MODELED WELLNESS: USING PERCEIVED SUPERVISOR WELLNESS
AND THE SUPERVISION RELATIONSHIP
TO PREDICT SUPERVISEE PERSONAL WELLNESS

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Modeled Wellness: Using Perceived Supervisor Wellness and the Supervision Relationship to Predict Supervisee Personal Wellness

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ABSTRACT

Wellness has become an increasingly important paradigm for counseling and clinical supervision. A heightened focus on counselor wellness in supervision has emerged as an intervention to improve quality of care to clients and prevent counselor impairment. Although researchers have examined the benefits of wellness interventions in supervision, we have little understanding of the supervisor’s ability to model wellness to their supervisees. Nor have researchers shown how a supervisor’s wellness influences supervisee wellness—and if and how the strength of the supervision relationship changes this influence. Thus, the purpose of this quantitative investigation was to (a) analyze the role of modeled wellness as a way for supervisors to influence the multifaceted aspects of supervisee wellness, and (b) identify if the factoring in the supervisory relationship changes this influence.

This quantitative study included a sample of 105 counselor education students enrolled in practicum or internship courses who were receiving supervision from a site-based supervisor. Results indicated that supervisee personal wellness was influenced by the supervisee’s perception of supervisor wellness. Certain second-order factors of perceived supervisor wellness (Creative and Coping Selves) were more predictive of the corresponding factor of supervisee personal wellness. When the strength of the supervisory relationship was considered, the model became more predictive despite the lack of correlation between the strength of the supervisory relationship and supervisee personal wellness. Results from this investigation suggest that the supervisory relationship can act as a suppressor variable, controlling for error in the equation and
making the perception of supervisor wellness a more valid predictor. A subsequent correlational analysis suggests that the error in prediction was primarily in supervisory relationships of moderate strength. The combination of the supervisee’s perception of their supervisor’s wellness and the strength of the supervisory relationship predicted 9% of the variance in supervisee wellness. Implications for counselors, supervisors, educators, and policy are discussed. Limitations and recommendations for future inquiry are highlighted based on the findings from this investigation.

*Keywords:* wellness, supervision, counselor education, supervisory relationship
For Lauryn, Blair, and our next baby soon to come,

We are so happy that we have you.
We dreamt all about you.
We just want you to be happy,
because we love you.
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CHAPTER ONE:
INTRODUCTION AND OVERVIEW

Clinical supervision is an essential component of counselor training in that supervisors are tasked to meet the developmental needs of their supervisees, while at the same time protecting client welfare (American Counseling Association, 2014; Borders et al., 2011). The importance of this relationship cannot be overstated since it has the potential to be highly influential in the development of novice counselors, with an ultimate impact in improving client health outcomes. Unlike mentoring relationships in other disciplines where, for example, a supervisor’s technical knowledge is a key factor, counseling supervisees learn from their supervisors in a number of ways that are subtle, but powerful (Bernard & Goodyear, 2014). One of those factors pertains to what is known as the holistic notion of wellness.

An increasingly important factor in the counseling setting is the concept of wellness. Collective wellness represents a dynamic process of mental, spiritual, emotional and physical optimization (Myers & Sweeney, 2004). While the significance of promoting optimal health and wellness for mental health clients has been known for decades (Myers, 1991), the wellness relationship between clinical supervisors and their supervisees as a potentially significant factor in the supervisory experience has only recently been investigated (e.g., Gnilka, Chang, & Dew, 2012; Lenz, Oliver, & Sangganjanavanich, 2014; Ohrt, Prosek, Ener, Lindo, 2015; Storlie & Smith, 2012; Thompson, Frick, & Trice-Black, 2011). Thus, this quantitative study is designed to determine how supervisees perceive their supervisor’s wellness, and the influence that perception has upon their own wellness. Because the nature of the relationship between the supervisee and supervisor influence those perceptions, that variable will be explored. To provide a context for this study, both foundational and contemporary models of wellness, along with
research highlighting the value and importance of the supervisory working alliance, are described herein.

For this study, wellness refers to the integration and balance of emotional, physical, cognitive, and spiritual aspects of the self for improved functioning. Importantly, it extends beyond the absence of illness to include an enthusiasm for living (Myers & Sweeney, 2004). This cross-sectional quantitative study will utilize linear regression analysis to determine the wellness relationship between supervisor and supervisee—specifically, if and how a supervisee’s wellness might be explained by the supervisee’s perception of the supervisor’s wellness, and if factoring in the supervisory relationship changes this influence. Limitations and implications will be discussed.

Context for This Investigation

Wellness as the Paradigm for Counseling

Wellness and counseling are intertwined—in terms of working with clients to empower them to make productive, healthy decisions that guide their own lives, and as a key component of counselor identity and professional training programs (Myers, 1991). Indeed, this notion of “maximizing human potential through positive life-style choices” (Myers, 1991, p. 183) has increasingly differentiated counselors from other mental health professionals. Wellness promotion has become an integral part of counselor education—so much so that it now serves as an educational pillar for programs seeking professional accreditation (Council for Accreditation of Counseling & Related Educational Programs, 2015). In fact, the wellness paradigm has become so important to the field and the profession that it has been incorporated into the American Counseling Association’s recent definition of counseling as “a professional relationship that empowers diverse individuals, families, and groups to accomplish mental
health, wellness, educational, and career goals” (American Counseling Association, 2014, p. 2). In other words, the concept of wellness represents far more than the absence of illness, but rather has come to signify a balance of all components of life (social, physical, spiritual, and emotional), that leads to a life led with passion and enthusiasm (Myers, 1991).

Beyond contributing to the holistic treatment of clients, researchers have suggested that the profession’s increasing emphasis on wellness could also be considered as an intervention for counselors themselves (Lawson, Venart, Hazler, Kottler, 2007; Lawson, 2007; Lawson & Myers, 2011), preventing ethical violations and counselor impairment (Hendricks, Bradley, Brogan, & Brogan, 2009). While the American Counseling Association’s Code of Ethics discusses wellness somewhat minimally, it does identify counselor impairment as a concern for counselor trainees and professionals in the field. Specifically, the American Counseling Association states that counselors, trainees, and supervisees should “monitor themselves for signs of impairment from their own physical, mental, or emotional problems and refrain from offering or providing services when impaired” (American Counseling Association, 2014, p. 9). When such circumstances exist, the American Counseling Association Code of Ethics further advises individuals to seek assistance from colleagues, supervisors, and professionals until the impairment no longer exists before resuming the provision of counseling services to ensure quality of care for clients (American Counseling Association, 2014). This stance on counselor impairment and quality of care led to recommendations for the use of wellness as a preventative measure (Lawson, 2007; Lawson & Myers, 2011; Cummins, Massey, & Jones, 2007; Hendricks et al., 2009) and increased the focus on wellness and how it is communicated to emerging counselors (e.g. counselor education students and counselors early in their careers).
Research shows that counseling students score higher on wellness assessments in comparison to the general population (Roach & Young, 2007). However, this did not preclude from the American Counseling Association from issuing wellness guidelines to encourage increased wellness as a way to improve the quality of care provided to clients. Important for this investigation is that these guidelines also stress the essential benefits that stem from a holistic approach to wellness, including increased compassion satisfaction, decreased compassion fatigue, and increased career-sustaining behaviors (Lawson & Myers, 2011). The perceived and proven benefits of wellness are so great that recommendations and guidelines have been made for counselor education programs (Yager & Tovar-Blank, 2007), schools, and mental health organizations (Young & Lambie, 2007)—all of which highlight the importance of understanding wellness as a guiding paradigm, as well as its influence on the ability to counsel effectively while attending to personal wellness.

A number of researchers have investigated strategies for increasing wellness among counselor education students. In examining the effect of a wellness course on student outcomes, Roach and Young (2007) discovered that a wellness course only accounted for minimal of variance in student wellness. This finding suggests that while teaching wellness has some benefit to students, there are other factors that may support the development of student wellness. One possible factor to consider is the role of clinical supervision in counselor education programs, which has been deemed the “signature pedagogy of the mental health professions” (Bernard & Goodyear, 2014, p. 2).

**Supervision as the Signature Pedagogy**

Not only have investigators considered clinical supervision to be an essential educational vehicle for training novice mental health counselors (Bernard & Goodyear, 2014), but effective
supervision is also linked to preventing counselor impairment and burnout through the provision of social support (Lambie, 2007; Young & Lambie, 2007). Young and Lambie (2007), for example, stressed that promoting a culture of wellness should include providing a socially supportive environment and delivering effective clinical supervision. This sense of support and connection is considered essential to the supervision process, which has been conceptualized through the supervisory working alliance (Bordin, 1983).

More than 30 years ago, Bordin (1983) stressed the importance of the supervisory working alliance in terms of the degree to which the supervisor and trainee agree on the tasks and goals of supervision, as well as whether the two share an emotional bond. While Bordin (1983) discussed the therapeutic working alliance between counselor and client as a sense of “liking, caring, and trusting” (p. 36), he differentiated the supervisor-supervisee bond—namely, the supervisory working alliance—as “[falling] somewhere between those of teacher to class members and therapist to patient” (p. 38). According to Bordin (1983), the key difference between the therapeutic working alliance and the supervisory working alliance rests with the evaluative aspect of the latter, which should not be a factor in the clinician-patient relationship.

Researchers have posited that when a supervisor develops a strong working relationship with a supervisee, supervision becomes more productive (Holloway, 1987). Indeed, Holloway (1987) argued that it is the relationship between supervisor and supervisee that ultimately transforms a supervisee from an untested novice into an independent, experienced practitioner. This evolution, however, is also dependent on several other factors. For example, Bernard and Goodyear (2014) asserted that supervisees gain knowledge and practice skills from three sources: theory/research, practice/experience, and self-insight. But it falls to the supervisor to facilitate the integration of these three factors in the preparation of a skilled clinician. Researchers
propose, however, that such a process is all but impossible in the absence of a strong working relationship (Holloway, 1987).

**Theoretical Underpinnings for this Investigation**

Bernard and Goodyear (2014) described how a strong supervisory working alliance aids supervisees in integrating these three sources of skills and knowledge: theory/research, practice/experience, and self-insight. One theory that supports the development of a strong supervisory working alliance is Social Learning Theory, which posits that people are influenced and learn from one another within a social context by observation and modeling the behavior of others (Bandura, 1977). Social Learning Theory has its roots in behavioral conditioning and asserts that people develop expectations and learn behaviors at the cognitive level through modeling and reinforcement (Brauer & Tittle, 2012). In other words, people develop behaviors by observing others with the expectation that similar outcomes will occur—either in the form of positive reinforcement (rewards) or negative reinforcement (punishment) (Blackburn, 1993).

The role of modeling and reinforcement is powerful. It provides opportunity for supervisors to impart positive practices. Of particular interest to this investigation is the notion of the parallel process in supervision (Friedlander, Siegel, & Brenock, 1989), which states that the therapy process between a counselor and client is mirrored in the supervisory relationship—which is something akin to the psychoanalytic concept of transference. Initially, the trainee is likely to be highly influenced by client-defined patterns. With more supervision, however, a trainee’s practices and beliefs will increasingly resemble those of his/her supervisor. In an analogous relationship, the harmful effects of poor supervision on supervisees may parallel the harmful effects of poor therapy for clients. Thus, when both supervisor and supervisee are aware of the similarities in both relationships, it will benefit the supervisory working relationship
(Friedlander et al., 1989). As the supervisee develops attitudes and behaviors similar to those modeled by the supervisor, the parallel process dissipates. This allows the supervisee to provide appropriate clinical care to their clients. This transaction of learning from modeled behavior to alleviate a potentially subconscious parallel process is a demonstration of Social Learning Theory within the supervisory relationship. While this example speaks to clinical concerns directly, it may be possible to expand to the development of supervisee professional identity as a counselor, of which the wellness paradigm plays a key role.

**Problem Statement**

The wellness relationship, and how attitudes and behaviors about wellness transfer between clinical supervisors and their supervisees within the supervisory relationship is a potentially significant factor in counseling and counselor education (e.g. Myers, Mobley, & Booth, 2003; Roach & Young, 2007; Yager & Tovar-Blank, 2007). The counseling profession exists to promote a client’s optimum health, wellness, positive functioning, and self-direction and practitioners in the counseling profession, counselors-in-training, counselors, and supervisors, are also charged with attending to their own personal wellness (Lawson et al. 2007). Indeed, researchers have investigated this relationship with mixed results.

Earlier studies examined the wellness levels of students enrolled in counselor education programs and compared them to those of the general population. For example, Myers et al. (2003) reported that counselor education students showed higher wellness levels in comparison to a cohort of adults in the general population, with doctoral students scoring significantly higher than entry-level masters students (summarized in Appendix A). Although this study provided the groundwork for studying the wellness characteristics of counselor education students, it was
limited in the sense that it could not determine unequivocally if the counselor education program itself had any effect on student wellness.

Following Myers et al.’s (2003) initial study, researchers began to discuss ways to promote wellness in counselor education programs (e.g., Yager & Tovar-Blank, 2007), as well as investigate the effects that counselor education programs had on the wellness of its students and the effectiveness of different interventions in promoting wellness (Roach & Young, 2007). Roach and Young (2007) reported that wellness does not tend to increase significantly across time as a result of engaging in counselor education training (summarized in Appendix A). Additionally, the researchers discovered that direct instruction (a wellness course) had only a minor impact on student wellness, while personal mental health counseling was not associated with increased wellness at all. In contrast, Yager and Tovar-Blank (2007) supported introducing wellness directly (such as through a wellness course) and encouraging personal counseling as a means of promoting student wellness. These conflicting results leave unanswered questions.

Despite the ambiguity about approaches for increasing wellness, the importance of wellness itself is unequivocal (e.g., Lawson & Myers, 2011), resulting in a heightened focus on wellness within supervision. This intensifying emphasis has given rise to a number of articles examining the way that wellness and the supervisory working alliance intersect. For example, recent studies (summarized in Appendix A) have examined the interaction between coping strategies/wellness and supervisory relationships (Gnilka et al., 2012; Storlie & Smith, 2012; Ohrt et al., 2015). Further, Lenz et al. (2014) and Thompson, Frick, & Trice-Black (2011) utilized qualitative studies to understand how supervisors use supervision as a way to teach wellness and self-care to counseling trainees (summary in Appendix A). As several of these studies describe seminal findings in the area of interest, each will be discussed in some detail.
Gnilka and colleagues (2012) utilized a quantitative approach to determine if and how stress and coping resources might be predictive of an effective supervisory working alliance. The authors determined that caseload, time in supervision, perceived stress and coping resources could explain 15.4% of the variance in supervisory working alliance. Specifically, supervises with high levels of specific coping skills and lower perceived stress were likely to have a stronger supervisory working alliance with their supervisors. This finding is important for wellness researchers since the concept of perceived stress and the associated coping mechanisms are similar to current models of wellness. While showing a connection between supervisory working alliances and coping/stress factors, the variance explained by the model was largely attributable to caseload and supervision factors. Further, their analysis was cross-sectional, and could not show that a direct improvement in coping strategies/decrease in stress would create stronger supervisory working alliances.

Storlie and Smith (2012) sought to address this issue by utilizing a longitudinal study employing before-and-after assessments of a wellness intervention to determine whether wellness increases would correspond with increases in the supervisory working alliance. The authors compared those scores against a control group to ascertain the effectiveness of the wellness intervention for supervisees. Analyzing differences between groups and pre/post intervention scores, Storlie and Smith (2012) determined that the experimental group showed a significant increase in wellness. In contrast, the control group’s change in wellness scores lacked statistical significance, despite increasing slightly. Additionally, the authors reported that ratings for the supervisory working alliance did not change significantly over time: some dropped very slightly while others remain constant. In conclusion, Storlie and Smith (2012) indicated that utilizing wellness interventions in supervision can increase the wellness of supervisees, but may
not have the desired effect of increasing the supervisory working alliance as they had anticipated. In terms of this study’s limitations, concerns regarding sample size and power limit the generalizability of findings. Further, additional concerns pertain to some of the standardization and normative features of the instrument selected to measure the supervisory working alliance—particularly regarding its use with university supervisors. For instance, if the supervisees’ ratings of their supervisors were initially very high, higher ratings at the post-test may have been unlikely. Therefore, the lack of increase in the supervisory working alliance may be attributable to limitations in the instrumentation.

Similarly to previous studies, Ohrt and colleagues (2015) examined the effects of a wellness intervention within group supervision on supervisee wellness and burnout. They utilized a pre/post test design, and analyzed differences between treatment and control groups (Ohrt et al., 2015). In contrast to Storlie and Smith’s (2012) findings the research team discovered no significant change in wellness amongst trainees (Ohrt et al., 2015). One key difference between the two studies was the role of the individual providing the wellness intervention. In the study by Ohrt et al. (2015) the intervention was provided by an outsider who was not part of the supervisory relationship, whereas the intervention in Storlie and Smith (2012) was provided within the supervisory relationship.

While the three aforementioned studies differed in their structure (longitudinal and cross-sectional) and findings, they were similar in that none of them investigated the interaction between supervisor wellness and the wellness of the supervisees. Specifically, Gnilka et al.’s (2012) investigation found that supervisee perceived stress/use of coping resources predicted a very small portion of the variance in the supervisory working alliance, while Storlie and Smith’s (2012) found that increased supervisee wellness did not effect the supervisory working alliance,
despite finding that supervisee wellness can be increased by wellness interventions within supervision. Further, Ohrt et al. (2015) found that interventions provided outside of the supervisory relationship did not catalyze an increase in wellness. The combination of these findings indicate that wellness may have a small effect or no effect on the supervisory relationship, we do not know if the strength of the supervisory relationship has an impact on how wellness is taught and/or modeled in supervision. In addition, these findings indicate that interventions provided within the supervisory relationship by the supervisor may be more effective than one-time interventions provided by an outsider. These factors highlight how actions taken (both intentionally and unintentionally) by supervisors to promote wellness amongst their supervisees is an area for continued investigation.

Recently, new models of supervision have been developed that place an intentional focus on promoting the supervisee wellness (Lenz & Smith, 2010; Blount & Mullen, 2015). Important to this investigation is the Wellness Model of Supervision proposed by Lenz and Smith (2010), which provides a new way of conceptualizing supervision. Based on wellness models for clinical care that focus on education, assessment, planning, and evaluation, the Wellness Model of Supervision is grounded in four guiding tenets: (a) Counselors-in-training (CITs) should be assessed regularly in terms of their wellness; (b) the practice of using self-selected wellness objectives should be incorporated into formal planning and evaluation activities; (c) CITs must identify “wellness domains” that are likely to have a positive impact on their development; and (d) supervisors should be mindful of the parallel process (between supervisor and CIT and between CIT and clients) in promoting a supervisory working alliance that incorporates a focus on wellness (Lenz, Sangganjanavanich, Balkin, Oliver, & Smith, 2012). In short, the structure of the Wellness Model of Supervision centers on teaching wellness theory and integrating wellness
into early clinical experiences. Both of these strategies speak to two of the three sources of knowledge described by Bernard and Goodyear (2014)—namely, theory/research and practice/experience—with the expectation that increases in knowledge and experience will increase one’s sense of self. Early qualitative feedback regarding the model has been largely positive, with participants in a recent qualitative study lauding the benefits of this approach in promoting wellness amongst supervisees (Lenz et al. 2014), which is detailed below.

Utilizing a qualitative case study design to better understand how the Wellness Model of Supervision was perceived in practice, Lenz et al. (2014) interviewed four counselor education interns whose supervisor had utilized the Wellness Model of Supervision. Interview data was assessed and categorized via qualitative coding. Results indicated that when wellness was incorporated as a guiding supervisory concept, CITs had a strong understanding of the counseling profession and their role in it, and a strong commitment to wellness and self-care, both for themselves and for their clients (Lenz et al., 2014).

Some inherent flaws in this study must be acknowledged—most notably the use of the primary researcher as both the supervisor utilizing the Wellness Model of Supervision and the research team’s interviewer. This dual role could have limited the amount of negative feedback from CITs about the model and the researcher’s objectivity in analysis. Furthermore, because there was only one supervisor for the CIT participants in this study, it is difficult to state with complete certainty whether the Wellness Model of Supervision or the personal influence of this one supervisor had a greater role in promoting the importance of wellness in the supervisory working alliance. In other words, could the approach be effective when used by others or was it a supervisor’s ability to model the importance and benefits of wellness that was effective? And
Indeed, some direct quotes from CITs indicate that the influence of role modeling was of paramount importance in communicating the value and importance of wellness.

Corresponding with Lenz et al.’s (2014) findings is Thompson, Frick and Trice-Black’s (2011) qualitative study. In this qualitative analysis regarding trainees understanding of self-care, burnout, and supervision, supervisees highlighted the value of the supervisor directly addressing self-care and wellness within supervision (Thompson et al., 2011). Supervisees described the value of supervisor modeling strong self-care practices, both with supervisors who addressed supervisee self-care and burnout directly and those who did not. This description of the importance of supervisor modeling is consistent with the descriptions provided by Lenz et al. (2014), and indicates that the concept of perceived supervisor wellness merits further examination.

While these qualitative studies do not provide direct evidence of the effectiveness of modeling wellness in supervision. They do suggest continued inquiry is important. There is general agreement that supervision is a critical pedagogical strategy in training novice clinicians (Bernard & Goodyear, 2014). However, questions remain about how supervisor wellness influences supervisee wellness and if the strength of the supervisory working alliance impacts the degree to which supervisees are influenced by their perception of their supervisor’s wellness related behavior.

Purpose of the Study

It is widely accepted that wellness plays a pivotal role in training counseling professionals. Supervisee education on wellness related matters are increasingly important to ensuring successful careers of mental health professionals. Given the critical importance of supervision in the development of supervisees, more empirical information is needed about the
ways that wellness and clinical supervision intersect — especially since current research has revealed conflicting results. On the one hand, Gnilka et al. (2012) reported that supervisee perception of stress and coping resources can be effective in predicting small amounts of variance in the supervisory working alliance. On the other hand, Storlie and Smith (2012) found that increasing wellness amongst supervisees within supervision is possible, but had a negligible effect on the supervisory working alliance (Storlie & Smith, 2012). Ohrt et al.’s (2015) findings contrast Storlie and Smith’s in that their wellness intervention did not improve supervisee wellness. This contradiction between the two studies is largely due to the structure of the interventions provided (by a supervisor vs. outsider to the supervisory relationship), and the function of the supervisory relationship. This difference in methodology, along with their difference in findings, indicates that the supervisory relationship is important in the transmission of wellness beliefs and behaviors between supervisors and supervisees.

Newer models have been developed that focus more on communicating the various aspects of holistic wellness to supervisees during supervision—mostly notably Lenz and Smith’s (2010) Wellness Model of Supervision. However, limitations in the research methodology of Lenz et al.’s (2014) resulted in inconclusive evidence of the effectiveness of the model, but did highlight interesting findings about supervisors modeling wellness/self-care. These findings regarding the importance of modeling wellness by the supervisor have been reiterated in the findings provided by Thompson et al., (2011).

Researchers have recognized the value of the supervisory relationship in developing and imparting professional behaviors and attitudes to their supervisees (Bordin, 1983; Friedlander et al., 1989). Utilizing supervisor modeling is a potentially powerful way to convey messages about professional identity and wellness that fits both with general learning theories and the
specific concerns regarding parallel process in supervision. Thus the purpose of this quantitative investigation is to analyze the role of modeled wellness as a way for supervisors to influence multifaceted aspects of supervisee wellness, and identify if the factoring in the supervisory relationship changes this influence. In short, does a supervisor’s level of wellness, have an effect on the supervisee’s own wellness?

**Research Questions**

Given the importance of wellness to the counseling profession, it is essential that we better understand how supervisor wellness relates to supervisee wellness in the supervisory relationship. Therefore, two research questions (and their sub-questions) guided this investigation:

- **Research Question 1 (RQ1):** What is the influence of a supervisee’s perception of their supervisor’s level of wellness on their own wellness?
  
  RQ1a: How does the inclusion of the strength of the supervisory relationship as a predictor change this model?

- **Research Question 2 (RQ2):** What is the influence of a supervisee’s perception of specific second-order factors of supervisor wellness (Creative Self, Coping Self, Social Self, Essential Self, Physical Self) on the corresponding factor of their own wellness?
  
  RQ2a: How does the inclusion of the strength of the supervisory relationship as a predictor change these models?

**Key Terms**

*Clinical Supervision:* The process by which a more senior member of a clinical profession oversees the training of a more junior colleague or colleagues. “This relationship is evaluative and hierarchical, extends over time, and has the simultaneous purposes of enhancing
the professional functioning of the junior person(s), monitoring the quality of professional services offered to the clients she, he, or they see, and serving as a gatekeeper for the particular profession the supervisee seeks to enter” (Falender & Shafranske, 2004, p. 9).

**Wellness:** The integration and balance of physical, emotional, cognitive, and spiritual aspects of the self for improved functioning; importantly, it extends beyond the absence of illness to include an enthusiasm for living (Myers & Sweeney, 2004).

**Supervisory Relationship:** Originally conceptualized as the Supervisory Working Alliance, it is the relationship between supervisees and their supervisors in which they focus on bonds, goals, and tasks for supervision (Bordin, 1983). The professional bond between supervisor/supervisee is particularly highlighted due to (a) the important nature of the relationship, and (b) the potential disruptions due to the evaluative nature of the relationship (Bordin, 1983).

**Supervisees:** Practicing counselors who have not yet attained professional licensure, or students enrolled in counselor education programs who have yet to begin their clinical internships. The term “counselor-in-training” or CIT is used interchangeably herein.

**Overview of Method**

This study will be undertaken as a cross-sectional quantitative analysis. Participant data for this study will be obtained via paper and pencil survey provided to approximately 200 counselors-in-training at universities win the United States. The instruments to be used for this investigation include (a) a validated wellness self-assessment, (b) a questionnaire regarding supervisee perceptions of their supervisor’s wellness, (c) an instrument measuring the supervisory working alliance, and (d) a demographic questionnaire. Once collected, data will be analyzed by linear regression analysis to determine if and to what degree a supervisee’s
perception supervisor wellness can predict the wellness of the emergent counselor. Additionally, wellness subscales will be analyzed to see if different aspects of wellness are more predictive than others. Further, data will be clustered according to strength of the supervisory relationship to analyze whether that has any effect on the differences between perception of supervisor wellness and supervisee wellness.

**Document Organization**

This document is organized into five chapters. Chapter One introduces the study and describes the context for this investigation. This chapter also provides the purpose of the study and lists the three research questions that will guide this study. The first chapter also contains important term definitions, a methodology overview, and a brief discussion of the limitations of the study. Chapter Two, the review of literature, assesses the recent scholarship associated with wellness and supervision, as well as describes the theoretical foundations for this investigation. Chapter Three focuses on the methodology I will use to conduct this investigation, including data collection methods and data analysis procedures. In Chapter Four, I will highlight the results and data attained from the survey materials, including a breakdown of demographic information, and results from the targeted analysis of the three research questions. In Chapter Five I will discuss the findings from the survey, and discuss the implications of the results as they relate to the three research questions, as well as highlighting limitations of the findings and avenues for future research.
CHAPTER TWO:

LITERATURE REVIEW

Introduction

The concept of wellness has been linked to the field of counseling and development for more than half a century (Myers, 1991). As such, there is a significant body of scholarship that emphasizes the importance of physical, spiritual, and emotional wellness as a guiding paradigm in counseling. What is less well understood, however, is how these messages are communicated to student trainees and early career professionals. The use of the supervisory relationship is one such way to communicate the value of wellness. Indeed, supervision has been identified as a pivotal strategy for teaching and education amongst the helping professions (Bernard & Goodyear, 2014), and the emphasis on wellness within supervision has gained more attention over the past ten years (i.e., Blount & Mullen, 2015; Cummins et al., 2007; Lenz et al., 2012; Lenz et al., 2014; Ohrt et al., 2015; Storlie & Smith, 2012). One intriguing aspect of this relationship is the effect the supervisory relationship has on supervisee wellness (i.e., Storlie & Smith, 2012)—specifically, how structured supervision methods can affect supervisee wellness. However, while viable models for enhancing this impact have been described, they only address the model that the supervisor presents tangentially (Lenz et al., 2012; Lenz et al., 2014). Thus, the purpose of this quantitative investigation was to (a) analyze the role of modeled wellness as a way for supervisors to influence the multifaceted aspects of supervisee wellness, and (b) identify if the factoring in the supervisory relationship changes this influence.
Context for the Study

Wellness Paradigm in Counseling

The wellness paradigm has played an instrumental role in the development of counselor education and provides a framework by which counselors have established a unique counselor identity that separates them from other mental health professions (Myers, 1991). Myers (1991) defined wellness as more than the mere absence of illness, but as an expansive enthusiasm and excitement for living. Even before the wellness paradigm was formally acknowledged by professional agencies and organizations in the counseling field, aspects of wellness played an integral role in the development of counselor identity and tradition (Myers, 1991). The concept of wellness has since become integral to the very definition of counseling as provided by the American Counseling Association: “a professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, educational and career goals” (ACA, 2014, 3). With counseling’s longstanding identity and practice linked to wellness, there has been a groundswell in research regarding its effects on the counseling relationship, and ways to promote wellness in both clients and counselors alike (Myers & Sweeney, 2008).

Wellness models, strategies, and assessments have begun to take root in the counseling field. One of the more recognizable models of wellness is the Wheel of Wellness (Myers, Sweeney, & Witmer, 2000) and its corresponding assessment tool, the Wellness Evaluation of Lifestyle (WEL) (Myers, Sweeney, & Witmer, 1998), which was designed to quantify the various wellness components included in the wheel. The Wheel of Wellness, which is based on Adlerian theory with a focus on holism (Myers, Sweeney, & Witmer, 2000), provides a strong foundation for wellness conceptualization and research. Similarly, the Wellness Evaluation of Lifestyle was developed by the authors to assess the five life tasks and subtasks of the wheel.
Although useful for helping to guide clients in making healthy lifestyle choices, the WEL lacked the ability to document the evidence-based cumulative effects of the various aspects of wellness (Hattie, Myers, & Sweeney, 2004).

Stemming from the Wheel of Wellness, Myers and Sweeney (2004) proposed the Indivisible Self: Model of Wellness, which includes five second-order factors that load onto one first-order factor called total wellness. The five second-order factors are further separated into seventeen third-order factors: the essential self is comprised of spirituality, self-care, gender identity, and cultural identity, the creative self is comprised of thinking, emotions, control, positive humor, and work, the coping self is comprised of realistic beliefs, stress management, self-worth, and leisure, the social self is comprised of friendship and love, and the physical self is comprised of exercise and nutrition (Myers & Sweeney, 2004). From this model, the researchers developed a user-friendly instrument known as Five Factor Wellness Inventory (Myers & Sweeney, 2004). A chart of second-order factors and corresponding third order factors (with definitions) are displayed in Appendix B.

With the development and subsequent validation of these various models and instruments, research examining wellness in counseling continued to expand—particularly with respect to various populations such as children/adolescents, undergraduate students (including those in military schools), adults across the lifespan, different ethnic groups (including Native Americans, Korean Americans, African Americans, and Caribbean Americans), LGB populations, and clinical populations (Myers & Sweeney, 2008).

Although the focus of the wellness paradigm in counseling started out as a way to help society and the clients that counselors serve, a new focus developed as counselor impairment became increasingly problematic in the counseling community (Sheffield, 1998). Counselor
impairment, defined as “a condition that compromises and reduces the quality of counseling received by clients” (Sheffield, 1998, p. 97), has been a concern both to counselors and counselor educators. Indeed, the American Counseling Association Code of Ethics (ACA) includes directives for ensuring the health of practitioners: “Counselors [should] monitor themselves for signs of impairment from their own physical, mental, or emotional problems and refrain from offering or providing professional services when impaired” (2014, p. 9). ACA continues to encourage counselors to seek assistance and refrain from providing services until the impairment is addressed.

This increasing concern about counselor impairment further emphasized the need to incorporate the wellness paradigm as a prevention/intervention measure (Hendricks, Bradley, Brogan, & Brogan, 2009; Lawson et al., 2007; Lawson, 2007; Sheffield, 1996). This emphasis on impairment prevention led to a focus on not only how counselors take care of themselves, but also to how their wellness practices are developed in educational settings. For example, Myers, Mobley, and Booth (2003) investigated the influence of a formalized wellness focus in counselor education programs (study summary included in Appendix A).

Utilizing a database of 3043 responses to the Wellness Evaluation of Lifestyle, they examined the 262 responses from graduate students (both master’s and doctoral candidates) in counseling programs, which were primarily female (70%), and primarily Caucasian (74%); the mean age of respondents was about 33 years with a standard deviation of 13.08. Myers and coworkers (2003) then utilized t-tests to understand differences between the overall respondent population (n = 3043) and the sample of graduate students (n = 262). Their aim was to understand the overall wellness of counselors in training, how that compared to the general
population, as well as if there were significant differences due to gender, ethnicity, and graduate student status.

In comparison to the norm for all respondents of the Wellness Evaluation of Lifestyle instrument, Myers et al. (2003) reported that entry-level master’s students did not display significantly higher total wellness scores, but did have higher wellness results in certain subscales, including sense of control, work, gender identity, friendship and love—all of which demonstrated a small effect size. In contrast, doctoral students demonstrated significantly higher total wellness results in comparison to both the entire sample and the master’s students, with a medium effect size (Myers et al., 2003). Further, specific groups scored significantly higher on certain wellness subscales (e.g., women on gender identity, and non-Caucasian on cultural identity) than others.

Although the Myers et al. (2003) study represents a seminal study in understanding wellness in counselor education programs, it is not without its limitations. Indeed, the researchers pointed out how norm scores from the WEL can be misleading since the focus of wellness is “optimal functioning,” but that the use of a norm group may not be an appropriate comparison when the comparative group is students invested in the promotion of wellness. Additionally, Wellness Evaluation of Lifestyle scale is somewhat outdated; thus, the Five Factor Wellness Inventory could provide a stronger assessment of in-group differences between counselor education students.

Despite these drawbacks, the findings reported by Myers et al. (2003) have been pivotal for researchers of wellness in counselor education programs—not only because they provide a baseline for understanding counseling student wellness, but also because they highlight the discrepancy between master’s students early in their professional identity development, and
doctoral students later in their careers. As such, this discrepancy examined in the proposed study as results will provide more information regarding the development of wellness in aspiring counselors. Of particular importance is what factors account for this change in wellness between the two cohorts (Ph.D. and Master’s students) as they progress through counselor education programs? Myers et al. (2003) only indicated correlation and expressed how further study regarding the change in students’ wellness is merited. Specifically, it is important to consider whether the incorporation of a wellness paradigm in the development of the professional identity of a counselor can account for any of this change.

Roach and Young (2007) examined this issue in their cross-sectional study of whether master’s students in counselor education programs reported higher levels of wellness at the end of their educational programs in comparison to analogous assessments obtained earlier in their programs (study summary included in Appendix A). The researchers utilized a cross-sectional quantitative design using the Five Factor Wellness Inventory (Myers & Sweeney, 2004) and a demographic questionnaire. Sample results obtained from a total of 204 students were drawn at three different points in their counseling career: 86 beginning students (those with less than 12 credit hours), 52 middle students (18-30 credit hours), and 66 students at an endpoint (45-60 credit hours). The sample was largely comprised of Caucasians (approximately 61%) and was predominantly female (approximately 86%); ages ranged from 21 to 58 years of age with a mean of 31.36 years with a standard deviation of 9.23. Importantly, the demographic questionnaire included questions regarding whether the students’ programs provided a wellness course (48% did), as well as whether the programs mandated personal counseling (62% did).

The researchers utilized multivariate analysis of variance (MANOVA) to determine trends, but were unable to identify any significant increase or decrease in wellness levels among
the three groups (Roach & Young, 2007). Additionally, ANOVA results indicated no significant differences in wellness levels among students whose programs mandated personal counseling. Conversely, Roach and Young (2007) did identify a significant change in wellness when they analyzed respondents according to both the amount of time they had been counseling students and the availability of a wellness course. However, they found that the course offering only accounted for a small (4%) proportion of the variance for wellness scores between groups at the beginning, middle, and end of the program.

It must be noted that the Roach and Young (2007) study was limited in that it featured a cross-sectional design, and the same participants were not tested at different points in their counseling programs. Because of this limitation, findings can only be discussed as program-related trends rather than as an indication of a direct progression of wellness in participants. Further, the researchers’ choice of study design meant that they were unable to take into account other contextual variables. For instance, students at the end of their program of study might have been feeling stress related to completing their degree (i.e., preparing for a comprehensive exam), or fearful anticipation about starting their careers. In contrast, students at the beginning of their studies might be optimistic and excited about starting their counselor education programs. Such contextual variables could have skewed the scores of the Five Factor Wellness Inventory.

Despite these limitations, Roach and Young’s (2007) research has direct implications for the study proposed herein, which pertains to the promotion of wellness amongst counselors in training. Despite the fact that the researchers indicated that there are ways to promote wellness amongst trainees—as evidenced by their findings related to the use of a wellness class—such an intervention did not seem to have as significant impact as perhaps was initially intended. Similarly, while it might seem logical to make personal counseling mandatory for trainees with
the expectation that it would help them develop greater self-insights about the importance of wellness, quantitative outcomes may not demonstrated the desired wellness effect. These two examples indicate that while it is desirable and possible to increase emergent counselor wellness, the strategies for reaching that goal may not be intuitive.

In this vein, researchers have proposed different strategies to develop wellness in counselor education programs, schools, and mental health agencies (Yager & Tovar-Blank, 2007: Young & Lambie, 2007). Yager and Tovar-Blank (2007) suggested a number of strategies for counselor education programs to stress the importance of wellness training, including directly introducing wellness, associating wellness with self-growth/awareness, modeling wellness for students, highlighting that perfection is not the goal, presenting wellness as a life-long commitment, encouraging personal counseling, focusing on the role of wellness in ethical behavior, promoting wellness in all courses, being creative in reinforcing wellness, and exposing students to humanistic ideals. Some of these recommendations have been investigated directly—for example Roach and Young’s (2007) study of personal counseling and the direct introduction of wellness (such as a wellness course)—while others have only been researched tangentially. For example, a recent study by Lawson and Myers (2011) analyzed value of a life-long commitment to wellness (study summary in Appendix A).

Lawson and Myers (2011) sought to better understand (a) levels of counselor wellness, (b) professional quality of life, and (c) career sustaining behaviors by comparing and contrasting the relationships between each construct with respect to other allied professions. To do so, the researchers used a tailored design method that targeted 1000 American Counseling Association members, with 506 members completing the survey. Their sample was primarily female (which was consistent with the gender balance in the field), and primarily Caucasian (89%, also
consistent with the field), with a mean age of 49 years old ($SD=11.1$). Their sample included multiple counseling settings and counselors with varying levels of education. Lawson and Myers’ (2011) non-linear, quantitative investigation utilized an observational (non-experimental) cross-sectional design. Their survey utilized validated scales—namely, the Five Factor Wellness Inventory (Myers & Sweeney, 2004), the Professional Quality of Life Scale (Stamm, 2005) and the Career Sustaining Behavior Questionnaire (Stevanovic & Rupert, 2004) (Lawson & Myers, 2011). The Professional Quality of Life Scale measures burnout (chronic decreased enjoyment and self efficacy), acute compassion fatigue (a reduced ability to work with clients), and compassion satisfaction (deriving pleasure from their work) (Lawson & Myers, 2011). The Career Sustaining Behavior Questionnaire (Stevanovic & Rupert, 2004) was designed to measure the personal and professional behaviors that individuals use to help them remain engaged in their work experiences. In this study, it was utilized to determine the differences in any career-sustaining behaviors in which counselors engage in comparison to their counterparts in other allied professions (Lawson & Myers, 2011). Their interpretation of the results utilized ANOVA and t-tests to understand the differences in means and the interactions between variables.

The researchers found that mean scores for every second-order factor on the Five Factor Wellness Inventory was significantly higher in the counselors who contributed to this study in comparison to the norm group, which included adults from various disciplines. Lawson and Myers (2011) also listed a number of career-sustaining behaviors in which counselors are most likely to engage: spending time with family, maintaining a sense of humor, maintaining balance in personal/professional lives, and maintaining self awareness. The researchers also noted that caseload variables such as level of risk and trauma tended to negatively affect counselor wellness and quality of life. Although the various findings reported by Lawson and Myers (2011) merit
further investigation, the outcome that holds the most bearing to the proposed study is the interaction between wellness and professional quality of life. Specifically, the researchers found that higher total wellness correlated with higher compassion satisfaction ($r = .57, p < .001, r^2 = .32$), and negatively correlated with burnout ($r = .58, p < .001, r^2 = .34$) and compassion fatigue ($r = .37, p < .001, r^2 = .14$) (Lawson & Myers, 2011). With this finding, they demonstrated the importance of counselor wellness as a lifelong practice. Not only can it provide a preventative measure against burnout and fatigue, but it also helps counselors increase their compassion satisfaction.

The Lawson and Myers (2011) study is limited in the sense that while it is clear that overall wellness levels and professional quality of life are linked, the direction of the relationship is unclear. In other words, it is unclear if those who are happier with their job are better able to shift their focus to other aspects of wellness and self care, or if increased wellness results in higher job satisfaction/performance. Further, while they established a baseline among American Counseling Association members, their sample was not solely comprised of counselors in training. Nonetheless, the scholarly contribution of Lawson and Myers (2011) is directly linked to the proposed study in the sense that it highlights the benefits of wellness to counselors. Additionally, they reiterated recommendations by Yager and Tovar-Blank (2007) that wellness is an important career/lifelong goal for counselors.

Yager and Tovar-Blank (2007) asserted that counselor wellness should be viewed holistically, and that the most effective practitioners will purposefully work to promote their personal wellness. The researchers provided a list of 10 specific directives to promote a philosophy of wellness in counselor education programs. While some of their recommendations have been confirmed and some refuted by published research, others have yet to be examined—specifically how wellness is modeled. As such, the concept of modeling wellness is of particular
interest for the current investigation. As discussed earlier, contemporary models of wellness
focus on holism (Myers, 2004). Someone who is “holistically well” would demonstrate this
wellness in multiple ways—including, but limited to, dealing with academic stressors, interacting
in formal and informal settings (with students, coworkers, superiors, etc.), demonstrating ethical
behavior, displaying positive attitudes/humor, and promoting appropriate educational practices.
The wellness status of a role model (a counseling supervisor) would be seen in a variety of ways
and in numerous settings. It is in this broad exposure that students have with their professors
and supervisors where learning takes place, learning from the attitudes and behaviors, which the
leaders in their program model desirable behaviors, which is in accordance with Social Learning
Theory (Bandura, 1977).

The Role of Social Learning Theory

Learning from modeled behavior has been an accepted theory in social sciences. Forty
years ago, Albert Bandura (1977) published his seminal work describing Social Learning
Theory, in which he asserted that “modeling is an indispensable aspect of learning” (p. 12-13),
and that “some complex behaviors can be only produced through the aid of modeling” (p. 12).
Bandura (1977) also argued that learning by observation allows humans to gain an understanding
of the value of complex behaviors in a much shorter amount of time in comparison to having to
engage in the trial-and-error of direct experience. This assertion would appear to hold true in our
understanding of how to effectively promote wellness in counselor education programs.
Recalling the mixed results from Roach and Young (2007) who reported that scores from
students who were engaged in a wellness course were only moderately correlated with increased
wellness scores over the course of a program, and interventions such as mandated personal
counseling seemed to have no effect over the same abbreviated time frame. However, neither of
these factors included the role of developing wellness as a result of on-the-job modeling from a supervisor. Using Bandura’s (1977) theory, modeling by a leader within an academic program or in a training situation would be critical to having students understand and master complex wellness attitudes and behaviors in the short time frame provided in an educational program.

There are numerous sources of modeled behavior within a typical counselor education program. Students will be exposed to core faculty members, non-core faculty members (adjunct or affiliate faculty members), and other students with different levels of experience (i.e., more experienced doctoral students) (Council for Accreditation of Counseling and Related Educational Programs, 2015). This study, however, will focus on the one fundamental component that provides a frequent and powerful role model: the supervisor.

**Supervision as the Signature Pedagogy**

Borders et al. (2014) highlighted the ongoing improvement of supervision practices as a key strategy for providing the field with its “biggest dividend” in educating counselors (p. 29). The researchers stressed that supervision is essential in connecting education concepts presented in educational programs and the use of those concepts in practical experience. Furthermore, the ACA (2014) argues that it is the role of the supervisor to impart “professional and ethical standards” to their supervisees (p. 13). The assimilation and accommodation of these standards is vital in supervision, and it is incumbent upon the supervisor to provide the environment and guidance to make this possible.

**Supervisory Relationships**

Early conceptualizations of the supervisory relationship have been largely based on conceptualizations of the counselor-client relationship (Bordin, 1983). Bordin (1983) described the supervisory relationship as similar to the therapeutic relationship, but highlighted how there
are differences in goals between the two. For example, the supervisory relationship differs in that supervisors have to provide feedback to supervisees regarding their skills, which is a dimension that is not present in therapeutic relationships. Due to this discrepancy, Bordin (1983) stated that the role of the supervisor is somewhere between teacher and therapist. He went on to so that, similar to a coach, demonstrating one’s skills and perspectives is important when conveying information to the supervisee.

The way(s) that supervisors demonstrate behavior and attitudes to their supervisees represents a key aspect to supervision—and one of particular importance when working with parallel processes in supervision. The term parallel process is defined as the manner “whereby trainees unconsciously present themselves to supervisors as clients have presented to them” (Friedlander et al., 1989, p. 149). Friedlander et al. (1989) posited that this parallel process in the supervisory relationship does not end until the supervisee “adopts attitudes and behaviors of the supervisor” in dealing with the client (p. 149). This concept highlights not only the potential power of the supervisory relationship to the supervisee, but how the supervisory relationship affects the services delivered to the client as well.

The notion of the parallel process has been widely investigated in the literature. For example, Patton and Kivilghan (1997) described a strong positive relationship between client ratings of the therapeutic working alliance, and the supervisee’s rating of the supervisory working alliance. Moreover, the relationship between supervisor and supervisee shows similarities with the types of relationships that are later established between counselor and client (Patton & Kivilghan, 1997). This finding has tremendous implications for the field and reinforces the importance on how supervisors relate to and train their supervisees.
As the value of strong supervision has become more apparent, best practices for individuals who provide supervision are being developed and scrutinized (Borders et al., 2014), including a renewed focus on the development and maintenance of the supervisory relationship. For example, Borders et al. (2014) stresses that the supervisor “appropriately engages in and models self-care” (p. 39). This statement indicates that not only is it important for supervisors to consider their own wellbeing as part of ethical supervision practices, but they should also display appropriate self-care/wellness attitudes and behaviors to their supervisees.

Wellness and clinical supervision are two constructs that are vital to counselor education and counselor identity. While wellness has long been considered a paradigm for counseling (Myers et al., 2008), clinical supervision is increasingly being viewed as the field’s signature pedagogy (Bernard & Goodyear, 2014). Given these joint emphases, it is important to understand how wellness is learned/taught within supervision for the development of appropriate practices and prevention of impairment. The American Counseling Association (2014) has also stressed that supervisors must “make their supervisees aware of professional and ethical standards and legal responsibilities” (ACA, 2014, p. 13). This pushes the burden of conveying appropriate wellness practices and beliefs to the supervisor even more. Although various researchers have alluded to the role of modeling wellness and professional behavior (e.g., Yager & Tovar-Blank, 2008; Borders et al., 2014), it has yet to be studied directly. Thus, the purpose of this quantitative investigation was to (a) analyze the role of modeled wellness as a way for supervisors to influence the multifaceted aspects of supervisee wellness, and (b) identify if the factoring in the supervisory relationship changes this influence.
Statement of the Problem

The Nature of Wellness in Supervision

Consistent with Social Learning Theory, supervisor attitudes and behaviors are important to the development of the supervisee (i.e., Borders et al., 2014; Friedlander et al., 1989; Bordin, 1983). Indeed, scholars have linked supervisor attitudes and behaviors—including attachment styles (White & Queener, 2003), supervisory style (Chen & Bernstein, 2000), and expert use of power (Schultz, Osokie, Fried, Nelson, & Bardos, 2002)—to the strength of the supervisory relationship. While wellness and coping strategies of supervisees and their effect on the supervisory relationship have been studied (i.e., Storlie & Smith, 2012; Gnilka et al., 2012), results have been inconclusive due to limitations or delimitations of those studies. The principal hindrance pertains to more fully conceptualizing the relationship between wellness and the supervisory relationship. Although two recent studies (Storlie & Smith, 2012; Gnilka et al., 2012) have attempted to address this scholarly deficit, both treat the supervisory working alliance as an outcome of increased wellness or coping strategies, rather than examining the converse relationship—namely, the supervisory relationship as an avenue for the transmission of wellness principles from supervisor to supervisee.

Given the importance of wellness to the counseling profession, it is essential that we investigate the following questions: (RQ1) What is the influence of a supervisee’s perception of their supervisor’s level of wellness on their own wellness? (RQ1a) How does the inclusion of the strength of the supervisory relationship as a predictor change this model? (RQ2) What is the influence of a supervisee’s perception of specific second-order factors of supervisor wellness (Creative Self, Coping Self, Social Self, Essential Self, Physical Self) on the corresponding
factor of their own wellness? (RQ2a) How does the inclusion of the strength of the supervisory relationship as a predictor change these models?

Gnilka et al. (2012) explored the relationship between perceived stress levels, coping strategies, and both the working alliance (i.e., between patient and provider) and supervisory working alliance (summarized in Appendix A). Their research questions focused on the relationships between the constructs, and if perceived stress levels and coping strategies were predictive of either or both alliances. It should be noted that their study was non-experimental (i.e., there was no treatment or control group) and focused on relationships between multiple constructs similar to wellness, rather than targeting the wellness relationships within the supervisory relationship, as this study is intended to undertake.

The researchers utilized direct email to solicit participation from known counselor education faculty (requesting they forward the survey to their students) and students themselves (Gnilka et al., 2012), as well as snowball sampling techniques to widen the pool of participants. Gnilka et al.’s (2012) final sample of 232 supervisees were enrolled in a master’s-level counseling program (200 women, 30 men, 2 transgender), and ranged in age from 22 to 66 years of age. Supervisees primarily identified as Caucasian (78%), with the remainder identifying as follows: 10.8% African American/Black, 5.2% multiracial, 3.4% Hispanic, and 2.6% Asian/Pacific Islander. The sample primarily identified as heterosexual (89.2%), with about 3.9% self-identifying as lesbian, 3.0% as gay, 2.2% as bisexual, 0.4% as queer, and 0.8% of participants choosing to not identify. The sample contained master’s students in a variety of internship settings: community mental health agencies, faith-based agencies, hospitals, private practices, schools, and university/college career centers (Gnilka et al. 2012).
Online survey links provided participants with access to a demographic sheet and four inventories/scales: (a) Working Alliance Inventory - Short Form (WAI-S; Tracey & Kokotovic, 1989); (b) Supervisory Working Alliance Inventory - Trainee Version (SWAI; Efstation, Patton, & Kardash, 1990); (c) Perceived Stress Scale (PSS; Cohen, Kamarck, & Mermelstien, 1983); and (d) Coping Resources Inventory for Stress - Short Form (CRIS-S; Curlette & Matheny, 2010). Using analyses of variance (ANOVAs) and independent t-tests, the research team analyzed demographic questionnaire responses to determine if specific factors (i.e. program details, internship setting, number of hours, etc.) had any significant effect on outcome measures (principally utilizing the SWAI for analysis). Gnilka et al. (2012) determined that both the number of supervision sessions ($r=.19, p<.05$) and the total number of counseling sessions per week ($r=.18, p<.05$) showed a significant correlation with scores for the supervisory working alliance. The connection between number of supervision sessions and supervisory working alliance seems logical (and pertinent to the study at hand), whereas the outcome associated with the number of counseling sessions per supervisee was unexpected. Given this finding, both factors will be included in the demographic questionnaire for the study proposed herein.

To determine if perceived stress and coping resources represented viable predictors for the supervisory working alliance, Gnilka et al. (2012) utilized a “stepwise multiple regression while covarying demographic information” (p. 66). Utilizing this method, the research team entered predictor variables in a blocked fashion, with variables being removed if alpha levels were too high. They developed their equation by first entering the two significant demographic covariates (number of supervision sessions and counseling sessions per week), then input results from the PSS and the CRIS-S. Their model was significant and predicted 15.4% of the variance.
in SWAI scores (F(4,170)=7.73, p<.001) in Perceived Stress (ΔR²=.047, β= -.14, p < .10) and Situational Control (ΔR²=.026, β= .18, p < .025).

There are a number of limitations with this study that must be noted—the first pertaining to their surveying procedures. The researchers’ use of snowball sampling means that response rates cannot be computed, as well as limits the ability to control the demographics of the targeted population. Further, Gnilka et al. (2012) did not provide any description of the graduate programs in which the participants were enrolled (i.e. accreditation status of the program, type of degrees offered, program ranking, etc.). All of these factors limit the generalizability of findings beyond the immediate sample.

In addition to concerns regarding the sampling procedures, the ways that the research team described their results is problematic. Despite the fact that the model employed by Gnilka et al. (2012) did produce statistically significant results—it did describe 15.4% of variance in the supervisory working alliance—it did not display the variance described by the covariates (number of supervision sessions, and number of clients per week). The predictors of interest accounted for small changes in R² – namely, 4.7% for perceived stress and 2.6% for situational control. Additionally, p-values were set to 0.1, creating a lower threshold for considering a finding to be significant. With such little variance in the supervisory working alliance explained by these two predictors, the overall findings lack practical significance.

Finally, despite utilizing a linear regression analysis that treats the supervisory working alliance as an outcome, the research team specifically noted that formulating a directional hypothesis was not possible (Gnilka et al., 2012). This flaw in their methodology, along with their lack of practical findings, supports the conceptualization that the supervisory relationship is
not an outcome of wellness (or stress/coping resources), but rather is a vessel to convey wellness as a part of professional identity.

Although Gnilka et al. (2012) documented relationships between coping strategies, stress, and the supervisory working alliance; they did not directly address the concept of wellness in supervision. Nonetheless, their findings that supervise stress and sense of supervisee control were statistically significant in predicting the strength of the supervisory relationship have implications for the proposed investigation. In other words, developing coping resources and effectively managing supervisee stress appear connected to the supervisory relationship, thereby heightening the need to further investigate the relationship between supervisory relationships and the transmission of wellness between supervisor and supervisee.

Storlie and Smith (2012) conducted a similar investigation, but targeted the effects of a wellness intervention on the supervisory working alliance (study summary in Appendix A). Specifically, the researchers sought to ascertain (a) are wellness interventions effective in supervision, and (b) does a wellness intervention have any impact on the supervisory working alliance? To determine findings, the research team developed a quantitative study using a quasi-experimental between groups repeated measures design (Storlie & Smith, 2012).

In order to recruit participants, Storlie and Smith (2012) contacted regional counselor education programs that offered concurrent practicum/internship classes. Three CACREP-accredited universities were identified as eligible, and participants from a total of eight classes were included in the study. The classes were divided into treatment groups and control groups, with a focus on providing an equal number of practicum and internship students. Storlie and Smith (2012) recruited a total sample of 42 students, who were equally divided (21 each) into the treatment group and the control group. Moreover, 21 students (half) were enrolled in a practicum
setting, while the other 21 were further along in their program and enrolled in an internship course. The treatment group presented with the following demographic breakdown: 20 women, 1 man, 19 Caucasian, 1 Asian, 1 African American, with a mean age of 29 years ($SD=6.34$). The control group identified as follows: 15 women, 6 men, 20 Caucasian, 1 Hispanic, with a mean age of 25.2 ($SD=5.05$). Two-thirds of the participants in the treatment group received both group and individual supervision, while the other third only received group supervision; in contrast, all of the control group received both individual and group supervision (Storlie & Smith, 2012).

In order to obtain baseline measurements of the supervisory working alliance and supervisee wellness, Storlie and Smith (2012) administered the 5F-WEL (Myers & Sweeney, 2004) and the SWAI-Trainee (Efstation et al., 1990) to both groups. After determining those baseline measures, the treatment group was instructed to (a) identify different aspects of wellness on which to work during the semester, (b) develop a wellness plan to follow, and (c) reflect on perceived outcomes during the course of the semester. At the end of the semester, the researchers administered the 5F-WEL and SWAI-Trainee again to the two cohorts to track any changes and analyze the results.

Storlie and Smith (2012) used a one-way ANOVA to analyze changes in mean scores across both groups. They found that the treatment group experienced significant changes in mean scores of wellness—from 82.47 to 84.44 ($F(1,40)=8.51, p<.01$)—while the mean scores for control group increased but were not significant—from 79.38 to 81.23 ($F(1,40)=1.65, p>.05$).

In their analysis of the supervisory working alliance, Storlie and Smith (2012) again used a one-way ANOVA to understand differences between groups; the researchers reported no significant differences between the treatment and control groups on the SWAI-Trainee ($F(1,40)=7.39, p>.05$). Additionally, they documented that the means for supervisory working alliance in the
treatment group decreased from first administration to second administration (6.10 with \(SD=0.7\) to 5.89 with \(SD=0.95\)), while the control group remained stable (6.62 with \(SD=0.55\) to 6.56 with \(SD=0.50\)).

With respect to study limitations, Storlie and Smith (2012) pointed out that small, homogenous sample sizes featuring large between group differences in composition (specifically male/female numbers) can negatively impact both the power and the generalizability of findings. A further concern stems from the manner in which they reported the means from the SWAI-Trainee instrument. Specifically, they stated that the scores ranged “from 19-133”; however, they indicated that mean scores on the instrument ranged from 6.62-5.89. Thus, Storlie & Smith (2012) may have transformed the results for interpretation purposes—but without any descriptive details about their analytical processes, actual results are difficult to discern. One possibility is that their reported means represent the average score for individual items. If this were the case, it would indicate that the samples scored the supervisory working alliance exceedingly high. Such a possibility would make it extremely difficult to determine any significant increase in supervisory relationship scores, as the relationships were extremely strong at the beginning.

Despite concerns regarding the assessment of the supervisory working alliance, the Storlie & Smith (2012) study has significant implications for the study proposed herein. Specifically, their findings imply that it is possible to improve wellness through actions taken during the supervisory relationship. In contrast, their findings indicated that increased supervisee wellness does not affect the supervisory relationship. Nonetheless, their finding that wellness can be improved in supervision supports the conceptualization of the interaction between the two concepts as suggested in the proposed investigation. In short, supervisee wellness should be seen
as an outcome of the supervisory relationship—not as something that is a predictor of the supervisory relationship

Other studies analyzing wellness interventions should also be discussed herein—particularly since they either contradict earlier work or fail to yield significant results. As an example of the former, Ohrt and colleagues (2015) utilized a quasi-experimental pre-posttest design with treatment and control groups to understand the effects of a wellness intervention (study summary in Appendix A). Specifically, the researchers explored how in-group supervision would affect trainee wellness, emotional exhaustion, depersonalization, personal accomplishment, and if wellness subscales corresponded with any or all of these factors.

Ohrt et al. (2015) used purposeful sampling to obtain their participant cohort from one large CACREP-accredited university in the southwestern U.S. A final sample of 88 individuals from 10 internship/practicum classes was divided equally into control and treatment groups. The treatment group consisted of 4 men and 43 women; there were 32 Caucasians, 4 Black/African Americans, 3 Hispanic/Latinos, 4 Asian/Pacific Islanders, 3 multiracial individuals, and 1 identified as “other.” Their ages ranged from 23-53 years and a mean age of 31.2 (no SD given). The control group consisted of 5 men and 36 women; there were 32 Caucasians, 3 Black/African Americans, 1 Hispanic/Latino, 2 Asian/Pacific Islanders, and 3 identified as multiracial. Their ages ranged from 23-59 years, with a mean age of 31.8 years (no SD given).

Both control and treatment groups were provided with pretests and posttests consisting of a demographic questionnaire, the Five Factor Wellness Inventory (Myers & Sweeney, 2004), and the Maslach Burnout Inventory (Maslach & Jackson, 1996), which measures emotional exhaustion (feelings of being over extended), depersonalization (cynical attitudes towards clients), and personal accomplishment (sense of achievement and competence) (Ohrt et al.,
The lead author of the study also delivered a psycho-educational presentation focusing on wellness and burnout for the treatment group during their second group session, during which trainees assessed current wellness and developed a wellness plan for time in supervision (Ohrt et al., 2015). Group supervisors monitored wellness plans throughout the semester, and provided trainees with opportunities to track their progress throughout the semester.

The research team utilized a multivariate analysis of covariance to understand potential group differences between the treatment and control groups. The researchers found no significant differences between the groups on the combination of dependent variables (Wilk’s $\Lambda = .91$, $F(8,79)=.93$, $p=.50$) (Ohrt et al., 2015). However, the research team did identify a significant progression with respect to emotional exhaustion from pretest to post-test for both the treatment group (mean from 15.17 to 19.53, $F(1,46)=9.76$, $p < .003$, partial $\eta^2 = .18$) and the control group (mean from 15.71 to 21.39, $F(1,40)=12.68$, $p < .001$, partial $\eta^2 = .24$ groups), after using a Bonferroni correction with alpha levels set at .005 with large effect size for both. Their findings indicate that experiences in student practicums/internships contributed significantly to supervisees feeling overwhelmed and overextended over the course of the semester. Further, through the use of a Pearson product-moment correlation, the research team discovered that emotional exhaustion was negative correlated with multiple wellness scales (total wellness, creative self, coping self, and social self), as was depersonalization (total wellness, creative self, and social self); in contrast, personal accomplishment was positively correlated with some scales (total wellness, creative self, coping self, and social self) (Ohrt et al., 2015). These correlations fit with the conceptualization of the wellness/burnout continuum as described by Lawson and colleagues (2007).
Although the research team hypothesized that there would be an increase in wellness and a decrease in burnout in the treatment group due to the wellness intervention, Ohrt and colleagues (2015) were unable to detect any significant differences in either wellness or burnout between the two groups. Therefore, their findings imply that wellness interventions may not be as effective in a group setting as they are in individualized one-on-one supervision. To some extent, these findings challenge Storlie and Smith (2012), who had earlier reported increased wellness in a sample of participants where some engaged in group supervision and some engaged in group and individual supervision. Additionally, the increased emotional exhaustion that trainees in the Ohrt et al. (2015) study experienced over the course of the semester is consistent with previous surveys indicating that individuals who experienced more group supervision tended to have higher rates of burnout in comparison to individuals who experienced less group supervision (Lawson, 2007).

There are two principal limitations associated with the Ohrt et al. (2015) study: the study’s sample and the lack of consideration for supervisor variables. First, the participant sample of 88 individuals was from a single academic institution, while close to 90% of the same was female. Thus, results could be generalized to female counseling students and/or to students at a CACREP-accredited university in the southwestern U.S., but findings could not be reliably applied beyond those groups. Second, the fact that an “outsider” provided the wellness/burnout intervention in the supervisory relationship means that this individual did not have a longstanding connection to the group in the supervision setting. Similarly, groups were conducted by a university supervisor, which created a further power differential between participants that may have affected the social desirability of responses, making them less likely to admit to experiencing burnout. These limitations could have resulted in a significant change
in responses, which then could account for discrepancies between the Ohrt et al. (2015) study and findings from Storlie and Smith (2012).

In contrasting the two articles, two primary differences emerge: (a) the role of the person providing the wellness intervention (an outsider to the supervisory relationship versus the supervisor in the supervisory relationship), and (b) the specificity of intervention (group only vs. individual and group). While group interventions in supervision have been described as beneficial (Lambie, 2006), Ohrt et al.’s (2015) results would indicate otherwise. It should also be noted that group supervision features some inherent limitations in comparison to one-on-one supervision—namely, the potential inability to meet the needs of individuals in the group, and potential impediments in the group process (Bernard & Goodyear, 2014). Furthermore, Bernard & Goodyear (2014) pointed out that there “is more limited opportunity for supervisees to learn from the supervisory interventions they observe” due to the group process (p. 183). While the intervention provided by Ohrt et al. (2015) may have been effective for many, it was not provided within the supervisory relationship and any modeled wellness intervention could have been diminished by group dynamics.

**Wellness as an Outcome of Supervision**

While the criticality of a holistic approach to wellness in the counseling relationship has long been known, the importance of wellness as an outcome of supervision is a more recent concept. In support of this relationship, Cummins and colleagues (2007) posited that “dialogue between supervisor and supervisee should be an ongoing and integral part of the wellness plan” (p. 42). Cummins et al. (2007) went on to stress that the focus on the wellness plan is a vital component of supervision that aids in the prevention of counselor impairment. Similarly, Storlie and Smith (2012) documented that supervisee wellness can be improved within clinical
supervision by developing and adhering to a wellness plan. It must be noted, however, that even though Storlie and Smith (2012) expected increased wellness to strengthen the supervisory working alliance, their findings were counter to their original hypothesis. Nonetheless, the results of their study did lend credence to both to older concepts and newer models of supervision that place higher value on increasing supervisee wellness (Lenz & Smith, 2010; Blount & Mullen, 2015).

Recognizing that wellness is a fundamental concept in counselor education, models for supervision have been developed that stress counselor wellness as the central component. One such model is Lenz and Smith’s (2010) Wellness Model of Supervision, which states that given the importance of wellness as a central construct in counseling, it must also be emphasized within the supervisory relationship. Using clinical models of wellness, the researchers transferred the concepts of wellness education, assessment, planning, and evaluation into the supervisory relationship (Lenz & Smith, 2010). For example, they advised that wellness should be explicitly discussed at the start of each supervision session for up to 20 minutes of every supervision hour. Early evidence regarding the effectiveness of the Wellness Model of Supervision in promoting supervisee wellness has been significant, albeit limited.

Lenz and colleagues (2012) took the first steps in providing an empirical analysis of the model by assessing its effectiveness in the development of wellness definitions, personal wellness, and helping skills amongst supervisees in comparison to alternative supervision models (study summary in Appendix A). They utilized a quasi-experimental design, hypothesizing that the Wellness Model of Supervision would (a) be more effective than other models of supervision in increasing counselors’ in-training definitions of wellness and personal wellness, and (b) be
similar to other supervision models in developing the clinical skills of trainees (Lenz et al., 2012).

Using a convenience sampling approach, Lenz et al. (2012) identified an initial participant sample of 44 master’s level counseling students completing their internship requirements—12 of whom did not complete both pretest and posttest measures—leaving final sample of 32 students, of whom 24 were female and 8 were male. Sixteen (16) of them were completing their internship requirements at a university-counseling clinic under the supervision of the first author who operated exclusively in the Wellness Model of Supervision (Lenz et al., 2012). The demographic breakdown of this participant cohort was as follows: 9 Caucasians, 4 Latinos/Latinas, 3 African Americans, 16 heterosexuals, 10 single, 4 married/partnered, 2 divorced, with a mean age of 34 years ($SD=11.8$). The other 16 participants were receiving supervision in alternative supervision modalities, and were placed in community-based internship settings. The demographic breakdown this second group was as follows: 10 Caucasians, 4 Latinos/Latinas, 2 African Americans, 15 heterosexuals, 1 lesbian, 10 single, 4 married/partnered, 2 divorced, with a mean age of 31 years ($SD=7.78$). All participants were required to have 1 hour of individual/triad supervision and 1.5 hours of group supervision per week. With a total sample of only 32 individuals, the research team performed an a priori analysis and determined that a minimum sample of 34 individuals would be required to detect a moderate effect of supervision type. Due to this limitation, Lenz et al. (2012) ran a sensitivity analysis to establish the necessary $F$ scores to show a moderate effect.

With the sample in hand, the research team used a pretest/posttest approach to understand changes in definitions of wellness, total wellness, and skills development of supervisees (Lenz et al., 2012). Pretests included a demographic questionnaire, an open-ended prompt to assess
personal definitions of wellness, and the Five Factor Wellness Inventory (Myers & Sweeney, 2004). Care was taken to ensure anonymity of responses—particularly given the fact that the first author was also serving as the supervisor for the cohort exposed to the Wellness Model of Supervision. Posttests were distributed after 10 weeks of supervision in the given modality; Lenz et al. (2012) also recorded counseling sessions to compare counseling skills progression using the Counseling Skills Scale (Eriksen & McAuliffe, 2003). Two individual raters familiar with definitions of wellness—specifically, the Indivisible Self Model of Wellness (Myers & Sweeney, 2004)—rated and interpreted definitions of wellness on both pretests and posttests to see how they developed. Similarly, two raters trained in the Counseling Skills Scale (Erikson & McAuliffe, 2003) assessed portions of the supervisee recordings, using an early recording as the pretest assessment, and the later recording as a posttest assessment, to understand how supervisee clinical skills had developed over the course of supervision. Subjective measures (such as the Counseling Skills Scale, and raters’ scores for definitions of wellness) were standardized to measure them quantitatively.

Lenz et al. (2012) found that (a) participants in the Wellness Model of Supervision group expanded their definitions of wellness more comprehensively than the cohort exposed to the other supervision modalities, and (b) this cohort achieved a similar level of counseling skills as the alternate group. It must be noted, however, that although this was a quantitative study that resulted in important findings, there is some potential subjectivity to the results due to of independent raters despite good inter-rater reliability (Lenz et al., 2012). Nonetheless, the research team’s focus on the influence of supervision modalities on improving supervisee wellness speaks directly to the study at hand.
In their analysis of the Wellness Model of Supervision’s effectiveness in developing supervisee wellness in comparison to other modalities—Lenz et al. (2012) used a split plot analysis of variance to confirm a statistically significant interaction between the supervisee wellness between pretest to posttest ($F(1,30)=5.65, p=.02, \eta_p^2=.16$), which also exceeded the necessary $F$ score to demonstrate a moderate effect size. This finding, combined with the directionality of mean scores, confirms that the Wellness Model of Supervision group increased mean personal wellness; in comparison, the other group’s score decreased. While this between-group difference is interesting, the research team did note that there was no main effect for time ($F(1,29)=.02, p=.86, \eta_p^2=.01$) or for between-group effects ($F(1,29)=.40, p=.53, \eta_p^2=.01$).

Moreover, Lenz et al. (2012) highlighted that while scores may have increased for the Wellness Model of Supervision group and decreased for the alternate group, this trend may represent a regression toward the norm, rather than an effect of the intervention.

The study by Lenz et al. (2012) is significant to the proposed investigation in that it links the nature of the supervisory relationship to supervisee wellness. Like Storlie and Smith (2012) who identified significant increases in supervisee wellness via supervision, researchers similarly noted that supervision could help improve supervisee wellness by positioning wellness as an outcome measure that can be altered by the supervision process. Similarly, notwithstanding the noted limitations associated with both Storlie and Smith (2012), this study also confirmed that supervisee wellness can be improved by supervisors who make it a priority in supervision.

The fact that the proposed investigation relies so heavily on these two studies merits revisiting their limitations so that they can be minimized, and thus produce results that can be generalized more broadly. The key limitation of the Lenz et al. (2012) study pertains to the sampling procedures the research team utilized. Recall that although the researchers were able to
detect a moderate effect of the supervision type, their small sample size of 32 limits the study’s validity and generalizability. Using a priori power analysis, Lenz and colleagues (2012) established that sample size of 34 was necessary to achieve a power of .80 (indicating generalizability). While their initial sample almost met this requirement, for the analysis of counseling skill development, the sample was only 24 falling quite short of their threshold (Lenz et al., 2012). This small sample size, coupled with the psychometric strength of the scales that they utilized that relied heavily on independent raters makes the results lack generalizability. Their results, while significant, cannot offer the clarity that a larger sample would provide. Therefore, replicating this study with a larger cohort would likely expand findings.

The other key limitation of the Lenz et al. (2012) study rests in the fact that Lenz himself served as the primary supervisor for the treatment group using his Wellness Model of Supervision (Lenz & Smith, 2010). As such, findings are specific to the supervisor himself, rather than the model as a whole. In other words, any gains in supervisee wellness could be attributed to individual supervisor traits, rather than the use of the model. Consider, for example, a supervisor who exhibits low personal wellness, but still utilizes the Wellness Model of Supervision. Her or his supervisees could potentially recognize this incongruence and fail to make the same gains they would have had they worked with a supervisor who utilized the model and modeled appropriate wellness behaviors and attitudes. Further, it is important to note the potential role conflict for the supervisees under Lenz’s supervision. His dual roles as supervisor and interviewer/researcher effectively eliminated the anonymity of participants, and could have influenced them to alter their responses to impress the supervisor/researcher, thereby skewing the resulting data. This social desirability factor represents a significant limitation for the study—more so because the scale that the research team utilized has also been linked to concerns
regarding respondents answering in a socially desirable way (Lenz et al., 2012). In summary, the lack of available scholarship, coupled with the limitations associated with the studies discussed herein, point to a gap in current knowledge.

Lenz and colleagues (2014) looked at supervisee perceptions of the Wellness Model of Supervision provides important guidance in the present study (study summary in Appendix A). Using a qualitative case study approach, Lenz et al. (2014) set out to understand (a) how trainees experienced the content and process of the Wellness Model of Supervision, (b) the ways in which they perceived this model to be helpful in their personal and professional development, and (c) if any artifacts would emerge from participation. This study was designed to further identify/elaborate on Lenz et al.’s (2012) and Storlie and Smith’s (2012) findings.

Lenz et al. (2014) utilized purposive-sampling procedures to recruit participants who were receiving direct supervision from Lenz himself using the Wellness Model of Supervision. Their sample consisted of four counselor education students who were completing their internship hours at a community-based counseling clinic, each of whom worked at the clinic 20-30 hours per week during the semester (Lenz et al., 2014). All participants were women (2 Caucasian, 2 Hispanic) between the ages of 25-42 years.

Lenz and colleagues (2014) collected qualitative data using both individualized semi-structured interviews and focus groups that included all of the participants. Lenz conducted the interviews himself at the internship site; he was also the site supervisor charge of evaluating student performance. Interviews were transcribed, after which Oliver and Sangganjanavanich (Lenz’s two coauthors) engaged in line-by-line coding of transcripts to develop initial codes. Following initial coding, Lenz et al. (2014) together assessed the codes, which resulted in the development of seven primary categories: initial response, engagement, understanding, benefits
to self, translation to professional practice, translation to professional relationships, and commitment to wellness (Lenz et al., 2014). These categories provide important perspectives on the supervisee experience, and how each of the four women reacted to the increased focus on wellness in their supervision sessions—from having difficulty seeing how wellness connected to their professional skills development, to being able to understand how a wellness approach could benefit them professionally and personally—and how that benefit would translate to their clients (Lenz et al., 2014).

The researchers also included a recommendation that is germane to the proposed investigation. Specifically, Lenz et al. (2014) posited that supervisors should model wellness practices in an intentional way, with the perspective that parallel process could transfer from supervisors, to supervisees, and ultimately to clients. In this recommendation lies the crux of the intended study here: *supervisees learn from supervisors who are able to effectively model wellness attitudes and behaviors*. The qualitative data produced by Lenz et al. (2014) appears to indicate this recommendation directly. For example, one of study’s participants spoke directly to this assertion, stating that her supervisor was a role model who provided an example for them in establishing their own attitudes and behaviors around wellness (Lenz et al., 2014). Despite the their findings about modeling wellness, this recent study shares some limitations with the main author’s prior work.

Lenz et al.’s (2014) primary limitation is in the dual role of the interviewer/supervisor, which lead to concerns regarding the reflexivity of the research team and the veracity of responses. The first author served as both primary supervisor for each of the four women and interviewer; therefore, this dual role had the potential to create a power differential that could have limited opportunities for negative responses during interviews. Moreover, in earlier articles
reviewed herein, concerns have raised about supervisor congruence (Storlie & Smith, 2012)—in other words, if a supervisor was perceived to be “unwell,” how would a wellness intervention translate in supervision? With the first author here playing both researcher and supervisor—and the power differential that caused—findings regarding the congruence of the supervisor’s wellness attitudes and behaviors in this study are unlikely to happen (Lenz et al., 2014). Thus, while the research team described some desirable outcomes of modeled wellness, there was no negative case to expand upon the effects on the modeling of poor wellness practices. Additionally, with only one supervisor providing the supervision, a description of those findings is limited specifically to that supervisor and cannot be expanded to include the Wellness Model of Supervision itself.

Lenz et al.’s (2014) focus was on the Wellness Model of Supervision, but participants’ qualitative responses pointed to a variety of concepts regarding the supervisory relationship, modeling, and the supervisor’s vulnerability and self-disclosure of wellness practices on the supervisees’ self-reported gains in wellness. While supervisor transparency and mutuality within supervision was not the focus of this study, this study highlights the value of integrating concepts of Relational Cultural Theory into supervisory practices. Lenz (2014) discussed that Relational Cultural Theory posits that humans are eager to form relationships based on “mutuality and empathy,” but that there are “community and cultural barriers” that prevent this from happening (p. 5), indicating that integrating these concepts within supervision could provide benefits to supervisees. While lacking empirical research into the value of creating more mutual, empathetic, and vulnerable supervisory relationships, rather than based on hierarchical models, Lenz (2014) highlighted how demonstrating this behavior allows supervisees to understand and develop these concepts and skills for working with their clients.
Despite the fact that a supervisory approach based on Relational Cultural Theory seems like a departure from the prior qualitative article by Lenz et al. (2014), the values posited in each model do overlap. One participant in the study utilizing the Wellness Model of Supervision even went so far as to state that a supervisor’s modeled wellness was not about being “perfect,” but rather just actively trying to remain well (Lenz et al., 2014). This modeled vulnerability of not being “perfect” and being able to forgive oneself and others is a vital skill for modeling to supervisees—especially given the fact that research shows that the ability to forgive has been linked to higher individual wellness (Hartwig-Moorhead, Gill, Minton, & Myers, 2012).

Recent scholarship has suggested that relationships between counselors based in forgiveness and mutuality can increase wellness and prevent impairment rather than traditional hierarchical values of supervision (Lawson et al., 2007). Similarly, Borders et al. (2014) stressed the value of value of modeling and creating these wellness relationships with supervisees. While still recognizing that evaluation within supervision is a vital piece of supervision that can affect the supervisory relationship (Bordin, 1983). Thus, it is important to know how a supervisee perceives both direct and indirect modeled messages from a supervisor regarding wellness within their supervisory relationship. Thompson, Frick, and Trice-Black (2011) designed a qualitative study to better understand how trainees are effected by distressing situations that lead to burnout, and how the “seeds of self-care are planted” within supervision (p. 153).

Thompson et al. (2011) utilized consensual qualitative research methods featuring open-ended, semi-structured interviews to investigate trainee perceptions of self-care, burnout, and supervisory practices that promote resilience (study summary in Appendix A). The researchers used criterion sampling to recruit participants in graduate level counseling programs who had completed a practicum experience or enrolled in an internship in a university or community-
based setting. Care was taken to ensure anonymity, and researchers excluded participants from their home institutions. The research sample included 14 individuals: 13 females and 1 male; 10 were enrolled in school counseling programs and 4 in clinical mental health programs, 13 identified as Caucasian and 1 identified as Hispanic. Their ages ranged from 24 to 52 years with a mean of 28. All participants were interviewed either face-to-face or by phone for approximately 50-70 minutes following semi-structured interview protocol; follow-up surveys were provided 6 weeks later to capture additional data (Thompson et al., 2011). The researchers then identified domains through the research protocol, which were coded as blocks, and from which core themes were highlighted both independently and later as a group (Thompson et al., 2011). The research team also invited an external auditor to confirm conclusions.

Thompson and colleagues (2011) identified five domains of interest: counselor burnout, counselor self-care, faculty supervision, site supervision, and improvements. Trainees described their experiences with burnout and the stressors that lead to burnout in practicum/internship settings, as well as their emerging definitions of self-care. Of particular importance to the study proposed herein are findings related to participant perceptions of faculty supervisors and site supervisors. Thompson et al. (2011) reported that the 14 people who took part in this investigation discussed how faculty supervisors provided a safe place for exploration of personal wellness and enhanced their ability to cope with the stressors of professional life. In particular, participants noted the benefits of direct conversations with faculty supervisors and the feedback they received regarding wellness; they also pointed out the significant value they found when supervisors actively modeled wellness through their demonstrations of self-care strategies (Thompson et al., 2011).
In contrast, the participants reported a somewhat different supervisory experience with site supervisors. Whereas faculty supervisors tended to discuss burnout prevention and self-care, site supervisors did not (Thompson et al., 2011). This deficit affected supervisee perceptions of supervision, with participants citing a lack of support. However, some supervisees did report positive experiences of supervisors modeling appropriate self-care behaviors, which they cited as beneficial. Overall, participants recommended that supervisors and educators be more attuned to supervisee self-care needs, directly address personal and professional balance, and focus more on self-care strategies throughout coursework (Thompson et al., 2011).

This study of self-care and burnout was limited by the homogeneity of the sample, which was primarily Caucasian and female, making it difficult to expand findings to a broader population of counselor education students (Thompson et al., 2011). Further, while steps were taken to ensure anonymity, the fact that the researchers recruited participants from their own counselor education program may have hindered respondents from speaking candidly about their supervisory experiences. In short, the study’s design could have introduced an element of social desirability into the qualitative findings.

Despite noted limitations, the implications of this qualitative study are still profound. In particular, Thompson et al.’s (2011) discussion of the importance of supervisee perceptions of supervisor wellness and how supervisors model wellness/self-care behaviors and attitudes represent major themes that will be addressed in the proposed investigation. The findings presented by Thompson et al. (2011) also support Lenz et al.’s (2014) suggestions that a “top down” approach to the concept of parallel process—with the supervisor modeling and conveying positive behaviors and attitudes for the counselor-trainee—will ultimately benefit the client. The findings from Thompson et al. (2011) further support concerns regarding incongruence by
supervisors, which was a potential limitation of the investigation conducted by Storlie and Smith (2012).

**A Gap in the Literature**

Ten years ago, Lawson and colleagues (2007) advocated coalescing research on counselor impairment and counselor wellness, remarking that the two constructs are inherently linked as the two end points on a continuum. At the same time, Cummins and colleagues (2007) asserted that effective supervision is critical for improving counselor wellness and preventing impairment. Lawson et al. (2007) reported that the "most healing relationships are those that promote mutual congruence and authenticity” (p. 15). With this stance in mind, it is important to recognize the importance of congruency in supervisory relationships. Borders et al. (2014) further highlighted the need to not only discuss the concept of wellness in supervision—but more importantly to model wellness behaviors and attitudes for supervisees.

Studies have shown that wellness and self-care can be improved through the supervisory working alliance (Storlie & Smith, 2012; Lenz et al., 2012). Further, qualitative feedback has reinforced the benefits of directly addressing wellness in supervision, as well as modeling appropriate wellness/self-care behaviors and attitudes (Lenz et al., 2014; Thompson et al., 2011). Additional research has alluded to the importance of a supervisory relationship based on mutuality, self-forgiveness, and realistic expectations and how such relationships can improve wellness within supervision (Lenz, 2014; Hartwig-Moorhead et al., 2012; Thompson et al., 2011).

However, when wellness and self-care strategies were proposed as predictors of the strength of the supervisory relationship—or the supervisory relationship was conceptualized as an outcome of supervisee wellness—results lacked statistical and/or practical significance (e.g.
Gnilka et al., 2012; Storlie & Smith, 2012). Further, wellness/self-care interventions within supervision have been shown to be ineffective when provided by individuals outside of the supervisory relationship (Ohrt et al., 2015). In contrast, interventions within the supervisory relationship (with ratings of a potentially high supervisory relationship) were effective in improving supervisee wellness (Storlie & Smith, 2012). Another limitation that must be noted is that other studies analyzing growth in wellness did not specifically examine the supervisory relationship (Lenz et al, 2012), or were limited in the generalizability of their findings due to methodological shortcomings (e.g. Lenz et al., 2014; Thompson et al., 2011).

In short, although the scholarly reports included herein describe wellness promotion as an important goal of the supervisory relationship, they also feature significant limitations in understanding direct and indirect strategies for improving supervisee wellness within supervision. Furthermore, their limitations of cohort size and diversity, coupled with study designs that introduce a potential limitation of social desirability, highlight a gap in our current understanding of the importance of modeled wellness by supervisors.

Given these deficiencies in the literature, an examination of the transmission of wellness between supervisor and supervisee is timely and necessary. In addition, the strength of the supervisory relationship and the effects of this on supervisee wellness warrants attention. Thus, the purpose of this quantitative investigation was to (a) analyze the role of modeled wellness as a way for supervisors to influence the multifaceted aspects of supervisee wellness, and (b) identify if the factoring in the supervisory relationship changes this influence.
CHAPTER THREE:

METHODOLOGY

This chapter presents the methodology employed in this investigation. It includes an overview of the primary purpose of the study, and an outline of the study itself (including sampling procedures, instruments, and analysis). The research questions are highlighted. Data analysis is discussed to show how results were achieved and interpreted for each of the research questions. Finally, limitations of the methodology are discussed and a summary of the chapter is provided.

Research Design

This study is designed with the aim of understanding how supervision, as a primary educational medium for counselors (Bernard & Goodyear, 2014), aids in the development of supervisee wellness, a key aspect of counselor identity (Myers, 1991), through demonstrated practices by the supervisor. Current literature on wellness and supervision has treated the supervisory relationship as an outcome affected by supervisee wellness, rather than conceptualizing the supervisory relationship as a way to communicate wellness practices, until recently (Lenz & Smith, 2010). Though results have indicated that increased supervisee wellness can be an outcome of supervision (Lenz et al., 2012; Storlie & Smith, 2012), research has only described the effect of modeling tangentially (Lenz et al., 2014; Thompson et al., 2011). The purpose of this quantitative investigation was to (a) analyze the role of modeled wellness as a way for supervisors to influence the multifaceted aspects of supervisee wellness, and (b) identify if the factoring in the supervisory relationship changes this influence.
Research Questions

The study was designed to investigate two principal research questions and their sub-questions:

Research Question 1 (RQ1): What is the influence of a supervisee’s perception of their supervisor’s level of wellness on their own wellness?

RQ1a: How does the inclusion of the strength of the supervisory relationship as a predictor change this model?

Research Question 2 (RQ2): What is the influence of a supervisee’s perception of specific second-order factors of supervisor wellness (Creative Self, Coping Self, Social Self, Essential Self, Physical Self) on the corresponding factor of their own wellness?

RQ2a: How does the inclusion of the strength of the supervisory relationship as a predictor change these models?

With these questions in mind, a quantitative cross-sectional study was designed to survey counselor education students enrolled in a practicum or internship course. Specifically, this study utilized a four-part survey to collect data, consisting of the following segments: the Five Factor Wellness Inventory (Myers & Sweeney, 2005), a section assessing supervisee perception of supervisor wellness (derived from the Five Factor Wellness Inventory), Short Version of the Supervisory Relationship Questionnaire (Cliffe, Beinart, & Cooper, 2014), and a demographic questionnaire. The survey was distributed to stakeholders (faculty members) in the counselor education community, who in turn distributed them to their practicum and internship students. Survey specifics, including instrument development and psychometrics, along with sampling procedures are described in the following sections.
Sample Selection

The survey was distributed to counselor education students enrolled in either practicum or internship settings. It was necessary for students to be enrolled in clinical experiences to ensure that they were receiving supervision from site supervisor. Due to potential developmental differences between practicum and internship students along with potential structural differences in practicum and internship courses, questions regarding level of clinical experience and exposure to supervision were included in the demographic questionnaire to understand the differences between supervisees. Further, this study focused exclusively on counselor education students due to the formative and educational nature of the supervisory relationship with their site supervisors.

Programs were identified utilizing purposive sampling. Stakeholders in Counselor Education Programs (faculty members) were identified through known contacts by the researcher, and through the literature review (researchers with a focus on wellness and supervision were also contacted). Stakeholders were emailed the Invitation for Participation (Appendix C) through their publicly available university email addresses. Once stakeholders confirmed they were willing to distribute the survey to their students, the researcher mailed the requested number of survey packets and a preaddressed, pre-stamped return envelope. The stakeholders distributed the surveys to the qualifying students, and made note of the number of surveys they distributed for response rate purposes. Upon completion students returned the survey packets to the stakeholder who placed them in the preaddressed envelope and returned them by mail to the researcher.

While purposive sampling comes with limitations, care was taken to contact stakeholders at a variety of different counselor education settings, including large research universities, small
liberal arts universities, full-time students, part-time students, different levels of accreditation, predominantly white institutions, and historically black colleges and universities. By doing so, the researcher anticipated that the sample would be reflective of the current field, and demographic information from the sample is described in Chapter 4 and compared to known demographic information from similar studies.

**Instrumentation**

Three instruments and a demographic questionnaire were administered to participants: Five Factor Wellness Inventory (Myers & Sweeney, 2005), the Perception of Supervisor Wellness Instrument, and Short Version of the Supervisory Relationship Questionnaire (Cliffe, Beinart, & Cooper, 2014). The instruments are described below and included in Appendix C.

**Five Factor Wellness Inventory**

In this study, supervisee wellness was measured utilizing the Five Factor Wellness Inventory (5F-Wel: Myers & Sweeney, 2005). The Five Factor Wellness Inventory was developed from the Wellness Evaluation of Lifestyle through the use of factor analysis (Hattie, Myers, & Sweeney, 2004). Based in Adlerian theory, with a focus on holism, the Indivisible Self Model of Wellness was developed by Myers and Sweeney (2004), who categorized individual wellness into 5 second-order factors (coping self, essential self, physical self, creative self, and social self), which are comprised of 17 third-order factors (Thinking, Emotions, Control, Work, Positive Humor, Exercise, Nutrition, Spirituality, Gender Identity, Cultural Identity, Self-Care, Friendship, Love, Leisure, Stress Management, Self-Worth, and Realistic Beliefs) (Myers & Sweeney, 2004). It is this conceptual model that the Five Factor Wellness Inventory measures.
The Five Factor Wellness Inventory is comprised of 74 items designed to measure wellness behaviors and beliefs as reflected by the 17 factors of wellness described by the Indivisible Self Model of Wellness, and provides scores for five second order scales, and one measure for Total Wellness. (Myers & Sweeney, 2005) The 74 items are rated on a 1-4 Likert scale by respondents, and takes approximately 15 minutes to complete. Mean scores for each subscale are then modified to a 100-point scale using linear transformation to make scores easily comparable, with higher scores indicating higher wellness. Reliability for second order scales have been reported as .96 for Creative Self, .89 for Coping Self, .96 for Social Self, .95 for Essential Self, and .90 for Physical Self, with Total Wellness reported as .98 (Myers & Sweeney, 2005).

The Five Factor Wellness Inventory is widely used in counselor education literature, and has received the more empirical attention than other assessments designed to measure wellness (Roscoe, 2009). However, it is not without its limitations. One such limitation is the fact that the second-order factors load unequally onto the total wellness scale, creating subjectivity in the way second-order factors are valued when considering total wellness. Further, subscale reliability has been lower than reported rates in many samples (Myers, Luecht, & Sweeney, 2004), as was consistent in the sample in this study (discussed in Chapter 4).

**Perception of Supervisor Wellness Instrument**

As there is no current measure for the perception of supervisor wellness, an instrument was developed based on the definitions for the 17 discrete factors of wellness from the Five Factor Wellness Inventory (Myers & Sweeney, 2005). For example, Self-Worth is defined as “Accepting who and what one is, positive qualities along with imperfections; acceptance of one’s physical appearance; affirming the value of one's existence; valuing oneself as a unique
individual.” (Myers & Sweeney, 2005). The corresponding item on the survey reads, “I perceive my site supervisor as accepting who and what [he/she] is, positive qualities along with imperfections; acceptance of [his/her] physical appearance; affirming the value of [his/her] existence; valuing [himself/herself] as a unique individual?” The instructions include an acknowledgement that wellness is complex in nature, and these items are scaling supervisee perception, therefore supervisees only need to indicate to their perception to the best of their ability.

Some definitions were split into multiple items on the instrument due to the length of the definition and to make them more readable for the participants. Additionally, portions of definitions that referred to illegal behavior (substance abuse) or unethical supervision practices (discussion of sexual behavior) were removed in an effort to improve response rates. Further, for each subscale, a reverse score item was added to monitor participant responses for survey fatigue.

The final instrument consists of 30 items on a 1-4 Likert scale to mirror that of the Five Factor Wellness Inventory. Similarly, items will mirror scoring procedures of the Five Factor Wellness Inventory, mean scores for scales are computed and transformed to a 100-point scale with higher scores indicating a higher perception of wellness. As this instrument has been developed strictly for the use in this study, previously reported reliability coefficients do not exist, but reliability of scales and subscales will be reported and implications discussed in the analysis of results.

**Short Version of the Supervisory Relationship Questionnaire**

Cliffe, Beinart, and Cooper (2014) developed the Short Version of the Supervisory Relationship Questionnaire (S-SRQ) in an effort to reduce the size of the original Supervisory
The Relationship Questionnaire (SRQ) while still maintaining strong psychometric properties. Utilizing original data from the SRQ the researchers analyzed external item quality by comparing the SRQ to similar scales, and determined internal item quality by analyzing Chronbach’s alpha, inter-item totals, item-totals and factor loadings for each SRQ item (Cliffe et al., 2014). Removing items iteratively this narrowed down the 67 items to 28, the research team then distributed the S-SRQ to 204 participants, and retested with 86 of the original participants a few weeks later (Cliffe et al., 2014). Following a factor analysis, the final measure was narrowed down to 18 items.

The S-SRQ identifies three components to the supervisory relationship, the “Safe Base”, Reflective Education, and Structure (Cliffe et al., 2014). The Safe Base subscale (which focuses on the components of a facilitative relationship) accounted for the largest proportion of variance (57.5%), with Reflective Education (which focuses on education and learning in the relationship) and Structure (or the organizational aspects of the relationship) accounting for a smaller proportion (7.1% and 4.8% respectively) (Cliffe et al., 2014). All three subscales provided strong internal reliability (alpha values for Safe Base, Reflective Education, and Structure, were .97, .89, .88 respectively), with the alpha for the overall scale being .96 (Cliffe et al., 2014). Further the scale showed strong test-retest reliability and convergent/divergent validity when compared to scales measuring similar constructs (Cliffe et al., 2014). The final scale is comprised of 18 items measured on a likert scale from 1 to 7, with one item reverse scored (Cliffe et al., 2014). Scores range from 18 to 126 with higher scores indicating a stronger supervisory relationship. Though the S-SRQ is a relatively new instrument to measure the strength of a supervisory relationship it shows strong reliability and validity and has been
recommended for use when assessing supervisee perspectives, and when a shorter assessment is required (Tangen & Borders, 2016).

**Demographic Questionnaire**

The demographic questionnaire is structured to provide a description of the sample (items include age, gender, and race). Further items were added to gain more information regarding the developmental level of the supervisee, types of supervision provided by the supervisor, and the amount of focus that was placed on wellness in supervision. For instance, participants were asked about the percentage of time during supervision that their site supervisor focused on personal wellness. Answers ranged on a scale from 0%, 1-10%, 11-20%, 21-30%, or more than 30%.

**Measures**

For the purpose of this study, results from both the perception of supervisor wellness instrument, and the Short Version of the Supervisory Relationship Questionnaire will be treated as the independent or predictor variables, whereas the results from the Five Factor Wellness Inventory will be treated as the dependent variable in a series of stepwise regression analyses. In RQ1, the total score for the perception of supervisor wellness instrument is the sole independent variable predicting the total score of supervisee wellness (as measured by the total score on the 5F-Wel), and in RQ1a the total score for the supervisory relationship from the S-SRQ was added as a second predictor variable in a stepwise regression analysis.

For the analysis of the second research question, the focus is on the subscales for both the Five Factor Wellness Inventory and the perception of supervisor wellness instrument. Each of the second-order subscales (Creative Self, Coping Self, Social Self, Essential Self, and Physical Self) on the Five Factor Wellness Inventory was treated as a dependent variable with the corresponding second-order factor from the perception of supervisor wellness instrument being
treated as an independent variable, creating a series of 5 separate regression analyses.

Additionally, for RQ2a, the total score for the S-SRQ was added as an independent variable for each of the 5 separate regression analyses (models displayed below).

**Assumptions and Analysis**

To answer the research questions, a series of stepwise regressions were employed. Stepwise regressions were selected due to the capability to predict/explain supervisee wellness as it relates to perceptions of supervisor wellness and the strength of the supervisory relationship.

There are four assumptions when utilizing a regression: linearity, independence of observations, normal distribution of errors, homogeneity of variance of errors, and the multicollinearity of predictors. Specifics of each analysis will be discussed at length herein.

**Assumptions**

The following assumptions had to be met in order to perform the linear regression analysis outlined for Research Questions 1 and 2:

*Linearity:* To check linearity, scatterplots were utilized to ensure a linear relationship between supervisee wellness and perception of supervisor wellness, as well as supervisee wellness and the supervisory relationship.

*Independence of Observations:* This study was designed to ensure that individual observations were independent from each other, ensuring that survey participants only engaged in and completed the survey once.

*Normal Distribution of Errors and Homogeneity of Variance of Errors:* In order to ensure that error and variance of error were held at a certain threshold, the researcher utilized residual plots to examine the residuals for each individual regression to ensure that appropriate analyses were conducted.
Multicollinearity: To check for multicollinearity, the researcher examined tolerance statistics and Variance Inflation Factors for each regression.

Data Analysis Procedures

Research Question 1 (RQ1): What is the influence of a supervisee’s perception of their supervisor’s level of wellness on their own wellness?

Once underlying assumptions were met, the researcher utilized a first step regression to assess how much variance in supervisee wellness can be explained by perception of supervisor wellness. In this regression analysis, the dependent variable is the Total Wellness score from the results from the 5F-Wel, which is being used to measure supervisee wellness. The sole predictor variable in this model is the Total Wellness score from the Perception of Supervisor Wellness Scale. It is important to remember that through linear transformation as described in the description of the instruments both mean scores are placed on a 100-point scale. As such, an increase in the predictor coefficient has a direct impact on supervisee wellness. The model is as follows:

(Supervisee Wellness) = (Constant) + b1(Supervisor Wellness)

Research Question 1a: How does the inclusion of the strength of the supervisory relationship as a predictor change this model?

Again, once underlying assumptions were met, the researcher ran a second iteration of a stepwise regression analysis to understand how much variance in supervisee wellness could be explained by the perception of supervisor wellness and the strength of the supervisory relationship. Analysis was similar the process described for RQ1; however, an additional predictor variable was included in this model: the strength of the supervisory relationship as measured by the total score S-SRQ. The model is as follows:
(Supervisee Wellness) = (Constant) + b_1(Supervisor Wellness) + b_2(Supervisory relationship)

Research Question 2 (RQ2): What is the influence of a supervisee’s perception of specific second-order factors of supervisor wellness (Creative Self, Coping Self, Social Self, Essential Self, Physical Self) on the corresponding factor of their own wellness?

Recognizing the differential loadings of the second-order factors on the Five Factor Wellness Inventory, it was imperative to understand how each perceived second-order factor of supervisor wellness was able to explain the corresponding second-order factor of supervisee wellness. In this first step in a series of stepwise regressions, the second-order factor of perceived supervisor wellness are the independent variables, predicting the corresponding second-order factor of supervisee wellness. This helps clarify if there are certain second-order factors of wellness that are more important to display in supervision than others. The models are as follows:

(Supervisee Creative Self) = (Constant) + b_1(Supervisor Creative Self)
(Supervisee Coping Self) = (Constant) + b_1(Supervisor Coping Self)
(Supervisee Physical Self) = (Constant) + b_1(Supervisor Physical Self)
(Supervisee Social Self) = (Constant) + b_1(Supervisor Social Self)
(Supervisee Essential Self) = (Constant) + b_1(Supervisor Essential Self)

Research Question 2a: How does the inclusion of the strength of the supervisory relationship as a predictor change these models?

Similar to RQ1a, after the initial regression takes place, the strength of the supervisory relationship, as measured by the total score of the S-SRQ, will be added in the second step as an
additional predictor variable to each of the five stepwise regression analyses. The models with the new variable are as follows:

(Supervisee Creative Self) = (Constant) + b_1(Supervisor Creative Self) + b_2(Supervisory relationship)
(Supervisee Coping Self) = (Constant) + b_1(Supervisor Coping Self) + b_2(Supervisory relationship)
(Supervisee Physical Self) = (Constant) + b_1(Supervisor Physical Self) + b_2(Supervisory relationship)
(Supervisee Social Self) = (Constant) + b_1(Supervisor Social Self) + b_2(Supervisory relationship)
(Supervisee Essential Self) = (Constant) + b_1(Supervisor Essential Self) + b_2(Supervisory relationship)

**Summary**

To conduct this study, individuals engaged in supervision in counselor education programs were recruited. Willing participants were provided with survey materials containing informed consent, demographic questionnaire, 5F-WEL, S-SRQ, and a questionnaire regarding their perception of supervisor wellness. The survey required approximately 20-30 minutes, and results were analyzed utilizing a series of stepwise regression models to understand the how much variance in supervisee wellness the perception of supervisor wellness and the strength of the supervisory relationship can explain.
CHAPTER FOUR:
RESULTS

The purpose of this quantitative investigation was to analyze the role of modeled wellness as a way for supervisors to influence multifaceted aspects of supervisee wellness, and identify if factoring in the supervisory relationship changes this influence. In this chapter, the sampling of participants, reliability of selected instruments, and the data cleaning procedures are reviewed. Additionally, this chapter contains the results from the following research questions:

RQ1: What is the influence of a supervisee’s perception of their supervisor’s level of wellness on their own wellness?

RQ1a: How does the inclusion of the strength of the supervisory relationship as a predictor change this model?

RQ2: What is the influence of a supervisee’s perception of specific second-order factors of supervisor wellness (Creative Self, Coping Self, Social Self, Essential Self, Physical Self) on the corresponding factor of their own wellness?

RQ2a: How does the inclusion of the strength of the supervisory relationship as a predictor change these models?

Sampling

This study sampled counselor education master’s students enrolled in an internship or practicum class. To reach this population, the researcher utilized purposive sampling and contacted stakeholders in counselor education programs to assess their willingness to distribute the survey materials. Care was taken to contact stakeholders at a variety of institutions to reach participants in varied counselor education settings. The stakeholders were known colleagues of the researcher, and therefore convenience sampling was utilized.
The researcher sent invitations for participation via university provided email addresses to 26 stakeholders at 21 separate institutions. If stakeholders did not respond, a subsequent invitation was sent. Of the 26 potential stakeholders contacted, 10 individuals either failed to respond to the invitation or stated that they were unable to access the target sample (no current students enrolled in internship/practicum, only online students, etc.). Of the remaining stakeholders, two did not complete survey distribution, and no survey packets were returned to the researcher. The final group of stakeholders consisted 14 individuals from 11 different institutions (three stakeholders were from one institution, and two at another institution). Final stakeholder response rate was 53.8% with 52.3% of the institutions represented. To better understand response rates, stakeholders recorded the number of potential participants to which survey materials were distributed. The 14 stakeholders reported that survey materials were distributed to 158 qualifying students, of which 105 completed the survey packets, producing an in-class response rate of 66.5%.

**Instrumentation**

In this section, the three instruments used in this study are reviewed: the Five Factor Wellness Inventory (5F-Wel; Myers & Sweeney, 2005), the perception of supervisor wellness instrument, and the Short Version of the Supervisory relationship Questionnaire (S-SRQ; Cliffe, Beinart, & Cooper, 2014). Description of the instrument, review of scoring procedures, and internal reliabilities are included.

**Five Factor Wellness Inventory**

The 5F-Wel (Myers & Sweeney, 2005) measures an individual’s wellness on first-order factor (Total Wellness) and five second-order factors (Creative Self, Coping Self, Social Self, Physical Self, Essential Self). The 5F-Wel consists of 73 items that are scored a 1-4 likert scale
(from strongly disagree to strongly agree) (Myers & Sweeney, 2005). The total score for each factor (total wellness and second-order factors) is computed by taking the mean score of all items on the scale/sub-scale, and multiplying by 25 (Myers & Sweeney, 2005). This transformation places scores on a scale of 25-100 to show differences more clearly (Myers & Sweeney, 2005). Higher scores indicate a greater level of wellness. Internal reliability for total wellness and second-order factors have been reported as strong, with Chronbach’s $\alpha$ reported as: Total Wellness = .98, Creative Self = .96, Coping Self = .89, Social Self = .96, Essential Self = .95, and Physical Self = .90 (Myers & Sweeney, 2005).

Chronbach’s $\alpha$ scores showed high internal consistency for the total score and each subscale. Chronbach’s Alpha for the sample were as follows: Total Wellness ($\alpha = .921$, $n = 95$, $N = 74$), Creative Self ($\alpha = .804$, $n = 103$, $N = 21$), Coping Self ($\alpha = .824$, $n = 102$, $N = 19$), Physical Self ($\alpha = .906$, $n = 102$, $N = 10$), Social Self ($\alpha = .862$, $n = 104$, $N = 8$), and Essential Self ($\alpha = .831$, $n = 99$, $N = 16$). While alphas trended slightly lower then reported previously, this is consistent with past usage of the 5F-Wel and internal consistency remains strong (Myers et al., 2004).

**Perception of Supervisor Wellness Instrument**

To measure the participant’s perception of their supervisor’s wellness, an instrument was developed based on the definitions for the 17 discrete factors that contribute to the five second-order factors of wellness, and primary factor of total wellness. Some definitions were divided into multiple items for readability, and portions of definitions regarding unethical (discussion of supervisor sexual activity) and illegal (substance abuse) activity were removed. One item from each second-order factor was reverse scored to monitor for participant survey fatigue.
The final instrument consists of 30 items that were scored on a 1-4 likert scale (Strongly Disagree to Strongly Agree) to remain consistent with that of the 5F-Wel (Myers & Sweeney, 2005). Similarly, Total Wellness and second-order factor scoring mirrors that of the 5F-Wel, calculating mean scores for items that comprise total wellness and each second-order factor and multiplying by 25 to highlight differences in scores. Internal reliability mirrored that of the 5F-Wel for this sample on some scales, while on others the measure demonstrated weak reliability. Chronbach’s alphas were as follows: Total Wellness ($\alpha = .923$, $n = 98$, $N = 30$), Creative Self ($\alpha = .831$, $n = 102$, $N = 9$), Coping Self ($\alpha = .795$, $n = 102$, $N = 7$), Physical Self ($\alpha = .468$, $n = 101$, $N = 2$), Social Self ($\alpha = .764$, $n = 102$, $N = 5$), Essential Self ($\alpha = .534$, $n = 100$, $N = 5$). The weak reliability of the Physical Self and Essential Subscales are likely attributable to two causes: the small amount of items measuring each subscale, and the lack of opportunity for the supervisee to accurately develop a perception regarding this factor during supervision. Both of these concerns will be further discussed in chapter 5.

**Short Version of the Supervisory Relationship Questionnaire**

To measure the participant’s perception of the supervisory relationship the Short Version of the Supervisory Relationship Questionnaire (S-SRQ; Cliffe, Beinart, & Cooper, 2014) was used. As newer assessment tool, it has been recommended for use with supervisees due to its brevity and strong psychometric properties (Tangen & Borders, 2016). The S-SRQ includes 18 items scored on a Likert scale from 1-7 (strongly disagree to strongly agree) (Cliffe et al., 2014). The S-SRQ (Cliffe et al., 2014) relies on three subscales to measure different aspects of the supervisory relationship: Safe Base, Reflective Education, and Structure. Items scores were summed to provide scores for subscales and the total score for the supervisory relationship, total scores ranged from 18 to 126 (Cliffe et al., 2014).
For this study, only the total score was utilized as a predictor variable. Cliffe et al. (2014) have reported high internal consistency for both total scores and subscales reporting Chronbach’s alphas as: Total Score .96, Safe Base .97, Reflective Education .89, and Structure .88. The instrument performed similarly in this sample with Chronbach’s alphas as: Total Score ($\alpha = .962$, $n = 102$), Safebase ($\alpha = .958$, $n = 104$), Reflective Education ($\alpha = .902$, $n = 103$), and Structure ($\alpha = .861$, $n = 104$).

**Data Screening**

Of 158 potential participants offered the survey, 105 participants completed the survey. The 5F-Wel (Myers & Sweeney, 2005), perception of supervisor wellness, and S-SRQ (Cliffe et al., 2014) were used to collect data. To answer RQ1 and RQ1a, only total scores were utilized in analysis. To answer RQ2 and RQ2a, second-order factor subscale scores of the 5F-Wel (Myers & Sweeney, 2005) and the perception of supervisor wellness instrument, and the total score of the S-SRQ (Cliffe et al., 2014) were used in analysis.

The researcher used Little’s Test for MCAR to show that missing data was missing completely at random for the data sample ($X^2=1755.590$, $df=2013$, $p=1.00$), and the dataset was missing an inconsequential amount of data (5-10%) (Dong & Peng, 2013). Operating under these assumptions, the data was assumed to be a random sample of the complete data without introducing bias into the analysis (Dong & Peng, 2013).

With these assumptions in place, the researcher removed cases pairwise for each stepwise regression that were missing more than 25% of the data on the constructs under analysis. The researcher imputed series means for any case with less than 25% missing data for the constructs in the individual analysis. With this method, final sample sizes differed for each stepwise analysis ranging from 100 to 104 participants.
Description of Participants

In the collection of the final sample, care was taken to contact various institutions with different missions and foci. The final sample included large land grant universities with the highest research priority, small universities with a liberal arts focus, master’s only counselor education programs, counselor education programs with doctoral and master’s programs, full-time cohort model programs, part-time programs, and counselor education programs with varying levels of CACREP Accreditation (non-pursuant, in process, and accredited).

A demographic questionnaire was distributed with the survey materials to develop a better understanding of the participants’ clinical experiences, frequency and type of supervision, and personal characteristics. The ages of the 105 participants ranged from 21-59 years of age (M=28.69, SD=8.29). Twelve were male (11.4%), 89 were female (84.8%), 2 were gender non-binary (1.9%) and 2 elected not to respond (1.9%) (Table 1).

Table 1.

<table>
<thead>
<tr>
<th>Gender</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>12</td>
<td>11.4</td>
</tr>
<tr>
<td>Female</td>
<td>89</td>
<td>84.8</td>
</tr>
<tr>
<td>Non-Binary</td>
<td>2</td>
<td>1.9</td>
</tr>
<tr>
<td>No Response</td>
<td>2</td>
<td>1.9</td>
</tr>
<tr>
<td>Total</td>
<td>105</td>
<td>100.0</td>
</tr>
</tbody>
</table>

The sample was primarily White or Caucasian (69.5%), 9 participants were African American or Black (8.6%), 7 were Latino/a (6.7%), 5 were Native American (4.8%), 2 were Asian or Pacific Islander (1.9%), 1 identified as Multiracial (1.0%), 6 identified as Other (1.9%), and 2 (1.9%) individuals elected not to respond. This information is provided in Table 2.

Table 2.

<table>
<thead>
<tr>
<th>Race</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>White or Caucasian</td>
<td>69.5%</td>
</tr>
<tr>
<td>African American or Black</td>
<td>8.6%</td>
</tr>
<tr>
<td>Latino/a</td>
<td>6.7%</td>
</tr>
<tr>
<td>Native American</td>
<td>4.8%</td>
</tr>
<tr>
<td>Asian or Pacific Islander</td>
<td>1.9%</td>
</tr>
<tr>
<td>Multiracial</td>
<td>1.0%</td>
</tr>
<tr>
<td>Other</td>
<td>1.9%</td>
</tr>
<tr>
<td>Total</td>
<td>100.0%</td>
</tr>
<tr>
<td>Race</td>
<td>Frequency</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>-----------</td>
</tr>
<tr>
<td>Native American</td>
<td>5</td>
</tr>
<tr>
<td>Asian or Pacific Islander</td>
<td>2</td>
</tr>
<tr>
<td>African American or Black</td>
<td>9</td>
</tr>
<tr>
<td>Caucasian or White</td>
<td>73</td>
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<tr>
<td>Latino/a</td>
<td>7</td>
</tr>
<tr>
<td>Other</td>
<td>6</td>
</tr>
<tr>
<td>Multiracial</td>
<td>1</td>
</tr>
<tr>
<td>No Response</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>105</td>
</tr>
</tbody>
</table>

A total of 44 participants (41.9%) were enrolled in a practicum, 39 (37.1%) were enrolled in the first semester of their internship course, 20 (19%) were enrolled in the second semester of internship course, and 2 (1.9%) declined to respond. This data is shown in Table 3.

Table 3.

**Class Level**

<table>
<thead>
<tr>
<th>Class Level</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practicum</td>
<td>44</td>
<td>41.9</td>
</tr>
<tr>
<td>1st semester of internship</td>
<td>39</td>
<td>37.1</td>
</tr>
<tr>
<td>2nd semester of internship</td>
<td>20</td>
<td>19.0</td>
</tr>
<tr>
<td>No Response</td>
<td>2</td>
<td>1.9</td>
</tr>
<tr>
<td>Total</td>
<td>105</td>
<td>100.0</td>
</tr>
</tbody>
</table>

A total of 10 participants reported receiving supervision from their onsite supervisor for less than one month (9.5%), 21 reported 1-2 months (20%), 28 (26.7%) 2-3 months, 25 (23.8%) 3-4 Months, 19 (18.1%) reported more than 4 months, and 2 individuals declined to respond. See Table 4.

Table 4.

**Length of Supervision**

<table>
<thead>
<tr>
<th>Length of Supervision</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 1 month</td>
<td>10</td>
<td>9.5</td>
</tr>
<tr>
<td>1-2 months</td>
<td>21</td>
<td>20.0</td>
</tr>
<tr>
<td>2-3 months</td>
<td>28</td>
<td>26.7</td>
</tr>
<tr>
<td>3-4 months</td>
<td>25</td>
<td>23.8</td>
</tr>
</tbody>
</table>
A total of 61 participants indicated they only received individual supervision from their site supervisor (58.1%), 2 reported they only received triadic supervision (1.9%), 2 reported they only received group supervision (1.9%), 38 reported that they received multiple forms of supervision (36.2%), and 2 individuals elected not to respond (1.9%). This information is shown in Table 5.

Table 5.
*Form of Supervision Provided*

<table>
<thead>
<tr>
<th>Form of Supervision</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>61</td>
<td>58.1</td>
</tr>
<tr>
<td>Triadic</td>
<td>2</td>
<td>1.9</td>
</tr>
<tr>
<td>Group</td>
<td>2</td>
<td>1.9</td>
</tr>
<tr>
<td>Multiple</td>
<td>38</td>
<td>36.2</td>
</tr>
<tr>
<td>No Response</td>
<td>2</td>
<td>1.9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>105</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

As shown in Table 6, 12 individuals reported that they received 0-20 minutes of supervision from their site supervisor per week on average (11.4%), 20 reported they received 21-40 minutes on average (19%), 31 reported they received 41-60 minutes on average (29.5%), 26 reported they received 61-80 minutes on average (24.8%), 14 reported that they received more than 80 minutes on average (13.3%), and 2 individuals elected to not respond.

Table 6.
*Time in Supervision per Week*

<table>
<thead>
<tr>
<th>Time in Minutes</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-20 minutes</td>
<td>12</td>
<td>11.4</td>
</tr>
<tr>
<td>21-40 minutes</td>
<td>20</td>
<td>19.0</td>
</tr>
<tr>
<td>41-60 minutes</td>
<td>31</td>
<td>29.5</td>
</tr>
<tr>
<td>61-80 minutes</td>
<td>26</td>
<td>24.8</td>
</tr>
</tbody>
</table>
As indicated in Table 7, 20 (19%) participants reported that their site supervisors did not spend any time discussing supervisee wellness during supervision, 36 (34.3%) reported that their supervisors spent 1-10% of the time during supervision sessions discussing supervisee wellness, 19 (18.1%) said supervisors spent 11-20% of the time discussing supervisee wellness, 16 (15.2%) reported that their supervisors spent 21-30% of the time focusing on wellness, 13 (12.4%) reported supervisors spent more than 30% of the time discussing supervisee wellness, and 1 person elected not to respond.

Table 7.

<table>
<thead>
<tr>
<th>Percentage of Time Focusing on Supervisee Wellness in Supervision</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td>20</td>
<td>19.0</td>
</tr>
<tr>
<td>1-10%</td>
<td>36</td>
<td>34.3</td>
</tr>
<tr>
<td>11-20%</td>
<td>19</td>
<td>18.1</td>
</tr>
<tr>
<td>21-30%</td>
<td>16</td>
<td>15.2</td>
</tr>
<tr>
<td>More than 30%</td>
<td>13</td>
<td>12.4</td>
</tr>
<tr>
<td>No Response</td>
<td>1</td>
<td>1.0</td>
</tr>
<tr>
<td>Total</td>
<td>105</td>
<td>100.0</td>
</tr>
</tbody>
</table>

A total of 30 (28.6%) participants reported working at Clinical Mental Health internship/practicum sites, 62 (59.0%) reported working in School Settings, 9 (8.6%) reported working in College/University placements, 2 (1.9%) reported they worked in other settings, and 2 elected not to respond. This information is shown in Table 8.

Table 8.

<table>
<thead>
<tr>
<th>Time in Supervision per Week</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Mental Health Counseling</td>
<td>30</td>
<td>28.6</td>
</tr>
<tr>
<td>School</td>
<td>62</td>
<td>59.0</td>
</tr>
</tbody>
</table>
As indicated in Table 9, 36 (34.3%) participants reported providing less than four hours of direct clinical services per week, 25 (23.8%) reported averaging between 5-9 direct hours, 24 (22.9%) reported averaging between 10-14 direct hours, 13 (12.4%) reported averaging between 15-20 direct hours per week, six (5.7%) reported averaging more than 20 direct hours per week, and 1 participant elected not to respond.

Table 9.

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4 hrs</td>
<td>36</td>
</tr>
<tr>
<td>5-9 hrs</td>
<td>25</td>
</tr>
<tr>
<td>10-14 hrs</td>
<td>24</td>
</tr>
<tr>
<td>15-20 hrs</td>
<td>13</td>
</tr>
<tr>
<td>more than 20</td>
<td>6</td>
</tr>
<tr>
<td>No Response</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>105</td>
</tr>
</tbody>
</table>

In addition to the demographic questionnaire, participants were provided the 5F-Wel (Myers & Sweeney, 2005) to assess levels of supervisee wellness, both on the first-order factor (Total Wellness) and the second-order factors (Creative, Coping, Essential, Physical, and Social Selves). Scores range from 25-100 with higher scores indicating higher levels of wellness (Myers & Sweeney, 2005). As indicated in Table 10, scores on the 5F-Wel (Myers & Sweeney, 2005) in this sample are consistently higher both on first-order and second-order factors. However, it should be recognized that the norming group for the 5F-Wel consisted of a wider sample of the general population (Myers & Sweeney, 2005); in contrast, this study focused only on students pursuing a Master’s degree in counselor education. The higher mean scores on the
5F-Wel (Myers & Sweeney, 2005) in this sample do affirm some concerns regarding the effects of social desirability as a potential limitation of the study. While these scores are higher than the general population, they are consistent with previous studies (Roach & Young, 2007). The potential effects of social desirability on the study are further discussed in Chapter 5.

Table 10.

Descriptive Statistics for the 5F-Wel

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Minimum</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Creative Self</td>
<td>105</td>
<td>81.8409</td>
<td>7.18581</td>
<td>68.75</td>
<td>96.25</td>
</tr>
<tr>
<td>Coping Self</td>
<td>105</td>
<td>76.4949</td>
<td>8.21450</td>
<td>57.89</td>
<td>92.11</td>
</tr>
<tr>
<td>Essential Self</td>
<td>105</td>
<td>78.5319</td>
<td>11.11490</td>
<td>50.00</td>
<td>98.44</td>
</tr>
<tr>
<td>Physical Self</td>
<td>105</td>
<td>70.5820</td>
<td>16.06977</td>
<td>32.50</td>
<td>100.00</td>
</tr>
<tr>
<td>Social Self</td>
<td>105</td>
<td>91.9260</td>
<td>9.22003</td>
<td>62.50</td>
<td>100.00</td>
</tr>
<tr>
<td>Total Wellness</td>
<td>105</td>
<td>79.3593</td>
<td>6.84641</td>
<td>65.20</td>
<td>93.57</td>
</tr>
</tbody>
</table>

Along with the demographic questionnaire and the 5F-Wel (Myers & Sweeney, 2005), an instrument to assess supervisees’ perceptions of their supervisor’s wellness was also distributed. Using discrete factor definitions from the 5F-Wel (Myers & Sweeney, 2005), the instrument measures each supervisee’s perception of his or her supervisor’s wellness on first-order and second-order factors. The instrument uses the same scoring procedures as the 5F-Wel (Myers & Sweeney, 2005) and scores are on a scale between 25-100 with higher scores indicating greater levels of wellness. As this instrument was unique to this study, there is no available data of the population with which to compare the data from the sample. It is interesting to note how both means and standard deviations tended to be larger for the supervisee’s perception of their supervisor’s wellness as compared to their own personal wellness (Table 11).
Table 11.

*Descriptive Statistics for the Perception of Supervisor Wellness Instrument*

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Minimum</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Creative Self</td>
<td>105</td>
<td>82.2931</td>
<td>12.04527</td>
<td>50.00</td>
<td>100.00</td>
</tr>
<tr>
<td>Coping Self</td>
<td>104</td>
<td>82.2573</td>
<td>11.04441</td>
<td>46.43</td>
<td>100.00</td>
</tr>
<tr>
<td>Essential Self</td>
<td>103</td>
<td>85.4490</td>
<td>9.65529</td>
<td>50.00</td>
<td>100.00</td>
</tr>
<tr>
<td>Physical Self</td>
<td>101</td>
<td>72.7723</td>
<td>18.23424</td>
<td>25.00</td>
<td>100.00</td>
</tr>
<tr>
<td>Social Self</td>
<td>102</td>
<td>82.1078</td>
<td>11.99084</td>
<td>45.00</td>
<td>100.00</td>
</tr>
<tr>
<td>Total Wellness</td>
<td>103</td>
<td>82.1412</td>
<td>9.58949</td>
<td>50.00</td>
<td>100.00</td>
</tr>
</tbody>
</table>

To gauge the strength of the supervisory relationship the S-SRQ (Cliffe et al., 2014) was used. The instrument is made of three subscales (Safe Base, Reflective Education, Structure) that are summed to comprise the total score for the measure (Cliffe et al., 2014). As indicated in Table 12, total scores range from 18-126, with higher numbers indicating stronger supervisory relationships (Cliffe et al., 2014).

Table 12.

*Descriptive Statistics for the S-SRQ*

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Minimum</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safe Base</td>
<td>104</td>
<td>54.6538</td>
<td>10.96045</td>
<td>18.00</td>
<td>63.00</td>
</tr>
<tr>
<td>Reflective Education</td>
<td>103</td>
<td>27.0097</td>
<td>7.00349</td>
<td>7.00</td>
<td>35.00</td>
</tr>
<tr>
<td>Structure</td>
<td>105</td>
<td>20.2825</td>
<td>5.90610</td>
<td>4.00</td>
<td>28.00</td>
</tr>
<tr>
<td>Total</td>
<td>104</td>
<td>101.9801</td>
<td>21.84871</td>
<td>30.00</td>
<td>126.00</td>
</tr>
</tbody>
</table>

**Findings**

This section will review the results from the analyses of the research questions. Underlying assumptions are discussed, and implications/limitations are highlighted.

**Assumption of Analyses**

The purpose of this quantitative investigation is to analyze the role of modeled wellness as a way for supervisors to influence multifaceted aspects of supervisee wellness, and identify if factoring in the supervisory relationship changes this influence. To meet this goal, the researcher
utilized a series of stepwise regressions to understand how perceived supervisor wellness (total wellness and second-order factors) predicts supervisee personal wellness (on the corresponding first or second-order factor), and how the addition of the supervisory relationship as a second predictor variable changes this prediction. When performing a stepwise regression, two important assumptions must be met: (1) normal distribution of the data, (2) linear relationships between variables (Howell, 2010).

Though the assumptions for each research question are the same, for clarity in the description of the variables, each research question will be addressed independently. To address the assumption of normality among the data, skewness and kurtosis of variables were assessed. When skewness and kurtosis are less than +/- 2, normal distribution can be assumed. All variables being analyzed in RQ1 fell below this threshold, as shown in Table 13.

Table 13.

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Skewness</th>
<th>Kurtosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supr Total Well</td>
<td>103</td>
<td>-.546</td>
<td>.299</td>
</tr>
<tr>
<td>Supe Total Well</td>
<td>105</td>
<td>.085</td>
<td>-.666</td>
</tr>
<tr>
<td>Sup Rel Total</td>
<td>105</td>
<td>-1.361</td>
<td>1.355</td>
</tr>
</tbody>
</table>

The second assumption necessary for analysis pertains to a linear relationship between variables. To confirm this assumption the researcher checked the relationships between variables for collinearity. Collinearity is assessed through the examination of Variance Inflation Factors (VIF) and tolerance statistics (Howell, 2010). To rule out collinearity, VIF must be low (<10) and tolerance should be high (> .1). As evidenced in Table 14, neither of the variables merit further investigation due to high tolerance statistics, and low VIF. With this, a linear relationship can be assumed.
Table 14.

**Collinearity Statistics**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Collinearity Statistics</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Tolerance</td>
<td>VIF</td>
</tr>
<tr>
<td>Sup Total Well</td>
<td>.426</td>
<td>2.349</td>
</tr>
<tr>
<td>Sup Rel Total</td>
<td>.426</td>
<td>2.349</td>
</tr>
</tbody>
</table>

Similar to the assumptions for RQ1, data met the assumptions for normality on all second-order factors for the perception of supervisor wellness instrument and the 5F-Wel (Myers & Sweeney, 2005) necessary for RQ2 (Table 15 and 17). Normality of the S-SRQ (Cliffe et al., 2014) was assessed previously.

Table 15.

**Second-order factors of Wellness for Perception of Supervisor Wellness**

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Skewness</th>
<th>Kurtosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Creative Self</td>
<td>105</td>
<td>-.798</td>
<td>.114</td>
</tr>
<tr>
<td>Coping Self</td>
<td>104</td>
<td>-.378</td>
<td>.360</td>
</tr>
<tr>
<td>Essential Self</td>
<td>103</td>
<td>-.673</td>
<td>.583</td>
</tr>
<tr>
<td>Physical Self</td>
<td>101</td>
<td>-.413</td>
<td>-.049</td>
</tr>
<tr>
<td>Social Self</td>
<td>102</td>
<td>-.323</td>
<td>-.114</td>
</tr>
</tbody>
</table>

Table 16.

**Second-order factors of the 5F-Wel**

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Skewness</th>
<th>Kurtosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Creative Self</td>
<td>105</td>
<td>.212</td>
<td>-.626</td>
</tr>
<tr>
<td>Coping Self</td>
<td>105</td>
<td>-.110</td>
<td>-.706</td>
</tr>
<tr>
<td>Essential Self</td>
<td>105</td>
<td>-.144</td>
<td>-.460</td>
</tr>
<tr>
<td>Physical Self</td>
<td>105</td>
<td>-.097</td>
<td>-.500</td>
</tr>
<tr>
<td>Social Self</td>
<td>105</td>
<td>-1.226</td>
<td>575</td>
</tr>
</tbody>
</table>

Additionally, as indicated in Tables 17-21 there are no concerns regarding collinearity for any of the five stepwise regressions to complete RQ 2a, as all tolerance statistics are greater than .1 high, and all VIF statistics are less than 10. Therefore, linear relationships were assumed.
Table 17.  
*Predicting Creative Self-Collinearity Statistics*

<table>
<thead>
<tr>
<th>Variables</th>
<th>Collinearity Statistics</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Tolerance</td>
<td>VIF</td>
</tr>
<tr>
<td>Sup Rel Total</td>
<td>.367</td>
<td>2.723</td>
</tr>
<tr>
<td>Supr Creative</td>
<td>.367</td>
<td>2.723</td>
</tr>
</tbody>
</table>

a. Dependent Variable: Supe Creative

Table 18.  
*Predicting Coping Self-Collinearity Statistics*

<table>
<thead>
<tr>
<th>Variable</th>
<th>Collinearity Statistics</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Tolerance</td>
<td>VIF</td>
</tr>
<tr>
<td>Sup Rel Total</td>
<td>.520</td>
<td>1.923</td>
</tr>
<tr>
<td>Supr Coping</td>
<td>.520</td>
<td>1.923</td>
</tr>
</tbody>
</table>

a. Dependent Variable: Supe Coping

Table 19.  
*Predicting Essential Self-Collinearity Statistics*

<table>
<thead>
<tr>
<th>Model</th>
<th>Collinearity Statistics</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Tolerance</td>
<td>VIF</td>
</tr>
<tr>
<td>SupRel Total</td>
<td>.755</td>
<td>1.325</td>
</tr>
<tr>
<td>Supr Essential</td>
<td>.755</td>
<td>1.325</td>
</tr>
</tbody>
</table>

a. Dependent Variable: Supe Essential

Table 20.  
*Predicting Physical Self-Collinearity Statistics*

<table>
<thead>
<tr>
<th>Variables</th>
<th>Collinearity Statistics</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Tolerance</td>
<td>VIF</td>
</tr>
<tr>
<td>Sup Rel Total</td>
<td>.978</td>
<td>1.023</td>
</tr>
<tr>
<td>Supr Physical</td>
<td>.978</td>
<td>1.023</td>
</tr>
</tbody>
</table>

a. Dependent Variable: Supe Physical

Table 21.  
*Predicting Social Self-Collinearity Statistics*

<table>
<thead>
<tr>
<th>Variables</th>
<th>Collinearity Statistics</th>
</tr>
</thead>
</table>
Findings for RQ1 and RQ1a

To analyze RQ1 and RQ1a (*What is the influence of a supervisee’s perception of their supervisor’s level of wellness on their own wellness? And how does the inclusion of the strength of the supervisory relationship as a predictor change the model?*), a stepwise regression was used. The total wellness score on the perception of supervisor wellness was used to predict supervisor wellness, and supervisee wellness was measured by the total wellness score on the 5F-Wel (Myers & Sweeney, 2005). In this model, perceived supervisor wellness explained 4.1% of the variance in supervisee wellness. The model was statistically significant (*F*(1,100)=4.275, *p*= .041, β= .202).

After the first step regression was completed the total score of the S-SRQ (Cliffe et al., 2014) was added to the model as a predictor variable in the second step to understand how the strength of the supervisory relationship changed the model. In this new model, 9.0% of the variance in supervisee wellness could be predicted by perceived supervisor wellness and the supervisory relationship as evidenced by an $R^2 = .090$. This model was also statistically significant (*F*(2,99)=4.878, *p*= .010). The addition of the supervisory relationship as a predictor variable provided significant increases in the predictability of the model (as evidenced by $\Delta R^2 = .049$), and the statistical significance (*p*= .041 to *p*= .010). In the model both perception of supervisor wellness ($\beta = .459$, *p*= .002) and the supervisory relationship ($\beta = -.338$, *p*= .023) were statistically significant.
Table 22.

**Predicting Total Wellness Model Summary**

<table>
<thead>
<tr>
<th>Model</th>
<th>R</th>
<th>$R^2$</th>
<th>SE</th>
<th>$\Delta R^2$</th>
<th>$\Delta F$</th>
<th>df1</th>
<th>df2</th>
<th>Sig. F Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>.202</td>
<td>.041</td>
<td>6.73</td>
<td>.041</td>
<td>4.275</td>
<td>1</td>
<td>100</td>
<td>.041</td>
</tr>
<tr>
<td>2</td>
<td>.300</td>
<td>.090</td>
<td>6.59</td>
<td>.049</td>
<td>5.298</td>
<td>1</td>
<td>99</td>
<td>.023</td>
</tr>
</tbody>
</table>

a. Predictors: (Constant), Supr Total Wel
b. Predictors: (Constant), Supr Total Wel, Sup Rel Total

d. One point of interest are the differences in correlation between the zero order and part
and partial correlations for the supervisory relationship. Where the supervisory relationship has
a negligible zero-order correlation with supervisee wellness, the relationship changes to a stronger negative correlation when accounting for perceived supervisor wellness (Table 25). This change, along lack of correlation with the outcome variable (supervisee wellness), high correlation with the other predictor variable (perceived supervisor wellness) (see Table 26, negative beta weight, and the increase in $R^2$ (Table 22 and 24), the supervisory relationship fits the definition of a suppressor variable in this equation (Friedman & Wall, 2005; Smith, Ager, & Williams, 1992).

Uncommon in psychological research (Howell, 2010), suppressor variables increase the predictive validity of other predictor variables when included in an equation (McKinnon, Kull, & Lockwood, 2000). Not to be confused with confounding or mediating variables, which are often assumed to reduce the strength of a relationship between a predictor and outcome variable (McKinnon et al., 2000), suppressor variables “contribute to the regression equation by removing error and hence by enhancing the ability of the first predictor to explain criterion variance” (Smith et al., 1992, p. 21). In this equation, the inclusion of the supervisory relationship enhances the predictive validity of perceived supervisor wellness when predicting supervisee wellness.

Table 25.

*Predicting Total Wellness Zero Order, Partial and Part Correlations*

<table>
<thead>
<tr>
<th>Model</th>
<th>Correlations</th>
<th>Zero-order</th>
<th>Partial</th>
<th>Part</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Supr Total Wel</td>
<td>.202</td>
<td>.299</td>
<td>.299</td>
</tr>
<tr>
<td></td>
<td>Sup Rel Total</td>
<td>.009</td>
<td>-.225</td>
<td>-.221</td>
</tr>
</tbody>
</table>

a. Dependent Variable: Supe Total Wel
Table 26.
Supervisee Wellness, Perceived Supervisor Wellness, and the Supervisory Relationship Correlations

<table>
<thead>
<tr>
<th></th>
<th>Supe Total Wel</th>
<th>Supr Total Wel</th>
<th>Sup Rel Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supe Total Wel</td>
<td>1</td>
<td>.202*</td>
<td>.009</td>
</tr>
<tr>
<td>Pearson Correlation</td>
<td></td>
<td>1</td>
<td>.758**</td>
</tr>
<tr>
<td>Sig. (1-tailed)</td>
<td>.020</td>
<td>.462</td>
<td>.000</td>
</tr>
<tr>
<td>N</td>
<td>105</td>
<td>103</td>
<td>104</td>
</tr>
<tr>
<td>Supr Total Wel</td>
<td>.202*</td>
<td>1</td>
<td>.758**</td>
</tr>
<tr>
<td>Pearson Correlation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sig. (1-tailed)</td>
<td>.020</td>
<td>.000</td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>103</td>
<td>103</td>
<td>102</td>
</tr>
<tr>
<td>Sup Rel Total</td>
<td>.009</td>
<td>.763**</td>
<td>1</td>
</tr>
<tr>
<td>Pearson Correlation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sig. (1-tailed)</td>
<td>.462</td>
<td>.000</td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>104</td>
<td>102</td>
<td>104</td>
</tr>
</tbody>
</table>

*. Correlation is significant at the 0.05 level (1-tailed).
**. Correlation is significant at the 0.01 level (1-tailed).

For a more comprehensive understanding of the suppression effect within this equation a more in-depth correlational analysis was conducted. The sample was divided into three separate sections based on scores on the S-SRQ (Cliffe et al., 2014). Individuals who scored less than 90 (indicating an average answer of less than “Slightly Agree” on all items and thereby indicating weaker supervisory relationships), individuals who scored from 90-108 (indicating averages of “slightly agree” to agree” and thereby indicating moderate supervisory relationships) and individuals scored above 108 (indicating averages of “Agree” or better, thereby indicating strong supervisory relationships) were placed in separate groups. The correlations from each group are as follows (Tables 27 – 29).
Table 27.

*Weak Supervisory Relationship Correlations*

<table>
<thead>
<tr>
<th></th>
<th>Supe Wel</th>
<th>Supr Wel</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supe Total Wel</td>
<td>Pearson Correlation 1</td>
<td>.407*</td>
</tr>
<tr>
<td></td>
<td>Sig. (1-tailed)</td>
<td>.030</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>22</td>
</tr>
<tr>
<td>Supr Total Wel</td>
<td>Pearson Correlation .407*</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Sig. (1-tailed)</td>
<td>.030</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>22</td>
</tr>
</tbody>
</table>

* Correlation is significant at the 0.05 level (1-tailed).

Table 28.

*Moderate Supervisory Relationship Correlations*

<table>
<thead>
<tr>
<th></th>
<th>Supe Wel</th>
<th>Supr Wel</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supe Total Wel</td>
<td>Pearson Correlation 1</td>
<td>.191</td>
</tr>
<tr>
<td></td>
<td>Sig. (1-tailed)</td>
<td>.156</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>30</td>
</tr>
<tr>
<td>Super Total Wel</td>
<td>Pearson Correlation .191</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Sig. (1-tailed)</td>
<td>.156</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>30</td>
</tr>
</tbody>
</table>

Table 29.

*Strong Supervisory Relationship Correlations*

<table>
<thead>
<tr>
<th></th>
<th>Supe Wel</th>
<th>Supr Wel</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supe Total Wel</td>
<td>Pearson Correlation 1</td>
<td>.367**</td>
</tr>
<tr>
<td></td>
<td>Sig. (1-tailed)</td>
<td>.004</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>52</td>
</tr>
<tr>
<td>Supr Total Wel</td>
<td>Pearson Correlation .367**</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Sig. (1-tailed)</td>
<td>.004</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>50</td>
</tr>
</tbody>
</table>

** Correlation is significant at the 0.01 level (1-tailed).

In the examination of the different correlations within the three groups it becomes apparent that perceived supervisor wellness displays a stronger correlation with supervisee wellness when supervisory relationships are either strong or weak. Whereas supervisees who
perceive their supervisory relationship as moderate (neither strong nor weak) perception of supervisor wellness and supervisee wellness are not correlated. This indicates that perceived supervisor wellness is influential to supervisee wellness, in strong supervisory relationships and in weak supervisory relationships, but is not influential in moderate supervisory relationships.

**Findings for RQ2 and RQ2a**

To analyze RQ2 and RQ2a (*What is the influence of a supervisee’s perception of specific second-order factors of supervisor wellness (Creative Self, Coping Self, Social Self, Essential Self, Physical Self) on the corresponding factor of their own wellness? And how does the inclusion of the strength of the supervisory relationship as a predictor change these models?*), a series of five stepwise regressions were used. Second-Order factor scores (Creative, Coping, Social, Essential, and Physical Selves) on the perception of supervisor wellness were used to predict the corresponding factor of supervisee wellness, which was measured by the corresponding second-order factor score on the 5F-Wel (Myers & Sweeney, 2005). Of the five first step regressions, perceived supervisor Creative Self and Coping Self proved to be statistically significant in predicting the corresponding second-order factors of supervisee wellness. Perceived supervisor Creative Self predicted 4.0% of the variance in supervisee Creative Self ($R^2 = .04, F(1,102)= 4.209, p=.043, \beta = .199$). Perceived supervisor Coping Self predicted 6.5% of the variance in supervisee Coping Self ($R^2 = .065, F(1,110)= 7.074, p=.009, \beta = .256$). Neither perceived supervisor Social Self ($F(1,99)= 2.346, p=.129$) perceived supervisor Essential Self ($F(1,100)= .562, p=.455$), or perceived supervisor Physical Self ($F(1,98)= .031, p=.861$) provided significant statistical prediction.

After the first step regressions were completed the total score of the S-SRQ (Cliffe et al., 2014) was added in the second step, as an additional predictor variable understand how the
strength of the supervisory relationship changed the models. The inclusion of the supervisory relationship provided minimal changes to the models. The prediction of supervisee Creative Self became statistically insignificant ($F(2,101)= 2.119, p= .125$).

Table 30.

*Predicting Creative Self ANOVA* \(^a\)

<table>
<thead>
<tr>
<th>Model</th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Regression</td>
<td>210.752</td>
<td>1</td>
<td>210.752</td>
<td>4.209</td>
</tr>
<tr>
<td>Residual</td>
<td>5107.747</td>
<td>102</td>
<td>50.076</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>5318.499</td>
<td>103</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Regression</td>
<td>214.152</td>
<td>2</td>
<td>107.076</td>
<td>2.119</td>
</tr>
<tr>
<td>Residual</td>
<td>5104.347</td>
<td>101</td>
<td>50.538</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>5318.499</td>
<td>103</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

\(^a\) Dependent Variable: Supe Cre  
\(^b\) Predictors: (Constant), Supr Cre  
\(^c\) Predictors: (Constant), Supr Cre, Sup Rel Tot

Table 31.

*Predicting Creative Self Model Summary*

<table>
<thead>
<tr>
<th>Model</th>
<th>R</th>
<th>R²</th>
<th>SE</th>
<th>ΔR²</th>
<th>ΔF</th>
<th>df1</th>
<th>df2</th>
<th>Sig. F Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>.199(^a)</td>
<td>.040</td>
<td>7.07644</td>
<td>.040</td>
<td>4.209</td>
<td>1</td>
<td>102</td>
<td>.043</td>
</tr>
<tr>
<td>2</td>
<td>.201(^b)</td>
<td>.040</td>
<td>7.10901</td>
<td>.001</td>
<td>.067</td>
<td>1</td>
<td>101</td>
<td>.796</td>
</tr>
</tbody>
</table>

\(^a\) Predictors: (Constant), SuperCre  
\(^b\) Predictors: (Constant), SuperCre, SRtot
Table 32.

**Predicting Creative Self Coefficients**

<table>
<thead>
<tr>
<th>Model</th>
<th>Unstandardized Coefficients</th>
<th>Standardized Coefficients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B</td>
<td>Std. Error</td>
</tr>
<tr>
<td>1</td>
<td>72.068</td>
<td>4.814</td>
</tr>
<tr>
<td></td>
<td>SuperCre</td>
<td>.119</td>
</tr>
<tr>
<td>2</td>
<td>71.838</td>
<td>4.917</td>
</tr>
<tr>
<td></td>
<td>SuperCre</td>
<td>.139</td>
</tr>
<tr>
<td></td>
<td>SRtot</td>
<td>-.014</td>
</tr>
</tbody>
</table>

a. Dependent Variable: SuperCre

While the prediction of supervisee Coping Self remained significant ($F(2,100)=4.047$, $p=.020$), change in $R^2$ was small ($\Delta R^2=.009$) and the supervisory relationship itself was not a significant predictor ($p=.315$) within the model.

Table 33.

**Predicting Coping Self ANOVA**

<table>
<thead>
<tr>
<th>Model</th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Regression 450.505</td>
<td>1</td>
<td>450.505</td>
<td>7.074</td>
<td>.009b</td>
</tr>
<tr>
<td></td>
<td>Residual 6432.260</td>
<td>101</td>
<td>63.686</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total 6882.765</td>
<td>102</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Regression 515.415</td>
<td>2</td>
<td>257.707</td>
<td>4.047</td>
<td>.020c</td>
</tr>
<tr>
<td></td>
<td>Residual 6367.350</td>
<td>100</td>
<td>63.674</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total 6882.765</td>
<td>102</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

a. Dependent Variable: Super Cop
b. Predictors: (Constant), Supr Cop
c. Predictors: (Constant), Supr Cop, Sup Rel Tot
Table 34.
*Predicting Coping Self Model Summary*

<table>
<thead>
<tr>
<th>Model</th>
<th>R</th>
<th>R²</th>
<th>SE</th>
<th>ΔR²</th>
<th>ΔF</th>
<th>df1</th>
<th>df2</th>
<th>Sig. F</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>.256a</td>
<td>.065</td>
<td>7.98033</td>
<td>.065</td>
<td>7.074</td>
<td>1</td>
<td>101</td>
<td>.009</td>
</tr>
<tr>
<td>2</td>
<td>.274b</td>
<td>.075</td>
<td>7.97957</td>
<td>.009</td>
<td>1.019</td>
<td>1</td>
<td>100</td>
<td>.315</td>
</tr>
</tbody>
</table>

a. Predictors: (Constant), Supr Cop
b. Predictors: (Constant), Supr Cop, Sup Rel Tot

Table 35.
*Predicting Coping Self Coefficients*

<table>
<thead>
<tr>
<th>Model</th>
<th>Unstandardized Coefficients</th>
<th>Standardized Coefficients</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B</td>
<td>Std. Error</td>
<td>Beta</td>
</tr>
<tr>
<td>1</td>
<td>(Constant)</td>
<td>60.842</td>
<td>5.937</td>
</tr>
<tr>
<td></td>
<td>Supr Cop</td>
<td>.190</td>
<td>.072</td>
</tr>
<tr>
<td>2</td>
<td>(Constant)</td>
<td>60.298</td>
<td>5.961</td>
</tr>
<tr>
<td></td>
<td>Supr Cop</td>
<td>.260</td>
<td>.099</td>
</tr>
<tr>
<td></td>
<td>Sup Rel Tot</td>
<td>-.051</td>
<td>.050</td>
</tr>
</tbody>
</table>

a. Dependent Variable: Supe Cop

Predictions of supervisee Social Self \((F(2,98)= 2.240, p= .112)\), Essential Self \((F(2,99)= 1.063, p= .349)\) and Physical Self \((F(2,97)= .872, p= .421)\) remained statistically insignificant.
Table 36.

**Predicting Social Self ANOVA**

<table>
<thead>
<tr>
<th>Model</th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Regression</td>
<td>196.813</td>
<td>1</td>
<td>196.813</td>
<td>2.346</td>
</tr>
<tr>
<td></td>
<td>Residual</td>
<td>8304.078</td>
<td>99</td>
<td>83.880</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>8500.890</td>
<td>100</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Regression</td>
<td>371.654</td>
<td>2</td>
<td>185.827</td>
<td>2.240</td>
</tr>
<tr>
<td></td>
<td>Residual</td>
<td>8129.236</td>
<td>98</td>
<td>82.951</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>8500.890</td>
<td>100</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

a. Dependent Variable: Supe Soc  
b. Predictors: (Constant), Supr Soc  
c. Predictors: (Constant), Supr Soc, Sup Rel Tot

Table 37.

**Predicting Essential Self ANOVA**

<table>
<thead>
<tr>
<th>Model</th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Regression</td>
<td>69.686</td>
<td>1</td>
<td>69.686</td>
<td>.562</td>
</tr>
<tr>
<td></td>
<td>Residual</td>
<td>12407.953</td>
<td>100</td>
<td>124.080</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>12477.640</td>
<td>101</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Regression</td>
<td>262.294</td>
<td>2</td>
<td>131.147</td>
<td>1.063</td>
</tr>
<tr>
<td></td>
<td>Residual</td>
<td>12215.346</td>
<td>99</td>
<td>123.387</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>12477.640</td>
<td>101</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

a. Dependent Variable: Supe Ess  
b. Predictors: (Constant), Supr Ess  
c. Predictors: (Constant), Supr Ess, Sup Rel Tot

Table 38.

**Predicting Physical Self ANOVA**

<table>
<thead>
<tr>
<th>Model</th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Regression</td>
<td>8.077</td>
<td>1</td>
<td>8.077</td>
<td>.031</td>
</tr>
<tr>
<td></td>
<td>Residual</td>
<td>25557.451</td>
<td>98</td>
<td>260.790</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>25565.528</td>
<td>99</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Regression</td>
<td>451.498</td>
<td>2</td>
<td>225.749</td>
<td>.872</td>
</tr>
<tr>
<td></td>
<td>Residual</td>
<td>25114.030</td>
<td>97</td>
<td>258.908</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>25565.528</td>
<td>99</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

a. Dependent Variable: Supe Phys  
b. Predictors: (Constant), Supr Phys  
c. Predictors: (Constant), Supr Phys, Sup Rel Tot
Throughout this set of stepwise regressions, there were instances when the supervisory relationship demonstrated traits of suppression in each equation (i.e. increasing predictive validity, negative beta weights etc.). However, there was no instance amongst these regressions in which the supervisory relationship improved the models to a statistically significant level.

**Summary**

In this chapter, the research questions were analyzed using a series of stepwise regressions, which enabled the researcher to analyze how the perception of supervisor wellness predicts supervisee personal wellness on both total wellness and second-order factors of wellness described by the Indivisible Self Model of Wellness (IS-WEL; Myers & Sweeney, 2004). The results from this analysis indicated that perceived supervisor wellness can be considered a statistically significant predictor of supervisee wellness described by the IS-WEL and 5F-Wel (Myers & Sweeney, 2005). Though the variance described by this model is small (4.1%), the prediction was increased (9%) with the inclusion of the supervisory relationship as a predictor variable, despite the lack of correlation between the supervisory relationship and supervisee personal wellness. In analyzing correlations, beta weights, and changes in $R^2$, it was determined that the supervisory relationship acted as a suppressor variable and increased the predictive validity of the perception of supervisor wellness by removing error from the prediction. With a further correlational analysis, it was revealed that perceived supervisor wellness was strongly correlated with supervisee wellness in strong and weak supervisory relationships.

Further, the researcher used subscale scores to identify if perceived second-order factors of supervisor wellness were predictive of the corresponding second-order factor of supervisee wellness. As expected, certain second-order factors perceived supervisor wellness were statistically significant predictors of the corresponding factor of supervisee wellness (Creative
Self and Coping Self), and some were not (Essential Self, Physical Self, and Social Self). Models that were statistically significant, described only small amounts of variance in second-order factors of wellness, with none exceeding an $R^2$ of .065.

When the supervisory relationship was included in the second step, only the model predicting Coping Self maintained statistical significance. However, in this model the supervisory relationship itself was not a significant predictor, despite the model remaining statistically significant. Throughout the five stepwise regressions examining second-order factors, the supervisory relationship showed signs of acting as a suppressor variable (negative beta weights, increased prediction of the other independent variable), however in each circumstance the supervisory relationship lacked statistical significance as a predictor.

Following in Chapter 5, the implications of these results will be highlighted, with a specific focus on supervisors and counselor educators. Further, the research will discuss the limitations of the study and opportunities for continued research.
CHAPTER FIVE:
DISCUSSION AND IMPLICATIONS

This chapter presents a thorough discussion of the findings from this investigation and possible explanations. The results from each research question are considered and the implications as they pertain to educators, supervisors, and counselors are indicated. Additionally, the limitations of the study and recommendations for future research are reviewed.

Overview of the Study

Wellness, which is a comprehensive term referring to an individual’s physical, emotional, spiritual and cognitive health, has become an increasingly important paradigm for counseling and an essential construct in the counselor professional identity (Myers, 1991; Myers, Sweeney, & Witmer, 2000). Indeed, educators, supervisors, and counselors have identified improving counselor wellness as key strategy in improving the quality of counseling services and preventing counselor impairment (Lawson et al., 2007; Hendricks et al., 2009). Recommendations for improving counselor wellness in counselor education programs (Yager & Tovar-Blank, 2007) and mental health systems (Young & Lambie, 2007) have highlighted specific strategies that could prove beneficial in improving counselor wellness. One such strategy for improving counselor wellness is the provision of quality clinical supervision that models wellness assessment and planning (Cummins et al., 2007; Young & Lambie, 2007).

Supervision is the “signature” pedagogy of the mental health field (Bernard & Goodyear, 2014) and a pedagogical foundation for the profession. As such, researchers have developed new models for supervision that focus on improving counselor wellness through assessment and planning (Blount & Mullen, 2015; Lenz & Smith, 2010). Recent studies concur that counselor wellness can improve as a result of the direct intervention of the supervisor (Storlie & Smith,
2012; Lenz et al., 2012). Qualitative findings have also highlighted the benefits of a wellness focus in supervision (Lenz et al., 2014; Thompson et al., 2011). In contrast, a wellness intervention provided by an outsider to the supervisory relationship has been shown to be largely ineffective in improving supervisee wellness (Ohrt et al., 2015). The discrepancies between these two approaches (wellness intervention by a trusted supervisor versus formalized health-promoting interventions) raise questions regarding the role of the supervisor in the promotion of supervisee wellness.

Within the established body of literature there is little focus on the role of supervisor modeling in the promotion of wellness, despite the fact that appropriate modeling of wellness attitudes and self-care behaviors are coming to the forefront as best practice in clinical supervision (Borders et al., 2014). While qualitative findings indicate a supervisor’s modeling wellness behaviors and attitudes can be important to the development of supervisee wellness (Lenz et al., 2014; Thompson et al., 2011), it remains largely unexplored in quantitative studies (e.g. Storlie & Smith, 2012, Lenz et al., 2012). Due to the contrast in findings between wellness interventions within a strong supervisory relationship (e.g. Storlie & Smith, 2012), in the absence of a strong supervisory relationships (Ohrt et al., 2015), and the lack of research on modeled supervisor wellness and its influence on supervisee wellness, it is important to further investigate the transmission of wellness attitudes and behaviors between supervisor and supervisee.

Therefore, the purpose of this quantitative investigation was to (a) analyze the role of modeled wellness as a way for supervisors to influence multifaceted aspects of supervisee wellness, and (b) identify if factoring in the supervisory relationship changes this influence. The researcher utilized purposive, convenience sampling techniques to attain a sample of 105 participants. Participants were counselor education graduate students who were enrolled in a
practicum or internship course and were receiving supervision from a site supervisor. Participants completed a survey packet containing: a perception of supervisor wellness instrument, the Five Factor Wellness Inventory (Myers & Sweeney, 2005), the Short Version of the Supervisory Relationship Questionnaire (Cliffe et al., 2014), and a demographic questionnaire. The researcher then utilized a series of stepwise regression equations to understand how perceived supervisor wellness (both total wellness and the second-order factors of wellness) influenced supervisee wellness on the corresponding wellness factor, and whether the inclusion of the supervisory relationship as a predictor variable changed this influence.

**Discussion**

**Research Questions 1 and 1a**

Research Question 1 sought to understand the degree to which a supervisee’s perception of their supervisor’s wellness could be predictive of supervisee wellness, and how the inclusion of the supervisory relationship as a predictor changed the model. The total score for the perception of supervisor wellness instrument was used to measure supervisee perception of supervisor wellness; the total score for the Five Factor Wellness Inventory (Myers & Sweeney, 2005) was used to measure supervisee wellness; and the total score on the S-SRQ (Cliffe et al., 2014) was used to measure the strength of the supervisory relationship. The researcher utilized a stepwise regression equation to understand this prediction, entering perceived supervisor wellness during the first step, and adding in the supervisory relationship during the second step.

**First Step Regression: RQ1**

In the first step, the perception of supervisor wellness predicted 4.1% of the variance in supervisee wellness ($R^2=.041$). The model was statistically significant ($F(1,100)=4.275$, $p=.041$, $\beta=.202$). This finding indicates that a supervisee’s perception of his or her supervisor’s level of
wellness did influence the personal wellness of the counselor-in-training—albeit to a small degree. Even though this influence had not previously been measured quantitatively (and thus there are no statistical findings to compare with the current investigation), there are some analogous qualitative reports that support this influence. As noted previously, participants in both Lenz et al.’s (2014) and Thompson et al.’s (2011) qualitative studies reported the wellness-promoting benefits of supervisor modeling. Thus, the findings from these two articles highlight the benefits of supervisor modeling, and the present study supports this relationship quantitatively.

It must be noted that, initially, this influence appears small, with perceived supervisor wellness only explaining 4.1% of the variance in supervisee wellness. However, one should take into account the holistic nature of wellness and the degree of inclusivity in the definitions provided by the Indivisible Self Model of Wellness (Myers & Sweeney, 2004) used in the Five Factor Wellness Inventory (Myers & Sweeney, 2005). With this in mind, it is notable that the mere modeling of wellness by an individual that most supervisees had been known for 2-3 months (or spent, on average, 45-60 minutes with per week) had any significant impact on supervisee wellness. Consistent with the concepts outlined by Bandura (1977), this finding supports the importance of modeling professional identity and self-care strategies and highlights the best practices in clinical supervision (Borders et al., 2014). While this is significant to the literature on supervisee wellness, perhaps more interesting is how the prediction of supervisee wellness changed when the supervisory relationship was added to the model.
Second Step Regression: RQ1a

In the second step of the regression model, the strength of the supervisory relationship was entered as a second predictor variable. The total score on the Short Version of the Supervisory Relationship Questionnaire (Cliffe et al., 2014) measured the strength of the supervisory relationship. The inclusion of this new measure resulted in both significant changes to the model, as well as provided a more conclusive answer to RQ1a (How does the inclusion of the strength of the supervisory relationship as a predictor change this model?). Specifically, the second-step regression equation predicted 9% ($R^2=.09$) of the variance in supervisee wellness. The inclusion of the supervisory relationship more than doubled the predictive ability of the equation as evidenced by a change in $\Delta R^2=.049$. The model was statistically significant ($F(2,99)=4.878$, $p=.010$), and the inclusion of the supervisory relationship decreased the p-value ($p=.041$ to $p=.010$), indicating the model became more accurate in its prediction of supervisee wellness. In addition, both perceived supervisor wellness ($\beta=.459$, $p=.002$) and the supervisory relationship ($\beta=-.338$, $p=.023$) were statistically significant predictors in the model.

These changes to the model are interesting for a variety of reasons. One such reason is the evidence that the supervisory relationship is a suppressor variable in the model. A suppressor variable “contribute(s) to the regression equation by removing error and hence by enhancing the ability of the first predictor to explain criterion variance” (Smith et al., 1992, p. 21). The supervisory relationship adds to the model by enhancing the predictive ability of the supervisee’s perception of their supervisor’s wellness. To gain better understanding correlational patterns between supervisee wellness and perceived supervisor wellness, three separate correlation analyses were used after grouping data by the strength of the supervisory relationship. Data were placed into three groups Weak, Moderate, or Strong supervisory relationships. These analyses
identified a clear pattern. Perceived supervisor wellness and supervisee wellness were significantly correlated in groups where supervisory relationships were strong and weak, but lacked significance in moderate supervisory relationships.

This finding addresses a delimitation in multiple studies discussed in this document (e.g. Storlie & Smith, 2012; Lenz et al., 2012; Ohrt et al., 2015) and corroborates qualitative findings that indicated modeled wellness is beneficial in strong supervisory relationships (e.g. Thompson et al., 2011; Lenz et al., 2014). The correlation between perceived supervisor wellness and supervisee wellness in strong supervisory relationships is $r(50) = .367, p = .004$. This correlation indicates that perceived supervisor wellness has a moderate correlation with supervisee wellness in stronger supervisory relationships. This finding highlights the delimitation in both Storlie and Smith’s (2012) and Lenz et al.’s (2012) findings. Storlie & Smith (2012) found that supervisee wellness could be increased through intervention in supervision. In their study, supervisory relationships were also rated as strong (Storlie & Smith, 2012). Storlie & Smith’s (2012) finding in conjunction with the findings outlined in this study indicates that there is greater potential to influence supervisee wellness, both directly and indirectly, in strong supervisory relationships.

The correlation between perceived supervisor wellness and supervisee wellness in weak supervisory relationships also addresses delimitations in the literature. While studies have shown that wellness can be improved in strong supervisory relationships (e.g. Storlie & Smith, 2012), and qualitative feedback reports that modeled wellness is beneficial to supervisee wellness (Lenz et al., 2014; Thompson et al., 2011), wellness in weak supervisory relationships has not been examined. When examining weak supervisory relationships in this sample, there was a statistically significant correlation, $r(22) = .407, p = .03$. This finding indicates that in
weak supervisory relationships there is also a greater correlation between a supervisee’s perception of their supervisor’s wellness and their own personal wellness.

Interestingly, the correlation between perceived supervisor wellness and supervisee wellness lacked a statistically significant correlation in moderate supervisory relationships ($r_{(30)} = .191, p = .151$). These three separate correlational analyses provide some clarity about how the supervisory relationship is acting as a suppressor in the equation, as most of the error that it is suppressing lies within these moderate supervisory relationships. Within these moderate supervisory relationships there is a lack of statistically significant correlation of supervisee wellness and perceived supervisor wellness. However, in strong and weak supervisory relationships, not only is the correlation statistically significant, but shows a stronger correlation then displayed in the original stepwise regression model described in research questions 1 and 1a.

The stepwise regression analyses along with the following correlational analyses indicate multiple things. First, that a supervisee’s perception of their supervisor’s wellness can influence their own personal wellness. Second, the strength of the supervisory relationship can suppress this effect making a supervisee’s perception of their supervisor’s wellness a more accurate predictor of supervisee wellness. A correlational analysis indicates that in strong and weak supervisory relationship a supervisee’s perception of supervisor wellness has a stronger correlation with supervisee wellness then in moderate relationships. This means that in strong supervisory relationships and in weak supervisory relationships a supervisee’s perception of their supervisor’s wellness has a stronger effect on that supervisee’s personal wellness. However, if their supervisory relationships fall into moderate range, their supervisee’s perception of their supervisor’s wellness are suppressed by the relationship and do not effect the personal wellness
of the supervisee. The implications that this suppression effect has on counselors, supervisors, and educators will be discussed in subsequent sections.

Though not the focus of this study, of further interest is the importance wellness in creating supervisory relationships. While supervisee personal wellness was not correlated to the strength of the supervisory relationship, the supervisee’s perception of supervisor wellness displayed a strong correlation. This finding itself is similar to those of White & Queener (2003) who examined attachment styles in supervision. They found that it was not supervisee attachment style that predicted the strength of the supervisory relationship, but rather the supervisor’s attachment style (White & Queener, 2003). Both of these findings indicate that it is important not only to focus on the process of supervision, but how they are and what they demonstrate to supervisees.

**Research Question 2 and 2a**

In Research Question 2 I sought to understand how predictive perceived second-order factors of supervisor wellness (Creative Self, Coping Self, Social Self, Essential Self, Physical Self) in relation to corresponding second-order factor of supervisee wellness, and how the inclusion of the supervisory relationship influenced perceptions among supervisees. The second-order factor subscale scores on the perceived supervisor wellness instrument measured perceived second-order factors of supervisor wellness, the separate second-order factor subscale scores on the Five Factor Wellness Inventory (Myers & Sweeney, 2005) measured second-order factors of supervisee wellness, and the total score on the S-SRQ (Cliffe et al., 2014) measured the supervisory relationship. The researcher utilized a series of five stepwise regressions to understand this prediction, entering perceived second-order factor of supervisor wellness on the first step, and adding in the supervisory relationship in the second step.
First Step Regression: RQ2

In the first step series of regressions, only two second-order factors of perceived supervisor wellness were statistically significant predictors of the corresponding second-order factor of supervisee wellness: Creative Self ($R^2 = .04$, $F(1,102) = 4.209$, $p = .043$, $\beta = .199$), and Coping Self ($R^2 = .065$, $F(1,101) = 7.074$, $p = .009$, $\beta = .256$). All other second-order factor predictions lacked statistical significance. In both regressions (Creative Self and Coping Self), the second-order factor predicted a small amount of variance in the corresponding second-order factor (4% and 6.5%, respectfully). These predictions are consistent with findings described for RQ1, where total wellness scores predicted a similar amount of variance.

Additionally, this outcome corresponds with the qualitative findings described by Lenz et al. (2014)—specifically; participants indicated that a supervisor’s manifestation of these second-order factors was beneficial to their own wellness. Intuitively, it makes sense that some factors would be more predictive/significant than other, as some factors would be less discernible in the supervisory relationship (unless through supervisor self-disclosure). Consider, for example, the components of Creative and Coping Selves, which are comprised of discrete factors that are similar to traits to that should be displayed in supervision (e.g., emotional intelligence, humility, maturity, self-awareness, etc.) as outlined by best practices in clinical supervision (Borders et al., 2014). These factors are more apparent in supervision, and therefore are easier to perceive on the supervisee’s part, particularly among novice counselors such as those in graduate programs. Conversely, Physical and Social Self disclosures by the supervisor would tend to fall outside of what would be deemed appropriate professional boundaries (e.g., discussions of supervisor physical health and personal relationships) (Borders et al., 2014). Therefore, these latter traits would be less common in supervision, and therefore harder to perceive and be less predictive.
Interestingly, perceived supervisor Essential Self was not a statistically significant predictor of supervisee Essential Self. This is notable because unlike Physical and Social Selves, accepted best practices in supervision include extensive multicultural considerations (Borders et al., 2014), which are closely tied to the factors included in the Essential Self. It is likely that the lack of statistical significance is tied to the lack of consistency on the perceived supervisor Essential Self subscale ($\alpha = .534$, $n = 100$, $N=5$), which might be attributable to the small number of items on the subscale (discussed further in the Limitations section). However, there is also the possibility that cultural considerations tied to modeling a strong Essential Self in wellness are not being perceived by the supervisee because they are not being modeled effectively by the supervisor.

**Second Step Regressions: RQ2a**

In the second step of the regression models, the strength of the supervisory relationship was entered as a second predictor variable. The total score on the Short Version of the Supervisory Relationship Questionnaire (Cliffe et al., 2014) measured the strength of the supervisory relationship. The inclusion of this new measure provided minimal statistically significant changes to the five regressions.

The second step regression model for predicting supervisee Creative Self lacked statistical significance with the addition of the supervisory relationship. Additionally, while the second step regression model for predicting supervisee Coping Self remained significant, the supervisory relationship itself was not a significant predictor within the model. Further, the three first-step regression models that lacked significance (predicting supervise Physical, Social, and Essential Selves) remained statistically insignificant with the inclusion of the supervisory relationship.
Initially, when looking at the changes to the models in the second step regression it appears that the supervisory relationship exerted a negligent impact on the models. Throughout the five second-step regressions analyzed in this question, the inclusion of the supervisory relationship showed signs of suppression (i.e. negative beta weights, increasing the initial predictors’ beta weights, etc.). However, throughout the five second-step regressions, the supervisory relationship was shown to lack significance as a predictor; and although it did meet some of the criteria outlined for a suppression variable (Smith et al., 1992), it did not meet all necessary requirements. One potential explanation for this outcome is the reduction in the reliability of the subscales used for the independent and dependent variables in RQ2. This concern will be further addressed in the Limitations section.

**Implications**

**Implications for Counselors**

The results from this investigation may be of significance for the counseling profession in terms of the influence that supervisors can have on counselor wellness. Recall that results obtained from the second-step regression model confirmed that the combination of a supervisee’s perception of their supervisor’s wellness and the strength of the supervisory relationship accounted for 9% of the variance in supervisee personal wellness. This level of variance is, I believe, astounding—especially in light of the fact that each supervisee-participant had been working with their supervisors for an average of an hour or less a week for 2-3 months. The subsequent correlational analysis confirmed that in both strong and weak supervisory relationships, there was a moderate correlation between a supervisee’s perception of their supervisor’s wellness and their own personal wellness; in contrast, there was no such correlation in moderate supervisory relationships. The conclusion to be drawn from this outcome is that
counselors-in-training (and counselors in general) should be mindful of their own wellness attitudes and behaviors, as well as purposefully cognizant of their supervisor’s wellness because the two are interrelated—despite how brief or limited the supervisory relationship may be. Indeed, counselors should be direct in discussing their wellness and drawing on the referent experiences of their supervisors in identifying attitudes, behaviors, and strategies that have been effecting in developing personal wellness. Specifically, supervisees have been able to describe the value of viewing positive (and negative) wellness attitudes and behaviors by their supervisors (Lenz et al., 2014; Thompson et al., 2011). When supervisees can identify these patterns it is important to bring them into the supervision process to actively discuss, because they have an influence on the supervisee’s own personal wellness.

Also important for counselors is their perception of the strength of the supervisory relationship and how they act on the nature of that dyad. As this study indicated, in supervisory relationships of moderate strength there was limited transmission of wellness between supervisor and supervisee; conversely, there was a stronger transmission of wellness in both weak and strong supervisory relationships. The implication of this finding is that counselor trainees need to be aware of their perceptions of their supervisor’s wellness, regardless of the strength of the supervisory relationship—that even a perceived weak relationship with one’s supervisor still has the potential to impact supervisee wellness. Moreover, counselors should be cognizant of second-order factors of wellness, which are more likely to be conveyed from supervisor to supervisee as evidenced by RQ2 (Creative and Coping Self). These second-order factors of wellness are comprised of counselor thoughts, emotions, sense of control, enjoyment of work, positive humor, stress-management, engagement in leisure activities, sense of self-worth, and realistic beliefs. These specific supervisor wellness factors have been shown to be more
predictive of a supervisee’s wellness and thus may be more important to discuss during supervision. In contrast, the counselor-trainee might be better served by focusing less on his or her perception of the supervisor’s Physical, Essential, and Social Selves.

**Implications for Supervisors and Educators**

The implications from this investigation for supervisors and educators are significant in three overarching areas: the importance of supervisor wellness, the value of the supervisory relationship, and the potential for supervisor self-disclosure/transparency as a strategy for suppressing/facilitating the transmission of wellness. These three implications will be discussed at length.

The first implication for supervisors and educators is the fact that modeled wellness by the supervisor has been shown to influence supervisee wellness. The findings from this study confirm that certain holistic aspects of wellness are predictive of supervisee wellness—with some second-order factors of wellness being potentially more integral to the process of clinical supervision than others. Supervisors need to monitor their own wellness because as this investigation indicated, it not only provides individual benefits but, additionally, the way that wellness is modeled can influence the system in which they work. In short, by improving their own level of wellness, supervisors can influence the wellness of their supervisees. It must be noted, however, that this influence is not consistent across the board; it can be suppressed by the strength of the supervisory relationship, as noted in the next section.

The second implication for supervisors and educators is how the supervisory relationship can suppress the effect that a supervisee’s perception of their supervisor’s wellness has on their own wellness. As described earlier, perceived supervisor wellness has a greater correlation with supervisee wellness in strong and weak supervisory relationships than it does in moderate
supervisory relationships. There is also a strong correlation between perceived supervisor wellness and the supervisory relationship, indicating that it is likely that supervisors with strong supervisory relationships are also demonstrating high levels of wellness, and supervisors with weak supervisory relationships are demonstrating low levels of wellness. It is in these upper and lower groupings where perceived supervisor wellness appeared to be much more predictive. In moderate supervisory relationships, the effect tended to suppressed and prone to error in prediction of supervisee wellness.

There are a number of likely reasons for this suppression in moderate supervisor-supervisee relationship. The first reason pertains to the level of transparency or self-disclosure on the part of the supervisor in supervision or, more specifically, a lack thereof. A suppressor variable adds to a regression model by controlling for the error in the first predictor variable (Smith et al., 1992). According to the correlational analysis described in Chapter Four, it is clear that the error in this prediction was linked to observations where there was a moderate supervisory relationship. In other words, there was a lack of correlation between supervisee wellness and perceived supervisor wellness in moderate relationships. This outcome could potentially be linked to a supervisor who is not inclined to self-disclose or be more transparent about his or her own personal wellness. In circumstances in which the supervisor actually does have a low level of personal wellness, this lack of transparency could benefit the supervisee by creating positive professional boundaries (i.e., developing a moderate supervisory relationship) that avoids a detrimental influence on supervisee wellness. Conversely, there is also the potential that a supervisor with a high level of personal wellness does a disservice to his or her trainee by not being more transparent. This lack of openness could be potentially detrimental (as evidenced by the data findings described herein) in that the supervisee will not benefit from the
transmission of the strong personal wellness of the supervisor. The results from this study imply that supervisors should be aware of their personal wellness (or lack thereof), and display it intentionally to supervisees to help them develop appropriate wellness attitudes and behaviors that will enhance their own wellness development.

Simply put, these are discussions that a supervisor should have with their supervisees. Supervisors need to recognize their own wellness—particularly when it comes to factors that comprise Creative and Coping Selves (thoughts, emotions, sense of control, enjoyment of work, positive humor, stress-management, engagement in leisure activities, sense of self-worth, and realistic beliefs)—since the quantitative findings described herein indicate that they are more transferable to supervisees. They need to discuss and model positive examples of these traits to their supervisees to help them develop their own wellness attitudes and behaviors, and address them frequently with supervisees. Supervisors should recognize that the traits that they bring into supervision, whether it be their own personal wellness as studied here or attachment styles (White & Queener, 2003), have the ability to insulate supervisees from the systemic stress of learning the counseling profession and influence not only their competency in the profession but their ability to cope with its unique stressors. Further, supervisors need to recognize the role that the supervisory relationship plays in this transference. It is important to note that whether supervisors have a strong or weak relationship with their trainees, the way their wellness attitudes and behaviors are perceived by supervisees have a positive correlation with supervisee wellness. This means that even if supervisees feel that they lack a connection with their supervisor (or their supervisor lacks the structure or ability to provide appropriate wellness education opportunities during sessions), they still pick up on both the positive and negative
wellness attitudes and behaviors that are modeled—which then impact their own personal wellness.

Of particular note for supervisors who do recognize that they are struggling with their own wellness is the recognition that a successful supervisory relationship is not wholly dependent on modeling a wellness component. As noted above, for supervisors who form moderate supervisory relationships, this transmission was found to be statistically insignificant. There are many potential reasons for this lack of correlation; one that merits further investigation is the use of transparency/self-disclosure in supervision. If a supervisor does not disclose, or is not transparent, regarding certain factors that have been shown to be transferable in the supervisory relationship (thoughts, emotions, sense of control, enjoyment of work, positive humor, stress-management, engagement in leisure activities, sense of self-worth, and realistic beliefs), then the supervisee is unlikely to have an accurate perception of their supervisor’s level of wellness with respect to these factors. As a consequence, the supervisor will be less influential in supporting a trainee’s personal wellness. The supervisor should recognize, however, that some of these influential factors are easier to hide/not share with supervisee’s than others.

These findings also have important implications for counselor educators who need to recognize the potential influence that supervisors can have on their supervisees and be intentional in how they select and identify site placements for their counselors-in-training. Further, educators need to recognize that the site supervisor is not the only supervisor from whom these interns and practicum students receive supervision. It is important that educators also take into account the potential influence exerted by university supervisors (i.e., faculty members and fellow doctoral students) as well. This may be of particular concern due to the stressful and rigorous nature of academia and doctoral studies.
Implications for Policy

The results from this study also have implications for the development of counseling policy. In the current Code of Ethics by the American Counseling Association (2014), impairment is addressed in Section C.2.g, which states that “Counselors assist colleagues or supervisors in recognizing their own professional impairment and provide consultation and assistance when warranted with colleagues or supervisors showing signs of impairment and intervene as appropriate to prevent imminent harm to clients” (p. 9). While not directly discussing impairment, the present study addresses wellness, which has been situated on the same continuum (Lawson et al., 2007). The results of this investigation highlight a concern in the wording of Section C.2g. of the ACA (2014) Code of Ethics, however—namely that supervisors should also rely on their supervisees to assist in identifying and intervening in their own impairment.

This study highlights the influence that low levels of supervisor wellness can have on supervisees. The results detailed herein also indicate that it is relatively common for counselors-in-training to form weaker supervisory relationships with their site supervisors, as evidenced by the fact that 22 out of 105 participants identified as such. In recognizing the hierarchical nature of supervision and the influence that perceived supervisor wellness has on supervisee wellness (and specifically in weak supervisory relationships), the ACA Code of Ethics places an unreasonable expectation on supervisees to intervene with supervisors whose low level of wellness is likely influencing their own wellness. As Lawson et al. (2007) noted, the focus on monitoring for impairment and influencing wellness in supervisors should be placed on peer relationships and superiors if available. The importance of this focus is reiterated in the results.
from the current investigation by the prevalence of site supervisors who are forming weak supervisory relationship with their supervisees and those who are displaying poor wellness.

**Limitations**

The results from this study are limited by two factors associated with the development of methodology: (a) sampling, and (b) the instruments used to assess the constructs of interest.

**Sampling**

To gain access to the sample desired, the researcher utilized purposive, convenience sampling. The participant sample for this investigation were stakeholders in counselor education programs known to the researcher through interactions in the Counselor Education community. Although care was taken to reach a variety of programs—and thus provide a sample that was indicative of the larger population of counselor education students—the relative lack of randomization inherently limits the results of a quantitative analysis. Nonetheless, the description of this study’s sample compared favorably to similar studies describing the demographics of the field (Roach & Young, 2007).

An additional concern in sampling is reaching an adequate sample size when factoring in effect size, α size, and number of predictors to reach adequate power of the study. Howell (2010) recently noted that a recorded power of approximately .8 implies a strong probability that the study correctly rejected the null hypothesis in favor of the alternate hypothesis. An *a priori* power analysis can be beneficial if there are approximations of effect size for the variables being assessed. In contrast, if there are no or limited approximations of effect size (as was the case when assessing and understanding perceived supervisor wellness in this study), a post hoc (or retrospective) analysis can be beneficial (Howell, 2010). In a post hoc power analysis in G*Power 3 (Faul, Erdfelder, Lang & Buchner, 2007) statistical software using observed effect
size, sample size, α level, and number of predictors, a power of 0.802 was recorded, indicating a strong probability that this study correctly rejected the null hypothesis in favor of the alternate hypothesis. This outcome indicates that while the final sample of 105 might seem small, it still provided sufficient power to the findings.

**Instruments**

Another limitation of this study lies in the selection of instruments. Specifically, the Five Factor Wellness Inventory (Myers & Sweeney, 2005) was cited by its developers as more one-dimensional, with subscales having higher inter-correlations than originally believed (Myers et al., 2004). Further, the reliability of the subscales has been less consistent than originally reported, and the use of so many subscales can render results convoluted and difficult to interpret (Myers et al., 2004). Thus, these specific limitations regarding the Five Factor Wellness Inventory (Myers & Sweeney, 2005) could have impacted the findings in both parts RQ2.

A further limitation of the instrumentation utilized in this investigation was the use of an undeveloped instrument to assess the supervisee’s perception of supervisor wellness. While the internal reliability of the total scale was strong, multiple subscales displayed weak reliability. This finding mirrors the known limitations of the Five Factor Wellness Inventory (Myers & Sweeney, 2005).

One final limitation that needs to be addressed is that of social desirability. Wellness as a multifaceted construct is becoming an increasingly important paradigm for counseling, and as such is a key component of counselor identity (Myers, 1991). This identity makes it socially desirable for counselors to display strong wellness attitudes and beliefs. While care was taken in the research design to increase anonymity and limit the effects of social desirability, the potential
remains that participants inflated their responses to display a stronger sense of wellness than they actually felt because they viewed it as socially desirable.

**Areas for Future Inquiry**

This study sought to understand the previously unexamined effects of a supervisor’s modeled wellness—as perceived by their supervisee—on that supervisee’s personal wellness. A secondary goal was to determine how the strength of the supervisory relationship changed this effect. The results from the study have opened multiple avenues for future inquiry within supervisory relationships, counseling relationships, and other hierarchical relationships.

**Supervisory Relationships**

One avenue for further inquiry would be to examine how and why the suppression effect from the supervisory relationship, which is discussed earlier, is taking place. One such explanation for this effect is the level of transparency/self-disclosure provided by the supervisor. A study utilizing a mixed-methods analysis or qualitative inquiry could prove beneficial in describing this phenomenon, as well as increase understanding of the impact of the relationship. With some additional work, the qualitative data collected within this study could help describe this effect more in depth. Additionally, due to the relative rarity of the suppression effect in the psychological literature, repetition is recommended (MacKinnon, Krull & Lockwood, 2000). With respect to the current investigation, repeating this study utilizing a population of counseling supervisees at the post-graduation level may be appropriate as there may be a larger distribution of both wellness and supervisory relationships.

**Counseling Relationships**

Another avenue for further investigation is how the counseling working alliance effects the transmission of wellness between counselor and client. One of the underlying premises for
this investigation is the role of parallel process. Friedlander and colleagues (1989) highlighted how supervisees who attain appropriate attitudes and behavior patterns from their supervisors can use those to better help their clients. Based on this premise, there is potential that the influence that was exhibited in this study between supervisors and supervisees, and the effect of the relationship, could be potentially exhibited again within the client and counselor relationship. Further, the potential importance of intentional transparency/self-disclosure in creating effective working alliances and suppressing any transmission of wellness could be expanded in a subsequent investigation.

**Other Relationships**

An important delimitation of this study was the specific focus on only one relationship and the transmission of wellness attitudes and beliefs. However, individuals are likely to have multiple relationships both inside and outside of their professional lives. With this in mind, other important avenues for future inquiry could include examining the transmission of wellness in relationships that are external to the counseling alliance and chains of parallel process. Relationships that may be of specific interest are those in educational programs (both counselor education programs and K-12 settings) and family relationships—both of which could have a significant impact on an individual’s wellness.

Yager and Tovar-Blank (2007) emphasized that demonstrating strong wellness attitudes and behaviors is critical for faculty in counselor education programs as way to encourage counselor education trainees to develop a strong sense of personal wellness. Indeed, they advocated that such a pedagogical approach be infused throughout the entire course of the educational program (Yager & Tovar-Blank, 2007). This perspective, combined with the findings of this study, provides motivation for further inquiry into the influence of faculty
personal wellness on student personal wellness. In short, do the relationships that students form with their faculty impact the wellness paradigm? A related analysis could target the boundaries between student and faculty and how transparent faculty members are about their own wellness practices and behaviors. Such an inquiry into how wellness beliefs and practices are conveyed in educational settings should not be limited to counselor education programs, however.

Examining the wellness relationship in K-12 settings (between administrators/teachers/students) as a way to increase wellness in schools and modify school social climates.

A future study could also investigate the nature of the wellness relationships that occur in family systems. Relationships that potentially provide the most interest are parent/child relationships and partner relationships. One potential limiting factor for the transmission of wellness between supervisor and supervisee is the fundamental nature of the relationship: It is a professional relationship with minimal weekly or long-term exposure. In contrast, the interactions between a parent and child or between partners is much more comprehensive and could demonstrate a much larger influence. Further, evidence of a high influence could have implications for clinical work with couples and families, and how progress with one family member/partner could prove beneficial to the entire system.

**Conclusion**

The purpose of this quantitative investigation was to (a) analyze the role of modeled wellness as a way for supervisors to influence the multifaceted aspects of supervisee wellness, and (b) identify if factoring in the supervisory relationship changes this influence. A purposive, convenience-sampling method yielded a sample of 105 participants from counselor education programs. A series of stepwise regression analyses were used to understand how wellness attitudes and behaviors modeled by the supervisor influenced the personal wellness of
their supervisees. The supervisee’s perception of their supervisor’s wellness was discovered to be influential in predicting supervisee personal wellness, with certain factors of perceived supervisor wellness being more predictive of the corresponding wellness factor or the supervisee.

Perhaps the most interesting finding from this study was the change in the models when the strength of the supervisory relationship was added to the models in the second-step regression. While analyzing subscales in RQ2a, there were minimal changes, which were potentially attributable to the inconsistency of the subscales on the instruments used to measure supervisee personal wellness, and perceived supervisor wellness. However, the second-step regression in RQ1a (analyzing the influence of total wellness and the supervisory relationship) yielded a fascinating result: The strength of the supervisory relationship added significantly to the model as a classical suppressor variable. As a suppressor variable, the strength of the supervisory relationship added to the model—not by directly explaining variance in the prediction of supervisee personal wellness, but indirectly by accounting for error in the supervisee’s perception of their supervisor’s wellness. This finding indicates that the supervisee’s perception of their supervisor’s wellness was a more accurate predictor of supervisee wellness when the strength of the supervisory relationship was included.

To understand where the supervisory relationship was suppressing this influence, a correlational analysis was completed using cut scores to divide the data into three groups based on the strength of their supervisory relationships: Strong, Moderate, and Weak. Data obtained from correlational analysis indicated significant correlations between perceived supervisor wellness and supervisee personal wellness in the strong and weak supervisory relationships; in contrast, there was no statistical significance for those in the moderate group. This pattern in the data indicates that the strength of the supervisory relationship is largely accountable for the error
in prediction when supervisory relationships are in the moderate range. By association, this finding indicates that supervisors modeling wellness attitudes and behaviors tend to have a stronger influence on the personal wellness of their supervisees when they form either weak or strong supervisory relationships. This outcome, when combined with the strong correlation between a supervisee’s perception of their supervisor’s wellness and the supervisory relationship, indicate that supervisors who have high or low perceived wellness are more likely to influence their supervisee’s wellness. Again, for supervisors who form moderately strong supervisory relationships, their supervisee’s perception of their wellness did not appear to have a significant correlation with their supervisee’s wellness. This is beneficial if the supervisor has a low level of perceived wellness by their supervisees, which is not transferred due to the moderate relationship. Conversely, it could be a missed opportunity if the supervisor has a high level of perceived wellness by their supervisees, but is not transferred to their supervisees in a moderate-level relationship.

In conclusion, this study shows that supervisors who model wellness attitudes and behaviors (both positive and negative) in supervision can influence their supervisee’s own personal wellness. Furthermore, the relative strength of the supervisory relationship increases the ability of the supervisee’s perception of their supervisor’s wellness to predict supervisee wellness by removing error from the supervisee’s perception of their supervisor’s wellness. The majority of this error occurs in moderate supervisory relationships, indicating that if supervisors who have a low level of perceived wellness can develop moderate relationships their perceived lack of wellness will not influence their supervisee’s wellness. Similarly, supervisors with high levels of perceived wellness should strive for strong relationships to encourage the transmission of their wellness attitudes and behaviors to their supervisees. Additionally, this study has shown
that some factors of wellness are more influential than others—specifically, the Creative and Coping Selves. Supervisors should focus on demonstrating positive attitudes and behaviors within these factors to their supervisees. Ultimately, supervisors should intentionally demonstrate their own wellness in supervision, recognizing that it can have meaningful consequences for their supervisees.
REFERENCES


doi:10.1080/07325223.2014.905814


<table>
<thead>
<tr>
<th>Author</th>
<th>Year</th>
<th>Pertinent Research Questions</th>
<th>Sample Design</th>
<th>Findings</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Myers, Mobley, &amp; Booth</td>
<td>2003</td>
<td>What are the levels of wellness amongst counselor education graduate students?</td>
<td>262 Masters and Doctoral students enrolled in Counselor Education Programs (70% Female, 74% Caucasian)</td>
<td>Students tended to score higher than the sample of student's WEL scores was compared against the overall population who had completed the WEL.</td>
<td>Social desirability of wellness, and cannot show longitudinal growth.</td>
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<tr>
<td>Roach &amp; Young</td>
<td>2007</td>
<td>Do counselor education programs promote wellness?</td>
<td>204 Counselor Ed students at 3 different points in their programs (61% Caucasian, 86% Female)</td>
<td>Quantitative: Utilized MANOVA to analyze trends in wellness scores, and ANOVAs to understand demographic differences.</td>
<td>Not longitudinal; could not account for contextual factors that could have affected wellness.</td>
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<tr>
<td>Author</td>
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<td>Pertinent Research Questions</td>
<td>Sample</td>
<td>Design</td>
<td>Pertinent Findings</td>
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<tr>
<td>Lawson &amp; Myers</td>
<td>2011</td>
<td>What is the relationship between wellness, career sustaining behaviors, and compassion satisfaction/fatigue/burnout?</td>
<td>506 ACA members: Primarily female, 89% Caucasian</td>
<td>Quantitative: Utilized ANOVAs and t-tests to compare group differences in constructs.</td>
<td>Found that Total wellness had a strong positive correlation with compassion satisfaction, and strong negative correlations with burnout, and compassion fatigue.</td>
</tr>
<tr>
<td>Thompson, Frick, &amp; Trice-Black</td>
<td>2011</td>
<td>What are counselor education students’ perceptions of self-care, burnout, and supervision?</td>
<td>14 Counselor Education Students: 13 female, 13 Caucasian</td>
<td>Qualitative: Utilized consensual qualitative methods with external auditor</td>
<td>Supervisees the benefits of supervisors creating a safe space to talk about burnout and self-care; Additionally supervisees discussed benefits of supervisor modeling wellness.</td>
</tr>
<tr>
<td>Author</td>
<td>Year</td>
<td>Pertinent Research Questions</td>
<td>Sample</td>
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<td>Gnilka, Chang, &amp; Dew</td>
<td>2012</td>
<td>Do Supervisee coping strategies, and perception of stress predict the Supervisory Working Alliance?</td>
<td>232 supervisees enrolled in counselor education programs. 86% female, 78% Caucasian</td>
<td>Quantitative: Utilized ANOVAs to understand demographic differences, and used a multiple regression using significant demographics, perceived stress, and coping strategies.</td>
<td>Found that counselor caseload, time in supervision, perceived stress, and coping strategies predicted 15.4% of variance in SWA.</td>
</tr>
<tr>
<td>Storlie &amp; Smith</td>
<td>2012</td>
<td>Does a wellness intervention in supervision improve supervisee wellness? Does it effect the supervisory working alliance?</td>
<td>42 Counselor Ed students split into two groups: Experimental and Control.</td>
<td>Quantitative: Quasi-experimental with between groups repeated measures design.</td>
<td>Found that counselor wellness could be increased significantly due to wellness interventions within supervision. Though increased wellness had little effect on SWAs.</td>
</tr>
<tr>
<td>Lenz, Sangganjanavanch, Balkin, Oliver, and Smith</td>
<td>2012</td>
<td>Does the Wellness Model of Supervision improve supervisee personal wellness?</td>
<td>32 masters’ level counseling students (60% white, 66% Female).</td>
<td>Quantitative: Pre-test/post-test method.</td>
<td>The WELMS (a wellness focused model) group showed significant increase in personal wellness after supervision.</td>
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<tr>
<td>Author</td>
<td>Year</td>
<td>Pertinent Research Questions</td>
<td>Sample</td>
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<tr>
<td>Lenz, Oliver, &amp; Sangganjanavani ch,</td>
<td>2014</td>
<td>How does Wellness Model of Supervision effect supervisee wellness?</td>
<td>4 Counselor Education Interns receiving supervision from the first author</td>
<td>Qualitative: Case Study Design</td>
<td>Participants described increased understanding and focus on wellness; Highlighted benefits of supervisor modeling</td>
</tr>
<tr>
<td>Ohrt, Prosek, Ener &amp; Lindo</td>
<td>2015</td>
<td>Does a group supervision intervention effect supervisee self-care and prevent burnout?</td>
<td>88 Counselor Education students enrolled in Practicum/Internship Classes (90% Female, 72% Caucasian)</td>
<td>Quantitative: Pretest/Post-test design, with treatment and control groups</td>
<td>Treatment group did not show significant differences in wellness, or in burnout as compared to the control group.</td>
</tr>
</tbody>
</table>
Definitions were provided for ease of use for Dissertation committee use and have since been redacted.

APPENDIX C: LETTER TO STAKEHOLDER

Dear Colleagues,

You are receiving this email because you have been identified as a key stakeholder within a Counselor Education program. My name is Kevin Doyle and I am a doctoral student at Virginia Tech working with Laura Welfare. I am conducting my dissertation on supervisee perceptions of site supervisor wellness and the effect it has on supervisee personal wellness, and would greatly appreciate your assistance in distributing a survey to student enrolled in an internship or practicum course.

Participation is completely voluntary and carries minimal risk. Responses will be anonymous and the survey will take approximately 15-25 minutes to complete. Virginia Tech IRB (#16-884) has approved this study.

To be eligible to participate, students must:
- Be enrolled in an internship or practicum course.
- Receiving supervision from a site supervisor during internship/practicum.

If you are interested in distributing the survey, and work with students that meet the above criteria, please contact me at either kevdoyle@vt.edu or (434) 996-2131.
APPENDIX D: SURVEY

Invitation for Participation

Dear Student,

I am a Doctoral student in Counselor Education at Virginia Tech. I am conducting a research study to better understand how a supervisee’s perception of site supervisor wellness affects his or her own personal wellness.

I am requesting your participation, which will involve completion of this survey packet. It is expected to take approximately 20 minutes. Your participation in this study is voluntary. If you choose to not participate there will be no penalty. The attached survey is anonymous. The results of the study may be published but your name will not be known.

The risks of the study are minimal, but may include mild discomfort in answering items regarding your own personal wellness and relationship with your site supervisor. The potential benefits include increased insight into supervision and how messages regarding wellness are relayed.

If you have any questions concerning the research study please email me at kevdoyle@vt.edu, or by phone at (434) 996-2131. The return of the completed questionnaire will be considered your consent to participate. Thank you.

Sincerely,

Kevin Doyle
Doctoral Candidate
Counselor Education
Virginia Tech
Perception of Site Supervisor Wellness

Perception of Supervisor Wellness Instrument was based off of the Five Factor Wellness Inventory (Myers & Sweeney, 2005) was provided for Dissertation Committee use and was redacted for the final document.

Five Factor Wellness Inventory

Instrument redacted from Final Document, available at:

Short Supervisory Relationship Questionnaire

The following statements describe some of the ways a person may feel about his/her supervisor. Please complete the survey with your practicum/internship site supervisor in mind.

To what extent do you agree or disagree with each of the following statements about your relationship with your site supervisor? Please tick the column, which matches your opinion most closely.

<table>
<thead>
<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Slightly Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Slightly Agree</th>
<th>Agree</th>
<th>Strongly Agree</th>
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<tbody>
<tr>
<td>1. My supervisor was approachable</td>
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<td>2. My supervisor was respectful of my views and ideas.</td>
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<td>3. My supervisor gave me feedback in a way that felt safe.</td>
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<td>4. My supervisor was enthusiastic about supervising me.</td>
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<td>5. I felt able to openly discuss my concerns with my supervisor</td>
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<td>6. My supervisor was non-judgemental in supervision.</td>
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<td>7. My supervisor was open-minded in supervision.</td>
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<td>8. My supervisor gave me positive feedback on my performance</td>
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<td>9. My supervisor had a collaborative approach in supervision</td>
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<td>10. My supervisor encouraged me to reflect on my practice</td>
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<td>11. My supervisor paid attention to my unspoken feelings and anxieties</td>
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<td>12. My supervisor drew flexibly from a number of theoretical models</td>
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<td>13. My supervisor paid close attention to the process of supervision</td>
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<td>14. My supervisor helped me identify my own learning/training needs</td>
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<td></td>
<td>Strongly Disagree</td>
<td>Disagree</td>
<td>Slightly Disagree</td>
<td>Neither Agree nor Disagree</td>
<td>Slightly Agree</td>
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<td>15. Supervision sessions were focused</td>
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<td>16. Supervision sessions were structured</td>
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<td>17. My supervision sessions were disorganised</td>
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<td>18. My supervisor made sure that our supervision sessions were kept free from interruptions</td>
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Demographic Questionnaire

Please indicate your:

1. Age:___________

2. Gender:
   1. Male
   2. Female
   3. Non-Binary

3. Race (circle all that apply):
   1. Native American
   2. Asian or Pacific Islander
   3. African American or Black
   3. Caucasian or White
   4. Latino/a
   5. Other:____________

4. Enrolled in:
   1. Practicum
   2. 1st Semester of Internship
   3. 2nd Semester of Internship
   4. Other: ____________

5. How long have you been receiving supervision from your current site supervisor at your internship?
   1. Less than 1 month
   2. 1-2 months
   3. 2-3 months
   4. 3-4 months
   5. More than 4 months

6. Forms of supervision provided by this site supervisor (circle all that apply):
   1. Individual
   2. Triadic
   3. Group

7. What is the average amount of individual or triadic supervision you receive from this site supervisor each week?
   1. 0-20 minutes
   2. 21-40 minutes
   3. 41-60 minutes
   4. 61-80 minutes
   5. More than 80 minutes
8. What percentage of your time in individual or triadic supervision is spent focusing on your own wellness as a counselor-in-training?
   1. 0%
   3. 1-10%
   4. 11-20%
   6. 21-30%
   7. More than 30%

9. Practicum/Internship Setting:
   1. Clinical Mental Health Counseling
   2. School
   3. College/University
   4. Other: ________________________________

10. Approximate Direct Client hours per week:
    1. 0-4 hours
    2. 5-9 hours
    3. 10-14 hours
    4. 15-20 hours
    5. More than 20 hours

11. Counseling is challenging work: How transparent is your site supervisor in describing how they manage their stressors?
    ______________________________________________________________________
    ______________________________________________________________________
    ______________________________________________________________________

12. How do your site supervisor’s wellness beliefs and behaviors affect you as a supervisee?
    ______________________________________________________________________
    ______________________________________________________________________
    ______________________________________________________________________

13. How do your site supervisor’s wellness beliefs and behaviors adhere to the professional expectations he/she outlined for you as a supervisee?
    ______________________________________________________________________
    ______________________________________________________________________
    ______________________________________________________________________

14. Are there others around you who model wellness (i.e. other supervisors, faculty, doctoral students, classmates, coworkers, etc.)? What effect do they have on your wellness?
    ______________________________________________________________________
    ______________________________________________________________________
    ______________________________________________________________________