WELLNESS AMONG COUNSELORS IN TRAINING: EXAMINING THE RELATIONSHIP BETWEEN TRAIT EMOTIONAL INTELLIGENCE, PERCEPTIONS OF STRESS, PERCEPTIONS OF WELLNESS, AND WELLNESS BEHAVIORS

by

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ABSTRACT

ERICA A. MERRILL, M.Ed, LPC, NCC. Wellness Among Counselors in Training: Examining the Relationship between Trait Emotional Intelligence, Perceptions of Stress, Perceptions of Wellness, and Wellness Behaviors.
(Under the direction of DR. DANIEL GUITIERREZ and DR. HENRY HARRIS)

Despite intention that the counseling profession be theoretically grounded as wellness oriented and preventative in nature, researchers propose that counselors are not competently equipped to address the connection between the biological, psychological and social factors which are part of the prevention healthcare paradigm. Although wellness has been acknowledged as a necessary ingredient for counselors to prevent impairment, little is offered on how disposition and appraisal of wellness and stress, influence CIT behaviors. Previous research has shown the necessity for wellness, emotional intelligence, and the importance of counselor perceptions, all of which influence effective counseling by allowing the counselor to connect with the client, perceive and manage emotions and guard against burnout.

The purpose of this study was to examine the relationship between trait emotional intelligence, perceptions of stress, and perceptions of wellness relate to wellness behaviors among counselors-in-training enrolled in CACREP programs. The majority of studies have examined traits that contribute to burnout among counselors and students. However, this study embraced a wellness orientation to examine traits and dispositions that are preventative in nature. In addition, this study examined the differences between a variety of education experiences, such as number of credits taken in the program, completion of practicum experience, and other traits that have been linked with counselor development.

The researcher collected data from a total of 276 CIT's, either through the paper or electronic survey. The survey included a general demographic questionnaire the

Emotional Intelligence Questionnaire- Short Form (TEIQue-SF), the Perceived Wellness Scale (PWS), the Perceived Stress Scale (PSS), and the Body- Mind- Spirit, Wellness Behavior and Characteristic Inventory (BMS-WBCI). Structural equation modeling (SEM) was used to apply multiple regressions and analyze the theoretical relationship between trait-emotional intelligence, perceptions of stress, perceptions of wellness, and wellness behaviors of CIT's. After following the two-step procedure for an SEM, results indicated that the use of a Path Analysis would be a better fit for examining the sub-constructs of wellness: mind, body, and spirit. The SEM results indicated that while perceptions of stress and wellness are not mediators between EI and wellbeing, the PA indicated that there is still a direct and significant effect between EI and the components of wellbeing, specifically, mind and spirit. The findings of the study emphasized the need for further research regarding the effects of EI on wellness, specifically the decrease in bodily wellness for CIT's. The findings also suggested that future research may consider the moderating effects of EI on wellness and stress for CIT's. Trait Emotional Intelligence appears to continue to play a pivotal role in the development of Counselors-in-Training, specifically in how they engage in mental and spiritual wellness behaviors. Implications of the findings from the study include (a) the inclusion of additional instruction for understanding wellness and developing a personal wellness plan for CIT's, and (b) the integration of emotional intelligence skills through training and supervision experiences for CIT's.

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DEDICATION

For Vicky Briseno Santellana, the matriarch, the bright and shining star of the family. Long before I learned about the importance of wellness, you taught me what it meant to live a life worth living. Long before I learned about the concept of emotional intelligence, you taught me to listen to my intuition, to value my inner strength, and to speak up for what is right. You are greatly loved and will be greatly missed.

TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

CHAPTER I: INTRODUCTION

Success in the counseling profession requires a delicate balance between personal wellness and professional engagement (Lawson & Myers, 2011). The responsibility to maintain an equilibrium between professional demands and personal care is placed squarely on mental health practitioners by several ethical codes, practice standards and guidelines (ACA Ethical Code, 2014; CACREP, 2016). Morse, Salyers, Rollins, De Vita, and Pfahler (2012) estimated that 21-67% of mental health workers may be experiencing increasingly elevated levels of burnout. Previous studies have identified that up to 54% of helping professionals specifically experience high emotional exhaustion and 38% of these professionals reported higher depersonalization (Webster & Hacket, 1999). For these reasons, the Council for Accreditation of Counseling and Related Educational Programs (CACREP; 2016) standards provide parameters and recommendations for monitoring and remediation of counselor wellness. The American Counseling Association (ACA; Section C.2.g., 2014) recommends that counselors attend to their personal and professional well-being by seeking assistance for problems to prevent impairment. Lawson and Myers (2011), in conjunction with other researchers, report that counselors who tend to their own wellness, experience greater functioning and improved professional quality of life (Lawson, Venart, Hazler, & Kottler, 2007; Lenz & Smith, 2010; Meyer & Ponton, 2006). Additional researchers have explored evidence that failure to prioritize and maintain an optimum wellness decreases the ability to effectively facilitate the therapeutic relationship, where-in the connection with clients is compromised (Lawson, 2007; Smith et al., 2007). This mandate can be distressing when considering that counselors who have experienced personal traumas or unresolved stress

may have a heightened susceptibility to burnout and impairment (Figley, 2002; Pearlman & Mac Ian, 1995; Yassen, 1993).

The Importance of Counselor Wellness

Although it is evident that *well* counselors are more helpful to their clients than those experiencing distress and impairment (Lawson & Myers, 2011; Lenz, Oliver, & Sangganjanavanich, 2014; Lenz & Roscoe, 2011; Lenz & Smith, 2010; Venart, Vassos, & Pitcher-Heft, 2007), researchers identify that distressed counselors also negatively impact the quality of services provided to clients, participate in behaviors that imply devaluing clients, and engage in incompetent practices that potentially harm clients (Lawson, Venart, Hazler, & Kottler, 2007; Lee, Cho, Kissinger & Ogle, 2010). Researchers have begun to recognize the variety of emotional stressors and career demands that contribute to professional distress, burnout, fatigue and impairment (Lee, Baker, Cho, Heckathorn, Holland, Newgent, Ogle, & Yu, 2007; Lenz, Oliver, & Sangganjanavanich, 2014; Osborn, 2004; Roach & Young, 2007; Thompson, Amatea, & Thompson, 2014). Cummins, Massey, and Jones (2007) suggest that even with adequate support and ample supervision, many sources continue to contribute to counselor burnout, empathy fatigue and ineffective counseling practice. Counselor wellness is important when considering both the ethical standards for counseling practice and in the preparation of counselors-in-training (CIT). It is with this understanding that CACREP (Section 4, Evaluation in the Program, 2016) mandates the teaching of competencies during training that ensure student's progress with evidence of personal self-awareness, emotional stability, sensitivity to others, and a basic understanding of the importance of relationship.

Statement of the Problem

Despite intention that the counseling profession be theoretically grounded as wellness oriented and preventative in nature (Kaplan & Gladding, 2011; Witmer, 1985; Wolf, Thompson, & Smith-Adcock, 2012), Barden, Conley, and Young (2014) propose that counselors are not competently equipped to address the connection between the biological, psychological and social factors which are part of the prevention healthcare paradigm. They are not alone in this assertion. Smith, Robinson, and Young (2007) identified a relationship between psychological distress and a decrease in wellness for CIT's. Roach and Young (2007) also questioned the cultivation of wellness in the counselor education process and concluded that irregular exposure to wellness practice during training is insufficient to promote counselor wellness.

Addressing this gap, Wolf, Thompson, and Smith-Adcock (2012) promote wellness in counselor preparation through advancement of individual well-being, which teach awareness to a variety of factors that influence wellness for CIT's. Barden, Conley, and Young (2014) suggest an adoption of wellness competencies as a standard for counselor preparation. Other researchers identify alternative means to integrate wellness preparation such as engaging in effective supervision (Skovholt, 2001), using a wellness model throughout supervision (Lenz, Faii-Sangganjanavanich, Balkin, Oliver, & Smith, 2012), promoting a clear and concise understanding and expectation of wellness, encouragement of CIT's to engage in their own counseling, integration of a wellness philosophy in all courses, and establishing an association of self-growth with the counselor education process (Yager & Blank, 2007). Recently, researchers have studied the application of specific strategies such as meditation (Gutierrez, 2014), gratitude

practices (Teague-Palmieri, 2017), and increasing traits such as emotional intelligence (Gutierrez & Mullen, 2016; Houghton, Wu, Godwin, Neck, & Manz, 2012; Perera & DiGiacomo, 2015) to decrease impairment while fostering coping and adjustment. Many of these suggested strategies target the growth in counselor ability to perceive, monitor, and manage emotions, develop awareness to their overall functioning, and increase cognitive and reflective abilities. While a litany of empirical research exists that examines the combination of emotions, stress, and behaviors. No empirical research exists to date that examines the role of trait emotional intelligence (EQ; Petrides & Furnham, 2001), perceptions of wellness, appraisal of stress, and wellness behaviors in counselors-in-training (CIT's).

If counselors-in-training, counselors, supervisors and counselor educators are to successfully address the challenges of maintaining wellness, they must increase understanding of factors that may influence wellness. Factors such as trait emotional intelligence (EI) influences different areas of professional functioning such as burnout (Gutierrez & Mullen, 2016), health and performance (Slaski & Cartwright, 2003), self-leadership and stress coping (Houghton, Wu, Godwin, Neck, & Manz, 2012), but little has been explored relative to counselor wellness. Perception, specifically self-perceived ability to recognize emotions in oneself and in others, is a primary ingredient in EI (Cherniss & Goleman, 2001; Petrides & Furnham, 2001). Wellness has been acknowledged as a necessary ingredient for counselors to prevent impairment, but little is offered on how disposition and appraisal of wellness and stress, influence CIT behaviors. The purpose of this dissertation is to examine the role of trait EI within wellness and the investigation of perceptions that may contribute to wellness behaviors. Hence, the

purpose of this study is to examine the relationship between trait emotional intelligence, perceptions of stress, and perceptions of wellness relate to wellness behaviors among counselors-in-training enrolled in CACREP programs.

Theories Guiding Wellness, Perception and Behavior

Current wellness theories and models are based on a holistic view of health and encompass multiple facets needed to attain health and wellbeing in body, mind, and spirit (Myers, Sweeney, & Witmer, 2000; Harari, Waehler, & Rogers, 2005). Factors that contribute to optimal functioning include six paradigms: (a) physical, (b) spiritual, (c) intellectual, (d) emotional, (e) occupational, and (f) social (Hettler, 1980). Additional models also account for influence of environment on wellbeing accomplished through life tasks, life forces, and global events (Witmer & Sweeney, 1992). Yet, additional models of wellness integrate the importance of behaviors and lifestyle choices where stress and illness abide in the same spectrum as wellness (Travis & Ryan, 1981, 1988). Zimpher (1992) embraced principles of wellness that emphasized the importance of personal attitudes towards wellness and individual beliefs about responsibility for health and healing. Other theorists continue these foundations towards wellness and build upon people's perceptions of each dimension, stating that if individuals view each paradigm as equally important, they are healthier (Adam, 1995; Adams, Bezner, & Steinhardt, 1997).

The connection between perceptions and behaviors are found throughout work from Lazarus and Folkman (1982, 1984) and their research on stress, emotions, and coping from a transactional perspective. They used the cognitive-relational theory of emotion and coping to emphasize the relationship between the environmental and personal antecedents (demands, resources, belief systems), mediating process (perception

and appraisal), and outcomes (emotional experience, wellbeing, somatic health), all of which contribute to a person's wellbeing (Lazarus & Folman,1987). This connection is identified again when Rosenstock (1990) linked beliefs, perceptions, and values with physical health by utilizing the health belief model. Bandura's (1986) social cognitive theory proposes that beliefs, values, and knowledge influence positive physical health behaviors (Hey, Calderon, & Carroll, 2006). Once again, the relationship between perceptions and behaviors are established throughout literature but the relationship between the tenets of wellness, trait disposition, perceptions, and counselor behaviors remain unknown. Currently, researchers agree that self-reflection is crucial for counselors to embrace change (Granello, 2010; Schmidt & Adkins, 2012;), they also agree that self-perception is a foundational factor of wellness (Adams, Bezner, & Steinhardt, 1997). However, specific types of self-reflection towards has remained unstudied. Perceptions toward wellness and stress may also be a contributing ingredient for counselors who distinguish themselves to have higher levels of wellness (Yager & Tovar-Blank, 2007).

Need for the Study

Although wellness is acknowledged as a necessary ingredient for counselors to prevent impairment, little is offered how disposition and appraisal may contribute to counselor wellness. These aspects are important due to the relationship between perceptions and behaviors established by Lazarus and Folkman (1987) as well as the connection between emotional intelligence (EQ) and social competence, emotion perception, and emotion management (Campo, Laborde, & Mosley, 2016; Fletcher, Leadbetter, Curran, & O'Sullivan, 2009; Ruiz-Aranda, Castillo, Salguero, Cabello, Fernández-Berrocal, & Balluerka, 2012). Multiple positive personal and professional

outcomes have been linked with increased trait EI, however trait EI has yet to be explored within the context of wellness. Considering the connections between EI and other positive psychological traits, it is possible that higher levels of trait EI may also lend itself to increased perceptions of personal wellness, it may influence perceptions of stress, and may increase the potential for CIT's to engage in wellness behaviors. Linely and Joseph (2007) are some of the few researchers that explored both the positive and negative aspects of therapy work on therapists, linking therapeutic bond with empathic connection to clients and associating a positive well-being in therapists. Continued exploration into the factors that contribute towards counselor wellness is encouraged (Houghton et al., 2012; Linely & Joseph, 2007). Studies have shown the necessity for wellness, emotional intelligence, and the importance of counselor perceptions, all of which influence effective counseling by allowing the counselor to connect with the client, perceive and manage emotions and guard against burnout (Adams, Bezner, Drabbs, Zambarano, & Steinhardt, 2010; Gutierrez & Mullen, 2016; Lenz, Oliver, & Faii Sangganjanavanich, 2014). To date, no research exists on how dispositional traits and perceptions influence wellness behaviors. This research may not only address the gaps identified in the literature, it may also advance our theories regarding counselor wellness. Once a relationship is established, we can begin to tailor time with CITs to include experiences that may directly improve counselor trait emotional intelligence, perceptions towards wellness and stress, as well as present and future health behaviors. There is a need to examine the inherent roles of dispositions and appraisals to better understand the difference between counselors who know how to make a wellness plan and counselors who know when to engage wellness behaviors.

Operational Definitions

Wellness Behaviors

Behavioral wellness simply defined, is an active, evolving process of making choices toward a more successful existence (Hey, Calderon, & Carroll, 2006) and described by the National Wellness Institute (1992) as a way of living that is responsive to the needs of the body, mind and spirit. Wellness behaviors will be measured by the Body-Mind-Spirit Wellness Behavior and Characteristic Inventory (BMS-WBCI; Hey, Calderon, & Carroll, 2006; See Appendix: J), and referred to as wellness behaviors (WB). The BMS-WBCI was designed to measure baseline wellness statements about behaviors and characteristics in the body, mind, and spirit dimensions of wellness that have occurred within the past month. The BMS-WBCI examines body, mind, and spirit dimensions of wellness behaviors using a 44-item survey. Each dimension is represented by a 3-point Likert scale ranging from 1 (rarely/seldom) to 3 (often/always). Both total score and sub-scores will be used in this study to determine levels of participation in positive health behaviors and agreement with characteristics that promote well-being. Higher scores indicate greater use of positive behaviors and increased over all well-being (Hey, Calderon, & Carroll, 2006). A full description and evaluation of the psychometric properties of the BMS-WBCI is provided in chapter three.

Emotional Intelligence

Emotional Intelligence (EQ) refers to the ability to monitor one's own and others' feelings and emotions, to discriminate among them, and to use this information to guide one's thinking and actions (Salovey & Mayer, 1990). According to Petrides and Furnham (2001) trait emotional intelligence (EI) comprises adaptability, assertiveness, emotional

appraisal, emotion expression, emotion management, emotion regulation, low impulsivity, relationship skills, self-esteem, self-motivation, social competence, stress management, trait empathy, trait happiness and trait optimism. The Trait Emotional Intelligence Questionnaire-Short Form (TEIQue-SF; Petrides & Furnham, 2009; See Appendix: G) will be used to measure EI and consists of 7-point Likert-type scales, ranging from completely disagree (1) to completely agree (7). The TEIQue-SF provides subscale scores that covers the 15 facets of EI and includes the following domains: (a) Well Being, (b) Self-Control, (c) Emotionality, (d) Sociability, and (e) Global Trait, total scores will be used when examining the relationship among variables. A full description and evaluation of the psychometric properties of the TEIQue-SF is provided in chapter three.

Perception of Stress

Perceived stress refers to the degree to which life situations are appraised as stressful (Cohen, Kamarck, & Mermelstein,1983). Perceived stress will be measured by the Perceived Stress Scale (PSS; Cohen, Kamarck, & Mermelstein,1983; See Appendix: I) designed to examine both current levels of experienced stress and explore how unpredictable and uncontrollable participants view their lives. There are ten questions that ask about feelings and thoughts during the last month. Responses range from "never" to "very often" on a 5-point scale. This scale will be used to provide a global measure of perceived stress in daily life. A full description and evaluation of the psychometric properties of the PSS are provided in chapter three.

Perception of Wellness

Perceived wellness refers to wellness as the sense that one is living in a

manner that permits the experience of consistent, balanced growth in the emotional, intellectual, physical, psychological, social, and spiritual dimensions of human existence (Adams, Bezner & Steinhardt, 1997). Perceived wellness will be measured by the Perceived Wellness Scale (PWS; Adams, Bezner & Steinhardt, 1997; See Appendix: H) which consists of three principles common to all conceptualizations of wellness: (a) multidimensionality, (b) balance among dimensions, and (c) salutogenesis (defined as causing health rather than illness). This model incorporates balance among the three dimensions and is defined by scores for six areas of wellness: (a) psychological, (b) physical, (c) emotional, (d) spiritual, (e) social, and (f) intellectual. Total scores will be used to measure perceived wellness, with higher scores indicating greater overall perceptions of wellness in the participant. A full description and evaluation of the psychometric properties of the PWS is provided in chapter three.

Purpose

The purpose of this study is to determine the relationship between trait emotional intelligence, perceived wellness, perceived stress, and wellness behaviors among counselors-in-training.

Research Questions

This study is comprised of multiple research questions. The primary research question evaluates the overall theoretical structural model: Does trait emotional intelligence of counselors-in-training (as measured by the TEIQue-SF) contribute to their levels of perceived wellness (as measured by the PWS), perceived stress (as measured by the PSS), and wellness behaviors (as measured by the BMS-WBCI)? Additional research questions include:

1. Is there a mediating effect of perceptions of stress on the relationship between trait emotional intelligence and wellness behaviors among counselors-in-training?
2. Is there a mediating effect of perceptions of wellness on the relationship between EI and wellness behaviors among counselors-in-training?

Hypothesis

There will be a relationship between CIT's emotional intelligence, perceptions, and strength and types of utilized wellness behaviors (as measured by the BMS-WBCI; Hey, Calderon, & Carroll, 2006). There will be a relationship between levels of perceived stress (as measured by the PSS; Cohen, Kamarck, & Mermelstein, 1983) and levels of perceived wellness (as measured by the PWS; Adams, Bezner & Steinhardt, 1997). There will be a relationship between emotional intelligence (as measured by the TEIQue-SF; Petrides & Furnham 2003) and wellness behaviors (as measured by the BMS-WBCI; Hey, Calderon, & Carroll, 2006). Participants with higher levels of emotional intelligence (as measured by the TEIQue-SF; Petrides & Furnham 2003) will have higher levels of perceived wellness (as measured by the PWS; Adams, Bezner & Steinhardt, 1997) and lower levels of perceived stress (as measured by the PSS; Cohen, Kamarck, & Mermelstein, 1983). Participants with higher levels of perceived wellness (as measured by the PWS; Adams, Bezner & Steinhardt, 1997) will also have higher levels of behavioral wellness (as measured by the BMS-WBCI; Hey, Calderon, & Carroll, 2006).

Study Design

This study engages a correlational research design that utilizes structural equation modeling to test the theoretical model of the directional relationships between emotional intelligence, perception of stress, perception of wellness, and wellness behaviors. A

Pearson product-moment correlation is used to assess the relationship between the constructs of interest. Participants of this study include counselors-in-training in the United States, enrolled in CACREP accredited counselor training programs. This study required a minimum of 200 participants based on the number of factors to be tested under SEM guidelines (Crockett, 2012; Kline, 2011). Counselors-in-training were given the option to participate in a drawing for one of twenty $15 Walmart gift cards and one of four $25 Amazon gift cards.

Assumptions

The assumptions made in this study are:

1. Participants responded honestly to the self-report surveys.
2. The surveys being used are valid and measures the variables accurately.
3. Participants will accurately comprehend and respond to the survey items to the best of their ability.

Delimitations

The factors the researcher can control in this study are:

1. Only graduate level mental health professionals will be included in the study.
2. The assessments will be administered in paper-and-pencil format.
3. Counselors in training will be recruited from contact with CACREP accredited institutions.

Limitations

The factors beyond the researcher's control that may limit the generalizability of this study's findings are:

1. Because the participants are limited to counselors-in-training, the results cannot be generalized to all mental health professionals.
2. The sample will not be randomly selected. It will be a convenience sample.
3. This investigation will utilize a correlational design; thus, causality cannot be determined by the relationships identified in this study (Kline, 2011).
4. The data collected in this study will be self-reported by participants. Therefore, social desirability may impact the results of this study. Participants may attempt to answer in a way to present themselves more favorably (Houser, 2015).

Definition of Terms

Burnout- Process of physical and emotional depletion, including symptoms of emotional exhaustion, depersonalization, the reduced sense of accomplishment, devaluing clients, professional incompetence, negative work environment, and deterioration of personal life (Lee et al., 2007; Maslach & Jackson, 1981; Osborn, 2004;

Counselor- A helping mental health professional with a graduate degree in counseling.

Counselor-in-training- A person currently enrolled in a counseling graduate training program with the intention of becoming a licensed mental health counselor.

Counselor Training Program- A graduate degree-awarding masters or doctoral level experience specifically in the field of counseling that includes clinical internship with direct client care in addition to classroom training.

Emotional Intelligence- The ability to identify, regulate and utilize emotions to understand and relate effectively with others (Davey, 2005).

Perception & Appraisal- The state of being or process of becoming aware of something through the senses and then act of estimating its value. In terms of perceiving and appraising stress, "for an event or situation to be considered stressful, it must be perceived as stressful via perceptual processes" (Roberti, Harrington, & Storch, 2006, p. 135; Lazarus, 1966; Lazarus & Folkman, 1994).

Stress- An emotional response to appraisal of negative person-environment relationship, creating states such as fear, anger, guilt, or shame (Lazarus & Folkman, 1987).

Wellness- Indivisible physical, mental, emotional, relational, and spiritual health marked by meaning-making, creativity, identity, and coping ability in all areas of life that may be built, supported or enhanced through a wide range of self-care practices and support the sense of well-being (Myers & Sweeney, 2004).

Trait Emotional Intelligence- Consisting of behavioral characteristics and self-perceptions such as empathy, emotional regulation, and adaptability (Petrides & Furnham, 2001), but emphasizing performance, personality and affective disposition.

Summary

This chapter outlined issues of balance between personal wellness and professional engagement. This chapter establishes the importance of counselor wellness, reviews current theories guiding wellness, perception and behavior, and introduces the reader to the operational definitions of wellness, EI, and role of perceptions and appraisals. The present study allows for the examination of trait EI within wellness and the perceptions of stress, and perceptions of wellness that may contribute to wellness behaviors. Wellness has been acknowledged as a necessary ingredient for counselors to

prevent impairment, but little is offered on what factors may contribute or mediate counselor wellness. This study may provide insight into the contributions of the both dispositions and the appraisal process, allowing researchers to differentiate between counselors who know how to make a wellness plan and counselors who know when to utilize wellness behaviors.

Organization of the Study

This dissertation includes five chapters. The first chapter proposes an argument for the study. It also gives operational definitions of the variables used in the study, including the background information on the significance of the variables; research questions; assumptions; limitations; and delimitations. In chapter two, a review of the literature is presented through an examination and synthesis of conceptual and empirical works related to the relevant variables. The proposed methodology for the study is presented in chapter three. This chapter includes a description of participants and procedures related to data collection. Instruments used in this study are described as well as the design of the study, research hypotheses and data analysis. Data collection results are reviewed in chapter four, while chapter five explores the study's findings, implications of emotional intelligence within counselor wellness, and suggestions for future research.

CHAPTER II: LITERATURE REVIEW

This chapter examines how emotional intelligence, perceptions of wellness, and perceptions of stress relate to wellness behaviors among counselors-in-training. The review of literature provides a rationale for the need of this study through a review of the conceptual and empirical literature related to these variables. The review is organized into four sections. The first section covers the relevant literature on wellness, foundational wellness models and the influence of wellness on counselors. This section will also explore factors measurement options for examining wellness behaviors. The second section covers relevant literature on emotional intelligence and the relationship between EI and counselor wellness. The third section provides a review of perceptions and appraisals, and examines the relationship between perceptions, wellness, and stress. Lastly, the fourth section identifies measurement tools for examining perceptions of wellness and perceptions of stress. Overall, the information in this chapter is intended to summarize the relevant literature related to factors that influence wellness in counselors-in-training. This chapter emphasizes the empirical evidence already found between factors and explores the potential relationship between wellness and previously unexplored factors. Lastly, I will summarize the information presented and link it with the research questions for this study.

Understanding Wellness

Health and wellness are important issues among students and professionals as well as the public at large (Bishop & Yardley, 2010; Hey, Calderon, & Carroll, 2006; Granello, 1999; Lee, Cho, Kissinger, & Ogle, 2010). The National Institute of Mental Health (NIMH, 2015) reported that approximately one in five adults in the United States,

suffers from a diagnosable mental health disorder. The relationship between mental health, physical activity and perception of health is notably established through numerous research studies, dating from the early 1990's to present day (Adams, Moore, & Dye, 2008; Goodwin, 2003; Pafenbarger, Lee, & Leung, 2004). However, it is important to understand that wellness is not simply the absence of disease, it requires a balance of physical, mental, and social well-being (WHO, 1947; 1958; 1964).

Among the most effected by deficits in wellness are people in helping professions (Lawson, 2007; Lawson & Myers, 2011), whose wellness decreases as demands are perceived as outweighing resources (Lambert & McCarthy, 2006; Linley & Joseph, 2007). Webster and Hacket (1999) identified up to 54% of helping professionals experience high emotional exhaustion and 38% of these professionals' report symptoms of depersonalization. Morse et al. (2012) estimate that 21-67% of mental health workers may be experiencing increasingly elevated levels of burnout. While it is understood that wellness is important for the counseling profession, it is often difficult to maintain balance between professional demands and personal care. Fortunately, more and more is discovered about the relationship between factors needed to achieve wellness.

To better understand the influence and importance of wellness, this section defines and conceptualizes the construct. Wellness theories are explored and related to the population of interest, counselors-in-training. The influence of counselor wellness is assessed as well as the consequences of failing to maintain personal and professional wellness. This section examines current methods for developing counselor wellness, and options for measuring wellness and healthy behaviors. Lastly, this section reviews gaps in the literature and presents the need for this study.

Definition and Conceptualization

Definitions of wellness have evolved since the World Health Organization (WHO, 1947; 1958; 1964) first began to examine health in terms of physical, mental, and social well-being and challenged the idea of traditional wellness as more than the absence of disease. Additional amendments included the idea of integrating multiple facets of functioning with personal achievement of potential, calling this form of wellness, *optimal health* (Dunn, 1961). The first prominent multidisciplinary definition of wellness was grounded in theories of growth and human behavior and introduced through the Wheel of Wellness, including both mental and physical illness during treatment (Sweeney & Witmer, 1991; Witmer & Sweeney, 1992). Myers, Sweeney, and Witmer (2000) later re-defined wellness as "a way of life oriented toward optimal health and wellbeing, in which body, mind, and spirit are integrated." (p. 252) and described the revised Wellness Wheel to address spirituality, self-direction and community to name a few. Other researchers have defined wellness as the perception that one is living in a manner that permits the experience of consistent, balanced growth in the emotional, intellectual, physical, psychological, social, and spiritual dimensions of human existence (Adams, Bezner & Steinhardt, 1997). Several researchers have encouraged the development of personal definitions of wellness to foster utilization of regular wellness practices (Myers & Sweeney, 2004; Lenz & Roscoe, 2011).

Tenets of Wellness

The concept of well-being has been examined from a variety of theoretical models, the most common of which is the Wheel of Wellness (Witmer, Sweeney, & Myers, 1998). The wheel was predicated upon viewing a person holistically, over the

course of a life-span, integrating five life-tasks and subtasks which are interwoven between spirituality, work and leisure, friendship, love, and self-direction (Hattie, Myers, & Sweeney, 2004). Self-direction is further examined through the 12 tasks of (a) sense of worth, (b) sense of control, (c) realistic beliefs, (d) emotional awareness and coping (e) problem solving and creativity, (f), sense of humor, (g) nutrition, (h) exercise, (i) self-care, (j) stress management, (k) gender identity, and (l) cultural identity. They are then examined through the lens of family, community, religion, education, government, media and industry. The purpose behind developing models of wellness were the following: (a) to shift the mindset from disease treatment to prevention, (b) to aid both physical and mental health care providers in viewing the patient through a holistic lens, and (c) to use the lens as a base for treatment planning (Myers, Sweeney, & Witmer, 2000). It is only in recent research that wellness models have been examined and adapted for use in counselor education and supervision. As previously identified, wellness is acknowledged as a necessary ingredient for counselors to prevent impairment by various ethical codes and standards (ACA Ethical Code, 2014; CACREP, 2016), but little is offered on what factors may contribute towards or mediate counselor wellness in terms of dispositions and perceptions.

Addressing the need to prepare counselors to achieve balance and wellness, researchers applied specific models of wellness to counselor education such as the Indivisible Self-Model of Wellness (IS-Wel; Myers & Sweeny, 2004) and found that students who are not educated on the use of wellness strategies during their training often graduate lacking in their ability to manage impairment (Wolf, Thompson, & Smith Adcock, 2012). These conclusions support previous studies that have questioned whether

counselor education programs have had a meaningful impact on the cultivation of wellness among counselors-in-training (Roach &Young, 2007). Lenz and colleagues (2012) suggest that failing to promote wellness during training may negatively influence a counselor's self-care habits, coping style and ability to respond to professional distress. These results are concerning, given a counselor's profession is geared towards helping clients achieve personal wellness and promoting self-awareness and self-care practices (Myers & Sweeney, 2005). Based on these previous studies, we now know that innovative strategies are needed to support students in understanding wellness. We may not fully appreciate the creation of new wellness strategies until we comprehend the foundational models they were built upon.

Wellness Models

There are multiple models and theories from which to examine wellness. Wellness models provide a structure from which researchers can explore, maintain, and promote wellness and healing. While there are a variety of models available, each model has progressed to address specific concerns about wellness. It is also evident that many early models have provided a foundation from which newer models have evolved (Blount, 2015; Myers, Leucht, & Sweeney, 2004; Witmer, 1981).

Hettler's Hexagonal Model. One of the first model's published is Hettler's Hexagonal Model of Wellness (Hettler, 1980). The author of this model was influenced by Dunn (1961) and researchers Travis and Ryan (1981), who were some of the first to initiate the wellness movement. Their contributions promoted insight into higher levels of functioning that incorporated health and wellness beyond a disease model of functioning. The Hexagonal Model of Wellness was developed out of Hettler's work establishing the

National Wellness Institute (NWI; 1980). This model includes occupational and spiritual dimensions, exploring meaning and purpose, in addition to intellectual, emotional, physical, and social areas of wellness. The model is designed to focus on areas of life that influence an inclusive definition of wellness.

Zimpher Wellness Model. Many wellness models were based on the treatment of biological illness, such as Zimpher's Wellness Model (Zimpher, 1992); which included medical health, immune function, and lifestyle management. This model widened the view of wellness and health by examining spiritual beliefs and attitudes, psychodynamics, energy forces and interpersonal relations, declaring that the ability to find meaning in life through spiritual is critical to overall wellness (Savolaine & Granello, 2002). Specifically, the Zimpher Wellness Model examined well-being in participants with cancer and other persistent diseases (Zimpher, 1992). This model was designed to promote wellness by developing awareness to resources and engage participants towards recovery. The Zimpher model (1992) is predicated upon the belief that individuals have an instinctive inclination toward health, as well as a focused blend of interpersonal support, medical and physical functioning, and the belief that wellness is psychodynamic.

Model of Spiritual Wellness. Other models, such as the Model of Spiritual Wellness (Chandler, Miner Holden, & Kolander, 1992), approached wellness through a holistic, yet slightly different, spiritual lens; which includes dimensions of physical, emotional, intellectual, occupational, and social health. Their work builds upon the hypothesis that spirituality is influential to all aspects of wellness, instead of viewing spirituality as a separate but equal contributor towards well-being. Chandler et al. (1992)

considered people to be optimally functioning when they maintained balance the personal and spiritual realms.

The Lifespan Development Model & Wheel of Wellness. The Lifespan Developmental Model (LDM; Sweeney & Witmer, 1991) shares attributes like both the Hettler model and the spiritual wellness model. LDM incorporates *life tasks* viewed as essential to achieve wellness. This model examines spirituality, self-direction, work and leisure, friendship and love, and was used to develop the Wheel of Wellness (Sweeney & Witmer, 1991; Witmer & Sweeney, 1992). The Wheel of Wellness identifies the interaction of each factor around the base of spirituality and incorporates LDM's life tasks. The tasks are broken down into 16 aspects: (a) spiritual, (b) sense of worth, (c) sense of control, (d) realistic beliefs, (e) emotional responsiveness, (f) Intellectual Stimulation, (g) Sense of humor, (h) exercise, (i) nutrition, (j) self-care, (k) gender identity, (l) cultural identity, (m) stress management, (n) work and leisure, (o) friendship, and (p) love. Sweeney and Witmer (1991) embraced the idea that life forces interacted with one another and influenced a person's general well-being.

Indivisible Self Model. The Indivisible Self-Model of Wellness (IS-Wel; Myers & Sweeney, 2004) shifts focus from the first-order overall wellness and defines five second-order factors, and 17 third-order factors. Second-order factors include the following: (a) coping self, (b) social self, (c) essential self, (d) physical self, and (e) creative self. Myers and Sweeney (2004) explain that the third-order factors are structured within the five self-factors, and occur within local, institutional, global and chronometrical contexts. The coping self encompasses leisure, stress management, self-worth, and realistic beliefs. The social self, incorporates friendship and love, while the

essential self, integrates spirituality, gender identity, cultural identify, and self-care. The physical self combines exercise and nutrition. Lastly, the creative self encompasses thinking, emotions, control, work, and humor (Myers & Sweeney, 2004). Each aspect is geared toward enhancing the quality of life by helping an individual make meaning through their experience of self and others.

The Clinical and Educational Model of Wellness.

The Clinical and Educational Model of Wellness (CEMW; Granello, 2000; 2013) addresses eight paradigms: (a) creativity, (b) social relationships, (c) physical and nutritional concerns, (d) emotional regulation, (e) context of environment and culture, (f) preventative self-care, (g) cognition, and (h) spirituality. This model emphasizes viewing each area within the context of the individual (Granello, 2013). While this model interactively assimilates each of the eight areas, it was created for use with clients in clinical setting and is not appropriate for use in the proposed study with counselors-in-training.

The Perceived Wellness Model. Lastly, the Perceived Wellness Model (PWM; Adams, 1995; Adams, Bezner, & Steinhardt, 1997) takes a unique view based on perceptions of wellness and postulates that "subjective perceptions are valid indicators of future objective health" (Adams, Bezner, Drabbs, Zabarno, & Steinhardt, 2010, p. 165). Adams et al. (1997; 2010) argue that perceived support has more influence that received support on health. The PWM consists of three principles common to all conceptualizations of wellness: (a) multidimensionality, (b) balance among dimensions, and (c) salutogenesis (defined as causing health rather than illness). The model is bidirectional, incorporating balance among the three dimensions (Adams, Bezner &

Steinhardt, 1997), and defined by six areas of wellness: (a) psychological, (b) physical, (c) emotional, (d) spiritual, (e) social, and (f) intellectual. This model is a particularly good fit for the problem introduced in chapter one, due to its emphasis on perceptions and connection with future behavior.

Wellness within Helping Professions

Several ethical codes, practice standards, and guidelines place responsibility to maintain balance between professional demands and personal care on mental health practitioners (ACA Ethical Code, 2014; APA Code of Conduct, 2017; CACREP, 2016; NASW, 2017). As previously noted, people in helping professions are identified as suffering from symptoms of burnout and experience frequent interruptions in personal wellness (Caldwell, 1984; Lawson, 2007; Lawson & Myers, 2011; Lee, Baker, Cho, Heckathorn, Holland, Newgent, Ogle, Powell, Quinn, Wallace, & Yu, 2007; Linley & Joseph, 2007; Thompson, Amatea & Thompson, 2014). Collectively, burnout is recognized as a combination of reduced sense of accomplishment, and emotional and physical depletion (Osborn, 2004; Pines & Maslach, 1978). Morse, Salyers, Rollins, Monroe-DeVita, and Pfahler (2012) reviewed the problem of burnout in health providers by conducting a meta-analysis of controlled intervention studies designed to increase wellness and decrease burnout among mental health staff. Out of eight studies, their analysis revealed the prevalence of burnout among providers, emphasized the association of additional problems that coincide with staff that is burned out, and identified individual and organizational strategies that are effective in addressing burnout in mental health practitioners. Morse et al. (2012) concluded that not only is wellness at risk for

health providers, but also that symptoms can be significantly improved with the application of intervention.

Wen, Hung, Liu, Cheng, Yen, Chang, & Huang (2011) observed 110 internists and 2872 patients, shifting focus from stress to well-being and identifying a significant relationship between greater perception, integration, and regulation of emotions (ability EI) with less burnout ($p<0.001$) and higher job satisfaction ($p< 0.001$). They also reported a correlation between higher patient satisfaction and less burnout ($p< 0.01$), and less burnout with higher job satisfaction ($p< 0.001$). Using the Maslach Burnout Inventory (MBI) Wen et al. (2011) to assess for doctor burnout, the Wong and Law Emotional Intelligence Scale (WLEIS; Law, Wong, & Song, 2004) to assess ability EI, and structural equation modeling (SEM) to reveal associations among the constructs. They conclude that EI may act as a protective factor for doctors which reduces burnout (Wen et al., 2011), thereby influencing well-being. Wen et al., (2011) suggest promoting a positive focus during medical training, that highlights the development of wellness, integrates emotional management, and increasing communication skills.

In addition to emotional regulation, researchers found evidence that prolonged empathic responses required during treatment of patients, increased residual stress leading to burnout in mental health professionals (Cummins, Masey, & Jones, 2007). However, Granello (1999) promotes caution when examining psychological variables such as empathy in relation to wellness of college students, due to the potential influence of developmental age. Granello (1999) implies that college age students between the ages of 18 and 22 may view wellness variables differently than adult populations. His research supports the continued examination of perceptions of wellness and actual health

behaviors among students, as well as the continued consideration of different developmental stages on perceptions of wellness.

Counselor Wellness

Counselors appear to be at high risk due to frequent contact with human suffering (Figley, 2002; Lee et al., 2007), and may be at even higher risk if counselors who have experienced personal traumas or unresolved stress may have a heightened susceptibility to burnout and impairment (Figley, 2002; Pearlman & Mac Ian, 1995; Yassen, 1993). Likewise, Pines and Maslach (1978) found that length of time in the field contributed to burnout, while Merriman (2015) identified and increase risk of burnout to interns and new counselors. While researchers may disagree on the timeframe to which counselors are most susceptible to burnout, many agree that the profession itself contributes to emotional exhaustion due to demanding schedules, stressful expectations, and lack of resources (Lawson, Venart, Hazler, & Kottler, 2007; Stebnicki, 2007). Therefore, for counselors to avoid impairment and maintain personal wellness, it is imperative that they develop awareness to emotional strain and learn preventative coping strategies to increase personal wellness.

Unfortunately, maintaining professional balance and personal wellness is not relegated to vetted counselors. Evidence has been examined suggesting a negative relationship between overall wellness and the counselor education process (Lenz, Sangganjanavich, Balkin, Oliver & Smith, 2012; Smith, Robinson, & Young, 2007). When comparing people who are drawn to the counseling profession to the general population, counseling students exhibit higher levels of initial wellness (Lawson & Myers, 2011). This preliminary wellness can be interrupted when counseling students

and counselors do not engage in a healthy lifestyle that promotes balance (Lawson, 2007). Researchers who have observed CIT's, suggest that counselor education has done little to prepare counselors on how to examine and tend to their own wellness (Lenz, Sangganjanavich, Balkin, Oliver & Smith, 2012; Smith, Robinson, & Young, 2007).

Only in recent research have investigators begun to emphasize the educational experiences of CIT's and embrace strategies for cultivating internal reflective practices to increase their ability to assess limitations and apply self-care practices (Ohrt, Prosek, Ener & Lindo, 2015; Wolf, Thompson, & Smith-Adcock, 2012). Testa and Sangganjanavanich (2016) recommend that educators and clinical supervisors encourage their supervisees in learning to assess, monitor and regulate their emotions. They propose that increased awareness of emotions allows for feeling a greater sense of control and personal accomplishment as well as ability to address impairment. Their contributions highlight the necessity for counselor educators to teach their students to develop introspection that increases personal awareness and increases counselor wellness. Attainment of such skills, may mean the difference between a counselor who knows how to make a wellness plan and a counselor who is able to utilize wellness behaviors.

Increasing Counselor Wellness

Additional researchers report the benefits of either integrating wellness within counselor education or offering a specific wellness course to counselors-in-training (Wolf, Thompson, & Smith-Adcock, 2012; Yager & Tovar-Blank, 2007). Propositions to increase counselor wellness include recognition of empathy as necessary to maintain the therapeutic relationship, while understanding that it can be costly to maintain if empathy is not used towards one's own self-care and nurture (Cummins, Masey, & Jones, 2007).

Skovholt (2001) indicates a relationship between counselor's reactions to stress and their cognitive coping ability, signifying that counselors may experience more distress dependent on their perceptions of ambiguous situations with their clients. Skovholt (2001) also informs counselors that they must be able to be reflective about their own emotions and take their own advice about wellness to be able to effective with complicated information received from their clients. Attention is not only directed towards increasing the wellness of new practitioners (Wolf, Thompson, & Smith-Adcock, 2012) but also the examination of characteristics and factors that may be related to counselor wellness (Lawson & Myers, 2011; Mobley, 2003; Myers, Mobley, & Booth, 2003; Roach, 2005; Smith et al., 2008; Wester et al., 2009).

Several studies examine characteristics that influence counselor wellness. Lawson and Myers (2011) examined wellness scores between counselors who work in private practice and counselors who work in school or community settings and found that practitioners in private practice scored higher on the 5F-Wel than other professionals. A study on gender role conflict (GRC) and counselor training found that male counselors experience greater wellness and less GRC than other professional men (Mobley, 2003). According to Roach (2005) counseling students who have access to wellness training, have higher wellness scores than students who do not take wellness courses. Research from Roach and Young (2007), reports that access to wellness training alone is insufficient to promote improved wellness in students. Researchers argue that strategies are needed to help students implement their knowledge of self-care practices (Roach & Young, 2007), and that approaches like meditation, yoga, and mindfulness based stress

reduction training should be infused with theory driven wellness training (Schure et al., 2008; Wolf, Thompson, & Smith-Adcock, 2012).

Specifically, Wolf, Thompson, and Smith-Adcock (2012) encourage the examination of individual factors of wellness using the indivisible-self model of wellness (IS-Wel; Hattie, Myers, & Sweeney, 2004) to increase student awareness to a variety of influences on CIT wellness. Their research examines the effect of contextual factors that either promote or hinder personal wellness, by addressing the following five selves: (a) creative self; thinking, emotions, control, work, humor, (b) coping self; managing stress, self-awareness, self-reflection, (c) social self; friendship and love, (d) essential self; connection, meaning, identity, spirituality, and (e) physical self; activity, diet, lifestyle (Myers & Sweeney, 2004; Wolf, Thompson, & Smith-Adcock, 2012).

One such contextual factor that encompasses a variety of these traits is emotional intelligence. Salovey, Mayer, Caruso, and Seung Hee (2008) identify emotional intelligence as awareness to emotions, perception of feelings in and around self, mindful use of emotions to creatively think and problem solve, appreciation of causes and complexity of emotions, and self-reflection that allows for the management of emotions. Recent research links trait emotional intelligence (EI) with a decrease in symptoms of impairment, and indirectly support the connection between wellness and emotional regulation (Gutierrez & Mullen, 2016). Houghton, Wu, Godwin, Neck and Manz (2012) presented qualitative data supporting the relationship between emotional intelligence, self-leadership, and stress coping among students. They suggest that emotional regulation may serve as a mediator between EI and stress coping. Overall, it appears there is an increase in research that supports the expansion of understanding of the influence of

emotions, and ability to regulate and manage emotions on health, burnout, and wellness (Cherniss et al., 2006; Gutierrez & Mullen, 2016; Pishghadam & Sahebjam, 2012). For these reasons, EI is introduced as a factor contributing towards wellness behaviors, along with perceptions of stress, and perceptions of wellness.

Measuring Wellness and Healthy Behaviors

While there are a variety of wellness assessments available, each type may have a different focus, purpose, level of effectiveness, and limitations. The Wellness Evaluation of Lifestyle (WEL; Myers, Sweeney, & Witmer, 1998) was developed from the Wheel of Wellness. Researchers discovered that the scale did not support the original model but led to the development of a new multidimensional model, the IS-WEL (Myers, Leucht, & Sweeney, 2004). The Five Factor Wellness Evaluation of Lifestyle (5F-Wel; Myers et al., 2004) was mentioned earlier in this manuscript and is the assessment that identifies the five essential factors and secondary factors in the Indivisible Self Model (Hattie et al., 2004). It was created to assess overall wellness in a variety of populations but contains three limitations. Limitations include potential issues with internal consistency values, cost to obtain the scale, and length of the instrument (Myers & Sweeney, 2005). Another option for measuring wellness is the Health Promoting Lifestyle Profile-II (HPLPII; Walker, Sechrist, & Pender, 1987). This scale is a 52-item self-report allowing identification of engagement in health maintenance activities, level of fulfillment, and self-actualization (Walker et al., 1987). Other assessments such as the Lifestyle Assessment Questionnaire (LAQ; NWI, 1983) were created to assess six dimensions of wellness but only result accurately measuring two of the six factors. The Helping Professional Wellness Discrepency Scale (HPWDS; Blount, 2015) was developed to aid

helping professionals' wellness by addressing perceptions of wellness and aspirational wellness. This instrument is geared towards helping counselor's evaluate current level of wellness, while promoting awareness to the discrepency between what they how well they would like to be and how well they actually are. Which is more suited for professionals than CIT's. Other assessments such as the Counselor Burnout Inventory **(**CBI; Lee et al., 2007) may be newer and shorter, but again, this assessment is reflective of burnout instead of wellness, and is geared for counselors instead of CIT's, who have yet to experience full assimilation into the field. Likewise, other assessments such as the Professional Quality of Life III (PRO-QOL-III-R; Stamm, 2005) and the Career-Sustaining Behaviors Questionnaire (CSBQ; Stevanovic & Rupert, 2004) are developed for professionals and not trainees. Although there are a variety of instruments developed to attain understanding of a participant's ability to perceive wellness strategies and indicate level of agreement with statements about stress prevention that were not explored further (F.A.M.I.L.Y Self-Care Assessment Inventory; Eckstein, 2001; LCI; Hinds, 1983; PRI; McCarthy & Lambert, 2003), the Body-Mind-Spirit Wellness Behavior and Characteristic Inventory (BMC-WBCI; Hey, Calderon, & Carroll, 2006) is the only scale that was normed on students and allows for the specific measurement of behaviors that occurred within the past month.

Body-Mind-Spirit Wellness Behavior and Characteristic Inventory (BMS-WBCI). In this study, wellness behaviors is measured with the Body-Mind-Spirit Wellness Behavior and Characteristic Inventory (BMS-WBCI; Hey, Calderon, & Carroll, 2006), and referred to as wellness behaviors (BW). The BMS-WBCI examines three domains in which the following are: (a) body; including aspects of fitness, nutrition, self-

care, and safety, (b) mind; including aspects of social awareness, emotional awareness and intellectual awareness behaviors, and (c) spirit; including spiritual and well-being measurements. Each domain has a different number of statements, resulting in a 44-item survey. The BMS-WBCI is designed to measure baseline wellness statements about behaviors and characteristics in the body, mind, and spirit dimensions of wellness that have occurred over the past month. Individuals engaging in wellness behaviors demonstrate the connection noted by the health promotion theory (Rosenstock, 1990) in which behaviors reflect positive physical health because of beliefs, perceptions, and values of maintaining wellness. Both total score and sub-scores were used in this study to determine levels of participation in positive health behaviors and use of characteristics that promote well-being. Higher scores indicate greater use of positive behaviors and increased over all well-being (Hey, Calderon, & Carroll, 2006). The developers of the BMS-WBCI instrument reported high internal consistency, high reliability and a positive correlation between all three subscales in two different studies involving college students. Psychometric properties are reviewed further in chapter three. This assessment presents the best fit for measuring wellness behaviors among CIT's.

Emotional Intelligence

In this section, emotional intelligence is defined and conceptualized. Emotional Intelligence is explored and related to counselor wellness. The influence of emotional intelligence is explored through an examination of empirical research. Lastly, current methods for measuring emotional intelligence are examined.

Definition and Conceptualization

Emotional Intelligence (EQ) refers to the ability to monitor one's own and others' feelings and emotions, to discriminate among them, and to use this information to guide one's thinking and actions (Salovey & Mayer, 1990). Brackett and Salovey (2006) further explored EI beyond perceiving emotion and included the use of understanding emotion to cultivate personal growth. This is sometimes referred to as a constellation of emotional self-perceptions located at the lower levels of the personality hierarchies laying outside of cognitive ability (Petrides, Pita, & Kokkinaki, 2007). Emotional Intelligence comprises four interconnected elements that assist awareness of the emotions of others and produces appropriate empathic responses as a result. It contains the ability to perceive feelings in and around self; increases creative thinking and problem solving with the mindful use of emotions; influences appreciation of causes of emotions and their complexity; and increases the reflection and self/other awareness with ability to manage emotions (Salovey, Mayer, Caruso, & Seung Hee, 2008). EQ is defined as "the ability to perceive emotions; to access and generate emotions to assist thought; to understand emotions and emotional knowledge; and to effectively regulate emotion to promote emotional and intellectual growth" (Salovey & Sluyter, 1997, p.6). Researchers that have examined emotional intelligence report that EQ may predict stress responses and adaptive coping strategies in a variety of settings (Matthews, Emo & Funke, 2006).

The two types of EQ models are recognized as: (a) ability based: related to the cognitive component of processing emotional information (Mayer, Salovey, & Caruso 2000), and (b) trait: personal perception of emotional intelligence. Petrides and Furnham (2001) emphasize that ability emotional intelligence and trait emotional intelligence are two separate constructs, ability seen as a measure of achievement and trait (EI) seen as

incorporating behavioral disposition and measured through self-report. Research conducted by Van Rooy and Viswesvaran (2004) recognized the core concept of emotional intelligence (EQ) as sharing features with intelligence and personality, but remained a distinct construct from either. Both definitions are needed to address the various aspect of EQ. However, this study will utilize the self-reported dispositions of trait emotional intelligence described by Petrides and Furnham (2001). Trait emotional intelligence (EI) is the most comprehensive definition of EQ to date, due to its inclusion of both cognitive-emotional aptitude and personality disposition (Cherniss & Coleman, 2001; Petrides & Furnham, 2001). Trait emotional intelligence (EI) consists of adaptability, assertiveness, emotional appraisal, emotion expression, emotion management, emotion regulation, low impulsivity, relationship skills, self-esteem, self-motivation, social competence, stress management, trait empathy, trait happiness, and trait optimism (Petrides & Furnham, 2001).

Emotional Intelligence and Wellness

Burnout and EI has been greatly explored but relatively little is known about EI's relationship to wellness. Conceptually, individuals with higher levels of EI should be able make use of their emotion regulation mechanisms effectively to create positive emotions as well as to promote emotional and intellectual growth (Wong and Law 2002). There has been enough exploration into the influence of EI to link it with increased resilience (Saklofske et al., 2013; Schneider et al., 2013), self-efficacy (DiFabio & Palazzeschi, 2008), and life satisfaction (Extremera & Fernádez-Berrocal, 2005). DeFabio and Saklofske (2014) examined fluid intelligence and found that participants with higher self-reported trait EI indicated feeling better able to adaptively cope with adversity. Slaski and

Cartwright (2002, 2003) identified significantly better health and wellbeing in participants with higher EI scores. More importantly, individuals in their study reported experiencing less overall stress.

Ability EI has been linked with personal accomplishment (Pishghadam et al., 2012), positive attitudes towards students (Mortiboys, 2005), and intrapersonal competency (Bar-On, 1997) among teachers. EI has been associated with outcomes such as enhanced professional judgement, cooperation, and trust among social workers (George, 2003). Other researchers have established links between EI and use of more effective stress management (Slaski & Cartwright, 2003) and engagement of health behaviors (hart & Kinman, 2008). Arguably, research on EI shows that emotionally intelligent people experience a better quality of life (Karim & Shah, 2013), as well as shown themselves to be more physically and psychologically healthy (Schutte et al., 1998). Specifically, trait EI has been linked with academic adjustment, achievement, performance among university students (Perera & DiGiacomo, 2015). Higher levels of trait EI are linked with higher levels of resilience among nursing students (Li, Cao, Cao, & Liu, 2015). Trait EI is important for counselors and counselors-in-training due to its integration of adaptability and self-awareness (Cherniss, Extein, Goleman, & Weissberg, 2006; Mayer, Salovey, & Caruso, 2008; Petrides & Furnham, 2001). Grant, Kinman and Alexander (2014) argued that students training for helping professions needed to be sufficiently emotionally intelligent to manage the emotional demands of practice and to be able to safeguard their well-being.

Counselor Emotional Intelligence

The benefits of higher levels of trait EI are not relegated to individuals, Kaplowitz, Safran, and Muran (2011) identified a relationship between counselors with greater emotional intelligence and more consistent, positive client outcomes along with lower client drop-out rates. Other researchers have found that higher levels of EI may result in greater empathetic understanding and sensitivity to the client's problems (Testa & Sangganjanavanich, 2016). Although trait emotional intelligence (EI) research within the field of counseling is relatively young, some research conducted on emotional intelligence and wellness, relate more to the decrease of burnout than the increase of optimal wellness.

One such empirical study examined the association of mindfulness, emotional intelligence to burnout among counselors-in-training by Testa (2014). It assessed CIT's (*n* =380) using the Maslach Burnout Inventory- Human Services Survey (MBI-HSS), the Brief Emotional Intelligence Scale-10 (BEIS-10), and the Five-Facet Mindfulness Questionnaire (FFMQ). Using a canonical correlation analysis to test the hypothesis that there would be a statistically significant relationship between the factors. Testa (2014) identified results that indicated higher scores in emotional intelligence along with higher mindfulness scores were associated with lower burnout among CIT's.

In another study, EI is linked with the decrease of burnout in professional counselors (Gutierrez & Mullen, 2016). Researchers Gutierrez and Mullen (2016) examined the trait EI and burnout levels of practicing mental health counselors and marriage and family counselors' (N=539) using the Counselor Burnout Inventory (CBI) and the Trait Emotional Intelligence Questionnaire- Short Form (TEIQue-SF). Using a two-step SEM approach, the researchers determined that EI accounted for 38% of the variance in

counselor burnout, and confirmed that individuals with higher EI have lower levels of counselor burnout. They propose that this is due to EI's ability to help counselors regulate, manage and cope with distressing emotions (Goleman, 2001). While multiple positive personal and professional outcomes have previously been noted as being linked with increased EI; trait EI has yet to be explored within the context of counselor wellness. Considering the connections between EI and other positive psychological traits, it is possible that higher levels of trait EI may also lend itself to increased personal wellness behaviors and influence a person's perceptions towards stress and wellness.

Measuring Emotional Intelligence

There are a variety of EQ scales available to measure both ability and trait EI. However, the right tool must include valid and reliable psychometric properties, accessible, and address the multifaceted nature of emotional intelligence. Schutte el al., (1998) developed Emotional Intelligence Scale (EIS) based on Salovey and Mayer's (1990) model of EI. Later, Davies et al. (2010) used the EIS to develop the Brief Emotional Intelligence Scale (BEIS-10) to examine five aspects of ability EI. Other ability EI scales include the Bar-On Emotion Quotient Inventory (EQ-I; Bar-On, 1997) and the Mayer Salovey Caruso Emotional Intelligence Questionnaire (MSCEIT; Mayer & Salovey, 1997) each with over 130 items. Lastly, the Wong and Law Emotional Intelligence Scale (WLEIS; 2002) is also a self-report trait EI measure developed for use in leadership and management. This study utilizes the characterization of trait emotional intelligence developed by Petrides and Furnham (2001) and best addressed by the Trait Emotional Intelligence Questionnaire-Short Form (Petrides, 2009).

Trait Emotional Intelligence Questionnaire-Short Form (TEIQue-SF). The Trait Emotional Intelligence Questionnaire-Short Form (TEIQue-SF; Petrides, 2009) is a 30-item inventory based on the full 153-item form of the TEIQue (Petrides & Furnham, 2003) used to measure trait emotional intelligence in CIT's. The TEIQue-SF provides five subscale scores that cover the 15 facets of EI and using the following domains: (a) Well Being, (b) Self-Control, (c) Emotionality, (d) Sociability, and (e) Global Trait, which includes factors of self-motivation and adaptability (Petrides, 2009). Higher total scores on the TEIQue-SF are reported as indicating higher trait EI. For this study, total score was primarily used during data analysis. While the full version of the TEIQue demonstrates strong convergent and criterion validity, researchers identified that two of the 15 facets differed in reliability depending on gender, and found low internal consistency on three of the 15 facets regardless of gender (Mikolajczak, Luminet, Leroy, & Roy, 2007). Petrides and Furnham (2006) developed the short version of the TEIQue after selecting two items from each subscale from the long form that correlated most highly with the latent constructs total scores. Gutierrez and Mullen (2016) used this scale successfully with counselors and counseling students with adequate reliability, finding that all the TEIQue-SF subscales made a statistically significant contribution ($p < .001$) to EI. More regarding the validation and psychometric properties will be shared in chapter three.

Perceptions and Appraisals

In this section, perceptions and appraisals are defined and conceptualized in terms of perceptions of stress and appraisal of wellness. The influence of perception and appraisal is explored through an examination of theory and empirical research. Current

methods for measuring perceptions of stress and perceptions of wellness are examined. Finally, the chapter summary discusses gaps in the current literature and emphasizes the contribution of the proposed study.

Definition and Conceptualization

The transactional model of stress and coping developed by Lazarus and Folkman (1984) is the most popular framework used to explore the response to stress. They used the cognitive-relational theory of emotion and coping to emphasize the relationship between demands, resources, and belief systems, while exploring the process of individual perception and appraisal. They identified the relationship between these factors and the experience of stress, defining stress as "a relationship between the person and the environment that is appraised by the person as relevant to his or her well-being and in which the person's resources are taxed or exceeded" (Folkman & Lazarus, 1985, p. 152). Stress, whether experienced as destructive (distress) or constructive (eustress) is a direct result of individual appraisal and a product of the perception of having the means to address the given situation (Selye, 1974). Folkman and Lazarus (1985) identify two types of coping: (a) problem-focused, and (b) emotion-focused. Problem focused coping alleviates distress, while emotion-focused coping regulates emotional distress. Folkman and Lazarus (1985) identify emotion-focused coping as reappraising the meaning of a problem, self-soothing, or distraction from a problem. Lazarus and Folkman (1987) shift their focus from the foundational premise of their work using cognitive –relational theory and move further towards the examination of the process of emotion as a system. In their review, they identify two kinds of appraisal: (a) primary; including experienced harm, potential challenge, anticipated threat, and (b) secondary; evaluative judgements.

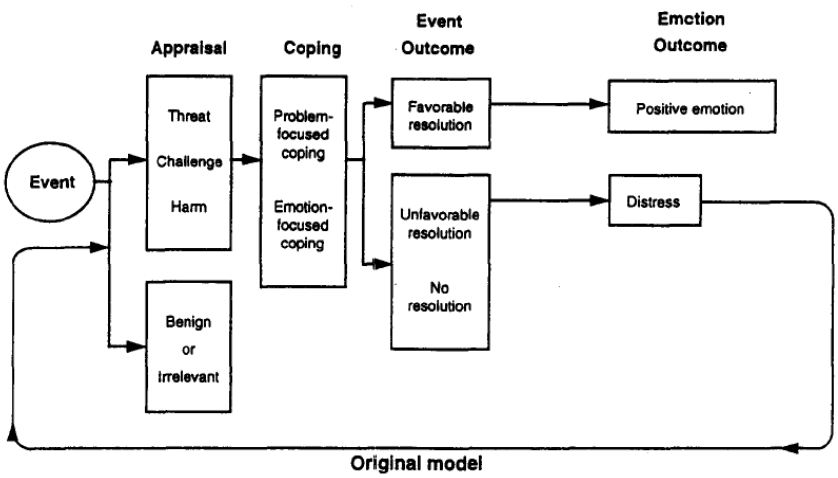

Figure 1: Model of Stress and Coping (Lazarus & Folkman, 1984)

Perceptions of Stress and Wellness

Lazarus and Folkman (1987) emphasized the need to turn towards the experience of emotion during the appraisal process. They urge researchers to focus on the emotional responses produced from stress such as fear, anger, guilt and shame, in addition to stress resulting from negative person-environment relationships. Slaski and Cartwright (2003) examined this shift away from appraisal of stress and towards the integration of emotions with thoughts and behaviors to reduce negative emotions. They concluded that emotional intelligence training had a significant and positive effect on measures of wellbeing, effectively decreasing appraisal of stress in their participants, but that more research was needed to explore if EI is a moderator or a consequence of stress.

Measuring Perceptions of Wellness

Wellness behaviors and measurements were thoroughly reviewed earlier in chapter two. While many of the inventories were indeed self-reports, few meet the criteria for specifically addressing perceptions of wellness. To meet this need, the Perceived Wellness Scale (PWS; Adams, Bezner & Steinhardt, 1997) is used as the

assessment tool in this study to examine a global score for perceptions of wellness. Perceived wellness refers to a level of appraised balance, professed by living in a manner that permits the experience of consistent, growth in the emotional, intellectual, physical, psychological, social, and spiritual dimensions of human existence (Adams, Bezner & Steinhardt, 1997). The *Perceived Wellness Scale* (PWS) is a 36-item instrument (See Appendix: H) which consists of three principles common to all conceptualizations of wellness: (a) multidimensionality, (b) balance among dimensions, and (c) salutogenesis (increasing health rather than illness). The model of wellness used in the PWS is reported to be dynamically bidirectional, which incorporates balance among the three dimensions (Adams, Bezner & Steinhardt, 1997). The scale is defined by scores for six areas of wellness: (a) psychological, (b) physical, (c) emotional, (d) spiritual, (e) social, and (f) intellectual.

Adams, Bezner, Drabbs, Zambarano, and Steinhardt (2010) elaborate on each component of wellness, providing a definition for each aspect in the table below.

Table 1 *Definitions of Components in the Perceived Wellness Survey*

Component	Definition
Emotional Centeredness	Secure self-identity and positive sense of self-regard
Intellectual Stimulation	Perception of being internally energized by an optimal amount of intellectually stimulating activity
Physical Resilience	Positive perception and expectation of physical health
Psychological Optimism	Perception that one will experience positive outcomes
Social Connectedness	Perception of having support available from outside sources and perceiving self as providing support to others
Spiritual Life Purpose	Positive sense of meaning and life purpose

Unfortunately, further examination of college psychology students (N = 317) found no psychometric evidence for its measurement of the existence of six separate subscale dimensions, as suggested by the authors of the PWS (Adams, Bezner, & Steinhardt, 1997) and the Perceived Wellness Model (Adams, 1995). Instead, Harari, Waehler, and Rogers (2005) suggest that if using the PWS (Adams, Bezner, & Steinhardt, 1997), researchers utilize the scale as a screening measure which identifies a global score by treating perceptions of wellness as a unidimensional construct. Likewise, Sigman et al. (2009) utilized the PWS with a college population (N= 611) and examined exercise self-efficacy using the Self-Efficacy and Exercise Habits Survey (Sallis, Pinksi, Grossman, Patterson, & Nader, 1990) and identified that feelings regarding exercise influenced other areas of wellness, self-efficacy was a predictor of five types of wellness, and they discovered that perceived wellness influenced overall wellness for participants (Sallis et al., 1990). To avoid potential threats to validity in this study, total score is utilized in the formation of both the structural model and in the alternative models. Additional psychometric properties are provided for this scale in chapter three.

Measuring Perceptions of Stress

The Perceived Stress Scale (PSS) is a popular measure of the self-perception of psychological distress (Cohen et al.,1983). While there are other scales such as the Stress Reaction Inventory (SRI; Yassen, 1995) are available and specifically made for counselors, the PSS has a wider range of use and may be more suited for use with CIT's due to the lack of professional counselor experiences. Researchers Cohen, Kamarck, and Mermelstein (1983) developed the scale in search of information regarding events that incite stress, the stress appraisal process, and individual experience of stress. Specifically,

Cohen (1994) states that items are designed to measure perceptions of stress in participants as unpredictable, uncontrollable, and overloaded. The development of the PSS is based on Lazarus's theories of stress and coping (Lazarus & Folkman, 1984; 1987) which states there is a transaction occurring between emotions based on the appraisal of stressors in the environment. The PSS is a 10-item instrument designed to measure the degree to which common situations are appraised as stressful. The items ask about feelings and thoughts during the past month and how often the participant felt a certain way in a specific situation. Cohen et al. (1983) successfully identified relationships between higher scores on the PSS and increased vulnerability depressive episodes elicited by life events, decreased ability to quit smoking, increased frequency of colds, and inability to control diabetes (Cohen et al., 1988; Cohen, 1994). Additional psychometric properties will be reviewed in chapter three.

Chapter Summary

In counselor education, students are asked to learn the skills necessary to connect with their clients, guide them towards increased functioning, balance personal and professional expectations, and maintain personal wellness to prevent impairment. The process of appraisal is evident in each factor identified in this study. Effective appraisal of emotion is a necessary ingredient for emotional intelligence. Likewise, perceptions of stress and wellness may very well influence the use of wellness behaviors. Research on emotional intelligence within helping professions is increasing in popularity due to the increasing evidence that EI can serve as a proactive factor in helping counselors meet their expectations. While the empirical evidence is continuing to grow, most studies utilizing these factors are conducted regarding the decrease of burnout and elimination of

impairment, instead of increasing wellness and overall counselor functioning. Based on the presented literature, it is logical to hypothesize a relationship among the constructs of EI, perceptions of stress and wellness, and wellness behaviors. This study may provide insight into the nature of the relationship between EI and wellness. It may also provide greater understanding as to the importance of holistically viewing well-being for counselors, CIT's, and clients.

CHAPTER III: METHODOLOGY

Chapter three explains the research design, methods, and procedures of the investigation. In this chapter, I provide a description of participants and procedures related to data, and review the instruments and their psychometric properties used in the study. The purpose of this study was to investigate the relationship between emotional intelligence, perceived wellness, perceived stress, and wellness behaviors among counselors-in-training. I test the theory that trait emotional intelligence (EI) as measured by *the Trait Emotional Intelligences Questionnaire- Short Form* (TEIQue-SF; Petrides, 2009), has a relationship with levels of appraisal of wellness (as measured by the *Perceived Wellness Scale* [PWS; Adams, Bezner, & Steinhardt, 1997]), appraisal of stress (as measured by the *Perceived Stress Scale* [PSS; Cohen, Kamarck, & Mermelstein, 1983]), and wellness behaviors (as measured by the *Body-Mind-Spirit Wellness Behavior and Characteristic Inventory* [BMS-WBCI; Hey, Calderon, & Carroll, 2006]) among counselors-in-training (CITs). Specifically, this investigation examines the relationships between counselor levels of EI and their contribution to appraisals of wellness, appraisals of stress, and wellness behaviors. The researcher also examines the direct relationship between EI and behaviors, as well as contextual factors between the variables that suggest a mediating influence on the relationships between factors (Little, Card, Boviard, Preacher, & Crandall, 2007). Baron and Kenny (1986) outline three parameters to qualify as a mediation effect: (a) the exogenous variable (EI) must effect the mediating variable (potentially perceived stress and perceived wellness); (b) the mediating variable must effect the endogenous variable (wellness behaviors); (c) the direct influence between the exogenous and endogenous variables must be significantly

reduced to identify the presence of mediation, after controlling for the mediating variables. Using a correlational research design, the researcher will determine the directional relationships between levels of emotional intelligence, levels of perceived wellness, levels of perceived stress, and frequency of wellness behaviors among counselors-in-training.

Research Questions

Does trait emotional intelligence (as measured by the TEIQue-SF; Petrides, 2009) of counselors-in-training, contribute to their levels of perceived wellness (as measured by the PWS; Adams, Bezner & Steinhardt, 1997), perceived stress (as measured by the PSS; Cohen, Kamarck, & Mermelstein, 1983) and wellness behaviors (as measured by the BMS-WBCI; Hey, Calderon, & Carroll, 2006)? Additional research questions guiding the investigation are:

1. Is there a mediating effect of perceptions of stress on the relationship between trait emotional intelligence and wellness behaviors among counselors-in-training?
2. Is there a mediating effect of perceptions of wellness on the relationship between trait emotional intelligence and wellness behaviors among counselors-in-training?

To answer these research questions, the researcher tested a structural equation model (SEM; Crockett, 2012). Lei and Wu (2007) states that one advantage of using SEM is its ability to study the relationships among constructs indicated by multiple measures. Unlike less complex correlational designs, SEM measures simultaneous effects with multiple exogenous and endogenous variables (Stage, Carter, & Nora, 2004). In SEM,

dependent variables are also known as endogenous variables, and independent variables are known as exogenous variables. Unique to SEM, constructs of interest can work as both endogenous and exogenous variables (Kline, 2011). This method allows researchers to develop comprehensive methods for testing hypothetical relationships using regression, path analysis and confirmatory factor models (Schumacker & Lomax, 2010). SEM is useful because it represents two kinds of models, (a) the measurement model, which indicates how manifest variables contribute to latent variables; and (b) the structural model, which identifies hypothesized relationships between constructs (Schumacker & Lomax, 2010). Another benefit of using SEM is the ability to account for measurement error and identify relationships between constructs (Crockett, 2012; Schumacker & Lomax, 2010). The theoretical model tested in this research will contain latent variables (e.g., behavioral wellness) and manifest variables (e.g., trait emotional intelligence, perceived wellness, perceived stress, social connection, spirituality, etc. etc.) these variables are identified within the subscale scores of each manifest variable (Kline, 2001; Schumacker & Lomax, 2010). This chapter introduces the following components of this research study: (a) description of participants, (b) data collection procedures, (c) instrumentation, (d) research design (e) research hypothesis and questions, (f) data screening, (g) data analysis methodology, (h) ethical considerations, and (i) study limitations.

Population and Sampling Procedures

This study investigated the relationship between trait emotional intelligence, perceptions of wellness, perceptions of stress, and wellness behaviors with a target population of counselors-in-training. Participants in the study included a purposive

sample of CIT's who were master's level counseling students. Participants were recruited from a variety of CACREP accredited programs from several areas of the country via methods described in the following section. Counselors-in-training were chosen for this study based on recent research by Lenz, Sangganjanavich, Balkin, Oliver and Smith (2012), and Smith, Robinson, & Young (2007) which suggests that the counselor education has not effectively prepared counselors on how to examine and tend to their own wellness. Utilizing CIT's as the population allowed me to examine their claims and explore what factors that may contribute to CIT's wellness.

Sample Size

According to Crockett (2012) and Kline (2011) researchers who intend to conduct SEM analysis in counseling research require larger sample sizes and suggest a minimum of 200 participants to produce an accurate parameter estimate. Beginning with population representation, larger sample sizes increase generalizability of the target population (Gall et al., 2007). It is also necessary to anticipate sample size to avoid making a Type II error (i.e., failing to reject a false null hypothesis; Balkin & Sheperis, 2011). Schumacker and Lomax (2010) recommend calculating *a priori* sample size for SEM. A priori power analysis using the software tools available at www.danielsoper.com indicated that a minimum sample size of 200 will be required to identify a small effect size (0.1) at a high power (.8) with one latent variable and three manifest variables at the probability of $p <$ .05. In addition, a minimum sample size of 200 is recommended to establish population representation (Gall et al., 2007).

Sampling Procedure

Counselors-in-training (CIT) were identified as the population of interest in this

proposed study. The identified population for this study included master's students, enrolled in a counseling education program, between the ages of 18 and 99 regardless of gender, race, ethnicity, or any other demographic variable. The researcher invited a convenience sample of CIT's to participate in this study through personal and professional contacts of the primary researcher, including students from (a) University of North Carolina at Charlotte, (b) North Carolina State, (c) University of North Carolina at Pembroke, (d) College of William and Mary, (e) The University of Central Florida, (f) Kent State University, (g) Malone University, and (h) University of Akron. The researcher remained open to establishing contact with additional universities in effort to obtain and utilize a diverse geographic sample from universities throughout the United States.

The researcher utilized face-to-face data collection to avoid potentially low response rates to the study but also made an electronic version of the survey available upon request. Current research has suggested that response rates for face-to-face data collection can be anticipated at 90% (Blount, 2015; Mullen, 2014). While web-based surveys are widely used as a convenient, low-cost and efficient manner of collecting data, non-response rates are often as high as 64% for online survey research (Cook, Health &Thompson, 2000). Other researchers have reported response rates to web-based surveys anywhere from 8-40% (Pike, 2008). The researcher prepared 400 survey packets administered throughout the participating CACREP counseling programs in the United States. The study was introduced to various faculty at the listed universities and the researcher requested access to be granted to their classes to recruit volunteers. The online link for the survey was provided to the faculty who requested alternate means of

distribution but were given instructions to administer the survey in the same manner in which the paper and pencil surveys were administered.

Data Collection Procedures

Prior to recruitment and data collection, the researcher obtained approval from the University of North Carolina at Charlotte's Institutional Review Board (IRB), after applying for permission to conduct human research. The application included the student consent form, copies of assessment instruments, the demographics questionnaire, and approvals from the multiple instrument authors. The instruments in this study are found online and available for free. However, the researcher worked to collect approval to use each of the assessments. Data collection commenced once the study received IRB approval (See Appendix A). The researcher began face-to-face data collection February 12, 2018 and continued until April 30, 2018. The researcher scheduled meeting dates with faculty at various universities and collected data in their master's level classrooms.

The researcher employed various procedures to collect data for the study. Invitations were extended to professors in various universities to participate in this study through personal and professional contacts of the primary researcher and advising faculty member using the Tailored Design Method (Dillman et al., 2009*)*. This method is designed to increase trust and perceived benefits of participation in research. Personal and professional contacts were approached via email and phone calls. The study was introduced to various faculty at the listed universities and participation requested. Faculty approached were asked to either allow the researcher to visit their classrooms and administer the paper and pencil survey in person, or given a script and copies of the survey from which to administer themselves. They were then asked to return the

completed surveys in a postage paid envelope to the researcher within two weeks of receiving the surveys. Once the faculty member chose the best means of administration, the researcher scheduled visits and sent packets to various universities, and collected responses from multiples classes willing to participate. Faculty who requested alternate means of distribution were given access to the online survey link and given instructions to administer the survey in the same manner in which the paper and pencil surveys were administered.

Whether collecting responses in person, online, or by mail, the researcher offered incentives to both the participants and faculty for participation. Incentive was offered in the form of gift cards, won in a randomized drawing to be held at the end of the administration of the surveys to each classroom. Participants that wished to participate in the drawing were offered an opportunity to provide their names at the completion of the survey and to be drawn to win one of 20-$15 Walmart gift cards immediately after the end class in which the survey was taken. Participants were given another opportunity to win one of four- $25 Walmart gift cards to be drawn at the end of the study. Faculty that choose to open their classrooms to the researcher will be entered to win one of five- $40 Amazon gift cards. Participating faculty were entered once for every class they allowed access. Drawings will be held at the end of each administration of the survey, whether proctored by the researcher or the faculty person participating in the research. Information from participants who wished to participate in the drawings were not connected to survey responses in effort to maintain anonymity and confidentiality.

Assessments included a total of four surveys and a demographic questionnaire. The surveys measured trait emotional intelligence, perceived wellness, perceived stress,

and wellness behaviors. A demographic questionnaire was used to collect information about the participants. Overall, the time participants spent taking assessments did not exceed 20 minutes. Prior to dispersion among CIT's, a pilot test was conducted to assess understanding of instruction, time needed to complete the survey and comprehension of the content for the target population. The survey packet included a cover page informing the participant of the purpose of the study, the voluntary nature of the study, the risks and benefits of participating in the study, appreciation for engagement in the study and estimated time for the study to be completed. The consent page provided details regarding the voluntary nature and confidentiality of respondents' participation. Should any questions or concerns arisen for participants, contact information for the researcher, faculty advisor and UNCC IRB were provided. All information collected was kept in secure and locked locations.

Informed consent. The consent form informed potential participants that they would have the option to not participate or to withdraw from the study at any time (See Appendix B). Potential participating faculty received an envelope without identifying information that includes the general demographics form, the Trait Emotional Intelligence Questionnaire- Short Form (TEIQue-SF; Petrides, 2009), the Perceived Wellness Scale (PWS; Adams, Bezner, & Steinhardt, 1997), the Perceived Stress Scale (PSS; Cohen, Kamarck, & Mermelstein, 1983), and the Body, Mind- Spirit Wellness Behavior and Characteristic Inventory (BMS-WBCI; Hey, Calderon, & Carroll, 2006). Participants who chose not to participate were able to return the incomplete or blank assessments to the envelope. Those who chose to participate in the study were allowed to complete the data collection packet, keep the consent form provided, and place the

completed assessments in the envelope. The researcher entered the data into the *Statistical Package for Social Sciences* (SPSS, Version 25). The researcher did not collect identifying information (e.g., name, student information, birth dates).

Instrumentation

The instruments are as follows: (a) the Trait Emotional Intelligence Questionnaire- Short Form (TEIQue-SF; Petrides, 2009), (b) Perceived Wellness Scale (PWS; Adams, Bezner, & Steinhardt, 1997), (c) the Perceived Stress Scale (PSS; Cohen, Kamarck, & Mermelstein, 1983), (d) the Body, Mind, Spirit- Wellness Behavior and Characteristic Inventory (BMS-WBCI; Hey, Calderon, & Carroll, 2006), (e) *general demographic questions*. Permission was requested from the developers of the instruments and documentation of their approvals will be noted in the appendices (See Appendices C, D, E, & F). The instruments (See Appendices G, H, I, J, & K) were combined into one collection packet and distributed to potential participants face-to-face or via Survey Share. The following section introduces the four data collection instruments, examines their use within diverse samples and the psychometric properties of the assessments.

Trait Emotional Intelligence Questionnaire-Short Form (TEIQue-SF).

Emotional Intelligence (EI) refers to the ability to monitor one's own and others' feelings and emotions, to discriminate among them, and to use this information to guide one's thinking and actions (Salovey & Mayer, 1990). Brackett and Salovey (2006) further defined EI beyond perceiving emotion and included the use of understanding emotion to cultivate personal growth. This ability is referred to as a constellation of emotional self-perceptions located at the lower levels of the personality hierarchies laying outside of cognitive ability (Petrides, Pita, & Kokkinaki, 2007). This study utilizes the

characterization of trait emotional intelligence developed by Petrides and Furnham (2001) defining EI as the dispositions and abilities to recognize and manage emotions in self and in others. The *Trait Emotional Intelligence Questionnaire-Short Form* (TEIQue-SF; Petrides, 2009) is a 30-item inventory based on the full 153-item form of the TEIQue (Petrides & Furnham, 2003) and was used to measure trait emotional intelligence by examining trait emotional self-efficacy. The TEIQue-SF provides subscale scores that covers the 15 facets of EI and using the following domains: (a) Well Being, (b) Self-Control, (c) Emotionality, (d) Sociability, as well as the total score known as (e) Global Trait, which includes factors of self-motivation and adaptability (Petrides, 2009). Items include a seven point Likert-type scale, ranging from 1 (completely disagree), to 7 (completely agree) that assess for participant's agreement with feelings and behaviors associated with various aspects of trait EI and emotional self-efficacy. Excerpts from each subscale, respectively, include, "I usually find it difficult to regulate my emotions," "I'm usually able to influence the way other people feel," "I often find it difficult to show affection to those close to me", and "Generally, I'm able to adapt to new environments." Higher total scores on the TEIQue-SF are reported as indicating higher trait EI. Petrides (2009) reports that the TEIQue-SF subscales tend to have lower internal consistencies than the full form of the inventory, and the short form yields scores on the four factors plus Global Trait but not on the 15 trait EI facets. For this study, total score will primarily be used during data analysis, however sub-scores were later examined to identify any nuanced relationships among variables.

While the full version of the TEIQue demonstrated strong convergent and criterion validity, researchers identified that two of the 15 facets differed in reliability

depending on gender, and found low internal consistency on three of the 15 facets regardless of gender (Mikolajczak, Luminet, Leroy, & Roy, 2007). Petrides and Furnham (2006) developed the short version of the TEIQue after selecting two items from each subscale from the long form that correlated most highly with the latent constructs total scores. Cooper and Petrides (2010) conducted multiple studies to examine the psychometrics, replicate, and confirm findings for the TEIQue-SF using item response theory (IRT) to provide information about measurement precision. They reported that the TEIQue-SF (Petrides, 2009) had moderate discrimination values, high discrimination parameters. A psychometric analysis of the TEIQue-SF using the item response theory (IRT) recognized the TEIQue-SF as having a good model fit, with no residuals over .04. In each of the studies, Cooper and Petrides (2010) identified recruitment of participants from universities and the general community. Gutierrez and Mullen (2016) used this scale successfully with counselors and counseling students with adequate reliability, finding that all the TEIQue-SF subscales made a statistically significant contribution ($p <$ .001) to EI. Their study confirmed a strong Cronbach alpha of .88 with counselors and counselors-in-training in a sample size of 539 participants. They reported that the TEIQue-SF subscales Well Being ($r = .79$), Global Trait ($r = .73$), and Emotionality ($r = .70$) were the strongest contributors to EI with Self-control ($r = .68$) and Sociability ($r = .53$) making the weakest contribution. Overall, Cooper and Petrides (2010) indicate the TEIQue-SF as having good measurement precision and strong internal consistency (α=.87 to .89). Additional psychometric analysis used exploratory factor analysis (EFA) to confirm the use of a unidimensional IRT model with factors loadings above 0.30,

suggesting that the TEIQue-SF provides an adequate short form assessment of individual differences in trait EI.

Perceived Wellness Scale (PWS). Wellness refers to perceived balance in the sense that one is living in a manner that permits the experience of consistent, balanced growth in the emotional, intellectual, physical, psychological, social, and spiritual dimensions of human existence (Adams, Bezner & Steinhardt, 1997). Similar dimensions exist in many wellness models (e.g., Chandler et al., 1992; Crose et al., 1992; Eberst, 1984; Greenberg, 1985; Hettler, 1984; Witmer & Sweeney, 1992). The *Perceived Wellness Scale* (PWS) is a 36-item instrument (See Appendix: H) which consists of three principles common to all conceptualizations of wellness: (a) multidimensionality, (b) balance among dimensions, and (c) salutogenesis (defined as causing health rather than illness). The model of wellness used in the PWS is also dynamically bidirectional, which incorporates balance among the three dimensions (Adams, Bezner & Steinhardt, 1997) defined by scores for six areas of wellness: (a) psychological, (b) physical, (c) emotional, (d) spiritual, (e) social, and (f) intellectual. Excerpts from each dimension, respectively, include, "In general, I feel confident about my abilities," "In the past, I have generally found intellectual challenges to be vital to my overall well-being," "I expect to always be physically healthy," "In the past, I have expected the best," "My friends will be there for me when I need help," and "I believe there is a real purpose for my life." Each dimension was represented by a six item Lickert-type scale, ranging from 1 (very strongly disagree) to 6 (very strongly agree). Dimensional scores are integrated into a wellness composite score, ranging from three to 29 (Adams, Bezner & Steinhardt, 1997). The wellness composite score is derived by dividing the magnitude score by the balance score (plus a

constant value, 1.25, to prevent invalidation). Total score, also identified as a wellness composite score, will be used during data analysis. However, sub-scores are later examined to identify the nuanced relationships among variables. Higher scores indicate greater appraisal of wellness by the participant.

Adams, Bezner, and Steinhardt (1997) indicated the PWS possesses excellent estimates of factorial and construct validity when used as a total scale, with a high internal consistency reliability of an average alpha of .91, with both student and corporate samples (Adams et al., 1997; Adams et al., 2010). Researchers Harari, Waehler, and Rogers (2005) confirm that the PWS has potential as a psychometrically sound instrument that relates to standardized measures of holistic wellness, successfully integrating portions of the body, mind, and spirit with similar internal consistency (α = .91). Unfortunately, their examination of college psychology students (n = 317) found no psychometric evidence for its measurement of the existence of six separate subscale dimensions, as suggested by the authors of the PWS (Adams, Bezner, & Steinhardt, 1997) and the Perceived Wellness Model (Adams, 1995). Instead, Harari, Waehler, and Rogers (2005) suggest that if using the PWS (Adams, Bezner, & Steinhardt, 1997), researchers utilize the scale as a screening measure which identifies a global score by treating perceptions of wellness as a unidimensional construct. To avoid potential threats to validity in this study, total score will be utilized in the formation of both the structural model and in the alternative models.

Perceived Stress Scale (PSS). The *Perceived Stress Scale* (PSS) is a popular measure of the self-perception of psychological distress (Cohen et al.,1983). Researchers Cohen, Kamarck, and Mermelstein (1983) developed the scale in search of information

regarding events that incite stress, the stress appraisal process, and individual experience of stress. Specifically, Cohen (1994) stated that items are designed to measure perceptions of stress in participants as unpredictable, uncontrollable, and overloaded. The development of the PSS was based on Lazarus's theories of stress and coping (Lazarus & Folkman, 1984; 1987) which states there is a transaction occurring between emotions based on the appraisal of stressors in the environment. The PSS is a 10-item instrument designed to measure the degree to which common situations are appraised as stressful. The items ask about feelings and thoughts during the past month and how often the participant felt a certain way in a specific situation. Responses range from "never" to "very often" on a 5-point scale. This scale was used to provide a global measure of perceived stress in daily life.

Cohen et al. (1983) tested its validity with three samples, two consisting of college students and one a heterogeneous sample of individuals with a high internal consistency with Cronbach's alphas of .90. The coefficient alphas were .84, and .85 for students and .86 for participants in a smoking cessation study. They successfully identified relationships between higher scores on the PSS and increased vulnerability depressive episodes elicited by life events, decreased ability to quit smoking, increased frequency of colds, and inability to control diabetes (Cohen et al., 1988; Cohen, 1994). Additional testing revealed a test-retest correlation at r= .85 for the two samples of college students, suggesting that the PSS serves as an accurate measure of perceived stress.

Body-Mind-Spirit Wellness Behavior and Characteristic Inventory (BMS-WBCI). In this study, wellness behaviors were measured by the *Body-Mind-Spirit*

Wellness Behavior and Characteristic Inventory (BMS-WBCI; Hey, Calderon, & Carroll, 2006), and referred to as wellness behaviors (WB). The BMS-WBCI was designed to measure baseline wellness statements about behaviors and characteristics in the body, mind, and spirit dimensions of wellness that are important to college students. Behavioral wellness simply defined, is an active, evolving process of making choices toward a more successful existence (Hey, Calderon, & Carroll, 2006) and described by the National Wellness Institute (1992) as a way of living that is responsive to the needs of the body, mind and spirit. BW relies on the Banduras (1986) social cognitive theory, which suggests that beliefs, values and knowledge contribute to positive healthy behaviors. Individuals engaging in behavioral wellness demonstrate the connection noted by the health promotion theory (Rosenstock, 1990) in which behaviors reflect positive physical health because of beliefs, perceptions, and values of maintaining wellness. The BMS-WBCI examines three domains in which the following are: (a) body; including aspects of fitness, nutrition, self-care, and safety, (b) mind; including aspects of social awareness, emotional awareness and intellectual awareness behaviors, and (c) spirit; including spiritual and well-being measurements. Each domain has a different number of statements, resulting in a 44-item survey. There were a total of nine body statements, excerpts included, “I limit risky behaviors (i.e., drive fast, bungee jumping, parachute, etc.)”, “I eat a balanced diet low in saturated fat and cholesterol”, and “I participate in recreational sports or activities that help maintain my fitness.” There is a total of 20 mind statements which include, “I am flexible to changes and can maintain stability in my life in healthy ways,”, “I express my feelings with others and consider their feelings,” and “I consider alternatives before making decisions.” The spirit dimension accounts for the

final 15 statements which included, “I recognize the positive contribution faith can make to the quality of my life”, “I know my purpose in life” and “I experience peace of mind.” Each dimension is represented by a 3-point Likert scale ranging from 1 (rarely/seldom) to 3 (often/always). Both total score and sub-scores were used in this study to determine levels of participation in positive health behaviors and agreement with characteristics that promote well-being. Higher scores indicate greater use of positive behaviors and increased over all well-being (Hey, Calderon, & Carroll, 2006).

The developers of the BMS-WBCI instrument reported high internal consistency, high reliability and a positive correlation between all three subscales in two different studies involving college students. The first study indicated Cronbach alphas for each subscale: mind (α= .88), body (α=.81), and spirit (α= .91). The second study (n= 141) resulted in similar outcomes: mind (α= .75), body (α=.87), and spirit (α= .92). The following three scales were used to assess for construct and criterion validity: (a) the TestWell, Wellness Inventory; (b) the National Institute of Health (NIH) Eating at America’s Table Study (EATS) Quick Food Scan; and (c) a self-report by participants of physical activity (Hey, Calderon, & Carroll, 2006). Results indicated concurrent criterion –related validity with correlations above .45 for body, mind and spirit scales. Construct validity indicated significant correlation between constructs and tests ($r = .522$, $p < .01$). Moreno and James (2010) further validated this instrument on college students (n= 106) and found an overall alpha of the BMS-WBCI of .91 and subscales alphas of mind (α= .87), body (α=.69), and spirit (α= .88). They recognized that the body subscale resulted in a lower alpha than reported by Hey, Calderon, and Carroll (2006) and proceeded by deleting item one of the body subscale. This action positively affected the alpha for the

body subscale but did not alter the alpha for the entire scale. Moreno and James (2010) recommend use of the BMS-WBCI in its entirety but emphasize consideration of the body scale.

The researcher utilized a general demographics questionnaire to collect descriptive information related to participants: (a) age, (b) gender, (c) ethnicity, (d) spiritual/religious identification, (e) whether Practicum experience was needed, in process, or completed, (f) stage within program determined by credits enrolled and completed, (g) area of intended specialty, and (h) current professional position or occupation. Only CACREP accredited schools were approached for this study.

Research Design

This study followed a non-experimental correlational design to determine directional relationships between levels of trait emotional intelligence, appraisals of wellness, appraisals of stress and wellness behaviors. Correlational research examines the relationship between multiple variables without any manipulation (Gall, Gall, & Borg, 2007). While causation is not indicated, strength and direction in relationships between variables can be found using correlational methods (Graziano & Raulin, 2007). Tabachnick and Fidell (2013) state that correlational studies allow investigations of potential cause and effect relationships and predictive outcomes. A more advanced form of seeking alternative explanations for relationships between variables can be found in Structural Equation Modeling (SEM; Crocket, 2012; Fassinger, 1987; Quintana & Maxwell, 1999). Schumacker and Lomax (2010) noted that SEM is a confirmatory procedure consisting of a variety of statistical methods including multiple regression, path analysis, and confirmatory factor analysis to examine the directional relationships of

multiple variables. Utilizing SEM allows the researcher to attempt to examine the significance of hypothesized directional relations among observed variables by simultaneously estimating a series of regression equations (Lei & Wu, 2007). One advantage of SEM is its simultaneous analysis of direct and indirect effects between exogenous and endogenous variables, allowing the observance of potential mediation or moderation relationships (Stage, Carter, & Nora, 2004; Crockett, 2012). Another advantage of using SEM, described by Schumacker and Lomax, 2010), is the recognition and accounting of measurement error, which when used in multiple regression equations can adversely impact the validity and reliability due to its assumptions of nonexistence (Barron & Kenny, 1986). SEM analysis is described by Crockett (2012) in five sequential steps including: model specification, model identification, model estimation, model testing, and model modification.

Threats to Validity

Gall et al. (2007) reported that correlational research designs are susceptible to threats regarding validity. The definition used by Gall et al. (2007) described validity as specific inferences made from test scores that are appropriate, meaningful and useful. There are three specific threats to validity including: (a) external, (b) internal, and (c) test validity. External validity is the extent to which results from a study in a sample can be generalized to the population, its importance relates to accurate representation of the population and awareness to unique characteristics of the sample participants (Fraenkel & Wallen, 2009; Gall et al., 2007; Heppner, Wampold, & Kivilghan, 2008). Internal validity refers to the degree of truth concluded about the results of a study (Johnson & Christensen, 2004). Threats to this study may include: (a) instrumentation; validity and

reliability of the instruments utilized, (b) characteristic correlations; controlled for by analyzing demographic relationships between covariate (Fraenkel et al., 2011), (c) testing; fatigue experienced during testing (Graziano & Raulin, 2006), (d) extraneous variables; uncontrolled variables that influence the variables of interest (Gall et al., 2007), and (e) attrition; missing data (Schumacker & Lomax, 2010; Crocker, 2012). Test validity includes construct, discriminant and convergent validity, which refers to the strength and reliability of psychometric properties of instruments to measure and represent observed variables and latent constructs (Reynolds, Livingston, & Wilson, 2010). Due to these potential issues, the researcher limits the influence of validation threats by taking steps to address each type of threat throughout the planning and implementation stages of the study.

Research Questions, Exploratory Questions and Hypothesis

The purpose of this study was to determine if there was a contribution between emotional intelligence, perceived wellness, perceived stress and behavioral wellness for counselors-in-training. The following section presents the primary research question, guiding research questions, and research hypothesis. Models for the research hypothesis, full structural model to be tested, and an alternative model is provided (See Figures 1 to 7).

Figure 2: Anticipated Path Model

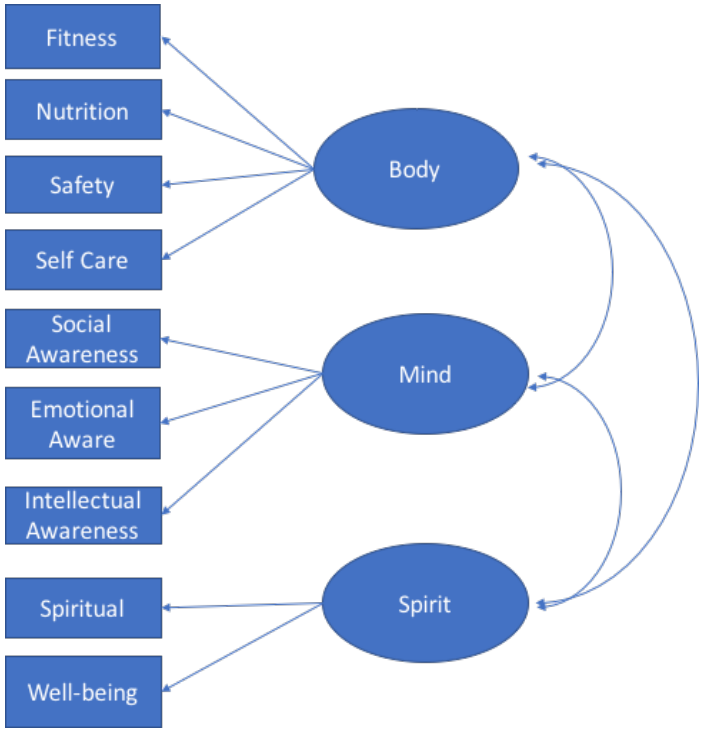

Figure 3: Hypothesized BMS_WBCI Measurement Model Path Diagram

Primary Research Question

Does trait emotional intelligence (as measured by the TEIQue-SF; Petrides, 2009) of counselors-in-training, contribute to their levels of perceived wellness (as measured by the PWS; Adams, Bezner & Steinhardt, 1997), perceived stress (as measured by the PSS; Cohen, Kamarck, & Mermelstein, 1983) and wellness behaviors (as measured by the BMS-WBCI; Hey, Calderon, & Carroll, 2006)?

Research Hypothesis

There will be a relationship between these three intrinsic factors and levels of wellness behaviors. Specifically, **t**here will be a relationship between the participant's emotional intelligence, appraisals, and strength and types of utilized wellness behaviors (as measured by the BMS-WBCI; Hey, Calderon, & Carroll, 2006. There will be a relationship between levels of perceived stress (as measured by the PSS; Cohen, Kamarck, & Mermelstein, 1983) and levels of perceived wellness (as measured by the PWS; Adams, Bezner & Steinhardt, 1997). There will be a relationship between emotional intelligence (as measured by the TEIQue-SF; Petrides & Furnham 2003) and levels of wellness behaviors (as measured by the BMS-WBCI; Hey, Calderon, & Carroll, 2006). Participants with higher levels of emotional intelligence (as measured by the TEIQue-SF; Petrides & Furnham 2003) may have higher levels of perceived wellness (as measured by the PWS; Adams, Bezner & Steinhardt, 1997) but lower levels of perceived stress (as measured by the PSS; Cohen, Kamarck, & Mermelstein, 1983). Participants with higher levels of perceived wellness (as measured by the PWS; Adams, Bezner & Steinhardt, 1997) may also have higher levels of wellness behaviors (as measured by the BMS-WBCI; Hey, Calderon, & Carroll, 2006).

The structure of this study allowed the researcher to examine the nature of the relationship between constructs in the following figures (see Figures 4-8). The researcher will identify the contribution of EI (as measured by the TEIQue-SF; Petrides, 2009) towards wellness behaviors (as measured by the BMS-WBCI; Hey, Calderon, & Carroll, 2006) among counselors-in-training (as seen in Figure 4). It also allowed the researcher to examine the relationship between EI (as measured by the TEIQue-SF; Petrides, 2009), appraisal of wellness (as measured by the PWS; Adams, Bezner & Steinhardt, 1997), and appraisal of stress (as measured by the PSS; Cohen, Kamarck, & Mermelstein, 1983), as seen in the following figure (Figure 5). This study also explored the relationship between appraisal of stress (as measured by the PSS; Cohen, Kamarck, & Mermelstein, 1983), appraisal of wellness (as measured by the PWS; Adams, Bezner & Steinhardt, 1997), and wellness behaviors (as measured by the BMS-WBCI; Hey, Calderon, & Carroll, 2006) among CIT's (see Figure 6).

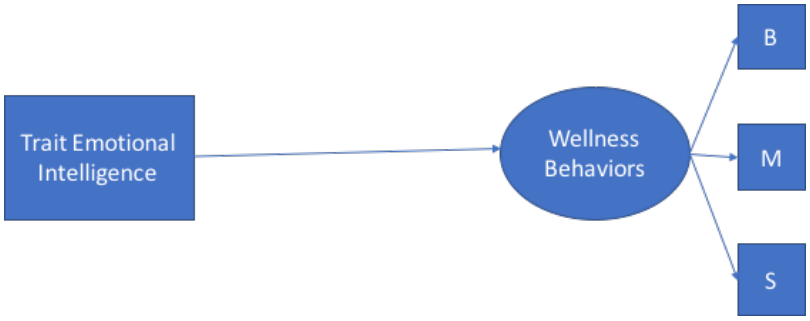

Figure 4: Hypothesized EI & BMS-WBCI Path Model

Figure 5: Hypothesized EI, PWS, & PSS Path Model

Figure 6: Hypothesized PWS, PSS, & BMS-WBCI Path Model

Additionally, this inquiry examined the presence of mediation among variables. The researcher will identify if there is a mediating effect of perceptions of stress (as measured by the PSS; Cohen, Kamarck, & Mermelstein, 1983) on the relationship between EI (as measured by the TEIQue-SF; Petrides, 2009) and wellness behaviors (as measured by the BMS-WBCI; Hey, Calderon, & Carroll, 2006) among counselors-in-training (see Figure 7), and if there is a mediating effect of perceptions of wellness (as measured by the PWS; Adams, Bezner & Steinhardt, 1997) on the relationship between

EI (as measured by the TEIQue-SF; Petrides, 2009) and wellness behaviors (as measured by the BMS-WBCI; Hey, Calderon, & Carroll, 2006) among counselors-in-training (see Figure 8).

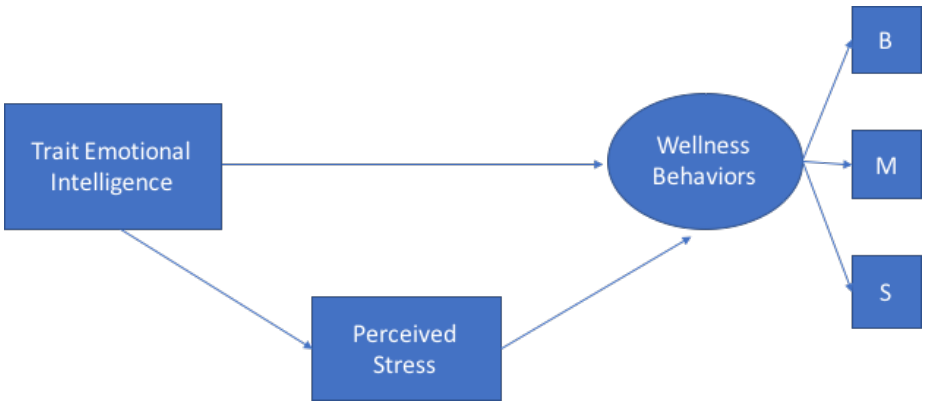

Figure 7: Hypothesized EI, PSS, & BMS-WBCI Path Model

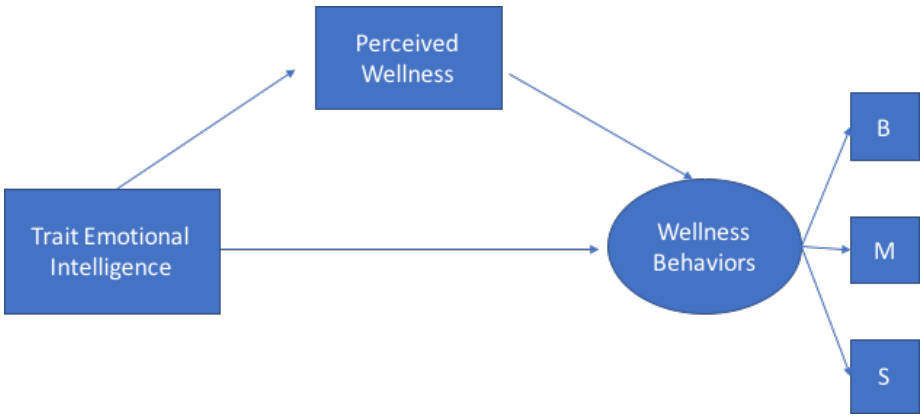

Figure 8: Hypothesized EI, PWS & BMS-WBCI Path Model

Data Screening

The researcher utilized data collected in person from the paper and pen format and from an electronic survey hosted on Survey Share (from administered surveys which will include a general demographic questionnaire and four assessment instruments including: (a) TEIQue-SF (Petrides, 2009), (b) PWS (Adams, Bezner & Steinhardt,

1997), (c) PSS (Cohen, Kamarck, & Mermelstein, 1983), and (d) BMS-WBCI (Hey, Calderon, & Carroll, 2006). The Statistical Package for the Social Sciences (SPSS, 2011) software program was utilized, along with the program Mplus (2013; for Structural Equation Modeling [SEM] analysis), which was used to prepare data, engage in descriptive analysis, apply multiple regressions and analyze theoretical models (Byrne, 2010). Prior to analysis, the data was thoroughly screened and examined for extreme outliers. This was accomplished through identification of variables three standard deviations from the mean as suggested by Osborne, (2012). Structural equation modeling (SEM) has been reported as being easily influenced by outlying data points, resulting with changes in means, standard deviations, and correlation coefficients, confirming that extreme outliers must be addressed (Schumacher & Lomax, 2010). Next, the fit between the distribution of the variance and the assumptions for the statistical analysis was employed (i.e., normality, homogeneity of variance, linearity, and multicollinearity) and analyzed. The assumption of normality is assessed by observing skewness in values. A plan was made for the treatment of non-normal data and discussed in the data analysis section. SEM analysis was used to prepare data, engage in descriptive analysis, apply multiple regressions and analyze theoretical models (Byrne, 2010).

Data Analysis

This investigation employed MPlus software (version 7.11; Muthen & Muthen, 2013) to test the research hypothesis using a structural equation model (SEM). SEM analysis was used to prepare data, engage in descriptive analysis, apply multiple regressions and analyze theoretical models (Byrne, 2010). Crocket (2012) identified a five-step process to conducting a SEM analysis. Five sequential steps included: model

specification, model identification, model estimation, model testing, and model modification (Bollen & Long, 1993; Crocket, 2012). During the model testing stage there was simultaneous analysis, using two-steps to test the measurement and structural models. In the first step a confirmatory factor analysis (CFA) was utilized to inspect the measurement model's fit with the data. Second, a conceptual model based on the research questions was tested for fit and modified if needed (Crockett, 2012). The hypothesized structural model and the conceptual models were evaluated with model fit indices, standardized residual covariance's, standardized factorial loadings, and standardized regression estimates and modifications will be made if needed. Fit indices include: (a) chi-square, (b) comparative fit index (CFI), (c) goodness-of fit (GFI), and (d) root mean square error of approximation (RMSEA). The researcher utilized data collected from administered surveys, which included a general demographic questionnaire and four assessment instruments including: (a) The Emotional Intelligence Questionnaire- Short Form (TEIQue-SF; Petrides & Furnham 2003), (b) Perceived Wellness Scale (PWS; Adams, Bezner & Steinhardt, 1997), (c) the Perceived Stress Scale (PSS; Cohen, Kamarck, & Mermelstein, 1983), and (d) the Body, Mind- Spirit Wellness Behavior and Characteristic Inventory (BMS-WBCI; Hey, Calderon, & Carroll, 2006). Relationships were examined among the demographic questions, specifically whether or not and how often wellness behaviors have been utilized. Other relationships included EI, perceived wellness, perceived stress and behavioral wellness total scores and sub-scores. The theoretical model tested in this research contains latent variables (e.g., behavioral wellness) and manifest variables (e.g., emotional intelligence, perceived wellness, perceived stress, social connection, spirituality, etc. etc.), which include subscale factor

scores of wellness behaviors assessment items (Kline, 2001; Schumacker & Lomax, 2010).

Variables

This investigation included multiple dependent and independent variables known in SEM as endogenous and exogenous variables. Kline (2011) indicated that SEM is unique compared other methods of quantitative analysis as it allows constructs to work as both endogenous and exogenous variables. This study explored wellness behaviors as the dependent/endogenous variable, with three manifest variables (a) body, (b) mind, and (c) spirit. Researchers identified nine factors of wellness behaviors. The BMS-WBCI (Hey, Calderon, & Carroll, 2006) recognized the nine factors falling under three domains in which the following are: (a) body; fitness, nutrition, self-care, and safety (b) mind; social awareness, emotional awareness and intellectual awareness behaviors, and (c) spirit; spiritual and well-being measurements. Each domain has a different number of statements, resulting in a 44-item survey.

Independent/exogenous variables were identified as emotional intelligence, perceptions of wellness and perceptions of stress. The latent construct of emotional intelligence was measured by five manifest factors which are domains of TEIQue-SF (Petrides & Furnham 2003): (a) wellbeing, (b) self-control, (c) emotionality, (d) sociability, and (e) global trait. Total score was utilized, making the TEIQue-SF a manifest variable. The latent construct of perceived wellness defined PWS (Adams, Bezner & Steinhardt, 1997) by scores for six areas of wellness: (a) psychological, (b) physical, (c) emotional, (d) spiritual, (e) social, and (f) intellectual, serving as manifest variables. Total score was utilized, making the PWS a manifest variable. The construct of

perceived stress is a manifest variable measured with a 10-item instrument designed to measure the degree to which common situations are appraised as stressful (PSS; Cohen et al.,1983).

Ethical Considerations

It's important to understand that some people, or cultures may define and experience wellness and stress differently. Sue and Sue (2008) state that the concepts of mental health, mental illness, and adjustment may differ for American Indians, Asian Americans, Blacks, and Hispanics when compared to a traditional western context. Differences in distinctions between mental and physical health between cultures make it likely that nonphysical health problems would be addressed differently (Rivera, 1984) and thus have an impact on the interpretation of assessment questions.

Ethical considerations were reviewed by the university's IRB and the researcher's dissertation committee prior to any recruitment of participants and data collection. These ethical considerations included but were not limited to:

1. The confidentiality and anonymity of participant data.

2. Voluntary participation in the study (e.g. participation or non-participation will *not* impact students academically).

3. Participants will be informed of their rights through informed consent (IRB approved) as research participants that included voluntary participation and the opportunity to withdraw from the study without consequence or retribution.

4. The researcher will receive permission to use the instruments in this study as well as to manipulate them or reproduce them for this study.

Study Limitations

The researcher previously noted the use of a correlational research design and listed potential threats to the validity of the study. Correlational research examines the relationship between multiple variables without any manipulation (Gall et al., 2007). While causation is not indicated, strength and direction in relationships between variables can be found using correlational methods (Graziano & Raulin, 2007). Validity concerns included external, internal, and test validity. Each threat includes the potential for self-report bias, and measurement error. In addition to concerns about validity and causality, use of convenience sampling is a limitation due to a potential lack of population representation. Lastly, the total number of survey and demographic questions are 120 items. The length of the packets and time needed to complete the surveys may lead to higher rates of participant non-responses.

In effort to address these limitations, the researcher conducted a thorough review of literature regarding the instruments, compared psychometric properties, and examined additional studies that further validate the assessments in the form they will be utilized. Each instrument must have a record of use with a similar sample (college students), demonstrating strong validity and reliability. Demographic information is also used to account for any unique relationships between the constructs. The researcher also offered an incentive to participants to increase probability of completion of the survey packets.

Summary

This chapter outlined the methodology used in this study. This purpose of this study was to investigate if there is a significant relationship between emotional intelligence, perceived wellness, perceived stress and wellness behaviors for counselors-in-training. Chapter three presented the research methods that were employed in this research study, including (a) population and sampling procedures, (b) data collection methods, (c) measurement and instrumentation, (d) research design and method, (e) research hypothesis and questions, (f) data analysis methodology, (g) ethical considerations, and (h) study limitations. Furthermore, this chapter outlined the endogenous and exogenous variables used in this study.

CHAPTER IV: RESULTS

In chapter four, the researcher presents the results of both the hypothesis and the exploratory questions of this investigation. The purpose of this dissertation was to test the theoretical model of the relationship between emotional intelligence (as measured by the *Trait Emotional Intelligence Questionnaire-Short Form* [TEIQue-SF; Petrides, 2009]), perceived wellness (as measured by the *Perceived Wellness Survey* [PWS; Adams, Bezner, & Steinhardt, 1997]), perceived stress (as measured by the *Perceived Stress Scale* [PSS; Cohen, Kamarck, & Mermelstein, 1983]), and behavioral wellness (as measured by the *Body, Mind, Spirit-Wellness Behavior Characteristic Inventory* [BMS-WBCI; Hey, Calderon, & Carroll, 2006]) for counselors-in-training. This study tested the theoretical relationship between the participant's emotional intelligence, appraisals, and strength of utilized wellness behaviors. Specifically, the study examined the hypothesized relationship between emotional intelligence and levels of wellness behaviors, supposing that participants with higher levels of emotional intelligence may have higher levels of perceived wellness, and lower levels of perceived stress. Additionally, this study investigated the relationship between participants with higher levels of perceived wellness with levels of wellness behaviors. Lastly, this study tested the relationship between counselors-in-training program specific information (e.g., practicum experience, number of credits in the program, program type, etc.) and trait emotional intelligence, appraisal of stress, appraisal of wellness, and wellness behaviors.

The research hypothesis questions were analyzed using a non-experimental correlational design to determine directional relationships between levels of trait emotional intelligence, appraisals of wellness, appraisals of stress and wellness

behaviors (Gall, Gall, & Borg, 2007). Structural equation modeling (SEM) was used to prepare data, engage in descriptive analysis, apply multiple regressions and analyze theoretical models (Byrne, 2010). Five sequential steps to SEM include: model specification, model identification, model estimation, model testing, and model modification (Bollen & Long, 1993, Crocket, 2012). The researcher presented an argument for using an alternate examination of the data and presents the results using Path analysis. Path analysis is described as part of the structural equation modeling family that allows examination of linear and causal relationships between variables (Randolph & Myers, 2013). The results are presented in the following order: (a) sampling procedures and data collection, (b) descriptive statistics, and (c) data analysis of the primary research questions using SEM, and an exploratory (d) Path analysis.

Sampling Procedures and Data Collection

The target population for the study included a convenience sample of counselors-in-training (CIT's) who are master's level students. CIT's were chosen for this study based on recent claims by researchers stating that the counselor education process has not effectively prepared counselors on how to examine and tend to their own wellness (Lenz, Sangganjanavich, Balkin, Oliver, & Smith, 2012; Smith, Robinson, & Young, 2007). Utilizing CIT's, as the population of interest allowed the researcher to examine their claims, and explore what factors that may contribute to CIT's wellness. In effort to mitigate threats to external validity, the researcher approached multiple universities across the United States from a variety of stages in CACREP accredited counseling programs. The researcher used personal and professional contacts to invite faculty at various universities to access CIT's for the research study. Faculty who agreed to

participate, allowed the researcher to approach students at the following universities: (a) College of William and Mary, (b) Northeastern Illinois University, (c) Stetson University, (d) University of Central Florida, (e) University of Colorado, (f) University of Mississippi, (g) University of North Carolina at Charlotte, (h) University of North Carolina at Pembroke, (i) University of North Texas, (j) Virginia Commonwealth University, and (k) Winthrop University.

The researcher predominantly used face-to-face survey administration but also made the survey available through the web (www.surveyshare.com), both followed Dillman's (2009) *Tailored Design Method*. The researcher approached faculty to request access to classrooms on February 7, 2018. Data collection for the paper-based survey was initiated between February 12th and continued until March 26th, 2018. Faculty from multiple universities requested access to the survey electronically for self-administration in place of using the paper packets or allowing the researcher to visit the classroom. The researcher obtained UNCC IRB modification approval on February 20, 2018 (see Appendix N). The researcher modified the survey to allow electronic access and provided faculty with the same set of stipulations and instructions for disseminating the online version within their classrooms as faculty who chose to provide the pen-and-paper version of the survey to participants. Only four of the participating universities chose to utilize the electronic version of the survey including: (a) University of Colorado, (b) University of Mississippi, (c) one class at UNCP, and (d) Virginia Commonwealth University. Faculty who provided access to the electronic survey were asked to provide the link during class time, read the instructions, and allot the same amount of time for participants to complete the surveys as participants that were given the paper version.

Sample Size

The researcher followed the recommended guidelines toward calculating *a priori* sample size for SEM (Schumacker & Lomax, 2010). Crockett (2012) and Kline (2011) stated that researchers who intend to conduct SEM analysis in counseling research require larger sample sizes and suggest a minimum of 200 participants to produce an accurate parameter estimate. A priori power analysis was established using the software tool available at www.danielsoper.com, which indicated that a minimum sample size of 200 was needed to identify both population representation (Gall et al., 2007) and a small effect size (0.1) at a high power (.8) with one latent variables and three manifest variables at the probability of $p < .05$. The researcher also considered testing a more complex model with three latent variables and fourteen manifest variables, after including the subscale scores for the TEIQue-SF (Petrides, 2009), PSS (Cohen, Kamarck, & Mermelstein, 1983), PWS (Adams, Bezner, & Steinhardt, 1997), and BMS-WBCI (Hey, Calderon, & Carroll, 2006), but found that a larger sample size is needed to meet criteria for population representation and maintain a small effect size. The total sample size collected for this study ($n = 276$) includes the use of both the electronic ($n = 27$) and paper surveys ($n = 249$).

Descriptive Statistics

Response Rate

The following section presents response rates from the electronic based survey and face-to-face data collection methods. The minimum response sample size suggested by Crockett (2012) and Kline (2011) to run and SEM is 200 participants. The researcher approached 31 faculty members from 17 different universities and requested access to their classes. A total of 19 faculty from ten different universities responded to the

researcher and provided access to 33 separate classes. The researcher scheduled dates for at face-to-face data collection with faculty for twelve classes, prepared six packages for faculty to administer to nine classes, and electronically provided the online survey to the remaining 12 classes. A total of 303 students were approached to participate in the face-to-face completion of the surveys with a total of 249 participants that completed responses. A total response rate of 82% was collected from the paper and pencil surveys. While a total of 125 participants were approached using the electronic survey, only 27 participants completed the request with a response rate of 22%. Combined, the researcher encountered a 64% response rate after collecting a total of 276 completed surveys from 428 administered surveys. Although Schumacker and Lomax (2010) suggest that studies which utilize SEM use 400-500 participants, identifying studies with higher sample sizes as stronger and more publishable, the total sample size (N = 276) met the minimum requirement to successfully run an SEM. The total number of 276 responses were utilized as no cases had over 50% missing data and any missing data was determined to be missing at random.

Participant Demographic Information

Descriptive data is presented for the final sample size of 276 participants (*N* = 276; see Table 2). The majority of participants identified as female (*n* = 235; 85.14%), followed by male participants (*n* = 38; 13.77%), one participant identified as a transgender man (.36%) and another participant identified as gender-queer/gender-nonconforming (.36%). Overall the participant's ages ranged from 18-64; however the majority were between the ages of 18-24 (*n* = 114; 52.2%) and 25-29 (*n* = 86; 31.2%). The next largest group of participants included those between the ages of 30-34 (*n* = 22;

9.06%), ages of 35-39 (*n* =18; 6.52%), ages 40-44 (*n* =8; 2.9%), ages of 45-49 (*n* =9; 3.26%), ages of 50-54 (*n* =6; 2.2%), ages of 55-59 (*n* =8; 2.9%), and those between ages 60 and over (*n* =1; .36%).

Ethnicity and race of participants was determines by a total response of 281, due to five participants acknowledging themselves as more than one race resulting in 205 (72.95%) White, 14 (4.98%) Hispanic, 29 (10.32%) African/African American, 12 (4.27%) Asian/Asian American, one identified as (.36%) Middle Eastern/North African, seven identified as (2.49%) Mixed Race, and three participants (1.1%) preferred not to report their background. Participants reported their religious affiliations indicating the majority identified as Christian (n =118; 42.75%), followed by Agnostics (n =34; 12.32%), while the next largest group reported not knowing (n = 26; 9.42%). The next largest group identified as Catholic (n =25; 9.06%), followed by other faith (n = 22; 7.97%), Atheist (n =15; 5.43%), Protestant (n =10; 3.62%), other Christian (n = 7; 2.54%), Jewish (n = 5; 1.8%), Buddhist (n =4; 1.45%), Orthodox (n = 2; .72%), Muslim (n = 2; .72%), Hindu (n = 1; .36%), and Mormon (n = 1; .36%).

Table 2
Participant Demographic Information

Demographic	Options	Total (n)	Percentage %
Age	18-24	114	52.17
	25-29	86	31.16
	30-34	22	9.057
	35-39	18	6.521
	40-44	8	2.898
	45-49	9	3.260
	50-54	6	2.173
	55-59	8	2.898
	60-64	1	.3623
	Over 65	0	0
Gender Identity	Female	235	85.14
	Male	38	13.77
	Gender-Queer/Nonconforming	1	.3623

	Transgender man	1	.3623
	Transgender woman	0	0
Race	African American/Black	29	10.32
	Asian/Asian American	12	4.27
	American Indian/Alaskan Native	10	3.56
	Caucasian/White	205	72.95
	Hispanic/Latino	14	4.98
	Middle Eastern/ North African	1	.356
	Mixed Race/Multiracial	7	2.49
	Native Hawaiian/Pacific Islander	0	0
	Other/Not Listed	0	0
	Preference not to Answer	3	1.07
Religious Affiliation	Agnostic	34	12.32
	Atheist	15	5.43
	Buddhist	4	1.45
	Christian	118	42.75
	Catholic	25	9.06
	Hindu	1	.3623
	Jehovah's Witness	0	0
	Jewish	5	1.811
	Mormon	1	.3623
	Muslim	2	.7246
	Orthodox	2	.7246
	Protestant	10	3.623
	Other Christian	7	2.536
	Other Faith	22	7.971
	Don't Know	26	9.420

Table 2 *Participant Demographic information (cont.)*

Participant Education-Specific Demographics

The researcher collected participant education-specific data to better understand the participants educational experiences and familiarity with wellness concepts through questions such as: (a) number of credits completed in the program, (b) completion of practicum experience, (c) type of counselor education program, (d) university, and (e) previous wellness training (N = 276; see Table 3). Most participants were students with 3-15 credit hours (n = 101; 36.59%), followed by students who had taken 46-60 credits (*n* = 60; 21.74%), students with 16-30 credits (n = 56; 20.29%), students with 31-45 credits (n = 41; 14.86%), and students with over 60 credits (n = 3; 1.08%). More students

identified as not yet taken their practicum courses (n = 144; 52.17%) than students who had already completed their practicum (n = 91; 32.97%). Participants predominantly reported enrollment in community mental health programs (n = 175; 63.41%) and then school counseling programs (n = 72; 26.09%). The remaining students identified enrollment in substance use and addictions program (n = 21; 7.60%), while the next largest signified enrollment in other programs, noting Marriage and Family Counseling programs (n = 19; 6.88%). Lastly, one participant reported enrollment in a counseling psychology program (n = 1; .36 %). The largest portion of participants were collected from the University of North Carolina at Charlotte (n = 104; 37.68%), followed by University of North Texas (n = 45; 16.3%), The College of William and Mary (n = 33; 11.96%), Stetson University (n = 31; 11.23%), University of North Carolina at Pembroke (*n* = 28; 10.14%), University of Mississippi (n = 10; 3.62%), Winthrop University (*n* = 9; 3.26%), Northeastern Illinois University (n = 6; 2.17%), Colorado State University (n = 5; 1.81%), and Virginia Commonwealth University (*n* = 5; 1.81%). Lastly, participants acknowledged having received wellness training through multiple avenues or not at all through their programs. A large majority of participants indicated that wellness had been at minimum mentioned in several classes during their training (n = 235; 85.14%). A smaller portion indicated that wellness had been inquired about during their supervision experience (n = 108; 39.13%). Only 22 participants reported having taken a stand-alone course regarding wellness (7.25%), while 17 students indicated that their program had never addressed wellness at all (6.16%). Five participants (1.81%) indicated having personal interests in wellness or wellness related training such as being a certified yoga instructor.

Table 3
Participant Education-Specific Demographics

Category	Options	Total (*n*)	Percentage %
Credits	3-15	101	36.59
	16-30	56	20.29
	31-45	41	14.86
	46-60	60	21.74
	Over 60	3	1.08
Practicum	Yes	91	32.97
	No	144	52.17
Program	Mental Health	175	63.41
	School Counseling	72	26.09
	Addictions/Substance	21	7.60
	Psychology	1	.362
	Other	19	6.88
University	Colorado State	5	1.81
	Northeastern Illinois University	6	2.17
	Stetson University	31	11.23
	UNC at Charlotte	104	37.68
	University of Mississippi	10	3.62
	University of North Texas	45	16.30
	UNC at Pembroke	28	10.14
	Virginia Commonwealth University	5	1.81
	William and Mary	33	11.96
	Winthrop University	9	3.26
Wellness Training	Full Course	22	7.25
	Addressed in multiple classes	235	85.14
	Discussed in Supervision	108	39.13
	Not addressed in Program	17	6.16
	Other	5	1.81

Table 3 *Participant Education-Specific Demographic (cont.)*

Trait Emotional Intelligence

The *Trait Emotional Intelligence Questionnaire-Short Form* (TEIQue-SF; Petrides, 2009) is a 30-item inventory and was used to measure trait emotional intelligence by examining trait emotional self-efficacy. The TEIQue-SF provides subscale scores that covers the 15 facets of EI and using the following domains: (a) Well Being, (b) Self-Control, (c) Emotionality, (d) Sociability, as well as the total score known as (e) Global Trait. Items include a seven-point Likert-type scale, ranging from 1

(completely disagree), to 7 (completely agree) that assess for participant's agreement with feelings and behaviors associated with various aspects of trait EI and emotional self-efficacy.

Although total scores are used to analyze the relationships between constructs, TEIQue-SF subscale measures of central tendencies and Cronbach's α can be found in Table 4. Each TEIQue-SF subscale has a total of six items, except for Emotionality which has a total of eight items. Total score for the TEIQue-SF is identified as the Global Trait score. The measures of central tendency for CIT's responses to this instrument are as follows: Mean= 5.367, Median= 5.433, Mode= 5.47, SD= .600. George and Mallery (2003) explain that internal consistency of the scale is stronger the closer the coefficient is to 1.00. Well Being and Global Trait alpha's appeared to show the greatest internal consistency, while the remaining subscales teeter on the edge of acceptability. Results further support the use of the total score of the TEIQue-SF(Petrides, 2009) for measuring trait emotional intelligence, instead of using the short form to examine EI as a latent variable with four subscales.

Table 4
Trait Emotional Intelligence-Short Form Central Tendencies

Factor	Mean	SD	Range	Median	Mode	Cronbach's α
Well Being	5.857	.865	4.17	6.000	6.00	.826
Self-control	4.821	.837	4.17	4.833	5.33	.608
Emotionality	5.709	.730	4.13	5.750	6.00	.644
Sociability	4.911	.844	4.50	4.833	5.17	.648
Global Trait	5.367	.600	3.60	5.433	5.47	.860

Perceptions of Wellness

The *Perceived Wellness Scale* (PWS; Adams, Bezner & Steinhardt, 1997) is defined by scores for six areas of wellness: (a) psychological, (b) physical, (c) emotional, (d) spiritual, (e) social, and (f) intellectual. Each dimension is represented by a six item

Lickert-type scale, ranging from 1 (very strongly disagree) to 6 (very strongly agree). Total score, also identified as a wellness composite score, is used during data analysis, but the sub-scale measures are identified in Table 5. Cronbach alphas indicate that the total score supports the strongest internal consistency. Results, once again, support the researchers decision to use the total score for the PWS (Adams, Bezner & Steinhardt, 1997) to measure the unidimensional construct of perceived wellness. The measures of central tendency for CIT's responses to this instrument are as follows: Mean= 14.51, Median= 14.29, Mode= 13.94, SD= 3.369.

Table 5
PWS Central Tendencies

Factor	Mean	SD	Range	Median	Mode	Cronbach's α
Psychological	4.608	.8035	4.83	4.667	4.50	.748
Physical	4.070	1.036	4.83	4.167	4.17	.804
Emotional	4.223	.8827	4.50	4.333	4.33	.760
Spiritual	4.805	.8111	4.33	5.000	5.00	.748
Social	4.808	.7815	3.83	5.000	5.50	.654
Intellectual	4.749	.6482	3.50	4.833	5.00	.591
Total	14.51	3.369	25.6	14.29	13.94	.888

Perceptions of Stress

The *Perceived Stress Scale* (PSS; Cohen et al.,1983) is a 10-item instrument designed to measure the degree to which common situations are appraised as stressful. The items ask about feelings and thoughts during the past month and how often the participant felt a certain way in a specific situation. Responses range from "never" to "very often" on a 5-point scale. This scale was used to provide a global measure of perceived stress in daily life, but the sub-scale central tendencies are provided in table 6 and examined in an alternative hypothesized model (see Figure 10). Researchers have recently examined the instrument as a unidimensional measure of stress and found that a

one-factor model is not as effective as a two-factor model in measuring the relationship between the ten items (Ramírez & Hernández, 2007; Taylor, 2015). The two-factor model has been split up into the following sub-scale constructs: as a perceived helplessness and a perceived loss of self-efficacy (Taylor, 2015). The two-factor model transforms perceptions of stress into a latent construct and examines helplessness using the reverse coded items four, five, seven, and eight, while the remaining items are used to measure loss of efficacy. The measures of central tendency for CIT's responses to this instrument are as follows: Mean= 18.13, Median= 18.00, Mode= 17.00, SD= 6.057. Although the Cronbach alpha's are considered acceptable, total score for the PSS (Cohen et al.,1983) is used as presented in the original hypothesized measurement model.

Table 6
PSS Form Central Tendencies

Factor	Mean	SD	Range	Median	Mode	Cronbach's α
Low-Efficacy	5.701	2.365	13.00	6.00	6.00	.840
Helplessness	12.43	4.306	21.00	12.00	10.00	.747
Total	18.13	6.057	33.00	18.00	17.00	.858

Wellness Behaviors

The *Body-Mind-Spirit Wellness Behavior and Characteristic Inventory* (BMS-WBCI; Hey, Calderon, & Carroll, 2006) examines three domains in which the following are: (a) body; including aspects of fitness, nutrition, self-care, and safety, (b) mind; including aspects of social awareness, emotional awareness and intellectual awareness behaviors, and (c) spirit; including spiritual and well-being measurements. Each domain has a different number of statements, resulting in a 44-item survey. There is a total of nine body questions, such as, "I limit risky behaviors (i.e., drive fast, bungee jumping, parachute, etc.)", "I eat a balanced diet low in saturated fat and cholesterol", and "I participate in recreational sports or activities that help maintain my fitness." There is a

total of 20 mind questions which include, “I am flexible to changes and can maintain stability in my life in healthy ways,”, “I express my feelings with others and consider their feelings,” and “I consider alternatives before making decisions.” The spirit dimension accounts for the final 15 questions which include, “I recognize the positive contribution faith can make to the quality of my life”, “I know my purpose in life” and “I experience peace of mind.” Each dimension is represented by a 3-point Likert scale ranging from 1 (rarely/seldom) to 3 (often/always). Both total score and sub-scores are used in this study to determine levels of participation in positive health behaviors and agreement with characteristics that promote well-being. The measures of central tendency for CIT’s responses to this instrument are as follows: Mean= 109.23, Median= 110.00, Mode= 112.00, SD= 10.80. Cronbach alpha’s for each scale fell within the acceptable ranges except for the spirit scale and the overall alpha for the total score, which showed high levels of internal validity at .891. The measures of central tendencies for the total score and three subscales of the BMS-WBCI (Hey, Calderon, & Carroll, 2006) are found in table 7. Table 8 is a collection of the total scores for all four instruments used in this study.

Table 7
BMS-WBCI Central Tendencies

Factor	Mean	SD	Range	Median	Mode	Cronbach’ α
Body	18.838	3.893	18.00	19.00	20.00	.770
Mind	54.587	4.110	21.00	55.00	58.00	.798
Spirit	35.778	6.174	27.00	36.00	34.00	.891
Total	109.226	10.80	57.00	110.00	112.0	.891

Table 8
Central Tendencies for Each Instrument

Scale	Mean	SD	Range	Median	Mode	Cronbach' α
BMS	109.23	10.80	57.00	110.00	112.0	.891
EI	5.367	.600	3.60	5.433	5.47	.860
PWS	14.51	3.369	25.6	14.29	13.94	.888
PSS	18.13	6.057	33.00	18.00	17.00	.858

Data Analysis for Research Hypothesis

The following portion of chapter four includes data analysis, examination of the statistical assumptions of SEM, and the examination of the research hypothesis and exploratory questions. Data was analyzed using the *Statistical Package for Social Sciences* (SPSS, Version 25) and the statistical modeling software program Mplus (Version 7.11). The researcher followed Byrne's (2010) suggestions for meeting the following assumptions for SEM: (a) utilizing a minimum sample size, (b) addressing missing data, (c) limiting multicollinearity and singularity, (d) accounting for outliers, (e) multivariate normality, and (f) linearity between variables. The researcher addressed the potential issue of sampling error by setting the alpha levels at .05 (Fraenkel & Wallen, 2009; Tabachnick & Fidell, 2013). Lastly, this section includes the results of a Path Analysis to further address concerns related to the variables after examining the Structural Equation Model (SEM).

Data Screening and Statistical Assumptions

Data screening included the examination of adequate sample size. Byrne (2010) and Kline (2011) agreed that a minimum of 200 participants is an adequate sample size for SEM, while other researchers encouraged the calculation of *a priori* sample size for SEM prior to collection (Schumacker & Lomax, 2010). A sample size calculator found at www.danielsoper.com, indicated that a minimum sample size of 200 was needed for

population representation (Gall et al., 2007) and to establish a small effect size (0.1) at a high power (.8) with one latent variables and three manifest variables at the probability of $p < .05$. In addition to the *a priori* calculation, Jackson (2003) suggested gathering a participant ratio of 20:1 per model variable. In consideration of the impact of potential missing data and the desire to test a more complex model, the researcher sought faculty guidance before including both the paper and pencil participant scores with the online participant scores. The total sample size collected for this study met the minimum criteria ($N = 276$) and included the use of both the electronic (n = 27) and paper surveys (n = 249) and the total number of responses were utilized as no cases were missing greater than 50% of their values. Although there were minimal amounts of missing responses, missing data was found to be missing at random.

The presence of missing data was assessed among the four major constructs (e.g., trait emotional intelligence, perceptions of stress, perceptions of wellness, and wellness behaviors) and omitted examining demographic data. According to Osborne (2013), this allowed the researcher to maintain a larger data set pertaining to the primary constructs. In total, 103 participant responses were missing from the entire data set with no more than six missing cases from one specific item. The researcher followed Kline's (2011) expectations regarding missing values and determined that no single variable was missing larger than 5% of its data. The researcher also examined missing data through Little's MCAR test ($\chi 2 = 5461.985$, $df = 5421$, $p = .345$), suggesting that data was missing completely at random. The researcher addressed missing data by declaring the discrete missing values in SPSS for the BMS-WBCI (Hey, Calderon, & Carroll, 2006), PSS(Cohen et al.,1983), and the PWS(Adams, Bezner & Steinhardt, 1997). The

researcher followed instructions from the author of the TEIQue-SF (Petrides, 2009) and replaced missing values with the middle value (4). Petrides (2009) recommended replacement except in cases where more than 15% of the values were missing. No cases were dropped from the files as no more than 2.2% were missing from any case.

Tabachnick and Fidell (2013) identified multicollinearity as existing when the relationship between independent variables are highly correlated (r = .9 and above). To test for the assumption of multicollinearity, the researcher examined the correlation matrix (see Table 9) and the tolerance and variance inflation factor (VIF).The researcher retained all of the constructs as each of the values among the independent variables fell above .7 (Pallant, 2011). Hair, Ringle, and Sarstedt (2011) stated that tolerance value indicates amount of variability explained between independent variables (0.2 or below), while VIF is an inverse of tolerance (below 5). Neither the tolerance (.45-.7) or VIF values (1.4-2.2) fell within ranges that would suggest multicollinearity. Thus, this data meets the necessary assumptions for multicollinearity.

Table 9
Pearson's Correlational Matrix

	EI	PWS	PSS	BMS
Total EI	1	.523**	-.664**	.636**
PWS	.523*	1	-.464	.596**
PSS	-.664**	-.464	1	-.527**
BMS	.636**	.596**	-.527**	1

**Correlation is significant at the 0.05 level (2-tailed).

Other points of consideration include the presence of outliers, normality, and linearity of data. Schumacker and Lomax (2010) encouraged researchers to examine data for the presence of outliers. Outliers are points of data that appear to be inconsistent with the rest of the data, sometimes recognized as an unusual permutation of two or more variables (Byrne, 2011). The researcher examined the data using Hoaglin, Iglewicz, and

Tukey's (1986) suggestion for calculating the interquartile range at 2.2 for assessing outliers and found that each instrument fell within range except for the PWS (Adams, Bezner & Steinhardt, 1997) which had two outliers that did not fall within the calculated range of acceptability. The researcher examined the outlying data to determine if the two cases were legitimate or due to data entry error. Osborne (2013) reported the likelihood that extreme values would become more likely the larger the data set, therefore the researcher did *not* remove the two scores as they were within a fraction of the range calculated and appeared to be legitimate entries. In addition to multicollinearity, the researcher assessed for normality and linearity within the data set. Q-Q plots and histograms were used to visually examine the normal distribution of data (e.g., bell-shaped curve) to ensure valid results (Tabachnick & Fidell, 2013; see Figures 9-16).

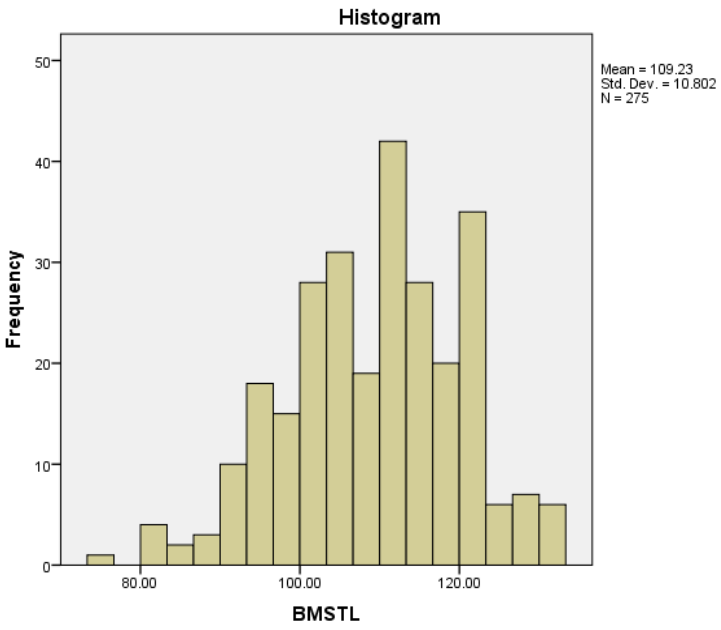

Figure 9: Histogram BMS_WBCI

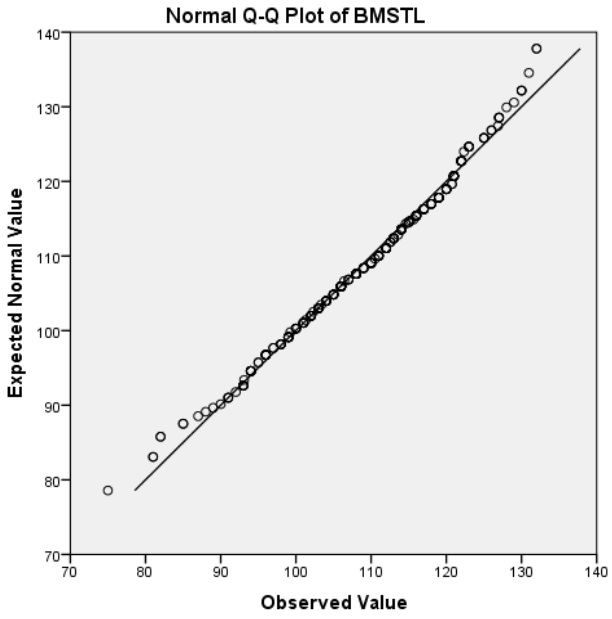

Figure 10: Normal Q-Q Plot of BMS-WBCI

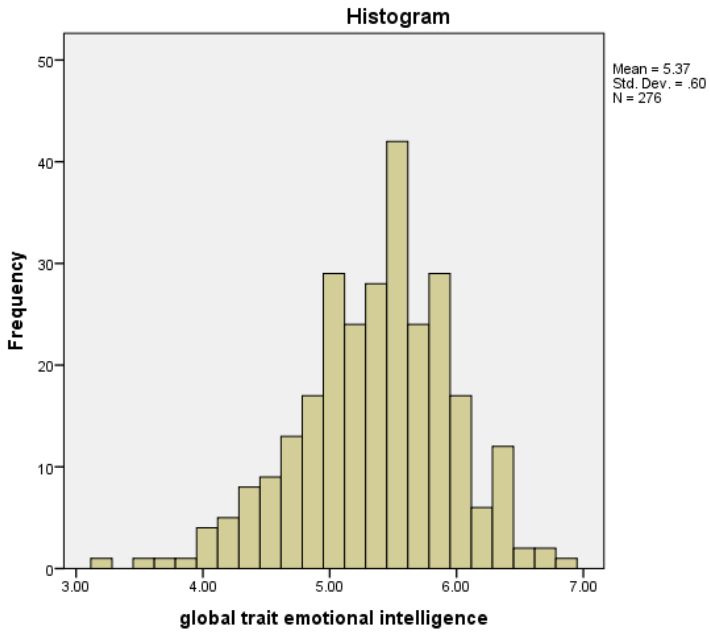

Figure 11: Histogram TEIQue-SF

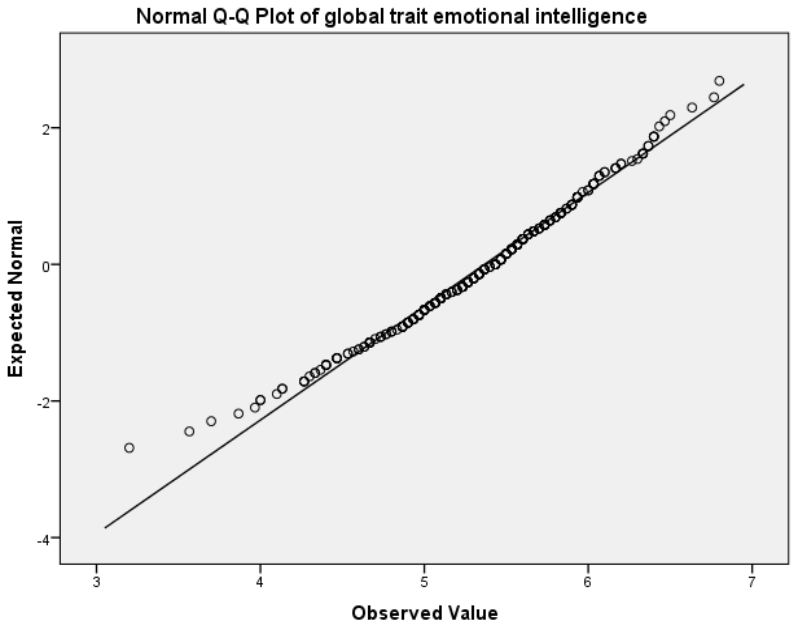

Figure 12: Normal Q-Q Plot of TEIQue-SF

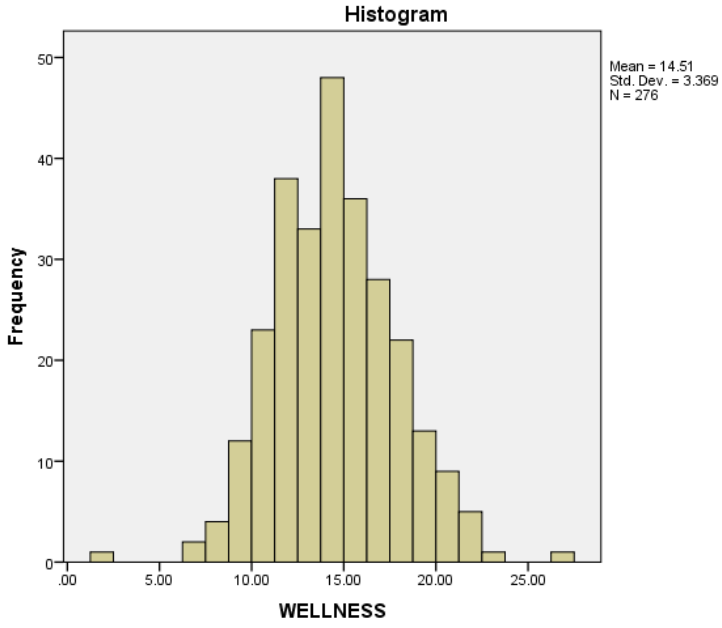

Figure 13: Histogram PWS

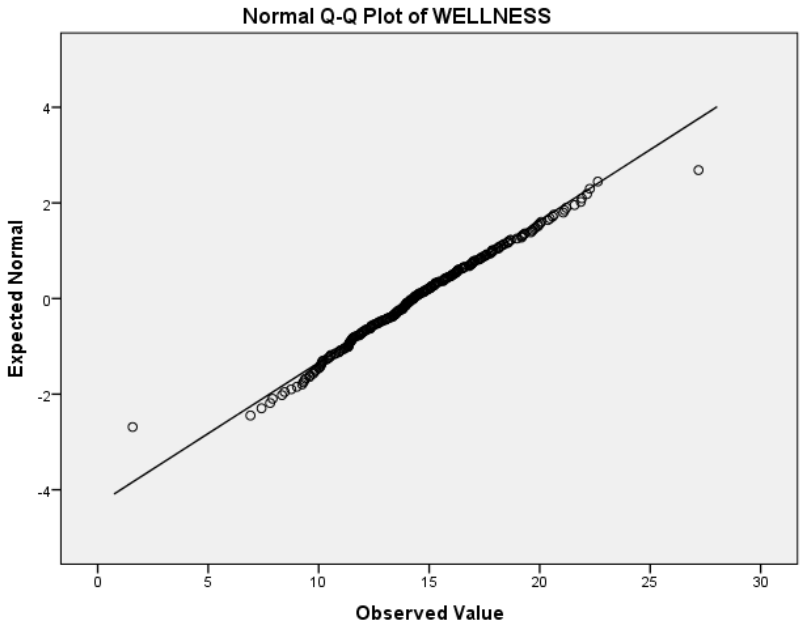

Figure 14: Normal Q-Q Plot of the PWS

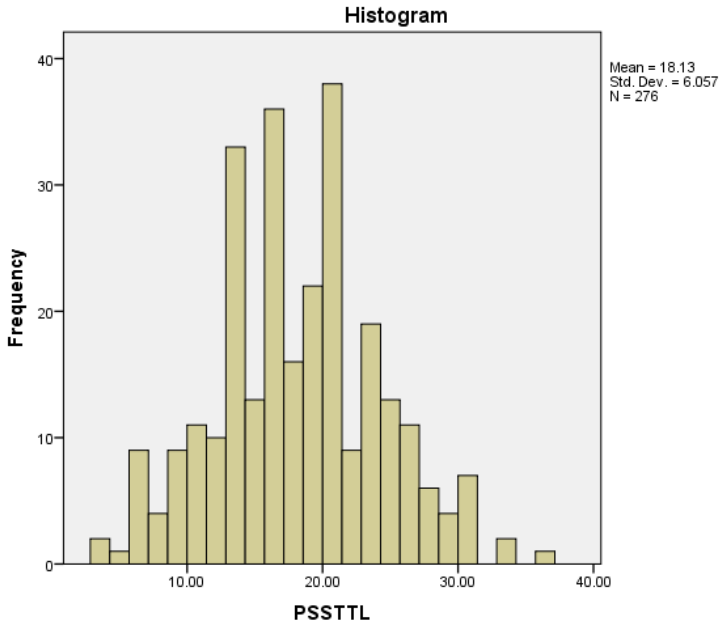

Figure 15: Histogram PSS

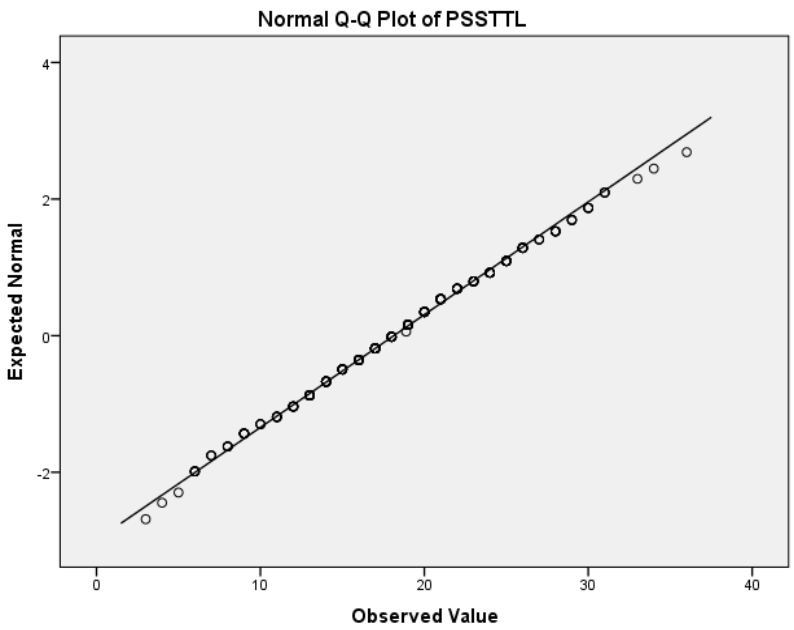

Figure 16: Normal Q-Q Plot of the PSS

The assumption of multivariate normality for SEM requires that all the individual univariate distributions be normal and all scatterplots be linear with homoscedastic residuals (Kline, 2016). The researcher inspected both the Q-Q Plots and Histograms for each variable (Figures 9-16) and identified that the all the variables appeared to be normally distributed except for wellness behaviors and emotional intelligence. The histogram for the BMS-WBCI appeared slightly leptokurtic (.676) but Kline (2016) indicates that the value did not fall outside the recommended cutoff for kurtosis. The histogram for TEIQue-SF appeared slightly negatively skewed but also within the confines of cutoff ranges.

Research Question Analysis

The purpose of this study was to investigate the relationship between counselors-in-training emotional intelligence, appraisal of stress and wellness to their wellness behaviors. The following portion reviews the results for the research hypothesis and exploratory questions. The researcher engaged data analysis using SEM and Pearson's

correlation. Crocket (2012) defined five steps to SEM for counseling research which are the following: (a) model specification, (b) model identification, (c) model estimation, (d) model testing, and (e) model modification. To determine model fit, the following indices were used: (a) Chi Squared ($\chi 2$), (b) Comparative Fit Index (CFI), (c) Goodness of Fit Index (GFI), (d) Root Mean Square Approximation (RMSEA), and (e) Tucker-Lewis Index (TLI). Crocket (2010) provided criteria as a set of guidelines including: (a) the existence of two or more latent variables, (b) at least three indicators per variable, (c) uncorrelated errors for each indicator, and (d) indicators loading only one factor. Although the original proposed hypothesized model (Figure 17) does *not* meet the guidelines set (e.g., the existence of two or more latent variables, and at least three indicators per variable), the alternative hypothesized measurement model *does* meet the criteria (see Figure 18). The researcher chose to utilize the total scores for three of the four assessments (TEIQue-SF; Petrides, 2009, the PWS; Adams, Bezner & Steinhardt, 1997, and the PSS; Cohen et al.,1983) due to the greater reliability of the instruments when used as unidimensional constructs. In addition to SEM, the researcher presented the results of the proposed model using Path analysis, which is a part of the structural equation modeling family that allows examination of linear and causal relationships between variables (Randolph & Myers, 2013).

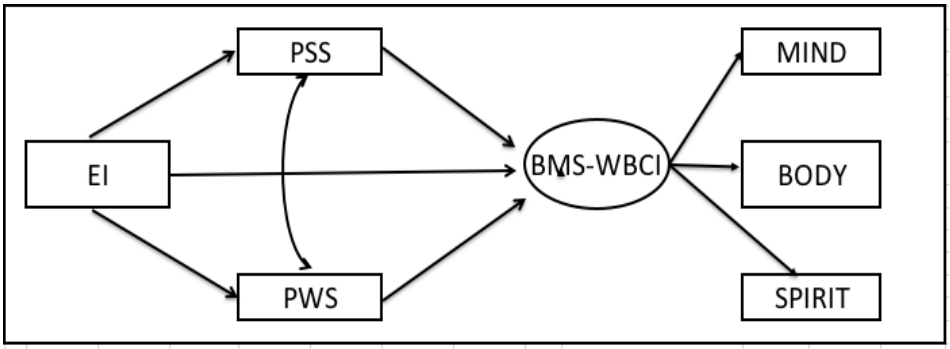

Figure 17: Path Diagram of the Proposed Structural Model

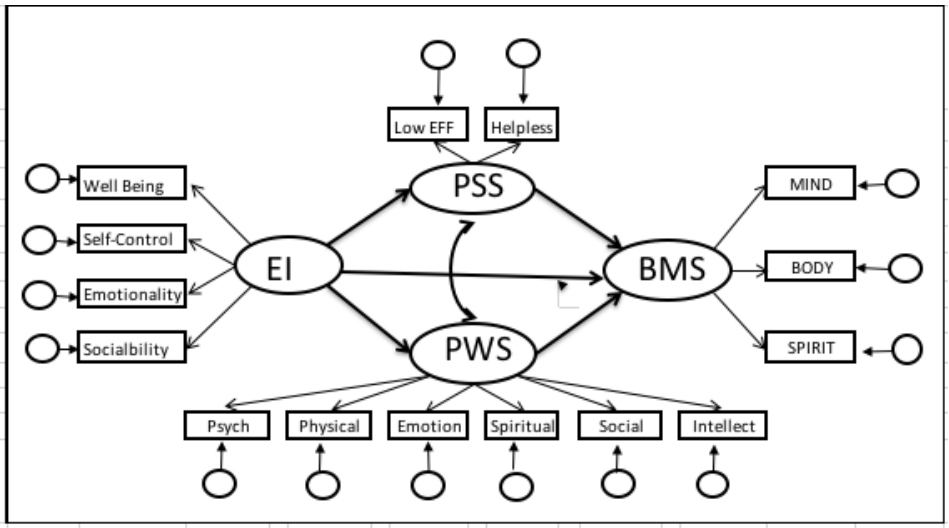

Figure 18: Path Diagram of Alternative Structural Model

Primary Research Question

The primary research question of the study was: Does trait emotional intelligence (as measured by the TEIQue-SF; Petrides, 2009) of counselors-in-training, contribute to their levels of perceived wellness (as measured by the PWS; Adams, Bezner & Steinhardt, 1997), perceived stress (as measured by the PSS; Cohen, Kamarck, & Mermelstein, 1983) and wellness behaviors (as measured by the BMS-WBCI; Hey, Calderon, & Carroll, 2006)?

Research Hypothesis

The main research hypothesis tested in the study was: The influence of trait emotional intelligence (as measured by the TEIQue-SF; Petrides, 2009) in counselors-in-training on wellness behaviors (as measured by the BMS-WBCI; Hey, Calderon, & Carroll, 2006) is partially mediated by both their appraisal of stress (as measured by the PSS; Cohen, Kamarck, & Mermelstein, 1983) and their appraisal of wellness (as measured by the PWS; Adams, Bezner & Steinhardt, 1997). Specifically, **t**he investigation tested the hypothesized directional relationship that participants with greater levels of emotional intelligence (as measured by the TEIQue-SF; Petrides, 2009) may have higher levels of perceived wellness (as measured by the PWS; Adams, Bezner & Steinhardt, 1997) but lower levels of perceived stress (as measured by the PSS; Cohen, Kamarck, & Mermelstein, 1983), and greater levels of strength and types of utilized wellness behaviors (as measured by the BMS-WBCI; Hey, Calderon, & Carroll, 2006). This study also tested they hypothesized relationship between levels of perceived stress (as measured by the PSS; Cohen, Kamarck, & Mermelstein, 1983) and levels of perceived wellness (as measured by the PWS; Adams, Bezner & Steinhardt, 1997).

Model Specification and Identification

Structural equation modeling (SEM) was used to prepare data, engage in descriptive analysis, apply multiple regressions and analyze theoretical models (Byrne, 2010). Five sequential steps to SEM include: model specification, model identification, model estimation, model testing, and model modification (Bollen & Long, 1993, Crocket, 2012). Step one, model specification (see Figures 2 & 17) can be revisited in Chapter 2 and Chapter 3. Step two in SEM is model identification (Schumacker & Lomax, 2010).

Model identification used confirmatory factor analysis (CFA) to assess the validity of the following measurement models (Byrne, 2010). These models correspond to the research questions and model fit were assessed through examination of the Chi Squared Goodness-of-Fit statistic (χ2), the Comparative Fit Index (CFI), the Goodness of Fit Index (GFI),The Root Mean Square Error of Approximation (RMSEA), the Standardized Root Mean Square Residual (SRMR), and the Tucker-Lewis Index (TLI). Authors suggest that researchers use values of .90 or higher to identify adequate fit (Bollen, 1989), while other recommendations address χ2/*df* of less than 2 or 3 as a better indicator of fit than chi square alone (Ullman, 2006). In addition, a value of .95 is suggested for the CFI and TLI indication of good fit (Hooper, Coughlan, & Mullen, 2008). McQuitty (2004) stated that the RMSEA has a confidence interval around its value, in which its lower limit should be close to 0 and the upper limit less than 0.08. Steiger (2007) recommended an SRMR limit value of .06 as an indicator of good fit.

Confirmatory Factor Analysis: Trait Emotional Intelligence

The researcher used the *Trait Emotional Intelligence Questionnaire- Short Form* (TEIQue-SF; Petrides, 2009). The researcher conducted a CFA on the anticipated factor structure of the TEIQue-SF and identified low and high factor loadings ranging from .43 to .84 (see Figure 19). Tabachnick and Fidell (2013) indicate that factor loadings greater than 0.4 is acceptable The chi-square value for the model was $\chi^2_{(2)} = .573$, $p < .0001$; $\chi^2/df = .286$. Goodness of fit was further assessed by the following fit indexes: CFI = .99, TLI = .99, RMSEA = .000 (90% CI =.000 to .082), and SRMR = .008. This model met almost all of the criteria needed for a good model fit, such as having a χ2/*df* of less than 2, a CFI

and TLI greater than 0.96, SRMR of less than .09. Each index adequately fit except this model has a RMSEA of.082, which is only a slightly higher range than the recommended upper limit of the confidence interval. The Cronbach's α for the entire instrument was .860 and the Cronbach's α for the *Well-Being* subscale was .826, both of which are considered to have good internal consistency (George & Mallery, 2003). Cronbach α's for the remaining subscales *Self-Control* (.608), *Emotionality* (.644), and *Sociability* (.648) indicated questionable ranges of internal consistency.

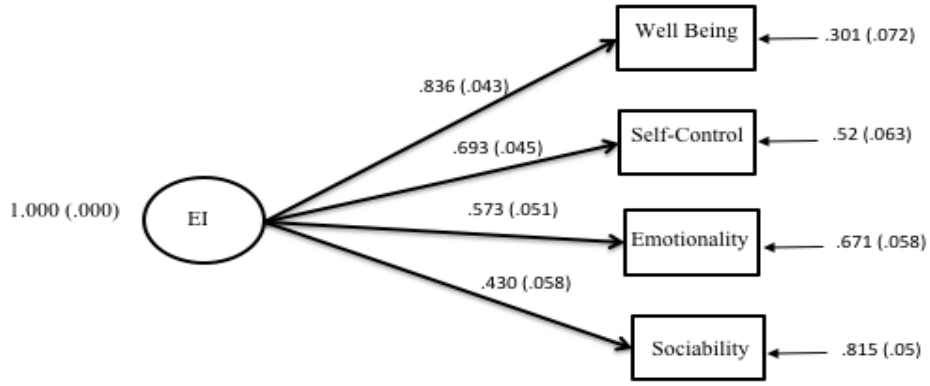

Figure 19. Trait Emotional Intelligence Measurement Model, Standardized

Confirmatory Factor Analysis: Perceptions of Stress

The researcher used the *Perceived Stress Scale* (PSS; Cohen, Kamarck, & Mermelstein, 1983). The researcher conducted a CFA on the anticipated factor structure of the PSS and identified weaker loadings ranging from .216 to .239 (see Figure 20). Kenny and Milan (2007) explain that a *just-identified* model, which can also be known as a *saturated model*, occurs when there is an equal amount of known and unknown information. In a model such as this, R-square is the goodness of fit used to explain the percentage of the variance between the two constructs of helplessness (r^2 = 5.7%) and low efficacy (r^2 = 4.6%) and the dependent variable (PSS). The Cronbach's α for the

entire instrument was .858 and the Cronbach's α for the *Low-Efficacy* subscale (6 items) was .840, both of which are considered to have good internal reliability and consistency (George & Mallery, 2003). Cronbach α's for the remaining subscale, *Helplessness* (4 items, α =.747), reported an adequate range of internal consistency (see Table 6).

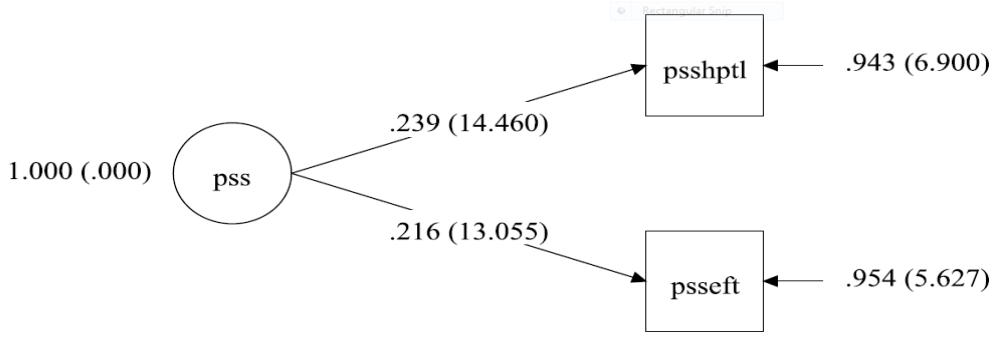

Figure 20. Perceptions of Stress Alternate Measurement Model, Standardized

Confirmatory Factor Analysis: Perceptions of Wellness

The researcher used the *Perceived Wellness Scale* (PWS; Adams, Bezner, & Steinhardt, 1997) to measure participant appraisal of personal wellness. The researcher conducted a CFA on the anticipated factor structure of the PWS and identified low and high factor loadings ranging from .319 to . 859 (see Figure 21). While most of the factor loadings were deemed acceptable (i.e., >.40; Tabachnick & Fidell, 2013), factor loadings for emotional wellness (.319) and physical wellness (.366) were particularly low. The chi- square value for the model was $\chi^2_{(9)} = 17.67$, $p<.0001$; $\chi^2/df = 1.963$. Goodness of fit was further assessed by the following fit indexes: CFI = .974, TLI = .957, RMSEA = .059 (90% CI = .0.013 to 0.100), and SRMR = .036. Therefore, this model met almost all of the criteria for good fit. The Cronbach's α for the entire instrument was .888, while the

Cronbach's α for the *Physical* (.804), *Emotional* (.760), *Psychological* (.748), and *Spirituality* (.748) subscales, were considered to have good to adequate internal consistency (George & Mallery, 2003). Cronbach α's for the remaining subscales *Social* (.654), and *Intellectual* (.591) reported questionable to poor ranges of internal consistency (see Table 5).

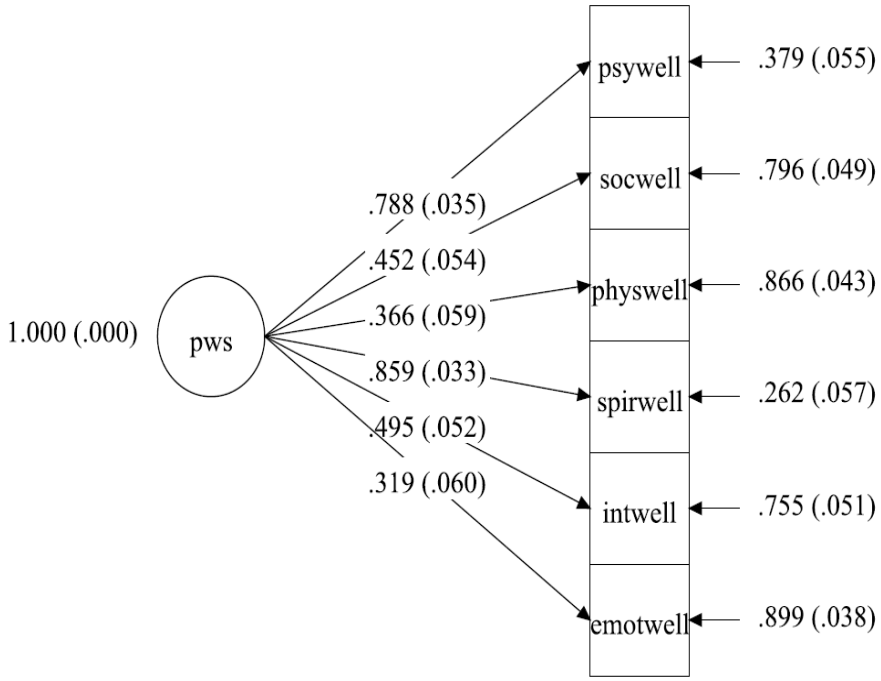

Figure 21. Perceptions of Wellness Measurement Model, Standardized

Confirmatory Factor Analysis: Wellness Behaviors

The researcher used the *Body, Mind, Spirit- Wellness Behavior Characteristic Inventory* (BMS-WBCI; Hey, Calderon, & Carroll, 2006) to measure participant personal wellness behaviors. The researcher conducted a CFA on the anticipated factor structure of the BMS-WBCI and identified incredibly low factor loadings for body (-.131) and higher factor loadings for mind (.765) and spirit (.778; see Figure 21). The analysis revealed that the BMS-WBCI is another example of a *just identified* model, which when

using a CFA, would always show perfect fit. The primary issue with this model is the statistical insignificance of the body scale, resulting in a wildly small coefficient. These results indicate that the body scale does not fit with this model. While the Cronbach's α for the entire instrument was .891, and the Cronbach's α for the *Spirit* (.891), *Mind* (.798), and *Body* (.770), were considered to have good to adequate internal consistency (George & Mallery, 2003; see Table 7), the model does not work in its present form.

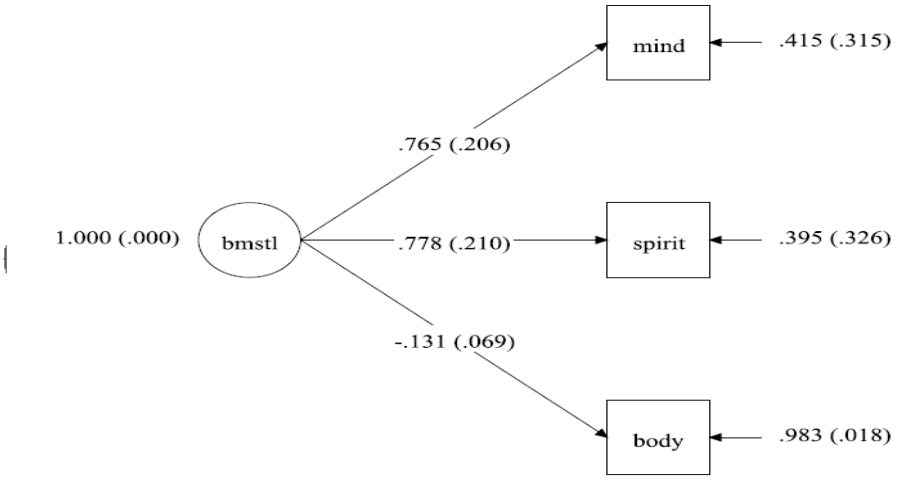

Figure 22. BMS-WBCI Measurement Model, Standardized

Structural Model

The researcher followed the recommended procedure for a SEM by first, establishing measurement models from latent variables, and second, proceeding to build and examine the structural models. Results indicated that the structural model for the BMS-WBCI was not a good fit in its present form. The researcher proceeded by dropping

the body subscale from the hypothesized model and proceeded by running the model with *spirit* and *mind* alone. Figure 23 provide the results of the modified structural model with *Body* excluded. The chi square value for the model was $\chi^2_{(2)} = 14.087$, $p<.0001$; $\chi^2/df = 7.0435$. Goodness of fit was further assessed by the following fit indexes: CFI = .976, TLI = .879, RMSEA = .149 (90% CI = .082 to .226), and SRMR = .024. Although this modification resulted in a better fit according to the CFI, GFI and SRMR values, the TLI and RMSEA values continue to emphasize poor fit. Most importantly, the modified model requires the researcher to omit the physical aspect of wellness, which is incredibly important to the holistic concept of well-being used for this study.

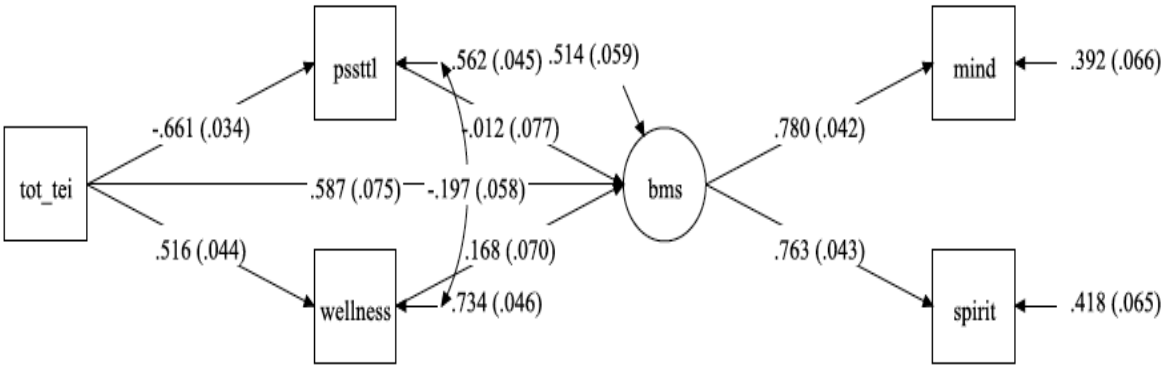

Figure 23. Structural Model with Body Excluded

While this model did not demonstrate adequate fit, the results of the model suggested two things among the relationships between constructs. First, this model showed the researcher that perceptions/appraisals do not serve as mediators between EI and wellness behaviors. Second, the model results identify a direct and strong effect between EI and appraisal of stress. The ideal action would be for the researcher to conduct a complete structural equation model with at least three latent variables and

fourteen manifest subscales. Unfortunately, the researcher was unable to attain a large enough sample size to test the alternative structural model as presented in Figure 18.

Path Analysis

The researcher engaged an alternate statistical analysis due to the difficulty experienced during the phase of model modification within the SEM and resulting in inability to satisfy criteria for a well fit model as well as the omission of a valuable and necessary component of wellness (body). Path analysis was used to determine how the pathways between the observed variables of trait emotional intelligence, appraisal of stress, and appraisal of wellness interact to influence the three different aspects of behavioral wellness: (a) mind, (b) body, and (c) spirit. This type of analysis allowed the researcher to examine the constructs as linear, causal relationships between variables (IV/exogenous) as they become predictor variables and the latent dependent (DV/endogenous) variable, as it shifted from a latent variable with three subscales into three observed variables (Randolph & Myers, 2013). According to Kline (2016), another difference between SEM and Path Analysis is a shift in language from observation of a mediator to observation of indirect effect. Figure 24 indicates that EI has a significant and direct effect on both *Mind* (0.549) and *Spirit* (0.347), but no significant effect on body (-0.083). EI has a significant and indirect effect on *Spirit* through PWS(.519, .239), as well as on body (.321) through PWS, but not on *Mind* (.028) through PWS. EI has a significant and indirect effect on *Body* through PSS (-.661, -0.156), but not on Mind (.019) or Spirit (-0.042) through PSS.

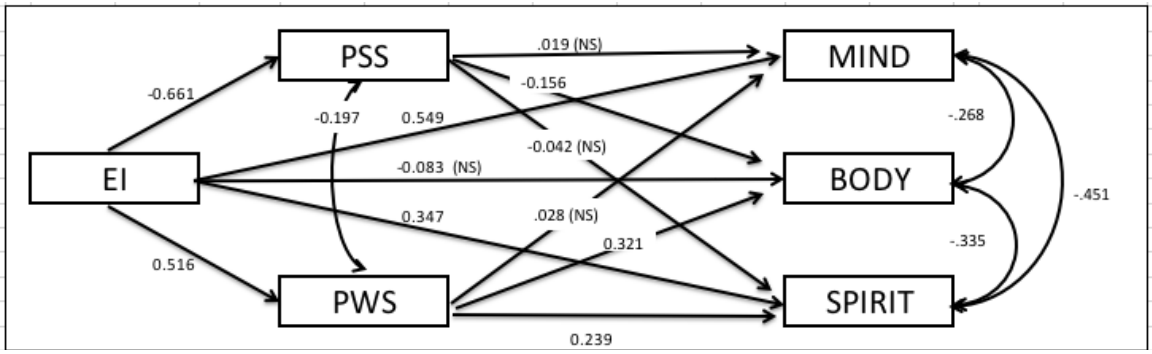

Figure 24. Path Analysis

The double-headed, curved arrow connecting PSS and PWS indicated an expectation of covariance between the factors. However, Figure 24 revealed a statistically significant, yet negative relationship of -0.197, contradictory to the researchers' expectations.

Chapter Four Summary

Chapter Four presented the results regarding (a) sampling and data collection procedures, (b) descriptive statistics of demographic information, (c) model specification and identification, (d) data analysis of the research hypothesis. The researcher engaged both SEM (Bollen & Long, 1993, Crocket, 2012) and PATH analysis (Randolph & Myers, 2013) to analyze the research hypothesis. In Chapter Five, the researcher presents a discussion of the results, and reviews potential implications for counselors-in-training, counselor educators and supervisors, and future research.

CHAPTER V: DISCUSSION

In Chapter Five, the researcher provides an overview of the methodology used in the study and discusses the significance of the results. The chapter compares the findings from the results with research presented in Chapter Two. This portion of the study reviews limitations, provides recommendations for future research, and explores implications of the research.

Study Summary

Despite intention that the counseling profession be theoretically grounded as wellness oriented and preventative in nature (Kaplan & Gladding, 2011; Witmer, 1985; Wolf, Thompson, & Smith-Adcock, 2012), researchers proposed that counselors are not competently equipped to address the connection between the biological, psychological and social factors which are part of the prevention healthcare paradigm (Barden, Conley, & Young, 2014). Although wellness has been acknowledged as a necessary ingredient for counselors to prevent impairment (Wolf, Thompson, & Smith-Adcock, 2012), little is offered on how disposition and appraisal of wellness and stress, influence CIT behaviors. Previous research has shown the necessity for wellness (Roach & Young, 2007), emotional intelligence (Gutierrez & Mullen, 2016; Houghton, Wu, Godwin, Neck, & Manz, 2012; Perera & DiGiacomo, 2015), and the importance of counselor perceptions (Hey, Calderon, & Carroll, 2006), all of which influence effective counseling by allowing the counselor to connect with the client, perceive and manage emotions and guard against burnout (Adams, Bezner, Drabbs, Zambarano, & Steinhardt, 2010; Gutierrez & Mullen, 2016; Lenz, Oliver, & Faii Sangganjanavanich, 2014). The purpose of this study was to examine the relationship between trait emotional intelligence, perceptions of stress, and

perceptions of wellness relate to wellness behaviors among counselors-in-training enrolled in CACREP programs. The majority of studies have examined traits that contribute to burnout among counselors and students (Lawson, 2007; Lawson & Myers, 2011). However, this study embraces a wellness orientation to examine traits and dispositions that are preventative in nature. In addition, this study examined the differences between a variety of education experiences, such as number of credits taken in the program, completion of practicum experience, and other traits that have been linked with counselor development.

After receiving approval from UNCC's IRB, the researcher collected data using paper and online formats (www.surveyshare.com). Data collection began on February 12th and continued until March 26th, 2018. A total of 303 students were approached to participate in the face-to-face completion of the surveys with a total of 249 participants that completed responses. A total response rate of 82% was collected from the paper and pencil surveys. While a total of 125 participants were approached using the electronic survey, only 27 participants completed the request with a response rate of 22%. The total sample included 276 counselors-in-training across universities across the United states, which included the use of both the electronic (n = 27) and paper surveys (n = 249).

The surveys utilized the following instruments: (a) the Trait Emotional Intelligence Questionnaire- Short Form (TEIQue-SF; Petrides, 2009), (b) Perceived Wellness Scale (PWS; Adams, Bezner, & Steinhardt, 1997), (c) the Perceived Stress Scale (PSS; Cohen, Kamarck, & Mermelstein, 1983), (d) the Body, Mind, Spirit-Wellness Behavior and Characteristic Inventory (BMS-WBCI; Hey, Calderon, & Carroll, 2006), (e) *general demographic questions*. Emotional intelligence was measured by the

Trait Emotional Intelligence Questionnaire-Short Form (TEIQue-SF; Petrides, 2009), which is a 30-item inventory based on the full 153-item form of the TEIQue (Petrides & Furnham, 2003). Appraisal of wellness was measured by the *Perceived Wellness Scale* (PWS), which is a 36-item instrument defined by scores for six areas of wellness: (a) psychological, (b) physical, (c) emotional, (d) spiritual, (e) social, and (f) intellectual. Appraisal of stress was measured by the *Perceived Stress Scale* (PSS; Cohen et al.,1983), which is a 10-item instrument designed to measure the degree to which common situations are appraised as stressful. Wellness behaviors were measured with the *Body-Mind-Spirit Wellness Behavior and Characteristic Inventory* (BMS-WBCI; Hey, Calderon, & Carroll, 2006), which is a 44-item survey that examines the following three domains: (a) body; including aspects of fitness, nutrition, self-care, and safety, (b) mind; including aspects of social awareness, emotional awareness and intellectual awareness behaviors, and (c) spirit; including spiritual and well-being measurements. The statistical analysis used in this study were Structural Equation Modeling (SEM; Crocket, 2012) and included confirmatory factor analysis, path analysis, and multiple regression. The researcher used an alpha level of .05 for SEM analysis. After following the two-step procedure for an SEM, results indicated that the use of a Path Analysis would be a better fit for examining the sub-constructs of wellness: mind, body, and spirit. The SEM results indicated that while perceptions of stress and wellness are not mediators between EI and wellness behaviors, the PA indicated that there is still a direct and significant effect between EI and the components of wellbeing, specifically, mind and spirit.

Descriptive Data Analysis

All participants in the study were graduate level college students who identified as counselors-in-training (N = 276). The majority of participants identified as female (n = 235; 85.14%), between the ages of 18-24 (n = 114; 52.2%), and White (n =205, 72.95%). The majority of participants identified their religious affiliation as Christian (n =118; 42.75%) and predominantly reported enrollment in community mental health programs (n = 175; 63.41%). The largest portion of participants were collected from the University of North Carolina at Charlotte (n = 104; 37.68%) with a large majority of the total participants indicating that wellness had been at minimum mentioned in several classes during their training (n = 235; 85.14%). The overall demographics of this study appear to reflect the general demographics of counselors-in-training as female, Christian, and heteronormative (Lee, Cho, Kissinger, & Ogle, 2010).

In addition, training specific demographics suggest that counselors are not adequately prepared to engage wellness as a multifaceted part of the healthcare paradigm (Barden, Conley, & Young, 2014). While burnout among CIT's was not measured in this study, researchers agree that without adequate training to maintain personal wellness it is only a matter of time before counselors become susceptible to the risk that comes with frequent contact with human suffering (Figley, 2002; Lawson, Venart, Hazler, & Kottler, 2007; Lee et al., 2007; Stebnicki, 2007).

Instrumentation and Measurement Models

The researcher utilized four instruments to collect data and measure the constructs of interest. Emotional intelligence was measured by the *Trait Emotional Intelligence Questionnaire-Short Form* (TEIQue-SF; Petrides, 2009). Appraisal of wellness was

measured by the *Perceived Wellness Scale* (PWS; Adams, Bezner & Steinhardt, 1997). Appraisal of stress was measured by the *Perceived Stress Scale* (PSS; Cohen et al.,1983) and wellness behaviors were measured with the *Body-Mind-Spirit Wellness Behavior and Characteristic Inventory* (BMS-WBCI; Hey, Calderon, & Carroll, 2006). A confirmatory factor analysis (CFA) was conducted for each instrument to confirm the relationship between the observed and latent constructs, as well as to develop the measurement models. After discovering that the CFA resulted in poor structural model fit, the researcher chose Path Analysis as an alternate evaluative tool to examine the relationships among the constructs. EI, perceptions of stress, perceptions of wellness, were kept as total scores and the construct of wellness behaviors was divided into three sub-constructs, identified as mind, body, and spirit.

Trait Emotional Intelligence. Trait emotional intelligence (EI) is the most comprehensive definition of EQ to date, due to its inclusion of both cognitive-emotional aptitude and personality disposition (Cherniss & Coleman, 2001; Petrides & Furnham, 2001). Trait emotional intelligence (EI) consists of adaptability, assertiveness, emotional appraisal, emotion expression, emotion management, emotion regulation, low impulsivity, relationship skills, self-esteem, self-motivation, social competence, stress management, trait empathy, trait happiness, and trait optimism (Petrides & Furnham, 2001). The short form of the assessment was used for this study, which reduces the fifteen aspects of EI into five reasonable categories. The TEIQue-SF (Petrides, 2009) provided subscale scores using the following domains: (a) Well Being, (b) Self-Control, (c) Emotionality, (d) Sociability, as well as the total score identified as (e) Global Trait. Items include a seven-point Likert-type scale, ranging from 1 (completely disagree), to 7

(completely agree) that assess for participant's agreement with feelings and behaviors associated with various aspects of trait EI and emotional self-efficacy. The average overall score for counselors-in-training that participated in this study Mean =5.37 and *SD* = .60, which is higher than samples gathered from the general population with means that range from 4.94 to 5.18 (Cooper & Petrides, 2010), but about the same as the averages gathered from another research study involving professional counselors and CIT's with a mean of 5,59 and SD of .51 (Gutierrez & Mullen, 2016). The results from this study indicated relatively little variance between CIT's scores with a median of 5.43, mode of 5.47 and SD of .60. These results appear to be quite representative of the counseling population as studies from Ivey and Ivey (2013) and Young (2013) report that elements of EQ such as the ability to recognize emotion is often fundamental skill taught in counseling programs.

Results of the CFA indicate acceptable to strong factor loadings ranging from .43 to . 84, with sociability falling on the cusp of appropriateness. Well Being and Global Trait alpha's appeared to show the greatest internal consistency, while the remaining subscales teeter on the edge of acceptability. Results further support the use of the total score of the TEIQue-SF (Petrides, 2009) for measuring trait emotional intelligence, instead of using the short form to examine EI as a latent variable with four subscales. The Cronbach's alpha for this study indicated an alpha at .86 for the total score, which is only slightly lower that the alpha coefficients from the authors of the scale ranging from .87 to .89 (Cooper & Petrides, 2010). Gutierrez and Mullen (2016) used this scale successfully with counselors and counseling students with adequate reliability, finding

that all the TEIQue-SF subscales made a statistically significant contribution ($p < .001$) to EI, while also finding a total Cronbach's alpha of .88.

Perceptions of Wellness. Perceived wellness is identified as a level of appraised balance, professed by living in a manner that permits the experience of consistent, growth in the emotional, intellectual, physical, psychological, social, and spiritual dimensions of human existence (Adams, Bezner & Steinhardt, 1997). The *Perceived Wellness Scale* (PWS) is a 36-item instrument which is defined by scores for six areas of wellness: (a) psychological, (b) physical, (c) emotional, (d) spiritual, (e) social, and (f) intellectual. Each dimension is represented by a six item Lickert-type scale, ranging from 1 (very strongly disagree) to 6 (very strongly agree). The PWS has scores ranging from 3 to 29 with higher scores indicating greater perceptions of wellness.

The measures of central tendency for CIT's responses to this instrument are as follows: Mean= 14.51, Median= 14.29, Mode= 13.94, SD= 3.369. This study indicated little variance between CIT's perceptions of wellness. It also indicated that the CIT's identified themselves as almost exactly in the middle of perceiving themselves as well. To date, there is no documentation of the PWS used specifically with CIT's, so it is impossible to compare average scores between them. However, the average perception of wellness scores among undergraduate college populations identified of Mean =23.2 and SD = 5.4, indicating that undergraduates perceive themselves as much more well than graduate level CIT's and undergraduates reported greater variance in those perceptions (Adams, Bezner, Drabbs, Zambarano, & Steinhardt, 2010). These differences could be a result of sampling differences or a representation of the differences in perceptions and

levels of personal of awareness, differences in work load, and differences in life experience and training between undergraduates and graduate students.

The researcher conducted a CFA on the anticipated factor structure of the PWS and identified low and high factor loadings ranging from .319 to .859. While most of the factor loadings were deemed acceptable (i.e., >.40; Tabachnick & Fidell, 2013), factor loadings for emotional wellness (.319) and physical wellness (.366) were particularly low. Cronbach alphas for this study indicated that the total score supported the strongest internal consistency (.888). This is supported by research from Adams, Bezner, Drabbs, Zambarano, and Steinhardt (2010) on the PWS with use on undergraduate students with alpha's at .91 for the total score. Use of the total score is further evidenced by research from Harari, Waehler, and Rogers (2005) and Sigman et al. (2009) after finding no psychometric evidence that six separate dimensions, but instead actually measured one unidimensional construction regarding perception of wellness.

Perceptions of Stress. Stress, whether experienced as destructive (distress) or constructive (eustress) is a direct result of individual appraisal and a product of the perception of having the means to address the given situation (Selye, 1974). The Perceived Stress Scale (PSS) is a popular measure of the self-perception of psychological distress (Cohen et al.,1983). The PSS is a 10-item instrument designed to measure the degree to which common situations are appraised as stressful. The items ask about feelings and thoughts during the past month and how often the participant felt a certain way in a specific situation. Responses range from "never" to "very often" on a five point Likert-type scale. Higher scores are equated with greater perceptions of stress.

The measures of central tendency for CIT's responses to this instrument are as follows: Mean= 18.13, Median= 18.00, Mode= 17.00, SD= 6.057. This study indicated surprisingly little variance between CIT's perceptions stress. However, these results are a higher than the general U.S. populations reported stress. When examining health status relationship to PSS, Cohen et al. (1988) measured information from 2,387 respondents in the U.S. with means ranging from 12.1 to 14.7 and SD's ranging from 5.0 to 7.2. While this study's SD appears to be within range at 6.06, the mean for CIT's PSS is unsurprisingly larger at 18.13 than the general populations.

Although the alpha's for a two-factor approach are considered acceptable, total score for the PSS (Cohen et al.,1983) was used for this study and resulted in a strong Chronbach's alpha of .86. While there is a plethora of research testing the PSS with other helping professionals such as nurses and doctors, it is difficult to find research that uses the PSS specifically with counselors or counselors-in-training. Cohen et al. (1983) tested its validity with three samples, two consisting of college students and one a heterogeneous sample of individuals with a high internal consistency with Cronbach's alphas of .90. The coefficient alphas were .84, and .85 for students and .86 for participants in a smoking cessation study, which is similar to the alpha found in this study at .86. Additional testing by Cohen et al. (1983) revealed a test-retest correlation at r= .85 for the two samples of college students, suggesting that the PSS serves as an accurate measure of perceived stress.

Wellness Behaviors. Behavioral wellness, for the purpose of this study, is defined as an active, evolving process of making choices toward a more successful existence (Hey, Calderon, & Carroll, 2006). It is also described by the National Wellness

Institute (1992) as a way of living that is responsive to the needs of the body, mind and spirit. The BMS-WBCI was designed to measure baseline wellness statements about behaviors and characteristics in the body, mind, and spirit dimensions of wellness that are important to college students. The BMS-WBCI examines three domains in which the following are: (a) body; including aspects of fitness, nutrition, self-care, and safety, (b) mind; including aspects of social awareness, emotional awareness and intellectual awareness behaviors, and (c) spirit; including spiritual and well-being measurements. Each domain has a different number of statements, resulting in a 44-item survey. Each dimension is represented by a 3-point Likert scale ranging from 1 (rarely/seldom) to 3 (often/always). Both total score and sub-scores were used in this study to determine levels of participation in positive health behaviors and agreement with characteristics that promote well-being. Higher scores indicate greater use of positive behaviors and increased over all well-being (Hey, Calderon, & Carroll, 2006).

The measures of central tendency for CIT's responses to this instrument are as follows: Mean= 109.23, Median= 110.00, Mode= 112.00, SD= 10.80. These results suggest relatively little variance between respondents scores. Once again, it is difficult to find research that uses this specific scale with mental health professionals, specifically counselors. However, the authors of this assessment developed this scale from a series of focus groups that utilized graduate students (Hey, Calderon, & Carroll, 2006), and then later normed on a variety of undergraduate students across the U.S. An additional study conducted by Mareno and James (2010) further validated the scale using undergraduate students, resulting in a mean of 108.73 and an SD of 12.41. Scores indicated a close resemblance to that of the CIT's in this study.

The researcher conducted a CFA on the anticipated factor structure of the BMS-WBCI and identified low and high factor loadings ranging from .770 to . 891. Cronbach alpha's for each scale fell within the acceptable ranges except for the spirit scale and the overall alpha for the total score, which showed high levels of internal validity at .891. Alphas for mind and body, registered at .798 and .770. These results appear consistent if not a little lower than Cronbach's alpha's from additional studies, including studies conducted by the authors of the scale. The developers of the BMS-WBCI instrument (Hey, Calderon, & Carroll, 2006) reported high internal consistency, high reliability and a positive correlation between all three subscales in two different studies involving college students. The first study indicated Cronbach alphas for each subscale: mind (α= .88), body (α=.81), and spirit (α= .91). The second study (n= 141) resulted in similar outcomes: mind (α= .75), body (α=.87), and spirit (α= .92). Moreno and James (2010) further validated this instrument on college students (n= 106) and found an overall alpha of the BMS-WBCI of .91 and subscales alphas of mind (α= .87), body (α=.69), and spirit (α= .88).

Results

Primary Research Question

The primary research question of the study was: What is the contribution between emotional intelligence (as measured by the *Trait Emotional Intelligence Questionnaire-Short Form* [TEIQue-SF; Petrides, 2009]), perceived wellness (as measured by the *Perceived Wellness Scale* [PWS; Adams, Bezner & Steinhardt, 1997]), perceived stress (as measured by the *Perceived Stress Scales* [PSS; Cohen, Kamarck, & Mermelstein, 1983]) and wellness behaviors (as measured by the *Body, Mind, Spirit-Wellness Behavior*

Characteristic Inventory [BMS-WBCI; Hey, Calderon, & Carroll, 2006]) for counselors-in-training.

Research Hypothesis

The main research hypothesis tested in the study was: The influence of trait emotional intelligence (as measured by the TEIQue-SF; Petrides, 2009) in counselors-in-training on wellness behaviors (as measured by the BMS-WBCI; Hey, Calderon, & Carroll, 2006) is partially mediated by both their appraisal of stress (as measured by the PSS; Cohen, Kamarck, & Mermelstein, 1983) and their appraisal of wellness (as measured by the PWS; Adams, Bezner & Steinhardt, 1997). Specifically, **t**he investigation tested the hypothesized directional relationship that participants with greater levels of emotional intelligence (as measured by the TEIQue-SF; Petrides, 2009) may have higher levels of perceived wellness (as measured by the PWS; Adams, Bezner & Steinhardt, 1997) but lower levels of perceived stress (as measured by the PSS; Cohen, Kamarck, & Mermelstein, 1983), and greater levels of strength and types of utilized wellness behaviors (as measured by the BMS-WBCI; Hey, Calderon, & Carroll, 2006). This study also tested the hypothesized relationship between levels of perceived stress (as measured by the PSS; Cohen, Kamarck, & Mermelstein, 1983) and levels of perceived wellness (as measured by the PWS; Adams, Bezner & Steinhardt, 1997).

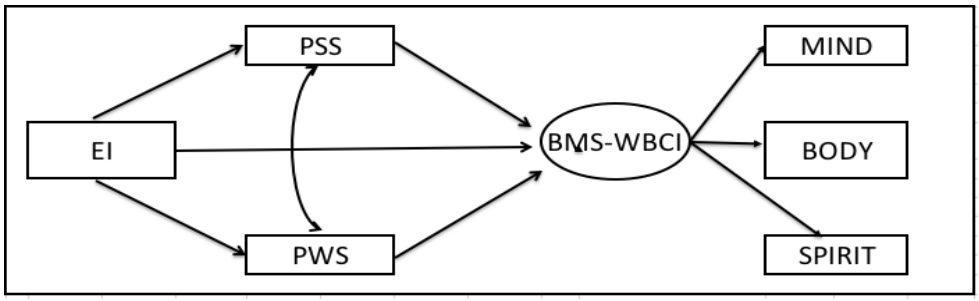

Figure 17. Hypothesized Structural Model

A structural model was developed based on the measurement model to investigate the hypothesis (shown in Figure 17). According to the tested structural model, this model did not demonstrate adequate fit. In spite of lack of fit, the results of the model suggested two things among the relationships between constructs. First, this model showed the researcher that perceptions/appraisals do not serve as mediators between EI and wellness behaviors. Second, the model results identify a direct and strong effect between EI and appraisal of stress. In order to test this model again, the researcher would need to conduct a complete structural equation model with at least three latent variables and fourteen manifest subscales. Unfortunately, the researcher was unable to attain a large enough sample size to test the alternative structural model as presented in Figure 18, and many of the scales used appear to be more reliable when using the total scores instead of the subscale scores.

Results also indicated that the structural model for the BMS-WBCI was not a good fit in its present form. The researcher proceeded by dropping the body subscale from the hypothesized model and proceeded by running the model with *spirit* and *mind* alone. Figure 23 shows the results of the modified structural model with *Body* excluded. The chi square value for the model was $\chi^2_{(2)} = 14.087$, $p<.0001$; $\chi^2 / df = 7.0435$. Goodness of fit was further assessed by the following fit indexes: CFI = .976, TLI = .879, RMSEA = .149 (90% CI = .082 to .226), and SRMR = .024. Although this modification resulted in a better fit according to the CFI, GFI and SRMR values, the TLI and RMSEA values continue to emphasize poor fit. Most importantly, the modified model requires the researcher to omit the physical aspect of wellness, which is incredibly important to the holistic concept of well-being used for this study. The researcher modified the

methodology and engaged an alternate statistical analysis after experiencing difficulty with model fit, resulting in the omission of a valuable and necessary component of wellness (body).

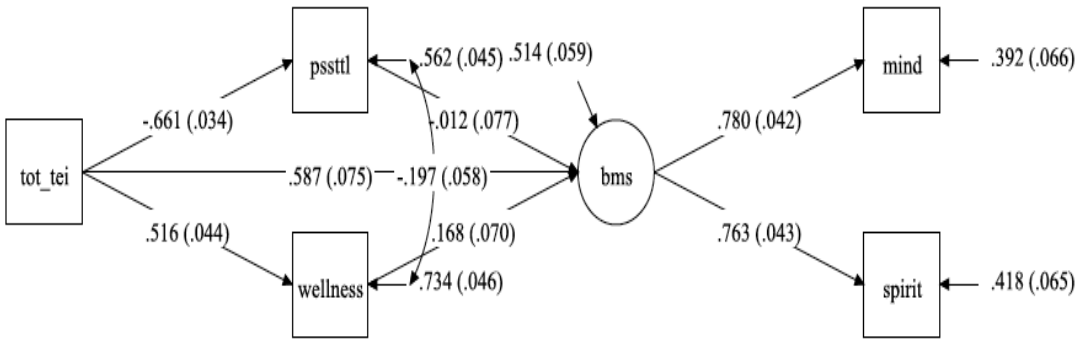

Figure 23 . Structural Model

Path Analysis

Figure 24 indicates that EI has a significant and direct effect on both *Mind* (0.549) and *Spirit* (0.347), but no significant effect on body (-0.083). EI has a significant and indirect effect on *Spirit* through PWS(.519, .239), as well as on body (.321) through PWS, but not on *Mind* (.028) through PWS. EI has a significant and indirect effect on *Body* through PSS (-.661, -0.156), but not on Mind (.019) or Spirit (-0.042) through PSS. The double-headed, curved arrow connecting PSS and PWS indicated an expectation of covariance between the factors. However, Figure 24 revealed a statistically significant, yet negative relationship of -0.197, contradictory to the researchers' expectations.

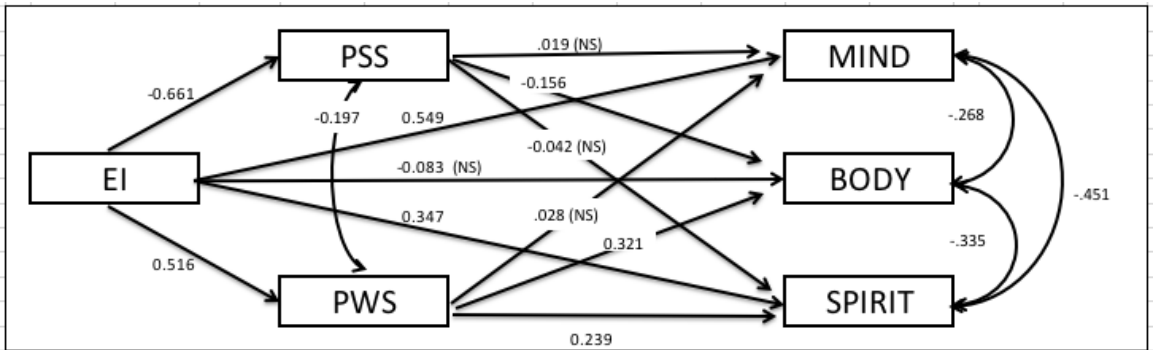

Figure 24. Path Analysis

Summary of the Results of the Hypothesis

Overall, the results of the SEM analysis did not support the hypothesis that perceptions of stress and wellness would be mediators between EI and wellness behaviors, the Path Analysis indicated that there is still a direct and significant effect between EI and the components of wellbeing, specifically, mind and spirit. The data analysis also confirmed that EI and perceptions of stress are highly and negatively correlated. The data analysis also indicated a non-significant relationship between EI and body wellness behaviors. Therefore, the data resulted in findings that did not support the hypothesized model.

As far as the researcher is aware, the relationship between trait emotional intelligence and wellness behaviors has *not* been explored in previous research. Therefore, the researcher is unable to compare these results to previous findings. The same is true between EI and perceptions of stress and perceptions of wellness. However, much has been examined between EI and elements of wellness such as mind and spirit development, and between EI and stress related burnout. Specifically, previous studies have shown that EI is associated with less anxiety (Yip & Cote, 2013) and influences

levels of counselor burnout (Gutierrez & Mullen, 2016), as well as less occupational burnout in teaching and medical professions (Pishghadam & Sahebjam, 2012).

In addition, the TEIQue-SF provides subscale scores uses five domains that reflects the 15 facets of EI: (a) Well Being, (b) Self-Control, (c) Emotionality, (d) Sociability, as well as (e) Global Trait, which includes factors of self-motivation and adaptability (Petrides, 2009), each of which has shared elements with the BMS-WBCI assessment. The BMS-WBCI examines three behavioral domains: (a) body; including aspects of fitness, nutrition, self-care, and safety, (b) mind; including aspects of social awareness, emotional awareness and intellectual awareness behaviors, and (c) spirit; including spiritual and well-being measurements (Hey, Calderon, & Carroll, 2006). It is quite clear that the conceptualization of trait emotional intelligence overlaps with the mind and spirit dimensions within behavioral wellness. Petrides, Pita, and Kokkinaki (2007) report that EI refers to emotional self-perceptions and are found in the sub-levels of personality hierarchies. This definition explains some of the overlap in concepts that contribute to mindful and spiritual behaviors of wellness, as they are often experiences in an internal and reflective nature. However, the conceptualization of EI does not account for the physicality of behavioral wellness and choices that result after utilizing EI for problem solving. Multiple studies have indicated that EI contributes to an increased ability to identify, discuss, and deal with emotions, including increased use of problem-solving strategies (Cooper & Ng, 2009; Jordan & Toth, 2002; Rahim et al., 2002). Unfortunately, problem solving strategies do not always equate to strategies for increasing physical wellness. Counselors appear trained only to focus on the mental and emotional aspects of personal or client wellness and are ill prepared to integrate physical

wellness or treat clients with interacting medical issues (Barden, Young, & Conley, 2015; Wolf, Thompson, & Smith-Adcock, 2012).

This gap in counselor training is further evidenced by the results in this study. One potential reason the original structural model dropped the body subscale, is that physical wellness is so different from the mental and spiritual aspects that overlap between EI and the other two subscales. Another, more evident option, is that counselors are not adequately trained to recognize and address the symptoms of physical wellness or incorporate an understanding of body wellness to their personal definitions of wellness (Yager & Blank, 2007). Additionally, researchers have often stated concern over counselor sacrifice of personal physical wellness in service of their clients and demands of their agencies (Barden, Young, & Conley, 2015; Wolf, Thompson, & Smith-Adcock, 2012). The same can be asserted about the process and rigors of a graduate program. Smith, Robinson, and Young (2007) identified a relationship between psychological distress and a decrease in overall wellness for CIT's. While Roach and Young (2007) also questioned the cultivation of wellness in the counselor education process and concluded that irregular exposure to wellness practice during training is insufficient to promote counselor wellness. Without the proper expectation built into the process of counselor training, our CIT's are simply unprepared to balance the unidimensional nature of behavioral body wellness for themselves or their clients.

As previously stated in chapter one, if counselors-in-training, counselors, supervisors and counselor educators are to successfully address the challenges of maintaining wellness, they must increase understanding of factors that may influence wellness. For this reason, Wolf, Thompson, and Smith-Adcock (2012) recommend

promoting wellness in counselor preparation and teaching CIT's awareness to a variety of factors that influence wellness through a multilevel approach. Barden, Conley, and Young (2014) suggest an adoption of wellness competencies as a standard for counselor preparation. While other researcher suggest identifying alternative means to integrate wellness preparation such as engaging in effective supervision (Skovholt, 2001), using a wellness model throughout supervision (Lenz, Faii-Sangganjanavanich, Balkin, Oliver, & Smith, 2012), promoting a clear and concise understanding and expectation of wellness throughout training, encouraging CIT's to engage in their own counseling, integration of a wellness philosophy in all courses, and establishing an association of self-growth with the counselor education process (Yager & Blank, 2007). The results from this research supports the need for counselor preparation to include a thorough understanding and integration of wellness and wellness models during training.

Limitations of the Study

This study included several limitations, therefore, caution should be used when interpreting the results of the study. Specific limitations include (a) research design, (b) sampling method, (c) power, and (d) instrumentation (Tabachnick & Fidell, 2013).

Research Design Limitations

This study utilized a correlational research design that engaged structural equation model and path analysis to test the theoretical model of the directional relationships between emotional intelligence, perception of stress, perception of wellness, and wellness behaviors. The researcher made efforts to limit the influence of threats to external, internal, and test validity. However, limitations continued with the failure to control for extraneous variables that may have influenced the relationship between constructs such

as social desirability of CIT's. The researcher has also not yet tested the demographic characteristics that might have influenced relationships between EI, perceptions, and behaviors.

Sampling Limitations

The researcher utilized the *Tailored Design Method* (Dillman et al., 2014) and provided incentive to participate, leading to a high response and participating rate. A total response rate of 82% was collected from the paper and pencil surveys. While a total of 125 participants were approached using the electronic survey, only 27 participants completed the request with a response rate of 22%. Combined, the researcher encountered a 64% response rate after collecting a total of 276 completed surveys from 428 administered surveys. All participants were recruited from CACREP accredited institutions to aid in ensuring approximate standards of training.

Tabachnick and Fidell (2013) indicate that SEM works more efficiently when researchers have a random sample of the identified population. Unfortunately, the researcher only had access to a convenience sample of counselors-in-training through a recruitment process of CACREP universities throughout the eight of the United States. The majority of students were recruited from universities in North Carolina. Hence, the results of this study are not generalizable to the CIT populations throughout the U.S or other countries. In addition to location within the U.S., many of the participants were female and white, making it difficult to apply results to graduate students of diverse backgrounds.

The researcher attempted to reduce the influence of self-selection bias through the facilitation of the assessments during class time and structuring the administration in the

same format during class regardless if the survey was in printed or electronic form. However, the researcher recognizes that students who chose to participate may have had a previous affinity for wellness or additional motivation to complete the surveys. For instance, CIT's that felt positive about their graduate program and with their current levels of wellness, may have had more energy and desire to provide feedback on a study focused on counselor wellness.

Power

Schumacker and Lomax (2010) recommend calculating *a priori* sample size for SEM to anticipate sample size and to avoid making a Type II error (i.e., failing to reject a false null hypothesis; Balkin & Sheperis, 2011). A priori power analysis using the software tools available at www.danielsoper.com indicated that a minimum sample size of 200 would be required to identify a small effect size (0.1) at a high power (.8) with one latent variables and three manifest variables at the probability of $p < .05$ and establish population representation (Gall et al., 2007). If the researcher were to run this study with the alternative structural model (Figure 18), using the BMS-WBCI as a latent variable and then changing the other assessments into latent variables (TEIQue-SF; PWS; PSS) this would change the minimum sample size to detect effect to 1,285 CIT's and model structure minimum to 700 instead of 200 participants. In effort to examine the relationship between all of the subscales within these constructs, the researcher recommends replicating the study with the suggested sample size.

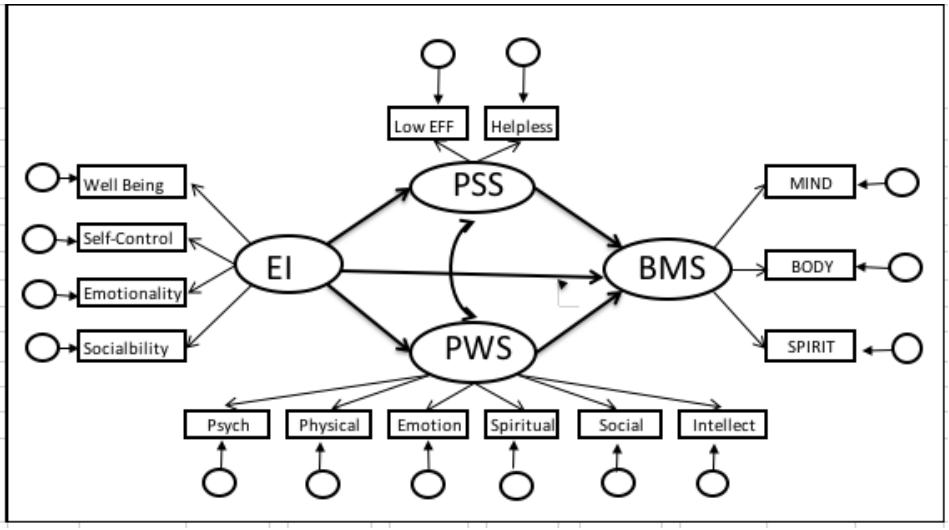

Figure 18: Path Diagram of Alternative Structural Model

Instrumentation Limitations

One of the most common limitations within research studies include limitations with self-report instruments (Gall et al., 2007). For instance, all instruments are subject to measurement error (Tabachnick & Fidell, 2013), which the use of SEM attempts to account for and rectify (Crocket, 2012). However, examples of instrument limitations and failure to measure the true value in this study include the issues with both the PWS and TEIQue-SF. Although they have been adjusted to reflect the larger and more rigorous conceptualization of their constructs as their full-length assessment counterparts (Adams, Bezner & Steinhardt, 1997; Petrides, 2009). Researcher have identified that these scales work best as total scores and unidimensional constructs, as used with total scores in this study. This is the opposite limitation as found with the BMS-WBCI which has been found to best used as three separate scales as multidimensional aspects of wellness.

Recommendations for Future Research

Future research should consider the limitations that were presented in this study. Efforts should be made to strengthen the external validity by increasing sample size.

Future researcher may also need to identify revised versions of the assessments and ensure strong psychometric properties for use with graduate populations across diverse backgrounds. Future data exploration may include questions like: What is the relationship between counselors-in-training's (a) trait emotional intelligence (as measured by the TEIQue-SF; Petrides, 2009), (b) levels of perceived wellness (as measured by the PWS; Adams, Bezner & Steinhardt, 1997), (c) levels of perceived stress (as measured by the PSS; Cohen, Kamarck, & Mermelstein, 1983), and (d) wellness behaviors (as measured by the BMS-WBCI; Hey, Calderon, & Carroll, 2006) with their reported demographic variables (e.g., age, gender, and ethnicity)?

Another option for exploration is: Is there a significant relationship between the constructs used in this study from counselors-in-training and their reported educational characteristics (e.g. practicum experience, number of credits in the program, program type)? The researcher will need to perform a series of multivariate analysis of variance (MANOVA) tests to assess whether there are any significant differences across participants' demographic and educational variables. Specifically, a one-way MANOVA will need to be conducted for each of the independent demographic variables.

Exploratory Research Questions for Future Research

1. Is there a significant relationship between counselors-in-training's trait emotional intelligence (as measured by the total scores of the TEIQue-SF) and their reported educational characteristics (e.g. practicum experience, number of credits in the program, program type)?
2. Is there a significant relationship between counselors-in-training's perceptions of wellness (as measured by the total scores of the PWS) and their reported

educational characteristics (e.g. practicum experience, number of credits in the program, program type)?

3. Is there a significant relationship between counselors-in-training's perceptions of stress (as measured by the total scores of the PSS) and their reported educational characteristics (e.g. practicum experience, number of credits in the program, program type)?
4. Is there a significant relationship between counselors-in-training's behaviors (as measured by the sub-scores of the BMS-WBCI) and their reported educational characteristics (e.g. practicum experience, number of credits in the program, program type)?
5. What is the relationship between counselors-in-training's (a) trait emotional intelligence (as measured by the TEIQue-SF; Petrides, 2009), (b) levels of perceived wellness (as measured by the PWS; Adams, Bezner & Steinhardt, 1997), (c) levels of perceived stress (as measured by the PSS; Cohen, Kamarck, & Mermelstein, 1983), and (d) wellness behaviors (as measured by the BMS-WBCI; Hey, Calderon, & Carroll, 2006) with their reported demographic variables (e.g., age, gender, and ethnicity)?

EI Moderating Stress & Wellness

While more information regarding the exploration of differences between variables across demographic categories is necessary, what may be more useful to the training of future counselors would be to answer the following questions: (a) Do wellness practices influence those with high stress/impact perceived stress?, (b) Are these relationships stronger for those with higher emotional intelligence? (c) Do people who have better EI

get more benefit in stress reduction out of their wellness practices?, and (d) Is the relationship between wellness and stress moderated by increased levels of trait emotional intelligence? These questions would shift the current study's focus from a wellness outcome to a stress outcome, and allow the researcher to verify the suspected link the EI does indeed influence levels of stress. This shift in focus would aid in confirming previous studies with counseling populations and decreases in burnout (Gutierrez & Mullen, 2016) as well as affirm the conceptual need to incorporate EI training in counselor programs (Barden, Conley, & Young, 2015).

Implications

The contributions of this dissertation to current counseling literature includes insight into trait-emotional intelligence, perceptions of stress, perceptions of wellness, and wellness behaviors among counselors-in-training. Despite the limitation of this study, the most significant finding from the results is the support for the relationship between trait emotional intelligence and wellness behaviors relating to mind and spirit. The relationship between EI and perceptions of stress cannot be ignored as well.

There is evidence to support the use of increased emotional intelligence to increase mind and spirit aspects of wellness, there is also evidence that suggests the counselor education process does not support the prioritization of physical wellness. These results are supportive of previous research that indicates the importance of counselor wellness and self-care. Specifically, the idea that *well* counselors are more helpful to their clients than those experiencing distress and impairment (Lawson & Myers, 2011; Lenz, Oliver, & Sangganjanavanich, 2014; Lenz & Roscoe, 2011; Lenz & Smith, 2010; Venart, Vassos, & Pitcher-Heft, 2007), researchers identified that distressed

counselors also negatively impact the quality of services provided to clients, participate in behaviors that imply devaluing clients, and engage in incompetent practices that potentially harm clients (Lawson, Venart, Hazler, & Kottler, 2007; Lee, Cho, Kissinger & Ogle, 2010). In addition, the promotion wellness in counselor preparation through advancement of individual well-being, may help future counselors develop a more holistic and inclusive view of wellness for themselves and their clients (Wolf, Thompson, & Smith-Adcock, 2012) which should include an expectation that wellness focus on body as well as mind and spiritual aspects. Lastly, clinical supervisors could also benefit from the implementation of strategic wellness and emotional intelligence strategies (Cummins, Massey, and Jones (2007), which may in turn decrease counselor burnout, empathy fatigue and ineffective counseling practice (Gutierrez & Mullen, 2016).

Chapter Five Summary

In this last chapter, the researcher compared findings from this investigation with previous research noted in chapter two. The results of this study indicated that perceptions of wellness and perceptions of stress do not serve as mediators within the relationship between trait emotional intelligence and wellness behaviors. While the proposed structural models did not prove to be a good fit, the researcher was able to examine the data using Path Analysis and confirm an intriguing relationship between the constructs of interest. The research tested the data and identified the results as confirmation that EI has a significant and direct effect on two of the three tenets of wellness behaviors, as seen on both *Mind* and *Spirit*. The researcher recognized that EI continued to not have significant direct effect on body behaviors, as originally suggested from the results of the SEM's structural model and lack of fit. Results from this study

also indicated that EI has a significant and indirect effect on *Spirit* behaviors, as well as on body behaviors, but not on *Mind* behaviors through a CIT's perception of wellness. However, results also indicated that EI has a significant and indirect effect on *Body* behaviors through the perception of stress, but not on Mind or Spirit behaviors. These outcomes indicate a relationship that is worth further examination of the four constructs in relation to both CIT's and other helping professionals and may be expounded upon with future research. It's important to recall the limitations of this study and remember to use restraint when interpreting the results. In spite of certain study limitations, the overall findings of this dissertation offer implications for future counselor educators, counselor supervisors, and future researchers. In all, the study has successfully contributed to a growing body of literature regarding emotional intelligence, the role of appraisal and perceptions of both stress and wellness, and wellness behaviors of helping professionals.

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APPENDIX A:
IRB LETTER

IRB Notice - 17-0492
Inbox x

IRB uncc-irb@uncc.edu via adminliveunc.onmicrosoft.com 11/25/17

to me, uncc-irbis, dgutier6, hharris2

To: Erica Merrill
Counseling

From: Office of Research Compliance

Date: 11/25/2017

RE: Administrative Preliminary Review and/or Return of incomplete submission

Submission Type: Initial

Study #: 17-0492

Study Title: WELLNESS AMONG COUNSELORS IN TRAINING: EXAMINING THE RELATIONSHIP OF TRAIT EMOTIONAL INTELLIGENCE, PERCEPTIONS OF STRESS, PERCEPTIONS OF WELLNESS, AND WELLNESS BEHAVIORS

This is not an IRB approval. You may *not* implement the research activities described in your submission until you have received a memo indicating final IRB approval.

The Office of Research Compliance has completed an administrative preliminary review of your submission and has determined that more information is needed and/or determined that the submission is incomplete. Following receipt of your response and revised application materials (as applicable), your submission will be re-reviewed and if found to be complete, will be submitted for IRB review.

Your review will be found online at the link below. You will be able to respond to each stipulation using the online system.

http://uncc.myresearchonline.org/irb/eform_routing_stipulations.cfm?masterid=168854

Please be sure to update the applicable sections of the application when responding to stipulations.

APPENDIX B:
INFORMED CONSENT

Department of Counseling
9201 University City Boulevard, Charlotte, NC 28223-0001
704-687-8962 (office) | 704-687-1636 (Fax)

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

Wellness Among Counselors in Training: Examining the Relationship between Trait Emotional Intelligence, Perceptions of Stress and Wellness, and Wellness Behaviors

You are being asked to participate in a research study. Whether you take part is completely up to you. The purpose of this research study is to better understand how emotional intelligence may influence your perceptions of stress and wellness behaviors. Please read the information carefully. Should you decide to participate, please continue to the rest of the packet to answer the questions to the best of your ability. You may keep this paper if you would like a copy of the consent for your records.

My name is Erica Merrill and I am a practicing mental health counselor and doctoral candidate at the University of North Carolina, Charlotte. Dr. Hank Harris, a UNC Charlotte Professor in the Department of Counseling will be supervising this research project. You have been contacted about this study because you have been identified as someone who is training as a mental health, school or addictions counselor. Your input would greatly assist this research.

Eligibility for this study requires that participants be individuals, of the minimum age of 18 years, who report being in a CACREP Masters level counseling program. If you do not meet these criteria, your interest is appreciated, but your participation is not recommended. Exclusion criteria include individuals who are not training to be professional counselors.

If you wish to participate, you will be asked to complete a set of questionnaires asking questions related to your perceptions of stress, wellness, emotional intelligence, and coping behaviors. In all, the assessments should not take more than 25-30 minutes to complete. Your participation in this study and any information you share is completely confidential. Furthermore, you may stop and withdraw from the study at any time.

Upon completion of the survey, participants of this study are offered an opportunity to take part in a drawing a $15 Walmart gift card, which will be drawn immediately after the survey is completed and handed in. Another drawing will be held at the end of the

study, allowing participants to enter to win one of four- $25 Walmart gift cards. If you would like to participate, please provide your email on the list provided in the front of the class room. Participants who choose to provide a contact email, may enter their e-mail from which drawing winners will be contacted. Gift card recipients will be contacted by June 2018. Participation in the drawing is subject to completion of the survey.

The decision to participate in this study is completely up to you. You will not be treated any differently if you decide not to be in this study. If you decide to be in the study, you have the right to withdraw from the study at any time. UNC Charlotte wants to make sure that all research participants are treated in a fair and respectful manner. Contact the university's Office of Research Compliance at (704)-687-1871 if you have questions about your rights as a study participant. If you have any questions about the purpose, procedures, and outcome of this project, contact Dr. Hank Harris, hharris2@uncc.edu.

By proceeding and completing the attached surveys, you are agreeing to consent in this study. Please proceed if you agree to the following: I have read the information in this consent form. I have had the chance to ask questions about this study, and those questions have been answered to my satisfaction. I am at least 18 years of age, and I agree to participate in this research project. I understand that by completing the questionnaires I am consenting to research participation. I understand that I may keep this document for my records.

APPENDIX C:
TEIQUE-SF APPROVAL

Petrides, Konstantinos <k.petrides@ucl.ac.uk> 11/22/17

to me

Dear Erica,

Thank you for your email and kind words. You do not need special permission to use any TEIQue form in your research. Please see our FAQ at http://www.psychometriclab.com/Home/Default/18

You can download the various TEIQue forms from the same website (see menu on the left), which also incorporates an automated on-line scoring system for the TEIQue and TEIQue-SF. For scoring information, please check http://www.psychometriclab.com/Home/Default/15

I hope this helps,

Dino

K V Petrides
www.psychometriclab.com

From: Erica Merrill [mailto:emerril5@uncc.edu]
Sent: Wednesday, November 22, 2017 16:21
To: Petrides, Konstantinos <k.petrides@ucl.ac.uk>
Subject: Fwd: Permission to use and modify the TEIQue-SF

Dear Dr. Petrides-

Hello, my name is Erica Merrill. I am a doctoral candidate at the University of North Carolina at Charlotte in the counselor education and supervision program. My dissertation will be examining the directional relationships between counselors-in-training on their levels of trait emotional intelligence, perceptions of wellness, perception of stress, and wellness behaviors. I am writing to you to ask for your permission to use your TEIQue- SF instrument as part of my measure of trait emotional intelligence. I am hoping to administer the survey face-to-face.

I also wanted to tell you that I found the information *on www.psychometriclab.com* to be extraordinarily helpful. I really appreciate the work you've done.

Thank you for your time and help!

Best,

Erica Merrill, MA Ed.
Doctoral Candidate
Counselor Education and Supervision
Graduate Research Assistant
Center for Educational Measurement and Evaluation
University of North Carolina Charlotte | College of Education
Office 283 | 9201 University City BLVD Charlotte NC 28223
Phone 419-283-9274

APPENDIX D:
EMAIL CORRESPONDENCE WITH PWS AUTHOR

Troy Adams <drtroyadams@gmail.com> 11/22/17

to me

wonderful. best wishes to you.
cheers

Troy

On Nov 22, 2017, at 9:36 AM, Erica Merrill <emerril5@uncc.edu> wrote:

Dear Dr. Adams-

Hello, my name is Erica Merrill. I am a doctoral candidate at the University of North Carolina at Charlotte in the counselor education and supervision program. My dissertation will be examining the directional relationships between counselors-in-training on their levels of trait emotional intelligence, perceptions of wellness, perception of stress, and wellness behaviors. I am writing to you to ask for your permission to use your PWS instrument as part of my measure of perceptions. I am hoping to administer the survey face-to-face.

I also wanted to tell you that I found the information *on www.perceivedwellness.com* to be extraordinarily helpful. I really appreciate the work you've done.

Thank you for your time and help!

Best,

Erica Merrill, MA Ed.
Doctoral Candidate
Counselor Education and Supervision
Graduate Research Assistant
Center for Educational Measurement and Evaluation
University of North Carolina Charlotte | College of Education
Office 283 | 9201 University City BLVD Charlotte NC 28223
Phone 419-283-9274

APPENDIX E:
EMAIL CORRESPONDENCE WITH PSS AUTHOR

Permission to use the PSS

Erica Merrill <emerril5@uncc.edu> 11/22/17

to scohen

Dear Dr. Cohen-

Hello, my name is Erica Merrill. I am a doctoral candidate at the University of North Carolina at Charlotte in the counselor education and supervision program. My dissertation will be examining the directional relationships between counselors-in-training on their levels of trait emotional intelligence, perceptions of wellness, perception of stress, and wellness behaviors. I am writing to you to ask for your permission to use your PSS instrument as part of my measure of perceptions. I am hoping to administer the survey face-to-face.

I also wanted to tell you that I found the information *on www.mindgarden.com* to be extraordinarily helpful. I really appreciate the work you've done.

Thank you for your time and help!

Best,

Erica Merrill, MA Ed.
Doctoral Candidate
Counselor Education and Supervision
Graduate Research Assistant
Center for Educational Measurement and Evaluation
University of North Carolina Charlotte | College of Education
Office 283 | 9201 University City BLVD Charlotte NC 28223
Phone 419-283-9274

APPENDIX F:

EMAIL CORRESPONDENCE WITH BMS-WBCI AUTHOR

OPE, HOLLY <HPOPE@mailbox.sc.edu> 11/22/17

to me

Hi Erica,

I am no longer in touch with the authors Dr. Willie Hey and Kristine Calderon. I tried to locate their contact information, but have not be successful. I played a very minor role in the paper, conducting the literature review and writing it for the article. Drs. Hey and Calderon were involved (particularly Dr. Hey from what I recall) in the work that led to the validity of the measures.

I wish I could be more helpful to you in locating the lead authors.

Sincerely,

Holly C. Pope (maiden name Carroll in the article :)

From: Erica Merrill [mailto:emerril5@uncc.edu]
Sent: Wednesday, November 22, 2017 11:48 AM
To: POPE, HOLLY <HPOPE@mailbox.sc.edu>
Subject: Permission to use and modify BMS-WBCI

Dear Dr. Pope-

Hello, my name is Erica Merrill. I am a doctoral candidate at the University of North Carolina at Charlotte in the counselor education and supervision program. My dissertation will be examining the directional relationships between counselors-in-training on their levels of trait emotional intelligence, perceptions of wellness, perception of stress, and wellness behaviors. I am writing to you to ask for help to find the authors of the BMS-WBCI to ask their permission to use the instrument as part of my measure of wellness behaviors. I am hoping to administer the survey face-to-face.

I really appreciate the work you've done. I hope to connect with your and learn more about your work that led to the establishment of the survey.

Thank you for your time and help!

Best,

Erica Merrill, MA Ed.
Doctoral Candidate
Counselor Education and Supervision
Graduate Research Assistant
Center for Educational Measurement and Evaluation
University of North Carolina Charlotte | College of Education
Office 283 | 9201 University City BLVD Charlotte NC 28223
Phone 419-283-9274

APPENDIX G:

TRAIT EMOTIONAL INTELLIGENCE QUESTIONNAIRE-SF

TEIQue-SF

Instructions: Please answer each statement below by putting a circle around the number that best reflects your degree of agreement or disagreement with that statement. Do not think too long about the exact meaning of the statements. Work quickly and try to answer as accurately as possible. There are no right or wrong answers. There are seven possible responses to each statement ranging from 'Completely Disagree' (number 1) to 'Completely Agree' (number 7).

1 . . . . . 2 . . . . . 3 . . . . . 4 . . . . . 5 . . . . . 6 7
Completely Completely
Disagree
Agree

1. Expressing my emotions with words is not a problem for me.	1	2	3	4	5	6	7
2. I often find it difficult to see things from another person's	1	2	3	4	5	6	7

viewpoint.							
3. On the whole, I'm a highly motivated person.	1	2	3	4	5	6	7
4. I usually find it difficult to regulate my emotions.	1	2	3	4	5	6	7
5. I generally don't find life enjoyable.	1	2	3	4	5	6	7
6. I can deal effectively with people.	1	2	3	4	5	6	7
7. I tend to change my mind frequently.	1	2	3	4	5	6	7
8. Many times, I can't figure out what emotion I'm feeling.	1	2	3	4	5	6	7
9. I feel that I have a number of good qualities.	1	2	3	4	5	6	7
10. I often find it difficult to stand up for my rights.	1	2	3	4	5	6	7
11. I'm usually able to influence the way other people feel.	1	2	3	4	5	6	7
12. On the whole, I have a gloomy perspective on most things.	1	2	3	4	5	6	7
13. Those close to me often complain that I don't treat them right.	1	2	3	4	5	6	7
14. I often find it difficult to adjust my life according to the circumstances.	1	2	3	4	5	6	7
15. On the whole, I'm able to deal with stress.	1	2	3	4	5	6	7
16. I often find it difficult to show my affection to those close to me.	1	2	3	4	5	6	7
17. I'm normally able to "get into someone's shoes" and experience their emotions.	1	2	3	4	5	6	7
18. I normally find it difficult to keep myself motivated.	1	2	3	4	5	6	7
19. I'm usually able to find ways to control my emotions when I want to.	1	2	3	4	5	6	7
20. On the whole, I'm pleased with my life.	1	2	3	4	5	6	7
21. I would describe myself as a good negotiator.	1	2	3	4	5	6	7
22. I tend to get involved in things I later wish I could get out of.	1	2	3	4	5	6	7
23. I often pause and think about my feelings.	1	2	3	4	5	6	7
24. I believe I'm full of personal strengths.	1	2	3	4	5	6	7
25. I tend to "back down" even if I know I'm right.	1	2	3	4	5	6	7
26. I don't seem to have any power at all over other people's feelings.	1	2	3	4	5	6	7
27. I generally believe that things will work out fine in my life.	1	2	3	4	5	6	7
28. I find it difficult to bond well even with those close to me.	1	2	3	4	5	6	7
29. Generally, I'm able to adapt to new environments.	1	2	3	4	5	6	7
30. Others admire me for being relaxed.	1	2	3	4	5	6	7

APPENDIX H:

Perceived Wellness Survey

The following statements are designed to provide information about your wellness perceptions. Please carefully and thoughtfully consider each statement, then select the <u>one</u> response option with which you <u>most</u> agree.

		Very Strongly Disagree					Very Strongly Agree
1.	I am always optimistic about my future.	1	2	3	4	5	6
2.	There have been times when I felt inferior to most of the people I knew.	1	2	3	4	5	6
3.	Members of my family come to me for support.	1	2	3	4	5	6
4.	My physical health has restricted me in the past.	1	2	3	4	5	6
5.	I believe there is a real purpose for my life.	1	2	3	4	5	6
6.	I will always seek out activities that challenge me to think and reason.	1	2	3	4	5	6
7.	I rarely count on good things happening to me.	1	2	3	4	5	6
8.	In general, I feel confident about my abilities.	1	2	3	4	5	6
9.	Sometimes I wonder if my family will really be there for me when I am in need.	1	2	3	4	5	6
10.	My body seems to resist physical illness very well.	1	2	3	4	5	6
11.	Life does not hold much future promise for me.	1	2	3	4	5	6
12.	I avoid activities which require me to concentrate.	1	2	3	4	5	6
13.	I always look on the bright side of things.	1	2	3	4	5	6
14.	I sometimes think I am a worthless individual.	1	2	3	4	5	6
15.	My friends know they can always confide in me and ask me for advice.	1	2	3	4	5	6
16.	My physical health is excellent.	1	2	3	4	5	6
17.	Sometimes I don't understand what life is all about.	1	2	3	4	5	6
18.	Generally, I feel pleased with the amount of intellectual stimulation I receive in my daily life.	1	2	3	4	5	6
19.	In the past, I have expected the best.	1	2	3	4	5	6
20.	I am uncertain about my ability to do things well in the future.	1	2	3	4	5	6
21.	My family has been available to support me in the past.	1	2	3	4	5	6
22.	Compared to people I know, my past physical health has been excellent.	1	2	3	4	5	6
23.	I feel a sense of mission about my future.	1	2	3	4	5	6
24.	The amount of information that I process in a typical day is just about right for me (i.e., not too much and not too little).	1	2	3	4	5	6
25.	In the past, I hardly ever expected things to go my way.	1	2	3	4	5	6
26.	I will always be secure with who I am.	1	2	3	4	5	6
27.	In the past, I have not always had friends with whom I could share my joys and sorrows.	1	2	3	4	5	6
28.	I expect to always be physically healthy.	1	2	3	4	5	6
29.	I have felt in the past that my life was meaningless.	1	2	3	4	5	6
30.	In the past, I have generally found intellectual challenges to be vital to my overall well-being.	1	2	3	4	5	6
31.	Things will not work out the way I want them to in the future.	1	2	3	4	5	6
32.	In the past, I have felt sure of myself among strangers.	1	2	3	4	5	6
33.	My friends will be there for me when I need help.	1	2	3	4	5	6
34.	I expect my physical health to get worse.	1	2	3	4	5	6
35.	It seems that my life has always had purpose.	1	2	3	4	5	6
36.	My life has often seemed void of positive mental stimulation.	1	2	3	4	5	6

APPENDIX I:

PERCEIVED STRESS SCALE

The questions in this scale ask you about your feelings and thoughts during the last month**. In each case, you will be asked to indicate by circling *how often* you felt or thought a certain way.**

Name _____

Date_____ Age _____ Gender (*Circle*): **M F** Other

_____

0 = Never 1 = Almost Never 2 = Sometimes 3 = Fairly Often 4 = Very Often 1. In the last month, how often have you been upset because of something that happened unexpectedly?	0	1	2	3	4
2. In the last month, how often have you felt that you were unable to control the important things in your life?	0	1	2	3	4
3. In the last month, how often have you felt nervous and "stressed"?	0	1	2	3	4
4. In the last month, how often have you felt confident about your ability to handle your personal problems?	0	1	2	3	4
5. In the last month, how often have you felt that things were going your way?	0	1	2	3	4
6. In the last month, how often have you found that you could not cope with all the things that you had to do?	0	1	2	3	4
7. In the last month, how often have you been able to control irritations in your life?	0	1	2	3	4
8. In the last month, how often have you felt that you were on top of things?	0	1	2	3	4
9. In the last month, how often have you been angered because of things that were outside of your control?	0	1	2	3	4
10. In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?	0	1	2	3	4

APPENDIX J:

Body-Mind-Spirit Wellness Behavior and Characteristic Inventory (BMS-WBCI)

Instructions: Participants should complete the BMS-WBCI by circling the number in the box next to the statement that describes the frequency they participate in positive health behaviors and agreement with characteristics that contribute to their overall well-being in the areas of body, mind, and spirit. Participants should circle only one number per statement. The number choices correspond to the following responses. The 1 represents the frequency choice of rarely/seldom, the 2 represents the frequency choice of occasionally/sometimes, and the 3 represents the frequency choice of often/always.

1. Rarely/seldom 2. Occasionally/sometimes 3. Often/always

Body

1. I limit risky behaviors (i.e., drive fast, bungee jumping, parachute, etc.). 1 2 3

2. I maintain my fitness by exercising regularly and maintaining my weight. 1 2 3
3. I have a reasonable amount of flexibility and do exercises that help maintain my range of motion. 1 2 3
4. I use warm-up activities before exercising to help prevent injuries. 1 2 3
5. I eat a variety of foods and get the recommended number of servings from each food group. 1 2 3
6. I eat a balanced diet low in saturated fat and cholesterol. 1 2 3
7. I participate in recreational sports or activities that help maintain my fitness. 1 2 3
8. I drink at least eight glasses of water a day. 1 2 3
9. I surround myself with physically healthy people. 1 2 3

Mind

10. I learn from my past life experiences. 1 2 3
11. I am open to new ideas. 1 2 3
12. I learn from my mistakes and try to behave differently the next time. 1 2 3
13. I talk with people rather than talk at people. 1 2 3
14. I accept responsibility for my actions. 1 2 3
15. I understand and accept the existence of cultural diversity and its contribution to the

quality of living. 1 2 3
16. I make good ethical decisions. 1 2 3
17. I consider alternatives before making decisions. 1 2 3
18. I focus on reality. 1 2 3
19. I am flexible to changes and can maintain stability in my life in healthy ways. 1 2 3
20. I have strong morals and healthy values. 1 2 3
21. I learn from the mistakes of others. 1 2 3
22. I have satisfying interpersonal relationships. 1 2 3
23. I feel loved and supported by family and friends. 1 2 3
24. I am tolerant of others whether or not I approve of their behavior or beliefs. 1 2 3
25. I set achievable goals for myself. 1 2 3
26. I handle various social settings well. 1 2 3
27. I analyze my thoughts (I think, question, and evaluate) before I act. 1 2 3
28. I make the best of bad situations. 1 2 3
29. I express my feelings with others and consider their feelings. 1 2 3
Spirit
30. I experience harmony within. 1 2 3
31. I experience peace of mind. 1 2 3
32. I am in touch with the soul within. 1 2 3
33. I experience happiness within. 1 2 3
34. I experience joy within. 1 2 3
35. I experience self-satisfaction. 1 2 3
36. I express my spirituality appropriately and in healthy ways. 1 2 3
37. My spirituality helps me remain calm and strong and helps me to better deal with difficult times. 1 2 3
38. I recognize the positive contribution faith can make to the quality of my life. 1 2 3
39. I routinely undertake new experiences to enhance my spiritual health. 1 2 3
40. I have a positive outlook on life. 1 2 3
41. I am content with who I am. 1 2 3
42. I know my purpose in life. 1 2 3
43. I read some form of spiritual literature on a regular basis. 1 2 3
44. I experience love of others and myself. 1 2 3

APPENDIX K: DEMOGRAPHICS

Education Questionnaire

Master's degree:

- ◯ Mental Health Counseling/Community Counseling
- ◯ School Counseling
- ◯ Addiction/Substance Abuse Counseling

◯ Pastoral Counseling

◯ Psychology

◯ Other:

Have you completed your Practicum experience?

Yes

No

Currently taking the class

How many credit hours have you competed in the program?

Demographic Questionnaire

Age

Gender

◯ Female

◯ Male

◯ Other

Race

Ethnicity

APPENDIX L: RECRUITMENT EMAIL, FACULTY

UNC CHARLOTTE

Department of Counseling
9201 University City Boulevard, Charlotte, NC 28223-0001

704-687-8962 (office) | 704-687-1636 (Fax)

Faculty Recruitment Letter
Wellness Among Counselors in Training: Examining the Relationship between Trait Emotional Intelligence, Perceptions of Stress and Wellness, and Wellness Behaviors

You are being asked to administer this research study in your master's level counseling classes. Whether you take part is completely up to you. An incentive will be offered for each class you agree to administer the study or allow the researcher to administer. The purpose of this research study is to better understand how emotional intelligence may influence the perceptions of stress, wellness, and wellness behaviors of counselors-in-training. Should you decide to participate, please review the enclosed surveys to see what assessments will be administered.

My name is Erica Merrill and I am a practicing mental health counselor and doctoral candidate at the University of North Carolina, Charlotte. Dr. Hank Harris, a UNC Charlotte Professor in the Department of Counseling and Dr. Daniel Gutierrez at the College of William and Mary will be supervising this research project. You have been contacted about this study because you have been identified as someone participates in training mental health, school or addictions counselors. Access to your classrooms would greatly assist this research.

Eligibility for this study requires that participants be individuals, of the minimum age of 18 years, who report being in a CACREP Masters level counseling program. If your students do not meet these criteria, their interest is appreciated, but their participation is not recommended. Exclusion criteria include individuals who are not training to be professional counselors. If you wish to participate, your students will be asked to complete a set of questionnaires asking questions related to their perceptions of stress, wellness, emotional intelligence, and coping behaviors. In all, the assessments should not take more than 25-30 minutes to complete. Upon completion of the survey, participants of this study are offered an opportunity to take part in a drawing a $15 Walmart gift card, which will be drawn immediately after the survey is completed and handed in. Another drawing will be held at the end of the study, allowing participants to enter to win one of four- $25 Walmart gift cards.

As faculty, if you would like to participate, you will be offered a chance to win one of five- $40 Amazon gift cards. Please provide your contact information to the researcher and how many classes with the number of students in each class. You will be entered once for each class that you allow to participate. Gift card recipients will be contacted by June 2018. Thank you for your consideration.

UNC Charlotte wants to make sure that all research participants are treated in a fair and respectful manner. Contact the university's Office of Research Compliance at (704)-687-1871 if you have questions about participant rights. If you have any questions about the purpose, procedures, and outcome of this project, contact myself, Erica Merrill at emerril5@uncc.edu or Dr. Hank Harris, hharris2@uncc.edu.

APPENDIX M: NOTICE OF MODIFICATION APPROVAL

OFFICE OF RESEARCH COMPLIANCE
9201 University City Boulevard
319 Cameron Hall
Charlotte NC 28223-0001
(704)-687-1871
Web site: http://research.uncc.edu/
Federalwide Assurance (FWA) #00000649

To: Erica Merrill
Counseling

From: Office of Research Compliance

Date: 2/20/2018
RE: Notice of Modification Approval (Exempt)
Exemption Category: 2.Survey, interview, public observation
Study #: 17-0492

Study Title: WELLNESS AMONG COUNSELORS IN TRAINING: EXAMINING THE RELATIONSHIP BETWEEN TRAIT EMOTIONAL INTELLIGENCE, PERCEPTIONS OF STRESS, PERCEPTIONS OF WELLNESS, AND WELLNESS BEHAVIORS

This modification submission has been reviewed and approved by the Office of Research Compliance.

Submission Description:

I will make the following two changes:

1. I have created on online survey to administer to online classes. Online participants will be offered the opportunity to participate in the both the $15 per class drawing and the $25 gift card drawing held at the end of the study. Before sending faculty the survey link, I will make sure I know the total students it will be provided to, so that I know the response rates. Faculty will be asked to administer the link during class time, in the same manner they were asked to provide class time for the pen and paper survey.

2. The $15 gift card drawings are no longer limited to the first 20 classes. Funds have been extended up to an additional $500, sponsored by the Center for Educational Measurement and Evaluation at UNCC. Instead of completing two separate forms, online survey participants will be given a chance to enter into the $15 & $25 drawings electronically by providing their emails at the end of the survey. All identifying information will be saved separately from survey responses. The PI will confirm timing of completed surveys and randomly choose a winner from each participating classroom. $15 gift card will be electronically provided to winners.

Investigator's Responsibilities:

1. It is the investigator's responsibility to promptly inform the committee of any changes in the proposed research, and of any adverse events or unanticipated risks to participants or others.
2. You are required to obtain Office of Research Compliance and/or IRB approval for any changes to any aspect of this study before they can be implemented.
3. Data security procedures must follow procedures as approved in the protocol and in accordance with ITS Guidelines for Data Handling.

Your approved consent forms (if applicable) and other documents are available online at http://uncc.myresearchonline.org/irb/index.cfm?event=home.dashboard.irbStudyManagement&irb_id=17-0492.

CC:
Daniel Gutierrez, Counseling
Henry Harris, Counseling