biracial/Multiracial, Latinx/Hispanic, and other please specify; with the option to check all that apply. Faculty positions included: assistant professor, Associate professor, professor, lecturer, visiting faculty, emeritus faculty, and adjunct professor. Ranges for number of years working as a Counselor Educator were: 1-2, 3-4, 5-6, 7-8, 9-10, 11 or above. Modes of teaching included an option to check all that apply: online, hybrid, face-to-face. CACREP regions will include: North Atlantic Region ACES, North Central Region ACES, Rocky Mountain ACES, Southern ACES, Western ACES, not applicable. Options for CACREP specialty areas included: Addiction Counseling, Career Counseling, Clinical Mental Health Counseling, Clinical Rehabilitation Counseling, College Counseling and Student Affairs, Marriage, Couple, and Family Counseling, School Counseling, Counselor Education and

Supervision Doctoral Program. This demographic information will be helpful in better understanding the contextual environment of each participant.

There were also three questions addressing mindfulness practices. Specifically, whether they practiced mindfulness (as a yes or no question), how often, and what type. Mindfulness practice was measured by weekly practice with options that included: once a week, twice a week, three times a week, four times a week, five times a week, six times a week, seven times a week, or more than seven times a week. Types of mindfulness practice were check all that apply with a final response of, other please specify: Body scan, Movement mediation (e.g. yoga, tai chi), Breathing mediation, Open awareness meditation, Feeling meditation, Thought meditation, Walking meditation, Mindful eating. This demographic information was helpful in relation to understanding mindfulness present moment awareness and wellness practices.

Procedure

This study was a quantitative correlational study. All data was collected through Qualtrics, an online survey software system available through the University of Tennessee Knoxville. Survey distribution began after IRB approval and approval of the wellness promotion survey pilot survey. The survey included informed consent, 5F-WEL, MAAS, the wellness promotion survey, and demographic information.

Participants were invited to take the surveys through e-mail, CESNET-L (a professional counseling listserv), NFIN-L (a new faculty listserv), the Chi Sigma Iota International Honors Society listserv, the regional ACES listservs, and word of mouth recruitment. The initial recruitment statement (Appendix K) included a description of the following: inclusion criteria, description of the study, rationale for the study, anticipated time requirement, summary of

71

incentives, a link to an online consent form and questionnaire, and contact information for myself and my dissertation chair. In addition, all participants could chose to enter a drawing. There were two rounds of drawings in which participants could win a wellness workbook or a mindfulness workbook. The informed consent (Appendix L) was obtained from the participants after they clicked the "I agree, and I want to participate in a drawing" button. After participants agreed to the informed consent they were directed to the survey questions. Those that choose "I do not agree and want to participate in the drawing" or "I do not agree and do not want to participate in the drawing" were directed to a page that states, "Thank you for considering taking the survey" (Appendix M). Participants who did not agree to participate but wanted to be entered into the drawing were directed to a page that asked for their email and thanked them for considering taking the survey. Only those that agree were able to take the survey questions.

After the informed consent (Appendix L), there was a screening question as participants needed to have at least one full year of faculty experience: "Have you worked as a counselor educator for at least one year?" Participants were expected to spend at least 30-45 minutes completing the surveys. Participants had the option to skip any question they choose. Upon completion of the survey, participants were directed to a thank you page (Appendix N) and had the option to type in their email address and be entered into a drawing for a wellness or mindfulness workbook. All contact information was kept on a separate database from survey scores.

Qualtrics is a secure site to gather and store data anonymously. Qualtrics provided anonymity by assigning each participant a user code instead of using identifying information. The Qualtrics site is password protected using my UTK net-id and password; therefore, my

faculty dissertation chair and I were the only researchers with access to the data. After data was collected, the survey was closed, and I conducted statistical analysis. I downloaded the data in a .CSV Excel file and immediately transferred it to a password-protected SPSS database for analysis. Email addresses for the drawing were randomly selected twice for two drawing winners; all email address were downloaded into a password protected computer, and deleted after receiving word from drawing winners of acceptance of the prize. Should a drawing winner not accept the price another drawing was done and after prizes were distributed all email addresses were erased from Qualtrics and the computer.

The initial email request was sent in February. Two weeks after the initial email request for participants was sent, a second e-mail, which was the same e-mail invitation as the original, was posted as a reminder to potential participants. One final email request was sent after three weeks. The only change to the email was the title of the email (2nd request, 3rd request). In the two and a half month period of data collection I sent out 400+ emails a week to individual programs and faculty in approved programs to increase numbers, and encouraged others to share with eligible faculty participants. Within two and a half months 145 participants had attempted the surveys, 125 participants had completed the surveys, with 118 completed surveys and demographic information.

Data Analysis

Pilot Testing

The WPS survey is designed specifically for the CEs − the population of interest. The survey was pilot tested among Counselor Educators from three different universities (University of Tennessee Knoxville, University of Wyoming, and Lipscomb University). Each program is a

CACREP-accredited university that taught mental health counseling, school counseling, community counseling, and/or marriage and family counseling and abides by the ACA code of ethics. Using CEs from counseling programs ensured that the pilot test population was similar to the population targeted for the surveys administration. Participants were contacted directly and asked to complete the survey and a short evaluation of the survey (Appendix E). A total of 10 participants completed the pilot. The pilot survey also included a demographic section, so participants could give feedback based on their experience in the evaluation form (Appendix E), and contribute to the procedural understanding of the survey.

The survey was sent electronically to the CEs chosen from each of the three Universities [n=10]. Electronic administration of the pilot survey was chosen because the actual survey was administered in the same format. The participants were sent an email, via their University email, to verify their willingness to participate in the pilot survey (Appendix B). Once they had responded to the initial email a second email was sent to their University email that contained the instructions and a hyperlink to the online survey (Appendix C). After the surveys were completed another email was sent to thank each CE for participation in the pilot survey and give participants the opportunity to access the survey results by replying to the email (Appendix F). If one of the CEs did not wish to participate in the pilot testing of the survey then another CEs from that same University was asked to participate.

Pilot data analysis. The data was managed using the Statistical Package for the Social Sciences software (SPSS). Since the survey was distributed online, the data was automatically entered into the SPSS software for analysis. The pilot group also gave valuable feedback on time to complete, clarity of questions, and clarity of instructions. I ran frequencies on every question

and looked for mistakes in coding. After this, I looked for missing data, outliers, and checked for normality. I reviewed the clarity of responses and considered if any wording revisions are needed. I also conducted a Cronbach's alpha to measure internal consistency for scale reliability (Colton & Covert, 2007).

The initial feedback on the WPS demonstrated the survey took five to ten minutes to complete. Overall, respondents rated the clarity of items and instructions highly, illustrating no need to reword questions or instructions. In a sample size of 10 the Cronbach's alpha for each the 48 items was .90 and each of the five factors scored highly: creative self 12 items α= .79, coping self 12 items α= .85, essential self 12 items α= .87, social self six items α= .82, and physical self six items α= .43.

There are two qualitative items on the survey to contribute an understanding of wellness promotion behaviors. The first item asks participants to explain their perceptions of the most important wellness promotion behaviors and why. The second asks participants to add any missing wellness promotion strategies which they have engaged (Saldaña, 2011). A qualitative content analysis was used to explore themes in connection to wellness promotion behaviors and possibly edit survey Likert scale questions (Robson & McCartan, 2016). I first made a plan for how to analyze the data; specifically, by each question. The content analysis coded responses into the constructs of the five factors wellness model as themes (creative, coping, essential, physical and social self). Each response was coded into categories by content and then connected to themes (Neuendorf, 2016).

Themes that emerged from the qualitative feedback aligned with the essential self, coping self, and creative self. Specific examples of essential self includes: "Relaxation and re-centering

as well as creative work" connects to the creative self theme with direct connection to self-care. Participants also cited "self-awareness" as necessary for wellness, aligning with essential self components of identity and self-care. Participants also demonstrated coping self through work that illustrated self-worth and realistic beliefs; "self-reflection. Through this practice much of the other wellness strengths and deficiencies are identified."

Initially, the qualitative feedback from the pilot included no new updates to the original 48 questions. The only other theme that came up was creating a *Wellness plan* in class; however, wellness plan is not specifically related to one of the five factors as it spans all five. The *Wellness plan* was specifically connected to "holistic wellness" in the classroom, and could not be connected to the initial five factor themes. However, in the larger sample "holistic wellness" came emerged as a new category as well, illustrating the addition of possible questions that addresses multiple factors or holistic wellness on the WPS. These will be addressed with more depth in Chapter 4.

Main Study Data Analysis

Research Question 1

What are the average levels of wellness, mindful present moment awareness, and wellness promotion behaviors in CEs? Are there differences by demographic variables (i.e., institution type, tenure track, teaching format, age, years of experience, or mindfulness practices)?

I conducted all descriptive and inferential statistics using SPSS (RQ1), and tested each hypothesis in accordance with best practices in statistical procedures (Cohen, Cohen, West, & Aiken, 2013).

Research Question 2

What strategies do CEs use to promote wellness behaviors? I took the initial results of the WPS to report scoring on the five factors measured in the survey. For this question responses to the behavior section of the WPS were evaluated specifically looking at the frequency of behaviors for each of the five subscales. Higher means on each subscale means more wellness promotion behaviors in that subscale.

Research Question 3

Are wellness promotion behaviors associated with level of wellness and mindful present moment awareness? I conducted a Pearson correlational matrix. The Pearson correlational matrix was used to assess the strength and direction of relationship between wellness overall scores, wellness factors mindfulness scores, and wellness promotion behaviors factors. The correlational matrix shows correlational coefficients between the variables, with each random variable correlated with each other to find pairs with the highest correlation (Cohen et al., 2013). I conducted a t-test and ANOVAs to describe differences by gender, ethnicity, and years working as a CE.

Research Question 4

Do level of personal wellness, mindful present moment awareness, and demographic variables (gender, CACREP-accreditation) predict level of wellness promotion behaviors in CEs? I conducted a multiple regression to assess if the predictor variables predict the criterion variable. RQ4 requires a multiple regression, since there is no logical basis for considering any variable priority in terms of hypothetical causal structure (Cohen et al., 2013). The factors of the WPS were the criterion variables. In this study, the predictor variables included wellness as

measured by the factors of the 5F-WEL and mindfulness as measured by the MAAS. Before completing the data analysis, I examined whether specific assumptions were met—normality, linearity, homoscedasticity and absence of multicollinearity. Normality assumes an equal distribution of scores on each measure.

Summary

The purpose of this chapter was to describe the research methodology of the present study and the survey pilot study. In summary, the study was a quantitative study to identify how CEs promote wellness by measuring wellness behaviors (WPS) and the relationships and predictability of CE's wellness levels (5F-WEL), mindfulness levels (MAAS), and wellness promotion behaviors (WPS). Chapter 4 will include the results of the data analysis of the present study. Chapter 5 will include a discussion of the implications for practice, limitation, and direction for future research.

Chapter 4: Results

I conducted the current study to investigate the relationship between Counselor Educators (CEs) wellness levels, mindful present moment awareness, and wellness promotion behaviors. Before data analysis, all data was cleaned. After creating an analysis plan and codebook, I coded variables and searched for any reversed coded variables in SPSS. Four questions on the 5F-WEL were reverse coded. I then ran initial frequencies to look for any initial errors and coding mistakes. After the initial data was explored I ran descriptive statistics and double checked previous cleaning. I then searched for outliers (e.g. scores greater than three standard deviations from the mean). There were few outliers and they were Winsorized by replacing the outliers with scores three standard deviations from the mean (Colton & Covert, 2007). I then assessed normality of each variable by evaluating skewness and kurtosis. Then I reviewed the descriptive statistics to find any missing data finding. There were no patterns in the missing data, but there was missing demographic information. Missing cases were then excluded from analysis, changing the number of participants from 125 to 118 that finished the surveys and demographic information. I then double checked the cell sizes for each variable. Each scale and subscale was within normal ranges for skewness and kurtosis (Kim, 2013). I then ran a final set of descriptive statistics and frequencies. For the final step I tested the assumptions of each statistical test (e.g. homoscedasticity and multicollinearity). Data was found to be normally distributed, with normal homoscedasticity, and no multicollinearity (VIF below 3 for all scales and subscales) (Hair, Anderson, Tatham, & Black, 1995). Assumptions for each statistical test will be addressed with each research question.

Participant Demographic Variables

A total of 118 eligible participants fully completed the surveys and demographic

variables. Ages of participants ranges from 27-72 years old with an average of 48 years old. Of

the 118 participants, 74.6% identified as women, 24.6% identified as men, and one participant

marked prefer not to answer. The predominate race/ethnicity of participants was Caucasian at

78.6%, followed by African American at 9.3%, Asian American/Pacific Islander at 2.6%, and

Hispanic/Latin at 2.6%. One participant was Native American, one participant marked both

African American and Caucasian and one participant marked Native American and Caucasian.

Participants were from mainly CACREP-accredited universities at 76.3%, 12.7% in progress,

and 11% not accredited. Table 4.1 illustrates participants' experiences as counselor educators.

I also explored participants' mindfulness practice. Of the participants, 89 (69.5%)

actively engaged in mindfulness practice, 25 (19.5%) did not, and 10.9% of participants did not

answer. Of the 89 participants that practiced mindfulness, 16.4% practiced three times a week,

13.3% practiced once a week, 9.4% practiced more than seven times a week, 8.6% practiced five

times a week, 7% practiced twice a week, another 7% practiced seven times a week, and 6.3%

practiced four times a week. The 89 participants practiced multiple types of mindfulness, the

most popular was breathing meditation (22.8%), followed by walking meditation (13%), then

thought meditation and body scan (11.7%), open awareness (9.9%), and the final was mindful

eating (8.6%). There was not enough variation in the sample by race, gender, CACREP

accreditation, ACES region, position, tenure status, specialization, mindfulness practice (yes/no),

or specific mindfulness intervention to meaningfully explore differences.

Table 4.1

Counselor Educator Experience Demographics

Experience	Percentages	Sample
Years		118
1-2 years	17.7%	
3-4 years	17.8%	
5-6 years	8.5%	
7-8 years	13.6%	
9-10 years	6.8%	
11 or more years	35%	
Position		118
Assistant Professor	48.3%	
Associate Professor	17.8%	
Full Professor	24.6%	
Lecturers	2.5%	
Visiting Professor	.8%	
Adjunct	5.1%	
Emeritus Professor	.8%	
Tenure		118
Tenured	63%	
On Tenure track	26.3%	
No Tenure system	21.2%	
Not on Tenure track	16.1%	
Teaching Format		118
Face-to-face	66.1%	
Hybrid/Online	33.9%	
Education Institution		118
Public	62.7%	
Private	37.3%	
ACES Region		118
SACES	45.8%	
NCACES	19.5%	
NARACES	19.1%	
WACES	4.2%	
No Affiliation	4.2%	
Specialization		118
Addiction	22	
Career	29	
Clinical Mental Health	6	
College	3	
School	20	
Counselor Education	14	
Not specified	24	

For each of the unused demographic information, samples had more than 60% of the variance dedicated to one factor (Colton & Covert, 2007). Differences by age and institution type (public/private) were considered, as well as years working as a CE– divided into 1-4 years, 5-10 years, and 11 or more to show enough variation and teaching format divided into face-to-face and online/hybrid.

The following paragraphs will attempt to answer the research questions and relate demographic information with the three scales (5F-WEL, MAAS, WPS) and subscales. The WPS was created to answer all the research questions; however, because of the exploratory nature of the WPS, research question 2 will be explored first to outline the exploratory factor analysis. The exploratory factor analysis is essential to answering the rest of the research questions; therefore the results section will start with research question 2.

Research Question 2: What strategies do CEs use to promote wellness behaviors?

The Wellness Promotion Survey (WPS) was used to measure CEs wellness promotion behaviors. The scores on the scale range from 1 *Never* to 6 *Always* with higher scores representing higher levels of wellness promotion behaviors. Wellness promotion behaviors were developed from the IS-WEL model (Myers et al., 2014). Therefore, I hypothesized that each of the items would load into five factors that paralleled the IS-WEL model – coping self (encompassing leisure, stress management, self-worth, and realistic beliefs), creative self (encompassing thinking, emotions, control, work, and positive humor), essential self (encompassing spirituality, gender identity, cultural identity, and self-care), social self (encompassing friendship and love), and physical self (encompassing exercise and nutrition). Questions were initially developed to measure how the five factors of wellness are demonstrated

in wellness promotion behaviors. Ideally, each question should load on the hypothesized factor, creating five factors in all.

I completed an exploratory factor analysis (EFA) to identify the underlying relationship between measured variables. I identified how questions loaded in relation to the five factors associated with the 5F-WEL (creative self, coping self, physical self, social self, and essential self). The sample of 125 was used as it fit the 2:1- 3:1 rule; specifically, there are 48 items on the WPS and 125 is greater than 2:1 (estimated 96) but less than 3:1 (estimated 126) (Kline, 1979, p. 40). Also, MacCallum, Widaman, Zhang, and Hong (1999) recommended at least 100 for a sample for exploratory factor analysis. According to Costello and Osborne (2005), 28.5% of articles use surveys that have between 2:1 - 5:1 sample sizes. However, these results can be viewed as preliminary for future studies to expand and perform a confirmatory factor analysis.

For this preliminary EFA, I ran a Principle Axis and a Promax for oblique data because items were highly correlated (0 to +1). The resulting Exploratory Factor Analysis (EFA) loaded into six factors: 1. essential self, 2. creative self, 3. physical self, 4. social self, 5. coping self, and 6. coursework incorporation. A scree plot demonstrated that the six factors attributed to 72.9% of variance. The Kaiser-Meyer-Olkin measure was .822 with a p value less than .005. All factors aligned with original WPS expectation factors except one social self question. One social self question was originally coded for the creative self factor; however, in further exploration of the EFA I found a more direct relation to social engagement in comparison to the factors that loaded separately as creative self factors. The specific question was, "I actively encourage my students' personal relationships." Therefore, the hypothesis was partially supported as one question loaded

to a different factor, and three other questions loaded to a new sixth factor – coursework incorporation.

The essential self factor has five items, the creative self factor has six items, the coping self has six items, the physical self has four items, and the social self factor has three items. The sixth factor, coursework incorporation, included items from three different original wellness factors (essential, physical, and creative); however, this factor loaded separately based on the question wording, and not the constructs. It has three items all beginning with "in my courses I actively incorporate …" From the initial 48 item WPS, 27 items strongly loaded into the six factors. Items were eliminated based on weak loading (scores < .4), cross loading (scores loading on multiple areas > .4), or lack of sufficient items to measure the factor (< 3 items). One item loaded greater than one with no negative estimated residual variances which is acceptable with an oblique rotation (Jöreskog, 1999).

It was found that the creative factor subscale's alpha level was .73 the coping factor subscale's alpha level was .77, social self was .75, physical self was .83, essential self was .78, and the classroom incorporation factor alpha level was .80. The overall alpha level for the WPS was .808, illustrating a high commonality with the set and dictating a lower sample size required (MacCallum, Widaman, Preacher, & Hong, 2001). In examining frequencies for the WPS, participants scored higher on essential self items; specifically, "I actively support my students: - cultural identity," "I actively support my students: - awareness of confidence," and "- awareness of autonomy." Scores on essential self ranged from 2.4 to 6 (M=4.9, SD=.92). Overall, CEs scored lower on physical self factors, specifically, "I actively encourage my students to: eat a healthy diet" and "engage in regular physical exercise." Scores on physical self ranged from 1.3

to 6 (M=3.9, SD=1.2). There was not enough variation in sample of race, gender, CACREP accreditation, ACES region, position, tenure status, specialization, mindfulness practice (yes/no), or specific mindfulness intervention to meaningfully explore differences. There were no statistically significant differences by age, institution type, years working as a CE, nor teaching format. The 27 items that loaded well on the six subscales were used for the rest of the study. Research question 3 will explore demographic information in more depth for the WPS. The overall score was used in the multiple regression as the sample was not big enough to explore the subscales for six wellness promotion subscales. However, I did run each WPS subscale as individual independent variables with the five factors of wellness, MAAS and demographic information to find if it was significant about any one type of WPS regression. The average for each of the found factors is outlined in Table 4.2.

WPS Qualitative Data

Participants were also asked to comment on their most important wellness promotion behavior and anything they would add to the WPS. Categories that emerged from the qualitative feedback included *balance*, *immediacy* and *wellness plans*. For the content analysis, each theme emerged from in-vivo coding (Robson & McCartan, 2016; Saldaña, 2011). The initial codes were then grouped into categories, and then connected to themes – which were grounded in the IS-WEL model (Saldaña, 2011). Therefore, each category was connected with a theme from the five factors of the 5F-WEL.

Balance was cited 20 times and is directly related to the coping theme in relation to self-care; CE's cited experiences in which they encouraged students to explore the balance of work and health, and make conscious decisions about their next steps.

Table 4.2
WPS Exploratory Factor Analysis (N=125)

Construct/ Items	Ess	Cope	Create	Phys	Soc	Incorp
Essential						
1. In my courses, I actively incorporate: awareness of autonomy	.989					
2. In my courses, I actively incorporate: awareness of confidence	.890					
3. I actively support my students: awareness of confidence	.866					
4. I actively support my students: awareness of autonomy	.856					
5. In my courses, I actively incorporate: cultural identity	.703					
Coping						
1. I Actively Encourage My Students to: engage in self-reflection		.807				
2. I Actively Encourage My Students to: take part in personal counseling		.772				
3. In my courses, I actively incorporate: assignments that help students explore diverse lifestyles		.605				
4. I actively create space in the classroom for students to: develop meaning in the counseling profession		.571				
5. I directly relate self-growth to wellness for my students		.501				
6. I actively help students connect: with mentors or advisers		.491				
Creative						
1. I Actively Encourage My Students to: maintain a healthy sense of humor			.753			
2. I Actively Encourage My Students to: engage in novel experiences			.721			
3. I Actively Encourage My Students to: seek out comforting objects (pictures, books etc.)			.657			
4. I Actively Encourage My Students to: arrange a comfortable work space			.657			
5. I Actively encourage my students to build on strengths in school work			.633			
6. I Actively Encourage My Students to: use positive affirmations			.448			
Physical						
1. For my students I actively model health nutrition				.854		
2. For my students I actively model health fitness practices				.792		
3. I actively encourage my students to eat a healthy diet				.787		
4. I actively encourage my students engage in regular physical exercise				.766		
Social						
1. I Actively Encourage My Students to: nurture personal relationships					.729	
2. I Actively Encourage My Students to: examine the quality of relationships					.688	
3. I Actively Encourage My Students to: engage in social events to decrease stress					.631	

Table 4.2 Continued

Construct/ Items	Ess	Cope	Create	Phys	Soc	Incorp
Incorporate						
1. In my courses, I actively incorporate: forms of bodily connection into classroom activities (e.g. yoga, mindfulness, dance, progressive muscle relaxation etc.)						.729
2. In my courses, I actively incorporate: workshops/group on healthy activities (e.g. hiking, yoga, exercise, nutrition, mindfulness, etc.)						.659
3. In my courses, I actively incorporate: assignments to develop wellness in self						.631

Immediacy was cited in moments and stories in which CE's chose to change an assignment, class meeting plan, or lesson plan based on the CITs needs at the time. CE's noticed physical health, mental health, or emotional needs in the CITs and responded immediately to those needs by changing the environment to help CITs wellness. Participants that came from online programs cited not being able to "model" wellness, but taking time to address immediate needs quickly. *Immediacy* also falls under the coping self theme as it relates directly to self-care.

Wellness plans were cited 12 times in the responses. *Wellness plans* are defined as a specific assignment created for students to address the five factors of their wellness in the start of a semester. In five separate accounts "holistic wellness" was used to expand the understanding of wellness plans as assignments. These plans were connected to semester goals and actions plans specific for each CIT. As stated above wellness plans do not fit into one of the five factors, but instead include all factors potentially pointing to additional questions for the WPS which connects to holistic wellness.

Research Question 1: What are the average levels of wellness, mindful present moment awareness, and wellness promotion behaviors in CEs? Are there differences by demographic variables (i.e., institution type, tenure track, teaching format, age, years of experience, or mindfulness practices)?

I ran descriptive analyses on the total scores from assessments that measured wellness (5F-WEL), mindful present moment awareness (MAAS), and wellness promotion behaviors (WPS). A normality test was run for all the scales, and a normal distribution was found for all scales. Each scale's skewness and kurtosis were within normal ranges; therefore, parametric measures could be run on each subscale and scale (Cohen et al., 2013). There was not enough variation in sample of race, gender, CACREP accreditation, ACES region, position, tenure status, specialization, mindfulness practice (yes/no), or specific mindfulness intervention to meaningfully explore differences. Differences by age and institution type were considered, as well as years of experience working as a CE (divided into 1-4 years, 5-10 years, and 11 or more to show enough variation) and teaching format (divided into facto-to-face and online/hybrid).

Wellness

The 5F-WEL (Myers et al., 2014) measured CE's wellness levels in five factors of wellness. The 4-point Likert scale ranged from *strongly disagree* to *strongly agree* (Myers, 2004; Myers et al., 2014). Wellness scores for each factor are calculated by adding the scores on the Likert scale for each factor's questions, dividing by the number of questions, and multiplying by 25 – equalizing the score to a range of 25-100 (Myers et al., 2014). The closer to 100, the higher the wellness level in that factor. See Table 4.3 for the range and averages.

Table 4.3
5F-WEL Scores

Scale Scores	Minimum	Maximum	Mean	SD
Total Wellness	68	97.6	82.4	7.5
Creative	69.1	100	85.3	8.1
Coping	40	76	59.5	6.9
Social	53.1	100	93.2	7.8
Essential	53.6	100	81.1	9.1
Physical	35	100	74.7	9.5

CEs overall wellness scores averaged 82.4, which is above the norm group score of 75.3 (Myers et al., 2014). The highest wellness levels were in the social self subscale. Results from the 5F-WEL suggested that participants have high levels of wellness in all factors, with physical and coping self being the lowest of the five for the 118 participants –following the norm sample (Myers et al., 2014). When examining the overall breakdown of the questions participants showed lower levels of wellness on questions in the coping and physical self factors. The lowest mean scores and min scores were found in these two factors, therefore the original hypothesis for the lowest scores in the essential self was not supported. Essential self scored as the third lowest score.

As compared to the norm group (Table 3.1), CEs scored higher on all subscales except coping self. The coping self mean was lower than the norm sample group. The coping self theme encompasses leisure, stress management, self-worth, and realistic beliefs of self; specifically CEs scored lower in realistic belief of self and leisure. There were no statistically significant differences among participants by teaching format, age, or institution. There was not enough variation in sample to race, gender, CACREP accreditation, position, ACES region, tenure status, mindfulness, or specialization. An ANOVA showed there was significant difference in levels of wellness among CE's years of experience, $F(5, 112) = 2.710$, p= .024. A Tukey posthoc test

showed that CEs with 1-4 years of experience (M=3.25, SD=.31) reported lower levels of wellness than CEs with 11 or more years (M=3.43, SD=.28). As levels of experience increased so did wellness promotion behaviors aligning with the hypothesis. An ANOVA showed there was significant difference in creative and coping self wellness among CE's years of experience: creative $F(5, 112) = 3.015$, p= .014; coping $F(5, 112)= 2.972$, p= .015. A Tukey posthoc test showed that CEs with 1-4 years of experience (creative M= 3.34, SD= .39; coping M=3.05, SD=.35) reported lower levels of creative and coping wellness than CEs with 11 or more years (creative M=3.53, SD= .36.; coping M=3.26, SD=.36) No other factors were significant.

Mindfulness

The Mindful Attention Awareness Scale (MAAS) measures the trait of mindfulness as present moment awareness (Brown & Ryan, 2003). The scores for this scale range from 1-6 (*Almost Never* to *Almost Always)*, with lower scores representing higher levels of mindful present moment awareness. Scores ranged from 1.13 to 4.87, with an average of 2.68, suggesting that these CEs demonstrated moderately high levels of mindfulness. CEs scored lower than both the community norm sample (M= 4.20) and the college student sample (M= 3.83) (Brown & Ryan, 2003). Lower scores represent higher mindful present moment awareness; therefore CEs have higher present moment awareness than the norm samples. When examining the overall breakdown of the questions participants showed less mindful attention on two questions specifically: "I find myself listening to someone with one ear, doing something else at the same time" and "I tend not to notice feelings of physical tension or discomfort until they really grab my attention." An ANOVA showed there was significant difference in mindful present moment awareness among CE's years of experience: $F(2, 116) = 4.322$, p= .016. A Tukey posthoc test

90

showed that CEs with 1-4 years of experience (M=2.9, SD=.72) reported lower levels of mindful present moment awareness than CEs with 11 or more years (M=2.43, SD.75). As the number of years working as a CE increase so does mindful present moment awareness (alpha .05). No other demographic factors were significant.

Wellness Promotion Behaviors

I explored the 27 item WPS and demographic information with a sample of 118 (Table 4.4). The EFA of the WPS resulted in six subscales that measure coping self, creating self, social self, essential self, physical self, and classroom incorporation. Higher scores in each subscale demonstrate more use of wellness promotion behaviors in that factor. A perfect score on the WPS on all six factors would be a score of 27; each subscales' sum scores are divided by six (the number of subscales) to create an overall wellness score. There were no statistically significant differences among participants by teaching format, age, institution type, or years of experience with overall WPS scores.

Table 4.4
Wellness Promotion Behavior Scores

Scale Scores	Minimum	Maximum	Mean	SD
Total Wellness Promotion	11.3	25.7	19.2	3.3
Creative	1.5	6	4.2	1.1
Coping	2.3	6	4.8	.82
Social	2	6	4.6	1.1
Essential	2.4	6	4.9	.92
Physical	1.3	6	3.9	1.2
Coursework	1	6	3.8	1.1

However, an ANOVA showed there was significant difference in creative wellness promotion behaviors among CE's years of experience: $F(2, 116) =.974$, p= .032 (alpha= .05). A Tukey posthoc test showed that CEs with 1-4 years of experience (M= 4.22, SD= .78) reported lower levels of creative wellness promotion than CEs with 11 or more years (M=4.96, SD=.77). There was not enough variation in sample for race, CACREP accreditation, position, ACES region, tenure status, mindfulness, or specialization. Ultimately, scores on this survey were indicative of participants showing moderate levels of wellness promotion at 19.2 out of 27. The highest score was 25.7, and lowest was 11.3. The original hypothesis stated that higher scores would occur in creative self as it can be easily infused in coursework (Yager & Tovar-Blank, 2007), however participants scored higher in coping and essential. The lowest scores were in coursework and physical WPS scores.

Research Question 3: Are wellness promotion behaviors associated with level of wellness and mindful present moment awareness?

Correlational analyses were used to examine the relationships between overall level of wellness, mindful present moment awareness, and overall wellness promotion behaviors. A normality test was run for all the scales, and a normal distribution was found across all scales and subscales. Correlation analysis was also run on years of experience, age, teaching format, and institution type (Table 4.5).

Mindful present moment awareness was negatively correlated with wellness promotion behaviors and wellness levels which aligned with the hypothesis (p=.001) (Table 4.6). As wellness promotion behaviors and wellness levels increased scores on the MAAS decreased; illustrating that higher present moment awareness correlates to more wellness promotion

behaviors. The correlational analysis shows evidence to support the original hypothesis.

Wellness promotion behaviors were also positively correlated with wellness levels as

hypothesized. As wellness levels increased so did wellness promotion behaviors. However, the

five factor subscales of the 5F-WEL also showed individual correlations to overall wellness

promotion behaviors. All variables were significant. Positive correlations were found between

the 5F-WEL and WPS, and both were negatively correlated with the MAAS. Therefore, as

subscale wellness levels increased wellness promotion behaviors also increased as hypothesized.

Table 4.5
Correlational Matrix of Major Constructs

	1	2	3
1. Mindful Present Moment Awareness	1		
2. Wellness Promotion	**-.225***	1	
3. Wellness Levels	**-.418****	**.422****	1

** Correlation is significant at the .01 level (2-tailed).

Table 4.6
Correlational Matrix of 5F-WEL Subscales and Overall Wellness Promotion Behaviors

	1	2	3	4	5	6
1. Wellness Promotion Behaviors	1					
2. Wellness Levels: Coping	**.436****	1				
3. Wellness Levels: Creative	**.446****	**.649****	1			
4. Wellness Levels: Physical	**.264***	**.562****	**.261****	1		
5. Wellness Levels: Essential	**.282****	**.470****	**.412****	**.438****	1	
6. Wellness Levels: Social	**.272****	**.497****	**.629****	**.292****	**.392****	1

** Correlation is significant at the .01 level (2-tailed).

The correlational analysis were also run on each of the 5 factors of wellness subscales

and the six wellness promotion behavior subscales. All wellness levels subscales were positively

correlated. The coping self subscale of the 5F-WEL positively correlated to the coping, creative,

physical, social, and essential subscales of the WPS; however, it was not correlated to the

coursework subscale. The creative self subscale of the 5F-WEL was positively correlated to all of the WPS subscales including the incorporation of coursework subscale. The other subscales had a few correlations. Subscales on the WPS did not completely correlate with related subscales on the 5F-WEL as hypothesized however, as scores increased on the creative subscale wellness levels, all wellness promotion subscale behaviors increased.

I expected to see mindful present moment awareness negatively correlated with overall wellness promotion and wellness subscales, however, mindful present moment awareness was only negatively correlated with physical, essential, and coursework subscales of the WPS. This illustrates that as participants show more mindful present moment awareness they also engage in more physical, essential, and coursework related wellness promotion behaviors (Table 4.7 in Appendix O).

After I explored mindful present moment awareness (Table 4.8), ach scale and subscale was also explored with descriptive variables. There were no statistically significant differences among participants teaching format. The 5F-WEL overall score showed significant positive correlation with CE's years of experience and age. Also the 5F-WEL subscales for coping, creative, and essential were associated with CE experiences in years; with creative and essential showing a positive correlation with age (Table 4.9). The WPS physical subscale was positively correlated to age, and the essential subscale was positively correlated to CE experiences. Mindful present moment awareness was negatively correlated with CE years of experience and age.

Ultimately, demographic information was indicative of participants with more years of experience also having higher mindful present moment awareness, overall wellness, creative, coping, and essential wellness, and essential and physical wellness promotion behaviors.

Demographic informational also illustrated that as age increased so did overall wellness, creative and essential self, mindful present moment awareness, and physical self wellness promotion behaviors.

Table 4.8
Correlation of MAAS and WPS subscales

	Coping WPS	Creative WPS	Physical WPS	Essential WPS	Social WPS	Coursework WPS
Mindful Present Moment Awareness	-.120	-.174	**-.260****	**-.256****	-.103	**-.200***

** Correlation is significant at the .01 level (2-tailed).

Table 4.9
Correlation Scales and Demographic Information

	Age	CE years of experience
1. Overall Wellness	**.234***	**.248****
2. Wellness Levels: Coping	**.339****	**.240****
3. Wellness Levels: Creative	**.213***	**.251 ****
4. Wellness Levels: Essential	**.190***	**.255 ****
5. Wellness Promotion: Essential	.080	**.207***
6. Wellness Promotion: Physical	**.210***	.158
7. Mindful Present Moment Awareness	**-.289****	**-.265****

** Correlation is significant at the .01 level (2-tailed).
*Correlation is significant at the .05 level (2-tailed).

Research Question 4: Do level of personal wellness, mindful present moment awareness, and demographic variables (gender, CACREP-accreditation) predict level of wellness promotion behaviors in CEs?

Before beginning the multiple regression, normality, homoscedasticity, and multicollinearity were tested across all scales and subscales. The data met all assumptions for a

multiple regression; multivariate normality, no multicollinearity, and homoscedasticity. I used the WPS overall score, and subscale scores as the criterion variables. I then used the MAAS overall scores and 5F-WEL overall scores and subscale scores as the predictor variables in the multiple regression analysis Several multiple linear regressions were used to evaluate what predictor variables predicted more wellness promotion behaviors. Multiple linear regressions test the strength of that relationship once all the other relationships are taken into account.

A multiple linear regression was calculated to overall predict wellness promotion behaviors (dependent variable) based on wellness levels and mindful present moment awareness (independent variable) (Table 4.10). No significant regression equation was found for the mindful present moment awareness. A significant regression equation was found for overall wellness levels $\underline{F}$(2,117)=14.568 , p<001), with a correlation coefficient of .199. This indicated that 19.9% of the variance of the WPS could be accounted for by overall wellness levels. Therefore, mindful present moment awareness did not significantly contribute to the prediction of the WPS. Overall wellness level explained 19.9% of the variance in total wellness promotion behaviors and was statistically significant at an alpha of .001. Wellness is positively associated with total wellness promotion behaviors such that, adjusting for the other variables in the model, wellness promotion behaviors is predicted to increase by .982, and this association was statistically significant (p=.000).

A multiple regression was also used to explore each wellness subscale with the overall WPS scores (Table 4.11). A significant regression equation was found for the creative wellness subscale (WPS, $\underline{F}$(5,112)= 3.789, p<.001), but not other subscales. I found a correlation coefficient of .220; which indicated that 22% of the variance of the WPS could be accounted for

by the creative 5F-WEL subscale. Therefore the creative subscale wellness level explained 22%

of the variance in total wellness promotion behaviors and was statistically significant at an alpha

of .001.

Table 4.10
Multiple Regression Predictors of Overall WPS

Variable	B	SE	β	F	R^2
5F-WEL	1.086	.6433	.447	26.096	**.199****
MAAS	-.210	.081	-.234	6.742	.055

**p<.001.

Table 4.11
Multiple Regression Wellness Subscale Predictors of Overall WPS

Variable	B	SE	β	R^2
Creative Wellness	**.710**	**.297**	**.170**	**.220***
Coping Wellness	.348	.302	.170	
Essential Wellness	.096	.175	.057	
Social Wellness	-.186	.271	.079	
Physical Wellness	.109	.153	.078	
MAAS	-.029	.093	-.032	

**p<.05.

The creative subscale is positively associated with total wellness promotion behaviors

such that, adjusting for the other variables in the model, wellness promotion behaviors is

predicted to increase by .710, and this association is statistically significant (*p*=.018). Higher

levels of creative self wellness predicted higher levels of overall wellness promotion behaviors

(Table 4.11).

I also used a multiple regression to evaluate if independent variables (5F-WEL subscales)

predicted more individual wellness promotion behavior subscales. Due to sample size, I ran each

WPS subscale as individual dependent variables with the five subscales of wellness, MAAS, and

demographic information as independent variables to find if it was significant with any one

97

subscales of the WPS. All five factors of the 5F-WEL were run with each of the six WPS subscales. The original hypothesis that higher levels in wellness subscales would predict wellness promotion behaviors on matching scales was partially supported. The evidence to support the hypothesis was that higher physical self wellness levels predicted higher physical wellness promotion behaviors.

However, the other variables did not align with the predicted factors. The creative self wellness subscales predicted essential and coping wellness promotion behaviors. The coping self wellness subscale predicted creative wellness promotion behaviors. The social and incorporated WPS scales did not have significant regression equations to any of the 5F-WEL subscales, no WPS subscales were significant with the MAAS. No significant regression equations were found for demographic variables. The hypothesis that gender predicted levels of wellness promoting behaviors and the hypothesis that CACREP accreditation would be significant could not be verified due to lack of variation in the sample (Table 4.12 in Appendix P).

Summary

The results of the analysis conclude that the variables that measure wellness and mindful present moment awareness are significantly correlated with wellness promotion behaviors. Results also suggested that mindful present moment awareness has some association with specific wellness promotion behaviors and wellness levels. However, there was evidence to suggestion that only wellness levels were predictive of wellness promotion behaviors. Chapter 5 will provide more detail and discussion regarding the implications of these results.

Chapter 5: Discussion and Implications

The Indivisible Self Model (IS-WEL, Myers et al., 2014) was the theoretical frame used to ground this study. The IS-WEL is a theory of wellness that divides wellness into five factors; coping self, creative self, social self, physical self, and essential self (Myers et al., 2014). Counselor educators (CEs) play an integral role in supporting wellness development for CITs, but little research exists exploring counselor educators' general wellness, mindfulness, and how the wellness levels of counselor educators impact how they promote wellness in CITs (Myers et al., 2016; Wester et al., 2009). CEs must work to educate students on wellness and overall well-being through promoting self-care strategies and understanding risk factors for impairment to evaluate and promote personal growth for CITs (CACREP, 2016). Wellness is important to counselor development, as counselors who are well work more efficiently, attend to clients' wellness, and enhance the therapeutic relationship (Lambert & Lawson, 2011).

The purpose of this study was to explore the relationship between levels of wellness, levels of mindful present moment awareness, and how wellness is promoted by counselor educators (CEs). Specifically, this quantitative study focused on wellness and mindful present moment awareness in CEs and how this impacts promotion of CITs' wellness in counselor training programs. Wellness promotion behaviors as constructs were grounded in Wellness Theory, which outlines wellness choices based on five general factors: (a) creative self, (b) coping self, (c) social self, (d) essential self, and (e) physical self that influence overall wellness (Hattie et al., 2004; Myers & Sweeney, 2005).

Discussion and Major Findings

The results of this study showed associations between wellness, mindful present moment awareness and wellness promotion behaviors, and the evidence to suggest a potential predictive relationship between wellness and wellness promotion behaviors. While there was no predictive value in mindful present moment awareness for wellness promotion behaviors, there was some correlational association between all three factors. Ultimately, wellness levels, specifically the creative wellness measure, was a predictor of wellness promotion behaviors. The findings suggest that as mindful present moment awareness increases so do wellness levels, and as wellness levels increase so do wellness promotion behaviors. Mindful present moment awareness could therefore, act as a mediating factor for wellness and wellness promotion. A more detailed discussion of these results can be found below.

Counselor Educators' Wellness Levels

Wellness is a continued process of making choices that maximize human potential (Myers 1991). Wellness is measured by the 5F-WEL, by dividing into five factors of wellness (Hattie et al., 2004; Myers & Sweeney, 2005). The 5F-WEL has been used in numerous studies to explore wellness for community members, college students, and counseling students. However, those drawn to the counseling field and attending counselor training programs generally score higher on wellness measures, a trend which was found in this study as well (Myers et al., 2003; Roach & Young, 2007). Myers, Mobley, and Booth (2003) suggested that the counseling field attracts people that are more willing to incorporate wellness practices in matching professional and personal values. CEs and CITs experience stress and demands that are

100

inherent in counselor training and practice, emphasizing why wellness is so important to professional development.

RQ1 focused on finding CEs average wellness levels, which linked to previous results showing CEs as having higher wellness levels than the general population (Wester et al., 2009). Similar to the results of Wester et al. (2009) CEs in this study demonstrated lower levels of the coping self subscale – specifically lower in realistic beliefs. However, this study also found lower results in physical self– specifically lower in exercise, potentially illustrating that academia presents another layer of occupational strain for CEs, based on lack of realistic beliefs and lower physical wellness measures such as time for exercise. Academic stressors may connect to a lack of time and work-life balance, demonstrating that wellness subscales could be in conflict with each other, and potentially the work environment (Hendel & Horn, 2008). Unrealistic beliefs can lead to over commitment and unrealistic expectations, suggesting that time impacts not only wellness, but specific types of wellness (Shillingford et al., 2013). Specifically, time to realistically complete tasks, and time to take care of physical health. While other studies found a significant correlation between wellness and teaching position and tenure, this study found that years of experiences had more association to wellness levels (Wester et al., 2009). As years of experience increased, so did wellness. The more experience also impacts realistic beliefs and increases wellness; potentially more experience as a CE impacts their ability to manage time and wellness.

Mindful Present Moment Awareness

Mindful present moment awareness is defined as acknowledging and accepting the moment, without getting stuck in thoughts or in emotional reactions (Baer, 2003; Shapiro et al.,

2006). This awareness can help promote changes and explore options an individual needs to grow (Sackett, Lawson, & Burge, 2012). CEs scored higher than the norm sample, which is comparable to research on CITs (Sackett et al., 2012) and their practicing counselor counterparts that also score higher than the norm (Shapiro et al., 2005). Previous research shows that both CITs and CEs who engage in mindfulness practice demonstrated better stress management and greater well-being (Rocco, Dempsey, & Hartman, 2012). An interesting point is that CEs in this study scored lowest on two specific questions: "I find myself listening to someone with one ear, doing something else at the same time" and "I tend not to notice feelings of physical tension or discomfort until they really grab my attention." The first item again demonstrates the element of time and the academic environment, in which CEs potentially hold themselves to unrealistic beliefs of work completion, hindering their concentration on one task at a time. The second item relates directly to physical self wellness and understanding the body and the impact of stress on the body. It is also of interest that in a profession that rests on the ability to listen, comprehend and empathize, CEs are scoring lower on listening in relation to mindful present moment awareness.

Much like wellness, mindful present moment awareness was also related to years of experience as a CE; as experience level increased so did mindful present moment awareness. Other studies cited increases in mindful present moment awareness as mindfulness practice increased (Christopher et al., 2011; Felton, Coates, & Christopher, 2013), and though the sample of mindfulness practitioners was small (N=89), the more time spent practicing and whether they practiced mindfulness or not was significantly correlated to the MAAS.

Wellness and Mindful Present Moment Awareness

Wester et al. (2009) cited that CEs wellness scores were higher than the norm sample from Myers and Sweeney's (2005) earlier study because CEs were aware of their own wellness and stress. Therefore, CEs were better able to edit behaviors to potentially improve wellness. Mindful present moment awareness was also correlated to each subscale of the 5F-WEL, which relates to previous research that connect awareness and wellness (Ivers et al., 2016). In this study, as each coping, creative, social, essential, and physical wellness score increased, so did mindful present moment awareness. This study demonstrates that mindfulness is connected to wellness as previous studies have concluded (Christopher et al. 2011; Greason & Cashwell, 2009; Grossenbacher & Parkin, 2006; Rothaupt & Morgan, 2007); however, mindfulness did not show as a predictive association to wellness promotion behaviors.

Wellness Promotion Behaviors

Counselor educators' wellness promotion behaviors have not been measured before; therefore, I developed a survey based on conceptual articles and qualitative studies on wellness promotion in counselor education. The Exploratory Factor Analysis (EFA) for the WPS decreased the original 48 items to 27 strongly loading factors. The 27 items align with all five of the subscales for the IS-WEL, plus one extra factor that explores coursework incorporation. These five factors can be used to evaluate wellness promotion for CEs, with the sixth factor exploring how CEs incorporate factors into coursework and curriculum. The development of this scale can be potentially useful for CEs to explore the ways they promote wellness, for programs to see how wellness is promoted, and for future research to evaluate the impacts of wellness promotion behaviors.

The average overall score on the WPS was 19 out of a potential 27. The highest scores were in essential self, which focuses on promoting confidence, autonomy, and cultural identity. The second highest was coping which focuses on self-reflection and awareness. This is a different outcome then expected as Yager and Tovar-Blank (2007) and Wolf et al. (2012) both suggested that creative self could be more easily infused into coursework. The lowest wellness promotion behaviors were in the physical and coursework subscales. The physical items related promoting nutrition and exercise; while the course work subscale related to active incorporation of forms of bodily connection, healthy activities, and wellness development. It seems CEs scored higher on encouraging and supporting wellness but lower on the incorporation of wellness into curriculum.

In the open-ended questions, participants cited both teaching practices to improve wellness (*balance* and *immediacy)* as well as the creation of a *wellness plan* to help understand individual holistic wellness. This can be connected with some training programs requiring students to create personal wellness plans before their first clinical practicum experiences (Cummin et al., 2007; Roach & Young 2007; Yager & Tovar-Blank, 2007). The qualitative section of the WPS demonstrated that while wellness connects with the IS-WEL themes, there is a need to also connect with classroom efficacy and philosophy. The themes *balance* and *immediacy* demonstrate the coping theme; however, they also relate to classroom management with a wellness perspective in mind, illustrating that wellness promoting behaviors may have underlying connections to CEs teaching philosophy. Similar to Foster's (2010) the Wellness Cube Model (WCM) which incorporated counseling coursework and wellness factors as defined

by the IS-WEL, the qualitative research cited moments to integrate wellness perspective into teaching philosophy and curriculum.

Wellness, Mindful Present Moment Awareness, and Wellness Promotion

The study showed strong correlations between wellness, mindful present moment awareness, and wellness promotion behaviors. CEs wellness levels were connected to mindful present moment awareness and wellness promotion behaviors. The correlation showed that as wellness increased so did wellness promotion behaviors and mindful present moment awareness. However, only the physical, essential, and coursework WPS subscales showed a correlation to mindful present moment awareness. This connects to past research, as mindfulness relates to mindfulness practices which are cited in both physical and coursework WPS subscales. The essential self WPS subscale related directly to increasing awareness which is connected to mindfulness (Baer, 2003; Bohecker et al., 2016; Ivers et al., 2016; Shapiro et al 2007). Therefore, mindfulness has a potential mediating relationship to wellness and wellness promotion.

The creative wellness subscale was the most correlated to all wellness promotion behavior subscales, followed by the coping self which was correlated to all WPS subscales except incorporation of coursework. The Physical self subscale was also correlated to the physical WPS subscale. The Social self subscale was correlated to the WPS social subscale and physical subscale. And, the essential self subscale was correlated to the essential self, as well as the coping, physical, and social. Creative self wellness had the most connection to overall wellness promotion and individual subscales. Therefore, CEs could focus on their own creative wellness to increase wellness promotion behaviors across subscales for CITs.

Scores on the 5F-WEL showed a strong predictive relationship to wellness promotion behaviors; however, mindful present moment awareness did not show a predictive relationship to wellness promotion behaviors. The strong correlations without predictive connection might demonstrate a different directional relationship between these variables. However, the results demonstrate that mindful present moment awareness is important in relation to wellness, and wellness is important in its connection to wellness promotion behaviors. Mindfulness has a predictive relationship to wellness in other research (Chrisman et al., 2009; Christopher et al., 2006; Newsome et al., 2006; Schure et al., 2008), therefore it was hypothesized that it would also connect to wellness promotion behaviors (Witmer & Young, 1996). However, mindfulness did not have the same predictive connection to wellness promotion as it did wellness. This suggests that wellness and mindfulness are connected, and wellness and wellness promotion behaviors are connected, but it may be that mindfulness's effect on wellness promotion is mediated through personal wellness rather than having a direct relationship. The exact direction of these three variables were not completely exposed; thus, the exact predictive relationship needs further study.

Creative wellness was the subscale that showed the largest predictive impact on overall wellness promotion behaviors. Therefore, there is evidence to suggest that creative wellness (thinking, emotions, control, work, and positive humor) has the most impact on CEs wellness promotion behaviors. The creative subscale might contribute to creative teaching strategies and maintaining work related wellness (Myers, Willse, & Villalba, 2011). Creative wellness specifically impacts: the need for intellectual stimulation, ability to express full emotional appropriately, belief in ability to create and achieve goals, the use of humor to resolve problems,

106

and feelings of satisfaction in order to complete work (Myers et al., 2011). These factors appear to impact how CEs promote wellness in the classroom, but potentially connect to teaching philosophy and classroom management. The importance of wellness and mindful present moment awareness and potential need to explore teaching philosophy, demonstrates that the directionality of the predictive relationships need further exploration. For example, the high correlation between mindful present moment awareness and coursework incorporation did not have a predictive relationship in which mindful present moment awareness predicted wellness promotion behavior. However, this relationship could be predictive in the opposite direction; demonstrating the potential for reciprocal relationship throughout these variables, and the need for further study.

Limitations

There are several limitation to this study. The first limitation is a smaller than predicted sample size. The initial calculations called for a sample of 150 for a multiple linear regression; however, with a moderate effect size (.3) and an alpha of .05, 118 is an appropriate size for other statistical calculations with less than six factors. The sample could be stronger with 150. Recruitment could have impacted sample size, as all participants were contacted by email rather than person-to-person contact. There may also be a nonresponse bias. Specifically, the sample is limited to CEs with access to email, who regularly check email, and do not treat enmass emails as spam. The length of the scales (30-45 min) also potentially influenced participants not completing the surveys. While 125 finished the 5F-WEL, MAAS, and WPS, only 118 finished the demographic sections limiting demographic variation.

In addition, the sample size and length of the survey could have impacted the variability in the sample for some demographics. The CE population is largely Caucasian women which prevented variation in the sample. While I specifically sought to find schools across the United States in a variety of counseling programs, the sample is also largely from the Southern region. The sample also mainly consisted of CACREP accredited programs so there could be no distinction made between CACREP and non CACREP accredited programs, or by differences in gender, race, region, or tenure status due to minimal variations in these demographics.

Also, all responses are self-report and therefore subject to participant biases. Therefore, caution is advised as participants are subject to fatigue, impression management, memory, and cultural limitations in self-report (Podsakoff, MacKenzie, Lee, & Podaskoff, 2003). Specifically, this study looked at wellness promotion behaviors CEs used, but not the impact on CITs. Therefore, all wellness promotion behaviors are not explored as impactful to wellness development, but instead their importance to CEs.

It is important to note that the Wellness Promotion Survey (WPS), was designed for this study; however, it is the first time it is being used and has no normative data. From the initial 48 items, only 27 remained strongly loaded; therefore data from the initial 48 items were not in final results. This could lead to a lack of information on wellness promotion behaviors specific to spiritual growth, cultural exploration, and social justice work. Also, the incorporation of a sixth factor –based on question wording and connecting across factors– made it harder to find connections between hypothesized factors. Caution should be taken in exploring the coursework factor in relation to other forms of wellness promotion. However, this also produces questions for future work on the development of the WPS as outlined in the next section.

Implications

Initial implications for this research demonstrate a need for further understanding of wellness for those in helping professions. Specially, the lack of understanding for the colloquial use of the term wellness as an occupational priority. I believe as a researcher I have fallen into the same trap that many counselors and CEs fall into: the need to justify why wellness is important. I caution counselors and CEs in feeling the need to justify seeking wellness with specific job requirements. I encourage the idea that wellness without specific job related necessity can be important in and of itself for individual CEs.

Future Research

There are several recommendations for research to expand the understanding of wellness, mindful present moment awareness, and wellness promotion. The first is a continuation of this study to gain a larger sample for the Wellness Promotion Survey (WPS). Future research should expand the exploratory factor analysis with a larger sample and complete a confirmatory factor analysis for the WPS. In regards to the research question the qualitative results of the WPS demonstrate that while wellness connects with the IS-WEL themes, there is a need to also connect with classroom efficacy and philosophy. For example, the *balance* and *immediacy* demonstrate the coping theme. However, they also relate to classroom management, illustrating that wellness promoting behaviors may have underlying connections to CEs teaching philosophy. Therefore, future implications for the survey may include adding questions devoted to classroom management (*balance* and *immediacy*) and holistic wellness through the use of *wellness plans*. Holistic wellness should be investigated more thoroughly as a wellness promotion behavior, as should specific questions to target coursework incorporation.

Future research for the WPS will include merging the WPS with feedback from counselors-in-training wellness levels. Future research could also explore changes in CITs wellness levels in relation to CEs wellness promotion behaviors. This research will be helpful to not only outline what CEs are using to support their CITs wellness development, but also what works. Potentially a pre-test post-test model could be used to explore wellness promotion. Future studies should also explore a longitudinal model to see what wellness promotion behaviors impact future counselor wellness as students move from CITs to practicing counselors.

Future research should also explore the relationship between wellness, wellness promotion behaviors, and mindful present moment awareness in different relations. There is evidence to suggest that creative wellness has a predictive impact on wellness promotion behaviors, and future research could also explore the impact of creative wellness on teaching philosophy and coursework incorporation. Each second order factor has third order factors that create the factors, for example coping self has realistic beliefs, self-worth, stress management, and leisure. A larger sample size could also expand the subscales into including the 17 third order factors for the second order factors, to find more specific relationships with wellness promotion behaviors.

With a CFA and a larger sample size researchers could explore the mediating relationship mindful present moment awareness has on wellness and wellness promotion. This could give more specific information on the reciprocity of the factors relationship. It is important to note that, according to the literature, wellness is expected to impact wellness promotion as is demonstrated in the isomorphic relationships in counselor-client and supervisors-CITs. However, it is important to question the implications the counseling field places on wellness as a product

110

and not a process in preparing future counselors– if we are to understand wellness as part of a relationship. While there was evidence to support the hypothesis that wellness predicted wellness promotion behaviors, perhaps there is validity to questioning that predictive relationship. Specifically, that promoting wellness in CITs and the necessity of modeling alters the expected relationship – with wellness promotion behaviors impacting wellness. I argue that perhaps, the relationship between wellness and wellness promotion behaviors could be explored as not only predictive but reciprocal. As a continuous process these factors potentially encourage each other, dependent on a CEs awareness of the interaction. Future research should more closely explore these factors and the directionality of the relationship.

More research is necessary to further verify and understand wellness for diverse CITs and CEs, taking into consideration race, sexual identity, gender, and other diverse populations. The lack of diversity of the sample is cited across many studies, both demonstrating a lack of diverse CEs, but also the lack of recruitment understanding for researchers. The interconnected nature of diversity to context illustrates the importance of continued exploration of the process of wellness considering cultural, social, and political contextual impacts. The lack of diverse voices in research hinders practice as counselors, counselor educators, and researchers.

Counselor Educators

This study helped to highlight how wellness impacts wellness promotion. It illustrated ways counselor educators promote wellness for counselors in training. Numerous researchers have contributed to the literature about well counselors impacting well clients; however, little is known about CEs wellness and the impact on their work. CE wellness is also found to be associated with higher levels of mindful present moment awareness. The practice of mindful

present moment awareness can be helpful to maintain wellness, in order to promote wellness in CITs. Therefore, CEs could benefit from growing mindful present moment awareness to contribute to overall wellness, which contributes to higher overall wellness promotion behaviors.

The Indivisible Self (IS-WEL) is a model of wellness based in developmental, strength-based, individual psychology (Myer & Sweeney, 2005). The five factors that build the model connect to Adler's proposed idea of holism, focusing on the whole of the parts rather than individual pieces (Myers & Sweeney, 2004). Therefore, coping self, creative self, essential self, social self, and physical self all connect in order to create holistic wellness. When counselors find lower levels in one subscale, it indicates lower overall wellness, and people must then work to fix subscale wellness deficiencies. The 5F-WEL is used to find deficient wellness areas, and clients, counselors, CITs, and CEs work to make choices to correct those deficiencies (Myers & Sweeney, 2004). Therefore, wellness assessments work to increase wellness awareness.

Wellness Assessment appears to create tension between theory and practice, in the sense that the 5F-WEL is meant to find deficiencies, but is built from the counseling field's propensity for strengths-based practice. Therefore, I argue that gaining awareness of wellness levels is important to finding not only deficiencies but also the wellness areas we are more naturally inclined to maintain. In knowing higher wellness subscales (wellness strengths) such as CEs higher scores on the social self subscale, CEs could potentially use social wellness factors to increase wellness in coping and physical areas. For example, CEs could use social connections to check in on unrealistic beliefs of self. CEs could engage in writing groups, support groups, family connection, or mentor relationships. CEs in this study with 11 or more years had higher overall wellness, mindful present moment awareness, and wellness promotion behaviors,

therefore, CEs can connect with mentors to help learn and create space for more coping self wellness. The awareness of physical self wellness could also be increased through social self wellness, by connecting with accountability groups, exercise groups, and connecting with friends, mentors, family, and co-workers to help make physical health goals known and gather support.

CEs might use social relationships to engage in the work environment in ways that encourage wellness. For example, working with colleagues to challenge the academic work culture within university settings. Work culture has many different factors that affect the work environment and occupational strain impacting CEs and CITs movement along the continuum between well and impaired (Gill, 2009; Wester et al., 2009). The individual psychological nature of the IS-WEL creates opportunity for CEs to explore their own wellness, in the context of their work environment, and engage in a decision making process on what changes they will and will not make in regards to their individual wellness. However, CEs can use their social wellness strength to help improve other wellness factors.

Counselor Educators also can pay specific attention to maintain awareness of creative self wellness levels as they closely contribute to wellness promotion behaviors across subscales and in overall wellness promotion. Counselor Educators can work to engage in wellness activities that address intelligence, control, emotion, humor, and work. Creative wellness might connect to teaching job requirements by promoting the need for intellectual stimulation, ability to express full emotional appropriately, belief in ability to create and achieve goals, the use of humor to resolve problems, and feelings of satisfaction in order to complete work (Myers et al., 2011). Maintaining awareness and evaluating creative wellness could help CEs combat the stressors of

both academia and counseling as creative wellness impacts factors directly related to problems solving, emotional regulation, and work.

CEs scored lowest on physical and coursework factors of the WPS. CEs could be more intentional in modeling healthy physical fitness and nutrition, and encouraging CITs to eat healthy and engage in regular exercise. Many classes for CITs take place during lunchtime or dinner and CEs can work to respect the times students need to eat, and if they bring food to class, incorporate healthy items to share. Adding in specific coursework about the importance of physical fitness and nutrition and how it impacts on the body and mind can help CITs' future work with clients, but also increase awareness of their current physical wellness.

Coursework incorporation covered essential, physical and creative self subscales. CEs scored higher in essential self wellness promotion, but lowest in assignments to directly develop essential self wellness promotion. While CEs scored higher on items about actively encouraging and supporting students' wellness, fewer CEs incorporated wellness into classroom work or activities. CEs can work to add wellness into classroom activities by creating wellness plans (as illustrated by our qualitative data), incorporating forms of bodily connection (e.g. yoga, mindfulness, dance, progressive muscle relaxation etc.), adding expressive arts (e.g. drawing, painting, and music), and engaging in service learning activities. Many of these activities could be used as future interventions for clients, therefore, CITs can benefit both professionally and personally through experiencing these wellness promotion strategies. Direct incorporation of wellness definition and activities into coursework can help CITs gain awareness of wellness in relation to professional identity.

CEs are exposing more CITs to wellness promotion behaviors for encouraging and supporting essential and coping self factors. Specifically, CEs promote factors related to essential self through cultural awareness, autonomy, confidence, and self-care, linking wellness promotion directly to both multicultural considerations and self-awareness. Multicultural considerations and self-awareness directly relate to Section 2 of the CACREP standards for professional identity development (CACREP, 2015). The direct link between essential self wellness promotion and professional identity may help CEs promote essential wellness in CITs. Coping self wellness promotion was the second highest score encompassing self-esteem, stress management, realistic beliefs of self, and leisure – potentially life work balance (Myers et al., 2011). CEs might not be modeling coping self wellness – specifically realistic beliefs of self – as CEs across many studies and this study showed lower signs of realistic beliefs of self (coping self wellness). However, CEs are working to promote coping wellness in CITs. Wester, Trepal and Myers (2009) used the IS-WEL to gain initial wellness levels and Perceived Stress Scale (PSS; Cohen, Kamarck, & Mermelstein, 1994) and found that CEs are aware of their own wellness and stress which helped increase wellness. Potentially, CEs awareness of lower wellness scores in coping might encourage them to promote coping self wellness factors in CITs (the opposite effect hypothesized). This demonstrates the potential importance for awareness of wellness levels in relation to wellness promotion, and once again calls into question the directionality of the relationship between variables.

Although this study did not explore if wellness promotion behaviors had their intended effect, CEs could add in wellness assessments to their work to find what is effective for their students. Myers, Sweeney, and Witmer (2000) introduced four phases to integrate wellness

interventions in counseling which can be translated to work with CITs. These include

introducing the wellness model, completing assessments based on the model, creating

interventions to enhance wellness deficits, and reviewing success of the intervention (Myers et

al., 2000; Sweeney & Myers, 2005). Following these same steps in a classroom setting, CEs

could assess wellness for individual students to evaluate the specific wellness promotion

behaviors that would be most beneficial to the students while simultaneously encouraging

students' awareness of their own wellness. This process could include encouraging a personal

wellness plan based not only on wellness scores, but also readiness and reflection. Interventions

should be based on the process of wellness, and each CE and CIT's choices. It can be

overwhelming to think of wellness overall, but CEs can help CITs breakdown wellness into the

five factors to engage in wellness promotion in the needed areas. Transparency in the teaching

process can be helpful to improve awareness of wellness, so CITs understand wellness

promotion behaviors, and solidify the importance of wellness the counseling profession and

professional identity. Changes in one wellness area will stimulate changes in other areas. CEs

can encourage CITs to continue to question and develop their satisfaction with their own

wellness by creating specific goals and creating their own wellness definitions. Educating CITs

about the different types of wellness can also be a helpful way to breakup self-care into

achievable goals.

Linking wellness promotion to the isomorphic relationship between CEs and CITs, CEs

could improve student awareness of their own wellness to promote wellness in themselves and

others. Therefore, CEs can use their awareness of their own wellness and of their CIT's wellness

to model and engage in wellness behaviors to promote needed wellness. This could be

accomplished by encouraging wellness promotion based on the lower scores of the class, or linking low with higher wellness strengths. For example, if CITs score similar to CEs with social being the highest, CEs could not only discuss how to incorporate these wellness strengths into increasing other wellness areas, but also model these behaviors. Therefore, CEs act as models, teaching, evaluators, and agents of change for their students by practicing awareness of their own and their CITs wellness; which encourages wellness promotion behaviors.

Conclusion

Counseling is rooted in wellness philosophy focusing specifically on prevention and a developmental perspective (Myers et al., 2000). The very nature of counseling is stressful, but counselors are not only expected to take care of their own wellness and that of their clients, but also monitor the wellness of other clinicians. Counselor wellness and counselor impairment rest on a continuum opposite each other. Therefore CEs have an ethical responsibility to practice awareness of where they rest on the continuum, work to maintain wellness, and also promote wellness in CITs. However, I caution counselors and CEs in feeling the need to justify seeking wellness with specific job requirements and encourage instead that wellness without specific job related necessity can be important in and of itself.

This study explored the relationship between CEs wellness, mindful present moment awareness, and wellness promotion behaviors. The results of the analyses concluded that wellness is associated with wellness promotion, though not directly aligned with each wellness and wellness promotion subscale. Positive relationships were found between each of these three variables in correlation; however, mindful present moment awareness did not have a predictive relationship with wellness promotion behaviors. Furthermore, the creative self wellness scores

117

are predictive for overall wellness promotion behaviors. The connections to wellness theory provide further evidence for continued work on CE wellness to support the development of future counselors. Caution should be used with addressing the predictive relationship of the variables and future research should focus on the variables that impact wellness promotion and a possibly reciprocal relationship. Further research into the understanding of wellness and wellness promotion should focus on the factors that contribute to wellness and classroom philosophy. Finally, CEs should work to practice awareness to maintain their wellness, and question how they incorporate wellness into CIT training to integrate wellness into professional identity.

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Appendix

Dear Counselor Educator:

My name is Rachael Marshall, I am a doctoral candidate in the Counselor Education Department at the University of Tennessee, Knoxville. I am working on developing a survey to determine how Counselor Educators promote wellness in their students; called the Wellness Promotion Survey (WPS). You are being contacted as you are a considered an expert in your field. You are serving as a content validity expert, to determine if the survey I composed represents the Indivisible Self Wellness Model.

I would like to ask for a few minutes of your time to complete a survey and comment on the survey which explores the ways in which you promote wellness in your students. You can provide information that could impact ways to increase wellness and decrease burnout in counseling students. All the information and responses to this survey are confidential.

I would greatly appreciate your participation in this study. If you choose you can have a copy of the survey results will be emailed to you. Again, thank you for your time and consideration in this endeavor.

Thank you,
Rachael Marshall
Doctoral Candidate Counselor Education
University of Tennessee Knoxville
(615) 830-9161
rmarsha6@vols.utk.edu

Faculty Advisor:
Melinda M. Gibbons, Phd, NCC
Professor and PhD Program Coordinator
Counselor Education
University of Tennessee
865-974-4477
mgibbon2@utk.edu

Appendix B: Pilot Study Welcome Email

Dear Counselor Educator:

My name is Rachael Marshall, I am a doctoral candidate in the Counselor Education Department at the University of Tennessee, Knoxville. I am working on developing a survey to determine how Counselor Educators promote wellness in their students; called the Wellness Promotion Survey (WPS).

I would like to ask for a few minutes of your time to complete a survey and comment on the procedure of the survey which explores the ways in which you promote wellness in your students. You can provide information that could impact ways to increase wellness and decrease burnout in counseling students. All the information and responses to this survey are confidential.

I would greatly appreciate your participation in this study. If you choose you can have a copy of the survey results will be emailed to you. Again, thank you for your time and consideration in this endeavor.

Thank you,
Rachael Marshall
Doctoral Candidate Counselor Education
University of Tennessee Knoxville
(615) 830-9161
rmarsha6@vols.utk.edu

Faculty Advisor:
Melinda M. Gibbons, Phd, NCC
Professor and PhD Program Coordinator
Counselor Education
University of Tennessee
865-974-4477
mgibbon2@utk.edu

Appendix C: Pilot Study Link Email

Dear Counselor Educator:

I greatly appreciate your participation in this study. You are invited to participate in a study to evaluate a survey instrument, the Wellness Promotion Survey (WPS). You are helping the researcher better understand the survey procedures. This survey will then be used to complete my dissertation.

I am completing this dissertation study as a part of my requirement as a doctoral candidate in the Counselor Education program at the University of Tennessee. The purpose of this survey evaluation is to better understand the validity and reliability of the WPS. Results from this study may improve our understanding wellness promotion strategies used by Counselor Educators.

Participation in this study is limited to individuals who meet the following inclusion criteria:

1. Hold a doctoral degree in Counselor Education or currently work as Faculty in a Mental Health Counseling, School Counseling, and/or Marriage and Family Counseling Program.

2. Have at least ONE year of experience as a Faculty member in a Mental Health Counseling, School Counseling, and/or Marriage and Family Counseling Program.

If you meet this criteria for participant please follow the link to take the survey:

Thank you,
Rachael Marshall
Doctoral Candidate Counselor Education
University of Tennessee Knoxville
(615) 830-9161
rmarsha6@vols.utk.edu

Melinda M. Gibbons, Phd, NCC
Professor and PhD Program Coordinator
Counselor Education
University of Tennessee
865-974-4477
mgibbon2@utk.edu

Appendix D: Pilot Study Informed Consent

Wellness Promotion Survey Pilot

Introduction

You are invited to participate in a study to evaluate a survey instrument, the Wellness Promotion Survey (WPS). You are helping the researcher better understand the survey procedures. This survey will then be used to complete my dissertation.

I am completing this dissertation study as a part of my requirement as a doctoral candidate in the Counselor Education program at the University of Tennessee. The purpose of this survey evaluation is to better understand the validity and reliability of the WPS. Results from this study may improve our understanding wellness promotion strategies used by Counselor Educators.

Participants' Involvement

During this study, you will be asked to complete the Wellness Promotion Survey and give your feedback via an evaluation form. The evaluation form should take no more than 15 min. After you have completed the survey and evaluation form you will receive a thank you email and may request a copy of your results.

Participant Criteria

Participation in this study is limited to individuals who meet the following inclusion criteria:

1. Hold a doctoral degree in Counselor Education or currently work as Faculty in a Mental Health Counseling, School Counseling, and/or Marriage and Family Counseling Program.

2. Have at least ONE year of experience as a Faculty member in a Mental Health Counseling, School Counseling, and/or Marriage and Family Counseling Program.

Potential Risks

There are no foreseeable risks other than those experienced in everyday life. Also, there is possible breach of confidentiality. The groups are small enough that it would be possible to identify individuals from the pilot survey if data were disaggregated into small enough groups. However, no names will be used in reporting data. Data will be kept in a password-protected file on a password-protected computer. Data will not be disaggregated by demographic categories.

Potential Benefits

There may be no personal benefit from your participation in the study. The survey measures how CEs promote wellness in their students, therefore, taking the survey bears the potential benefit for the participants to find our ways you ARE promoting wellness, and discover other ways you COULD promote wellness for your students.

The overall benefit of this research is the creation of a survey that can help Counselor Educators understand wellness promotion in the classroom, and extend research opportunities in wellness promotion as there is currently no survey available for this measure.

Compensation & Costs
There is no compensation or cost for participation in this study.

Confidentiality
All information obtained about you in this study is strictly confidential unless disclosure is required by federal or state law or you waive your right. Demographic information will not be used in the final study. The results of this study will be used in the creation of a survey for future dissertation and presentation, but I will protect your identity in all results.

Contact Information
If at any time you have questions about the study or procedures, or you experience any problems related to the study, please contact Is listed below:

Primary Researcher:
Rachael Marshall, MS
Doctoral Candidate Counselor Education
University of Tennessee Knoxville
615-830-9161
rmarsha6@vols.utk.edu

Faculty Advisor:
Melinda M. Gibbons, Phd, NCC
Professor and PhD Program Coordinator
Counselor Education
University of Tennessee
865-974-4477
mgibbon2@utk.edu

If you have questions or concerns about your treatment in this research or your rights as a participant, please contact the University of Tennessee IRB Compliance Officer at 865-974-7697 or utkirb@utk.edu.

Voluntary Participation
Your participation in this study is voluntary; you may decline to participate without penalty. If you decide to participate, you may withdraw from the study at any time without penalty and without loss of benefits to which you are otherwise entitled. If you withdraw from the study before data collection is completed your data will be deleted and not used for data analysis or reporting purposes.

Please check in the appropriate boxes below:

☐ I choose to participate in the research study.
☐ I choose NOT to participate in this research study.

Appendix E: Pilot Study Evaluation Form

Evaluation of Survey

Please answer the following questions to the best of your ability. Your answers will help us make this the best survey it can be. Please answer each question honestly – your feedback is important to us. Thank you for your help.

1. How would you rate the written directions for this survey?

       Very unclear   Unclear Clear   Very clear

2. How would you rate the actual survey?

       Very unclear   Unclear Clear   Very clear

3. Were any of the questions on this survey confusing to you?   Yes   No

4. If you answered yes to question 3, please list the question number(s) that you found confusing and why it was confusing:

5. How was the length of this survey?   Too short   Just right   Too long

6. How long did it take you to complete this survey?

  Less than 5 minutes   5-10 minutes   10-15 minutes   15-20 minutes   20+ minutes

7. Any other comments that you think would help improve this survey:

Appendix F: Pilot Thank You

Thank you for participating in the Wellness Promotion Survey. Your responses and information will assist with the development of my Dissertation project in Counselor Education, and contribute to understanding wellness promotion for Counselors-in-training.

If you would like results from you survey please contact Rachael Marshall.

Thank you again for your time and interest in this survey!

Rachael Marshall, Doctoral Candidate
Counselor Education
The University of Tennessee
Rmarsha6@vols.utk.edu

Melinda Gibbons, PhD
Professor
Counselor Education
The University of Tennessee
Mgibbon2@utk.edu

Appendix G: Pilot Study Wellness Promotion Survey (WPS)

Wellness Promotion Survey

Directions: Please respond to each item in this survey. For the first section, you will answer how often you engaged in the wellness promotion activity. For example, if the activity was "I encourage my students to engage in physical exercise", you will choose from "1-Never, 2- Almost Never, 3- Sometimes, 4-Fairly Often, 5-Very Often, 6- Always." ONLY RESPOND FOR LISTED ACTIVITIES YOU HAVE ALREADY DONE, NOT WHETHER IF YOU PLAN TO DO THE LISTED ACTIVITY. For the second section, you will respond to 2 open-ended questions.

Part I: **BEHAVIORS SECTION:** Select how often you have used the following activities with you students.

BEHAVIOR	Never	Almost Never	Sometimes	Fairly Often	Very Often	Always
I Actively Encourage Students:						
1. to put school work aside without guilt						
2. to engage in self-reflection						
3. to engage in personal therapy						
4. to accept self even when not perfect						
5. to values themselves as a unique person						
6. to engage in leisure activities that satisfy them						
7. to participant in peer support groups						
8. to arrange a comfortable work space						
9. to set limits with colleagues						
10. to set limits with clients						
11. to participant in leisure activities in which they can lose themselves or time stands still						
BEHAVIOR	Never	Almost Never	Sometimes	Fairly Often	Very Often	Always

I Actively Encourage Students:						
12. to find humor in serious tasks						
13. to laugh at self						
14. to use personal abilities in school work						
15. to find creative solutions to hard problems						
16. to take time away from phones, email, or internet						
17. to engage in novel experiences						
18. experiences for students to develop meaning in the counseling profession						
19. to use positive affirmations						
20. to seek out comforting objects						
21. to say no to extra responsibilities						
22. to challenge unrealistic beliefs about self						
23. to express full their range of feelings						
24. to work to nurture relationships						
25. to examine the quality of relationships						
26. social events to decrease isolation						
27. to find someone to with which to keep satisfying relationships						
28. students to ask for help when needed						

150

29. to keep secure relationships					
30. to exercise 20 min a day for at least 3 days					
31. to eat a healthy diet					
32. to engage in a stretching activity 3 times a week					
33. to engage in advocacy					
34. to engage in social justice work					
35. to engage in service or volunteer					
36. to reflect on their cultural experiences					
37. to try new things					
38. to refrain drinking in excess					
39. to refrain tobacco use					
40. o refrain from illegal drug use					
I Model:					
41. healthy relationships for my students					
42. health nutrition for my students					
43. healthy fitness practices for my students					
I Help Students:					
44. connect with mentors					
45. connect to faculty advisors					
I Incorporate:					
46. art in coursework					
47. music in coursework					

151

48. service learning in the classroom					
49. poetry in coursework					
50. 42. Assignments that help student explores diverse lifestyles to expand personal wellness					
51. forms of bodily connection into classroom activities such as:					
a. yoga					
b. mindfulness					
c. Tai Chi,					
d. Qi Gong					
e. dance					
f. progressive muscle relaxation					
52. workshops/group activates on healthy activities such as:					
a. hiking					
b. yoga					
c. nutrition					
d. fitness					
e. mindfulness					
53. for students to celebrate holidays					
54. for students to explore their spiritual growth					
55. for students to celebrate personal accomplishments					
I Support:					
56. I support students in their gender identity presentation					

57. I support awareness of students' autonomy						
58. I support awareness of students' confidence						
Final Questions:						
59. When I bring food for the class I bring fruits, vegetables, and/or whole grains						
60. I directly relate self-growth to wellness						

Part II: **OPEN-ENDED QUESTIONS:**

Of all these different behaviors what do you see as the most important and why?

Are there any other wellness promotion strategies you use in the classroom not listed above? Please explain.

Appendix H: Five Factor Wellness Inventory Permission to Use (5F-WEL)

Five Factor Wellness
Inventory (FFWEL)
2^(nd) Edition Manual

Appendix I: 5F-WEL Sample Questions

I am satisfied with how I cope with stress.

My cultural background enhances my quality of life.

Appendix J: Mindful Attention Awareness Scale (MAAS)

Day-to-Day Experiences

Instructions: Below is a collection of statements about your everyday experience. Using the 1-6 scale below, please indicate how frequently or infrequently you currently have each experience. Please answer according to what *really reflects* your experience rather than what you think your experience should be. Please treat each item separately from every other item.

1	2	3	4	5	6
Almost Always	Very Frequently	Somewhat Frequently	Somewhat Infrequently	Very Infrequently	Almost Never

Statement						
I could be experiencing some emotion and not be conscious of it until some time later.	1	2	3	4	5	6
I break or spill things because of carelessness, not paying attention, or thinking of something else.	1	2	3	4	5	6
I find it difficult to stay focused on what's happening in the present.	1	2	3	4	5	6
I tend to walk quickly to get where I'm going without paying attention to what I experience along the way.	1	2	3	4	5	6
I tend not to notice feelings of physical tension or discomfort until they really grab my attention.	1	2	3	4	5	6
I forget a person's name almost as soon as I've been told it for the first time.	1	2	3	4	5	6
It seems I am "running on automatic," without much awareness of what I'm doing.	1	2	3	4	5	6
I rush through activities without being really attentive to them.	1	2	3	4	5	6
I get so focused on the goal I want to achieve that I lose touch with what I'm doing right now to get there.	1	2	3	4	5	6
I do jobs or tasks automatically, without being aware of what I'm doing.	1	2	3	4	5	6
I find myself listening to someone with one ear, doing something else at the same time.	1	2	3	4	5	6

1	2	3	4	5	6
Almost Always	Very Frequently	Somewhat Frequently	Somewhat Infrequently	Very Infrequently	Almost Never

I drive places on 'automatic pilot' and then wonder why I went there.	1	2	3	4	5	6
I find myself preoccupied with the future or the past.	1	2	3	4	5	6
I find myself doing things without paying attention.	1	2	3	4	5	6
I snack without being aware that I'm eating.	1	2	3	4	5	6

Appendix K: Study Invitation E-mail and Link

E-mail Invitation and Link

Dear Counselor Educator:

My name is Rachael Marshall, I am a doctoral candidate in the Counselor Education Department at the University of Tennessee, Knoxville. I am completing this study as a part of my requirement as a doctoral candidate in the Counselor Education program at the University of Tennessee.

You are invited to participate in this study entitled, "Counselor Educators' Wellness Levels' Impact On How They Promote Wellness." This study backed by a SACES research grant explores how levels of wellness and mindfulness impact how Counselor Educators promote wellness in their students. Results may improve our understanding of wellness promotion behaviors used by Counselor Educators.

During this study, you will be asked to complete the Five Factor Wellness Inventory, Mindful Attention Awareness Scale, the Wellness Promotion Survey, and a few demographic questions. It should take no more than --- min. After you have completed the surveys you will receive a thank you email and an opportunity to enter a two drawings for a wellness workbook or a mindfulness workbook.

Participation in this study is limited to individuals who meet ALL THREE of the following inclusion criteria:

1. Hold a PhD or EdS in Counselor Education or closely related field (human services, social work, nursing, or psychology)

2. Currently work as Faculty in a Mental Health Counseling, School Counseling, Community Counseling, Rehabilitation Counseling, Professional Counseling, and/or Marriage and Family Counseling Program.

3. Have at least ONE year of experience as a Faculty member in a Mental Health Counseling, School Counseling, and/or Marriage and Family Counseling Program.

Your participation in this study could impact ways to increase wellness and decrease burnout in counseling students. All the information and responses to this survey are confidential.

I would greatly appreciate your participation in this study. Again, thank you for your time and consideration in this endeavor.

Please click this link to read the informed consent and take the surveys:

Thank you,
Rachael Marshall
Doctoral Candidate Counselor Education,
University of Tennessee Knoxville
(615) 830-9161
rmarsha6@vols.utk.edu

<center>**Appendix L: Study Informed Consent**</center>

Counselor Educators' Wellness Levels' Impact On How They Promote Wellness
Introduction
You are invited to participate in a study backed by a SACES research grant exploring how levels of wellness and mindfulness impact how Counselor Educators promote wellness in their students. You are helping I better understand the survey procedures. This information will then be used to complete my dissertation.

I am completing this dissertation study as a part of my requirement as a doctoral candidate in the Counselor Education program at the University of Tennessee. Results from this study may improve our understanding wellness promotion strategies used by Counselor Educators.

Participants' Involvement
During this study, you will be asked to complete the Five Factor Wellness Inventory, Mindful Attention Awareness Scale, the Wellness Promotion Survey, and a few demographic questions. It should take no more than --- min. After you have completed the surveys you will receive a thank you email and an opportunity to enter a drawing for a wellness workbook or a mindfulness workbook.

Participant Criteria
Participation in this study is limited to individuals who meet the following inclusion criteria:

1. Hold a PhD or EdS in Counselor Education or closely related field (human services, social work, nursing, or psychology)

2. Currently work as Faculty in a Mental Health Counseling, School Counseling, Community Counseling, Rehabilitation Counseling, Professional Counseling, and/or Marriage and Family Counseling Program.

3. Have at least ONE year of experience as a Faculty member in a Mental Health Counseling, School Counseling, and/or Marriage and Family Counseling Program.

Potential Risks
There are no foreseeable risks other than those experienced in everyday life. Also, there is possible breach of confidentiality. The groups are small enough that it would be possible to identify individuals from the pilot survey if data were disaggregated into small enough groups. However, no names will be used in reporting data. Data will be kept in a password-protected file on a password-protected computer. Data will not be disaggregated by demographic categories.

Potential Benefits
There may be no personal benefit from your participation in the study. The survey measures how CEs promote wellness in their students, therefore, taking the WPS bears the potential benefit for

the participants to find our ways you ARE promoting wellness, and discover other ways you COULD promote wellness for your students.

The 5F-WEL bear the potential benefit of helping CEs understand their own wellness levels. The overall benefit of this research is to better understand how Counselor Educators understand wellness promotion in the classroom, and extend research opportunities in wellness promotion.

Compensation & Costs
You will have the opportunity to enter two drawings for a free Wellness workbook or Mindfulness workbook. If at any time you choose not to continue through the surveys you can still enter for the drawing. Email addresses will be gathered on the Thank you page if you want to enter.

Confidentiality
All information obtained about you in this study is strictly confidential unless disclosure is required by federal or state law or you waive your right. The results of this study will be used in presentation, publication, and final dissertation.

Contact Information
If at any time you have questions about the study or procedures, or you experience any problems related to the study, please contact Is listed below:
Primary Researcher:
Rachael Marshall, MS
Doctoral Candidate Counselor Education
University of Tennessee Knoxville
615-830-9161
rmarsha6@vols.utk.edu

Faculty Advisor:
Melinda M. Gibbons, Phd, NCC
Professor and PhD Program Coordinator
Counselor Education
University of Tennessee
865-974-4477
mgibbon2@utk.edu

If you have questions or concerns about your treatment in this research or your rights as a participant, please contact the University of Tennessee IRB Compliance Officer at 865-974-7697 or utkirb@utk.edu.

Voluntary Participation
Your participation in this study is voluntary; you may decline to participate without penalty. If you decide to participate, you may withdraw from the study at any time without penalty and without loss of benefits to which you are otherwise entitled. If you withdraw from the study

before data collection is completed your data will be deleted and not used for data analysis or reporting purposes.
Please check in the appropriate boxes below:

☐ I choose to participate in the research study with the opportunity to enter a drawing
☐ I choose NOT to participate in this research study but want to enter the drawing
☐ I choose NOT to participate in this research study but want to enter the drawing

Appendix M: Thank You E-mail, Decline

Thank you for considering to participant in this study.

If you have any questions please contact:

Rachael Marshall, Doctoral Candidate
Counselor Education
The University of Tennessee
Rmarsha6@vols.utk.edu

Melinda Gibbons, PhD
Professor
Counselor Education
The University of Tennessee
Mgibbon2@utk.edu

Appendix N: Thank you E-mail, Accept

Thank you for your participation in this study.

If you have any questions please contact:

Rachael Marshall, Doctoral Candidate
Counselor Education
The University of Tennessee
Rmarsha6@vols.utk.edu

Melinda Gibbons, PhD
Professor
Counselor Education
The University of Tennessee
Mgibbon2@utk.edu

Table 4.7
Correlational Matrix of Major Construct Subscales

	1	2	3	4	5	6	7	8	9	10	11
1. Wellness Levels: Coping	1										
2. Wellness Levels: Creative	.649**	1									
3. Wellness Levels: Physical	.562**	.261**	1								
4. Wellness Levels: Essential	.470**	.412**	.438**	1							
5. Wellness Levels: Social	.497**	.629**	.292**	.392**	1						
6. Wellness Promotion: Coping	.254**	.452**	.017	.094	.242**	1					
7. Wellness Promotion: Creative	.367**	.332**	.123	.097	.141	.545**	1				
8. Wellness Promotion: Physical	.462**	.210**	.623**	.440**	.212*	.215*	.432**	1			
9. Wellness Promotion: Essential	.281**	.423**	.017	.153	.237*	.565*	.516*	.244*	1		
10. Wellness Promotion: Social	.262**	.315**	.104	.208*	.257*	.517*	.676*	.442*	.518*	1	
11. Wellness Promotion: Incorporated	.171	.223*	.110	.151	.084	.460**	.458**	.148	.316**	.365**	1

** Correlation is significant at the .01 level (2-tailed).
*Correlation is significant at the .05 level (2-tailed).

Appendix P: Table 4.12

Table 4.12

Regression Predictors of 5F-WEL, MAAS, and Demographics on WPS Subscales

Variables: DV/IV	B	SE	β	R²
Coping WPS subscale				**.161**
Years Experience	.109	.103	.106	
Creative Self 5F-WEL	1.377	.359	**.510***	
Coping Self 5F-WEL	..034	.359	.014	
Physical Self 5F-WEL	-.137	.182	-.082	
Essential Self 5F-WEL	-.153	.208	-.077	
Social Self 5F-WEL	-.103	.322	-.037	
MAAS average	.004	.111	.003	
Creative WPS subscale				**.174**
Years Experience	.061	131	.047	
Creative Self 5F-WEL	.834	.464	.241	
Coping Self 5F-WEL	1.168	.472	**.376***	
Physical Self 5F-WEL	-.141	.236	-.066	
Essential Self 5F-WEL	-.202	.274	-.079	
Social Self 5F-WEL	-.516	424	-.143	
MAAS average	.022	.145	.016	
Essential WPS subscale				**.226**
Years Experience	.224	.106	.208	
Creative Self 5F-WEL	1.102	.368	**.390****	
Coping Self 5F-WEL	.117	.374	.046	
Physical Self 5F-WEL	-.267	.190	-.154	
Essential Self 5F-WEL	-.003	217	-.002	
Social Self 5F-WEL	-.079	.336	-.027	
MAAS average	-.189	.115	-.167	
Social WPS subscale				.113
Years Experience	-.083	.117	-.071	
Creative Self 5F-WEL	.620	.421	.202	
Coping Self 5F-WEL	.438	.429	.159	
Physical Self 5F-WEL	-.151	.217	-.080	
Essential Self 5F-WEL	.260	.249	.115	
Social Self 5F-WEL	.122	.385	.038	
MAAS average	.005	.132	.004	
Physical 5F-WEL				**.226**
Years Experience	.114	.102	.106	
Creative Self 5F-WEL	1.102	.368	**.390****	
Coping Self 5F-WEL	.117	.374	.046	
Physical Self 5F-WEL	-.267	.190	-.154	
Essential Self 5F-WEL	-.003	.217	-.002	
Social Self 5F-WEL	-.079	.336	-.027	
MAAS average	-.189	.115	-.167	
Coursework WPS subscale				.128
Years Experience	-.064	.125	-.052	
Creative Self 5F-WEL	.893	.450	.274	
Coping Self 5F-WEL	.032	.458	.011	
Physical Self 5F-WEL	.011	.232	.005	
Essential Self 5F-WEL	.229	.266	.095	
Social Self 5F-WEL	-.527	.411	-.155	
MAAS average	-.251	.141	-.192	

*p<.05 **p<.01 ***p<.001.

Vita

Rachael Camille Marshall is a Tennessee native, growing up in Nashville, attending undergraduate school at the University of Tennessee, Knoxville attaining a bachelor's degree in Psychology. She received a master's degree in Mental Health Counseling at Lipscomb University in Nashville TN. During her master's degree she worked as a Kindergarten and Pre-K teacher in Nashville; working summers as a camp counselor to pay for school. After finishing her master's she worked at Nashville State Community College as an academic counselor. Her work brought out her interest in career counseling, with first generation college students, immigrants, and international students. Her work with students encouraged her to continue her education to expand the information on career development and preparing future counselors.

Marshall returned to the University of Tennessee Knoxville to pursue her doctorate in Counselor Education. In Knoxville, she worked with the Center for Career Development – continuing her exploration and interest in career counseling. Through CCD and other opportunities at UT, Marshall published five peer-reviewed articles, was an invited speaker/guest lecturer at five presentations across the U.S., and presented at 35 local, regional, national, and international conferences during her tenure as a doctoral student. Her research interests fall under the umbrella of career development, with three domains in which her research expands. The first domain includes of undergraduate and graduate student experiences includes: major exploration, attrition, graduate student athletes, and international Students. The second domain counselor development includes: wellness and burnout and master's and PhD level student experiences. The final domain counselor training includes: contemplative pedagogy, mindfulness, and wellness promotion.

Additionally, she gained the Qualitative Research Certificate and the Grief, Loss, and Trauma Certificate while completing her PhD. After her degree completion she will begin her first faculty position at California State University, Sacramento as a tenure-track Assistant Professor in the College Graduate and Professional Studies in Education, Department of Counselor Education.