

# Wellness and Professional Quality of Life in Counselor-in-Training Interns: Assessment of Wellness and Non-Wellness-Infused Supervision in Pre-Professionals

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## ABSTRACT

**Introduction:** Counselors-in-training (CITs) commonly encounter issues of burnout, compassion fatigue, and/or vicarious traumatization due to the nature of their jobs in the helping profession. Wellness infused supervision may help CITs foster personal wellness and mitigate deleterious effects of helping. This investigation examined connections related to counselor-in-training wellness and professional quality of life during an internship-level supervision course across a wellness and control section.

**Methods:** A quasi-experimental design was piloted, comparing a wellness-focused supervision internship section with a non-wellness control group supervision internship section during one academic semester. Participants included 15 clinical mental health CITs (9 experimental; 6 control), who were randomly assigned into the wellness or control internship section. Internship classes consisted of two-hour meetings across a 16 week semester, with participants working towards 300 clock hours of experience. All participants who were offered inclusion into internship accepted, and were randomly assigned into the wellness-infused or control internship sections, which took place within a large, Council for Accreditation in Counseling and Related Educational Program (CACREP) accredited program.

**Results:** Results indicated decreased wellness scores in both internship sections from pre-to-post assessment, no differences between wellness-based internship and the control group in wellness or professional quality of life, and an increase in compassion satisfaction in the wellness-based internship group.

**Conclusion:** Although counselors are vulnerable to compromised wellness due to the nature of their work, training CITs to work from a wellness paradigm in their personal and professional lives may facilitate well-being, and mitigate the effects of burnout and fatigue. Results from this study shed light on how CITs are viewing their personal wellness and how supervisors can utilize assessments to facilitate reflective conversations with supervisees about their wellness and quality of life.

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## INTRODUCTION

Counselors-in-training (CITs) regularly encounter stressors causing burnout, compassion fatigue, and/or vicarious traumatization that may diminish personal and professional wellbeing and mitigate positive client outcomes [1-4]. Contemporary counselor training programs recognize the concept of holistic wellness as a guiding principle of the counseling discipline and central to the wellbeing of CITs and their ability to effect positive counseling outcomes with those they serve. To minimize the potential of these or other negative outcomes, CITs are trained to identify and draw from an idiosyncratic set of personal strengths embedded within holistic wellness [2,3]. Successfully identified and applied in clinical settings, a CIT's personal strengths may act as a buffer to deleterious effects of stressors within the helper role [1].

Although the notion of holistic wellness is often instilled across counselor training curricula, it is the field-based practicum and internship courses where CITs are most likely to encounter nuanced, real-time clinical and administrative situations testing their personal strengths. Each experience has inherent personal and professional implications for the CIT, from the complexity of their cases and growing awareness of their efficacy as a counselor, to insights into their sense of personal wellness and its potential implications for their clinical decision making [4]. Professionals considered as well, for instance, are found to be more actively engaged in activities and are more likely to have positive client outcomes [4-8]. Studies also suggest that well helping professionals are more capable of meeting their client needs, while those who remain more vulnerable to the inherent stressors of working with distressed

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clients are more inclined to experience vicarious trauma, compassion fatigue, and burnout [5, 9-12]. In addition to increasing the risk for substance abuse, anxiety, relationship issues, sleep disturbances, depression and suicidal ideation or suicide, counselor burnout may lead to diminished clinical judgement, and poorer attitudes towards clients [5]. Ultimately, while internships offer CITs experiences designed to develop their clinical acumen, they also serve as a gateway for a more critical examination of personal wellness and its potential to effect the quality of their current and future well-being and clinical efficacy [3,10]. To do so, however, requires that CITs practice under the tutelage of experienced clinicians with advanced training in clinical supervision. This study seeks to explore the notion that supervisors who utilize a wellness-based supervision approach are uniquely positioned to facilitate a CIT's awareness of the implications of personal wellness relative to their personal and professional quality of life and the quality of services they provide to clients. The following sections highlight the areas of professional quality of life and wellness and highlight how these variables might be important to CIT development throughout the training experience and beyond.

### Professional Quality of Life

The connection among personal wellness, professional competence, and client care is at the center of this and other investigations involving professional quality of life. To assess quality of life, the Professional Quality of Life Scale (ProQoL) is commonly utilized [7]. Mullen et al. [12] examined the relationship among stress, burnout, and job satisfaction of school counselors (N = 750) and found that participants' burnout and perceived stress had a negative correlation with job satisfaction. Puig et al. [10] investigated burnout in helpers (N = 129) and found that burnout accounted for a large amount of the variance in personal wellness. Thus, professional quality of life is assessed alongside wellness in this investigation.

### Wellness & Counselor Training

Wellness is "a way of life oriented toward optimal health and well-being in which the body, mind, and spirit are integrated by the individual to live more fully" [13]. Contemporary wellness research and practice in the counseling field are grounded in the strength-based Indivisible Self Model of wellness [14], which is based on the Wheel of Wellness [14]. The Indivisible Self Model highlights Coping, Social, Physical, Creative, and Essential parts as overarching components of wellness [14]. Multiple studies support the importance and utility of the wellness approach across a range of populations [15-20] and among students and educators within counselor preparation programs [14, 21-25]. The notion of facilitating counselor well-being is a core ideal of the counseling discipline and codified within the profession's ethical standards [26]. Consistent with this recognition is an increased focus among researchers relative to the development and application of wellness-based supervision models and interventions as a central feature of counselor development [8, 27-30].

### Wellness-Informed Supervision

Current research on the impact of wellness-informed supervision strategies on CIT wellness and client outcomes is promising yet limited [4, 30-31]. Lenz and colleagues' [4] meta-review of wellness-informed supervision models (e.g., Wellness Model of Supervision; WELMS) [4] and Integrative Wellness Model; IWM [32]) suggested a foundational level of empirical support for wellness-informed supervision models and strategies. Lenz et al. [4] evaluated features of wellness-informed approaches to supervision and found preliminary support for wellness approaches in supporting CIT development. We aimed to build upon Lenz and colleagues' [4] findings by exploring relationships between CIT wellness and professional quality of life during a wellness-based internship and control group internship section. Wellness-informed supervision allows CITs the opportunity to identify and apply their assets and resources in supervision and therapeutic settings, potentially enhancing their well-being and the well-being of their clients in a parallel process [32]. In turn, counselor educators and supervisors are better able to monitor CIT knowledge and skill development while remaining attentive to client well-being and safety—thus promoting a residual focus on wellness in the counseling profession [33-34].

## METHODS

### Purpose of the Study

The purpose of this investigation was to explore CIT wellness and professional quality of life through a pretest-posttest quasi-experimental design—within a single-semester clinical mental health counseling internship experience. See **Figure 1 (next page)** for the Flow Diagram of the Quasi-Experimental Intervention. The course lasted 16 weeks, with a total of 2 hours of dedicated classroom time each week. Participants were able to register for their Clinical Mental Health Counseling (CMHC) internship section initially and then the internship sections were randomly assigned as a wellness-based supervision section or a control-based supervision section. The wellness-infused supervision followed the Wheel of Wellness and Indivisible Self Model to educate students on wellness, assess wellness levels, and develop plans of action to improve wellness. Specifically, the wellness section used the aforementioned models as discussion pieces and also:

- explored CIT overall wellness at pre-and-post supervision experience as measured by the Five-Factor Wellness Inventory (5F-Wel)14;
- assessed CIT professional quality of life at pre-and-post supervision experience as measured by the Professional Quality of Life Scale (ProQoL)7;
- assessed social desirability as measured by the Marlow Crown Social Desirability Scale-X135; and
- assessed potential group differences (between wellness-based supervision internship and control supervision internship) in the aforementioned areas.

We examined the overall wellness scores, professional quality of life, and mean group differences in wellness or professional quality of life in both CIT supervision sections.

CONSORT 2010 Flow Diagram

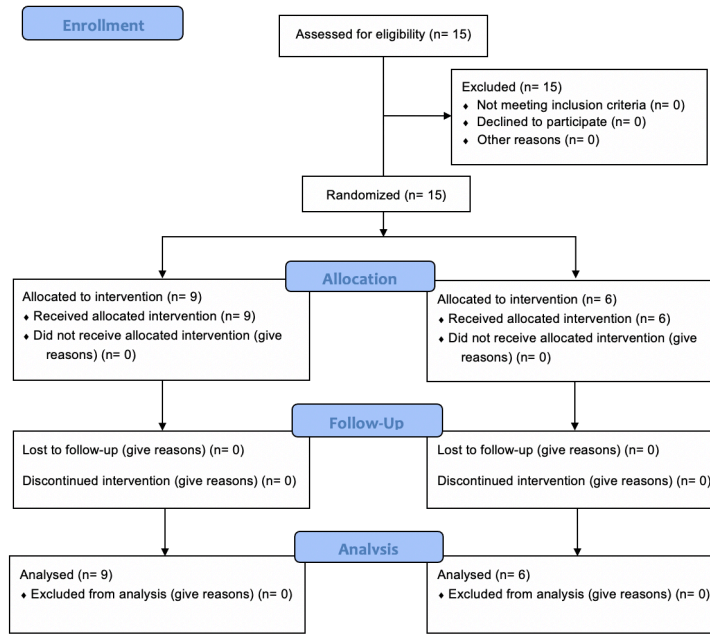


Figure 1: Flow Diagram of Quasi-Experimental Intervention

**Instruments**

**Demographic Questionnaire**

All CIT participants completed a general demographic questionnaire answering questions relating to ethnicity, sex, primary population served, earned degrees, and time in the field or profession.

**MCSDS-X1**

Participants completed the MCSDS-X1 [35], which is a 10-item shorter version of the Marlowe-Crowne Social Desirability Scale [36], assessing if participants are answering truthfully, or in a socially desirable way. Sample items from the MCSDS-X1 are "I'm always willing to admit it when I make a mistake," and "I like to gossip at times." Furthermore, MCSDS-X1 item scoring is based on a 1 (items that are socially desirable) to 0 (items that are not socially desirable) range, with total scores on the assessment ranging from 0 to 10. Individuals scoring higher than five are viewed as answering in a socially desirable manner. The MCSDS-X1 has an internal consistency range of around 0.50 to 0.90 [37-40]. The internal consistency reliability for the MCSDS-X1 with these data was 0.689, which was acceptable [41].

**5F-Wel**

The Five-Factor Wellness Inventory (5F-Wel) [14] is an evidence-based wellness instrument used to assess wellness characteristics. The current version of the 5F-Wel is a 91-item self-report assessment ranging from strongly disagree, disagree, agree, and strongly agree, with high scores indicating increased levels of wellness. Example items include: "I am optimistic about

the future" and "My religion helps my well-being". Reliability coefficients range from  $\alpha = 0.94$  for total wellness to an average of  $\alpha = 0.92$  for the second-order factors (Creative Self, Coping Self, Social Self, Physical Self, and Essential Self) [14].

**ProQol**

The ProQoL [42] is a 30-item self-report assessment measuring compassion fatigue and compassion satisfaction. Compassion fatigue is further divided into two subscales, burnout and secondary traumatic stress. Thus, the ProQoL consists of three subscales: (a) Burnout (10 items), (b) Compassion Satisfaction (10 items), and (c) Secondary Traumatic Stress (10 items). Participants report the frequency of experiences on a Likert scale ranging from 0 (never) to 5 (very often). Sample items include: I am happy and I feel trapped by my job as a helper. Internal consistency coefficients range from  $\alpha = 0.78$  (Burnout) to 0.80 (Compassion Fatigue) to  $\alpha = .84$  (Compassion Satisfaction) [7].

**Intervention**

Following Institutional Review Board (IRB) approval, CITs enrolled in two internship courses were invited to participate in the investigation. One of the groups was randomly selected as the experimental group, in which the interns (n = 9) participated in a wellness-infused supervision experience.

**Wellness Group Supervision**

The wellness group supervision and education components were based largely on the Indivisible Self Model, and Wheel of Wellness described above) and included:

- a. pre-assessment (prior to the start of the first course);
- b. wellness education (during every internship course meeting, involved 15 minutes of wellness-based discussion using the wheel of wellness tenets and Indivisible Self Model factors);
- c. development of individual wellness plans (during the third internship course meeting, **Figure 2**);
- d. weekly wellness-focused supervisory check-ins (10 minutes where participants could freely talk about wellness and elicit/offer feedback), and
- e. post-assessment (following internship course completion).

During the pre-assessment phase, the CITs first received an informed consent document for participation in the study. Participants completed the battery of assessments (e.g., demographic form, 5f-Wel, Helping Professional Wellness Discrepancy Scale, ProQol, MCSDS-X1). CITs were given assessment results and developed a Wellness Plan [43] (see Figure 1) based on both assessment results and the supervisees personal preference. At the end of the semester, the CITs participated in post-assessments (i.e., 5F-Wel, HPWDS, ProQoL, MCSDS-X1).

Figure 2: Wellness Plan Example

Dimension of Wellness	Things I regularly do to strengthen this dimension	Goal for improving this dimension	Obstacles	What is my motivation?	Date to notice progress?	I commit to this goal: Initials here
Physical						
Emotional						
Spiritual						
Intellectual						
Social						
Occupational						
Environmental						

\*Adapted from Granello and Young (2012)

### Control Group Supervision

In the control internship group (n = 6), participants went through the following:

- a. pre-assessment,
- b. weekly supervisory check-ins, and
- c. post-assessment.

Pre-and-post assessments were the same as the wellness-based experimental format, however, CITs in this section did not receive wellness assessment results, were not offered wellness-infused supervision, and did not create individualized wellness plans. Following post-assessment, CITs were able to receive their assessment results and consult with the instructors if they wanted more information or assistance with creating a personalized wellness plan.

### Data Analysis

Following the data collection process, data were cleaned and scored, entered into an excel file, and analyzed by the Statistical

Package for the Social Sciences (Version 19.0). Prior to beginning the data analysis process, the data was screened and preliminary analyses were conducted. Data were assessed for normality and checked for outliers. A sample size of 20 was deemed acceptable for identifying a large effect size (power = 0.80) at the 0.10 level (Cohen, 1992)—based on a significance Cohen’s d effect sizes of 0.2 = small effect, 0.5 = medium effect, and 0.8 = large effect [44]. Due to the power total and Council for Accreditation of Counseling and Related Educational Programs (CACREP) student/faculty ratios (a faculty to student ratio of 12:1 is required, but clinical courses are often 6-9 students total) our sample of 15 was deemed appropriate for this investigation [45].

## RESULTS

### Participant Characteristics

Participants included internship one-level CITs enrolled in a 300-hour field experience course in a Midwestern, CACREP program. All 15 participants were completing CMHC degrees and exclusion criteria was not being enrolled in the internship course. Twelve participants identified as females, three participants identified as males, and zero participants identified as other. Five participants identified as married, nine participants identified as single, and one participant preferred not to answer. Regarding employment status, six participants stated they worked full-time in addition to school, eight participants said they were employed part-time in addition to school, and one participant was currently unemployed. Finally, one participant identified as African American, thirteen participants identified as Caucasian, and one participant identified as Hispanic/Latinx. See **Table 1** for a demographic breakdown.

Table 1: Demographic Breakdown

	Experimental Group (n = 9)	Control Group (n = 6)
<b>Biological Sex</b>		
Female	8 (88.9%)	4 (66.7%)
Male	1 (11.1%)	2 (33.3%)
<b>Marital Status</b>		
Married	3 (33.3%)	2 (33.3%)
Single	6 (66.7%)	3 (50%)
Prefer Not To Answer	0 (0%)	1 (16.7%)
<b>Employment Status</b>		
Employed Full Time	3 (33.3%)	3 (50%)
Employed Part Time	5 (55.6%)	3 (50%)
Not Working	1 (11.1%)	0 (0%)
<b>Education</b>		
Graduate Student	9 (100%)	6 (100%)
<b>Cultural Background</b>		
African American	1 (11.1%)	0 (0%)
Caucasian	7 (77.8%)	6 (100%)
Hispanic/Latinx	1 (11.1%)	0 (0%)
Other	0 (0%)	0 (0%)

### ProQol

A review of the measures of the results for the ProQol indicated that participants in the wellness-based internship group pre-test were: (a) Burnout (10 items; M = 19.33, SD = 5.50), (b) Secondary Traumatic Stress (10 items; M = 21.33, SD = 5.48), and (c) Compassion Satisfaction (10 items; M = 38.44, SD = 5.50). The results for the post-test were: (a) Burnout (10 items; M = 20.55, SD = 4.33), (b) Secondary Traumatic Stress (10 items; M = 20.22, SD = 5.04), and (c) Compassion Satisfaction

(10 items;  $M = 42.33$ ,  $SD = 4.24$ ). For the control internship group, pre-assessment results were: a) Burnout (10 items;  $M = 19.83$ ,  $SD = 6.27$ ), (b) Secondary Traumatic Stress (10 items;  $M = 21.33$ ,  $SD = 6.80$ ), and (c) Compassion Satisfaction (10 items;  $M = 41.66$ ,  $SD = 6.83$ ). The results for the post-test were: (a) Burnout (10 items;  $M = 20.83$ ,  $SD = 4.26$ ), (b) Secondary Traumatic Stress (10 items;  $M = 17.83$ ,  $SD = 4.40$ ), and (c) Compassion Satisfaction (10 items;  $M = 39.83$ ,  $SD = 3.55$ ).

A paired samples t-test was utilized to assess within group differences within the ProQoL subscales at pre-and post-assessment. For the experimental wellness-based internship section Burnout subscale, we found no statistical significance:  $t(8) = -0.757$ ,  $p < 0.47$ . For the Secondary Traumatic Stress subscale, we found no statistical significance:  $t(8) = 0.533$ ,  $p < 0.609$ . Finally, for the Compassion Satisfaction subscale, we found a statistically significant change:  $t(8) = -2.84$ ,  $p < 0.022$ . Regarding the control group internship section Burnout subscale, we found no statistical significance:  $t(5) = -0.248$ ,  $p < 0.81$ . For the Secondary Traumatic Stress subscale, we found no statistical significance:  $t(5) = 1.27$ ,  $p < 0.26$ . Finally, for the Compassion Satisfaction subscale, we also found a statistically non-significant change:  $t(5) = 0.617$ ,  $p < 0.564$ . See **Table 2** for ProQoL results.

Table 2: ProQoL Results

	Wellness Internship Course	Control Internship Course
<b>Pre-Test</b>		
Burnout	19.33	19.83
Sec. Traumatic Stress	21.33	21.33
Compassion Satisfaction	38.44	41.66
<b>Post-Test</b>		
Burnout	20.55	20.83
Sec. Traumatic Stress	20.22	17.83
Compassion Satisfaction	42.33	39.83
<b>Within Group Differences</b>		
Burnout	$t(8) = -.757, p < .47$	$t(5) = -.248, p < .81$
Sec. Traumatic Stress	$t(8) = .533, p < .609$	$t(5) = 1.27, p < .26$
Compassion Satisfaction	$*t(8) = -2.84, p < .022$	$t(5) = .617, p < .564$

\*Denotes Statistical Significance

Effect sizes were calculated and analyzed using Cohen's  $d$ . For the wellness-based internship group, the following findings emerged: Burnout ( $d = 0.25$ ), Secondary Traumatic Stress ( $d = 0.21$ ), and Compassion Satisfaction ( $d = 0.79$ ), indicating small effects for burnout and secondary traumatic stress scores and a large effect for compassion satisfaction at pre-and-post assessment. For the control internship group: Burnout ( $d = 0.19$ ), Secondary Traumatic Stress ( $d = 0.6$ ), and Compassion Satisfaction ( $d = 0.34$ ), indicating small effects for burnout and compassion satisfaction and a medium effect for secondary traumatic stress.

Table 3: 5F-Wel Results

	Wellness Internship Course	Control Internship Course
<b>Overall Wellness Pre-Test</b>	$M = 81.07$	$M = 82.65$
<b>Overall Wellness Post-Test</b>	$M = 79.4$	$M = 79.44$
<b>Within Group Differences</b>	$t(8) = .905, p = .392$	$t(5) = .771, p = .475$

## 5F-Wel

Because of the normality of the data, a paired samples t-test was utilized to assess within-group differences on overall wellness. Participants' analysis indicated a decrease in wellness scores for the wellness-based internship group pre-test ( $M = 81.07$ ,  $SD = 5.91$ ) and post-test ( $M = 79.4$ ,  $SD = 2.99$ );  $t(8) = 0.905$ ,  $p = 0.392$ . Scores indicated that participants were "well" and scored high on overall wellness for pre-and-post assessment. Though there was not a significant decrease in wellness scores, it is interesting that overall wellness scores decreased following a wellness-based internship course. Control group analysis indicated a statistically non-significant decrease in wellness scores as well; pre-test ( $M = 82.65$ ,  $SD = 5.53$ ) and post-test ( $M = 79.44$ ,  $SD = 9.37$ );  $t(5) = 0.771$ ,  $p = 0.475$ . See **Table 3**. Mean wellness scores at pre and post assessment indicated participants were functioning well and scored high on overall wellness. The effect size for the experimental group was 0.4, indicating a medium effect, while the effect size for the control group was 0.7, indicating a large effect. Participants in the control group initially scored higher on overall wellness than the wellness-based internship group. Both groups appeared to end their internship experience with the same overall wellness average at post-assessment (approximately  $M = 79$ ).

No statistically significant differences in overall wellness were found in the control section ( $M = 82.65$ ,  $SD = 5.5$ ) and wellness-based section ( $M = 81.1$ ,  $SD = 5.91$ ) at pre assessment:  $t(13) = -5.17$ ,  $p < 0.614$  for the control section ( $M = 79.44$ ,  $SD = 9.38$ ) and wellness based section ( $M = 79.4$ ,  $SD = 2.99$ ) at post-assessment:  $t(13) = -0.012$ ,  $p < 0.99$ . For professional quality of life subscales, we found no statistically significant difference in burnout, compassion satisfaction, or compassion fatigue between the control and wellness-based internship groups at pre-and-post assessment.

## DISCUSSION

Though non-significant, the decrease in wellness among both internship sections poses interesting questions. Obtaining 300 clock hours of work with clients, though integral to CIT development, could cause increased levels of stress and anxiety. The (re) exposure to the wellness paradigm may have allowed students in the wellness group to report their sense of wellness more accurately and to engage in a thorough analysis of their level of functioning [2]. The use of wellness strategies during the internship may have triggered more CIT reflection and influenced the decrease in overall well-being. This seemingly neutral finding may reveal a vital opportunity to blend reflective and wellness-informed pedagogical and supervision strategies as a means for enhancing CIT self-awareness and, by extension,

clinical and ethical competence. The intentional confluence of reflection and wellness-informed supervision strategies fits naturally into the inherent developmental aspect of CIT supervision, allowing for reflective strategies tailored to the supervisee's idiosyncratic strengths and developmental level. This framework also creates research opportunities for examining the efficacy of wellness-based supervision formats (individual, triadic, group, and direct supervision) across distinct supervision models [46-49]. Individual supervisor and supervisee characteristics are known to influence the supervisory alliance could also be investigated, as well as client outcomes [46-47].

Results specific to professional quality of life include a more critical exploration of non-significant findings. First, as framed in the previous section, the multidimensional, dynamic, and holistic nature of the wellness model warrants close examination of even non-significant relationships between CIT total wellness and the ProQol. It may be reasonable to assert that disparities in wellness factors would emerge across second and third-order factors (as measured on by the 5F-Wel) between the CIT groups, and that those disparities could yield valuable insights into how CIT personal wellness may interact with the distinctive elements of CIT professional quality of life. Empirical support for this notion is found in the statistically significant increase in pre-post compassion satisfaction element of ProQol.

Several inferences may be drawn from the significant pre-post compassion satisfaction score. First, CITs are experiencing a sense of pleasure and accomplishment in the care they are providing at an early phase of their professional training [50]. This is consistent with the compassion satisfaction of experienced professional counselors [51]. Second, these findings support wellness-informed supervision as central to grounding CITs in work-life balance philosophy, which may protect them from future compassion fatigue and burnout [52-53]. Third, findings related to compassion satisfaction offer insight into the complicity between second and third order wellness factors and focusing on fostering compassion satisfaction could support CIT skill development and professional competence and also serve as a protective factor against compassion fatigue and unwellness.

### Limitations & Future Research

A limitation in this investigation was that power was slightly lower than the recommended 20. However, we wanted to focus on a single internship semester to maintain the integrity and homogeneity of the study, and adhere to the CACREP faculty/student ratios limiting the number of students in the internship courses. Thus, future investigations could increase the power by increasing the overall sample size. An additional limitation involves the demographics of the study, with the majority of participants identifying as Caucasian and Female. A final limitation of the investigation is that causality between the investigation and the outcome cannot be inferred, as the study is quasi-experimental in nature. Therefore, the results and generalizability should be examined with caution.

Future research could explore wellness in-depth and the complexities within the 5F-Wel by involving longitudinal investigations of both wellness and career satisfaction for CITs. Further, future supervision studies assessing the idiosyncratic

nature of CITs second and third-order wellness traits and professional quality of life are needed. Our results support the utility of wellness-based supervision as a framework for exploring associations between CIT wellness and professional quality of life, and the potential implications for CITs current and future personal wellness, professional competence, and client care. Additionally, it would behoove future researches to examine things like student/instructor dynamics, the CITs developmental stage, and the instructors' or CITs implicit or explicit bias associated with incorporating wellness into internship courses to offer a more robust explanation of CIT wellness in counselor training programs.

Since group supervision occurs primarily within classroom settings during internships in counselor preparation programs, future research opportunities surrounding wellness-informed strategies in relation to group dynamics and the teaching styles of the course instructor/group supervisor. On the other hand, the similar non-significant decrease in wellness between the pre and post-tests offers a lane for more intentional studies regarding the personal characteristics and experiences of the supervisee over a semester that could weaken their sense of overall wellness. Closer inspection of CIT second and third-order wellness dimensions (e.g., available via the 5F-Wel but not included in this investigation) may highlight more nuanced CIT wellness resources and dynamics that could form the basis for designing more intentional wellness-based supervision strategies. Trainees may draw upon alternate personal assets and resources to offset those that may be inaccessible or diminished in response to stressors occurring during internship [14]. The significant improvement in compassion satisfaction noted in the ProQOL data is evidence of the need to consider all wellness data and its relationship to other supervisory relational or procedural constructs, holistically.

### CONCLUSION

Although counselors are vulnerable to compromised wellness due to the nature of their work, training CITs to work from a wellness paradigm in their personal and professional lives may facilitate well-being and mitigate the effects of burnout and potential impairment. At the very least, having discussions about wellness can lead to an increased sense of awareness and offer CITs an increased level of satisfaction in their work. Overall, this study sheds light on how CITs view their personal wellness and how supervisors can utilize assessments to facilitate reflective conversations with supervisee about their perceptions.

### REFERENCES

1. Granello PF. *Wellness Counseling*. Boston: Pearson; 2013.
2. Blount AJ, Lambie GW. Development and factor structure of the helping professional wellness discrepancy scale. *Meas Eval Couns Dev* [Internet]. 2017;51(2):92-110. Available from: <http://dx.doi.org/10.1080/07481756.2017.1358060>
3. Lambie GW. The contribution of ego development level to burnout in school counselors: Implications for

- professional school counseling. *J Couns Dev* [Internet]. 2007;85(1):82–8. Available from: <http://dx.doi.org/10.1002/j.1556-6678.2007.tb00447.x>
4. Lenz AS, Blount AJ, Norris CA. A multi-method synthesis of studies evaluating wellness-informed approaches to counselor supervision. *Clin Superv* [Internet]. 2018;37(2):339–59. Available from: <http://dx.doi.org/10.1080/07325223.2018.1507858>
  5. Kumar S. Burnout and doctors: Prevalence, prevention and intervention. *Healthcare (Basel)* [Internet]. 2016;4(3):37. Available from: <http://dx.doi.org/10.3390/healthcare4030037>
  6. Lawson G, Cook JM. Wellness, self-care, and burnout prevention. In: *Clinical Mental Health Counseling: Elements of Effective Practice* [Internet]. 2455 Teller Road, Thousand Oaks California 91320: SAGE Publications, Inc.; 2017. p. 313–36. Available from: <http://dx.doi.org/10.4135/9781071801253.n14>
  7. Lawson G, Myers JE. Wellness, professional quality of life, and career-sustaining behaviors: What keeps us well? *J Couns Dev* [Internet]. 2011;89(2):163–71. Available from: <http://dx.doi.org/10.1002/j.1556-6678.2011.tb00074.x>
  8. Lenz AS, Smith RL. Integrating wellness concepts within a clinical supervision model. *Clin Superv* [Internet]. 2010;29(2):228–45. Available from: <http://dx.doi.org/10.1080/07325223.2010.518511>
  9. Sharon Jayson UT. Burnout up among employees. *USA today* [Internet]. 2012 Oct 23; Available from: <https://www.usatoday.com/story/news/nation/2012/10/23/stress-burnout-employees/1651897/>
  10. Puig A, Baggs A, Mixon K, Park YM, Kim BY, Lee SM. Relationship between job burnout and personal wellness in mental health professionals. *J Employ Couns* [Internet]. 2012;49(3):98–109. Available from: <http://dx.doi.org/10.1002/j.2161-1920.2012.00010.x>
  11. Young ME, Lambie GW. Wellness in school and mental health systems: Organizational influences. *J Humanist Couns Educ Dev* [Internet]. 2007;46(1):98–113. Available from: <http://dx.doi.org/10.1002/j.2161-1939.2007.tb00028.x>
  12. Mullen PR, Blount AJ, Lambie GW, Chae N. School counselors' perceived stress, burnout, and job satisfaction. *Prof Sch Couns* [Internet]. 2017;21(1). Available from: <http://dx.doi.org/10.1177/2156759x18782468>
  13. Myers JE, Sweeney TJ, Witmer JM. The wheel of wellness counseling for wellness: A holistic model for treatment planning. *J Couns Dev* [Internet]. 2000;78(3):251–66. Available from: <http://dx.doi.org/10.1002/j.1556-6676.2000.tb01906.x>
  14. Myers JE, Sweeney TJ. The indivisible self: An evidence-based model of wellness. *The Journal of Individual Psychology* [Internet]. 60(3):234–44. Available from: <http://dx.doi.org/10.1177/1066480709348034>
  15. Granello PF. College students' wellness as a function of social support and empathic ability. *J Coll Couns* [Internet]. 1999;2(2):110–20. Available from: <http://dx.doi.org/10.1002/j.2161-1882.1999.tb00149.x>
  16. Hodges E, Myers J. Counseling adult women survivors of childhood sexual abuse: Benefits of a wellness approach. *J Ment Health Couns* [Internet]. 2010;32(2):139–53. Available from: <http://dx.doi.org/10.17744/mehc.32.2.t537j335522kx62q>
  17. Kissinger DB, Grover KS, Turner RC. Pediatric stroke caregiver well-being: A holistic wellness perspective. *Rehabil Couns Bull* [Internet]. 2019;63(4):245–55. Available from: <http://dx.doi.org/10.1177/0034355219846653>
  18. Myers JE, Mobley AK, Booth CS. Wellness of counseling students: Practicing what we preach. *Couns Educ Superv* [Internet]. 2003;42(4):264–74. Available from: <http://dx.doi.org/10.1002/j.1556-6978.2003.tb01818.x>
  19. Tanigoshi H, Kontos AP, Remley TP Jr. The effectiveness of individual wellness counseling on the wellness of law enforcement officers. *J Couns Dev* [Internet]. 2008;86(1):64–74. Available from: <http://dx.doi.org/10.1002/j.1556-6678.2008.tb00627.x>
  20. Watson JC, Kissinger DB. Athletic participation and wellness: Implications for counseling college student-athletes. *J Coll Couns* [Internet]. 2007;10(2):153–62. Available from: <http://dx.doi.org/10.1002/j.2161-1882.2007.tb00015.x>
  21. Barden S, Conley A, Young M. Integrating health and wellness in mental health counseling: Clinical, educational, and policy implications. *J Ment Health Couns* [Internet]. 2015;37(2):152–63. Available from: <http://dx.doi.org/10.17744/mehc.37.2.1868134772854247>
  22. Moorhead HJH, Gill C, Minton CAB, Myers JE. Forgive and forget? Forgiveness, personality, and wellness among counselors-in-training. *Couns Values* [Internet]. 2012;57(1):81–95. Available from: <http://dx.doi.org/10.1002/j.2161-007x.2012.00010.x>
  23. Roach LF, Young ME. Do counselor education programs promote wellness in their students? *Couns Educ Superv* [Internet]. 2007;47(1):29–45. Available from: <http://dx.doi.org/10.1002/j.1556-6978.2007.tb00036.x>
  24. Smith L, Foley PF, Chaney MP. Addressing classism, ableism, and heterosexism in counselor education. *J Couns Dev* [Internet]. 2008;86(3):303–9. Available from: <http://dx.doi.org/10.1002/j.1556-6678.2008.tb00513.x>
  25. Wester KL, Trepal HC, Myers JE. Wellness of counselor educators: An initial look. *J Humanist Couns Educ Dev* [Internet]. 2009;48(1):91–109. Available from: <http://dx.doi.org/10.1002/j.2161-1939.2009.tb00070.x>
  26. American Counseling Association. *ACA Code of Ethics*. Alexandria, VA; 2014.
  27. Blount AJ, Bjornsen AL, Moore MM. Work values, occupational engagement, and professional quality of life in counselors-in-training: Assessments in a constructivist-based career counseling course. *Prof Couns* [Internet]. 2018;8(1):60–72. Available from: <http://dx.doi.org/10.15241/ajb.8.1.60>
  28. Lenz AS, Oliver M, Sangganjanavanich VF. Perceptions of the wellness model of supervision among counseling interns. *Clin Superv* [Internet]. 2014;33(1):45–62. Available from: <http://dx.doi.org/10.1080/07325223.2014.905814>

29. Lenz AS, Sangganjanavanich VF, Balkin RS, Oliver M, Smith RL. Wellness model of supervision: A comparative analysis. *Couns Educ Superv* [Internet]. 2012;51(3):207–21. Available from: <http://dx.doi.org/10.1002/j.1556-6978.2012.00015.x>
30. Meany-Walen KK, Davis-Gage D, Lindo NA. The impact of wellness-focused supervision on mental health counseling practicum students. *J Couns Dev* [Internet]. 2016;94(4):464–72. Available from: <http://dx.doi.org/10.1002/jcad.12105>
31. Storlie CA, Smith CK. The effects of a wellness intervention in supervision. *Clin Superv* [Internet]. 2012;31(2):228–39. Available from: <http://dx.doi.org/10.1080/07325223.2013.732504>
32. Blount AJ, Mullen PR. Development of an integrative wellness model: Supervising counselors-in-training. *Prof Couns* [Internet]. 2015;5(1):100–13. Available from: <http://dx.doi.org/10.15241/ajb.5.1.100>
33. Bernard JM, Goodyear RK. *Fundamentals of clinical supervision*. Upper Saddle River, NJ: Pearson; 2014.
34. Goodyear RK, Bunch K, Claiborn CD. Current supervision scholarship in psychology: A five year review. *Clin Superv* [Internet]. 2006;24(1–2):137–47. Available from: [http://dx.doi.org/10.1300/j001v24n01\\_07](http://dx.doi.org/10.1300/j001v24n01_07)
35. Strahan R, Gerbasi K. Short, homogeneous versions of the Marlowe-Crowne social desirability scale. *Journal of Clinical Psychology*. 1972;28:191–3.
36. Crowne DP, Marlowe D. A new scale of social desirability independent of psychopathology. *J Consult Psychol*. 1960;24(4):349–54.
37. Ballard R. Short forms of the Marlowe-Crowne Social Desirability Scale. *Psychol Rep*. 1992;71(3 Pt 2):1155–60.
38. Barger SD. The Marlowe-Crowne affair: short forms, psychometric structure, and social desirability. *J Pers Assess*. 2002;79(2):286–305.
39. Fischer DG, Fick C. Measuring social desirability: Short forms of the Marlowe-Crowne Social Desirability Scale. *Educ Psychol Meas*. 1993;53(2):417–24.
40. Mullen PR, Lambie GW, Conley AH. Development of the ethical and legal issues in counseling self-efficacy scale. *Meas Eval Couns Dev* [Internet]. 2014;47(1):62–78. Available from: <http://dx.doi.org/10.1177/0748175613513807>
41. Streiner DL. Starting at the beginning: an introduction to coefficient alpha and internal consistency. *J Pers Assess* [Internet]. 2003;80(1):99–103. Available from: [http://dx.doi.org/10.1207/S15327752JPA8001\\_18](http://dx.doi.org/10.1207/S15327752JPA8001_18)
42. Stamm BH. *The concise ProQOL manual* [Internet]. 2nd ed. 2010. Available from: [ProQOL.org](http://ProQOL.org)
43. Granello D, Young ME. *Counseling today: Foundations of professional identity*. Upper Saddle River, NJ: Pearson; 2012.
44. Cohen J. *Statistical Power Analysis*. *Current Directions in Psychological Science*. 1992;1(3):98–101.
45. Council of the Accreditation of Counseling and Related Educational Programs [Internet]. CACREP.org. Available from: <http://www.CACREP.org>
46. Stoltenberg CD, McNeill B, Delworth U. *An Integrated Developmental Model for Supervising*. San Francisco, CA: Jossey-Bass; 1989.
47. Stoltenberg CD, McNeill BW. *IDM supervision: An integrative developmental model of supervision*. 3rd ed. New York, NY: Routledge; 2010.
48. Bernard JM. Supervisor Training: A Discrimination Model. *Couns Educ Superv*. 1979;19(1):60–8.
49. Bernard JM. The discrimination model. In: C E Watkins (Ed), *Handbook of psychotherapy supervision*. New York, NY: Wiley; 1997. p. 310–27.
50. Mangoulia P, Koukia E, Alevizopoulos G, Fildissis G, Katostaras T. Prevalence of secondary traumatic stress among psychiatric nurses in Greece. *Arch Psychiatr Nurs* [Internet]. 2015;29(5):333–8. Available from: <http://dx.doi.org/10.1016/j.apnu.2015.06.001>
51. Carmel MJS, Friedlander ML. The relation of secondary traumatization to therapists' perceptions of the working alliance with clients who commit sexual abuse. *J Couns Psychol* [Internet]. 2009;56(3):461–7. Available from: <http://dx.doi.org/10.1037/a0015422>
52. Thompson EH, Frick MH, Trice-Black S. Counselor-in-training perceptions of supervision practices related to self-care and burnout. *Prof Couns* [Internet]. 2011;1(3):152–62. Available from: <http://dx.doi.org/10.15241/eht.1.3.152>
53. Lawson G, Venart E, Hazler RJ, Kottler JA. Toward a culture of counselor wellness. *J Humanist Couns Educ Dev* [Internet]. 2007;46(1):5–19. Available from: <http://dx.doi.org/10.1002/j.2161-1939.2007.tb00022.x>