# IMPLICATIONS FOR PROFESSIONAL QUALITY OF LIFE AND WELLNESS-BASED SUPERVISION

A Dissertation

by

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This dissertation meets the standards for scope and quality of
Texas A&M University-Corpus Christi and is hereby approved.

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# ABSTRACT

Supervision of counselors-in-training (CITs) is the signature pedagogy within counselor preparation programs that moderates and regulates personal and professional development. There are few empirical studies demonstrating causal relationships between wellness-based supervision and the effects on CITs professional quality of life. This dissertation evaluated the efficacy of the Wellness Model of Supervision (WELMS; Lenz & Smith, 2010) for promoting desired change across CITs perception of their professional quality of life across three variables: secondary traumatic stress, compassion satisfaction, and burnout.

A small series A-B single-case research design (SCRD) with multiple baselines was implemented to evaluate the degree of efficacy for the WELMS to promote professional quality of life characteristics among CITs over time. This design was selected based on practicality for estimating functional relationships associated with an intervention and target outcomes. Three women who identified as Caucasian ($n$ = 1) and Hispanic ($n$ = 2) and were enrolled in Internship at a Council for Accreditation of Counseling and Related Educational Programs (CACREP) accredited program participated in the study. Results indicated that the WELMS may be efficacious across client-CIT interactions, and CITs who receive the WELMS are likely to show improvement in the secondary traumatic stress and burnout subscales of the ProQOL.

These results are consistent with previous studies utilizing the WELMS with CITs and provided several recommendations for future researchers regarding implementing the WELMS while considering unique student characteristics. Wellness-based approaches within supervisory relationships can inspire CITs to improve their personal wellness and professional quality of life while enhancing skill development and career sustaining behaviors.

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## Overview of Prospectus

This dissertation prospectus will provide an overview of a small series single-case research design (SCRD) implemented as an evaluation of the efficacy of the Wellness Model of Supervision (WELMS; Lenz & Smith, 2010) for promoting professional quality of life and degree of working alliance between clients and counselors-in-training. In chapter 1 of this prospectus, I will introduce the problem statement, state the purpose and significance of this study, and provide a definition of terms. Chapter 2 of this prospectus will provide a description and overview of the theoretical framework, constructs, and state of the literature related to the project. In chapter 3, I will provide a detailed description of the method that will be utilized in conducting this study including potential limitations. The Appendix will comprise of a collection of appendices including copies of instruments, and other relevant materials.

## Introduction

Supervision of counselors in training's (CITs) field experience is the signature pedagogy within counselor preparation programs that is composed of structured and unstructured interventions to promote skill development, monitor client welfare, and assess students' fitness to practice (Bernard & Goodyear, 2014; Goodyear, Bunch, & Claiborn, 2006). Although CITs spend a considerable proportion of their degree programs in classroom-based, didactic learning environments, field experiences provide community-based venues for implementing counseling skills with the client populations they will service following matriculation. The supervision process is developmentally supportive during this time, while also promoting professional identity through monitoring counselor activities that promote positive client outcomes. Additionally, the Association for Counselor Education and Supervision (ACES) has

recommended a number of best practices for supervisors to implement that are evidence-based approaches for promoting CIT self-evaluation and reflection (ACES, 2011). One of those best practices situates counseling supervisors as a gatekeeper for the profession by monitoring the development, functioning, and wellness that are indicative of fitness to practice. Taken together, the most effective approaches to CIT supervision will contribute to client welfare by not only developing clinical skills, but also promoting student well-being.

Myers, Sweeney, and Witmer (2000) suggested that wellness is a way of life oriented toward optimal functioning and health, wherein there is an integration of the mind, body, and spirit to facilitate a full life within human and natural communities. Some counselor educators (Smith, Robinson, & Young, 2007; White & Franzoni, 1990) have suggested that CITs have a higher level of psychological distress than more experienced helping professionals, and the increased exposure to psychological distress can impact the overall wellness of CITs over time. This importance of this supposition is reflected in the American Counseling Association *Code of Ethics* (ACA; 2014) which stipulates that counselors are obligated to engage in self-care activities that monitor and maintain their wellbeing as part of their professional responsibilities. Self-care activities are valued critically as counselors are encouraged to monitor two vital relationships. These important relationships are between their personal well-being and therapeutic effectiveness, and the relationship between counselors and their colleagues. One construct used as a proxy for the coalescence of these three relationships is *professional quality of life* (Anderson-White, 2011; Lawson & Myers, 2011; Mullen, 2014).

Professional quality of life (ProQOL) is the quality of the work done in relation to the individual's work as a counselor in training. ProQOL includes compassion satisfaction and compassion fatigue, and may be affected based on the nature of one' work (Stamm, 2010). For

example, when CITs are exposed to stressors with the potential to diminish their mental and physical resources, their ProQOL decreases. Vicarious trauma, compassion fatigue, and burnout may negatively affect the CITs ProQOL. Unrealistic expectations may cause CITs to become disappointed or disillusioned, which may eventually lead to burnout. A lack of compassion and burnout, due to a decreased professional quality of life, may lead to feelings of anxiety, depression, and helplessness in CITs (Perkins & Sprang, 2013). Maslach, Jackson, and Leiter (1997) suggested that the emotional connection formed with clients and the emotional investment of helping professionals are the important factors in differentiating burnout from other forms of occupational stress.

By contrast, when professional quality of life and therefore, wellness are positively influenced, CITs have a well-developed corps of interpersonal and intrapersonal resources to mitigate stress levels. CITs with these resources have a greater chance of experiencing self-awareness, personal wellness, and overall balance in their personal and professional lives. CITs with these attributes who are actively working toward a state of wellness may be more effective counselors. In addition, having these healthy attributes may help CITs to establish a deeper level of connection with their clients and increased levels of compassion (Burck, Bruneu, Baker, & Ellison, 2014; Neswald-Potter, Blackburn, & Noel, 2013; Warren, Morgan, Morris, & Morris, 2010; Yager & Tovar-Blank, 2007)

It can be difficult to separate CITs attributes such as interpersonal skills, nonjudgmental attitude, and empathic response from conditions that foster therapeutic alliance, as they may overlap despite being interdependent (Lambert & Barley, 2001). According to Rogers (1961), therapeutic alliance, also known as working alliance (Bordin, 1979), is identified as a significant factor in determining counseling outcomes. Little is known about the relationship of counselor

wellness to working alliance (Jang, 2009); however, this relationship is of continued interest due to the connection between working alliance and counseling outcomes (Hatcher & Gillaspy, 2006; Horvath, Del Re, Fluckinger, & Symonds, 2011; McLeod, 2011). Lei and Duan (2014) suggested that the degree to which counselors make a connection with the client's emotions may correlate with client perceptions of the therapeutic relationship.

Without establishing an emotional connection with the client, CITs may experience difficulties building therapeutic alliance, as they may experience a sense of disconnection from their client. In short-term inpatient settings, working alliance may be important for client stabilization and goal attainment for discharge (Schmit, 2015). Similarly, this alliance may be significant in outpatient settings for positive clinical outcomes (Patterson, Anderson & Wei, 2014). Since client-counselor relationships (i.e. working alliance) may contribute to approximately 30% of the variance in client outcomes, CITs have a responsibility to establish a healthy working alliance that will contribute to positive outcomes in therapy (Lambert & Barley, 2001). As a consequence, it is a prudent activity for counselor educators and supervisors to make an effort to address strategies for fostering these relational skills.

Time spent during supervision presents an opportunity to learn more about CITs professional development and working alliance. Supervisors may have a chance to learn how CITs cope with the demands of the profession and monitor how stressors associated with counseling may impact the personal wellness of CITs. Since CITs are expected to maintain ethical and professional standards, early intervention with CITs during supervision, using a wellness model, may help to increase working alliance and personal wellness. In addition, a wellness model of supervision may help to avert gatekeeping issues, such as burnout and unethical behavior that may rupture working alliance. Therefore, a model of supervision

integrating wellness monitoring and development may be essential in preventing and managing the risks associated with counseling. A wellness model of supervision may also provide an opportunity for personal and professional growth (Lawson & Myers, 2010; Lenz & Smith, 2010).

## Statement of the Problem

Several scholars have suggested that there is a positive relationship between a CIT's personal wellness and their professional performance (Blount & Mullen, 2015; Lenz, Oliver, & Sangganjanavanich, 2014; Lenz, Sangganjanavanich, Balkin, Oliver, & Smith, 2012; Lenz & Smith, 2010; Ohrt, Prosek, Ener, & Lindo, 2015). Although CITs expend considerable effort promoting use of wellness strategies among their clients, they may have difficulty in adapting these wellness principles into their own lifestyle, leading to an increased risk to the deleterious effects of vicarious trauma that can lead to burnout (O'Halloran & Linton, 2000; Smith et al., 2007). Counselors-in-training who are unable to meet their professional and ethical responsibilities to their clients may also experience disconnection with clients due to a shift in their psychological wellbeing (Williams, Helm, & Clemens, 2012). This vulnerability to decreased wellness may disrupt the working alliance with clients and may result in negative clinical outcomes. Thompson, Frick, and Trice-Black (2011) suggested that CITs desired supervisor support about strategies for work-life balance; however, there is currently only a few empirical studies demonstrating causal relationships between wellness-based supervisory interventions and their related effects on CIT wellness (Lenz, Sangganjanavanich, & Balkin, 2012; Storlie & Smith, 2012). Furthermore, no studies to date have been published investigating causal associations between wellness-based supervisory interventions and their related effects on working alliance. In the absence of this body of literature, it is not possible for counselor educators to make data driven decisions about supervisory interventions that may be most

efficacious for promoting development the development clinical skills, monitoring client welfare, and assessing students' fitness to practice.

## Purpose of the Study

The purpose of the study is to evaluate the efficacy of the Wellness Model of Supervision (WELMS; Lenz & Smith, 2010) for promoting desired change across two dependent variables: (a) CIT perceptions of professional quality of life and (b) client perceptions of working alliance. These variables were selected based on the logic that both outcomes will concurrently promote career sustaining behaviors and positive client outcomes. This study will utilize an A-B single-case research design (SCRD), featuring multiple baselines to evaluate the efficacy of the WELMS. SCRDs are a hands-on way to evaluate efficacy of an intervention, using the same participants as their own comparison group. SCRDs may be applied in a variety of settings, and the results from SCRDs may be helpful when reporting about treatment efficacy and community impact (Kazdin, 2011; O'Neill, McDonnell, Billingsley, & Jenson, 2011).

Measures for the study include the Professional Quality of Life Scale (ProQOL; Stamm, 2010), the Working Alliance Inventory-Short (WAI-SF; Tracey & Kokotovic, 1989), and the Five Factor Wellness Inventory (5F-WEL; Myers & Sweeney, 2005). The ProQOL measures counselor quality of life using a 30-item self-assessment with subscales, including compassion satisfaction, compassion fatigue, burnout, and secondary traumatic stress. The WAI measures working alliance between counselor and client and includes 12 items and subscales, such as goals, tasks and bonds, as rated by the client and CIT. The 5F-WELis an evidence-based tool used to evaluate the characteristics of wellness as a basis for helping individuals develop plans that support healthier life choices. The 5F-WEL is a 74-item self-scoring tool that measures 17

discrete scales based on the Indivisible Self Model of Wellness (IS-WEL; Myers & Sweeney, 2005).

## Significance of the Study

The Council for Accreditation of Counseling and Related Educational Programs standards (CACREP, 2016) requires counselor education programs to include wellness and self-care components within their curriculum. Graduates of CACREP programs are also expected to demonstrate the ability to integrate these components into their routine professional activities (Lenz & Smith, 2010). There is limited information about the effectiveness of a wellness-based model of supervision when used with counselors-in-training for improving professional quality of life or working alliance. However, several researchers have written on the topics of counselor wellness and supervision, and the impact of wellness practices on personal and professional development. (Blount & Mullen, 2015; Lawson, 2007; Lenz & Smith, 2010; Myers et al., 2003; Roach & Young, 2007; Roscoe, 2009),

Although there is evidence suggesting the impact of greater wellness practices as it relates to improved mental health, there is insufficient research on the use of wellness interventions to reduce the risk of burnout with CITs (Ohrt et al., 2015). A study on the use of a wellness-based model of supervision to observe changes in professional quality of life, as well as, the impact on the working alliance will add to the literature on this topic by providing a more comprehensive depiction of benefits associated with change. The results from this study may also provide a reference for counselor educators and supervisors when making decisions about best practices in training and supervision to foster healthy development of CITs.

Supervisors have an ethical obligation to help supervisees develop healthy coping skills, including careful attention to holistic development and self-care. CITs may be encouraged to

explore the meaning behind their work with clients and seek assistance when difficulties arise which may threaten their abilities (Ohrt et al., 2015). Therefore, creating a forum to discuss and assess personal wellness and professional quality of life, in an interactive way, may encourage deeper conceptualization and implementation of wellness practices. This discussion can be facilitated through clinical supervision (Lenz & Roscoe, 2011).

Time spent during supervision presents an opportunity to learn more about CITs, specifically their personal wellness habits, professional development, and working alliance. Supervisors may have an opportunity to learn how CITs cope with the demands of the profession. Supervision can be a time to monitor how stressors associated with counseling may impact the personal wellness of CITs. Since CITs are expected to maintain ethical and professional standards, early intervention with CITs during supervision using a wellness model may help to increase working alliance, professional quality of life, and personal wellness. In addition, a wellness model of supervision may help to avert gatekeeping issues, such as burnout and unethical behavior, which may rupture working alliance.

Early intervention with CITs during supervision using a wellness model, may help to increase working alliance, professional quality of life, and personal wellness. In addition, a wellness model of supervision may help to avert gatekeeping issues which may rupture therapeutic alliance, such as burnout and unethical behavior. This study seeks to assist counselor educators to develop protocols for supervision. These protocols can benefit counselors-in-training in a master's program as they learn about the role of their professional quality of life and working alliance with clients. Students within counselor education programs may also benefit from the results of this study.

An additional benefit of this study is to provide students in a counselor education doctoral program with another supervision model during their preparation as supervisors-in-training. This study provides a non-standardized wellness model of supervision with potential to inspire change in counselors-in-training, as their professional quality of life and personal wellness are discussed and assessed in relation to their professional identity development. This non-standardized model of supervision may help counseling students develop better attunement with themselves and their clients, and as a result, clients benefit from receiving counseling interventions from a more holistic perspective.

## Definition of Terms

***Client participant*** is defined, for the purpose of this study, as any individual, couple, or family receiving counseling services at the CNEP Counseling and Training Clinic.

***Cognitive Behavioral Therapy Supervision*** is based on the philosophy of Cognitive Behavior Therapy (CBT). The supervisor is concerned with how the supervisee conceptualizes their client cases, and their thoughts, emotions and behaviors as a counselor. Supervision sessions are flexible (Bernard & Goodyear, 2014).

***Counseling and training clinic*** is an on-campus clinic which offers free counseling services to individuals, couples, families, and children residing in the community. Counseling students in a private and confidential setting provide the sessions. A licensed professional supervises counseling students.

***Counselors-in-training*** refers to an individual enrolled in a CACREP accredited masters level counseling practicum/internship course and actively accruing hours under approved supervision.

***Efficacy*** refers to the ability of the WELMS intervention to produce a desired result. For the purpose of this study, efficacy of the WELMS refers to the power of the intervention to produce an increase in professional quality of life and working alliance.

***Internship*** is post-practicum experience where supervised clinical experience is provided. The student has the opportunity to refine and enhance basic counseling skills and further develop their knowledge and skills (CACREP, 2016).

***Multiple Baseline*** refers to data collected simultaneously, before the intervention begins, with the intervention being introduced at different points in time for groups of participants (O'Neil, McDonnell, Billingsley, & Jenson, 2011).

***Non-overlap analysis*** refers to the analysis done on data points that exceed any noteworthy points within the baseline phase. The analysis is done using a ruler and pencil to draw straight lines though the graphical representation of the data (Lenz, 2013).

***Professional quality of life*** refers to the quality of the work done, as related to the student's work as a counselor in training. Professional quality of life includes compassion satisfaction and compassion fatigue (Stamm, 2010).

***Single Case Research Design (SCRD)*** is a research design used to investigate and demonstrate causal or functional relationships between variables (O'Neil et al., 2011).

***Supervision*** is an intervention that is evaluative and extends over time. This intervention can enhance the functioning of the CIT and can be provided by a doctoral student or approved faculty member. Supervision may be conducted in individual, group or triadic format and can be a form of gatekeeping.

***Visual analysis*** refers to the process of determining intervention effectiveness based on visual representations of the data in graphical form. Visual analysis takes levels, variability, and trends into consideration (Lenz & Callender, 2016).

***Wellness*** is an oriented way of life that leads to optimal health and wellbeing where one's body, mind and spirit are integrated for a life that is full (Myers, Sweeny, & Witmer, 2000).

***Wellness Model of Supervision (WELMS)*** is a model of clinical supervision integrating wellness into the education, planning, assessment, and evaluation of the supervisee and respective clients. Supervisees are introduced to theories of wellness and engage in formal or informal wellness assessment and planning. Evaluation is based on progress towards wellness goals and application of wellness into case conceptualization and client treatment planning (Lenz & Smith, 2009).

***Working alliance*** is a collaborative, professional relationship between a counselor and client. This relationship includes an agreement on tasks, goals and bond formation (Bordin, 1979).

## SECTION II: Review of the Literature

The clinical supervision of counselors-in-training (CITs) during the counselor education program field experience provides an opportunity to implement best practices for promoting skill development and career sustaining behaviors. A holistic, developmental approach to supervising CITs is a professional imperative as we train counseling students to become new professionals. These holistic approaches may inspire students to take a more proactive role in their wellness and therapeutic relationships and spur the growth and development that will strengthen their bond to the counseling profession. Unfortunately, there are limited empirical studies demonstrating causal relationships between a holistic, wellness-based models of supervision and the effects on CITs wellness (Lenz et al., 2012; Lenz & Smith, 2010). Furthermore, there is also an absence of studies examining the relationship between wellness-based models of supervision and working alliance. Therefore, this study will evaluate the efficacy of the Wellness Model of Supervision (WELMS; Lenz & Smith, 2010) for promoting desired changes across two dependent variables: (a) the CIT perceptions of their professional quality of life, and (b) the client perceptions of the working alliance with the CITs. A study on the efficacy of a wellness model of supervision on professional quality of life and working alliance will add to the literature and provide an estimation of the viability for such a model to support counseling supervisors.

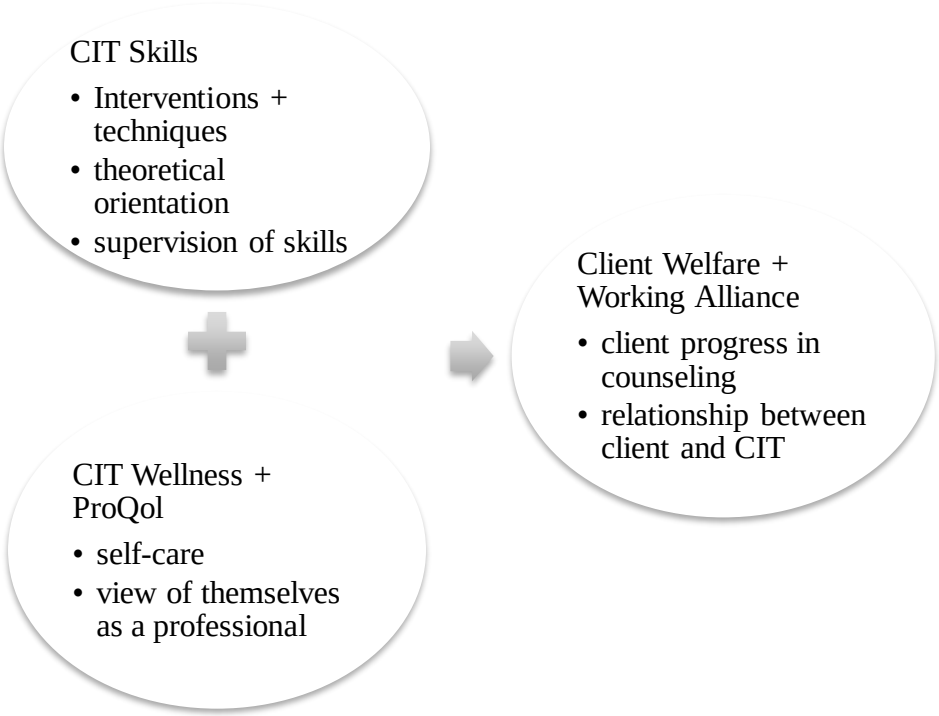
The organization and content of the literature review section is depicted as follows: (a) The Framework Guiding the Study, (b) The Social Construction of Variables, (c) Supervision, (d) Wellness Among Counselors and CITs, (e) ProQOL as an Indication of Counselor Well-being, (f) Working Alliance, (g) WELMS as a Supervisory Intervention, (h) Logic behind the WELMS for Promoting Skills Development and Personal Wellness, and (i) Summary. Within

each topic area (Supervision, Wellness Among Counselors and CITs, ProQOL as an Indication of Counselor Well-being, Working Alliance, and WELMS as a Supervisory Intervention), there will be (a) a definition of the construct, (b) a review of the present state of the literature, (c) bulleted points of research findings and (d) an integrated summary of information as it relates to the study.

## Framework Guiding the Study

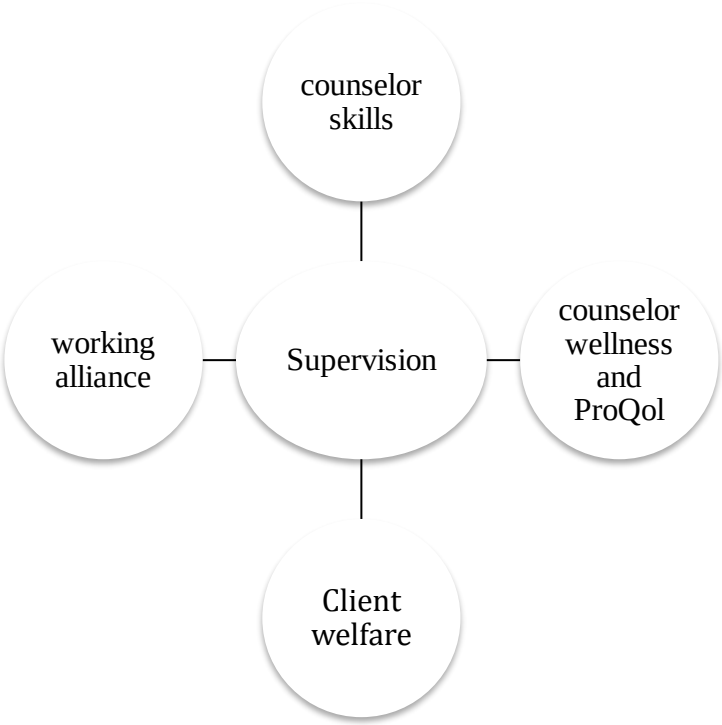
The framework for this study integrates several factors explaining how learning takes place for the counselors-in-training (CITs), and how the CITs create their personal meaning of wellness, professional quality of life, and working alliance. From this framework, supervision is conceptualized as the driving force that mediates and regulates the therapeutic intervention between counselor and client. Supervision is also seen as the mechanism by which therapeutic interventions move from a linear process (Figure 1) to a circular framework (Figure 2).

Figure 1. *Linear Flow of Counseling*



In the linear flow of counseling, the intervention is seen as a process between the counselor and client. Within this linear process, the CIT's skills, wellness, and professional quality of life are seen as separate entities. This linear process represents the counseling relationship without a wellness-based supervisory intervention. In this linear relationship, supervision is used to monitor how the CIT uses their skills within the counseling relationship. However, the personal wellness dimensions are not a focus of clinical supervision.

Figure 2. *Circular Flow of Counseling*




Within the circular framework the intervention is mediated by supervision, specifically the WELMS, creating a circular flow through which the supervisor monitors not only the counselor's skill level, personal and professional development, but also the welfare of the client and the working alliance. This is done from a wellness-based perspective where the supervisor takes a more holistic approach to supervision, monitoring the wellness dimensions of the CIT in relation to its impact on professional development and working alliance. Therefore, utilizing the

WELMS moves supervision from what is demonstrated in Figure 1 as a linear process, to what is outlined in Figure 2 as a more inclusive and circular process.

The framework of this study is rooted in the theoretical orientation of Individual Psychology (IP) as proposed by Adler (1927, 1954). This theoretical framework provides a foundation for the literature review and the concepts and definitions that are relevant to this study (Grant & Osanloo, 2014). In this section I give a brief overview of each theory, explain how they connect with each other in relation to the study, and describe how wellness, professional quality of life, and working alliance are socially constructed by counseling students.

**Individual Psychology (IP) and Holism**

In his theory of individual psychology, Adler proposed the concept of the unity of individuals, and believed in having intimate knowledge of the individual as a whole. Adler suggested that by understanding individuals as a whole, it then becomes easier to understand the different parts that constitute the whole person (Adler, 1924). Holism refers to the individual's ability to make choices and decisions as a whole within the context of others. Individuals are viewed as being indivisible, therefore the various dimensions of their lives cannot be viewed as separate parts. The body, mind, and emotions work together to achieve the ultimate life goal (Dreikurs & Ferguson, 2000).

Individuals are social beings with a purpose, who use creative approaches to enhance their lives as they integrate the body, mind, and emotions. Individuals are best understood from a holistic perspective as they navigate major life tasks. These major life tasks include: work, friendship, love, self, and spirituality. This holistic view of the individual is seen as a relationship between the body and mind (Sweeney, 2009). It is necessary to understand the concept of holism in order to understand the theory of wellness as holism is central to understanding human

behavior. Wellness involves the integration of various areas of human functioning to achieve a favorable level of health (Myers & Sweeney, 2005; Pomeroy & Clark, 2015). According to Adler and colleagues, these areas of functioning are characterized by a set of life tasks.

**Life Tasks According to Adler**

Adler theorized that life tasks develop from a desire for association with others, caring for an offspring, and maintaining a livelihood. Adler believed that life tasks are inescapable, therefore individuals must decide how they will confront problems that arise. If one task is avoided, the individual experiences discouragement and conflict in the other areas. These problems in life can be divided into three areas of focus: (a) problems at work, (b) problems of love, and (c) problems of communal life. Adler believed that individuals strive towards overcoming problems, perfection, success, and superiority (Adler, 1982; Lachney, 1994). Mosak and Dreikus (1967) proposed two additional life tasks, coping with self and spirituality, which were added to constitute five life tasks based on the common themes in Adler's writings. Since these five life tasks are common to all individuals, they also represent a common attribute to the CITs personal and professional development while matriculating through a counseling program (Foster, Steen, O'Ryan, & Nelson, 2016; Myers, Sweeney, & Witmer, 2000; Sweeney & Witmer, 1991). Myers and colleagues (2000) further expanded on the five life tasks (spirituality, self-direction, work and leisure, friendship, and love)

**Spirituality**. This life task is an important factor in the perception of quality of life, while using religious affiliations help to maintain a healthy life-style. The spirituality life task reflects the individual's creative energy source for living a purposeful life (Mosak & Dreikurs, 2000; Sweeney & Witmer, 1991).

**Self-direction**. This refers to the way individuals discipline, regulate, and directs themselves in daily activities as they pursue life goals. Self-direction also refers to a mindful and intentional manner in which individuals meet their life goals (Myers et al., 2000).

**Work and leisure**. During this life task, individuals have an opportunity to engage in pleasurable experiences that provide a sense of accomplishment. These opportunities challenge and engage skills, interests, and the senses to create a flow. This flow is a state in which the individual loses awareness of themselves as they are highly engaged in the task at hand (Myers et al., 2000).

**Friendship**. Although friendships demand a level of self-disclosure and risk taking, the foundation of lasting relationships is positive regard for the other person. Social support is essential for mental and physical health, and the quality of life is related to satisfying social relationships (Myers et al., 2000; Sweeney & Witmer, 1991).

**Love**. Healthy relationships involve intimacy, which constitutes the life task of love. Healthy love relationships include the following characteristics: (a) the ability to self-disclose, be intimate, and trusting with another person, (b) receive and give affection, (c) experience non-possessive caring that respects the unique characteristics of the other person, (d) having enduring stable relationships in one's life, (e) concern for the growth and nurturing of others, and (f) satisfaction with one's sex life and need for physical intimacy (Myers et al., 2000).

## The Social Construction of Variables

How we understand the world around us is based on the information we learn and the experiences that accompany our knowledge. Constructivists suggest that we learn by fitting new knowledge into what we already learned, and as new experiences or understanding occurs our schema changes. Therefore, learning involves a personal transformation (Fry, Ketterridge, &

Marshall, 2003). From a social constructivist perspective, individuals describe, explain, and account for the world in which they live, and acknowledge that their experiences and the understanding of how the world functions is interchangeable among people. Socially constructing the world around us is an active process which involves change (Gergen 2003). CITs learn how to create meaning of wellness, professional quality of life, and working alliance from several sources, including classroom experiences, internship, and supervision.

During the classroom experience, CITs learn about the history of counseling, various techniques, theoretical orientations, and skill development. CITs are also exposed to knowledge about professional identity. Professional identity is developed based on personal views, the training program's identity, and an aggregation of professional and personal self-concept. CITs are expected to develop their own personal identity before establishing a professional identity, which influences the CITs professional quality of life and the development of their counseling skills (CACREP, 2016; Gibson, Dooley, Kelchner, Moss, & Vacchino; Mascari & Webber, 2013; Spurgeon, 2012).

In the classroom, when CITs are first introduced to counseling skills, they may find this to be a challenge especially if they lack prior experience, and may struggle with understanding how to apply the skills (Adams, Vasquez, & Prengler, 2015). During internship, CITs have a chance to incorporate what they learned in the classroom while actively practicing their skills under a supervised experience. When CITs engage in internship, they have an opportunity to begin socially constructing their view of themselves as a counseling trainee and learn how to further define their professional identity under supervision.

When CITs attend supervision sessions, the supervisor helps to create an environment where professional growth and development can occur. CITs may use supervision sessions to

further construct their professional meaning of life as a counseling trainee, explore new knowledge, and learn how to transition knowledge into practice. Supervision is a time when the welfare of clients is explored, and the CIT is empowered to engage in some self-supervision of their goals as a counseling professional (Corey, Haynes, Moulton, & Muratori, 2010).

Empowering CITs to maintain career sustaining behaviors becomes more practical when supervisors understand the CITs from a holistic perspective, as they work towards achieving their life tasks. By viewing CITs as whole individuals working towards achieving goals in their various life tasks, supervisors may gain more insight into how CITs construct meaning in their personal and professional life. By understanding how CITs construct their personal and professional development from a holistic viewpoint, supervisors are better able to assist CITs in improving the various dimensions of their personal and professional life. When CITs are more mindful of their personal needs in their life task dimensions, and can mitigate early signs of burnout, incompetence, and compassion fatigue, they have a higher level of attunement with their clients (Decker et al., 2015; Puig et al., 2012; Schomaker & Ricard, 2015)

## Clinical Supervision

Supervision is a formal arrangement with specific roles, responsibilities, expectations, and skills (Corey, Haynes, Moulton, & Muratori, 2010). Supervision is an evaluative and hierarchal intervention, provided over time by a more senior member of a profession (supervisor) to a more junior member of the same profession (supervisee). Supervisors may help to enhance the professional functioning of the supervisee while ensuring client welfare (Bernard & Goodyear, 2014). Supervision is a fundamental and routine part of the educational experience of professional counselors and CITs. Supervision is a unique profession with a central role of developing skills, enhancing competence, and gatekeeping.

The relationship established between the supervisor and supervisee is a foundational component of counselor supervision. This relationship helps to promote the growth and development of CITs. The alliance formed in supervision has potentially positive impact on the change that occurs with supervisees. In addition, this alliance is acknowledged and accepted across various supervision models (Watkins, 2014). Although all supervision models aim to enhance counselor competence, there are increasing efforts to identify the mechanisms and practices that enable effective clinical supervision. Despite the model of supervision used, the quality of supervision impacts the quality of client care. The parallel process in supervision helps CITs to increase their understanding of the clients, increase their self-awareness and gain insight as to how best to use their skills. This insight develops as a result of observing the skills modeled during supervision. (Borders, 2005; Falender, Shafranske, & Ofek, 2014; Giordano, Clarke & Borders, 2013; Merriman, 2015).

- High ratings of supervisee stress levels negatively impacts the supervision process, however the level of satisfaction in supervision significantly increased when there was access and availability of coping mechanisms (Gnilka, Chang, & Dew, 2012).
- Interventions that place client safety and supervisee development should be considered first during the supervision process as each supervisee is unique in their rate of development. Supervisors may utilize a card-sorting activity to explain their rationale for prioritizing supervisor interventions which the supervisee may highly value. This encourages the supervisee to ask questions and facilitate supervisee growth and development (Li et al., 2016).
- Supervisors facilitate supervisee growth and development through several strategies which constitute pantheoretical change mechanisms. These strategies include modeling, providing

feedback, direct instruction, and self-regulated learning. Supervision is not only about facilitating learning, but it is a mediator between learning and practicing sills (Goodyear, 2014).

- Supervision of internship CITs provides a transition from the education in the classroom to professional challenges while working with clients. The experience, thoughtful analysis of their work as a counselor, and guidance from a mentor begins in supervision and continues throughout their professional career developing counselor-client relationships (Ponton & Sauerheber, 2014).

Supervisors play a critical role in helping CITs develop their level of competence as a future professional counselor. Supervision therefore provides CITs with experiences that are essential to their growth, development, and process of learning. In addition, supervisors are also obligated to ensure the welfare of the clients receiving counseling services from CITs. Therefore, supervision is a necessary component of this study as CITs are monitored to assess and evaluate their professional quality of life, their working alliance with clients, and their personal wellness. Supervision provides an opportunity to monitor these aspects of the CITs development while mediating between the CITs skill level and client interaction. During this study supervision will be used to expose the CIT to wellness based opportunities to enhance their personal wellness, their professional quality of life, and working alliance with their clients.

**Wellness Among Counselors and Counselors in Training.**

Individuals are best understood from a holistic perspective as they navigate major life tasks which include work, friendship, love, self, and spirituality (Adler, 1982; Mansager & Gold, 2000; Mosak & Dreikurs, 2000). This holistic view of the individual is seen as a relationship between the body and mind (Sweeney, 2009). It is necessary to understand the concept of holism

in order to understand the theory of wellness as the integration of various areas of human functioning is an essential practice to achieve a favorable level of health and wellness (Pomeroy & Clark, 2015).

Wellness is a way of life oriented toward optimal functioning and health wherein the mind, body, and spirit are integrated to facilitate a full life within human and natural communities. Assessing for wellness among counseling trainees is important as changes in one area of the CIT's wellness may affect the other areas in both positive and unfavorable ways (Myers, Sweeney, and Witmer, 2000). The supervisor should be attentive to vulnerabilities to burnout. Information obtained from wellness assessments may assist supervisors in addressing psychological distress or impairment, which may have the potential to affect the performance of the CIT (Puig et al., 2012; Smith, Robinson & Young, 2007).

- Assessing for wellness among counseling trainees is important, in addition, the supervisors should be attentive to vulnerabilities to burnout. Information obtained from wellness assessments may assist supervisors in addressing psychological distress or impairment, which may have the potential to affect the performance of the CIT (Puig et al., 2012; Smith, Robinson & Young, 2007).
- Wellness is a synergistic and multidimensional construct. Supervisors are able to explore the complex nature of wellness when they have a means to measure and assess the construct of wellness. An interactive and relational means of assessing wellness may provide a more authentic portrayal of the individual's state of wellness (Lenz & Roscoe, 2011).
- Individuals should be seen as unique and treated with positive regard, understanding and engage in genuine relationships. Wellness initiatives should not focus on disorder or dysfunction within the individual. Instead, wellness approaches should be based on nurturing

and enhancing human abilities. In addition, well ness initiatives should result in the individual striving for their highest level of functioning (Granello & Witmer, 2013).

- Counselor impairment may be a result of neglecting self-care needs. Counselor impairment may be as a consequence of burnout, vicarious trauma, compassion fatigue, or stressors. Counselors should pay particular attention to address their physical and emotional needs and utilize creative approaches to achieve a balanced state of wellness (Bradley, Whisenhunt, Adamson, & Kress, 2013).
- Although students and faculty may be busy during the semesters and academic years, they should ensure that time is allocated to self-care and wellness strategies. A counselor education training program that promotes wellness through the curriculum creates an environment for students to explore stressors and share various wellness practices. Individual wellness efforts may be reinforced through supervision by faculty (Wolf, Thompson, & Smith-Adcock, 2012).

Counseling professionals and students who engage in wellness practices, and are aware of the behaviors that help them to maintain their personal wellness may experience a better quality of life which results in career sustaining behaviors. The wellness of counselors and CITs is an important area of study as it provides pertinent information on the reduction of impairment which may lead to ethical violations, and increased risk of losing professional counselors due to an inability to provide best practice care to clients (Bradley et al., 2013; Puig et al., 2012; Smith, Robinson, & Young, 2007). This study is designed to demonstrate the importance of wellness and well-being in the development of healthy CITs and the impact of wellness on the working alliance between CITs and their clients.

## Professional Quality of Life as an of Indicator of Counselor Well-Being

Professional quality of life (ProQOL) refers to the quality of the work done, as related to the student's work as a counselor in training. ProQOL includes compassion satisfaction and compassion fatigue (Stamm, 2010). ProQOL may be compromised based on the nature of the job. Counselors may experience high levels of stress, job frustration, exposure to complex client cases, and trauma stories. A lack of compassion and burnout, due to a decreased professional quality of life, may lead to feelings of anxiety, depression, and helplessness in CITs. Those CITs who experience burnout may be unable to cope with the stressors of the profession, and have unrealistic expectations which can result in delusional thoughts and expectations that eventually leave the CIT disappointed. CITs who are more competitive may suffer from burnout and compassion fatigue at a faster rate (Perkins & Sprang, 2013).

- The professional quality of a counselor's life should reflect self-awareness skills, an appreciation for the complexity of society, and a genuine respect for human diversity. Training and preparation for a professional quality of life includes having a secure base of trust, safety, and comfort. Counselors should place an emphasis on developing relational skills to prepare them for a life of service that is confident and passionate (Mahoney, 2005).
- Counselors who are aware of their burnout profile are better able to uncover the individual and societal contributors to burnout. This may result in the ability to develop preventative strategies (Lee, Cho, Kissinger, & Olge, 2010).
- Counseling professionals are at an extremely higher risk for compassion fatigue and burnout (Christopher & Maris, 2010). Some factors responsible for this increased risk are (a) prolonged exposure to suffering, (b) personal life demands, (c) response to the client, (d)

personal traumatic stories, and (e) a lack of clear boundaries (Decker, Constantine Brown, Ong, & Stiney-Ziskind, 2015).

- Emotional self-care activities may play a significant role in professional quality of life. Through social support networks, spending time with friends and family, and support from employers and educators, counselors can boost their emotional support and professional quality of life (Bloomquist, Wood, Friedmeyer-Trainor, & Kim, 2015).

The ProQOL is an important dimension to investigate as it can be a reflection of the quality of work that CITs engage in with their clients. A study investigating the professional quality of life of CITs is essential to assist students to identify their potential to experience burnout and compassion fatigue. In addition, a study on ProQOL would help counselor educators and supervisors to have a better understanding of how CITs view themselves as professionals.

## Working Alliance

Working alliance, or therapeutic alliance, can be traced back to Freud (1913) who identified the special relationship between counselor and client as an alliance (Horvath & Greenberg, 1994). Bordin (1979) defined the working alliance construct as collaboration between clients and counselors based on the attachment and shared commitment to the goals set in the counseling session. According to Rogers (1961), therapeutic alliance, also known as working alliance, is identified as a significant factor in determining counseling outcomes. The quality of the therapeutic relationship appears to be a major factor in the process of change and the development of problems. Rupture and repair of alliance are crucial factors studied in the success of psychotherapy (Schechter, Goldblatt, & Maltsberger, 2013). One way to address issues in therapeutic relationships is to focus attention on the alliance between counselor and client (Hathcher, 2010).

- In short-term inpatient settings, working alliance may be important for client stabilization and goal attainment for discharge (Schmit, 2015); similarly, this alliance may be significant in outpatient settings for positive clinical outcomes (Patterson, Anderson & Wei, 2014).
- Since client-counselor relationships may contribute to approximately 30% of the variance in client outcome, CITs have a responsibility to establish a healthy working alliance that will contribute to positive outcomes in therapy (Lambert & Barley, 2001).
- Lei and Duan (2014) suggested that the degree to which counselors make a connection with the client's emotions may correlate with client perceptions of the therapeutic relationship.
- Positive counseling outcomes can be predicted by the strength of the therapeutic alliance. Duff & Bedi (2010) discovered that counselor behaviors such as validation, reflecting feeling, eye contact, honesty, encouraging the client, making positive comments, and asking questions were all strongly correlated with therapeutic alliance.
- Mindfulness training had a significant impact on counselor-client attunement scores which may be efficacious for improving therapeutic alliance skills. This is an important development since the counseling relationship is an important element of client outcome in therapy (Schomaker & Ricard, 2015)

Research on the working alliance between counselor and client can help to reinforce the notion that good alliance is encouragingly related to positive counseling outcomes across settings, populations, and therapeutic intervention (Horvath & Greenberg, 1994). Alliance may be conceptualized and measured differently across treatment modality, and based on the population (McLeod, 2011). In order to understand what happens during the counseling intervention, there is a need for increased studies measuring the working alliance between

counselor and client, since the alliance may enhance the efficacy of the treatment provided (Horvath & Luborsky, 1993).

## WELMS as a Supervisory Intervention

Myers, Sweeney, and Witmer (2000) developed their model of wellness based on perspectives from clinical, health, social, personality, and developmental psychology. Myers and colleagues also considered stress management, psychoneuroimmunology, and behavior medicine. This model of wellness proposed five life tasks and twelve subtasks. The life tasks include (a) self-regulation, (b) spirituality, (c) work, (d) friendship, and (e) love. The twelve subtasks include (a) sense of worth, (b) sense of control, (c) realistic beliefs, (d) emotional coping and awareness, (e) creativity and problem solving, (f) humor, (g) nutrition, (h) exercise, (i) self-care, (j) stress management, (k) gender identity, and (l) cultural identify. Based on this model Myers and colleagues believed that changes in one dimension of wellness causes positive or negative change in other areas. Based on this model, a Holistic Model for Treatment Planning was established.

The WELMS was developed based on the holistic, wellness-based approach towards client care as outlined in the Holistic Model for Treatment Planning. Lenz and Smith (2010) adopted the concepts of this model in the development of the WELMS. According to Myers et al., (2000), personal wellness relies on (a) wellness education (b) self-assessment, (c) goal setting and planning, and (d) an evaluation. Storlie and Smith (2012) suggested that wellness approaches within supervision are necessary to not only meet the needs of the CITs but to also strengthen the profession.

This supervisory intervention involves a few steps. First, the CITs will be asked to complete the 5F-WEL inventory. The results will be used to develop a personal wellness

supervision plan which prioritizes the wellness dimensions that the CIT deems most important to attend to during supervision. The CIT will select the most important dimension in which they have a deficit and which may be the most detrimental to their work as a CIT. During the first 20 minutes of the WELMS, I will monitor the progress of the CITs personal wellness based on the dimensions they identified on their supervision plan. During this time, CITs will discuss what steps they took, since the last supervision meeting, to work on achieving their personal goal and what plans they have for the upcoming week. The supervision plan will entail (a) the identified wellness domain, (b) current satisfaction rating with that dimension, (c) ways that changes in this domain will positively affect their life, (d) intervention with objectives and strategies, and (e) how the CITs will know when they have made some progress.

- Storlie and Smith (2012) found that there is a strong possibility that CITs who received wellness interventions during their internship may experience significant increase in their personal wellness.
- Elements of the WELMS include the five dimensions identified by Myers et al. (2000. An orientation to the WELMS occurs to provide an overview of the expectations to students. Within the WELMS there is an overt attention to wellness which is presented as a check in during the first 20 minutes of the sessions. This is done as an intentional aspect of the supervision session (Lenz & Smith, 2010).
- When CITS participate in the WELMS, they engage in a self-study designed process experiences within the counseling relationship. Throughout their supervision, CITs are exposed to various models of wellness in an attempt to understand self and others, develop a personal wellness plan, complete and interpret personal wellness assessments (Lenz et al., 2012).

- The WELMS is flexible and amenable to diverse training settings. In a study conducted with 32 masters-level counseling students, participants in the WELMS group developed more comprehensive definitions of wellness. In addition, there was a greater conceptualization of the clients when CITs had an expanded definition of wellness, increased personal wellness practices, and increased skill development when compared to CITs not receiving the WELMS (Lenz et al., 2012).
- A qualitative study conducted by Lenz, Oliver, and Sangganjanavanich (2014), CITs developed a greater understanding of the importance of including wellness into clinical supervision and their personal lives. Integrating wellness into supervision encouraged resilience and increased well-being among CITs, and they gained greater insight into holistic concepts that promote empathic understanding of the client experiences.

When CITs are exposed to the WELMS they may develop a desire to strive towards personal awareness and self- development from a holistic perspective (Lenz et al., 2012). There are few supervision models that include a wellness component or wellness focus (Lenz et al., 2012; Lenz & Smith, 2010), and there is a lack of supervision literature that contains a wellness based model of supervision (Blount & Mullen, 2015). Supervision is a pivotal aspect of counselor training and development, and since we want to keep CITs in the profession and train well developed, holistic students, the WELMS is essential to that goal. CITs who take care of themselves and establish a wellness routine and less likely to experience burnout and compassion fatigue. They also stand a better chance of establishing a better working alliance with their clients as they can be more attuned when they attend to their personal needs.

## Logic Behind WELMS for Promoting Skills Development and Personal Wellness

When CITs first learn basic counseling skills, it can be an overwhelming process and they may feel challenged as they learn new information. CITs are expected to obtain mastery in basic skills and learn how to apply them appropriately (Adams, Vasquez, & Prengler, 2015). When CITs enter practicum and subsequently internship, they are placed in the field and provided with the opportunity to refine and enhance basic counseling skills and further develop their knowledge base and skill level (CACREP, 2016).

Within counselor education programs, supervision is a central and routine part of the educational experience of professional counselors and CITs. During supervision, the CITs are monitored for progress and development in their personal characteristics, their knowledge and application of professional skills, and their general wellness and self-care practices. Supervisors have an ethical obligation to attend to the holistic wellbeing and self-care of CITs (Ohrt et al., 2015). Therefore, supervision is conceptualized as the driving force that mediates and regulates the personal and professional development of CITs, and the therapeutic intervention between CITs and client.

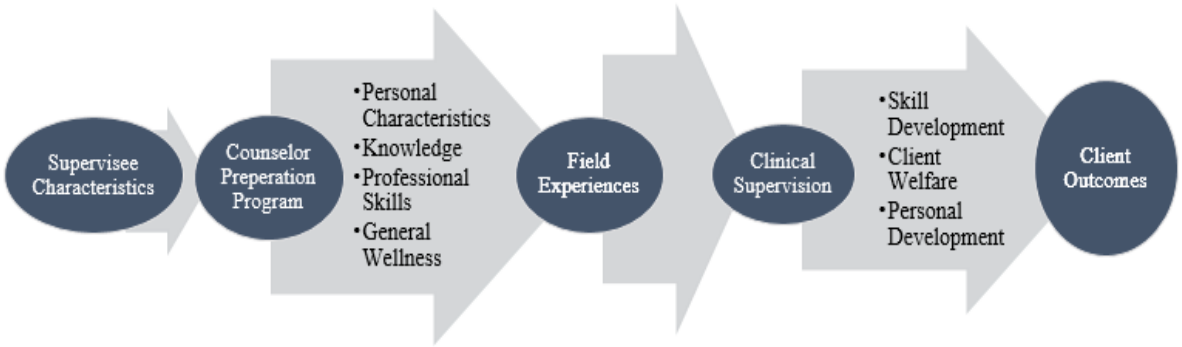
Clients bring their own personality and dynamics into the counseling session, however, the client-counselor relationship is an important factor when considering client outcomes. Clients have expectations from counseling that should be met by their counselor. Therefore, the need to form a strong alliance is imperative (Leibert & Dunne-Bryant, 2015). When CITs are able to work on and develop their skills, attune to their client's needs, and attend to their personal development, their clients receive better outcomes as the CITs approach counseling from a holistic and balanced perspective.

Lenz et al. (2014) found that CIT wellness during the graduate program has considerable implications for professional and personal development. In addition, their findings also suggest that the quality of the counseling experience is higher for their clients when compared to CITs who did not receive the WELMS. Lenz et al., (2012) discovered, through a qualitative study, that one mechanism for increasing the self-care practices of CITs is through the WELMS. The WELMS also provided a way for supervisors to facilitate continuous wellness related activities during internship when it is most applicable and practical.

In this study, I attempt to establish significance through replicating and extending the findings of the study conducted by Lenz et al. (2014). Lenz and colleagues encouraged counseling researchers to further investigate into the effects of integrating wellness into supervision. Therefore, instead of investigating counseling skills of the CITs as the dependent variable, I will examine the working alliance between the CITs and their respective clients as I examine the effects of integrating wellness-based interventions into supervision.

Figure 3 shows the logic model of the WELMS as it relates to promoting CIT skill development and their personal wellness to ensure better client outcomes.

*Figure 3: The Logic Model of the WELMS for Promoting Skills Development and Personal Wellness*



## Summary

A holistic approach to supervising CITs, through wellness-based supervision, is essential in an attempt to inspire CITs to be more proactive with their personal wellness, and to improve the counseling relationships with their clients by identifying factors that may impede counselor-client attunement. Unfortunately, there are limited empirical studies demonstrating causal relationships between a wellness-based model of supervision and the effects on CITs wellness (Lenz, Sangganjanavanich, & Balkin, 2012; Lenz & Smith, 2010). In addition, there is dearth studies examining the relationship between wellness based supervision and working alliance.

Clinical supervision plays an essential role in monitoring the wellbeing of CITs and the welfare of their respective clients. Through the WELMS, CITs have an opportunity to pay attention to their personal wellness and identify factors which may lead to burn out and compassion fatigue. The WELMS provides CITs with an opportunity during supervision, to place emphasis on setting goals that enhance their personal and professional development, which may lead to greater client outcomes.

## SECTION III: Methodology

This study will implement a small series single-case research design (SCRD), with mulitple baselines to evaluate of the efficacy of the Wellness Model of Supervision (WELMS) for promoting professional quality of life and degree of working alliance attunement between client and counselors-in-training.

### Research Questions

This study is unique as it will include CIT outcomes as related to their professional quality of life while participating in the WELMS. Client outcomes will be related to their perceived working alliance with the CIT.

The research questions for this study include the following:

a) To what degree is the WELMS efficacious for maintaining or promoting CIT professional quality of life?
b) To what degree is the WELMS efficacious for promoting client perceptions of working alliance with CITs?
c) What is the lived experience of CITs being supervised with the WELMS?

### Research Design

In order to evaluate the effectiveness of the intervention (WELMS), I will use an A-B single-case research design (SCRD) with multiple baselines to observe for changes in CITs professional quality of life and working alliance attunement associated with participation in the WELMS.

**Single case research designs (SCRDs)**. SCRDs are experimental research designs that provide a practical way to investigate and demonstrate functional or causal relationships between intervention and dependent variables. Due to the nature of the study, this design is suited for a

school and community based site where treatment services for clients are distinct and based on diagnostic category. Client participants will not be identified based on their selection of a particular type of service at the CTC. This SCRD design is also appropriate for the CIT population as it may not be in the best interest of the CIT to withdraw the WELMS once it has been implemented as I intend to encourage career sustaining behaviors through the introduction of the intervention (Lenz, 2015).

There are several steps to conducting an SCRD. These steps include: defining the research question, identifying subjects, choosing measurement instrument, defining intervention, and selecting the specific SCRD. Unlike other classifications of experimental designs, researchers using SCRDs focus on manipulating the intervention which leads to causal inferences that can be made about the effectiveness of the intervention. Another unique feature of SCRDs is that participants function as their own comparison group. The unit of interest in SCRDs is not limited to one individual, instead the single case can be represented as a group or system. (Kazdin, 2011; Lenz & Callender, 2016; O'Neill, McDonnell, Billingsley, & Jenson, 2010; Ray, 2015).

The A-B design is the most basic SCRD and involves an initial series of baseline measurement when no intervention is present (A) followed by the introduction of the intervention (B). Characteristics features of all SCRDs include: continuous assessment, baseline measurement, and stability of performance within phases. SCRDs yield data suitable for making causal inference under two circumstances- when evaluating data across replications of A-B phases and when introducing the intervention at different times across participants, thus establishing multiple baselines (Kazdin, 2011).

**Multiple baseline design.** Multiple baselines contribute to evidence-based data and authenticate a functional relationship between the intervention and dependent variable through the replication of effects across settings, behaviors, participants, or context. Baseline data are collected concurrently across two or more behaviors and involves three possible applications. These applications include the measurement of target behaviors for one participant, target behaviors across settings, or the same target behavior across multiple participants. Researchers collect baseline data at the same time, but the intervention is introduced at various points in time for each participant. Multiple baselines establish the effect of the intervention by demonstrating that behavior changes only when the intervention is introduced (Kazdin, 2011; Kratochwill et al., 2010; O'Neill et al., 2010; Ray, 2015)

**Application to study**

In this study, the intervention is the WELMS and it will be evaluated using a basic A-B design that features multiple baselines to establish a stronger empirical basis for making causal inferences about treatment effect. To implement this design, the following steps will be followed: (1) dependent variables and measurements will be operationally defined, (2) an operational definition of the intervention will be provided, (3) the baseline phase (A) will be implemented until stability has been established for each participant, (4) the WELMS will be introduced to represent the intervention phase (B) and implemented throughout the remainder of the study term (O'Neil et al., 2011). Data produced by single-case research designs (SCRDs) may support counselors as they monitor the progress of their clients. In addition, data yielded from SCRDs can be important for completing program evaluations, providing information to stakeholders and support evidence-based practices (Lenz, 2013).

## Sampling Procedure

This study will rely on data collected from CITs obtaining their internship hours at the Counseling and Training Clinic and their respective clients.

**CIT participants.** A non-parametric sample of participants will be recruited from students enrolled in the Masters of Counseling Program within the Department of Counseling and Educational Psychology (CNEP) at Texas A&M University-Corpus Christi. Specifically, participants will be those students who are completing requirements for their internship coursework by accruing direct client contact hours through therapeutic service delivery at the CNEP CTC. I will request a list of internship students from the CTC Director, and subsequently solicit participation in the study through a personal request. I will visit the CTC at the beginning of the fall semester to distribute a written recruitment script to CITs and personally invite them to participate in the study.

Inclusion criteria for CIT participation in this study includes: a) CITs must be a master's student enrolled in internship class with the CTC as their approved site, b) CITs must be willing to participate in the study, c) must be assigned to an approved WELMS doctoral student supervisor at the CTC, and d) must have a client assigned to their case load. Exclusion criteria for this study includes: a) students who are not enrolled in the internship course, b) not completing internship at the CTC, c) those CITs with no clients on their case load, and d) those students not assigned to the WELMS doctoral student supervisor.

**Client participants.** A sample of clients will be recruited from men and women attending the CTC, who are receiving counseling from the identified Internship master's students. Clients will be recruited through a personal request. The minimum number of client participants for this study is five clients. I will provide CITs at the CTC with recruitment letters

to distribute to each of their clients requesting participation in the study. In addition, copies of the recruitment letter will also be placed in the waiting room of the CTC for clients to access.

Inclusion criteria for client participants includes the following: (a) clients must be at least 18 years of age, (b) receiving counseling services from the CTC, (c) must be willing to participate in the study, (d) must be medication compliant, not actively psychotic, (e) not under the influence of alcohol or mood altering substances that were not prescribed to them, and (f) must be engaged in a treatment plan with an assigned counselor at the CTC. Exclusion criteria includes: (a) clients who are under the age of 18 years, (b) clients whose first language is not English, (c) clients who are unable to read or write in English, (d) clients who are actively psychotic, (e) noncompliant with medication directions, (f) under the influence of alcohol or mood altering substances not prescribed to them, and (g) clients who are unwilling to participate in this study will be excluded.

**Participants**

Participants for this study will be a combination of counselors-in-training (CITs) and their respective clients. CIT participants will be master's level students enrolled in internship at the CTC. Participants will be enrolled in a counseling program that is accredited by the Council for Accreditation of Counseling and Related Educational Programs (CACREP). A doctoral supervisor trained in the implementation of the WELMS, and enrolled at TAMUCC in a counseling program that is accredited by CACREP, will supervise all participants. The minimum number of CIT participants for this study is five internship students.

The client participants for this study will be men and women over the age of 18 years who are receiving counseling services from an internship student at the CNEP Counseling and Training Clinic. Clients may present to the Clinic as individuals, couples, or as a family. Clients

should have English as their first language, and be able to communicate orally and through written format in English. Clients should be medication compliant and engaged in a treatment plan with the internship CIT. The minimum number of participants for this study is five clients.

**Setting of the Study**

This study will be conducted at the on-campus Counseling and Training Clinic (CTC) at TAMUCC, which is a clinic affiliated with a CACREP accredited counseling program. The Clinic is located in the TAMUCC Natural Resources Center, Suite 2700, and operates between the hours of 11:30 am and 8pm, Tuesday through Thursday. Appointments are scheduled from 11:30 am to 6:30 pm and are typically 45 minutes in length. The Clinic offers counseling services to members of the community at no cost. These services include individual and family counseling, couples counseling, group counseling, and services for children, adolescents, and adults. Counseling sessions are provided by counseling trainees in a private and confidential setting.

Upon entering the CTC, members of the community are greeted by a counseling trainee seated in the waiting room at a desk with a laptop and miniature Zen sandtray. In this waiting room, there are five chairs, a lamp, magazines, framed pictures on the wall, and a display with community resources. There are a total of eight rooms used by the CTC staff for counseling services: five of these rooms are located within the CTC Suite and three rooms are located in the hallway of the NRC Building on the same floor as the CTC Suite. Four of the rooms located in the CTC have dim lights, noise cancellation machines outside each door, couches, and chairs for the counselor(s) to sit. These rooms are equipped with a recording device that is only focused on the area where the counseling trainee sits. There is a monitoring room located opposite these counseling rooms, which is not accessible to members of the community. Inside this monitoring

room, supervisors and peers are able to view sessions on a monitor and listen to the sessions via headphones. This is done to monitor live sessions, as this Clinic is a training facility. Session notes and other planning activities are also conducted in this monitoring room.

Activities of the CTC are supervised by a fully licensed counseling faculty member whose office, as the CTC Director, is located in the Clinic suite. The Director's office is the fifth room in the CTC, which is sometimes used for counseling sessions as needed and is also equipped for recording sessions. There are also three additional conference rooms on the same floor available for larger group work and for working with children. Out of these three conference rooms, the only room equipped with recording devices is the room assigned for therapy with children.

Students are supervised by the Clinic director and counseling doctoral students. On average, there are at least two doctoral supervisors in each semester, including summer. Supervision usually occurs before the CTC opens for the members of the community, and sessions may last anywhere from half an hour to one hour. During these routine supervision sessions, CITs meet with their assigned doctoral supervisor to review their case load. In the event that their assigned doctoral supervisor is not available, they seek out supervision with another doctoral supervisor.

Access to the clinic for counseling services is based on the academic calendar as outlined by TAMUCC. The Clinic operates during the spring, fall, and summer semesters, with scheduled breaks. During these breaks, the clinic is not open to members of the community for counseling services. Clients have the option to continue at the Clinic throughout the academic year and are not required to terminate services once a semester ends, unless such termination was pre-determined by the counseling team at the Clinic.

## Measurement of Constructs

Measures for the study include the Professional Quality of Life Scale (ProQOL; Stamm, 2010), which will be used as a self-score scale to establish a baseline at the beginning of this study and administered weekly throughout the study. The Working Alliance Inventory-Short (WAI-SF; Tracey & Kokotovic, 1989) will be used to measure working alliance from the perspective of the client and CIT as a baseline and repeated weekly throughout the study. The Five Factor Wellness Inventory (5F-WEL; Myers & Sweeney, 2005). This inventory will be used as a pretest and posttest measure of wellness. Counselors-in-training will complete this inventory at the beginning of the study to establish a baseline, before introducing the WELMS, and also at the end of the study.

**Professional Quality of Life.** The Professional Quality of Life Scale (ProQOL; Stamm, 2010) was developed as a measure used to assess the effects of working with others who may have experienced stressful events. Originally developed to be administered to therapists, the ProQOL may be used with other groups such as social service employees, public service employees, medical health professionals, teachers, and humanitarian workers (Stamm, 2010). The ProQOL is a 30 item self-report that measures four subscales. These four subscales are; *compassion satisfaction* which is the pleasure derived from doing well with your work, *compassion fatigue* which is frustration, exhaustion, depression and work related trauma, *burnout* refers to the negative effects of caring for others and includes feelings of hopelessness and feeling ineffective at one's job. The fourth subscale is *secondary traumatic stress*, which is an element of compassion fatigue and refers to negative effects as a result of exposure to others who have experienced traumatic events (Stamm, 2010). The 10 item compassion satisfaction scale includes items such as "I get satisfaction from being able to help people" and "I am happy

that I chose to do this work." The burnout scale has 10 items with questions such as "I feel trapped by my job as a helper" and "I am not as productive at work because I am losing sleep over traumatic experiences of the persons I help." The 10 item secondary trauma scale has items such as "I am preoccupied with more than one person I help" and "I can't recall important parts of my work with trauma victims." The ProQOL has reliability scores for each of the scales. The compassion satisfaction scale has an alpha reliability of .88, the burnout scale has an alpha reliability of .75, and the alpha reliability for the secondary trauma scale is .81. The values indicate strong reliability of the items. The ProQOL is a dependent variable in this study.

**Working Alliance.** The Working Alliance Inventory- Short Form (WAI-SF; Tracey & Kokotowitc, 1989) is a revision of the original Working Alliance Inventory (WAI; Horvath, 1982), and was originally developed to assess the collaboration between the counselor and client. The WAI-SF is a 12-item self-report scale used to measure working alliance. The WAI-SF is available as a client rating form and a counselor rating form. The WAI-SF consists of a 7-point Likert-type scale with responses ranging from (1) never, (2) rarely, (3) occasionally, (4) sometimes, (5) often, (6) very often, and (7) always. The three subscales include; agreement on goals, agreement on tasks, and establishment of a bond. High scores on the WAI-SF will indicate a higher rate of working alliance. The 4 item scale of agreement on goals has items such as "____does not understand what I am trying to accomplish today" and "____and I have different ideas on what my problems are." The agreement on task scale has 4 items, such as "____and I agree about the things I will need to do in therapy to improve my situation" and "what I am doing in therapy gives me new ways of looking at my problem." The 4 item establishment of a bond scale has items such as "I believe ____ likes me" and "I feel that ____appreciates me." High internal consistency scores were reported ranging from .83 to .92 on subscales and .95 to

.98 on the total score (Hanson, Curry & Bandalos, 2002). The working alliance is a dependent variable in this study.

**Wellness**. The Five Factor Wellness Inventory (5F-WEL; Myers & Sweeney, 2005) is an evidence-based tool, used to evaluate the characteristics of wellness as a basis for helping individuals make healthier life choices. This instrument is based on The Indivisible Self: Evidence Based Model of Wellness (IS-WEL, Myers & Sweeney, 2005). The 5F-WEL was originally developed to assess the adult population. The normative sample of 3, 343 adult participants were recruited through university classes, professional workshops, and through research. The authors acknowledge the underrepresentation of men and the overrepresentation of African Americans in relation to other minority groups. Users of the 5F-WEL are encouraged to used local norms for score interpretation. The 5F-WEL is a 91-item self-scoring tool that measures 17 discrete scales based on the Indivisible Self with responses ranging from *strongly disagree, disagree, agree,* and *strongly agree*. Some items include "I value myself as a unique person," "I do not use tobacco," "I have at least one close relationship that is secure," "I can show my feelings anytime," and " I am proud of my cultural heritage" (Myers & Sweeney, 2005). Hattie, Myers, and Sweeny (2004) reported reliability measures for the five second order factors. These include Creative Self (.93), Coping Self (.92), Social Self (.94), Essential Self (.91), and Physical Self (.90). Reliability scores for total wellness was .94. The 5F-WEL will be used to support the intervention and facilitate planning in this study.

**Intervention**

The Wellness Model of Supervision (WELMS; Lenz & Smith, 2010) is a comprehensive model of supervision that is integrative in nature and based on the theory of the Holistic Model for Treatment Planning delineated by Myers, Sweeney, and Witmer (2000). The WELMS is

grounded in a positive approach with emphasis on health, nutrition, personal well-being, goal setting, values, and self-meaning. The WELMS is based on the fundamental elements of education, assessment, planning, and evaluation from a holistic and wellness-based approach. This intervention is intended to be used as an integrated approach in supervising CITs. Focus on the wellness of the CITs will be demonstrated as an intentional monitoring process that does not dominate the entire supervision session; instead, it will be implemented within the first 20 minutes of the supervision session. During the WELMS, CITs will keep a journal to document their experience of supervision (Lenz & Smith, 2010).

CITs will be asked to complete the 5F-WEL inventory and the results will be used to develop a personal wellness supervision plan. During the first 20 minutes of the WELMS, I will monitor the progress of the CITs personal wellness based on the dimensions they identified on their supervision plan. During this time, CITs will discuss what steps they took, since the last supervision meeting, to work on achieving their personal goal. The supervision plan will entail (a) the identified wellness domain, (b) current satisfaction rating with that dimension, (c) ways that changes in this domain will positively affect their life, (d) intervention with objectives and strategies, and (e) how the CITs will know when they have made some progress. After the first 20 minutes of reviewing the WELMS plan, CITs will then discuss their respective clients, process case conceptualizations, treatment planning, and intervention techniques.

**Procedure**

Upon approval of the study by the institutional review board (IRB) at TAMUCC, CITs enrolled in the internship course will be contacted and asked to participate in the study. These CITs will be classified as internship students accepted to complete internship hours at the CNEP Counseling and Training Clinic. The purpose of the study and participant eligibility will be

discussed. CITs who volunteer to be included in the study will be provided with consent forms, a pseudonym, and initial assessments, including the ProQOL, to measure professional quality of life, and the 5F-WEL, to be used to develop a personal wellness plan for supervision.

The 5F-WEL will be completed online and a score report will be generated for each participant. In this score report, the CIT will be able to identify how the dimensions were scored and will identify one dimension with a low score that can have an impact on their functioning as a CIT. The results from the 5F-WEL will be used to develop a personal wellness plan for each internship CIT. These wellness plans will guide the supervision sessions and each plan is unique to the CIT completing it, based on the identified dimension and target goals for the duration of the study. Within the WELMS plan, the CIT will set practical and realistic goals in an attempt to make improvements on the selected wellness dimension. CITs will take the 5F-WEL at the beginning of the treatment intervention and at the end of the intervention phase.

Clients who are actively engaged in counseling services at the CTC will be asked, via a recruitment script, to consider participating in the study. The recruitment script, purpose of the study, and participant eligibility will be discussed with clients who agree to participate in the study. Consent forms and WAI-SF (client) will be administered by the CIT they are assigned to. Clients will complete the WAI-SF post-session in the waiting room of the CTC. Clients will fill out the form on an iPad, however there will be paper copies in the event that there is technical difficulty or someone has difficulty using technology. Only clients who are being seen by internship CIT students will be allowed to participate in the study, and questions about the study can be answered by the Clinic Director, Dr. Yvonne Castillo, Dissertation Chair, Dr. A. Stephen Lenz, or myself.

All internship CITs will meet with clients at the clinic under the supervision of the Clinic Director and myself. Clients will complete the WAI-SF (client) assessment and CITs will complete the WAI-SF (counselor) to rate perceptions of working alliance at the end of each session. When clients complete the WAI-SF the will be asked to include the time of session, date of session, and the initials of the counselor seen that day. When CITs fill out the WAI-SF, they will be asked to include their pseudonym, time of session, date of session, and the initials of the client.

During the baseline period, I will collect data for different lengths of time across participants to establish multiple baselines. O'Neil and colleagues (2011) identified multiple baselines as a way to verify functional relationships between behaviors and an intervention. With multiple baselines, the baseline data are collected simultaneously across conditions with the intervention being introduced at different points in time for each condition. During the baseline period, I will supervise the CITs using a cognitive behavioral therapy model (CBT) and without the WELMS. CITs will be asked to complete the ProQOL and WAI-SF each week. The CITs respective clients will also be asked to complete the WAI (client version) each week. Upon completion of the baseline phase, each participant will then develop a personal wellness plan with me as preparation for the introduction of the WELMS.

During the WELMS phase, CITs and their respective clients will be asked to continue completing the WAI-SF at the end of each session. CITs will be supervised based on their individualized wellness plans. During supervision, the first 15 minutes will be dedicated to wellness check-in to determine if CITs are making progress on their wellness plans. The other 45 minutes of supervision will be conducted using a cognitive-behavioral therapy format (CBT). CBT supervision is very structured and includes processing the thoughts and behaviors of CITs.

In addition, CBT supervision includes action plans, formerly known as homework. During the WELMS supervision experience, CITs will be asked to keep a journal to document their experience receiving the WELMS. CITs will be asked to meet with me weekly for one hour of supervision that will be scheduled ahead of time to allow for planning and reduce the chance of scheduling conflicts. Supervision is considered to be a routine part of the CITs educational experience.

At the end of the WELMS supervision, and ultimately the end of the semester, CITs will be asked to submit their journal entries, to me, based on their wellness plan goals, which will then be reviewed to understand how CITs experienced the WELMS. The journal entries will be used as a way to reinforce the Wellness Model of Supervision (WELMS). Journal prompts for each week: (a) Describe your satisfaction with your wellness dimension this week; (b) In what ways did you improve on your wellness dimension this week?; (c) How would you describe your working alliance with clients this week?; (d) How would you describe your professional quality of life this week?; and (e) What was your experience of supervision this week?

**Confidentiality**

To ensure confidentiality during the study, the assessments will be kept in a locked box, in a secure room in the CTC. Upon completion of the study, CITs will turn in journal entries which will be kept in the same locked box, in a secure room at the CTC. Only my dissertation chair and I will have access to the data.

**Evaluating Fidelity of the Intervention**

To ensure fidelity, I will consult with the authors of the WELMS (Lenz & Smith, 2010) to ensure I am following the correct protocol for the implementation of the intervention. I will also be receiving supervision of my supervision with the master's level Internship students by

one of the authors of the WELMS. In addition, I will consult pertinent literature on supervision, wellness and working alliance to guide my study.

**Data Collection**

During the baseline period, data will be collected using multiple baselines. During this time, CITs will be supervised using a cognitive behavioral therapy model (CBT) and without a wellness model. CITs will be asked to complete the ProQOL and WAI each week. The CITs respective clients will also be asked to complete the WAI (client version). Participant 1 will complete the baseline for 3 weeks, participant 2 will complete baseline data for 4 weeks, participant 3 will complete 6 weeks of baseline data, participant 4 will complete 7 weeks of baseline data, and participant 5 will complete baseline data for 8 weeks. Upon completion of the baseline phase, each participant will then develop a personal wellness plan with me as preparation for the introduction of the WELMS.

During the WELMS phase, CITs and their respective clients will be asked to continue completing the Working Alliance Inventory- Short (WAI-S) at the end of each session. CITs will be supervised based on their individualized wellness plans. During supervision, the first 15 minutes will be dedicated to wellness check-in to determine if CITs are making progress on their wellness plans. The other 45 minutes of supervision will be conducted using a cognitive-behavioral therapy format (CBT). CBT supervision is very structured and includes processing the thoughts and behaviors of CITs. In addition, CBT supervision includes action plans, formerly known as homework. During the WELMS supervision experience, CITs will be asked to keep a journal to document their experience receiving the WELMS. CITs will be asked to meet with me weekly for one hour of supervision that will be scheduled ahead of time to allow for planning

and reduce the chance of scheduling conflicts. Supervision is considered to be a routine part of the CITs educational experience.

At the end of the WELMS supervision, and ultimately the end of the semester, CITs will be asked to submit their journal entries to me, and participate in a focus group to discuss their experience of the WELMS. I will use my personal journal entries to formulate the questions for the focus group, based on my observations of them functioning as counselors in training at the CNEP Counseling and Training Clinic, and based on my observations during supervision. The focus group will be video recorded using the CNEP counseling and training clinic equipment for recording, and a DVD for storing the recording.

**Data Analysis**

The primary method of data analysis for SCRDs is based on visual analysis. The rationale for using visual analysis is to encourage researchers to focus on interventions that are effectual, and the effects that can be obviously seen from inspecting the data. Therefore, visual analysis serves as a filter for the researcher to observe clear and potent interventions which can be interpreted as producing reliable effects. The researcher can make a reasonable hypothesis about the relationships, or lack thereof, between intervention and dependent variables (Kazdin, 2011; Parsonson & Baer, 1992). The advantages of using visual inspection include (a) quick yield to conclusions, (b) graphical representation can be quickly constructed with paper, pencil, straight edge, and grid paper, (c) graphs can be formatted in a variety of ways, (d) graphical representation of data is immediate and easily accessible, and (e) theoretical premise for graphical data is minimal (Parsonson & Baer, 1992). This analysis involves four steps and six variables.

The four steps of visual analysis include (a) documenting a baseline with a predictable pattern, (b) assessing each phase for patterns, (c) assessing the effect of the intervention by comparing the data between phases, and (d) integrating data from all phases to determine whether there are at least three signs of an effect. The six variables to be considered within and between phases in visual analysis include (a) mean and level of each phase, (b) slope of the data within a phase (trend), (c) amount of difference between each individual data point and the trend within a phase (variability), (d) immediacy of the effect of the intervention through observed changes in data patterns, (e) overlap within data, and (f) data pattern consistency. These six variables are assessed individually and collectively to determine wither the results demonstrate a causal relationship (Karotchwill et al., 2010; Ray, 2015).

**Mean and level of each phase**. In this variable, the mean score for data within each phase (A and B) is analyzed. The researcher then observes for the difference in the mean and level values. Steady changes in the mean can help the researcher determine whether the data pattern reflects the requirements of the design. Changes in the level refer to a shift of discontinuity of performance from the end of one phase (A) to the beginning of the other (B). Changes in the level are independent of changes in the mean and answers the question of what happened immediately after the intervention was implemented (Kazdin, 2011)

**Trend.** The trend indicates the slope of the most appropriate straight-line for the data within a phase. Changes in trend are important in visual inspection as it refers to the propensity for the data to increase or decrease over time. A significant change in the slope suggests that something reliable occurred and altered the predicted pattern of performance from the prior phase (Kazdin, 2011; Ray, 2015). This information is useful to explain complexities such as unauthentic peaks and valleys in the data (Lenz & Callender, 2016)

**Variability.** This refers to the difference between the individual data points and the slope (trend) within a phase. The variability is expressed through the range or standard deviation of the data as it represents how the data varies in relation to the overall mean (Kazdin, 2011; O'Neill et al., 2011). Highly variable baseline data may result in a less defensible argument about the way the intervention influenced the dependent variables (Lenz & Callender, 2016).

**Immediacy of the effect of the intervention through observed changes in data patterns**. This provides information about how rapidly the intervention influenced an effect which is demonstrated by a change in the data pattern once the intervention is introduced. A delay in the immediacy of the effect may be as a result of cumulative intervention effects (such as counseling relationships). Immediate change may be a result of the manipulation of the intervention variable (Karotchwill et al., 2010; Ray, 2015).

**Overlap within data**. Overlap refers to how many data points or to what degree do data points overlap with data between phases. The proportion of overlapping data points indicates the effect of the intervention. Low rates of overlap indicate a higher intervention effect (Karotchwill et al., 2010; Vannest & Ninci, 2015).

**Data pattern consistency.** This variable refers to observing data from all phases (A and B) within the same condition to observe the extent of consistency in the pattern of the data. Consistent data patterns across the participants supports credibility of findings (Karotchwill et al., 2010; Ray, 2015).

Data analysis in SCRDs should be based on the research question and characteristics of the baseline data (Lenz & Callender, 2016). Data in this study will be analyzed based on the following research questions: (a) to what degree is the WELMS efficacious for maintaining or

promoting CIT professional quality of life? and (b) to what degree is the WELMS efficacious for promoting client perceptions of working alliance with CITs?

Data will be analyzed using visual and non-overlapping data and will be analyzed at various points during the course of the study. Visual data will be displayed and analyzed by using graphical figures, which will identify the dependent variables, time frame of study, and intervention used. The average mean performance within phases will be analyzed to observe for variation in the data. Slopes will then be analyzed to determine if levels increased, decreased or remained the same across the phase (O'Neil et al., 2011). Non-overlapping data will be data exceeding noteworthy points within baseline phases. This analysis will be done using a ruler and pencil to draw straight lines through the graphs (Lenz, 2013).

**Estimating Treatment Effect**

SCRD treatment effect may be calculated using the amount of data non-overlap recorded in the baseline phase and within the treatment phase of the intervention. Although there are no standard calculations for treatment effect estimation when using SCRDs (O'Neil, et al., 2011), Lenz (2013) suggested three main ways of calculating this information; through percentage of non-overlapping data (PND), percentage of data exceeding the mean (PEM), and percentage of all non-overlapping data (PAND). These choices provide important information to explain the magnitude of variation between baseline and intervention (Lenz & Callender, 2016). PND is an alternative to using visual analysis alone and is the percentage of data in the treatment phase that exceeds a single point of interest within the baseline phase. PEM accommodates outliers in the baseline condition which may adversely impact the evaluation of an intervention. PEM is also recommended when there is variability over time. PAND is a suggested alternative to PND and PEM, which uses a ratio based on non-overlap data between phases. PAND utilizes data from

both phases to determine treatment efficacy, however a minimum of 20 observations to control for baseline trend (Lenz, 2013).

The degree of treatment effect associated with the WELMS will be estimated for each participant using the Tau-U procedure combining AB phase non-overlap with Phase B trend. This procedure is an alternative to a regression-based model. The Tau-U adjusts to variable baseline trends, accommodates smaller data sets, maintains non-overlap when evaluating treatment effect, utilizes all data in the study, and is directly interpretable as a consistent index of improvement. Interpretation of Tau-U is relative to the participants, setting, and intervention. Tau-U values greater than .80 represent a very large effect size, values ranging from .60 to .80 represent large effect sizes, scores from .20 to .60 indicate small to moderate effect sizes, and scores below .20 are regarded as small effect size. The meaningfulness of the outcome is understood in the context of each participant's circumstance (Scruggs & Mastropieri, 1998; Vannest & Ninci, 2015).

**Limitations**

This study will utilize an AB design, which is considered the standard in single-case research, however, although the information from this design will be valuable, an AB design is not considered evidence-based. The sample was small and non-randomized, and results may not be generalized to a larger population. This research design also infuses multiple baselines, which may extend the period of research, impacting the design implementation (Ray, 2015). An A-B design documents change at single points, therefore there is the possibility of threats to the internal validity of this study (O' Neill et al., 2011). CITs may become frustrated due to repeating the same assessment weekly and clients may not consistently attend sessions and provide the necessary rating. Clients may drop out from sessions and CITs may have fast

turnovers with caseload. Data was collected from one site with the researcher serving a dual role of a supervisor and researcher.

Limitations also include the inability to generalize data collected from the qualitative data, co-counseling format at the CNEP counseling and training clinic, and possible inconsistency with clients. Since this study seeks to understand the effect of a wellness model of supervision (WELMS) on professional quality of life and perceived client working alliance, a possible limitation is that CITs may not have an established idea of how their professional quality of life should be represented. CITs may not be honest in the self-assessments and their clients may feel some intimidation when completing the working alliance inventory (WAI). In addition, the data collected from CITs and clients relied on self-report. Finally, my bias could impact the results of the study as I will be conducting supervision with the CITs with predetermined expectations of outcomes.

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## Preface to Summary Manuscript

The initial study, "Implementing the Wellness Model of Supervision with Counselors-in-Training: Indications for Professional Quality of Life and Working Alliance" was designed to evaluate the efficacy of the Wellness Model of Supervision (WELMS; Lenz & Smith, 2010) for promoting desired changes across two dependent variables: (a) counselors-in-training perception of professional quality of life and (b) client perceptions of working alliance. These variables were selected based on the logic that both outcomes will concurrently promote career sustaining behaviors and positive client outcomes.

During the study, data was collected for both dependent variables; however, due to the lack of consistent and substantial client responses I was unable to utilize this data to determine whether the WELMS was efficacious for client perceptions of working alliance. Research questions were then revised prior to data analysis to reflect the adjusted variables. Therefore, the subsequent data analysis included only results for the counselors-in-training perception of professional quality of life. The results within the following summary manuscript depict the subscales of the Professional Quality of Life Scale (ProQOL; Stamm, 2010); secondary traumatic stress, compassion satisfaction, and burnout. The title of the completed dissertation was changed to accurately reflect the variables analyzed and is entitled, "Implications for Professional Quality of Life and Wellness-Based Supervision."

# Implications for Professional Quality of Life and Wellness-Based Supervision

Abstract

This study evaluated the efficacy of the Wellness Model of Supervision (WELMS; Lenz & Smith, 2010) for promoting changes across counselors-in-training perceptions of professional quality of life. Participants were three women who identified as Caucasian ($n$ = 1) and Hispanic ($n$ = 2), enrolled in a CACREP accredited program. Results of a single case research design (SCRD) with multiple baselines indicated the WELMS was efficacious across client-CIT interactions on professional quality of life.

*Keywords*: Wellness, Supervision, Single-Case Research Design, Professional Quality of Life

## Implications for Professional Quality of Life and Wellness-Based Supervision

Supervision of counselors-in-training (CITs) is the signature pedagogy within counselor preparation programs that promotes skill development, monitors client welfare, and assesses students' fitness to practice using structured and unstructured interventions to (Bernard & Goodyear, 2014; Goodyear, Bunch, & Claiborn, 2006). Whereas CITs spend a considerable proportion of their degree programs in classroom-based, didactic learning environments, field experiences provide community-based, experiential educational venues for implementing counseling skills with client populations. Supervision processes are developmentally supportive during this time, while also fostering professional identity through monitoring interventions that promote positive client outcomes. Borders et al. (2014) recommended several evidence-based best practices for supervisors to implement for promoting CIT self-evaluation and reflection. One of those best practices situates counseling supervisors as gatekeepers for the profession by monitoring the development, functioning, and wellness of CITs; qualities indicative of fitness to practice. Taken together, the most effective approaches to CIT supervision will contribute to client welfare by not only developing clinical skills, but also promoting student career sustaining behaviors.

The importance of this supposition is reflected in the American Counseling Association *Code of Ethics* (ACA; 2014), which stipulates counselors engage in self-care activities that monitor and maintain their well-being as part of their professional responsibilities. Counselors are therefore encouraged to monitor two vital relationships: between their personal well-being and therapeutic effectiveness, and the relationship between counselors and their colleagues. One construct used as a proxy for the coalescence of these three relationships is *professional quality of life* (Lawson & Myers, 2011). Professional quality of life (ProQOL) refers to the value of the

work done in relation to the individual's role as a counselor-in-training which includes compassion satisfaction and compassion fatigue (Stamm, 2010). When CITs are exposed to triggers with the potential to diminish their mental and physical resources, their ProQOL decreases. A lack of compassion and burnout, due to a decreased professional quality of life, may lead to feelings of anxiety, depression, and helplessness in CITs (Perkins & Sprang, 2013).

By contrast, when professional quality of life, and therefore wellness, are positively influenced, CITs have well-developed traits of interpersonal and intrapersonal resources to mitigate stress levels, and CITs with these attributes, who are actively working toward a state of wellness, may increase their effectiveness as counselors. In addition, having these healthy attributes may help CITs to establish a deeper level of connection with their clients and increased levels of compassion (Burck, Bruneu, Baker, & Ellison, 2014; Neswald-Potter, Blackburn, & Noel, 2013)

Time spent during supervision presents an opportunity to learn more about CITs' professional development. Supervisors may have a chance to learn how CITs cope with the demands of the profession and monitor how stressors associated with counseling may affect the personal wellness of CITs. In addition, a wellness model of supervision may help to avert gatekeeping issues, such as burnout and unethical behavior that may rupture career-sustaining behaviors. Therefore, a model of supervision integrating wellness monitoring and development may be essential in preventing and managing the risks associated with counseling. A wellness model of supervision may also provide an opportunity for personal and professional growth (Lawson & Myers, 2011; Lenz & Smith, 2010).

### Logic Behind WELMS for Promoting Skills Development and Personal Wellness

During supervision, supervisors monitor CITs' development in their knowledge and application of professional skills, and their general wellness and self-care practices for progress. Supervisors have an ethical obligation to attend to the holistic well-being and self-care of CITs (Ohrt, Prosek, Ener, & Lindo, 2015). Therefore, supervision is conceptualized as the driving force mediating and regulating the personal and professional development of CITs, and the therapeutic intervention between CITs and client.

Thompson, Frick, and Trice-Black (2011) suggested that CITs desired supervisor support about strategies for work-life balance; however, there are currently only a few empirical studies demonstrating causal relationships between wellness-based supervisory interventions and their related effects on CIT wellness (Lenz, Sangganjanavanich, & Balkin, 2012; Meany-Walen, Davis-George, & Lindo, 2016; Storlie & Smith, 2012). In the absence of this body of literature, it becomes difficult for counselor educators to make data driven decisions about supervisory interventions that may be most efficacious for promoting the development of clinical skills, monitoring client welfare, and assessing students' fitness to practice.

Several scholars suggested a positive relationship between CITs' personal wellness and their professional performance (Blount & Mullen, 2015; Lenz, Oliver, & Sangganjanavanich, 2014; Lenz, Sangganjanavanich, Balkin, Oliver, & Smith, 2012; Lenz & Smith, 2010; Ohrt et al., 2015). Although CITs expend considerable effort promoting the use of wellness strategies among their clients, they may have difficulty adapting these wellness principles into their own lifestyle, leading to an increased risk to the deleterious effects of vicarious trauma that can lead to burnout.

Lenz et al. (2014) found that CIT wellness during the graduate program has considerable implications for professional and personal development. In addition, their findings suggest that the quality of the counseling experience is higher for their clients when compared to CITs who did not receive the WELMS. Lenz et al. (2012) discovered, through a qualitative study, that one mechanism for increasing the self-care practices of CITs is the WELMS. The WELMS also provided a way for supervisors to facilitate continuous wellness related activities during internship when it is most applicable and practical.

The professional quality of a counselor's life (ProQOL) should reflect self-awareness skills, an appreciation for the complexity of society, and a genuine respect for human diversity. Training and preparation for a professional quality of life includes having a secure base of trust, safety, and comfort. Counselors should place an emphasis on developing relational skills to prepare them for a life of service that is confident and passionate. Emotional self-care activities may play a significant role in professional quality of life (Bloomquist, Wood, Friedmeyer-Trainor, & Kim, 2015). The ProQOL is an important dimension to investigate as it can reflect the quality of work that CITs engage in with their clients. A study investigating the ProQOL of CITs is essential to assist students to identify their potential to experience burnout and compassion fatigue. In addition, a study on ProQOL would help counselor educators and supervisors have a better understanding of how CITs view themselves as professionals. This study provided a structured, yet individualized, wellness model of supervision with potential to inspire change in counselors-in-training, as their professional quality of life and personal wellness are discussed and assessed in relation to their professional identity development.

## Purpose of the Study

The purpose of the study was to evaluate the efficacy of the Wellness Model of Supervision (WELMS; Lenz & Smith, 2010) for promoting desired change across CIT perceptions of professional quality of life. This variable was selected based on the logic that the outcome will concurrently promote career sustaining behaviors and positive client outcomes. This study aimed to assist counselor educators in further understanding the efficacy of wellness interventions and provide protocols for a non-standardized model of supervision which can benefit counselors-in-training in a master's program as they learn about the role of their professional quality of life with clients. We were guided by two research questions: (a) What is the course of response to intervention for self-reported compassion satisfaction, burnout, and secondary traumatic stress associated with participation in the WELMS?; (b) To what degree is the WELMS efficacious for stimulating desired treatment effect for CIT level of compassion satisfaction, burnout, and secondary traumatic stress over time?

## Method

We implemented a small series A-B single-case research design (SCRD) with multiple baselines to evaluate the degree of efficacy for the WELMS in promoting professional quality of life among CITs over time. This design was selected based on practicality for estimating functional relationships associated with an intervention and target outcomes (Kazdin, 2011).

### Participant Characteristics

Participants were women enrolled in a mental health counseling internship course (300 hours) in a CACREP-accredited counseling program and completing field experience requirements at their university counseling and training clinic. Two of the three participants were completing degree programs in marriage, family, and couples counseling and one was pursuing a

clinical mental health counseling specialty. Two participants were in internship II and one participant in internship I. Two participants identified with a Hispanic (67%) ethnic identity and one (33%) identified as Caucasian.

**Diane**. Diane was a 50-year-old Hispanic woman, married with adult children. Diane was enrolled in Internship II, worked full time and attended school full time. She was affable, curious, motivated, and appreciated structure. She was very committed to her clients and was comfortable with micro-skills. Diane had periods of very high stress and appeared overwhelmed with her personal circumstances. Despite the external challenges, Diane persevered throughout the semester and showed resilience amid chaos. Initially, during supervision she was very guarded, did not appear very open to sharing details about her clients, and was reluctant to accept suggestions or challenge her clinical skills. As time progressed, Diane became more open and receptive to feedback and began improving her clinical skills. She had an average of 10 clients per week, primarily adults. Her clients' presenting issues included depression, anxiety, bereavement, trauma, and substance abuse. Diane identified a desire to improve her Creative Self domain of the 5F-WEL with the expectation that she would (a) "not have an ache in my stomach due to anxiety," (b) "no racing thoughts," (c) "won't feel miserable with myself," and (d) "less countertransference." Diane was compliant with the WELMS supervision plan and reported engaging in her wellness plan as often as she could.

**Susan.** Susan was a 24-year old, single, Hispanic woman who attended school full time. Susan was an Internship I student and worked part-time. She displayed a gentle demeanor and was internally motivated, caring, and organized. Susan presented as comfortable with her clients and her role as a counselor-in-training. She was intentional about her approach and became personally invested in the progress of her clients, motivating her to explore several options in

session to help her clients attain their goals. She was open to feedback while processing client conceptualization during supervision. Susan had an average of 20 clients per week ranging from children to adults. Her clients' presenting issues included depression, anxiety, trauma, sexual abuse, and adjustment disorder. Susan identified a desire to improve her Physical Self domain of the 5F-WEL with the expectation that she would (a) "have more energy," (b) "be more effective and present with clients," "would not feel like a drag at the end of the day," and (c) "improve sleep." Susan was compliant with the WELMS supervision plan and reported consistent engagement in her wellness activities.

**Mary.** Mary was a 49-year old, married, Caucasian woman with adult children who was enrolled in Internship I, and attended school fulltime. She was very organized, internally motivated, and eager to learn new skills. She used humor to connect with her clients and to build rapport with others around her. Mary presented as anxious and had the tendency to take control during sessions with new clients or when faced with difficulty in session. Mary was very amicable, cooperative, and openly shared about her clients during supervision. She tended to rely less on her clinical intuition and more on structured methods such as worksheets. Mary responded well to verbal encouragement and when prompted she made the effort to challenge her clinical skills. Mary had an average of 20 clients per week ranging from children to adults. Her clients' presenting issues included depression, anxiety, substance use disorder, and adjustment disorder. Mary identified a desire to improve her Physical Self domain of the 5F-WEL and expected to (a) "have more energy," (b) "be happier when working with clients," and (c) "be more encouraging to clients to try something new because I have done that." She was compliant with the WELMS supervision plan and reported consistent engagement in her wellness activities.

## Measurement of Constructs

**Professional Quality of Life.** The Professional Quality of Life Scale (ProQOL; Stamm, 2010) was developed to assess the effects of working with others who may have experienced stressful events. The ProQOL is a 30-item self-report measure that yields multiple subscales. The 10-item *Compassion Satisfaction* subscale was intended to quantify the degree of pleasure derived from doing well with your work, using items such as "I get satisfaction from being able to help people." Higher scores indicate higher levels of compassion satisfaction while lower scores indicate compassion fatigue. The 10-item B*urnout* subscale refers to the negative effects of caring for others and includes feelings of hopelessness and feeling ineffective at one's job, using items such as "I am not as productive at work because I am losing sleep over traumatic experiences of the persons I help." Higher scores on the burnout subscale indicate the individual believes they are not making a difference in their work, they may be overwhelmed, or function in a non-supportive environment. The 10-item *secondary traumatic stress* subscale, which is an element of compassion fatigue and refers to negative effects caused by exposure to others who have experienced traumatic events, is measured by items such "I can't recall important parts of my work with trauma victims." Higher scores on the secondary traumatic stress subscale indicate the individual is experiencing intrusive thoughts or images, experiencing sleep difficulties, or avoiding any reminder of their client's trauma (Stamm, 2010). Stamm reported scores on the ProQOL within the good range for internal consistency for the Compassion Fatigue, Burnout, and Secondary Trauma subscales ($\alpha$ = .88, .75, .81, respectively).

**Wellness**. The Five Factor Wellness Inventory (5F-WEL; Myers & Sweeney, 2005, 2014) is an evidence-based assessment, used to evaluate the characteristics of wellness as a basis for helping individuals make healthier life choices. The 5F-WEL is a 91-item self-scoring tool

measuring 17 discrete scales (third order factors) based on the Indivisible Self with responses ranging from *strongly disagree, disagree, agree,* and *strongly agree* with higher scores indicating greater degree of wellness. Hattie, Myers, and Sweeny (2004) reported reliability coefficients within the excellent range for 5F-WEL total wellness (α = .94) and the second-order factors of Creative Self (α = .93), Coping Self (α = .92), Social Self (α = .94), Essential Self (α = .91), and Physical Self (α = .90), indicating a robust reliability of scores.

**Study Setting**

The study was implemented at the counseling and training clinic (CTC) located at a Hispanic-serving institution in the Southern region of the United States, that offers free counseling services to members of the community across the lifespan within individual, couples, family, and group modalities. Counseling sessions were provided by counseling trainees in a private and confidential setting, and activities of the CTC were supervised by a licensed counseling faculty member and counselor education doctoral students. Access to counseling services was based on the academic calendar of the university.

**Intervention**

The WELMS was developed by Lenz and Smith (2010) and is based on the holistic, wellness-based approach towards client care as outlined in the Holistic Model for Treatment Planning (Myers, Sweeney, & Witmer, 2000). The WELMS has two distinct qualities: (a) an overt emphasis on wellness education, appraisal, planning, and evaluation to promote supervisee skill development and client outcomes, and (b) a holistic, developmental perspective of supervisee lifestyle that supports engagement in career sustaining activities. Supervisory interventions were provided using the WELMS to promote development through four interrelated activities: Education, Assessment, Planning, and Evaluation (Lenz & Smith, 2010).

These activities were initially sequential, but became cyclical through the supervisory relationship.

The first step of the WELMS is education about the overall supervision model, identifying the supervisee's definition of personal wellness, reviewing formal models of wellness to be used during case conceptualizations, and explaining how improvement in wellness may contribute to the development of the supervisee's professional and personal life. Next, the WELMS involves an assessment of the supervisee's personal wellness using formal or informal assessments of wellness. Following, assessment results are used to develop an individual wellness plan for each supervisee based on the identified dimension that the supervisee deemed to be important to work on as they moved towards greater wellness and improved abilities as a counseling professional. Once the supervisee identified one specific dimension, the behavioral plan is developed by setting realistic and time-sensitive goals. Wellness plans include (a) an identified domain for monitoring and development, (b) a scaled satisfaction rating, (c) description of presumed ways that changes target domain may affect their personal and professional life, (d) related interventions, and (e) indications of progress (see Lenz & Smith, 2010). Finally, supervisees were encouraged to commit to the supervision plan for at least four weeks and evaluated weekly during the wellness check-in aspect of the supervision sessions. After four weeks, supervisees were asked to report formative progress toward their goals and the wellness plan was modified as needed.

**Procedure**

Following institutional review board approval, CITs enrolled in the internship course, and obtaining internship hours at the CTC, were invited to participate in the study.

**Baseline phase**. Supervision with CITs was limited to case load management, case conceptualizations, and treatment planning from a cognitive behavioral therapy framework. Each week, the CITs completed the ProQOL assessment online via Qualtrics. Lengths of this baseline phase varied systematically between Diane (7 weeks), Susan (9 weeks), and Mary (11 weeks) to establish a multiple baseline paradigm for evaluation. Each participant completed the 5F-WEL assessment online at the end of the baseline phase and used the generated score report to develop an individualized wellness plan with the first author in preparation for beginning the WELMS.

**Intervention Phase**. Lengths of this intervention phase varied systematically between Diane (10 weeks), Susan (8 weeks), and Mary (5 weeks). CITs completed the ProQOL weekly and received one hour of weekly supervision for one hour, based on the WELMS and in reference to their individualized wellness plans. The first 15 minutes of supervision was dedicated to a wellness check-in and supporting CITs development and progress toward their wellness plans. The remaining 45 minutes focused on using the CBT framework, but also integrated holistic client conceptualization when identifying client issues. CITs maintained a weekly journal to document their experience receiving the WELMS. The journal prompts for each week were: (a) Describe your satisfaction with your wellness dimension this week, (b) In what ways did you improve on your wellness dimension this week? (c) How would you describe your professional quality of life this week? and (d) What was your experience of supervision this week?

## Data Analysis

Participant ratings on the ProQOL during the baseline and treatment conditions were entered into Microsoft Excel files. Overall scores were calculated per the ProQOL manual, and visual depictions were generated for each participant according to the three subscales. Participant

ratings for compassion satisfaction, burnout, and secondary trauma are situated on the ordinate axis and time/phases on the abscissa. Course and efficacy of the WELMS were estimated across dependent variables using visual analysis and estimation of treatment effect.

**Visual analysis**. We completed the visual analysis of the ProQOL data by inspecting the differences in level, trend, and variability across the treatment phases (Kazdin, 2011). Changes in the level were deduced by comparing the mean for baseline to the treatment phase. A change in the mean across phases indicated the degree of change reported by the participant. The trend was evaluated by identifying the pattern of the data in the baseline and intervention phase, and drawing celebration lines using the split-middle line of progress. Variability was evaluated based on the range of scores within and between phases. The greater the degree variability in the treatment phase indicates less stability and a less defensible argument for the effectiveness of the intervention. By contrast, less variability indicates less vacillation and increased stability in behavior or performance and it can be stated that the intervention was effective (Lenz 2013).

**Estimating Treatment Effect**. The estimate of treatment effect was calculated using the Percentage of Data Exceeding the Median (PEM; Ma, 2006), which uses the median score in the baseline phase to determine the degree of nonoverlap between baseline and intervention data points (Vannest & Ninci, 2015). Therefore, if the WELMS is efficacious, most data points will be either above the median point in the baseline for compassion satisfaction or below the median point in the baseline for burnout and secondary trauma. PEM was computed by: (1) identifying the median data point in the baseline phase, (2) using a ruler and pencil to draw a line through the data points in the baseline and treatment phases at the level of the median data point in the baseline, (3) counting the number of data points above or below the line in the treatment phase, (4) dividing the number of data points identified in step 3 by the total number of data points in

the treatment phase (Lenz 2013; Parker, Vannest, & Davis, 2011). PEM values range from 0 (0%) to 1 (100%) with each PEM score representing the treatment effect (Ma, 2006). We used interpretation guidelines by Scruggs and Mastropieri, (1998) to determine whether scores represented a very effective intervention (> 90%), moderate effective intervention (70%-89%), debatable intervention (50%-69%), or ineffective (< 50%).

## Results

Visual depictions of scores for secondary traumatic stress, compassion satisfaction, and burnout are presented in Figures 4, 5, and 6 respectively.

### Secondary Traumatic Stress

**Diane.** Inspection of the mean level for Diane's baseline data indicated an average score of 14 on the secondary traumatic stress subscale of the ProQOL across seven weeks of measurement. By contrast, scores representing perceptions of secondary traumatic stress were slightly lower during the intervention phase ($M$ = 13), suggesting a modest decrease of construct level over time. Evaluation of data trends between phases revealed a curvilinear, yet decreasing trend for ratings of secondary traumatic stress during the baseline phase, followed by an immediate and stable level of the data once beginning the WELMS intervention. Analysis of variability of data between phases revealed a 7-point range of scores during the baseline phase as opposed to a 3-point degree of variation during the intervention. The PEM estimate of treatment effect indicated that only 10% (PEM = .10) of data points in the intervention phase were not overlapped with the baseline median (13) which is suggestive of an intervention that may not be effective. Taken together, these findings suggest that while the mean score for Diane's ratings on the secondary traumatic stress subscale decreased only slightly between the baseline and intervention phases, the reported effect showed an immediate and considerable degree stability

within the therapeutic range of her reported values. However, the magnitude of treatment effect reported by Diane suggests these differences may not have had a practically significant effect on her experience of secondary traumatic stress during internship.

**Susan.** Analysis of the mean level for Susan's baseline data showed an average score of 24 on the secondary traumatic stress subscale of the ProQOL across nine weeks of measurement. However, scores representing secondary traumatic stress on the intervention phase were lower ($M$ = 22), indicating a modest decrease of construct level over time. Inspection of data trends between phases revealed a curvilinear, yet decreasing trend for secondary traumatic stress scores during the baseline phase, followed by an immediate reduction and continued trend toward the desired effect among scores once the WELMS was implemented. Evaluation of variability of data between phases revealed a 6-point range of scores during the baseline and intervention phase. The PEM estimate of treatment effect indicated that 88% (PEM = .88) of data points in the intervention phase were not overlapped with the baseline median (24), suggesting that the intervention may be moderately effective. Collectively, these findings suggest that while the mean score for Susan's ratings on the secondary traumatic stress subscale decreased slightly between the baseline and intervention phases, the reported effect showed an immediate reduction in her scores. The magnitude of treatment effect reported by Susan suggests these differences may have had a practically significant effect on her experience of secondary traumatic stress as an internship student.

**Mary**. Evaluation of the mean level for Mary's baseline data indicated an average score of 14 on the secondary traumatic stress subscale of the ProQOL across 11 weeks of measurement. By contrast, the scores representing secondary traumatic stress during the intervention phase were slightly lower ($M$ = 13). This indicates a modest decrease of construct

level over time. Analysis of data trends between phases revealed a curvilinear, yet decreasing trend for ratings of secondary trauma, followed by an immediate and stable level of the data once the WELMS was executed. Inspection of variability of data between phases revealed a 5-point range of scores during the baseline phase as opposed to a 3-point degree of variation during the intervention phase. The PEM estimate of treatment effect indicated that 60% (PEM = .60) of the data points in the intervention phase did not overlap with the baseline median (14). This suggests that the intervention may be within the debatably effective. Taken together, these findings suggest that while the mean score for Mary's ratings on the secondary traumatic stress subscale decreased slightly between the baseline and intervention phases, the reported effect showed an immediate reduction in her scores. The magnitude of treatment effect reported by Mary suggests these differences may have had a practically significant effect on her experience of secondary traumatic stress as an internship student.

**Compassion Satisfaction**

**Diane.** Inspection of the mean level for Diane's baseline data showed an average score of 39 on the compassion satisfaction subscale of the ProQOL across seven weeks of measurement. Compassion satisfaction scores on the intervention phase remained consistent ($M$ = 39), indicating stability of the construct over time. Evaluation of data trends between phases revealed a linear trend for ratings of compassion satisfaction in the baseline phase, followed by an immediate and stable trend of data once the WELMS was implemented. Analysis of the variability of data between phases revealed a 7-point range of scores during the baseline phase. By contrast, variability during the intervention phase indicated a 2-point range of scores. The PEM estimate of treatment effect indicated that no data points (0%; PEM = 0) in the intervention phase were not overlapped with the baseline median (40) which suggests that the intervention

may be ineffective. Together, these findings suggest what while the mean score for Diane's ratings on the compassion satisfaction subscale did not increase between the baseline and intervention phases, the reported effect showed an immediate and considerable degree of stability within the therapeutic range of her reported values. However, the magnitude of treatment effect reported by Diane suggests these differences may not have had a practically significant effect on her experience of compassion satisfaction during internship.

**Susan**. Evaluation of the mean level for Susan's baseline data showed an average score of 38 on the compassion satisfaction subscale of the ProQOL across nine weeks of measurement. By contrast, the average score representing compassion satisfaction during the intervention phase was slightly higher ($M$ = 39). Inspection of data trends between phases revealed a curvilinear trend for ratings of compassion satisfaction in the baseline phase, followed by an immediate and increasing trend of data once the WELMS was implemented. Analysis of the variability of data between phases revealed a 7-point range of scores during the baseline phase. By contrast, variability during the intervention phase indicated a 5-point range of scores. The PEM estimate of treatment effect indicated that 50% (PEM = .50) of the data points in the intervention phase were not overlapped with the baseline median (38) which suggests that the intervention may be debatably effective. Collectively, these findings suggest that while the mean score for Susan's ratings on the compassion satisfaction subscale increased slightly between the baseline and intervention phases, the reported effect showed an immediate and considerable increase in her scores. However, the magnitude of treatment effect reported by Susan suggests these differences may have had a practically significant effect on her experience of compassion satisfaction during internship.

**Mary**. Analysis of the mean level for Mary's baseline data indicated an average score of 47 on the compassion satisfaction subscale of the ProQOL across 11 weeks of measurement. By contrast, the scores representing compassion satisfaction during the intervention phase were slightly lower ($M$ = 46), indicating a slight decrease of the construct level over time. Evaluation of data trends between phases revealed a curvilinear, yet decreasing trend for ratings of compassion satisfaction, followed by an immediate reduction of the data once the WELMS was executed. Analysis of variability of data between phases revealed a 7-point range of scores during the baseline phase as opposed to a 6-point degree of variation during the intervention phase. The PEM estimate of treatment effect indicated that no data points (0%; PEM = 0) in the intervention phase were not overlapped with the baseline median (48) which suggests that the intervention may be ineffective. Together, these findings suggest that the mean score for Mary's ratings on the compassion satisfaction subscale decreased slightly between the baseline and intervention phases, and the reported effect showed an immediate reduction in her scores. The magnitude of treatment effort reported by Mary suggests these differences may not have had a practically significant effect on her experience of compassion satisfaction as an internship student.

**Burnout**

**Diane.** Evaluation of the mean level for Diane's baseline data showed an average score of 20 on the burnout subscale of the ProQOL across seven weeks of measurement. However, scores representing burnout were slightly lower during the intervention phase ($M$ = 19), suggesting a modest decrease of construct level over time. Analysis of data trends between phases indicated a curvilinear yet decreasing trend for ratings of burnout during the baseline phase, followed by an immediate curvilinear yet increasing trend once the WELMS was

initiated. Inspection of variability between data phases revealed a 6-point range of scores during the baseline phase as opposed to a 4-point degree of variation during the intervention phase. The PEM estimate of treatment effect indicated that 50% (PEM = .50) of the data points in the intervention phase were not overlapped with the baseline median (20), indicating that the intervention may be debatably effective. Taken together, these findings suggest that while the mean score for Diane's ratings on the burnout subscale decreased only slightly between the baseline and intervention phases, the reported effect showed an immediate degree of stability within the therapeutic range of her reported scores. However, the magnitude of treatment effect reported by Diane suggests these differences may have a practically significant effect on her experience of burnout.

**Susan**. Inspection of the mean level for Susan's baseline data indicated an average score of 24 on the burnout subscale of the ProQOL across nine weeks of measurement. Scores representing perceptions of burnout were lower during the intervention phase ($M$ = 22). Combined, this suggests a modest decrease of construct level over time. Analysis of data trends between phases revealed a curvilinear yet increasing trend for ratings of burnout during the baseline phase, followed by an immediate decrease and decreasing trend of the data once the WELMS was implemented. Evaluation of variability of data between phases revealed a 5-point range of scores during the baseline phase as opposed to a 6-point degree of variation during the intervention. The PEM estimate of treatment effect indicated that 63% (PEM = .63) of data points in the intervention phase did not overlap with the baseline median (24), indicating that the intervention may be debatably effective. Collectively, these findings suggest that while the mean score for Susan's ratings on the burnout subscale moderately decreased between the baseline and intervention phases, the reported effect showed an immediate and significant reduction in her

scores. The magnitude of treatment effect reported by Susan suggests these differences may have had a practically significant effect on her experience of burnout as an internship student.

**Mary**. Analysis of the mean level for Mary's baseline data indicated an average score of 19 on the burnout subscale of the ProQOL across 11 weeks of measurement. Burnout scores on the intervention phase remained consistent ($M$ = 19), indicating stability of the construct over time. Inspection of data trends between phases indicated a curvilinear yet increasing trend for ratings of burnout, followed by an immediate reduction and decreasing trend of the data once the WELMS was initiated. Evaluation of variability of data between phases indicated a 6-point range of scores during the baseline phase as opposed to a 4-point degree of variability during the intervention phase. The PEM estimate of treatment effect indicated that 20% (PEM = .20) of the data points in the intervention phase did not overlap with the baseline median (19). This suggests that the intervention may not be effective. Taken together, these findings suggest that while the mean score for Mary's ratings on the burnout subscale did not decrease between the baseline and intervention phases, the reported effect showed an immediate and considerable degree of stability within the therapeutic range of her reported values. However, the magnitude of treatment effect reported by Mary suggests these differences may not have had a practically significant effect on her experience of burnout as an internship student.

## Discussion

This study provided some preliminary evidence associated with the efficacy of the WELMS for influencing aspects of professional quality of life with a sample of CITs completing internship requirements. In particular, the evaluation of the WELMS using a multiple baseline SCRD provided the impetus for inferences related to the utility of the intervention with respect to course and magnitude of effect and the importance of intervention dosage.

Two (Susan and Diane) out of three CITs' scores decreased on the secondary traumatic stress scale of the ProQOL. This suggests the WELMS was effective for reducing and stabilizing the negative effects associated with others who have experienced traumatic events. This effect was noted in one case (Susan) by an immediate and marked decrease in ProQOL scores once the WELMS was introduced, while Diane's scores became stable once the WELMS began and remained level throughout the course of the intervention. By contrast, Mary did not report a change in secondary traumatic stress characteristics over time. Taken together, these findings depict trends for improvement, stabilization, and no improvement among secondary traumatic stress symptoms associated with 10, 8, and 5 weeks (respectively) of participation in the WELMS. One explanation for this trend among scores relates to the interaction between dosage of intervention and degree of response. It is plausible that with greater exposure to the WELMS, participants were able to use supervision in a manner that mitigated the influence of client-CIT interactions on their professional quality of life. Inversely, minimal exposure to the intervention resulted in extended influence of secondary traumatic stress characteristics. Similar results were detected by Meany-Walen et al. (2016) who concluded CIT engagement in the WELMS was a protective factor for the experiences of increased risk for psychological stress during internship.

One (Susan) out of three CITs' scores increased on the compassion satisfaction subscale of the ProQOL. This suggests that the WELMS was debatably effective for increasing and stabilizing the degree of pleasure derived from working as a CIT. In one case (Susan) there was an immediate and marked increase in ProQOL scores once the WELMS was introduced, while Diane's scores immediately became stable once the WELMS was introduced and maintained this stability throughout the course of the intervention. By contrast, Mary's self-reported scores revealed a decrease in compassion satisfaction scores over time. Collectively, these findings

depict trends for stabilization, improvement, and no improvement among compassion satisfaction symptoms associated with 10, 8, and 5 weeks (respectively) of participation in the WELMS. Similar to the trends for secondary trauma, one explanation for this trend among scores is related to the interaction between dosage of intervention and the degree of response. It is possible that with increased time with the WELMS, participants were able to use supervision to help mitigate and stabilize the impact of client-CIT interactions and understand how self-compassion influences compassion satisfaction by having time to implement loving-kindness activities. Inversely, minimal exposure to the WELMS resulted in minimal mitigating effects. This is consistent with findings based on Storlie and Smith (2012) who suggested using wellness based interventions during supervision help to enhance the healthy development of CITs to be better prepared for the challenges of counseling others.

Two (Susan and Mary) out of three CITs' scores decreased on the burnout subscale of the ProQOL. This suggests that the WELMS was effective for reducing and stabilizing the negative effects of caring for others. This effect was observed in two cases (Susan and Mary) by an immediate and marked decrease in ProQOL scores once the WELMS was initiated. By contrast, Diane's scores fluctuated with an upward trend despite the introduction of the WELMS. Taken together, these findings depict trends for no improvement associated with 10 weeks of participation in the WELMS and improvement associated with weeks 8 and 5 among burnout symptoms associated with participation in the WELMS. This trend among scores may be attributed to the timeliness of the intervention. It is plausible that when CITs are exposed to the intervention earlier in their training they were able to use supervision time in a manner that mitigated the effects of client-CIT interactions on their professional quality of life. One explanation for this trend among scores relates to the diverse personal stressors and

complications related to degree completion. By contrast, earlier intervention resulted in maximized mitigating effects. Lenz et al., (2014) found that CITs experienced greater resilience and well-being and gained an awareness how their self-care translates into client care because of participating in the WELMS.

Results of this study provide evidence for the course of treatment of the WELMS for professional quality of life across three dependent variables: compassion satisfaction, burnout, and secondary trauma. The course of treatment and trends seems to be immediate across participants and across dependent variables. Evaluations of treatment effect, as evidenced by the PEM scores, were mixed but also appear to be a function of the interaction between dosage effect and time. For those participants who received 10 and 8 weeks of the WELMS, the intervention appears to be effective; however, for the one participant who did not receive a reasonable dosage of the WELMS, minimal effect was indicated. Although these results for the WELMS are promising, it is recommended that counselor supervisors consider unique student factors and the implementation of the WELMS to maximize intervention effectiveness.

**Recommendations for Counselor Supervisors**

Several recommendations for use of the WELMS with counseling students are available from the context of these findings within the context of professional literature. When considering that CITs are required to learn and demonstrate skills necessary for maintaining their professional quality of life, there is a body of evidence indicating the utility of integrating proactive approaches to develop career sustaining behaviors during the practicum and internship experiences (Lenz et al., 2012; Meany-Walen et al., 2016; Ohrt et al., 2015). Lawson (2007) found that in the absence of these skills, counselors are vulnerable to experiencing burnout and decreased clinical effectiveness. Therefore, it is important for supervisors to identify the baseline

levels of distress and burnout of CITs with the understanding that practicum and internship activities may compound the effects of stressors over time. With this conceptualization of student experience, supervisors should implement the WELMS to mitigate negative influences on professional quality of life early during the relationship. Prompt introduction of the WELMS is justified by the noted pattern across their ProQOL variables wherein length of exposure during academic semester was associated with greater protective utility.

Furthermore, it is essential for supervisors to consider goodness of fit between the WELMS and important student characteristics including self-awareness, openness, and existing coping style. CITs with greater self-awareness regarding socioemotional processes during practice and internship placements may be better candidates for maximizing supervision experiences in general. However, when CITs are open to holistic conceptualizations of their development and proactive in understanding the many ways that individuals and groups can become well, professional quality of life may be a more achievable experience. Conversely, CITs who neglect to meet personal challenges with insight and openness may experience more countertransference and difficulty regulating emotions when under duress. For this reason, supervisors should help CITs develop WELMS interventions that are not only realistic and suitable to their needs, but also account for existing coping style. With a personalized approach to supervision and wellness engagement, CITs may progress through internship with a dynamic supportive framework to promote professional quality of life.

**Limitations of the Study and Recommendations for Future Research**

Although the results of this study provide some preliminary evidence of efficacy for the WELMS in relation to professional quality of life characteristics, some caveats are noted related to the study sample size, measurement of constructs, research method, and generalization of findings.

Although the sample size for this study is sufficient to establish modest evidence for evidence-based practice, the results of three participants cannot be generalized to the population of CITs in CACREP programs. Furthermore, the participants and supervisor in this study were all women and therefore any inferences based on interactions between the WELMS and ProQOL scores may not be indicative of the experiences of men. Therefore, future SCRDs are needed with larger samples of diverse participants across multiple sites.

Additionally, our participants self-reported ProQOL data over 15 weeks, which may have increased the risk for them to self-report responses that are more desirable or respond in a manner they believed was anticipated. Future researchers are encouraged to collect data through varied approaches including more objective estimations that are less sensitive to test bias. Due to the nature of the setting, participants received supervision from multiple persons with varied clinical and supervisory experience at the CTC and in their assigned internship courses. Although each participant received an hour of the WELMS per week, participants also received supervision from multiple perspectives that may have obscured some of the true influence of the WELMS on ProQOL scores. Future researchers may consider having only one supervisor to work with participants to reduce the influence of these extraneous variables. Also, given the very controlled nature of the CTC setting, researchers are encouraged to investigate the usefulness of the WELMS in community and school settings where degrees of autonomy and oversight are disparate.

Finally, we utilized multiple baselines to support inferences about causal association between the WELMS and ProQOL scores, yet researchers are encouraged to depict further treatment effects using different types of research designs such as between-groups and mixed methods studies. Adding a qualitative study with this design may help further explain and understand the lived experiences of students as they receive a wellness based model of supervision. In addition, implementing studies

across the practicum and internship courses, such as extended multiple baseline designs or follow up studies (3, 6, and 12 months) may be beneficial to understanding the longitudinal impact of the WELMS.

## Conclusion

Wellness based approaches to supervision can inspire CITs to become more proactive in their personal wellness and professional quality of life as supervisors help promote CIT skill development and career sustaining behaviors. However, few studies in which researchers have utilized a wellness model of supervision with CITs exist. Using an SCRD with multiple baselines, we found promising results for using the WELMS with CITs to help mitigate and stabilize client-CIT interactions on their professional quality of life. The results indicate that CITs who receive the WELMS are likely to show improvement in their professional quality of life, especially in the secondary traumatic stress and burnout subscales. The results also reveal the importance of using the WELMS in a time sensitive manner based on unique student needs.

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Figure 4. Secondary Traumatic Stress

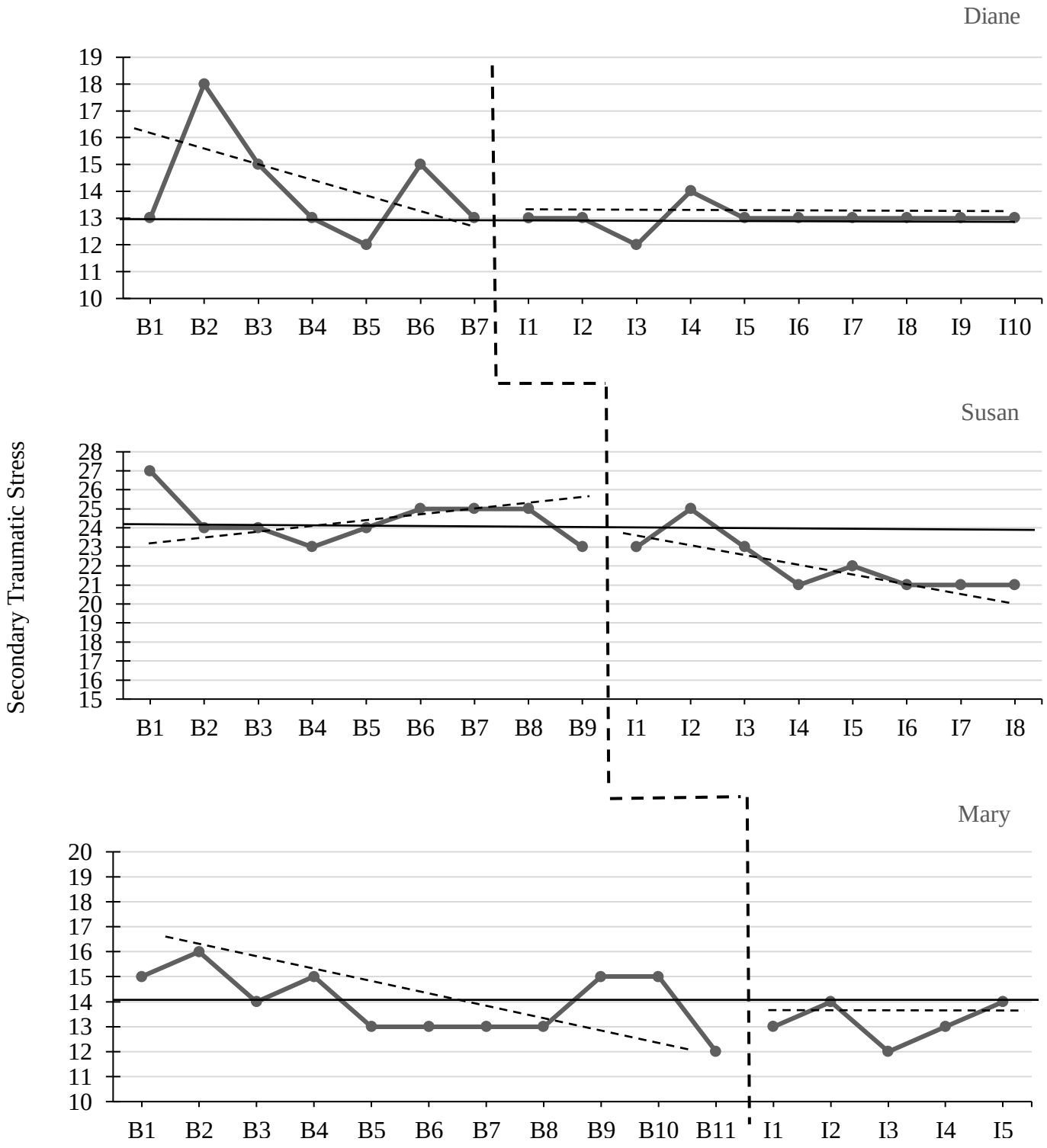


Figure 1. Visual depictions of participant scores on the secondary trauma scale of the ProQOL. A decrease in scores is desirable.

Figure 5. Compassion Satisfaction

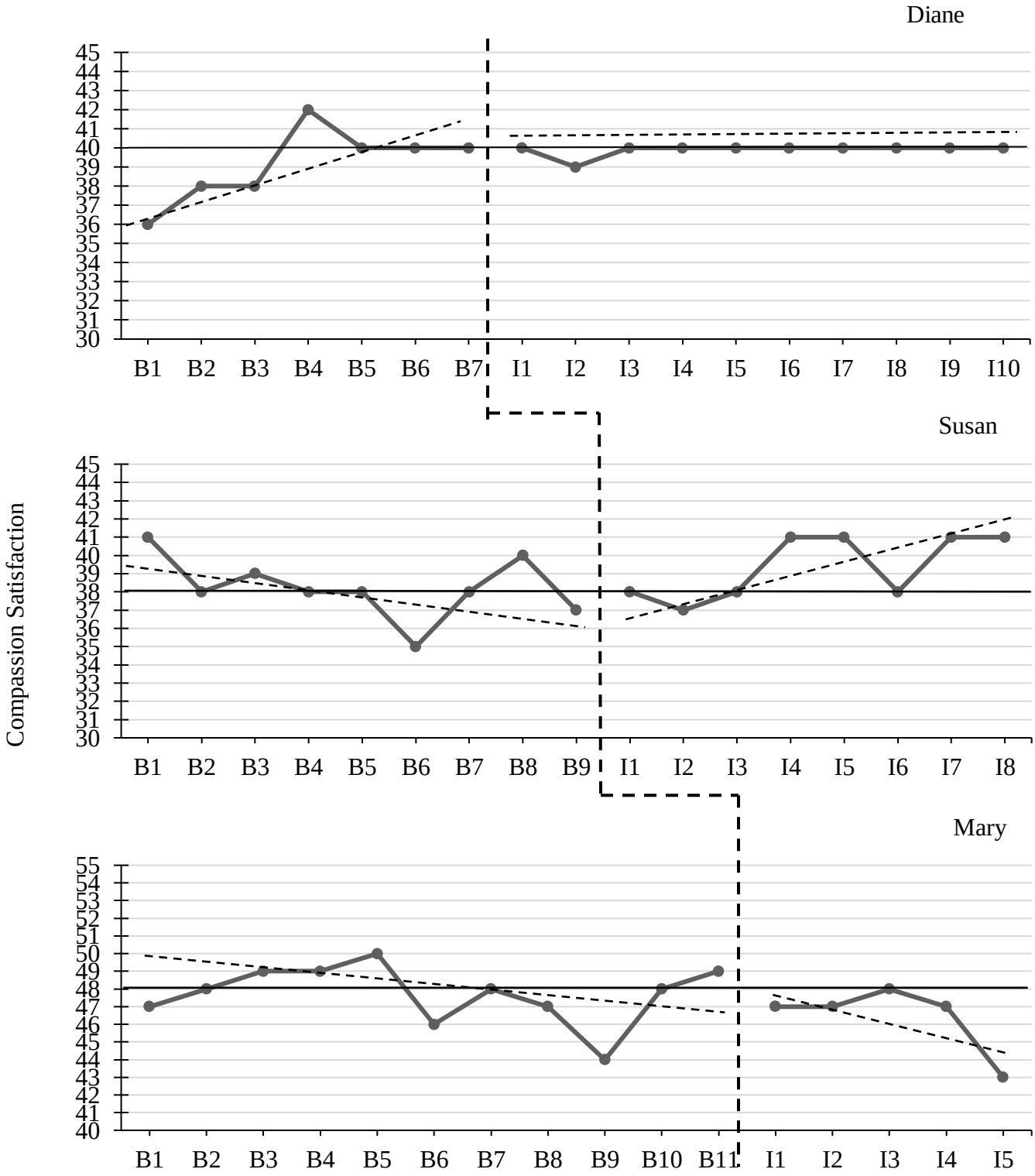


Figure 2. Visual depictions of participant scores on the compassion satisfaction scale of the ProQOL. An increase in scores is desirable.

Figure 6. Burnout

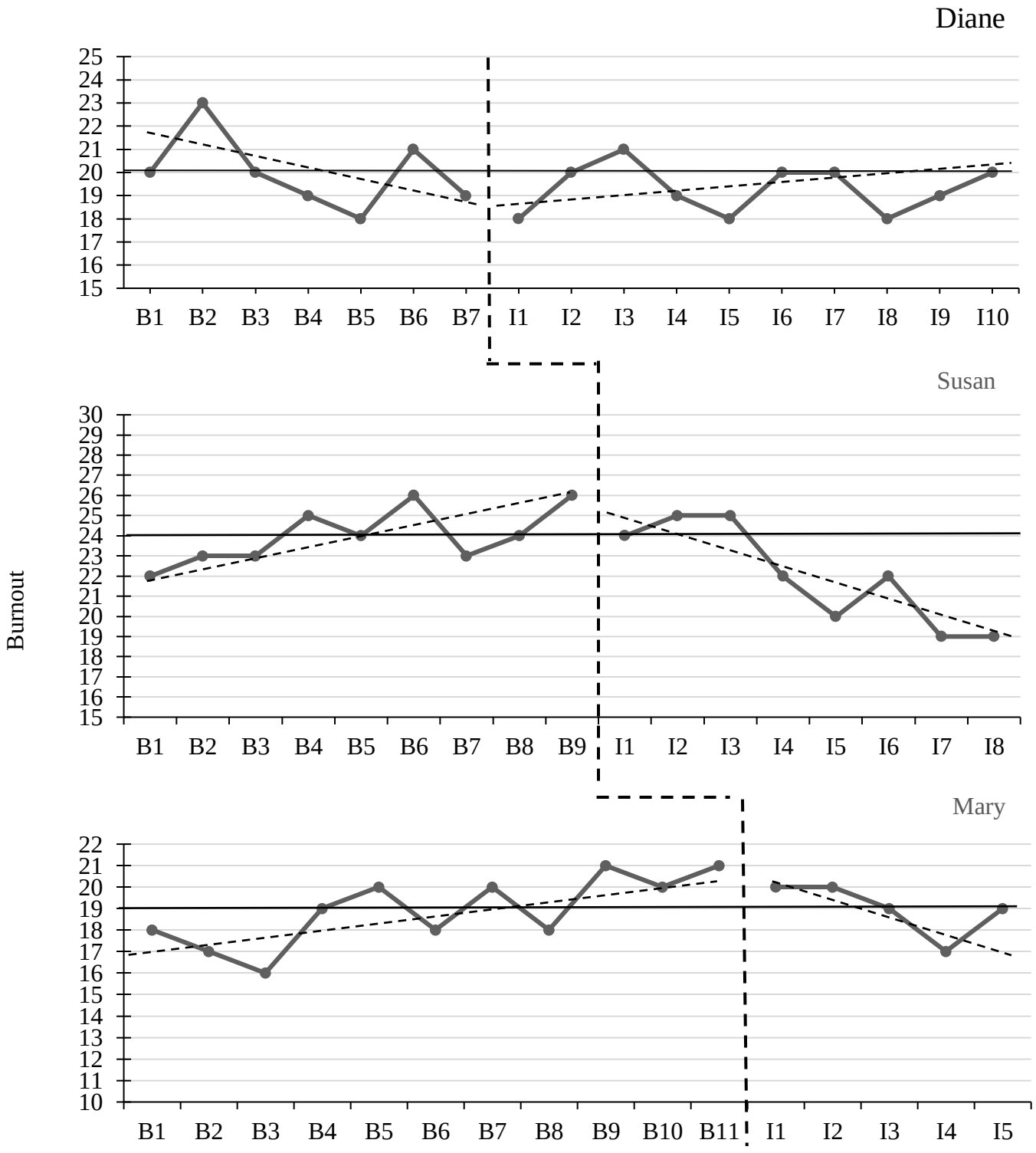


Figure 3. Visual depictions of participant scores on the burnout scale of the ProQOL. A decrease in scores is desirable.

# APPENDIX A

## Consent Forms and Recruitment Scripts

## CONSENT FORM (Client)

Implementing the Wellness Model of Supervision with Counselors-In-Training: Indications for Professional Quality of Life and Working Alliance

**Introduction**
The purpose of this form is to provide you information that may affect your decision as to whether or not to participate in this research study. If you decide to participate in this study, this form will also be used to record your consent.

You have been asked to participate in a research project studying the effectiveness of using a Wellness Model of Supervision with Counselors-in-Training. The purpose of this study is to evaluate whether using a Wellness Model of Supervision with Counselors in Training has any effect on the counselor's perception of their professional quality of life, and also their client's perceptions of working alliance with the counselor. You were selected to be a possible participant because you are a client at the Counseling and Training Clinic.

**What will I be asked to do?**
If you agree to participate in this study, you will be asked to receive weekly supervision by the researcher, and complete a Working Alliance Inventory (WAI-SF) (counselor) to provide information about your sessions with your counselor. You will be asked to complete this assessment at the end of your weekly session. This study will last a total of 12-15 weeks, however, your participation will be for the duration of weeks you meet with your counselor. The WAI-SF (counselor) should take approximately 5 minutes to complete, at the end of your session.

**What are the risks involved in this study?**
The risks associated with this study are minimal, and are not greater than risks ordinarily encountered in daily life. You may experience some discomfort when you provide a rating of your working alliance with your assigned counselor

**What are the possible benefits of this study?**
The possible benefits of participation includes an opportunity for you to build a closer connection with your counselor, and develop a better understanding of the working alliance with your counselors. In addition, as a result of the study, you may be exposed to counselors who are better skilled at self-care and as a result have an increased sense of awareness of the needs of their client. This may result in a stronger therapeutic alliance.

**Do I have to participate?**
No. Your participation is voluntary. You may decide not to participate or to withdraw at any time without your current or future relations with Texas A&M University-Corpus and the Counseling and Training Clinic being affected.

**Who will know about my participation in this research study?**
This study is confidential. No identifiers linking you to this study will be included in any sort of report that might be published. Research records will be stored securely and only Karisse A. Callender and Dr. A. Stephen Lenz will have access to the records.

**Whom do I contact with questions about the research?**
If you have any questions about this study, you may contact the CNEP Counseling and Training Clinic Director, Dr. Yvonne Castillo, phone: 361-825-3988 or email: yvonne.castillo@tamucc.edu, or Dr. A. Stephen Lenz, phone: 361-825-3467 or email: stephen.lenz@tamucc.edu, or Karisse A. Callender, phone: 361-825-2469 or email: kcallender@islander.tamucc.edu

**Whom do I contact about my rights as a research participant?**
This research study has been reviewed by the Research Compliance Office and/or the Institutional Review Board at Texas A&M University-Corpus Christi. For research-related problems or questions regarding your rights as a research participant, you can contact Caroline Lutz, Research Compliance Officer, at (361) 825-2497 or caroline.lutz@tamucc.edu

**Signature**
Please be sure you have read the above information, asked questions and received answers to your satisfaction. You will be given a copy of the consent form for your records. By signing this document, you consent to participate in this study. You also certify that you are 18 years of age or older by signing this form.

**Signature of Participant:** _____ **Date:** _____

**Printed Name:** _____

**Signature of Person Obtaining Consent:** _____ **Date:** _____

**Printed Name:** _____

**CONSENT FORM (Counselors-In-Training)**

Implementing the Wellness Model of Supervision with Counselors-In-Training: Indications for Professional Quality of Life and Working Alliance

**Introduction**

The purpose of this form is to provide you information that may affect your decision as to whether or not to participate in this research study. If you decide to participate in this study, this form will also be used to record your consent.

You have been asked to participate in a research project studying the effectiveness of using a Wellness Model of Supervision with Counselors-in-Training. The purpose of this study is to evaluate whether using a Wellness Model of Supervision with Counselors in Training has any effect on the counselor's perception of their professional quality of life, and also their client's perceptions of working alliance with the counselor. You were selected to be a possible participant because you are a Counselor-in-Training (CIT) at the Counseling and Training Clinic.

**What will I be asked to do?**

If you agree to participate in this study, you will be asked to complete a few assessments and engage in supervision. The study will last a total of 12-15 weeks. You will be asked to complete a Professional Quality of Life Scale (ProQOL) and Working Alliance Inventory (WAI-SF), Five Factor Wellness Inventory (5F-WEL), and complete journal prompts weekly. During this study, you will be asked to engage in supervision weekly for 12-15 weeks with me. Here is a breakdown of the requirements:

Week 1-12/15: You will be asked to complete the Professional Quality of Life Scale (ProQOL) and Working Alliance Inventory (WAI-SF) (counselor) to provide information about your perception of your professional quality of life and your working alliance with your client. You will complete these forms weekly, as a reflection of your session for that week. During this study, you will be asked to engage in supervision with me for the duration of 12-15 weeks. You will also complete journal prompts weekly.

Week 3-10: You will be asked to complete a Five Factor Wellness Inventory (5F-WEL) to develop a supervision plan. You will also complete journal prompts weekly.

**What are the risks involved in this study?**

The risks associated with this study are minimal, and are not greater than risks ordinarily encountered in daily life. You may experience some emotional discomfort as you process your personal wellness and what you need to do in order to make improvements in your life.

**What are the possible benefits of this study?**

The possible benefits of participation in this study may include increased awareness of personal wellness, a stronger and more concrete definition of your professional quality of life, and the ability to process various client cases in a supervisory environment.

**Do I have to participate?**
No. Your participation is voluntary. You may decide not to participate or to withdraw at any time without your current or future relations with Texas A&M University-Corpus Christi or the CNEP Counseling and Training Clinic.

**Will I be compensated?**
You will receive a $15 Coffee Waves gift card as compensation for participation in this study. Disbursement will occur at the end of the study. If you do not fully participate in the study (complete 15 weeks of supervision, including all assessments), you will not receive compensation.

**Who will know about my participation in this research study?**
This study is confidential. No identifiers linking you to this study will be included in any sort of report that might be published. Research records will be stored securely and only Karisse A. Callender and Dr. A. Stephen Lenz will have access to the records.

**Whom do I contact with questions about the research?**
If you have any questions about this study, you may contact the CNEP Counseling and Training Clinic Director, Dr. Yvonne Castillo, phone: 361-825-3988 or email: yvonne.castillo@tamucc.edu or Dr. A. Stephen Lenz, phone: 361-825-3467 or email: stephen.lenz@tamucc.edu, or Karisse A. Callender, phone: 361-825-2469 or email: kcallender@islander.tamucc.edu

**Whom do I contact about my rights as a research participant?**
This research study has been reviewed by the Research Compliance Office and/or the Institutional Review Board at Texas A&M University-Corpus Christi. For research-related problems or questions regarding your rights as a research participant, you can contact Caroline Lutz, Research Compliance Officer, at (361) 825-2497 or caroline.lutz@tamucc.edu

**Signature**
Please be sure you have read the above information, asked questions and received answers to your satisfaction. You will be given a copy of the consent form for your records. By signing this document, you consent to participate in this study. You also certify that you are 18 years of age or older by signing this form.

**Signature of Participant:**_____ **Date:**_____

**Printed Name:** _____

**Signature of Person Obtaining Consent:**_____ **Date:**_____

**Printed Name:** _____

**Implementing the Wellness Model of Supervision with Counselors-In-Training: Indications for Professional Quality of Life and Working Alliance**

**Recruitment Script for Clients**

Greetings,

My name is Karisse A. Callender and I would like to invite you to participate in a research project studying the effectiveness of a Wellness Model of Supervision (WELMS). The purpose of this study is to measure how effective the WELMS is, in improving levels of professional quality of life in your counselor, and also your perception of the working alliance between you and your counselor. You were selected to be a possible participant because you are a client at the CNEP Counseling and Training Clinic.

If you agree to participate in this study, you will be asked to complete a Working Alliance Inventory-Short Form (client) (WAI-SF) each week, at the end of your session. This assessment should take approximately 5 minutes to complete. This study will take approximately 12-15 weeks, depending on how long you engage in counseling sessions at the Clinic.

The risks associated in this study are minimal, and are not greater than risks ordinarily encountered in taking part in a counseling session. You may experience some discomfort when you provide a rating of the working alliance with your assigned counselor. Benefits of participation in this study includes an opportunity for you to build a closer connection with your counselor, and develop a better understanding of the working alliance with your counselors. In addition, as a result of the study, you may be exposed to counselors who are better skilled at self-care and as a result have an increased sense of awareness of the needs of their client. This may result in a stronger therapeutic alliance.

Your participation is voluntary. You may decide not to participate or to withdraw at any time without your current or future relations with Texas A&M University-Corpus and the CNEP Counseling and Training Clinic being affected.

If you wish to participate in this study, please read the informed consent document carefully before signing. If you have any questions about this study, you may contact the CNEP Counseling and Training Clinic Director, Dr. Yvonne Castillo, phone: 361-825-3988 or email: yvonne.castillo@tamucc.edu, or Dr. A. Stephen Lenz, phone: 361-825-3467 or email: stephen.lenz@tamucc.edu, or Karisse A. Callender, phone: 361-825-2469 or email: kcallender@islander.tamucc.edu

Thank you.
Karisse A. Callender

**Implementing the Wellness Model of Supervision with Counselors-In-Training: Indications for Professional Quality of Life and Working Alliance**

**Recruitment Script for Counselors-in-Training**

Greetings,

My name is Karisse A. Callender and I would like to invite you to participate in a research project studying the effectiveness of a Wellness Model of Supervision (WELMS). The purpose of this study is to evaluate whether using a Wellness Model of Supervision with Counselors in Training has any effect on the counselor's perception of their professional quality of life, and also their client's perceptions of working alliance with the counselor. You were selected to be a possible participant because you are a Counselor-in-Training (CIT) at the CNEP Counseling and Training Clinic.

If you agree to participate in this study, you will be asked to complete a few assessments and engage in supervision with me. The study will last a total of 15 weeks. You will be asked to complete a Professional Quality of Life Scale (ProQOL) and Working Alliance Inventory (WAI-SF), Five Factor Wellness Inventory (5F-WEL), and complete journal prompts weekly. During this study, you will be asked to engage in supervision with me weekly for 12-15 weeks. Here is a breakdown of the requirements:

Week 1-12/15: You will be asked to complete the Professional Quality of Life Scale (ProQOL) and Working Alliance Inventory (WAI-SF) (counselor) to provide information about your perception of your professional quality of life and your working alliance with your client. You will complete these forms weekly, as a reflection of your session for that week. During this study, you will be asked to engage in supervision with me for the duration of 12-15 weeks. You will also complete journal prompts weekly.

Week 3-10: You will be asked to complete a Five Factor Wellness Inventory (5F-WEL) to develop a supervision plan. You will also complete journal prompts weekly.

The risks associated with this study are minimal, and are not greater than risks ordinarily encountered in daily life. You may experience some emotional discomfort as you process your personal wellness and what you need to do in order to make improvements in your life. The possible benefits of participation in this study may include increased awareness of personal wellness, a stronger and more concrete definition of your professional quality of life, and the ability to process various client cases in a supervisory environment.

Your participation is voluntary. You may decide not to participate or to withdraw at any time without your current or future relations with Texas A&M University-Corpus and the CNEP Counseling and Training Clinic being affected.

If you wish to participate in this study, please read the informed consent document carefully before signing. If you have any questions about this study, you may contact the CNEP Counseling and Training Clinic Director, Dr. Yvonne Castillo, phone: 361-825-3988 or email:

yvonne.castillo@tamucc.edu, or Dr. A. Stephen Lenz, phone: 361-825-3467 or email: stephen.lenz@tamucc.edu, or Karisse A. Callender, phone: 361-825-2469 or email: kcallender@islander.tamucc.edu

Thank you.
Karisse A. Callender

# APPENDIX B

## Special Permissions for the Study

**Texas A&M University-Corpus Christi**
Department of Counseling and Educational Psychology
**Counseling and Training Clinic**
Natural Resources Center, Suite 2700
6300 Ocean Drive, Unit 5855
Corpus Christi, TX 78412
(361) 825-3988

June 15, 2016

Internal Review Board
Texas A&M University - CC

Dear Committee:

I am excited about the research that Karisse Callender will be conducting at the Counseling and Training Clinic. I fully support and give her access to students and clients willing to participate in her study, *"Implementing the Wellness Model of Supervision with Counselors-in-Training: Indications for Professional Quality of Life and Working Alliance."*

Practicum and Internship students (counselors-in-training) who choose to complete hours at the clinic are continually supervised. Supervision is one of the largest components for counselors-in-training while at the clinic. While counselors-in-training are in a session peers monitor and supervise their work. Once out of session, supervision occurs for these students as they complete telephone intakes or complete session notes. Each student has an assigned supervisor who is either the clinic director, assistant clinic director, or licensed professional counselor intern. These supervisors offer constant supervision throughout the counselors'-in-training day but also require these students meet individually or triadically for one hour with the assigned supervisor.

The Counseling and Training Clinic at Texas A&M University-Corpus Christi is an excellent place for this time of research to occur. We welcome the opportunity to help with this however we can.

Sincerely,

Yvonne Castillo, Ph.D., LPC Approved Supervisor
Director, Counseling and Training Clinic
Texas A&M University-Corpus Christi

SFU SIMON FRASER UNIVERSITY
THINKING OF THE WORLD

Ms. Karisse Callender

Texas A&M University- Corpus Christi
Counseling and Educational Psychology
6515 Ocean Dr. Unit 309
Corpus Christi Texas
78412
United States

April 26,2016

LIMITED COPYRIGHT LICENSE (ELECTRONIC) # 2016264.27

Dear Ms. Callender

You have permission to use the Working Alliance Inventory (WAI) forthe investigation:

"Implementing the Wellness Model of Supervision with Counselors-in-Training: Indications for Professional Quality of Life and Working Alliance"

This limited copyright release extends to all forms of the WAI for which I hold copyright privileges, but limited to use of the inventory for not-for-profit research, and does not include the right to publish or distribute the instrument(s) in any form.

I would appreciate if you shared the results of your research with me when your work is completed so I may share this information with other researchers who might wish to use the WAI. If I can be of further help, do not hesitate to contact

Dr. Adam O. Horvath
Professor
Faculty of Education and
Department of Psychology

e-mail: horvath@sfu.ca
Internet: http://wai.profhorvath.com

TEXAS A&M UNIVERSITY
CORPUS CHRISTI

OFFICE OF RESEARCH COMPLIANCE
Division of Research, Commercialization and Outreach

6300 Ocean Drive, Unit 5844
Corpus Christi, Texas 78412
O 361.825.2497 • F 361.825.2755

| Human Subjects Protection Program | Institutional Review Board |
|---|---|

| | |
|---|---|
| APPROVAL DATE: | August 18, 2016 |
| TO: | Ms. Karisse A. Callender |
| CC: | Dr. Stephen Lenz |
| FROM: | Office of Research Compliance<br>Institutional Review Board |
| SUBJECT: | Initial Approval |

| | |
|---|---|
| Protocol Number: | #77-16 |
| Title: | Implementing the Wellness Model of Supervision with Counselors-In-Training: Indications for Professional Quality of Life and Working Alliance |
| Review Category: | Expedited (7) |
| Expiration Date: | August 18, 2017 |

**Approval determination was based on the following Code of Federal Regulations:**

Eligible for Expedited Approval (45 CFR 46.110): Identification of the subjects or their responses (or the remaining procedures involving identification of subjects or their responses) will NOT reasonably place them at risk of criminal or civil liability or be damaging to the their financial standing, employability, insurability, reputation, or be stigmatizing, unless reasonable and appropriate protections will be implemented so that risks related to invasion of privacy and breach of confidentiality are no greater than minimal.

Criteria for Approval has been met (45 CFR 46.111) - The criteria for approval listed in 45 CFR 46.111 have been met (or if previously met, have not changed).

(7) Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies. (NOTE: Some research in this category may be exempt from the HHS regulations for the protection of human subjects. 45 CFR 46.101(b)(2) and (b)(3). This listing refers only to research that is not exempt.)

| Provisions: | |
|---|---|
| Comments: | The TAMUCC Human Subjects Protections Program has implemented a post-approval monitoring program. All protocols are subject to selection for post-approval monitoring. |

This research project has been approved. As Principal Investigator, you assume the following responsibilities:

1. Informed Consent: Information must be presented to enable persons to voluntarily decide whether or not to participate in the research project unless otherwise waived.

2. Amendments: Changes to the protocol must be requested by submitting an Amendment Application to the Research Compliance Office for review. The Amendment must be approved by the IRB before being implemented.
3. Continuing Review: The protocol must be renewed each year in order to continue with the research project. A Continuing Review Application, along with required documents must be submitted 45 days before the end of the approval period, to the Research Compliance Office. Failure to do so may result in processing delays and/or non-renewal.
4. Completion Report: Upon completion of the research project (including data analysis and final written papers), a Completion Report must be submitted to the Research Compliance Office.
5. Records Retention: All research related records must be retained for three years beyond the completion date of the study in a secure location. At a minimum these documents include: the research protocol, all questionnaires, survey instruments, interview questions and/or data collection instruments associated with this research protocol, recruiting or advertising materials, any consent forms or information sheets given to participants, all correspondence to or from the IRB or Office of Research Compliance, and any other pertinent documents.
6. Adverse Events: Adverse events must be reported to the Research Compliance Office immediately.
7. Post-approval monitoring: Requested materials for post-approval monitoring must be provided by dates requested.

# APPENDIX C

Forms

**Implementing the Wellness Model of Supervision with Counselors-In-Training: Indications for Professional Quality of Life and Working Alliance**

## Journal Prompts

- Describe your satisfaction with your wellness dimension this week
- In what ways did you improve on your wellness dimension this week?
- How would you describe your working alliance with clients this week?
- How would you describe your professional quality of life this week?
- What was your experience of supervision this week?

**Implementing the Wellness Model of Supervision with Counselors-In-Training: Indications for Professional Quality of Life and Working Alliance**

**Demographic Questionnaire for Counselors-in-Training**

Participant Code: _____

1. Gender
    a. Male
    b. Female
    c. Other: _____
2. Internship level
    a. Internship I
    b. Internship II
3. Counseling track
    a. Clinical mental health
    b. Marriage, couple, and family
    c. Addictions counseling
    d. School counseling
4. Is this your first semester at the Counseling and Training Clinic?
    a. Yes
    b. No

# APPENDIX D

Assessments of Relevant Constructs

Five Factor Wellness Inventory (5F-WEL)

Professional Quality of Life Scale (ProQOL)

Working Alliance Inventory – Short Form (Client)

Working Alliance Inventory – Short Form (CIT)

# Five Factor Wellness Inventory
## Form A2

The purpose of this inventory is to help you make healthy lifestyle choices. The items are statements that describe you. Answer each item in a way that is true for you **most of the time. Think about how you most often see yourself, feel or behave.** Answer all the items. Do not spend too much time on any one item. Your honest answers will make your scores more useful.



Name: _____ Gender: _____

Highest grade completed: _____ Birth Date: _____

ID #: _____

Mark only one answer for each item using this scale:

| | |
|---|---|
| **Strongly Agree** | If it is true for you most or all of the time |
| **Agree** | If it is true for you some of the time |
| **Disagree** | If it is usually not true for you |
| **Strongly Disagree** | If it is almost or never true for you |

EXAMPLE

| | Strongly Agree | Agree | Disagree | Strongly Disagree |
|---|---|---|---|---|
| I like meeting new people. | A | X | C | D |

A. Strongly Agree
B. Agree
C. Disagree
D. Strongly Disagree

| | | | | | |
|---|---|---|---|---|---|
| 1. | I engage in a leisure activity in which I lose myself and feel like time stands still. | A | B | C | D |
| 2. | I am satisfied with how I cope with stress. | A | B | C | D |
| 3. | I eat a healthy amount of vitamins, minerals, and fiber each day. | A | B | C | D |
| 4. | I often see humor even when doing a serious task. | A | B | C | D |
| 5. | I am satisfied with the quality and quantity of foods in my diet. | A | B | C | D |
| 6. | Being a male/female is a source of satisfaction and pride to me. | A | B | C | D |
| 7. | When I have a problem, I study my choices and possible outcomes before acting. | A | B | C | D |
| 8. | I do not drink alcohol or drink less than two drinks per day. | A | B | C | D |
| 9. | I get some form of exercise for 20 minutes at least three times a week. | A | B | C | D |
| 10. | I value myself as a unique person. | A | B | C | D |
| 11. | I have friends who would do most anything for me if I were in need. | A | B | C | D |
| 12. | I feel like I need to keep other people happy. | A | B | C | D |
| 13. | I can express both my good and bad feelings appropriately. | A | B | C | D |
| 14. | I eat a healthy diet. | A | B | C | D |
| 15. | I do not use tobacco. | A | B | C | D |
| 16. | My cultural background enhances the quality of my life. | A | B | C | D |
| 17. | I have a lot of control over conditions affecting the work or schoolwork I do. | A | B | C | D |
| 18. | I am able to manage my stress. | A | B | C | D |
| 19. | I regularly get enough sleep. | A | B | C | D |
| 20. | I can take charge and manage a situation when it is appropriate. | A | B | C | D |
| 21. | I can laugh at myself. | A | B | C | D |
| 22. | Being male/female has a positive effect on my life. | A | B | C | D |
| 23. | My free time activities are an important part of my life. | A | B | C | D |
| 24. | My work or schoolwork allows me to use my abilities and skills. | A | B | C | D |
| 25. | I have friends and/or relatives who would provide help for me if I were in need. | A | B | C | D |
| 26. | I have at least one close relationship that is secure and lasting. | A | B | C | D |
| 27. | I seek ways to stimulate my thinking and increase my learning. | A | B | C | D |
| 28. | I am often unhappy because my expectations are not met. | A | B | C | D |
| 29. | I look forward to the work or schoolwork I do each day. | A | B | C | D |
| 30. | I usually achieve the goals I set for myself. | A | B | C | D |

A. Strongly Agree
B. Agree
C. Disagree
D. Strongly Disagree

| | | | | | |
|---|---|---|---|---|---|
| 31. | I have sources of support with respect to my race, color, or culture. | A | B | C | D |
| 32. | I can find creative solutions to hard problems. | A | B | C | D |
| 33. | I think I am an active person. | A | B | C | D |
| 34. | I take part in leisure activities that satisfy me. | A | B | C | D |
| 35. | Prayer or spiritual study is a regular part of my life. | A | B | C | D |
| 36. | I accept how I look even though I am not perfect. | A | B | C | D |
| 37. | I take part in organized religious or spiritual practices. | A | B | C | D |
| 38. | I am usually aware of how I feel about things. | A | B | C | D |
| 39. | I jump to conclusions that affect me negatively, and that turn out to be untrue. | A | B | C | D |
| 40. | I can show my feelings anytime. | A | B | C | D |
| 41. | I make time for leisure activities that I enjoy. | A | B | C | D |
| 42. | Others say I have a good sense of humor. | A | B | C | D |
| 43. | I make it a point to seek the views of others in a variety of ways. | A | B | C | D |
| 44. | I believe that I am a worthwhile person. | A | B | C | D |
| 45. | I feel support from others for being a male/female. | A | B | C | D |
| 46. | It is important for me to be liked or loved by everyone I meet. | A | B | C | D |
| 47. | I have at least one person who is interested in my growth and well-being. | A | B | C | D |
| 48. | I am good at using my imagination, knowledge, and skills to solve problems. | A | B | C | D |
| 49. | I can start and keep relationships that are satisfying to me. | A | B | C | D |
| 50. | I can cope with the thoughts that cause me stress. | A | B | C | D |
| 51. | I have spiritual beliefs that guide me in my daily life. | A | B | C | D |
| 52. | I have at least one person with whom I am close emotionally. | A | B | C | D |
| 53. | I am physically active most of the time. | A | B | C | D |
| 54. | I use humor to gain new insights on the problems in my life. | A | B | C | D |
| 55. | I can put my work or schoolwork aside for leisure without feeling guilty. | A | B | C | D |
| 56. | I have to do all things well in order to feel worthwhile. | A | B | C | D |
| 57. | I feel a positive identity with others of my gender. | A | B | C | D |
| 58. | I am appreciated by those around me at work or school. | A | B | C | D |
| 59. | I plan ahead to achieve the goals in my life. | A | B | C | D |
| 60. | I like myself even through I am not perfect. | A | B | C | D |
| 61. | I am satisfied with my free time activities. | A | B | C | D |
| 62. | I do some form of stretching activity at least three times a week. | A | B | C | D |

A. Strongly Agree
B. Agree
C. Disagree
D. Strongly Disagree

| | | | | | |
|---|---|---|---|---|---|
| 63. | I eat at least three meals a day including breakfast. | A | B | C | D |
| 64. | I do not use illegal drugs. | A | B | C | D |
| 65. | I believe in God or a spiritual being greater than myself. | A | B | C | D |
| 66. | I can experience a full range of emotions, both positive and negative. | A | B | C | D |
| 67. | I view change as an opportunity for growth. | A | B | C | D |
| 68. | I eat fruits, vegetables, and whole grains daily. | A | B | C | D |
| 69. | My spiritual growth is essential to me. | A | B | C | D |
| 70. | When I need information, I have friends whom I can ask for help. | A | B | C | D |
| 71. | I am proud of my cultural heritage. | A | B | C | D |
| 72. | I like to be physically fit. | A | B | C | D |
| 73. | I have at least one person in whom I can confide my thoughts and feelings. | A | B | C | D |
| 74. | I am satisfied with my life. | A | B | C | D |
| 75. | I have enough money to do the things I need to do. | A | B | C | D |
| 76 | I feel safe in my home. | A | B | C | D |
| 77. | I feel safe in my workplace or school. | A | B | C | D |
| 78. | I feel safe in my neighborhood. | A | B | C | D |
| 79. | I feel safe in my daily life. | A | B | C | D |
| 80. | I am afraid that I or my family will be hurt by terrorists. | A | B | C | D |
| 81. | I am optimistic about the future. | A | B | C | D |
| 82. | My government helps me be more well. | A | B | C | D |
| 83. | My education has helped me be more well. | A | B | C | D |
| 84. | My religion helps my well-being. | A | B | C | D |
| 85. | I know I can get a suitable job when I need one. | A | B | C | D |
| 86. | I watch TV less than two hours each day. | A | B | C | D |
| 87. | World peace is important to my well-being. | A | B | C | D |
| 88. | Other cultures add to my well being. | A | B | C | D |
| 89. | I look forward to growing older. | A | B | C | D |
| 90. | I like to plan the changes in my life. | A | B | C | D |
| 91. | Changes in life are normal. | A | B | C | D |

**Professional Quality of Life Scale (ProQOL)**

*Compassion Satisfaction and Compassion Fatigue, (ProQOL) Version 5 (2009)*

When you *[help]* people you have direct contact with their lives. As you may have found, your compassion for those you *[help]* can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a *[helper]*. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the *last 30 days*.

**1=Never 2=Rarely 3=Sometimes 4=Often 5=Very Often**

1. I am happy.
2. I am preoccupied with more than one person I *[help]*.
3. I get satisfaction from being able to *[help]* people.
4. I feel connected to others.
5. I jump or am startled by unexpected sounds.
6. I feel invigorated after working with those I *[help]*.
7. I find it difficult to separate my personal life from my life as a *[helper]*.
8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I *[help]*.
9. I think that I might have been affected by the traumatic stress of those I *[help]*.
10. I feel trapped by my job as a *[helper]*.
11. Because of my *[helping]*, I have felt "on edge" about various things.
12. I like my work as a *[helper]*.
13. I feel depressed because of the traumatic experiences of the people I *[help]*.
14. I feel as though I am experiencing the trauma of someone I have *[helped]*.
15. I have beliefs that sustain me.
16. I am pleased with how I am able to keep up with *[helping]* techniques and protocols.
17. I am the person I always wanted to be.
18. My work makes me feel satisfied.
19. I feel worn out because of my work as a *[helper]*.
20. I have happy thoughts and feelings about those I *[help]* and how I could help them.
21. I feel overwhelmed because my case [work] load seems endless.
22. I believe I can make a difference through my work.
23. I avoid certain activities or situations because they remind me of frightening experiences of the people I *[help]*.
24. I am proud of what I can do to *[help]*.
25. As a result of my *[helping]*, I have intrusive, frightening thoughts.
26. I feel "bogged down" by the system.
27. I have thoughts that I am a "success" as a *[helper]*.
28. I can't recall important parts of my work with trauma victims.
29. I am a very caring person.
30. I am happy that I chose to do this work.

**Working Alliance Inventory**
Short Form (C)
**Instructions**

On the following pages there are sentences that describe some of the different ways a person might think or feel about his or her therapist (counsellor). As you read the sentences mentally insert the name of your therapist (counselor) in place of _____in the text.

Below each statement inside there is a seven point scale:

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Rarely | Occasionally | Sometimes | Often | Very Often | Always |

If the statement describes the way you always feel (or think) circle the number 7; if it never applies to you circle the number 1. Use the numbers in between to describe the variations between these extremes.

This questionnaire is CONFIDENTIAL; neither your therapist nor the agency will see your answers.

Work fast, your first impressions are the ones we would like to see. (PLEASE DON'T FORGET TO RESPOND TO EVERY ITEM.)

Thank you for your cooperation.

1. _____ and I agree about the things I will need to do in therapy to help improve my situation.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Rarely | Occasionally | Sometimes | Often | Very Often | Always |

2. What I am doing in therapy gives me new ways of looking at my problem.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Rarely | Occasionally | Sometimes | Often | Very Often | Always |

3. I believe _____ likes me.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Rarely | Occasionally | Sometimes | Often | Very Often | Always |

4. _____ does not understand what I am trying to accomplish in therapy.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Rarely | Occasionally | Sometimes | Often | Very Often | Always |

5. I am confident in _____ 's ability to help me.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Rarely | Occasionally | Sometimes | Often | Very Often | Always |

6. _____ and I are working towards mutually agreed upon goals.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Rarely | Occasionally | Sometimes | Often | Very Often | Always |

7. I feel that _____ appreciates me.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Rarely | Occasionally | Sometimes | Often | Very Often | Always |

8. We agree on what is important for me to work on.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Rarely | Occasionally | Sometimes | Often | Very Often | Always |

9. _____ and I trust one another.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Rarely | Occasionally | Sometimes | Often | Very Often | Always |

10. _____ and I have different ideas on what my problems are.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Rarely | Occasionally | Sometimes | Often | Very Often | Always |

11. We have established a good understanding of the kind of changes that would be good for me.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Rarely | Occasionally | Sometimes | Often | Very Often | Always |

12. I believe the way we are working with my problem is correct.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Rarely | Occasionally | Sometimes | Often | Very Often | Always |

**Working Alliance Inventory**
Short Form (T)
**Instructions**

On the following pages there are sentences that describe some of the different ways a person might think or feel about his or her client. As you read the sentences mentally insert the name of your client in place of _____in the text.

Below each statement inside there is a seven point scale:

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Rarely | Occasionally | Sometimes | Often | Very Often | Always |

If the statement describes the way you always feel (or think) circle the number 7; if it never applies to you circle the number 1. Use the numbers in between to describe the variations between these extremes.

This questionnaire is CONFIDENTIAL; neither your therapist nor the agency will see your answers.

Work fast, your first impressions are the ones we would like to see. (PLEASE DON'T FORGET TO RESPOND TO EVERY ITEM.)

Thank you for your cooperation.

1. _____ and I agree about the steps to be taken to improve his/her situation.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Rarely | Occasionally | Sometimes | Often | Very Often | Always |

2. My client and I both feel confident about the usefulness of our current activity in therapy

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Rarely | Occasionally | Sometimes | Often | Very Often | Always |

3. I believe _____ likes me.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Rarely | Occasionally | Sometimes | Often | Very Often | Always |

4. I have doubts about what we are trying to accomplish in therapy.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Rarely | Occasionally | Sometimes | Often | Very Often | Always |

5. I am confident in my ability to help _____

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Rarely | Occasionally | Sometimes | Often | Very Often | Always |

6. We are working towards mutually agreed upon goals.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Rarely | Occasionally | Sometimes | Often | Very Often | Always |

7. I appreciate _____ as a person.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Rarely | Occasionally | Sometimes | Often | Very Often | Always |

8. We agree on what is important for _____ to work on.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Rarely | Occasionally | Sometimes | Often | Very Often | Always |

9. _____ and I have built a mutual trust.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Rarely | Occasionally | Sometimes | Often | Very Often | Always |

10. _____ and I have different ideas on what her/his problems are.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Rarely | Occasionally | Sometimes | Often | Very Often | Always |

11. We have established a good understanding between us of the kind of changes that would be good for _____

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Rarely | Occasionally | Sometimes | Often | Very Often | Always |

12. I believe the way we are working with her/his problem is correct.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Never | Rarely | Occasionally | Sometimes | Often | Very Often | Always |