Journal of Counselor Preparation and Supervision

Volume 15 | Number 2 Article 13

2022

The Influence of Race/Ethnicity, Gender, Age, Social Support, Religion/Spirituality, and Occupational History on the Total Wellness of Counseling Practicum Graduate Students: A Pilot Study

Devona M. Stalnaker-Shofner
Antioch University New England, dstalnakershofner@antioch.edu

Kevin Lyness
Antioch University of New England, klyness@antioch.edu

Sean Keck
Antioch University New England, seankeck94@gmail.com

The Influence of Race/Ethnicity, Gender, Age, Social Support, Religion/Spirituality, and Occupational History on the Total Wellness of Counseling Practicum Graduate Students: A Pilot Study

Abstract

This study sought to identify and explore the differences in participants' Total Wellness scores with respect to race/ethnicity, gender, age, social support, spirituality, and occupational history. It was asserted that there would be observable differences in the delineated demographic research factors and that these differences would influence students' Total Wellness as measured by the 5F-Wel Inventory. The sample was comprised of 30 graduate students enrolled in a community mental health counseling program. Hierarchal linear regression indicated that demographic variables did not predict a change in Total Wellness when controlling for pretest scores; however, pretest Total Wellness scores were significantly predictive of post-test Total Wellness scores. Implications for counseling practice and clinical supervision, suggestions for integrating wellness into counseling education, as well as areas for future research including replication and expansion of the current study are offered.

Keywords

Counselor Wellness, Student Wellness, Counselor Education, Clinical Supervision

Author's Notes

Correspondence concerning this article should be addressed to Devona Stalnaker-Shofner, 40 Avon Street, Keene, NH, 03431, dstalnakershofner@antioch.edu.

Wellness, personal growth, and professional development are fundamental aspects in the theory and practice of the counseling profession (Corey et al., 2011; Frame & Stevens-Smith, 1995; Hattie et al., 2004; Hendricks et al., 2009; Lawson & Venart, 2005; Myers, 1991, 1992; Witmer & Young, 1996). As such, counseling graduate programs have made efforts to incorporate an emphasis on wellness as a component of self-awareness and professional development in recent years. Professional organizations and associations such as the American Counseling Association (ACA) and the Council for the Accreditation of Counseling and Related Educational Programs (CACREP) individually and collectively have outlined the significance of personal growth: the ACA Code of Ethics (2014) includes self-growth to emphasize its importance to counselor supervision and training, and the CACREP (2016) standards devote an entire section to personal growth (Section II.3), citing knowing different theories of growth, outside influences on growth, and the effects diversity on growth as essential. There is significant research in areas regarding the concept of wellness, wellness models, and the importance of wellness to clients seeking counseling services as well as for counseling professionals to prevent or address professional impairment (Cobia & Pipes, 2002; Cummins et al., 2007; Elman & Forrest, 2007; Emerson & Markos, 1996; Forrest et al., 1999; Hazler & Kottler, 1996; Myers & Sweeney, 2005a; Olsheski & Leech, 1996; Orr, 1997; Roscoe, 2009). The foundation for this research study is examining factors which may impact wellness.

Factors Influencing Wellness

Race and Ethnicity

Myers and Sweeney's (2005b, 2004/2005d) Indivisible Self Wellness (IS-Wel) model examines the influence cultural identity as an aspect of the Essential Self, a subfactor of one's total wellness. Cultural Identity, another subfactor, is defined as "satisfaction with and feeling supported

in one's cultural identity, and the ability to feel comfortable with persons of other cultural backgrounds as well as with your own" (Myers & Sweeney, 2005b, p. 12). Evans (1997) examined the wellness of a sample of 91 African American counselors and noted that the sample reported frequently using activities related to spiritual and emotional wellness, which may be attributed to culture and the historically significant role that religion and spirituality have traditionally held within the African American community. In addition, Spurgeon and Myers (2010) examined 203 African American male junior and senior college students from predominantly White institutions (PWIs) who were compared to students from historically Black colleges and universities (HBCUs), and they found significant differences on internalization of racial identity attitudes, physical self-wellness, and social self-wellness. A similar study from Oliver et al. (2017) found that Black and White students at a PWI mediate stress and coping differently, suggesting that race may be an influencing factor on wellness. Research on the influence of race and ethnicity and wellness seems to support further exploration as to the nature of the interaction between these factors and the need for race and ethnicity to be included as subject variables of focus in this research study.

Gender

In addition to exploring wellness across the lifespan, researchers have examined gender differences related to individual wellness. Generally speaking, research regarding gender differences in total wellness notes no differences in wellness between men and women (Diener et al., 1999; Myers et al., 2003; Myers & Mobley, 2004; Ryff & Keyes, 1995). Though gender differences may be invariant in research regarding total wellness, further exploration reveals distinct gender differences on subscales related to specific factors of wellness (Myers & Mobley, 2004). In an examination of wellness in undergraduate students, Myers et al., (2003) reported no gender differences in wellness; however, it was noted that women scored significantly higher in

gender identity. Myers and Bechtel (2004) also noted gender differences in wellness. Women scored higher on self-care, which includes a focus on nutrition and exercise, but particularly emphasizes wellness through preventive care such as routine medical visits and safety habits. Also, there is limited, but substantive research on the health and wellness of transgender and gender nonconforming individuals. In a study by Rider et al. (2018) on gender and healthcare utilization, the researchers found that high school students who identify as transgender or gender nonconforming reported significantly poorer health, lower rates of preventative health checkups, and more nurse office visits than cisgender youths. Additionally, those whose gender was perceived as congruent with their gender identity had higher levels of wellness. The discussion of gender differences related to wellness seems to indicate that there is little difference in the total wellness of men and women; however, *how* men and women actually *experience* wellness as well as how they *achieve* wellness may vary. As such, inclusion of gender as a subject variable for analysis seems prudent.

Age

Granello (2001) examined wellness in emerging/young adults (mean age of 21) and middle adults (mean age of 46) using the Wellness Evaluation of Lifestyle inventory (Myers et al., 2000). Granello reports there is a marked variation in the reported wellness of young and middle-aged adults, specifically young adults reported a higher level of overall wellness; however, middle-aged adults scored higher in the dimension of Self-Care. Additionally, Gibson and Myers (2006) replicated the aforementioned study with similar findings, noting that younger Citadel cadets also reported higher levels of wellness, particularly in the areas of self-worth and mattering. Degges-White and Myers (2006) examined the wellness of older adults and report findings that suggest age is positively correlated with wellness, specifically that life satisfaction and wellness may not

be negatively affected by life transitions associated with middle adulthood (mean age of 47 years). This is also supported by later research done by Walsh (2015). Particularly noteworthy is that the life transitions explored in this study, "Returned to school" and "Entered/re-entered the job market," were correlated to higher reports of wellness. The sample for this study was composed of young and middle-aged adults; as such, examining age as a factor of wellness is prudent.

Social Relationships and Support

In their IS-Wel model, Myers and Sweeney (2005b, 2005c, 2004/2005d) note the importance of social support in relation to individual wellness. Myers and Sweeney note the mainstay of social support is family, and that friendships and intimate relationships enhance one's quality of life. They cite additional research (Lightsey, 1996; Lu & Shih, 1997; Myers & Shurts, 2002) suggesting that social support can be the best predictor of positive mental health and wellness over the lifespan. Regarding the significance of social support and wellness, Shurts and Myers (2008) further assert a positive correlation between social support and wellness; specifically, healthy platonic relationships and healthy attitudes regarding loving relationships are predictive of greater wellness. In a review of related literature and research on wellness counseling, Myers and Sweeney (2008) discuss the importance of positive social relationships and wellness, and they argue that mattering (or a sense of belonging) and social relationships are positively correlated with individual wellness levels. In more recent research, Ho (2014) extends the premise asserted by Myers and Sweeney (2008) and examines the use of social media as a platform for the promotion of wellness; the research supports the efficacy of social media as a platform for the promotion of wellness. Succinctly, social wellness highly correlates with and predicts perceived and reported overall wellness. Accordingly, to examine the influence of social support as a subject variable related to individual wellness is warranted.

Religion/Spirituality

Karl Marx (1844/2002) described religion as "the opiate of the masses," suggesting that religion and spirituality contribute to greater feelings of well-being. Spirituality is a second-order factor of wellness on the Five Factor Wellness Inventory (5F-Wel) and includes religious beliefs, practices, and an individual's understanding of a higher power. In an examination of three decades of research, Diener et al. (1999) noted that religion and spirituality may provide both psychological and social benefits by providing a sense of meaning. Additionally, Diener and Ryan (2009) report that religious or spiritual persons tended to report higher levels of perceived and total wellness. Furthermore, the research from this study suggests that these higher levels may be attributed to increased sense of meaning and purpose, from the interpersonal connectivity and social support associated with religious and spiritual gatherings (i.e., attending churches, mosques, synagogues, or other), and private religious practices (Gill et al., 2010). Such findings seem to support the inclusion of spirituality as a subject variable for exploration in this proposed study.

Occupational History

Research examining wellness and career begins with Hettler (1980, 1984), who proposed one of the first integrated models of wellness with a focus on occupational functioning; one's ability to contribute to a work environment is an element of total wellness. Dorn (1992) examined literature which emphasized a relationship between work environment experiences and their influence on individuals' physical and emotional health and advocated for the integration of career and vocational domains into general counseling. Dorn's (1992) research suggests that future research consider how the understanding of one's self-concept may serve as an antecedent to career satisfaction and occupational wellness. Smith et al. (2002) discuss the benefits of integrating a holistic wellness model into the curriculum of career and life planning courses taught to

undergraduates as a means to promote self-awareness to enhance career development and career decision-making. Because career planning is inseparable from identity development and lifestyle (Savickas, 1998), Smith et al. (2002) assert that a holistic emphasis can promote wellness across occupational and vocational dimensions and can affect life-planning decisions based on personal awareness and a greater understanding of self. Also noteworthy is research conducted by Degges-White and Myers (2006), which indicated that transitional factors related to occupation and work history influenced the wellness of midlife women; examples included "Returning to school," "Voluntarily left job," "Laid-off or fired from a job," "Retired from a job," and "Entered or re-entered job market." Participants were asked to assess the perceived impact of the aforementioned transitions, which had a mean rating indicating "strongly impact." Additionally, transitions reflecting personal growth (i.e., "Returning to school" and "Entered or re-entered job market" did not negatively affect life satisfaction and wellness. Such research seems to support examining occupational history as a subject variable of this study.

Method

Participants

Participants were identified and selected from the roster of graduate students in a master's program in counseling at a large southeastern U.S. metropolitan city utilizing convenience sampling. Convenience sampling was selected as the primary means of participant recruitment because this was a pilot study. The researchers sent a letter to the codirectors of the training office detailing the study and seeking permission to contact seminar instructors regarding recruitment of students. Seminar instructors were provided with an overview of the study. The researcher secured permission to recruit participants from both the codirectors of the training office and the seminar instructors. A total of 123 master's students were identified as potential participants and invited to

participate in the study; from this population, 73 students volunteered to participate in the study to comprise the initial study sample. Of the 73 participants who initially enrolled in the study, 30 participants completed all study requirements.

The sample is composed of participants from diverse racial and ethnic backgrounds, including Caucasian (27.3%), African American (63.6%), Hispanic/Latino (3%), and Asian (3%) ethnicities. Regarding gender, the sample was composed of 27 female (81.8%) and 6 male (18.2%) participants. The age range of participants was 20–60 years old; the mean (*M*) age range of participants was 35–39 years old. Regarding education, because all participants were enrolled in a graduate degree program, all of them held at least a bachelor's degree; however, 20% of participants also had previously earned a master's degree. All participants were enrolled in school on full-time status. Additionally, 60% of the participants were employed either full-time (40%) or part-time (20%); 40% of the participants were unemployed. Regarding relationship status, 50% of the participants were single/never married, 36.7% were married or partnered, and 13.3% were separated or divorced.

As in all quantitative studies, increasing the sample size increases the statistical power of the convenience sample (Creswell & Creswell, 2020). For this study, the statistical power of the final sample size using Cohen's *d* was $(78.51 - 77.67) / 7.94705 = 0.1057$, which according to Sawilowsky (2009) indicates very small to small effect.

Instrumentation

Demographic Questionnaire

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

history/work status, and educational status. The demographic information obtained from the questionnaire was used to identify additional variables possibly contributing to differences in wellness levels. Such data can also be used to determine areas for future analyses and research.

The Five Factor Wellness Inventory (5F-Wel)

The Five Factor Wellness Inventory (5F-Wel), developed by Myers and Sweeney (2005a, 2005b, 2004/2005d), is a 98-item self-report assessment designed as an instrument of measure based on the Indivisible Self Wellness (IS-Wel) model created by Myers and Sweeney (2004). Responses are recorded using a 4-point Likert rating scale, based on the following options: *strongly agree*, *agree*, *disagree*, and *strongly disagree*. The 5F-Wel assesses personal wellness based on holistic characteristics, with 73 of its items yielding a composite total wellness score based on 5 factors with 17 corresponding secondary subfactors, delineated as follows: Creative Self (Thinking, Emotions, Control, Work, Positive Humor); Coping Self (Leisure, Stress Management, Self-Worth, Realistic Beliefs); Social Self (Friendship and Love); Essential Self (Spirituality, Gender Identity, Cultural Identity, Self-Care); and Physical Self (Nutrition and Exercise). Seven demographic items are included to gather the following information: relationship, employment, and student status; education levels, sex, and cultural background (Myers & Sweeney, 2005b, 2004/2005d). This study utilized the A version of the 5F-Wel created by Myers and Sweeney (2005b); permission to use the 5F-Wel-A was obtained from Dr. Jane Myers by the researchers of this pilot study.

Regarding reliability, alpha coefficients for the 5F-Wel-A were: Total Wellness = .98, Creative Self = .96 (related context scales ranging from .79 to .88), Coping Self = .89 (related context scales ranging from .58 to .91), Social Self = .96 (related context scales ranging from .92 to .95), Essential Self = .95 (related context scales ranging from .89 to .92), and Physical Self =

.90 (related context scales ranging from .87 to .89). Regarding validity, Myers and Sweeney (2005b) report evidence of convergent and divergent validity related to ethnic identity, acculturation, body image, self-esteem, spirituality, moral identity, social interest, academic self-concept, mattering, life satisfaction, and gender role conflict based on the utilization of the 5F-Wel in numerous studies. Hattie et al. (2004) examines the construct validity of the 5F-Wel based on a comparison of it to similar measures (e.g., Testwell, Coping Responses Inventory, Measures of Psychosocial Development, Inventory of Self-Actualizing Characteristics, and Developmental Counseling and Therapy); reported correlations range from .28 to .74 and are indicative of the construct validity of the 5F-Wel as a measure of wellness.

Research Question and Hypothesis

This study posed a focal research question to better understand wellness based on demographic factors: What differences exist in students' pre- and posttest 5F-Wel Total Wellness scores with respect to student demographics? The posited research hypothesis was that Total Wellness scores within the pilot sample would vary based on demographic factors such as age, gender, race/ethnicity, relationship status/social support, religion/spirituality, and occupational history. Conversely, the null hypothesis was that these specific demographic factors would not affect student wellness.

Procedures

Pretest

During Weeks 1–3 of counseling practicum, the researcher attended the first 30 minutes of seminar classes and spoke with students regarding the nature of the research and to request voluntary participation in the study. Students who volunteered to participate were then given a study packet by the researcher; each packet was labeled by the researcher with a study-generated

ID to protect participants' anonymity. The initial packets contained the following: (a) the informed consent document that each student must review and sign (a second copy of the informed consent was in the packet for the student's records); (b) the demographic questionnaire; (c) the pretest 5F-Wel; and (d) an invitation to participate in the wellness intervention with specific listed dates for attendance (a copy of the wellness intervention outline and agenda was provide for the participant, and a return slip with the selected attendance date was to be returned to the researcher in the completed packet). The researcher offered brief instructions regarding the completion of the packets, and then was seated in the rear of the room while students completed the packets. The researcher was present only to answer subsequent questions if needed. Once the packets were completed, the researcher collected the packets from the students. Upon completion of this phase, study participants were given a letter (also contained in the initial study packet) denoting the second phase of their study involvement—administration of the treatment, the wellness intervention.

Wellness Intervention

After the identification of study participants as well as the establishment of the proposed sample and initial data collection of 5F-Wel pretest scores, participants were invited to attend and participate in the wellness intervention, held over the course of Weeks 4–6 of the practicum period. The intervention was a 3-hour workshop conducted by the researchers and designed based on the *Five Factor Wellness and Habit Change Workbook* (Myers & Sweeney, 2005c), a supplement to the 5F-Wel Inventory. The intervention was designed as an experiential seminar and workshop, during which the researcher defined wellness, explored a history of the concept of wellness, and educated participants on the Indivisible Self Wellness (IS-Wel) model. At the conclusion of the seminar, participants engaged in the workshop component of the intervention, during which the

researchers reviewed with participants their pretest 5F-Wel scores and the preliminary wellness profile generated by their responses. This information was then used by participants to conceptualize their understanding of their current state of wellness, and this understanding helped to inform their development of a personal wellness plan. Participants worked in groups to identify and discuss specific ways to implement their individual wellness plans. At the conclusion of the wellness intervention, participants were asked to complete a wellness seminar and workshop survey to evaluate their perceived efficacy of the intervention.

Posttest Administration

The posttest administration of the 5F-Wel occurred during Weeks 13–15 of the students' counseling practicum. The researcher attended seminar classes during Weeks 13–15 to distribute the final study packet, which contained the posttest 5F-Wel Inventory and the wellness post-study survey. Once the researcher distributed the packets, the researcher provided instructions for the completion of the materials and was seated in the rear of the class, present only to answer any subsequent questions regarding the completion of the final packet. Once packets were completed, they were returned to the researcher. This concluded participants' commitment to the study.

Throughout the entire study, participants were monitored for potential deleterious effects of participation. The researcher assessed for the manifestation of potential risks and harm to participants utilizing direct inquiry and participant self-report. No such negative effects related to study participation were reported or observed. Participants were able to voluntarily withdraw from the study at any time; participants who withdrew from the study were noted under participant attrition. Only data collected from participants who complete all phases of the study—pretest, wellness intervention, and posttest—were included in data analysis.

Table 1

Demographic Factors Based on Pre- and Posttest Total Wellness

Demographic factors	Frequency	Pretest Total Wellness *M*	Pretest Total Wellness *SD*	Posttest Total Wellness *M*	Posttest Total Wellness *SD*
Race/Ethnicity		80.75	6.54	80.95	9.14
Caucasian/Non-Hispanic	8	77.42	7.54	77.99	9.63
African American	19	71.00	5.92	73.97	9.67
Hispanic/Latino	1	72.00	—	77.05	—
Asian/Pacific Islander	1	70.00	—	75.00	—
Other	1	77.67	—	78.52	—
Gender		77.83	6.54	78.14	9.14
Male	6	77.62	7.08	78.61	8.03
Female	24	77.67	6.60	78.52	9.55
Age Range		77.67	6.54	78.52	9.14
20–24	1	80.00	—	80.14	—
25–29	6	75.00	7.48	78.43	4.80
30–34	4	80.75	6.18	81.17	5.97
40–44	5	78.20	7.66	78.29	8.72
45–49	5	74.67	8.33	81.05	6.05
50–54	3	80.67	8.02	77.05	13.27
60+	3	79.67	1.53	81.85	5.35
Social Support		80.00	6.54	71.92	9.15
Family, Friends	9	81.50	4.63	80.65	5.77
Spouse/Partner, Family Friends	6	76.00	9.40	79.62	10.77
Multiple Sources	15	74.63	6.68	77.10	10.99
Religion/Spirituality					
Place of Worship	4	78.24	3.50	78.60	4.81
Multiple Sources	21	78.00	7.51	79.75	10.15
Other	2	75.50	3.54	67.81	0.97
Occupational History		77.67	6.54	78.52	9.14
Soc. Svcs/MH	14	76.43	6.98	77.18	10.87
Non-Soc. Svcs/MH	16	78.35	4.73	78.23	5.38

Data

Note. Soc.

Svcs/MH = social service/mental health.

Analysis

All data were analyzed using IBM SPSS Statistics, Version 26. Descriptive statistics such as measures of central tendency (i.e., mean, median, and mode), distribution, and dispersion (i.e., range, standard deviation) were used to analyze demographic data. In order to answer the posited research questions, linear regression was employed using age, gender, occupational history,

race/ethnicity, social support, and spirituality as independent variables and posttest Total Wellness as the dependent variable to address the research question.

Results

In order to examine the influence of demographic variables, descriptive statistics were employed. The mean and standard deviation for demographic variables such as race/ethnicity, gender, age, social support, religion/spirituality, and occupational history are presented in Table 1, and participants' pre- and posttest Total Wellness scores are offered for comparison. Regarding test-retest reliability, the Cronbach's alpha coefficient was .650, which indicates moderate, but acceptable reliability (Taber, 2018). Also noted is the frequency of each subgroup within the demographic characteristic.

Based on the reported analysis of the demographic variable of race/ethnicity, those participants with the largest change in wellness are African American. Although Table 1 shows notable changes in participants who identified as Hispanic/Latino or Asian/Pacific Islander, these differences were not more significant because there was only one participant for each respective race/ethnicity. Regarding gender, there appears to be little variation between male and female participants with nearly identical pretest Total Wellness scores, with mean scores of 77.62 and 77.67, respectively, and mean posttest Total Wellness scores of 78.61 and 78.52, respectively. With respect to the demographic variable of age, the largest observed difference in pre- and posttest Total Wellness scores was noted in the 45–49 year-old age group, with mean scores of 74.67 and 81.05, respectively. In examining social support, participants who indicated having a "spouse/partner, family, and friends" have a greater difference in their pre- and posttest Total Wellness score, with mean scores of 76.00 and 79.62, respectively. Regarding religion/spirituality, participants who noted having multiple sources of religious practices and expressions of

spirituality had observed differences in pre- and posttest Total Wellness scores, with mean scores of 78.00 and 79.75. Regarding occupational history, 14 participants who indicated a social service/mental health (Soc. Svcs/MH) occupational history had observed differences in pre- and posttest Total Wellness scores, with mean scores of 76.43 and 77.17, respectively. Additionally, the five participants who indicated a business occupational history had observed differences in pre- and posttest Total Wellness scores, with mean scores of 83.80 and 85.14, respectively. The most change in Total Wellness scores with respect to occupational history was observed in participants who indicated an education background, with mean scores of 75.00 and 78.99, respectively. Given the small sample size and small cell sizes, analysis of variance showed that none of these group differences were statistically significant, nor did any of the demographic variables predict change in wellness scores from pretest to posttest.

To compare the predictive power of demographic variables and Total Wellness (as measured by the 5F-Wel), a hierarchal multiple regression was conducted with demographic factors of race/ethnicity, gender, age, social support, religion/spirituality, and occupational history as independent variables, and posttest Total Wellness as the dependent variable, with pretest Total Wellness scores included as a control. Race/Ethnicity was recoded to a binary (African American vs. other), while occupational history and social support were recoded to be linear, with higher scores indicating higher levels of occupational history and social support. While pretest scores significantly predicted posttest scores, none of the demographic variables significantly predicted posttest Total Wellness (similar nonsignificant results were found for an analysis that did not include the pretest Total Wellness scores). See Table 2 for regression results.

Table 2

Hierarchical Multiple Regression Predicting Posttest Total Wellness

Variable	β	*t*	*R*	R^2	ΔR^2
Step 1			.508	.252	.252**
Pretest Total Wellness	.508	3.12**			
Step 2			.511	.261	.003
Gender	.028	.153			
Race	−.008	−.040			
Occupational History	.049	.237			
Social Support	.010	.051			

Note. ** $p < .01$

In summary, the presented data analysis findings, a sample of 30 master's level counseling students in clinical practicum was obtained in order to investigate the influence of a wellness intervention on the students' reported total wellness as measured by the 5F-Wel Inventory. While descriptive statistical analyses showed observed differences in pre- and posttest Total Wellness scores based on demographic factors such as race/ethnicity, gender, age, social support, and religion/spirituality, given the small sample size none of these observed differences was statistically significant. Regarding reliability and validity of study scores, the observed alpha coefficients were congruent with those previously reported by Myers and Sweeney (2005b).

Discussion

This study examined factors that may influence participants' Total Wellness scores. Specifically, it was asserted that age, gender, race/ethnicity, social support, religion/spirituality, and occupational history would influence reported Total Wellness scores in participants. Exploratory descriptive statistics show differences reported include changes in pre- and posttest mean Total Wellness scores for study participants who were African American (race demographic), 45–49 years old (age demographic), participants with spouse/partner, family, and friends (social support variable), and multiple sources of religious practices and expressions of spirituality. Also, participants who indicated an occupational history in education were observed

to have had the largest difference in mean Total Wellness scores. Lastly, there was little difference observed with respect to gender.

Though differences were observed as noted by increases in mean pre- and posttest Total Wellness scores, inferences as to the reasons for these differences are not offered due to the small sample size; this is a principal limitation regarding this aspect of this exploratory study. The small sample size (30 participants) did not allow for sufficient power in using inferential statistics, which may have revealed the possible influence of specified demographic variables as noted in earlier research efforts (Degges-White & Myers, 2006; Diener et al., 1999; Diener & Ryan, 2009; Dorn, 1992; Evans, 1997; Lightsey, 1996; Lu & Shih, 1997; Myers & Mobley, 2004; Myers et al., 2003; Myers & Shurts, 2002; Ryff & Keyes, 1995). Future research efforts should ensure an adequate sample size which will allow for the utilization of inferential statistics to report not only observed differences, but the significance of those differences.

Though no inferences are offered, the differences noted in the descriptive statistics may also be viewed through the lens of prior research. With respect to gender, no observed differences in Total Wellness scores were observed; although inferences cannot be made regarding significance, it appears consistent with the research completed by Diener et al. (1999), Myers and Mobley (2004), Myers et al. (2003), and Ryff and Keyes (1995), which evidenced no differences in total wellness between men and women. Noted differences reported based on the demographic factor of race/ethnicity were higher in study participants who were African American; this may be attributed to the fact that African Americans comprised the largest race/ethnicity group of the sample, totaling 19 out of 30 participants. Changes in pre-and posttest Total Wellness were observed in other race/ethnicities, specifically, Hispanic/Latino and Asian/Pacific Islander;

however, each group was represented by only one participant. This indicates the need for further research efforts.

Regarding age, the demographic group with the greatest observed difference in pre- and posttest Total Wellness scores was noted in participants within the 45–49 year-old age group. This appears consistent with research reported by Degges-White and Myers (2006) that examined the wellness of older adults. In their research focusing on transitions, wellness, and life satisfaction, Degges-White and Myers reported findings that suggest age is positively correlated with wellness; specifically, that life satisfaction and wellness may not be negatively affected by life transitions associated with middle adulthood. Participants with a mean age of 47 years who reported life transitions such as "Returned to school" and "Entered/re-entered the job market," were correlated to higher reports of wellness; it is possible that this applies to this study's participants as well, but further exploration is needed. With respect to occupational history, Degges-White and Myers may also provide a context for understanding noted differences in participants' Total Wellness scores in this area. Participants whose prior work history included positions in education, business, or other had higher differences in pre-and posttest Total Wellness scores. One possible explanation for this may be attributable to life transitions. It is possible that participants who returned to school to pursue counseling as a new career may have experienced higher mean Total Wellness scores simply based on this transition. It is an area worth further exploration in future research efforts.

With respect to religion/spirituality, participants who noted having multiple sources of religious practices and expressions of spirituality had observed differences in pre- and posttest Total Wellness scores, with mean scores of 78.00 and 79.75, respectively. There is some research which suggests that these higher levels may be attributed to increased sense of meaning and purpose as well as from the interpersonal connectivity and social support associated with religious

and spiritual gatherings (i.e., attending churches, mosques, synagogues, or other). In the reported findings, religion and spirituality may have a statistically significant influence on total wellness. Diener and Ryan (2009) reported that religious or spiritual persons tended to report higher levels of perceived and total wellness. It is also significant to note that of the 30 participants in the sample, 19 (or 63.3%) of the participants identified as African American/Black. Evans (1997) discussed spirituality and wellness in African American counselors, noting that African American counselors reported religion and spirituality as a resource for wellness, frequently using activities related to spiritual and emotional wellness. It appears descriptive findings related to race/ethnicity, religion/spirituality, and wellness may be consistent with existing research.

Lastly, differences in Total Wellness scores based on social support were noted with respect to the mean scores of the total sample, in that mean Total Wellness and Social Self wellness factor scores appeared to have decreased between pre- and posttest administrations of the 5F-Wel. Closer examination of the individual participant scores revealed marked decreases in the reported social wellness of one participant. Roach and Young's (2007) findings may offer an explanation to account for the significant decrease in Total Wellness reported by the one participant, whose scores subsequently resulted in a left-skewing of the final posttest Total Wellness frequency distribution and overall average decrease in the collective sample's Social Self wellness factor scores. A closer review of the participant's scores indicated declines in all aspects assessed by the 5F-Wel, specifically with the following decreases: Total Wellness, −31.16; Creative Self, −27.50; Coping Self, −27.58; Social Self, −52.32; Essential Self, −43.25; and Physical Self, −10.00. Possible explanations for such differences may be attributable to significant life transitions, changes, or losses. Total Wellness is not a static construct (Myers & Sweeney, 2005c), and changes in wellness can be chronometric, or across the lifespan. One key area with the highest decrease in

pre- to posttest score in the participant outlier was the reported decrease in wellness in the Social Self, which focuses on interpersonal relationships. Myers and Sweeney (2005b, 2005c, 2004/2005d) noted the importance of social support in relation to individual wellness. They cited additional research (Lightsey, 1996; Lu & Shih, 1997; Myers & Shurts, 2002) suggesting that social support can be the best predictor of positive mental health and wellness over the lifespan and the strongest wellness factor (Sinclair & Myers, 2004). Social Self wellness factor scores remained fairly consistent across all study participants (pretest mean is 88.93, posttest mean is 90.30) and participants who indicated multiple sources of social support (i.e., spouse/partner, friends, and family) showed the least change of all the wellness factors. This seems to support that a significant life event involving changes in social support may explain the data reported by the one outlier participant.

Recommendations

Based on the limited size of the research sample, it is recommended that future research studies utilize a sample size of not less than 50 persons. As such, this would allow for the use of inferential statistical analyses and measures to explore the influence of demographic variables on total wellness. Another area for further research is a case study. If a wellness paradigm is incorporated into counselor education, training, and development, formative and summative program evaluation research examining the efficacy of such a curriculum would be ideal. Additional qualitative research efforts could involve phenomenological or grounded theory research designs.

Lastly, the most significant recommendations for the utility of this study is the prospect of a wellness intervention as an educational component of master's students' training. Ideally, wellness can be an integral part of counselor education and training; a body of research champions

this philosophy (Hensley et al., 2003; Myers et al., 2003; Myers & Sweeney, 2008; Roach &Young, 2007; Sheffield, 1998; Yager & Tovar-Blank, 2007). Adopting a wellness-based teaching paradigm and educational philosophy and incorporating specific wellness interventions are viable alternatives. An ounce of prevention is worth more than a pound of cure related to counselor distress, impairment, and professional burnout.

References

American Counseling Association. (2014). *Code of ethics and standards of practice.*

Cobia, D. C., & Pipes, R. B. (2002). Mandated supervision: An intervention for disciplined professionals. *Journal of Counseling and Development*, *80*, 140–144.

Corey, G., Corey, M. S., & Callanan, P. (2011) *Issues and ethics in the helping professions* (8th ed.). Brooks/Cole.

Council for the Accreditation of Counseling and Related Educational Programs (2016). *CACREP 2016 standards*.

Creswell, J. W., & Creswell, J. D. (2020). *Research design: Qualitative, quantitative, and mixed methods approaches* (6th ed.). Sage Publications.

Cummins, P. N., Massey, L., & Jones, A. (2007). Keeping ourselves well: Strategies for promoting and maintaining counselor wellness. *Journal of Humanistic Counseling, Education, and Development, 46*, 35–49.

Degges-White, S., & Myers, J. E. (2006). Transitions, wellness, and life satisfaction: Implications for counseling midlife women. *Journal of Mental Health Counseling, 28*, 133–150.

Diener, E., & Ryan, K. (2009). Subjective well-being: A general review. *South African Journal of Psychology, 39*(4), 391–406.

Diener, E., Suh, E. M., Lucas, R. E., & Smith, H. L. (1999). Subjective well-being: Three decades of progress. *Psychological Bulletin, 125*(2), 276–302.

Dorn, F. J. (1992). Occupational wellness: The integration of career identity and personal identity. *Journal of Counseling and Development, 71*(2), 176–178.

Elman, N. S., & Forrest, L. (2007). From trainee impairment to professional competence problems: Seeking new terminology that facilitates effective action. *Professional Psychology: Research and Practice, 38*(5), 501–509.

Emerson, S., & Markos, P. A. (1996). Signs and symptoms of the impaired counselor. *Journal of Humanistic Education & Development, 34*(3), 108–117.

Evans, K. M. (1997). Wellness and coping activities of African American counselors. *Journal of Black Psychology, 23*, 24–35.

Forrest, L., Elman, N., Gizara, S., & Vacha-Haase, T. (1999). Trainee impairment: A review of identification, remediation, dismissal, and legal issues. *The Counseling Psychologist, 27*(5), 627–654.

Frame, M. W., & Stevens-Smith, P. (1995). Out of harm's way: Enhancing monitoring and dismissal processes in counselor education programs. *Counselor Education and Supervision,* 35(2), 118–129.

Gibson, D. M., & Myers, J. E. (2006). Perceived stress, wellness, and mattering: A profile of first-year Citadel cadets. *Journal of College Student Development, 47*(6), 647–660.

Gill, C. S., Minton, C. A. B., & Myers, J. E. (2010). Spirituality and religiosity: Factors affecting wellness among low-income, rural women. *Journal of Counseling & Development, 88*(3), 293–302.

Granello, P. F. (2001). A comparison of wellness and social support networks in different age groups. *Adultspan, 3*(1), 12–22.

Hattie, J. A., Myers, J. E., & Sweeney, T. J. (2004). A factor structure of wellness: Theory, assessment, analysis, and practice. *Journal of Counseling & Development, 78*, 251–266.

Hazler, R. J., & Kottler, J. (1996). Following through on the best of intentions: Helping impaired professionals. *Journal of Humanistic Education & Development, 34*(3), 156–159.

Hendricks, B., Bradley, L. J., Brogan III, W. C., & Brogan, C. (2009). Shelly: A case study focusing on ethics and counselor wellness. *Family Journal, 17*(4), 355–359.

Hensley, L. G., Smith, S. L., & Waller-Thompson, R. (2003). Assessing competencies of counselors-in-training: Complexities in evaluating personal and professional development. *Counselor Education & Supervision, 42*, 219–230.

Hettler, B. (1980). Wellness promotion on a university campus: Family and community health. *Journal of Health Promotion and Maintenance, 3*, 77–95.

Hettler, B. (1984). Wellness: Encouraging a lifetime pursuit of excellence. *Health Values, 8*, 13–17.

Ho, K. (2014). Harnessing the social web for health and wellness: Issues for research and knowledge translation. *Journal of Medical Internet Research*, *16*(2). https://doi.org/10.2196/jmir.2969

Lawson, G., & Venart, B. (2005). Preventing counselor impairment: Vulnerability, wellness, and resilience [Paper presentation]. 2005 American Counseling Association National Conference, Atlanta, GA, United States.

Lightsey, O. R. (1996). What leads to wellness? The role of psychological resources in well-being. *The Counseling Psychologist, 24*(4), 589–735.

Lu, L., & Shih, J.B. (1997). Sources of happiness: A qualitative approach. *Journal of Social Psychology, 137*, 181–188.

Marx, K. (2002). Critique of Hegel's philosophy of right. In J. Raines (Ed.), *Marx on religion* (pp. 170–181). Philadelphia, PA, USA: Temple University Press. (Original work published 1844)

Myers, J. E. (1991). Wellness as the paradigm for counseling and development: The possible future. *Counselor Education and Supervision, 30*(3), 183–193.

Myers, J. E. (1992). Wellness, prevention, development: The cornerstone of the profession. *Journal of Counseling & Development, 71*, 136–139.

Myers, J. E. & Bechtel, A. (2004). Stress, wellness, and mattering among cadets at West Point: Factors affecting a fit and healthy force. *Military Medicine*, *169*(6), 475-481.

Myers, J. E., & Mobley, A. K. (2004). Wellness of undergraduates: Comparisons of traditional and nontraditional students. *Journal of College Counseling, 7*, 40–49.

Myers, J. E., Mobley, A. K., & Booth, C. S. (2003). Wellness of counseling students: Practicing what we preach. *Counselor Education & Supervision, 42*, 264–274.

Myers, J. E., & Shurts, W. M. (2002). Measuring positive emotionality: A review of instruments assessing love. *Measurement and Evaluation in Counseling and Development, 34*, 238–254.

Myers, J. E., & Sweeney, T. J. (2005a). *Counseling for wellness: Theory, research, and practice.* American Counseling Association.

Myers, J. E., & Sweeney, T. J. (2005b). *Manual for the Five Factor Wellness Inventory.* Mindgarden Publishers.

Myers, J. E., & Sweeney, T. J. (2005c). *The Five Factor Wellness and Habit Change Workbook.* Mindgarden Publishers.

Myers, J. E., & Sweeney, T. J. (2005d). The indivisible self: An evidence-based model of wellness. *Journal of Individual Psychology, 61,* 269–279. (Reprinted from "The indivisible self: An evidence-based model of wellness," 2004, *Journal of Individual Psychology*, *60*[3], 234–245).

Myers, J. E., & Sweeney, T. J. (2008). Wellness counseling: The evidence base for practice. *Journal of Counseling & Development, 86*, 482–493.

Myers, J. E., Sweeney, T. J., & Witmer, J. M. (2000). The wheel of wellness counseling for wellness: A holistic model for treatment planning. *Journal of Counseling & Development, 78*, 251–266.

Olsheski, J., & Leech, L. L. (1996). Programmatic interventions and treatment of impaired professionals. *Journal of Humanistic Education & Development, 34*(3), 128–140.

Oliver, M. D., Datta, S., & Baldwin, D. R. (2017). Wellness among African-American and Caucasian students attending a predominantly White institution. *Journal of Health Psychology*, *24*(12), 1637–1645. https://doi.org/10.1177/1359105317694484

Orr, P. (1997). Psychology impaired. *Professional Psychology: Research and Practice, 28*(3), 293–296.

Rider, G. N., McMorris, B. J., Gower, A. L., Coleman, E., & Eisenberg, M. E. (2018). Health and care utilization of transgender and gender nonconforming youth: A population-based study. *Pediatrics*, *141*(3), e20171683. https://doi.org/10.1542/peds.2017-1683

Roach, L. F., & Young, M. E. (2007). Do counselor education programs promote wellness in their students? *Counselor Education & Supervision, 47*, 29–45.

Roscoe, L. J. (2009). Wellness: A review of theory and measurement for counselors. *Journal of Counseling & Development, 87*, 216–226.

Ryff, C. D., & Keyes, C. L. M. (1995). The structure of psychological well-being revisited. *Journal of Personality and Social Psychology*, *69*, 719–727.

Savickas, M. (1998). Career style assessment and counseling. In T. J. Sweeney, *Adlerian counseling: A practitioner's approach* (4th ed., pp. 329–360). Accelerated Development.

Sawilowsky, S. S. (2009). New effect size rules of thumb. *Journal of Modern Applied Statistical Methods*, *8*(2), Article 26.

Sheffield, D.S. (1998). Counselor impairment: Moving toward a concise definition and protocol. *Journal of Humanistic Counseling Education and Development,* 37(2), 96–106.

Shurts, W. M., & Myers, J. E. (2008). An examination of liking, love styles, and wellness among emerging adults: Implications for social wellness and development. *Adultspan, 7*(2), 51–68.

Sinclair, S. L., & Myers, J. E. (2004). The relationship between objectified body consciousness and wellness in a group of college women. *Journal of College Counseling, 7*, 150–161.

Smith, S. L., Myers, J. E., & Hensley, L. G. (2002). Putting more life into life career courses: The benefits of a holistic wellness model. *Journal of College Counseling, 5*, 90–95.

Spurgeon, S. L., & Myers, J. E. (2010). African American males: Relationships among racial identity, college type, and wellness. *Journal of Black Studies*, *40*(4), 527–543.

Taber, K. S. (2018). The use of Cronbach's alpha when developing and reporting research instruments in science education. *Research in science education, 48*(6), 1273-1296.

Walsh, B. (2015). America's evolution toward wellness. *Generations: Journal of the American Society on Aging*, *39*(1), 23–29.

Witmer, J. M., & Young, M. E. (1996). Preventing counselor impairment: A wellness approach. *Journal of Humanistic Education and Development, 34*(3), 141–155.

Yager, G. G,. & Tovar-Blank, Z. G. (2007). Wellness and counselor education. *Journal of Humanistic Counseling, Education, and Development, 46*, 142–153.