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Organizational Culture as a Predictor of Counselors' Wellness

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2020

Abstract

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by

Ashley N. Davis

MEd, Lincoln Memorial University, 2016

BS, University of Tennessee, 2013

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Counselor Education and Supervision

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Abstract

The foci of existing literature related to counselor wellness are on counselors as individuals, and researchers have failed to consider counselors as part of a larger system. Researchers have found that demanding work environments are more likely to lead to compassion fatigue and burnout for counselors which pose threats to the well-being of clients. The organizational culture also affects counselor self-efficacy, which influences the emotional state of the counselors. Limited research exists on institutional-level factors, such as the organizational culture, in counselor wellness which demonstrates the importance of this study. The purpose of this quantitative nonexperimental survey study was to explore the variable of organizational culture as a predictor of counselors' level of wellness. This study examined organizational culture as a predictor for counselors' wellness while controlling for counselor self-efficacy. The indivisible self model of wellness and organizational social context provided the framework for this study. Survey data from 70 counselors were analyzed using descriptive statistics and hierarchical linear regression. Findings indicated that organizational culture was not a significant predictor of counselor wellness. Counselor self-efficacy accounted for a significant amount of variance in counselors' wellness. These findings support the premise of the indivisible self model of wellness and suggest that individual-level factors have a larger impact on counselors' wellness compared to institutional-level factors. Findings can lead to improvements in counselor wellness through individual self-care practices and an increased emphasis on self-care by counselor educators and supervisors.

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Dedication

I would like to dedicate this dissertation to my husband, Tom. At times, this process was as hard on you as it was on me. I would not have been able to get this far without you.

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Chapter 1: Introduction to the Study

Counselor wellness has been a prevalent topic in scholarly literature. Topics have included recommendations for counselor self-care, wellness in counselor training programs, and wellness in school counselors (Cummins et al., 2007; Venart et al., 2007; Yager & Tovar-Blank, 2007). However, there is limited literature on counselor wellness in organizations. In this study, I explored organizational factors that influence counselor wellness. This study provides implications for improvements in organizational culture that can improve counselor wellness.

An important consideration for the study is the onset of a global health crisis, COVID-19, which occurred during the development of this study. COVID-19 was declared an epidemic by the World Health Organization. As of April 5th, 2020, there were over 1,000,000 confirmed cases and over 62,000 deaths from COVID-19 globally (World Health Organization, 2020). This pandemic has changed the physical work environment for many counselors. It has also been linked to increases in depression, anxiety, and stress among individuals in China where the first outbreak occurred (Rajkumar, 2020).

In Chapter 1, I provide the background that demonstrates the importance of the study and the theoretical and conceptual framework that serves as the foundation for the study. I describe the identified problem, the purpose of the study, and the research question. I define key terms and present the research design. Finally, I describe the assumptions, delimitations, and limitations to this study.

Background

Research has shown associations between work-related factors, counselor wellness, and client services. Work-related factors of low conflict, low emotional exhaustion, cooperation, role clarity, job satisfaction, and personalization were associated with improved client outcomes (Falkenstrom et al., 2018). Bickell et al. (2017) also found that organizational culture affected client outcomes. Additionally, turnover rates and absences from work were associated with work-related fatigue in counselors (Williams & Beidas, 2018). These organizational factors affect counselor wellness which, in turn, affects client outcomes. Myers et al. (2000) found that feelings of competency in employment contributed to overall wellness. Bandura (1977) described this perceived competency as self-efficacy. According to Bandura (1993), stress from the organizational culture mediates self-efficacy levels. For example, counselors with lower counseling self-efficacy may struggle to cope with the stress of the organizational culture. Bandura (1993) reported that this occurs because of an individual's belief that they are unable to cope with stress. Conversely, Bandura's (1993) concept of self-efficacy indicates that counselors with high counseling self-efficacy may cope better with a stressful organizational culture.

The ability to cope with stressful situations also contributes to overall wellness (Myers et al., 2000). Schunk and Pajares (2010) also confirmed the association between wellness and self-efficacy for individuals. They reported that self-efficacy provides that foundation for well-being (Schunk & Pajares, 2010). Individuals with low self-efficacy

will not engage in practices to maintain their well-being (Schunk & Pajares, 2010). Research has indicated a bidirectional relationship between self-efficacy and wellness. Just as self-efficacy influences the level of functioning (Bandura, 1993), physical and emotional well-being can influence self-efficacy (Schunk & Pajares, 2010).

Additionally, factors that have influenced self-efficacy in counselors include their emotional state, work stress, the supervisory working alliance, job demands, and burnout (Chui et al., 2016; Enlow et al., 2019; Marmarosh et al., 2013; Morrison & Lent, 2018; O'Sullivan & Bates, 2014; Schunk & Pajares, 2010). These factors are influenced by the organizational culture and organizational climate (Glisson, 2007). Self-efficacy may influence and be influenced by wellness and the organizational social context (OSC). Counselor self-efficacy may explain some variation in the relationship between organizational culture and counselor wellness. Therefore, to determine whether organizational culture predicts levels of wellness in counselors, I controlled for counselor self-efficacy.

Problem Statement

Counselor self-care has been a prevalent topic in academic literature. Researchers have examined counselor self-care for counselors working in various populations and settings including rural Christian counselors (White, 2014), counselors who work with children with cystic fibrosis (Storlie & Baltrinic, 2015), and counselors who work with individuals struggling with trauma and addiction (Burke et al., 2006). Other researchers have focused on self-care to prevent burnout (Bradley et al., 2013; Coaston, 2017).

Additionally, many researchers have described steps that counselors can take to practice effective self-care. These strategies included relaxation, balanced exercise and nutrition, adequate rest, cognitive restructuring, spiritual practices (Storlie & Baltrinic, 2015), talking with colleagues, social activities with friends and families, listening to music, and walking in nature (Burke et al., 2006). The foci of these existing studies were on counselors as individuals; however, these studies failed to consider counselors within the context of a larger system.

The OSC describes the context of this larger system and how it affects wellness. The OSC is comprised of the organizational culture and organizational climate (Glisson, 2007). Glisson (2007) defined organizational culture as the way things are done in the organization. The organizational climate describes the employees' perceptions of the impact of their work on their own well-being (Glisson, 2007). Demanding work environments were more likely to lead to compassion fatigue and burnout for counselors (Kim et al., 2018; Westwood et al., 2017). Organizational factors that contributed to counselor burnout included working with high-risk clients, higher caseloads, agency culture, and lack of resources (Lawson & Myers, 2011; Ohrt & Cunningham, 2012).

Compassion fatigue, burnout, and the OSC also posed threats to the well-being of clients. Compassion fatigue decreased counselors' ability to be empathetic towards clients (Beaumont et al., 2016; Sinclair et al., 2017) and burnout led to self-destructive and risk-taking behaviors that impeded clients' safety (Hall et al., 2016; Sinclair et al., 2017). Compassion fatigue and burnout led to impairment, which poses a threat to the

well-being of clients (Lawson & Venart, 2005). Additionally, the OSC affected the quality of services and client outcomes in child welfare organizations (Falkenstrom et al., 2018). Poorer OSC also increased clinician turnover, which led to a decrease in engagement in services (Babbar et al., 2018; Williams & Beidas, 2018).

Kozina et al. (2019) defined counselor self-efficacy as "the beliefs and attitudes embodied by the helping professional or trainees that impact their capacity for the effective delivery of counseling or psychotherapy services" (p. 118). Counselor self-efficacy was also associated with OSC and counselor wellness. The OSC was found to affect counselor self-efficacy (Enlow et al., 2019; Marmarosh et al., 2013; Morrison & Lent, 2018; O'Sullivan & Bates, 2014; Schunk & Pajares, 2010). Counselors' self-efficacy in the work environment influenced their emotional state (Chui et al., 2016). Counselors' emotional state and self-efficacy influenced their work with clients (Chui et al., 2016). Myers et al. (2000) also reported that self-efficacy was associated with the level of wellness of an individual.

After a thorough literature review, I found limited research on institutional-level factors, such as the organizational culture, on counselor wellness (Lawson & Myers, 2011; Lent & Schwartz, 2012). Several researchers have examined the impact of organizational culture and climate on client outcomes (Bickell et al., 2017; Falkenstron et al., 2018; Jordan et al., 2009). However, researchers have not explored the connection of organizational culture with counselor wellness.

Purpose of the Study

The purpose of this quantitative nonexperimental survey study was to explore the variable of organizational culture as a predictor of counselors' level of wellness while controlling for counselor self-efficacy. Existing studies only examine counselor wellness, burnout, and the effect of counselor wellness on client outcomes (Bickell et al., 2017; Bradley et al., 2013; Coaston, 2017; Falkenstron et al., 2018; Jordan et al., 2009; Storlie & Baltrinic, 2015). The connection between organizational factors and counselor wellness is a missing piece in research literature. Additionally, this study occurred in the context of a global health crisis.

Research Question and Hypotheses

RQ: Does organizational culture as measured by the Work Environment Scale (WES) predict counselor wellness (DV) as measured by the Five-Factor Wellness Inventory (FFWEL) while controlling for counselor self-efficacy as measured by the Counselor Self-Estimate Inventory (COSE)?

$H_0$1: Organizational culture as measured by the WES does not predict counselor wellness (DV) as measured by the FFWEL while controlling for counselor self-efficacy as measured by the COSE.

H_a1: Organizational culture as measured by the WES does predict counselor wellness (DV) as measured by the FFWEL while controlling for counselor self-efficacy as measured by the COSE.

Framework

In this section, I provide an overview of the theoretical and conceptual frameworks that I used in this study. The theoretical framework was the indivisible self model of wellness (Myers & Sweeney, 2004) and the conceptual framework was the OSC (Glisson, 2007). I discuss the indivisible self model and OSC in more detail in Chapter 2.

Theoretical Framework

The theoretical framework for this study was the indivisible self model of wellness as developed by Myers and Sweeney (2004). The indivisible self model of wellness is a holistic approach to overall well-being because it considers the whole person. Myers et al. (2000) defined wellness as optimal well-being through the integration of body, mind, and spirit. The indivisible self model is the only wellness theory in the field of counseling that has been empirically researched (Myers & Sweeney, 2004; Myers et al., 2000; Roscoe, 2009; Witmer & Sweeney, 1992). This model posits that there are interconnected factors that influence an individual's level of wellness (Myers et al., 2000). The application of this theory in the present study supports the hypothesis that internal (self-efficacy) and external (OSC) factors are associated with counselors' level of wellness.

Conceptual Framework

The conceptual framework was based on Glisson's (2007) OSC model. The OSC provided a comprehensive view of factors influencing the workplace and includes constructs of the organizational culture and organizational climate (Glisson, 2007;

Glisson & Green, 2011; Glisson, Landsverk et al., 2008; Hemmelgarn et al., 2006). Glisson defined the organizational culture as the norms and values of the organization. The culture determines how things are done within the organization (Glisson, 2007). The organizational climate is the employees' shared perception of the work environment (Glisson, 2007). Glisson reported that the terms organizational culture and organizational climate were used interchangeably in much of the academic literature. However, the OSC framework provided operational definitions for the variables of organizational culture and organizational climate in this study. The OSC framework also differentiated between the two terms and described how these constructs affect employees' well-being and performance (Bickell et al., 2017).

Nature of the Study

The nature of this study was a quantitative nonexperimental survey design. Surveys were appropriate in this design as they examine relationships between variables (Glasow, 2005; Ponto, 2015). Surveys are tools used to collect data about attitudes, behaviors, characteristics, actions, or opinions (Glasow, 2005; Ponto, 2015; Sukamolson, 2007). The variables of counselor self-efficacy, organizational culture, and counselor wellness align with survey research. In this study, I explored the variable of organizational culture as a predictor of counselors' level of wellness while controlling for counselor self-efficacy.

I used existing questionnaires that were administered electronically to gather data on the variables of interest. Web-based surveys can reach many participants and provide

the ease of clicking a link to complete the survey (Ball, 2019). Web-based surveys are an easy and cost-effective way to gather data (Buchanan & Hvizdak, 2009).

This study was completed during a worldwide health crisis, namely COVID-19. This crisis may have influenced the variables in this study. Although COVID-19 may be a confounding variable, there was no statistical method to measure the impact that COVID-19 may have had on the variables in the present study.

Definitions

In this section, I provide definitions of the variables and terms used in the present study.

Organizational culture: Glisson, Landsverk, et al. (2008) defined the organizational culture as the norms and expectations of the work environment. This included aspects of discretion or flexibility (autonomy), how employees approach the work (work pressure and task orientation), bureaucratic rules and regulations (managerial control), and innovation (Glisson, 2007).

Counselor wellness: Counselor wellness is the optimal health and well-being of counselors in which "body, mind, and spirit are integrated to live more fully" (Myers et al., 2000, p.252).

Counselor self-efficacy: Counselor self-efficacy is the counselor's belief in their ability to be an effective counselor.

Mental health counselor: Mental health counselors are professionals whose focus is clinical mental health. This excludes mental health professionals from other disciplines (marriage and family therapy, psychology, and social work).

Full-time employment: Employees who work 25 hours or more per week. This excludes counselors who work as independent contractors, sole proprietors, or are incorporated.

Accredited graduate program: Graduate counseling programs that are accredited by the Council for Accreditation of Counseling and Related Programs (CACREP).

Assumptions

Assumptions in this study included participant truthfulness and representativeness. I assumed that all participants in the study would meet inclusionary criteria for the sample and would respond truthfully to survey questions. Participants may have responded to survey questions in a favorable manner defined as social desirability bias (Kreuter et al., 2008), thus decreasing the validity of the results. I reduced the incidence of social desirability bias by using electronic surveys and ensuring the anonymity of participants (Kreuter et al., 2008).

I also assumed that I would gather a representative sample of participants. I recruited participants through national social media groups and a national listserv for counselor educators. Additionally, I collected demographic data to determine the representativeness of the sample. A representative sample increases the generalizability of the results.

Scope and Delimitations

The scope of this study was limited to the influence of the organizational culture on counselor wellness while controlling for self-efficacy. I did not control for other factors such as life stressors on the counselor, personality factors, or participation in supervision. The decision to include the variable of organizational culture was based on Glisson's (2007) concept of OSC. I was unable to control for the possible effects of COVID-19. Additionally, the effects of COVID-19 would fall under the institutional and global contexts, according to the indivisible self model (Myers & Sweeney, 2008). Many counselors experienced work-related changes such as working from home, providing telehealth counseling, and social distancing in the workplace. These work-related changes are part of the institutional context. Additional effects of COVID-19 that are part of the global context are outside the scope of this study. The focus of this study was only on the institutional context; specifically, the focus was on the organizational culture and not on other work-related changes (see Myers & Sweeney, 2008).

One delimitation of the study was the population. Inclusionary criteria for participants included (a) mental health counselors, (b) full-time employees at an agency or organization, (c) graduate degree from a program accredited by the CACREP, (d) practicing in the United States, and (e) employed at their agency or organization for a minimum of 1 year. Participants whose work status was part-time, independent contractor, or sole proprietor were excluded from the study. Participants from other disciplines such as psychology, social work, and marriage and family therapy were

excluded from participation in the study. The results of this study are generalizable to counselors working full-time for an agency or organization within the United States.

Limitations

This study focused on predictors of organizational culture while controlling for counselor self-efficacy. I did not gather information on counselors working in private practice who are sole proprietors or independent contractors which limits the generalizability of the findings to these settings. Some challenges in this study included participant recruitment, the length of the surveys, and the current global health crisis. A limitation was the inability to generalize findings to other mental health professions. I recruited through social media and a national listserv for counselor educators. I joined various mental health-related social media and social networking groups and received permission to solicit participants from group administrators. However, counselors who were not active on these social media platforms or were not members of the listserv did not have the ability to participate in this study.

In this study, I administered three surveys (which were combined into one) with 177 questions total. The approximate time to complete these measures was 35 minutes. Because of the length of these surveys, some participants may have dropped out before completing the measures. This study was limited to counselors. The exclusion of other mental health providers such as psychologists, marriage and family therapists, and social workers from this study limited the generalizability of the results to these other mental health professions.

Finally, I did not have the ability to control for the effects of COVID-19. COVID-19 was correlated with an increase in depression, anxiety, and stress among individuals in China (Rajkumar, 2020). To date, there are no studies examining the effects of COVID-19 on mental health counselors' wellness. However, researchers have explored the occurrence of vicarious trauma in mental health counselors during COVID-19 (Aafjes-van Doorn et al., 2020). Previous researchers have also explored counselors' experiences during national crises and disasters. The researchers reported that counselors had both positive and negative responses (Bauwens & Tosone, 2010; Tedeschi & Calhoun, 2004).

Significance

Researchers have identified the impact of counselor wellness on client outcomes. Numerous studies have examined barriers and facilitators to counselor wellness (Kim et al., 2018; Lawson & Venart, 2005; Nelson et al., 2018; Puterbaugh, 2008). According to the indivisible self model of wellness, the five dimensions (i.e., creative, coping, social, essential, and physical selves) and three contexts (i.e., local, institutional context, global, and chronometrical) of wellness are interconnected (Myers & Sweeney, 2004, 2008). When there is an issue in one dimension, the other four dimensions are affected (Myers & Sweeney, 2008). This highlights the importance of considering all wellness dimensions. A factor of wellness that had not been sufficiently researched was the counselor's workplace culture (Lawson & Myers, 2011; Lent & Schwartz, 2012). Although work was not identified as a primary factor of wellness in the indivisible self model, it was found to be a secondary factor of wellness within the creative self (Hattie et al., 2004).

Additionally, Myers and Sweeney (2004) described the influence of the organizational culture on wellness within the institutional context. This study will contribute to positive social change by examining the variable of organizational culture and how it contributed to counselor wellness. The results of this study could provide implications for optimal workplace practices, reduction in counselor burnout and impairment, and improvements in counselor self-care and wellness, which in turn could enhance client outcomes (Kim et al., 2018; Lawson & Venart, 2005). These improvements could lead to greater client outcomes by decreasing symptoms and improving clients' ability to function in the community (Falkenstrom et al., 2018; Glisson, 2007).

Summary

Counselor wellness is influenced by numerous factors. The present study examined the factor of the organizational culture on counselor wellness. In this chapter, I provided an overview of the present study including the theoretical and conceptual framework, the nature of the study, the research questions, and the design of the study. In Chapter 2, I provide a comprehensive review of the literature related to the study. I begin the chapter by discussing the theoretical and conceptual framework.

Chapter 2: Literature Review

Counselor self-care has been a focus of many studies in academic literature (Bradley et al., 2013; Burke et al., 2006; Coaston, 2017; Storlie & Baltrinic, 2015; White, 2014). The foci of these studies were counselors' personal self-care and wellness. Demanding work environments have been found to be more likely to lead to compassion fatigue and burnout for counselors (Kim et al., 2018; Westwood et al., 2017). Compassion fatigue, burnout, and the counselor's emotional state can lead to impairment and negatively influence their work with clients (Beaumont et al., 2016; Chui et al., 2016; Figley, 2002; Freudenberger, 1974; Hall et al., 2016; Lawson & Venart, 2005). Counselor impairment poses a threat to the well-being of clients (Lawson & Venart, 2005). Additionally, Glisson (2007) found that the organizational culture and organizational climate affected the quality of services and client outcomes in child welfare organizations. Thus far, most studies on these topics have not considered counselors as part of a larger organizational system. Research on counselor self-care and wellness, the effects of the OSC on client welfare, and the limited research of the organizational culture on counselor wellness demonstrate the importance of this study.

The purpose of this quantitative survey study was to examine the influence of organizational culture on counselors' level of wellness. Bandura (1993) reported that mood and stress were mediators for self-efficacy. He stated that those low in self-efficacy may struggle to cope with stressors (Bandura, 1993). Physical and emotional well-being also influence self-efficacy (Schunk & Pajares, 2010). In this study, I analyzed variables

of organizational culture and counselor wellness while controlling for self-efficacy. Exploring these factors was vital as they will improve counselor self-care, organizational practices, and client outcomes.

In this chapter, after discussing the literature search strategy, I provide a description of the theoretical and conceptual frameworks that guided this study. I then review literature related to key concepts in this study including counselor impairment, burnout, organizational factors, self-care, and self-efficacy.

Literature Search Strategy

I started the search for literature by exploring the key variables of the study: *counselor wellness* and *organizational culture*. I used the Walden University Library and Google Scholar. My initial search consisted of peer-reviewed articles from the last 5 years. As I explored articles related to these constructs, I identified additional concepts that were important to my topic. I accessed numerous databases through the Walden University Library, including PsycINFO, ERIC, EBSCOHost, ScienceDirect, Education Source, Gale eBooks, CINAHL Plus with Full Text, PsycARTICLES, Social Sciences Citation Index, Academic Search Complete, Social Work Abstracts, Business Source Complete, Gale Academic OneFile Select, International Security & Counter Terrorism Reference Center, and SocINDEX with Full Text. I searched the following key terms: *wellness theory, wheel of wellness, Indivisible Self, organizational culture, organizational climate, workplace, work environment, community mental health, compassion fatigue, burnout, counselor impairment, counselor self-efficacy, counselor*

self-care, counselor supervision, counselor working alliance, counselor development, organization social context, novice counselor, and *mental health*. Additionally, I searched pairs of keywords: *mental health and organizational culture; novice counselor and wellness; novice counselor and self-efficacy, novice counselor and working alliance; indivisible self and work; burnout and community mental health; workplace and wellness;* and *work environment and wellness*. I also used the following Boolean search terms to find more productive results: *counselors* or *therapists* or *psychotherapists*; *wellness* or *well-being* or *wellbeing*; and *burnout* or *burn-out* or *burn out*. Finally, I searched for seminal work beginning in the 1970s related to *constructs of wellness theory, organizational social context, burnout, compassion fatigue,* and *self-efficacy*.

Theoretical Framework

The theoretical framework for this study was wellness theory. In this section, I discuss the origin and development of wellness theory, describe the major constructs of this theory, and provide the rationale for the use of wellness theory as the theoretical framework for the study.

Origin and Development of Wellness Theory

Witmer and Sweeney (1992) developed the first wellness theory for counselors. They titled their model the wheel of wellness. Myers and Sweeney (2004) later revised this model and called it the indivisible self model. More recently, Reese and Myers (2012) proposed an addition to the indivisible self model termed eco-wellness. This was

the connection between humans and nature, which Myers and Sweeney did not include in the previous wellness model.

Sweeney and Witmer (1991) conceptualized wellness theory through the creation of the five-dimensional wheel of wellness to treat the whole person. Wellness theory provided a holistic lens through which counselors could conceptualize clients' symptoms. Counselors who use this lens analyze lifestyle factors and help clients to improve their quality of life in positive and proactive ways (Witmer & Sweeney, 1992). Myers et al. (2000) defined wellness as "a way of life oriented toward optimal health and well-being in which body, mind, and spirit are integrated by the individual to live more fully" (p. 252). This theory of wellness provided a holistic approach, looking at the whole person. Wellness theory posited that the five dimensions of wellness were interconnected and could affect the emotional well-being of an individual (Myers et al., 2000).

The Five Life Tasks

As noted, Witmer and Sweeney (1992) proposed the first wellness theory in counseling. They stated that all things were interconnected, and major themes related to wholeness are the mind, body, spirit, and community. They described five life tasks of a healthy person that make up a wheel of wholeness (Witmer & Sweeney, 1992). These life tasks were spirituality, self-regulation, work, friendship, and love, which Witmer and Sweeney explained as follows:

- Spirituality included a desire to attain inner peace and a sense of wholeness, having a meaning in life, being optimistic about future events, and using values as a guide for relationships and decision-making.
- Self-regulation included an individual's sense of worth, their sense of control, having realistic beliefs, being spontaneous and emotionally responsive, engaging the brain in intellectual stimulation, problem-solving and creativity, having a sense of humor, being physically active, and having good health habits.
- Work included the things that people do to sustain themselves and others (i.e., employment, childrearing, homemaking, education, etc.) and things that increase their self-esteem, self-efficacy, competence, social benefits, and economic resources.
- Friendship focused on connections with others, social support, and protection against health issues.
- Love included intimate connections with significant others, children, and friends.

Societal Institutions and Global Influences

In addition to the five life tasks, wellness theory posited that life forces and global events influence wellness. These life forces included family, religion, education, community, media, government, and the work environment. Global events were things such as threats of war and terrorism, the hope of new medical discoveries, and

discovering secrets of the universe (Sweeney & Witmer, 1991). These external influences could affect an individual's level of wellness.

Indivisible Self Model

As noted earlier, Myers and Sweeney (2004) later revised the wheel of wellness model to the indivisible self model. This revision was a result of testing the wheel of wellness model which resulted in a factorial model. This model proposed five second-order factors that comprise a higher-order factor of wellness, the indivisible self. These five factors were the creative self, coping self, social self, essential self, and physical self. The components of these factors were the 17 third-order factors of the indivisible self model.

Creative Self

The creative self included the attributes that make individuals unique in social interactions and help individuals to positively interpret the world (Myers & Sweeney, 2008). This factor focused on problem-solving, creativity, a sense of control, emotional awareness, coping, sense of humor, and work (Hattie et al., 2004). The creative self was comprised of the third-order factors of thinking, emotions, control, work, and positive humor.

Thinking. This third-order factor included attributes of being open-minded, creative, experimenting, having curiosity, a desire to learn, and the ability to problem-solve (Myers & Sweeney, 2008).

Emotions. This factor addressed individuals' ability to regulate emotions. Individuals with higher levels in this factor can identify, express, and experience positive and negative emotions (Myers & Sweeney, 2008).

Control. This third-order factor focused on planning and working towards desired goals. Individuals with higher levels of wellness in this factor believed that they could achieve their goals, had a sense of planfulness, and were able to express their needs (Myers & Sweeney, 2008).

Work. Individuals high in this third-order factor of wellness received satisfaction in their work, felt financially secure, were able to manage job-related stress, and felt that their skills were being used appropriately at work (Myers & Sweeney, 2008).

Positive Humor. The third-order factor of positive humor included individuals' ability to laugh at their mistakes, to laugh at unexpected things that happen, and to use humor to accomplish tasks (Myers & Sweeney, 2008).

Coping Self

The coping self included elements that help individuals manage responses and cope with life events (Myers & Sweeney, 2008). Hattie et al. (2004) described this domain as responding to stressors in a way that promotes healthy functioning. The third-order factors that make up the coping self were leisure, stress management, self-worth, and realistic beliefs.

Leisure. The third-order factor of leisure included being satisfied with the activities done in an individual's spare time and having at least one activity during which an individual loses track of time when they engage in it (Myers & Sweeney, 2008).

Stress Management. Stress management included the individual's perception of how they managed stress, their perception of change, and self-assessment of coping mechanisms (Myers & Sweeney, 2008).

Self-Worth. The third-order factor of self-worth was determined based on individuals valuing themselves as unique. This included both positive qualities and imperfections (Myers & Sweeney, 2008).

Realistic Beliefs. Realistic beliefs focused on the beliefs and goals that an individual has about themselves. It included feeling comfortable and having the courage to be imperfect (Myers & Sweeney, 2008).

Social Self

The social self focused on connections with others (Myers & Sweeney, 2008). The two third-order factors that comprised the social self were friendships and love. The level of intimacy differentiated these two third-order factors (Hattie et al., 2004).

Friendship. Friendships were the connections with others that do not have a marital, sexual, or familiar commitment. Individuals with high levels of wellness on this factor had friends they could trust and that provided support (Myers & Sweeney, 2008).

Love. The third-order factor of love included the ability to trust, the ability to solve conflict and communication in a healthy manner, and having shared spiritual

values. This factor focused on support, mutual appreciation, intimacy, and self-disclosure (Myers & Sweeney, 2008).

Essential Self

Myers and Sweeney defined the essential self as the part of the self that makes meaning in life (Myers & Sweeney, 2008). Individuals high on the essential self felt that they had a purpose in life, felt a sense of meaning, and had a sense of a power greater than themselves (Hattie et al., 2004). The essential self included the things that make an individual unique, faith in their own abilities, how they defined themselves, and how they took care of themselves. This factor encompassed optimism and hope (Hattie et al., 2004). The essential self included third-order factors of spirituality, gender identity, cultural identity, and self-care.

Spirituality. The factor of spirituality focused on the recognition that a person is more than their body and mind (Myers & Sweeney, 2008). This factor included beliefs, behaviors, and practices that the individual engages in to find meaning, purpose, and hope in their lives (Myers & Sweeney, 2004).

Gender Identity. This third-order factor focused on a person feeling satisfied and supported in their gender (Myers & Sweeney, 2008). It was the internal and external experience of their gender identity (Myers & Sweeney, 2008).

Cultural Identity. This factor was similar to gender identity as it included feeling satisfied and supported in an individual's cultural identity (Myers & Sweeney, 2008).

This may reaffirm the individual's cultural identity and is essential to the meaning-making processes in life (Myers & Sweeney, 2004).

Self-Care. Self-care included the behaviors and activities that an individual engages in to prevent and minimize harmful stimuli in their lives (Myers & Sweeney, 2008).

Physical Self

The physical self addressed biological and physiological behaviors that constitute an individual's physical development and functioning (Hattie et al., 2004; Myers & Sweeney, 2008). Third-order factors that make up the physical self were exercise and nutrition.

Exercise. Exercise focused on physical activity and flexibility which was necessary to maintain a good physical condition (Myers & Sweeney, 2008).

Nutrition. The factor of nutrition included eating a balanced diet, maintaining a healthy weight, and avoiding overeating (Myers & Sweeney, 2008).

Contextual Factors

In addition to the second- and third-order factors of wellness in the indivisible self model, Myers and Sweeney (2008) considered contextual variables. Contextual variables included local, institutional, global, and chronometrical contexts (Myers & Sweeney, 2008).

Local Context. This context addressed the systems where an individual lives such as the family, neighborhood, and community (Myers & Sweeney, 2008). The interactions in this context were the main influences that affect individuals (Hattie et al., 2004).

Institutional Context. The institutional context included education, religion, government, business and industry, and the media (Hattie et al., 2004). These social and political systems affected an individual's functioning by empowering or limiting development (Myers & Sweeney, 2008).

Global Context. The global context became more noticeable through the media. This context included politics, culture, global events, and the environment (Hattie et al., 2004). These things connected individuals to the world (Myers & Sweeney, 2008).

Chronometrical Context. This context considered how individuals change throughout the lifespan. Healthy lifestyle choices result in a positive effect as people age (Hattie et al., 2004).

The indivisible self is affected by and has effects on these contexts (Myers & Sweeney, 2004). For example, natural disasters can affect individuals by limiting resources and increasing anxiety. This, in turn, can influence an individual's level of wellness. Additionally, the individual can affect these contexts through their behaviors, such as lobbying for changes to legislature.

Previous Research Using Wellness Theory

The wheel of wellness and the indivisible self models are the only wellness models distinct to the profession of counseling supported with empirical research (Myers

& Sweeney, 2004; Roscoe, 2009; Sweeney & Witmer, 1991). Researchers have applied these concepts in other studies for a variety of populations and settings. Jane Myers, who assisted in the development of the wheel of wellness and the indivisible self models of wellness, participated in much of the research that was conducted (Degges-White et al., 2003; Gill et al., 2010; Hartwig & Myers, 2003; Hodges & Myers, 2010; Lawson & Myers, 2011; Lewis & Myers, 2010; Lewis & Myers, 2012; Makinson, & Myers, 2003; Myers & Bechtel, 2004; Myers et al., 2003; Myers et al., 2011; Rayle & Myers, 2004; Reese & Myers, 2012; Shurts & Myers, 2008; Smith et al., 2002; Villalba & Myers, 2008). In this section, I review the literature relevant to wellness in counselors.

In 2007, Volume 46 of the Journal of Humanistic Counseling, Education, and Development was devoted to the topic of counselor wellness (Lawson et al., 2007). This volume introduced wellness as a way to prevent counselor impairment (Lawson et al., 2007). It included recommendations on how counselors could maintain wellness, ways that they could improve wellness in times of stress, and factors that interfered with counselor wellness (Cummins et al., 2007; Venart et al., 2007). Additionally, the journal provided suggestions on how counselor educators could increase wellness in counselors in training programs (Yager & Tovar-Blank, 2007). These recommendations included good nutrition, physical activity, self-awareness, expressing emotions, personal development, celebrating accomplishments, time with friends and family, peer support, and seeking consultation (Venart et al., 2007). Researchers also made recommendations for counselor educators to promote wellness in counselor training programs. Counselor

educators should directly discuss wellness with students, infuse wellness into the curriculum, encourage students to participate in wellness-oriented workshops outside of their normal coursework, and model wellness (Wolf et al., 2012; Yager & Tovar-Blank, 2007).

Wolf et al. (2012) developed a wellness program for counselor training programs. Then they implemented and tested the effectiveness of this program through a quantitative study (Wolf et al., 2014). The participants included 38 master's and doctoral counseling students who participated in 14 wellness workshops (Wolf et al., 2014). Wellness was measured before and after participation in the workshops by the FFWEL (Wolf et al., 2014). The results indicated significant changes for four of the five second-order factors of the FFWEL including the creative self, coping self, essential self, and physical self. Results also showed statistically significant changes in seven of the 17 third-order factors (thinking, control, work, positive humor, leisure, stress management, and nutrition). Next, Wolf et al. (2014) asked participants to complete a qualitative semi-structured interview. Three of the 38 participants completed the interview. Wolf et al. (2014) identified themes in the interviews of a willingness to change, self-awareness, connection to spirituality, and maintaining balance. However, these themes lacked trustworthiness due to the small sample size.

Researchers have examined several factors that influence counselor wellness related to their personal life, clients, and the OSC. Cummins et al. (2007) reported that a personal history of trauma, life stressors, ongoing personal issues, and emotional

depletion from work with clients can affect a counselor's level of wellness. Additionally, Moorehead et al. (2012) found that counselors' disposition to practice forgiveness contributed to a significant portion (10%) of the variance in their overall wellness.

Ohrt and Cunningham (2012) conducted a phenomenological study on how counselors' work environment influenced their sense of wellness. Five themes were identified in the study including agency resources, time management, occupational hazards, agency culture, and individual differences (Ohrt & Cunningham, 2012). Ohrt and Cunningham reported that barriers to counselor wellness included the workload, low salary, lack of staff coverage, administrative duties, paperwork requirements, and the psychologically intense nature of the work. Additionally, Ohrt and Cunningham found that the agency culture and individual perceptions influenced counselors' sense of wellness. This study showed that counselors perceive their work environment as impacting their overall wellness. However, to date, there is no study to quantitatively measure the relationship between the workplace cultureand mental health counselors' wellness.

A recent study analyzed the relationship between the OSC and school counselors' wellness. Randick et al. (2019) examined the relationship between the performance of school counseling duties, school counselor wellness, and organizational factors. Specific school counselor duties measured in this study included counseling, consultation, curriculum, and coordination and the organizational factors measured were whether

schools following a recognized American School Counselor Association (ASCA) model program designation, supervision, support, and training (Randick et al., 2019).

Although the results indicated that there was a significant positive relationship between school counselor duties of consultation and curriculum with wellness, the performance of these duties were not significant predictors of wellness (Randick et al., 2019). Randick et al. (2019) found that there was not a significant relationship between the performance of coordination and wellness. Finally, Randick et al. found that the organizational factor of support was a significant predictor for counselor duties of counseling, consultation, curriculum, and coordination. The recognized ASCA model program designation was a significant predictor for the duties of coordination and counselor (Randick et al., 2019).

Randick et al. (2019) sought to identify predictors of school counselors' wellness. They hypothesized that a more positive school environment would lead to higher quality of services for students (Randick et al., 2019). Although this study did not identify significant predictors of school counselor's wellness, it highlighted the importance of a positive OSC on wellness and client outcomes. The present study sought to examine organizational factors as predictors of mental health counselors' wellness, thus contributing to the literature on counselor wellness.

Rationale for Use of Wellness Theory

In 1992, Myers described the commitment of the American Counseling Association (ACA) to human development and wellness over the lifespan of individuals.

Myers provided the resolution adopted by the ACA (previously the American Association for Counseling and Development) on July 13, 1989. In the resolution, the ACA stated their position as advocates towards wellness within society and stated that ACA members should subscribe to values that promote "optimum health and wellness" over the lifespan (Myers, 1992, p. 136). The ACA later focused on counselor wellness and impairment. They created the taskforce on Counselor Wellness and Impairment in 2003 (Lawson & Venart, 2005). The ACA also adopted ethical standards related to impairment (ACA, 2014).

Over the past 30 years, the ACA has promoted wellness, human development, and prevention to achieve optimal well-being. This wellness orientation has made the counseling profession distinct from other clinical professions (Mellin et al., 2011). Additionally, Myers, Sweeney, and Witmer (2000) developed the only theory of wellness for counseling (Myers & Sweeney, 2004; Myers et al., 2000; Witmer & Sweeney, 1992). Wellness theory has been applied in numerous other studies as described in the previous section. The importance of wellness in counseling, the specialized development of wellness theory for counselors, and the recurrent application of wellness theory in research made this the most appropriate theory to be used in this study. The indivisible self model is the only theory of wellness for the counseling profession and the only theory adopted by the Governing Council of the ACA (Myers, 1992). Additionally, Roscoe (2009) compared the indivisible self model to other wellness theories and found that it had more empirical support than other wellness theories. The research question for

this study was: Does organizational culture predict counselor wellness while controlling for counselor self-efficacy? This research question built on the existing research of the indivisible self model by providing information on how the third-order factor of work predicts wellness in counselors.

Conceptual Framework

The conceptual framework for this study was the OSC (Glisson, 2007). Charles Glisson developed the OSC which included constructs of organizational climate and organizational culture. First, researchers examined the OSC in child welfare organizations (Glisson & Green, 2006; Glisson et al., 2012; Glisson & James, 2002; Hemmelgarn et al., 2006). Then, researchers applied the OSC to mental health service organizations (Glisson, Landsverk, et al., 2008; Glisson, Schoenwald, et al., 2008). The constructs of organizational climate and organizational culture were often confused. Glisson (2007) reported that earlier researchers used the terms culture and climate interchangeably. In Glisson's (2007) development of the OSC, he sought to provide a definition for the terms *organizational climate* and *organizational culture* in relation to child welfare agencies.

Organizational Climate

Glisson (2007) and Glisson and James (2002) defined the organizational climate as the shared perception among employees of how their work environment affects their individual well-being. Glisson stated that this perception is the property of the individual. Glisson and Hemmelgarn (1998) reported that the organizational climate was an

important determinant of the organization's effectiveness and was a predictor of service provider attitudes and of the outcome of services. Organizational climate included the following aspects of the work environment: level of conflict, role clarity, job satisfaction, cooperation, and personalization (Glisson & Hemmelgarn, 1998). Glisson and James also reported that the organizational climate represented the psychological safety and meaningfulness of the work environment for the individual employee. Glisson posited that there were three dimensions of organizational climate. These dimensions were engagement, functionality, and stress (Glisson, 2007). He stated that engaged climates included those where employees felt that they were able to accomplish many worthwhile tasks, remain personally involved in their work, and were concerned about their clients (Glisson, 2007). Functional climates were those in which employees felt that they received the cooperation and assistance needed from coworkers, felt that administrators did a good job, had a clear understanding of how they fit in, and felt that they could work successfully within the organization (Glisson, 2007). Finally, stressful climates were those where employees felt emotionally exhausted from their work and felt that they were unable to accomplish necessary tasks (Glisson, 2007).

Organizational Culture

Glisson (2007) defined organizational culture as the norms and expectations held by the organization. Whereas the organizational climate is the property of the individual employee, organizational culture is the property of the organization (Glisson, 2007). It is "the way things are done in an organization" (Glisson, 2007, p. 739). Glisson and James

(2002) stated that the organizational culture dictated the way work is approached and was the basis for the socialization of new employees. They described the organizational culture as consisting of two layers (Glisson & James, 2002). The visible outer layer involved the shared behavioral expectations and norms and the invisible inner layer included values and assumptions of the organization (Glisson & James, 2002). Glisson described three types of cultures. These were rigid, proficient, and resistant cultures. He stated that rigid cultures were those in which individuals had little discretion or flexibility, employees had limited input in important decisions, and bureaucratic rules, regulations, and red tape controlled the organization (Glisson, 2007). Proficient cultures allowed employees to prioritize the well-being of clients and expected competent and knowledgeable employees (Glisson, 2007). Glisson described resistant cultures as those where employees showed little interest in change or innovations in services and would suppress efforts to change with criticism and apathy.

Previous Application of the OSC

The OSC model was first examined in child welfare organizations (Glisson & Green, 2006; Glisson et al., 2012; Glisson & James, 2002; Hemmelgarn et al., 2006;). It was then applied to mental health service organizations (Glisson, Landsverk, et al., 2008; Glisson, Schoenwald, et al., 2008). Findings were consistent that there was a connection between the OSC and job satisfaction, commitment, service quality, turnover, outcomes, and sustainability of new treatments or programs in mental health clinics (Glisson et al.,

2012; Glisson & Green, 2011; Glisson & Hemmelgarn, 1998; Glisson & James, 2002; Glisson, Landsverk, et al., 2008).

Other helping professions have used the OSC to explore the influence of the organizational culture and climate on employees. Trus et al. (2019) analyzed the connection between organizational culture and climate and empowerment in nurse managers at the team and organizational level in a quantitative correlational study. Participants were nurse managers that worked at seven university and general-level hospitals in Lithuania. Results indicated a statistically significant association between proficient and resistant cultures and structural and psychological empowerment in nurse managers (Trus et al., 2019). There were also correlations between engaged and functional climates and verbal and outcome empowerment in nurse managers (Trus et al., 2019).

Trus et al. (2019) reported that nurse managers were more empowered in proficient cultures which were demonstrated by the opportunity to grow, being motivated, feeling self-confident, and being satisfied in their work. Additionally, nurse managers felt empowered in climates that were engaged and functional. This led to feeling able to accomplish meaningful activities, feeling supported in their work, and role clarity (Trus et al., 2019). These experiences are described in the indivisible self model of wellness (Myers & Sweeney, 2008). This study provided support for the influence of organizational factors on wellness. The present study expanded on this study by examining how organizational culture may predict other factors of wellness.

Additionally, O'Brennan et al. (2017) conducted a study that demonstrated the connection between organizational factors and wellness. They investigated the relationship between school staff perceptions and school contextual factors on staff burnout. O'Brennan et al. (2017) analyzed variables of personal connectedness, connectedness to students, connectedness to administration, efficacy, feelings of safety, and staff demographics (gender, race, role at the school, and years working in the school) at the staff-level. At the school-level, O'Brennan et al. (2017) analyzed school contextual factors (student-teacher ratio, suspension rate, percentage of students receiving free and reduced-price meals, urbanicity) and perceptions of school environment while controlling for positive behavioral interventions and supports (PBIS).

The results indicated greater burnout for "females ($\beta = 0.06$, $p < .05$), White ($\beta = 0.08$, $p < .05$), or in a teaching role ($\beta = 0.36$, $p < .01$)" and less burnout for participants who worked at their school for three years or less ($\beta = -0.05$, $p < .05$) at the staff-level (O'Brennan et al., 2017, p.170). Additionally, staff members who reported "higher personal connectedness to their schools ($\beta = -0.31$, $p < .01$)," higher connectedness to their students ($\beta = -0.10$, $p < .05$), higher connectedness to their administration ($\beta = -0.10$, $p < .01$), "more efficacy in handling difficult behaviors ($\beta = -0.16$, $p < .01$)," and feeling "safe at their schools ($\beta = -0.16$, $p < .01$) reported lower levels of burnout" at the staff-level (O'Brennan et al., 2017, p. 171). At the school level, higher suspension rates were significantly related to "higher levels of burnout ($\beta = 0.004$, $p < .01$)" (O'Brennan et al., 2017, p. 171). The researchers also calculated intraclass correlations to determine

variability in burnout across staff and between schools (O'Brennan et al., 2017). O'Brennan et al. (2017) reported that burnout variability was 1% between schools and 27.14% within-schools.

O'Brennan et al. (2017) reported that staff experienced less burnout when they felt they had the skills they needed, felt a sense of belonging and connectedness, and felt a sense of safety. This decrease in burnout and feelings of being overwhelmed can be described as an increase in wellness. The indivisible self model of wellness describes this efficacy, connectedness, and safety in the second-order factors of the creative self and the social self (Myers & Sweeney, 2008).

Application to the Present Study

Glisson and James (2002) reported that previous researchers often used the terms organizational culture and organizational climate interchangeably in academic literature. They defined these terms through a cross-level examination (Glisson & James, 2002). Hemmelgarn et al. (2006) postulated that organizations create a social context for the services they provide. This social context included factors of organizational culture and organizational climate (Hemmelgarn et al., 2006). Due to the interchangeable use of organizational climate and organizational culture as descriptors of the work environment, Glisson's (2007) operationalization of these constructs was used to define the variable of organizational culture in this study. The use of the OSC provided a framework for the aspects of the work environment that make up the organizational culture.

Literature Review Related to Key Concepts

In this section, I review the key concepts and variables related to my study. I start by discussing counselor impairment, burnout, and emotional exhaustion. Then, I review organizational factors that impact counselors and the consequences of these factors. Finally, I review the literature on self-efficacy and discuss how it relates to the present study.

Counselor Impairment

Counselor impairment first appeared in academic counseling literature in 1996 (Witmer & Young, 1996). Lawson and Venart (2005) reported that counselor impairment occurs when "there is a significant negative impact on a counselor's professional functioning which compromises client care or poses the potential for harm to the client" (p. 243). They identified potential causes of impairment as substance abuse or dependency, mental illness, traumatic events or vicarious trauma, burnout, life crisis, and physical illness or debilitation (Lawson & Venart, 2005). Lawson (2007) also reported that counselor impairment occurs when counselors have persistently focused on clients while neglecting or minimizing their own needs.

Lawson et al. (2007) described impairment as occurring on a spectrum with ranges of stressed, distressed, and impaired. Stressed counselors experience stressors in one or more domains of wellness and compartmentalize those stressors so that they do not affect their clients (Lawson et al., 2007). "Distressed counselors allow external stressors to interfere with the counseling process" (Lawson et al., 2007, p. 13). Finally,

impaired counselors meet their own needs at the expense of the client by neglecting the client's emotional needs (Lawson et al., 2007).

To address concerns of counselor impairment and the potential negative impact on clients, the American Counseling Association (ACA) established the Taskforce on Counselor Impairment in 2003 (Lawson & Venart, 2005). The task force shifted the focus of research from illness and treatment to wellness and prevention (Lawson et al., 2007). They reported that wellness and self-care strategies could protect against impairment (Lawson et al., 2007). The task force recommended counselors engage in self-monitoring and self-care activities to protect against impairment (Lawson & Venart, 2005).

Impaired counselors are at greater risk of ethical violations. Lawson et al. (2007) described potential breaches of ethical standards as engaging in inappropriate relationships, fostering dependence on themselves, or violating the trust of clients. The ACA *Code of Ethics* also addresses issues of counselor wellness and impairment (ACA, 2014). Section C.2.g. of the ACA *Code of Ethics* states that counselors have a professional responsibility to monitor themselves for impairment, refrain from offering services when impaired, and seek assistance for impairment (ACA, 2014). Counselors are also ethically bound to "assist colleagues or supervisors in recognizing their own impairment and provide consultation and assistance when warranted… and intervene as appropriate to prevent imminent harm to clients" (ACA, 2014, p. 9). Additionally, section F.5.b. provided similar provisions for impairment in students and supervisees. Students and supervisees are ethically obligated to monitor themselves for signs of impairment,

refrain from providing professional services when impaired, notify faculty or supervisors, and seek professional assistance for impairment (ACA, 2014).

Burnout and Emotional Exhaustion

Lee et al. (2007) defined counselor burnout as occurring when counselors had significant difficulty performing the necessary functions of their job at an objectively competent level. Freudenberger (1974) was the first to describe burnout. He reported physical signs of feeling exhausted and fatigued, a lingering cold, headaches, gastrointestinal issues, sleeplessness, and shortness of breath. These are common physiological reactions to stress. He also described behavioral signs of burnout. Individuals experiencing burnout are more irritable, have less patience and tolerance, are more emotionally reactive, and are easily overwhelmed (Freudenberger, 1974). They may appear more rigid, inflexible, and depressed (Freudenberger, 1974). This also results in decreased productivity. Freudenberger (1974) reported that burnout can result in self-destructive and risk-taking behaviors. He provided examples of excessively using tranquilizers and barbiturates on patients and self-medicating (Freudenberger, 1974). These self-destructive and risk-taking behaviors could lead to threats to clients' welfare.

Emotional exhaustion, vicarious traumatization, and compassion fatigue can be precursors to burnout (Figley, 2002). Compassion fatigue and vicarious trauma referred to a state in the helping profession that results from actions of empathic compassion, caring, and a view of the client as someone who suffers (Sadler-Gerhardt & Stevenson, 2012) Figley (2002), who was the first to describe compassion fatigue, described this

experience as the “cost of caring” (p. 2). Figley reported that compassion fatigue occurred when counselors experienced a reduced capacity to bear the suffering of others. The experience of compassion fatigue caused disruptions in counselors’ daily lives and decreased their ability to be empathic with clients (Figley, 2002). Compassion fatigue is less serious than experiences of burnout or impairment. However, all counselors are vulnerable to this emotional exhaustion because of the nature of their work (Figley, 2002).

Researchers found that work-related factors increased the experience of burnout and emotional exhaustion in counselors. Lent and Schwartz (2012) reported that burnout was higher in counselors working in community mental health outpatient settings compared to counselors working in private practice and inpatient settings. They also stated that the personality characteristic of neuroticism was the strongest predictor of burnout for counselors as this predicted higher levels of emotional exhaustion and depersonalization and a lower sense of personal accomplishment (Lent & Schwartz, 2012). However, Westwood et al. (2017) reported that the work environment was a better predictor of burnout than personal characteristics. Westwood et al. found that factors of excessive workload, time pressures, role ambiguity, lack of support, inequity in the workplace, and insufficient rewards were predictors of burnout in counselors. Additionally, Kim et al. (2018) stated that counselors with increased work demands such as high caseloads and long work hours were more at risk for emotional exhaustion.

Organizational Factors

Organizational factors such as the organizational setting and organizational qualities can contribute to emotional exhaustion and burnout which may lead to counselor impairment. These factors may also have effects on clinicians' behaviors and client outcomes. In this section, I discuss these organizational factors.

Organizational Setting

The organizational setting accounts for variations in counselor wellness and impairment. Counselors may work in community mental health centers, schools, hospitals, or private practice settings. Additionally, those working in private practices may work as an employee, independent contractor, or a sole proprietor. These various settings may differ in organizational practices, leadership, autonomy, and client population. Lawson and Myers (2011) described setting-specific factors of client acuity and caseload size differing between school-based or community mental health counselors and counselors who work in private practice. Lent and Schwartz (2012) also described factors that differed between settings of private practice, inpatient, and community mental health settings including workload, level of organizational efficiency, supervisory support, compliance guidelines, and budget.

Organizational Qualities

Qualities and characteristics of organizations impact the counselor. Ohrt and Cunningham (2012) identified five themes of the work environment that were barriers and facilitators for wellness. These themes were agency resources, time management,

occupational hazards, agency culture, and individual differences in perspectives (Ohrt & Cunningham, 2012). Clossey and Rheinheimer (2014) also found that employees' perceptions of the organization influenced employees' feelings. They found that the workplace culture was a better predictor of employees' perceived support in the workplace compared to the quality of the organization's programs (Clossey & Rheinheimer, 2014). A study by O'Sullivan and Bates (2014) also supported these themes. They found that higher caseloads were associated with exhaustion, a negative work environment, deteriorating personal life, and burnout in rehabilitation counselors (O'Sullivan & Bates, 2014).

Consequences of the Organizational Environment

In addition to experiences of emotional exhaustion and burnout, the OSC affects clinician behavior and client outcomes. Williams and Beidas (2018) studied clinician turnover during system-wide evidence-based treatment implementation. They found that clinician turnover was 5.8 times more likely in the least proficient cultures compared to the most proficient cultures (Williams & Beidas, 2018). They reported that improvements in culture reduced the turnover rate by 48% over two years (Williams & Beidas, 2018). This suggested a connection between culture and clinician turnover. Babbar et al. (2018) found that clinician turnover had an impact on clients with nearly half of the youth receiving services at a community mental health clinic experiencing therapist turnover. They reported that these youth were less engaged in services when they experienced a change in therapist due to turnover (Babbar et al., 2018).

Organizational factors also influenced clinician's implementation of changes in the organization. Prendergast et al. (2017) found that organizational factors predicted successful implementation of changes for assessment and case-planning for mental health services for the rehabilitation of offenders. Adequate programming, an ample number of staff members, good communication, supportive supervision, and positive attitudes towards rehabilitation led to better implementation of changes (Prendergast et al., 2017). However, higher staffing needs, training needs, stress, and burnout hindered the successful implementation of changes (Prendergast et al., 2017).

Finally, organizational factors affected client outcomes. Falkenstrom et al. (2018) found that factors related to the organizational culture and organizational climate impacted services outcomes for children and youth. Specifically, the factors of leadership, perceived support, inspiration, and mutual respect were predictors of client outcomes. Organizations with higher levels of engagement and more growth opportunities also had better outcomes for children in the welfare system (Goering, 2018).

Self-Care, Coping, and Preventative Maintenance

Self-care, coping styles, and level of wellness can be ways to prevent counselor impairment. Godfrey et al. (2011) defined self-care as activities "to promote physical, mental and emotional health, maintain life and prevent disease… and meet social and psychological needs… to maintain well-being" (p. 11). Coaston (2017) posited that counselor self-care plans reflect an inadequacy of the individual and stated that this

narrow focus brings criticism and judgment. She proposed a need to increase self-compassion as a means for practicing self-care to increase attentiveness to the counselor's own needs, reduce the risk of burnout, and increase effectiveness with clients (Coaston, 2017).

Nelson et al. (2018) also proposed self-compassion to practice self-care. They reported that individuals who practice self-compassion have more adaptive coping skills and increased well-being. Nelson et al. recommended being kind to oneself, recognizing that suffering is part of the human experience, and practicing mindfulness as ways that counselors could practice self-compassion. These are often skills that counselors teach their clients to improve their well-being but do not always apply to themselves (Nelson et al., 2018). Additionally, Beaumont et al. (2016) found that self-compassion and self-kindness were associated with lower levels of compassion fatigue and burnout. They also found that self-compassion increased well-being and compassion satisfaction (Beaumont et al., 2016). In essence, counselors can practice self-care by being kind and compassionate towards themselves.

Researchers have offered other suggestions for counselor self-care. Fulton and Cashwell (2015) recommended mindfulness practices, using peer support and supervision, taking time off, and engaging in relaxing and enjoyable activities. Storlie and Baltrinic (2015) advised counselors to practice relaxation, engage in balanced exercise and nutrition, get adequate rest, use cognitive restructuring, and take part in spiritual practices. Finally, Burke et al. (2006) reported that counselors should talk with

colleagues, attend social activities with friends and families, listen to music, and walk in nature (Burke et al., 2006). These self-care practices can aid in the prevention of burnout and impairment in counselors.

Counselors in Crisis

COVID-19, the worldwide pandemic, is an unprecedented and far-reaching crisis. It has required counselors to function in a dual capacity. Counselors are experiencing the same trauma as their clients. For many counselors, this is a new situation. However, counselors in the United States have experienced this before. Bauwens and Tosone (2010) interviewed counselors in Manhattan about their experiences after the terrorist attacks of September 11, 2001 (9/11). Bauwens and Tosone (2010) described the negative and positive experiences of counselors. They reported experiences of vulnerability, loss, traumatic symptoms, and blurred roles with clients (Bauwens & Tosone, 2010). Conversely, counselors also had the experience of posttraumatic growth. Tedeschi and Calhoun (2004) defined posttraumatic growth as the "positive psychological change experienced as a result of the struggle with highly challenging life circumstances" (p.1). Researchers have found that personal variables influence posttraumatic stress or posttraumatic growth in counselors (Bauwens & Tosone, 2010; Cooper et al., 2018). Additionally, Bauwens and Tosone found that self-care prevented secondary trauma and compassion fatigue in Manhattan counselors' post-9/11.

Self-Efficacy

Bandura was the first to identify the concept of self-efficacy as a part of his social cognitive theory. Bandura (1977) described self-efficacy as an individual's perception of their capabilities. He reported that there are four ways that self-efficacy regulates functioning: cognitive, motivational, affective, and selection processes (Bandura, 1977; Bandura, 1993). The cognitive and motivational processes are regulated by forethought. The way in which an individual views ability (inherent or acquired) guides the goals they accomplish and their motivation to achieve these goals (Bandura, 1993). Additionally, mood and stress act as mediators for self-efficacy. Those high in self-efficacy can better cope with stress because they believe they have the skills to manage it. Those low in self-efficacy may have higher anxiety and poorer coping skills because of their belief that they are unable to cope with difficulty (Bandura, 1993). In this way, self-efficacy affects the level of functioning of an individual.

Schunk and Pajares (2010) reported that self-efficacy provides the foundation for motivation, well-being, and accomplishment. Individuals with low self-efficacy will not engage in practices to maintain their well-being. Self-efficacy and wellness may have a bidirectional relationship. Just as self-efficacy influences the level of functioning (Bandura, 1993), physical and emotional well-being can influence self-efficacy. Schunk and Pajares (2010) reported that improvements in physical and emotional health may reduce negative emotional states which would, in turn, improve self-efficacy.

Additionally, Bandura (1997) reported that self-efficacy determines how one copes with stress. Poorer coping leads to lower levels of wellness (Myers & Sweeney, 2004).

Pomeroy and Clark (2015) postulated a connection between wellness theory and self-efficacy. They reported that those with higher self-efficacy may have better wellness as they may feel more capable of handling stressful situations (Pomeroy & Clark, 2015). Those with higher self-efficacy levels may be better able to deal with a stressful OSC than those with lower levels of self-efficacy. Factors such as job satisfaction, turnover rates, and quality of services may be influenced by self-efficacy.

Organizational Factors and Self-efficacy

Researchers found that organizational factors also influence self-efficacy levels. O'Sullivan and Bates (2014) reported that higher counselor caseloads were associated with exhaustion, a negative work environment, deteriorating personal life, and burnout in rehabilitation counselors. The results of these studies show that the OSC and workplace demands have an impact on counselor well-being. The OSC describes these work-related factors. Schunk and Pajares (2010) found that work stress may lead to lower self-efficacy due to the emotional state and degree of confidence. A negative emotional state and lower levels of confidence lead individuals to perceive that they are unable to manage stress. Additionally, Høigaard et al. (2015) found that academic self-efficacy mediated the relationship between school psychological climate and students' helping behaviors. That is, self-efficacy explained the relationship between the climate and students' behaviors.

Influences of Supervision on Self-efficacy

Self-efficacy is determined by social persuasion, through perception and judgment of others (Schunk & Pajares, 2010). Novice counselors may have lower levels of counseling self-efficacy because of their lack of experience. Goreczny et al. (2015) found that counselors with advanced training levels had higher counseling self-efficacy than those with less training. Ikonomopoulos et al. (2016) found that counseling self-efficacy increased over the practicum experience for counseling students. Additionally, Kozina et al. (2019) reported that counselor self-efficacy increased over eight weeks of training in novice counselors.

Bakalim et al. (2018) found that self-efficacy increased over one semester of group supervision in psychological counseling students. They reported that the supervision improved self-efficacy by decreasing nervousness, increasing confidence, helping supervisees feel good about clients' positive changes, increasing their sense of professional identity, helping supervisees to increase their use of basic counseling skills and other counseling techniques, and improving time management techniques (Bakalim et al., 2018).

These studies show how supervision increases counseling self-efficacy. The working alliance and supervisory relationship are other important factors that contribute to changes in self-efficacy. Supervisory relationships that are characterized by avoidant attachments or anxious attachments led to lower levels of self-efficacy for counselor supervisees (Mesrie et al., 2018). Healthy attachment styles in the supervisory

relationship may create a warm and open relationship that promotes growth and increases self-efficacy.

Summary

Wellness affects and is affected by many factors (Myers & Sweeney, 2008). Carr et al. (2003) also reported that organizational factors influence psychological well-being. Glisson (2007) found that organizational factors such as climate and culture influenced job satisfaction, turnover rates, service quality, and client outcomes in child welfare and mental health services. These studies show that wellness influences and is influenced by the OSC. Additionally, the stressors experienced in the work environment influenced self-efficacy (Rabaino et al., 2017). The effects of low self-efficacy, poor OSCs, and low levels of counselor wellness can be detrimental to the clients being served. This potential detriment highlights the importance of the present study.

In this chapter, I described the theoretical and conceptual frameworks that guide this study. I also discussed key variables of the study including the OSC, counselor wellness, and counselor self-efficacy. I start Chapter 3 with an introduction to the design of the study. I describe how the key variables were used to examine the influences of organizational factors and self-efficacy on counselor wellness.

Chapter 3: Research Method

The purpose of this study was to examine the organizational culture as a predictor of counselor wellness while controlling for self-efficacy. In this chapter, I discuss the research methodology for this study. I start by describing the research design and the rationale for selecting this design. Next, I identify the population, sampling procedures, and procedures for recruitment. I also describe the instruments and variables examined in the study. Finally, I discuss validity and ethical considerations.

Research Design and Rationale

Existing research has demonstrated relationships among the variables in this study. Myers and Sweeney (2008) identified work-related factors that comprise the creative self. They reported that work includes satisfaction with one's work, financial security, appropriate use of skills, and the ability to cope with workplace stress. The ability to cope with stress can also be attributed to self-efficacy. Bandura (1993) stated that those high in self-efficacy can better cope with stress because they believe that they have the skills to do so. Those lower in self-efficacy had higher anxiety and poorer coping because they believed that they could not cope with difficulties (Bandura, 1993). Work-related stressors were directly related to the OSC of the work environment (Hemmelgarn et al., 2006). Additionally, Carr et al. (2003) found that organizational climate was associated with the psychological well-being of employees. The independent variable in my study was organizational culture, and the dependent variable was counselor wellness. Counselor self-efficacy was the confounding variable in this design. I

analyzed the data through a multiple regression analysis to determine the cause and effect relationship between the independent and dependent variables.

Methodology

In this section, I identify the target population for the study and detail sampling and recruitment procedures. I describe how I collected data and the instruments used. I also identify the plan for data analysis, threats to validity, and ethical considerations in the study.

Population

The target population in this study included mental health counselors who graduated from a CACREP-accredited master's program, worked a minimum of 25 hours per week within an agency or organization, and have worked for that organization for a minimum of 1 year. Lent and Schwartz (2012) conducted a study on the influence of the work setting and personality factors on counselor burnout. They described the work setting as inpatient (hospitals and residential treatment centers), community mental health outpatient, and private practice outpatient. These categories were used to describe organizations where counselors may work. Private practice outpatient settings may be an independent setting where the counselor is the sole proprietor, a group setting in which the counselor is an independent contractor, or a group setting where the counselor is employed by the practice. Participants in this study worked in an agency or organization including psychiatric hospitals, residential mental health treatment centers, community mental health outpatient, and private practice outpatient settings. Participants who

worked in a private practice setting must have been an employee of the practice. I excluded counselors who were sole proprietors and independent contractors. To gain a representative sample, I targeted counselors across the United States.

Sampling and Sampling Procedures

This study used nonprobability convenience sampling. Due to the identified characteristics of the target population, a probability or randomized sample was not appropriate. Etikan et al. (2016) reported that nonprobability sampling methods focus on participants with specific elements and does not give everyone an equal chance of being included. A convenience sampling method is used when a researcher recruits participants because of accessibility, availability, or the willingness to participate (Etikan et al., 2016). In this study, I recruited participants who were accessible through social media, a social networking website, and a listserv for counselor educators who were available and willing to participate in the study. I recruited participants across the United States. The inclusion criteria for the sample included mental health counselors who worked at least 25 hours per week within an agency or organization. Exclusionary criteria included counselors who worked as a sole proprietor or independent contractor in private practice.

To determine the appropriate effect size, I reviewed research related to counselor wellness. Most studies had a moderate effect size (Foreman, 2018; Lee et al., 2018; Petros & Solomon, 2019; Taylor et al., 2018). Next, I conducted a G*Power analysis to determine the sample size with a moderate effect for a multiple regression analysis with two predictor variables. The a priori power analysis included an effect size of .15, power

of .80, and an alpha of .05 (Faul et al., 2009). The recommended sample size for this study was 68. However, due to attrition, I sought a sample of 100. Ball (2019) reported that the representativeness of the sample can increase the validity of the results. I gathered data on demographic information to determine the diversity and representativeness of the sample.

Procedures for Recruitment, Participation, and Data Collection

I recruited the sample for this study through a counselor educator listserv and groups for therapists on social media and social networking websites. I contacted administrators of each of the social media groups and the listserv to request permission to recruit participants. After receiving permission from the Walden University Internal Review Board (IRB# 08-17-20-0978799), I posted an invitation including the link for the electronic survey on these platforms. In this post, I included a written description of the study including inclusionary and exclusionary criteria.

When prospective participants clicked this link, they were directed to Survey Monkey (https://www.surveymonkey.com/) and asked questions to ensure that they met inclusionary criteria for the study (see Appendix A). If they answered "no," indicating that they did not meet these criteria, they were taken to an exit page thanking them for their participation in the study. If they answered "yes," they were provided written informed consent. Informed consent included the purpose of the study, emphasized the voluntary nature of the study, and participants' ability to withdrawal from the study at any time. The informed consent also explained that the results were anonymous and

confidential. Participants granted informed consent by clicking “next” to continue with the survey.

Next, I collected the following demographic information to determine the representativeness of the sample: gender, ethnicity, changes in the workplace due to COVID-19, age, and current participation in a supervision or consultation group (see Appendix B). Then, the FFWEL (see Appendix C; Myers & Sweeney, 2005), the WES (see Appendix D; Moos & Insel, 1974), and the COSE (Larson et al., 1992) were administered through Survey Monkey.

Instrumentation and Operationalization of Constructs

Three measures were used in this study to gather data on the variables of interest: the FFWEL (Myers & Sweeney, 2005), the WES (Moos & Insel, 1974), and the COSE (Larson et al., 1992). In this section, I provide information on the development of each instrument, their psychometric properties, and the appropriateness of the instruments for the present study.

FFWEL

In this study, I used the total score of the FFWEL (Myers & Sweeney, 2005) to measure the variable of counselor wellness. The FFWEL was an appropriate measure for this variable as it aligns with the theoretical orientation of this study, provides an evidenced-based operationalization of the construct of wellness, and quantitatively measures total wellness. The FFWEL includes 91 items (18 of which are experimental) and takes approximately 25 minutes to complete (Myers & Sweeney, 2005). It is

measured on a 4-point Likert scale with responses ranging from *strongly agree* to *strongly disagree* (Myers & Sweeney, 2005). Higher scores on this measure indicate higher levels of wellness (Myers & Sweeney, 2005). The publisher, Mind Garden, has granted permission to use this measure through purchasing licenses on the publisher's website.

Hattie et al. (2004) developed the FFWEL through confirmatory factor analyses (CFA) of the Wellness Evaluation of Lifestyle (WEL). The WEL measured the wheel of wellness model (Myers et al., 2000). Through CFA of the WEL measure, Hattie et al. proposed the indivisible self model of wellness and created the FFWEL. This analysis identified five second-order factors of wellness (Hattie et al., 2004). These factors were the creative self, the coping self, the social self, the essential self, and the physical self (Hattie et al., 2004). I described these factors in detail in Chapter 2. CFA also showed that GFI was acceptable with RMSEA = .042 (Hattie et al., 2004).

Shannonhouse et al. (2020) synthesized the results of 59 studies that used the FFWEL and provided detailed psychometric properties for this measure including internal consistency, convergent validity, and interfactor correlations. Shannonhouse et al. reported high internal consistency for total wellness and the five second-order factors. They provided averages and ranges for alpha scores: "total wellness (α = .90, range = .87-.93), creative self (α = .85, range = .82-.88), coping self (α = .83, range = .80–.86), social self (α = .83, range = .80–.86), essential self (α = .83, range = .80–.86), and physical self (α = .86, range = .83–.89)" (Shannonhouse et al., 2020, p. 97). Shannonhouse et al. also

reported moderate to high convergent validity with overall wellness (weighted and combined *r*s ranging from .59 to .86). Interfactor correlations were low (Shannonhouse et al., 2020). Shannonhouse et al. reported that this supported the multifactorial model of wellness measured by the FFWEL.

WES

Moos and Insel (1974) were two of the first researchers to develop a means of measuring the psychosocial qualities of environments. Through their exploration of psychiatric wards, community psychiatric treatment programs, correctional facilities, military training programs, student housing, high school classrooms, work environments, and other groups, they identified a pattern of environments (Moos & Insel, 1974). This pattern included three dimensions of environment: (a) relationship dimensions, (b) personal development or goal-oriented dimensions, and (c) system maintenance and change dimensions (Moos & Insel, 1974).

Relationship Dimension. The relationship dimension assesses relationships within the work environment (Moos, 1994). The subscales in the relationship dimension are involvement, coworker cohesion, and supervisor support (Moos, 1994). Involvement measures how concerned employees are about their jobs and how committed they are to their jobs (Moos, 1994). Coworker cohesion measures how friendly and supportive coworkers are with one another (Moos, 1994). Supervisor support measures how supportive and encouraging supervisors are towards their employees (Moos, 1994).

Personal Growth Dimension. The professional growth dimension focuses on the potential opportunity for growth and development in the workplace (Moos, 1994). This includes aspects such as independence, getting the job done, and job demands (Moos, 1994). The personal growth dimension consists of subscales of autonomy, task orientation, and work pressure (Moos, 1994). Autonomy measures how much freedom employees have to make their own decisions (Moos, 1994). Task orientation measures the emphasis the organization places on getting work done (Moos, 1994). Work pressure measures how much pressure and urgency the organization places on employees (Moos, 1994).

System Maintenance and System Change Dimension. The system maintenance and change dimension measures the expectations, response to change, and physical setting of the organization (Moos & Insel, 1974). The subscales in this dimension are clarity, control, innovation, and physical comfort (Moos, 1994). Clarity measures the clarity of expectations of the employees (Moos, 1994). Managerial control measures the control that management places on employees through policies and regulations (Moos, 1994). Innovation measures how open organizations are to change (Moos, 1994). Physical comfort refers to the comfortability of the physical work environment (Moos, 1994).

Billings and Moos (1982) revised and standardized the WES through a study of 1442 employees. They reported acceptable internal consistency of all 10 subscales (Cronbach's Alpha = 0.69-0.86), test-retest reliability (0.69-0.83), and construct validity

demonstrated in numerous studies (Billings & Moos, 1982). The revised version of the WES consists of 90 items with 10 subscales and nine items per subscale with true or false responses (Moos, 1994). The subscales I used in this study were autonomy, task orientation, work pressure, managerial control, and innovation. These subscales refer to aspects of the work environment that describe the organizational culture, whereas the remaining subscales describe the organizational climate. Glisson (2007) reported that the organizational culture included aspects of discretion or flexibility (autonomy), how employees approach the work (work pressure and task orientation), bureaucratic rules and regulations (managerial control), and innovation (Glisson, 2007). The publisher, Mind Garden, has granted permission to use this measure through purchasing licenses on the publisher's website.

COSE

Larson et al. (1992) developed the COSE to measure counselor's self-efficacy. I used the COSE to measure the variable of counselor self-efficacy in this study. The COSE is a 37-item survey measured on a 6-point Likert scale with responses ranging from strongly disagree to strongly agree (Larson et al., 1992). Higher scores indicate higher levels of self-efficacy. Larson et al. conducted five studies in their development and testing of the COSE measure. These studies provided factor analysis, convergent and discriminant validity, test-retest reliability, and criterion validity (Larson et al., 1992). Larson et al. found that the COSE measured five dimensions including microskills, process, difficult client behaviors, cultural competence, and awareness of values. Larson

et al. reported that convergent validity estimates suggested that the COSE is positively related to counselor self-concept, self-evaluation, positive affect, outcome expectations, and class satisfaction and negatively related to state and trait anxiety and negative affect. Discriminant validity showed that the COSE was minimally correlated with defensiveness, aptitude, achievement, personality type, age, and time spent as a climate (Larson et al., 1992). Larson et al. reported that the internal consistency reliability was $\alpha = .93$ for the total score of the COSE, $\alpha = .88$ for microskills, $\alpha = .86$ for process, $\alpha = .87$ for difficult client behaviors, $\alpha = .80$ for cultural competence, and $\alpha = .78$ for awareness of values. I received permission from Lisa Larson to use the COSE in this study (Appendix E).

Operationalization

The three variables in this study were organizational culture, counselor wellness, and counselor self-efficacy. I followed Glisson's (2007) definitions of organizational culture. Organizational culture is the norms and expectations of the work environment (Glisson, 2007). I used the total score of five subscales of the WES to measure organizational culture (Moos & Insel, 1974). Myers et al. (2000) defined wellness as "optimal health and well-being in which body, mind, and spirit are integrated by the individual to live more fully" (p. 252). I defined counselor wellness as this optimal health and well-being in counselor. I measured counselor wellness with the total wellness score of the FFWEL (Myers & Sweeney, 2005). I defined counselor self-efficacy as

counselors' belief in their ability to be an effective counselor. I measure counselor self-efficacy with the COSE (Larson et al., 1992).

Data Analysis Plan

I used the Statistical Package for the Social Sciences (SPSS, Version 25), to analyze the data in this study. I gathered data through the use of Survey Monkey. Then, I exported the data into a spreadsheet in Microsoft Excel. Metadata including participants' IP addresses were included in the Microsoft Excel spreadsheet. Once I downloaded the data, I eliminated the IP addresses from the spreadsheet. Next, I cleaned the data. Chu et al. (2016) reported that failure to clean data in quantitative research may lead to inaccurate and unreliable results. Examples of errors in the data include missing values, typos, mixed formats, and replicated entries (Chu et al., 2016). The first step of data cleaning is to detect errors (Chu et al., 2016). I visually reviewed the data to ensure that that data in SPSS matches the data of Survey Monkey and that no responses were duplicated or coded incorrectly. Survey Monkey provided information on surveys with missing data. I excluded cases in which there was missing data.

Research Question and Hypothesis

RQ: Does organizational culture as measured by the WES predict counselor wellness (DV) as measured by the FFWEL while controlling for counselor self-efficacy as measured by the COSE Inventory?

$H_0$1: Organizational culture as measured by the WES does not predict counselor wellness (DV) as measured by the FFWEL while controlling for counselor self-efficacy as measured by the COSE.

H_a1: Organizational culture as measured by the WES does predict counselor wellness (DV) as measured by the FFWEL while controlling for counselor self-efficacy as measured by the COSE.

I conducted a multiple regression analysis to determine the predictive relationship between one dependent variable (counselor wellness) and one independent variable (organizational culture) while controlling for self-efficacy. Researchers have demonstrated the association between self-efficacy, wellness, and the OSC (Chui et al., 2016; Enlow et al., 2019; Morrison & Lent, 2018; Myers et al., 2000). Therefore, to determine if organizational culture predicts counselor wellness, I controlled for counselor self-efficacy.

Threats to Validity

Onwuegbuzie and McLean (2003) reported that it is important for researchers to discuss threats to internal and external validity because it allows the reader to place the findings in the proper context, provides directions for future research, and promotes the use of external replications of research. Onwuegbuzie and McLean argued that these things are essential in improving validation and furthering future research. In this section, I discuss threats to external validity, internal validity, and ethical procedures in the present study.

External Validity

External validity refers to the transferability of findings (Mohajan, 2017). Threats to external validity include sampling error and lack of random sampling (Onwuegbuzie & McLean, 2003). Mohajan (2017) reported that external validity could be increased by having a representative sample and providing a precise description of the study so that the study can be replicated with other populations. I increased external validity in this study by gathering demographic information on participants to ensure representativeness of the sample. I also provided detailed descriptions of the sampling strategy, population, data collection, and data analysis so that the study could be replicated in the future.

Internal Validity

Internal validity refers to the credibility of the findings (Mohajan, 2017). Threats to internal validity include socially desirable and inattentive responding (McKibben & Silvia, 2016). McKibben and Silvia (2016) reported that this increases the chance of a type II error. Socially desirable responding occurs when participants provide favorable responses instead of responding truthfully (McKibben & Silvia, 2016). Inattentive responding occurs when participants do not pay attention to the items in the survey (McKibben & Silvia, 2016). Examples of inattentive responding include skimming, skipping instructions, misreading items, or responding without reading items (McKibben & Silvia, 2016). Another threat to internal validity is selection bias (Lesko et al., 2017). Selection bias occurs in nonrandom sampling (Lesko et al., 2017). Finally, the effects of

COVID-19 may be a confounding variable for this study. Because I was unable to statistically measure this variable, it was a threat to validity.

I took steps to minimize the threats to internal validity in this study. To decrease socially desirable responses, I administered electronic surveys anonymously (Kreuter et al., 2008). I detected inattentive responding through a post hoc analysis (Kreuter et al., 2008). I reported this in my findings. Random sampling was not appropriate for the nature of this study due to the inclusionary criteria for participants. Therefore, I was unable to eliminate the possibility of selection bias in this study. However, Lesko et al. (2017) reported that minor threats to internal validity are tolerable if it leads to greater external validity.

Ethical Procedures

Ethical procedures in research are governed by the American Counseling Association (ACA), the U.S. Department of Health & Human Services National Institute of Health (NIH), and university IRBs. The ACA *Code of Ethics* (2014) reports that counselors must take steps to protect confidentiality. Privacy and confidentiality were considered in the storage of data. For the present study, I stored the anonymous data in a Microsoft Excel file on my computer. Once these data were downloaded from Survey Monkey, I eliminated the IP addresses. This file was password protected and the computer required a password to log on. I was the only person with passwords to the Microsoft Excel file and computer. NIH (2016) provided guidelines on ethical research including informed consent, treatment of participants, and independent review.

Participants were provided with a written informed consent prior to beginning the study. The informed consent included the purpose of the study, explained that it was voluntary and that participants may withdraw at any time. I showed respect for participants by including information on the anonymous and confidential nature of the study. Additionally, I sought an independent review of my research proposal by the Walden IRB prior to beginning the study.

I recruited participants through social media, a social networking website, and a counselor educator listserv. I gained access from the administrators of the social media groups. Interactions with participants were limited to electronic communication for recruitment, informed consent, and instructions for completing the survey. This eliminated the concern for the treatment of human participants.

Summary

In this chapter, I described the research methodology for the present study. In the study, I used a multiple regression analysis to analyze the relationship between organizational culture and counselor wellness. I recruited counselors through social media, a social networking website, and a counselor educator listserv. Participants completed a survey comprised of the three instruments previously discussed. Finally, I took steps to minimize threats to validity and adhere to ethical considerations. In Chapter 4, I describe procedures for data collection and analysis.

Chapter 4: Results

The purpose of this quantitative nonexperimental survey was to examine organizational culture as a predictor for counselors' wellness while controlling for counselor self-efficacy. The sample for this study included counselors who worked at an agency or organization for at least 1 year. The research question and hypotheses are listed below:

RQ: Does organizational culture as measured by the WES predict counselor wellness (DV) as measured by the FFWEL while controlling for counselor self-efficacy as measured by the COSE Inventory?

$H_0$1: Organizational culture as measured by the WES does not predict counselor wellness (DV) as measured by the FFWEL while controlling for counselor self-efficacy as measured by the COSE.

H_a1: Organizational culture as measured by the WES does predict counselor wellness (DV) as measured by the FFWEL while controlling for counselor self-efficacy as measured by the COSE.

In Chapter 3, I described the research design and methodology for this study. In this chapter, I review the research design and present the findings of the statistical analysis. This chapter will also include a detailed review of data collection and relate the results to the research question.

Data Collection

As discussed in Chapter 3, the intended population for this study was counselors in the United States who are employed at an agency or organization. These participants were recruited through social media and networking websites and through a listserv for counselor educators. In this section, I describe the precise steps of the data collection process including recruitment, response rates, and data cleaning.

Recruitment and Response Rates

Data collection began August 17, 2020 and lasted through August 23, 2020. I posted invitations for participation in groups for therapists on a social media website, in groups for therapists on a social networking website, and on a national listserv for counselor educators. I posted and reposted to a social media website throughout data collection. I posted the invitation in five groups on August 17, 2020, one group on August 18, 2020, six groups on August 19, 2020, two groups on August 20, 2020, four groups on August 21, 2020, four groups on August 22, 2020, and one group on August 23, 2020. I reposted the invitation to two social media groups on August 21, 2020, to two groups on August 22, 2020, and to one group on August 23, 2020. I posted to three groups on a social networking website on August 17, 2020, two groups on August 20, 2020, one group on August 21, 2020, and two groups on August 22, 2020. Finally, I posted the invitation on a listserv for counselor educators on August 17, 2020.

As stated in Chapter 3, the desired sample size was 100 to account for attrition rates with a need for 68 completed surveys. Two hundred fifty-four participants started

the survey; however, only 103 (40.6%) met inclusionary criteria for the survey and consented to participate in the study. Seventy participants completed the survey with 33 (32%) participants dropping out before completion. The response rate for completed surveys was 68%.

The invitation for participation was posted to more social media groups than identified in Chapter 3. When participants clicked on the link to participate in the study, they were provided with questions to ensure they met the criteria for the study (see Appendix A). If participants responded "no" to any of these questions, they were taken to a disqualification page and thanked for their participation in the study. If participants met inclusionary criteria by answering "yes" to all four questions, they were taken to the informed consent page. To provide consent to participate in the study, participants clicked "yes – I have read the informed consent and wish to continue with the survey." If participants clicked "no – I do not consent and wish to exit the survey," they were taken to the thank you page. Next, participants completed the demographic questionnaire (see Appendix B), the FFWEL (see Appendix C), the WES (see Appendix D), and the COSE.

Description of the Sample

The sampling frame for this study including counselors who work an average of 25 hours or more at an agency or organization. Counselors had to have graduated from a CACREP-accredited counseling program and been employed at their current workplace for at least 1 year. Invitations were posted in numerous groups on social media and social networking sites and emailed through a listserv for counselor educators. I was not able to

gather a true estimate of how many counselors the survey reached because some members of these groups were mental health professionals from other disciplines (i.e., social workers, psychologists, etc.) and some members may not have seen the invitation. Therefore, I am unable to determine if this sample was representative of the population of counselors.

Data Cleaning

Before I could run the multiple regression analysis, I had to transform and clean the data. I downloaded an XLS file of the 70 completed surveys. I did not include responses with missing data. Upon opening this file, I removed the IP addresses that were collected by Survey Monkey to ensure the anonymity of the sample and maintain the privacy of participants. I visually checked this file for incorrect and duplicate responses. I transformed and scored the results of the FFWEL. I coded the responses of the FFWEL by replacing responses with the corresponding number (*strongly disagree* = 1, *disagree* = 2, *agree* = 3, and *strongly agree* = 4). Then I reverse scored the items for the realistic beliefs subscale (*strongly disagree* = 4, *disagree* = 3, *agree* = 2, and *strongly agree* = 1). The results were scored by adding the number for all items, dividing the sum by 91, and then multiplying the quotient by 25. The product was the total wellness score with higher scores indicating a higher level of wellness.

After scoring the FFWEL, I scored the subscales of the WES. To score the WES, I highlighted the participants' responses that matched the scoring key. I counted the number of highlighted responses for each subscale, which ranged from 0 to nine. Next, I

reverse scored the total score for the subscales of work pressure and managerial control by subtracting the score from 9. To calculate the total WES score, I averaged the total scores for each subscale and the reversed scores from the work pressure and managerial control subscales of the WES.

Finally, I scored the COSE. I coded the responses of the COSE by replacing responses with the corresponding number (*strongly disagree* = 1, *moderately disagree* = 2, *slightly disagree* = 3, *slightly agree* = 4, *moderately agree* = 5, and *strongly agree* = 6). Then I reverse-scored items 2, 6, 7, 9, 16, 18, 19, 21, 22, 23, 24, 26, 27, 28, 31, 33, 35, 36, and 37 (*strongly disagree* = 2, *moderately disagree* = 3, *slightly disagree* = 4, *slightly agree* = 5, *moderately agree* = 6, and *strongly agree* = 7). I calculated the total score by adding the numbered responses for each participant. Higher scores on the COSE indicated higher levels of counseling self-efficacy.

Results

The results of this study are presented through descriptive statistics and hierarchical multiple regression analysis. Descriptive statistics provide information about the representativeness of the sample and can help make sense of the results of the analysis. The use of the hierarchical multiple regression analysis deviated from the data analysis plan presented in Chapter 3. A hierarchical multiple regression was the more appropriate analysis to use when controlling for a confounding variable. In the following section, I present the descriptive statistics, check the statistical assumptions for a hierarchical multiple regression analysis, and describe the results of the analysis.

Descriptive Statistics

The majority of participants self-identified as female (91.4%), five participants (7.1%) identified as male, and one participant (1.4%) identified as nonbinary. The sample was also largely White (*n* = 52; 74.3%) with minimal participants who identified as other ethnicities. Participants from all age groups were represented in the sample with the majority of participants in age groups 26-30 (28.6%), 31-35 (18.6%), and 41-45 (20%). Tables 1 displays information on these descriptive statistics.

Table 1

Demographics

Demographic categories	**Frequency**	**Percent**
Gender		
Female	64	91.4%
Male	5	7.1%
Other: Nonbinary	1	1.4%
Race/Ethnicity		
White	52	74.3%
White and Hispanic, Latino or Spanish origin	3	4.3%
White and American Indian or Alaska Native	2	2.9%
White and Native Hawaiian or Other Pacific Islander	1	1.4%
Black or African American	5	7.1%
Hispanic, Latino, or Spanish origin	3	4.3%
Asian	2	2.9%
American Indian or Alaska Native	1	1.4%
Prefer not to answer	1	1.4%
Age		
20-25	3	4.3%
26-30	20	28.6%
31-35	13	18.6%
36-40	6	8.6%
41-45	14	20%
46-50	9	12.9%
51-55	4	5.7%
61 and older	1	1.4%

In addition to basic demographic information, I collected information on the changes in work setting due to COVID-19 and participation in professional supportive services. Participants identified a variety of changes in the way they delivered counseling services including providing telehealth counseling services at home and at the office and providing in person counseling services. The majority of participants provided telehealth counseling from their home (41.4%). See Table 2 for descriptive statistics of the changes in the service delivery method.

Table 2

Service Delivery Method During COVID-19

Service delivery method	Frequency	Percent
In-person only	4	5.7%
In-person and telehealth from work	1	1.4%
In-person and telehealth (unknown location)	24	34.3%
Telehealth from home only	29	41.4%
Telehealth from home and work	5	7.1%
In-person and telehealth from home and work	4	5.7%
Telehealth from work	3	4.3%

Respondents also participated in professional support services of supervision and consultation. Participants were asked if they took part in one or both of these professional supports at a minimum of once every two weeks. The majority of participants participated in one or both (64.3%). Table 3 shows the number of participants involved in these supports.

Table 3

Involvement in Professional Support Services

Professional support services	Frequency	Percent
Consultation	14	20%
Supervision	20	28.6%
Both	11	15.7%
None	25	35.7%

Descriptive statistics were also analyzed for the three variables of interest. Counselor wellness ranged from 57 to 86 with a median score of 72. Organizational culture ranged from 1.6 to 7.2 with a median score of 4.0. Counselor self-efficacy ranged from 126 to 219 with a median score of 178 (see Table 4).

Table 4

Variable Frequencies Table

Frequency	Counselor wellness	Organizational culture	Counselor self-efficacy
Mean	72.37	4.317	176.94
Median	72.0	4.0	178.0
Std. Deviation	6.103	1.6257	20.346
Range	29	5.6	93
Minimum	57	1.6	126
Maximum	86	7.2	219

Figure 1

Counselor Wellness Frequency Graph

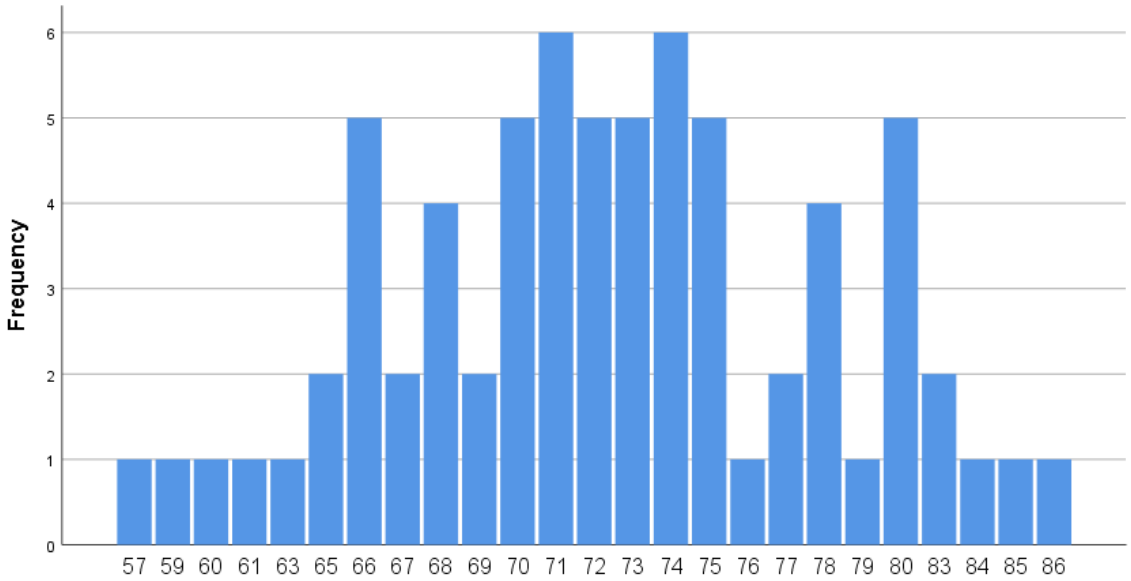


Figure 2

Organizational Culture Frequency Graph

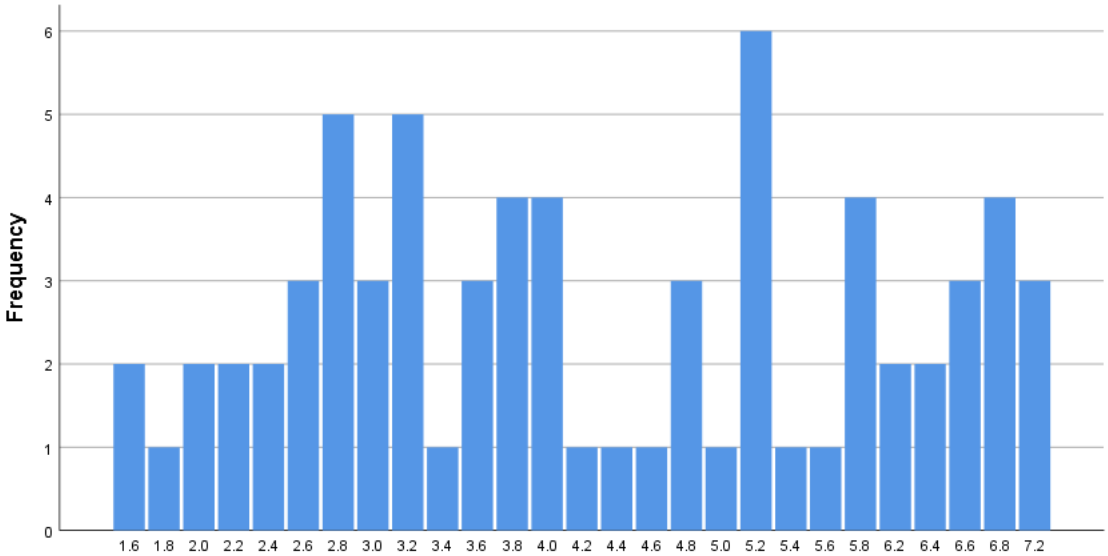
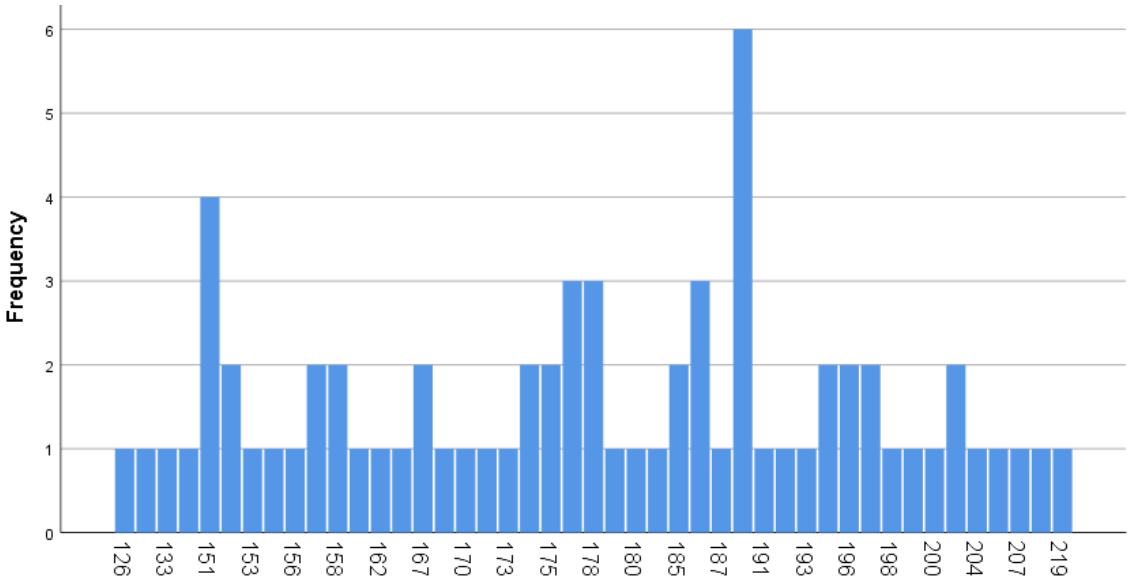


Figure 3

Counselor Self-Efficacy Frequency Graph



Statistical Assumptions

I used a hierarchical multiple regression to analyze the data for this study. For a multiple regression analysis, there are several assumptions that must be met. I tested the following assumptions: linearity of regression, independence of errors, homoscedasticity, and multicollinearity. I discuss the results of testing these statistical assumptions in the next section.

Linearity of Regression

The assumption of linearity means that there is a linear relationship between the variables (Ernst & Albers, 2017; Williams et al., 2013). To test this assumption, I examined a scatterplot of the relationship between the dependent variable of counselors' wellness and each of the predictor variables (organizational culture and counselor self-

efficacy). Based on the scatter plot, there appears to be a linear relationship between counselors' wellness and counselor self-efficacy (see Figure 1). There does not appear to be a linear relationship between counselors' wellness and organizational culture (see Figure 2). Next, I examined a scatterplot of the standardized residuals against the predictor variable (Figure 3). This plot shows both positive and negative residuals that are randomly distributed across the range of the predictor variable. The points are scattered and do not display an obvious pattern. This plot supports the assumption of linearity.

Figure 4

Scatterplot of the Relationship between Counselors' Wellness and Counselor Self-Efficacy.

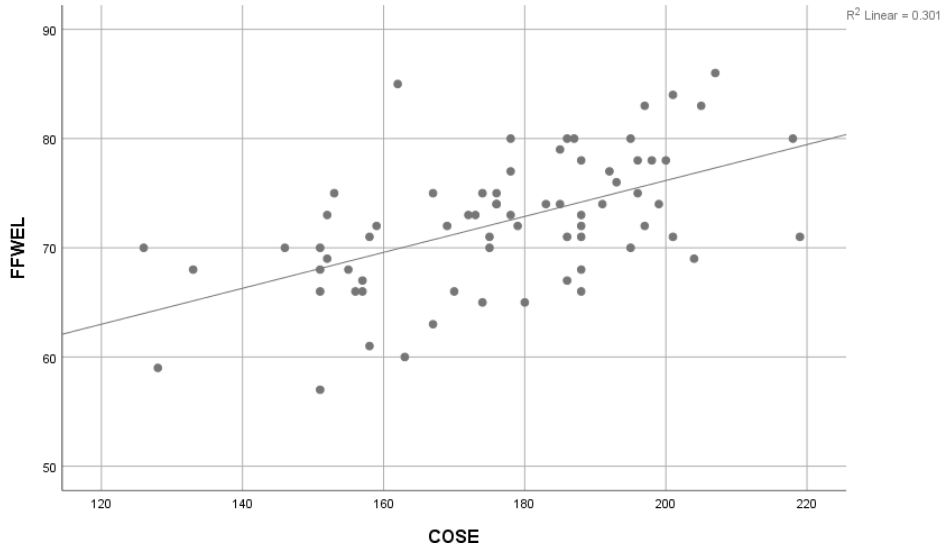


Figure 5

Scatterplot of the Relationship between Counselors' Wellness and Organizational Culture.

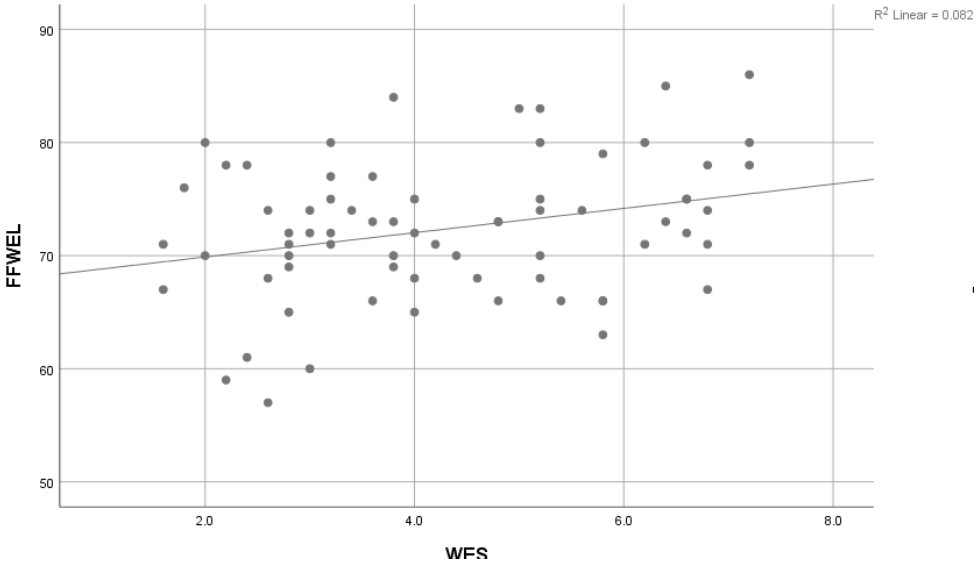
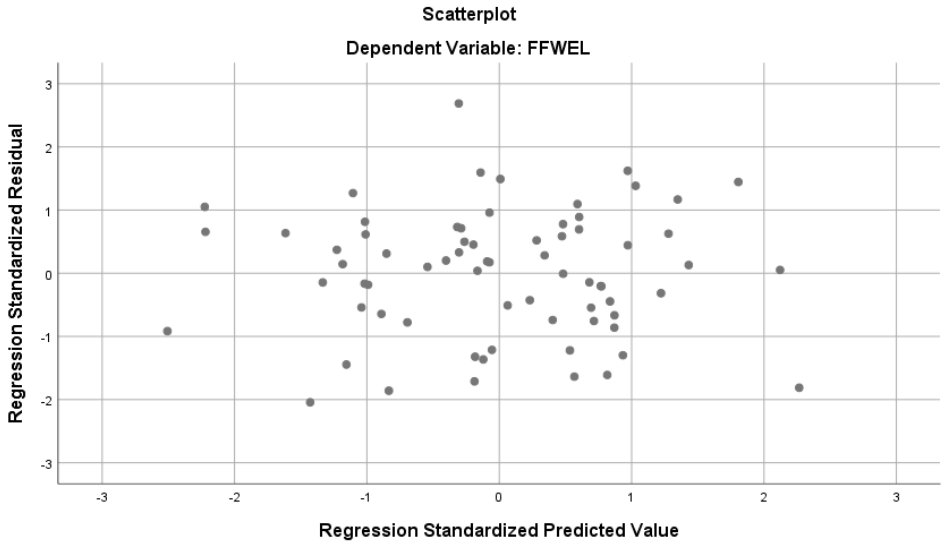


Figure 6

Scatterplot of Standardized Residuals against the Predictor Variable.



Independence of Errors

The independent error assumption means that residuals should not have a relationship and should not be correlated (Ernst & Albers, 2017; Williams et al., 2013). I tested this assumption by examining a scatterplot of the standardized residuals against the predictor variable (see Figure 3). The data appeared to be scattered with no runs above or below the mean. This supports the assumption of independence of errors.

Homoscedasticity

The homoscedasticity assumption considers the variation of the predicted values (Ernst & Albers, 2017; Williams et al., 2013). I examined a scatterplot of the standardized residuals against the predictor variable to test this assumption (see Figure 3). The residuals appeared to be scattered which indicated that the variance of the residuals was constant.

Multicollinearity

Multicollinearity occurs when there are two or more variables that are very closely linearly related (Williams et al., 2013). This makes it difficult to assess which of the two variables are significant in the multiple regression analysis (Williams et al., 2013). To test the multicollinearity assumption, I examined a correlation matrix for high coefficients (see Table 5). The correlation coefficient was low (.257) indicating that this assumption was met.

I also checked for more subtle violations of the multicollinearity assumption by examining the variance inflation factor (VIF) and tolerance value. The VIF indicates that

the predictor has a strong linear relationship with the other predictors when it is less than 10. The tolerance value is the reciprocal of the VIF. Tolerance values below 0.2 indicate a strong relationship between predictor variables. The VIFs were 1.0 and 1.071 and the tolerance values were 1.0 and .934 (see Table 6). This indicates that the multicollinearity assumption was met.

Table 5

Correlation Matrix

Variable	Correlation	Counselor wellness	Organizational culture	Counselor self-efficacy
Counselor wellness	Pearson Correlation	1	.286	.548
	Sig. (2-tailed)		.016	.000
	N	70	70	70
Organizational culture	Pearson Correlation	.286	1	.257*
	Sig. (2-tailed)	.016		.032
	N	70	70	70
Counselor self-efficacy	Pearson Correlation	.548	.257*	1
	Sig. (2-tailed)	.000	.032	
	N	70	70	70

Table 6

Collinearity Statistics

Model		Tolerance	*VIF*
1	Counselor self-efficacy	1.000	1.000
2	Counselor self-efficacy	.934	1.071
	Organizational culture	.934	1.071

Statistical Analysis

To approach the research question, I conducted a hierarchical multiple regression analysis to evaluate the prediction of counselor wellness from organizational culture while controlling for counselor self-efficacy. For the first block analysis, the predictor variable counselor self-efficacy was analyzed. The results of the first block hierarchical multiple regression analysis revealed a statistically significant model F(1, 68)=29.256, p <.05. Additionally, the R^2 value of 0.301 associated with this regression model suggests that counselor self-efficacy accounts for 30.1% of the variation in counselor wellness, which means that 69.9% of the variation in counselor wellness cannot be explained by counselor self-efficacy alone. A different outcome was found in the second block analysis.

For the second block analysis, the predictor variable organizational culture was added to the analysis. The results of the second block hierarchical multiple regression analysis revealed a model to be statistically significant $F(2, 67) = 16.013$, $p < .05$. Additionally, the R^2 change value of 0.23 associated with this regression model suggests

that the addition of organizational culture to the first block model accounts for 2.3% of the variation in counselor wellness. However, organizational culture was not a significant predictor of counselor wellness when controlling for counselor self-efficacy β = 0.156, 95% CI (-.195, 1.363), $p > .05$. Organizational culture as measured by the WES does not predict counselor wellness (DV) as measured by the FFWEL while controlling for counselor self-efficacy as measured by the COSE.

Table 7

Model Summary and ANOVA Results for Hierarchical Multiple Regression

	Model summary[c]						ANOVA		
Model	R^2	*Adjusted* R^2	ΔR^2	ΔF	*df (1,2)*	*p*	*F*	*df (1,2)*	*p*
1[a]	.548	.301	.301	29.256	1, 68	.000	29.256	1, 68	.000
2[b]	.569	.303	.023	2.238	1, 67	.139	16.013	2, 67	.000

[a]Predictors: (Constant), counselor self-efficacy

[b]Predictors: (Constant), counselor self-efficacy, organizational culture

[c]Dependent Variable: counselor wellness

Table 8

Coefficients Table for Hierarchical Multiple Regression

Model		β	*p*	95% Confidence Interval
1	Counselor self-efficacy	.548	.000	.104, .225
2	Counselor self-efficacy	.508	.000	.090, .215
	Organizational culture	.156	.139	-.195, 1.363

Summary

The purpose of this quantitative nonexperimental survey study was to examine organizational culture as a predictor for counselor wellness. Descriptive statistics and a hierarchical multiple regression analysis were conducted to test the research question posed in this study. The hierarchical multiple regression analysis indicated that organizational culture was not a significant predictor of counselor wellness when counselor self-efficacy was controlled. Counselor self-efficacy accounted for more of the variance in counselor wellness than organizational culture. This may indicate that individual-level factors are more impactful than organizational factors on counselors' level of wellness. In Chapter 5, I review existing literature as it related to the findings in this study. I also present implications for social change and directions for future research.

Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this quantitative nonexperimental survey study was to examine organizational culture as a predictor for counselors' wellness while controlling for counselor self-efficacy. The sample in this study was counselors who worked full-time at an agency or organization for at least 1 year. A total of 70 counselors participated in this study after attrition. I conducted a hierarchical multiple regression analysis to test the variables in this study. The results indicated that organizational culture was not a significant predictor of counselors' total wellness. The results also demonstrated that counselor self-efficacy was a significant predictor of counselors' wellness. These results confirm and contradict the existing literature related to the variables in this study. As I interpreted the data, I also considered the impact of COVID-19, the global health crisis that occurred during data collection. In this chapter, I discuss my interpretation of the results, describe the limitations of this study, and identify recommendations and implications derived from this study.

Interpretation of the Findings

The results of this study indicated that organizational culture is not a significant predictor of counselors' wellness. However, the results showed that counselor self-efficacy accounts for 30.1% of the variance in counselor wellness. In this section, I use existing literature, descriptive statistics, and the results of the hierarchical multiple regression analysis to interpret the results of this study.

Indivisible Self Model of Wellness

According to the indivisible self model of wellness, organizational culture falls under the institutional contextual variable. Hattie et al. (2004) described this context as the social and political systems such as education, religion, government, business, industry, and the media. Myers and Sweeney (2008) reported that these systems can empower or limit an individual's development and functioning. Another contextual variable is the global context, which includes politics, culture, global events, and the environment (Hattie et al., 2004). At the time of data collection, participants were experiencing the effects of the global pandemic. It is possible that the effects of COVID-19 mitigated the effects of organizational culture as it changed the physical work environment. The majority of participants (94.3%) reported changes in their physical work environment because of COVID-19. These changes included providing telehealth counseling services from home and from work with 41.4% of participants working strictly from home.

Lawson et al. (2007) reported that stressed counselors experience stressors in one or more domains of wellness and compartmentalize those stressors so that they do not affect their clients. Stress alone may not negatively affect wellness. Those who can cope better with the stress of the organizational culture do not experience the negative effects of the organizational culture (Bandura, 1993). Therefore, ability to cope with stress may mitigate the effects of organizational culture, which may explain the results of this study.

Self-Care as a Buffer for Counselor Wellness

Self-care has been a recurrent topic in the academic literature related to wellness. Myers and Sweeney (2008) identified self-care as a third-order factor of the indivisible self model. They described self-care as the behaviors and activities that an individual engages in to prevent and minimize harmful stimuli (Myers & Sweeney, 2008). Data were not collected in this study about counselors' self-care practices. However, it is possible that counselors who regularly practice self-care have higher levels of wellness, which may mitigate the impact of a negative organizational culture. The median score on the WES was 4.0, which indicated a below-average organizational culture for the participants in this study. Counselors who engage in regular self-care practices may decrease their vulnerability to the effects of a negative organizational culture. This may explain the findings in the study as self-care practices may increase counselors' wellness despite a negative organizational culture.

Professional Support and Self-Efficacy

Supervision may act as a buffer for the effects of a poor organizational culture. Most participants in this study were involved in supervision or consultation groups (64.3%). Bakalim et al. (2018) reported that supervision increased counselor self-efficacy by decreasing nervousness, increasing confidence, improving counseling skills, and improving time management. Counselors who participate in supervision or consultation may have higher levels of self-efficacy and may receive support to help them manage the stress of the organizational culture.

Additionally, counseling self-efficacy increases with advanced training. Goreczny et al. (2015) reported that counselors with more training had higher self-efficacy. Ikonomopoulos et al. (2016) reported that counselor self-efficacy increased over their practicum experiences. Finally, Kozina et al. (2019) reported that counselor self-efficacy increased over eight weeks of training for novice counselors. Information on how long counselors have been in practice and their training level was not gathered in this study. Training level and length of practice may be a confounding variable on counselor self-efficacy and counselor wellness.

In the present study, counselor self-efficacy accounted for 30.1% of the variance in counselor wellness. Schunk and Pajares (2010) reported that physical and emotional well-being influenced self-efficacy. Bandura (1993) also stated that mood and stress were mediators for self-efficacy. As self-efficacy increases, individuals are better able to cope with stressors (Bandura, 1993). The range for the total score on the COSE is 37 to 222 (Larson et al., 1992). Participants in the present study had a median score on the COSE of 178 with scores ranging from 126 to 219. This may indicate that participants in the study are better able to cope with stressors in their organizational culture. Therefore, counselor self-efficacy may mediate the relationship between the organizational culture and counselor wellness.

Organizational Culture

Results of the present study suggest that the organizational culture may be more indicative of the delivery of services, client outcomes, and job performance than the level

of wellness. Randick et al. (2019) analyzed the relationship between the work environment and school counselors' wellness. They found that the organizational factor of support was a significant predictor of school counselor duties and hypothesized that a more positive school environment would lead to higher quality of services for students (Randick et al., 2019). However, this study did not identify significant predictors of school counselors' wellness (Randick et al., 2019).

Ohrt and Cunningham (2012) identified five themes of how the work environment influenced counselors' wellness: agency resources, time management, occupational hazards, agency culture, and individual differences. They also described barriers to counselor wellness as workload, low salary, lack of staff coverage, administrative duties, paperwork requirements, and the psychologically intense nature of the work (Ohrt & Cunningham, 2012). Many of the facilitators and barriers to counselor wellness as described by Ohrt and Cunningham are more descriptive of the organizational climate than the organizational culture. Glisson (2007) defined the organizational culture as the norms and expectations of an organization. The organizational culture dictates how the work is approached including behavioral expectations, norms, values, and assumptions of the organization (Glisson & James, 2002).

Ohrt and Cunningham (2012) reported that the agency culture and individual perceptions influenced counselors' sense of wellness. The individual perceptions and counselors' sense of wellness are best described by the organizational climate. Although the organizational culture is important as it influences the delivery of services and job

performance, the organizational climate may have more of an impact on counselors' wellness (Glisson, 2007).

Organizational Climate

The present study examined organizational culture as a predictor for counselor wellness and found that organizational culture was not a significant predictor of counselors' wellness. Organizational climate may be a better predictor of counselors' wellness. Glisson (2007) and Glisson and James (2002) defined the organizational climate as the shared perception among employees of how their work environment affects their individual well-being. Organizational climate is an individual-level factor of wellness and may have more of an impact on total wellness than the institutional-level factor of organizational culture. Glisson and Hemmelgarn (1998) reported that organizational climate included the level of conflict, role clarity, job satisfaction, cooperation, and personalization in the work environment. The organizational climate also represented the psychological safety and meaningfulness of the work environment for employees (Glisson & James, 2002).

O'Brennan et al. (2017) examined the relationship between school staff perceptions and school contextual factors on staff burnout. They found that staff experienced less burnout when they felt they had the skills they needed, felt a sense of belonging and connectedness, and felt a sense of safety. These factors are best described by the organizational climate. The decrease in burnout and feelings of being overwhelmed can also be described as an increase in wellness. This study demonstrates

that organizational culture is not a significant predictor of counselors' wellness. Examining the organizational climate may lead to more significant findings related to counselor wellness.

Westwood et al. (2017) reported that the work environment was a predictor of burnout. They described work-related factors of excessive workload, time pressure, role ambiguity, lack of support, inequity in the workplace, and insufficient rewards as predictors of burnout in counselors. Additionally, Kim et al. (2018) found that factors of increased work demands, high caseloads, and long work hours increased the risk of emotional exhaustion in counselors. These factors represent both the organizational culture and the organizational climate. More research is needed to distinguish between the impact of the organizational culture and climate on counselors' wellness.

Limitations of the Study

There were several limitations in this study, including the chosen variables, the current global pandemic, and the representativeness of the sample. Existing literature suggests that there are numerous variables that may influence the relationship between the organizational culture and counselors' wellness. The third-order factor of the indivisible self model of work including factors of income, stress management techniques, and how counselors felt about the work they do with their clients was not measured in this study (Myers & Sweeney, 2008). Counselors' wellness was measured by the total score on the FFWEL. The relationship between organizational culture and

counselor wellness may be better understood by evaluating organizational culture and the second-order factors of the FFWEL.

Another limitation was the failure to control for other variables that may contribute to a counselors' level of wellness. Cummins et al. (2007) reported that other personal factors such as a history of trauma, life stressors, personal issues, and emotional depletion from work with clients may affect a counselors' level of wellness. Additionally, during the data collection phase of this study, counselors were experiencing a worldwide pandemic, COVID-19. As this was the first time that counselors experienced a global crisis such as this, there were no existing instruments to measure the effects of this. Therefore, I was unable to control for the impact of COVID-19 on counselors' wellness.

The final limitation of this study was the participants. Individuals who participated in this study were mostly white females. This may not be representative of the population of counselors across the nation. Additionally, this study was limited to mental health counselors who were employed at agencies or organizations, therefore limiting the ability to generalize the results of this study to other mental health disciplines and counselors working in other settings.

Recommendations

Future research can build on the findings in this study and address limitations. There is a need to examine the relationship between organizational climate and counselor wellness to better understand the influence of the organizational culture on counselors' well-being. Additional variables of counselors' self-care practices and the influence of

professional support should also be explored. Future research can expand on this study by investigating these effects based on the work setting (i.e., community organization, hospital, etc.). Finally, future research on these variables may be able to control for the impact of COVID-19. As more research is conducted, an instrument may be developed to measure the effects of this crisis on individuals and work environments.

Implications

The results of this study provide implications for positive social change, research methodology, and future practice. The implications provided in this section may improve counselor wellness, research practices, and counselor training programs. Additionally, the implications discussed in this section emphasize the importance of counselor self-care practices.

Positive Social Change

I anticipated that the results of this study would provide implications for social change at the organizational level. Although the results did not suggest improvements for organizations, the results indicated a need for improvements in counselor self-care and counselor self-efficacy. Positive social change can occur through a continued focus on counselors' well-being. Counselor supervisors and counselor educators can elicit this change by providing support and increasing counselors' skills and confidence in their counseling ability. Counselor supervisors and educators should continue to emphasize the importance of counselor self-care practices as this can decrease counselors' vulnerability to the effects of a negative organizational culture.

Methodological Implications

The present study demonstrates a need for more complex statistical analyses to fully understand the relationship between counselors' wellness and the organizational culture. There are numerous work-related factors that are encompassed within the organizational culture and organizational climate. Additionally, there are individual-level factors that facilitate and impede counselors' level of wellness. Future quantitative studies should include these assorted variables to understand the dynamic relationship between the counselor and the organizational culture.

Recommendations for Practice

Counselors should continue to engage in regular self-care practices and supervisors should continue to provide a supportive working alliance. Counselors who practice self-compassion, self-kindness, and have a disposition towards forgiveness have higher levels of wellness (Beaumont et al., 2016; Coaston, 2017; Moorehead et al., 2012). Additionally, counselors should engage in self-care practices of mindfulness, peer support, supervision, time off, leisure activities, relaxation, balanced exercise and nutrition, adequate rest, and social activities (Burke et al., 2006; Fulton & Cashwell, 2015; Storlie & Baltrinic, 2015).

The working alliance and supervisory relationship are other important factors that contribute to improvements in self-efficacy and wellness in counselors. Supervisory relationships that are characterized by avoidant attachments or anxious attachments led to lower levels of self-efficacy for counselor supervisees (Mesrie et al., 2018). Healthy

attachment styles in the supervisory relationship may create a warm and open relationship that promotes growth, increases self-efficacy, and improves counselor wellness.

Conclusion

The purpose of this study was to examine organizational culture as a predictor for counselors' wellness while controlling for counselor self-efficacy. The results of this study indicated that organizational culture is not a significant predictor of counselors' wellness and counselor self-efficacy accounts for a significant amount of variance in counselors' wellness. These findings support the premise of the indivisible self model of wellness and suggest that individual-level factors have a larger impact on counselors' wellness compared to institutional-level factors. Future research is needed to better understand the relationship between counselor wellness and the organizational culture. Counselors can decrease their vulnerability to the effects of the organizational culture by continued engagement in self-care practices. Counselor supervisors and counselor educators can emphasize the importance of this and continue to provide a warm and accepting supervisory relationship that will contribute to counselors' overall wellness.

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Appendix A: Participant Eligibility Questions

1. Are you employed by a mental health agency or organization (i.e., receive a W2) as a counselor in the United States?

   Yes

   No

2. Do you work at least 25 hours per week on average?

   Yes

   No

3. Did you graduate from a CACREP-accredited counseling program?

   Yes

   No

4. Have you worked for your current employer for one year or longer?

   Yes

   No

Appendix B: Demographic Questionnaire

1. My gender is:

   Male

   Female

   Other (specify): _____

   Prefer not to answer.

2. How would you describe your ethnicity (check all that apply)?

   American Indian or Alaska Native

   Asian

   Black or African American

   Native Hawaiian or Other Pacific Islander

   White

   Hispanic, Latino, or Spanish origin

   Non-Hispanic, Latino, or Spanish

   Prefer not to answer.

3. How has COVID-19 affected your work (check all that apply)?

   I provide telehealth/distance counseling from home.

   I provide telehealth/ distance counseling from my workplace.

   I provide in-person counseling only.

I provide telehealth/ distance counseling only.

I provide both in-person and telehealth/ distance counseling.

I lost work.

None.

Other (please describe) _____.

4. My current age is:

   20-25

   26-30

   31-35

   36-40

   41-45

   46-50

   51-55

   56-60

   61+

5. I am currently:

   Receiving supervision at least once every other week.

   Part of consultation group that meets at least once every other week.

   None of the above

Appendix C: Sample Questions for Five-Factor Wellness Inventory

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

Mark only one answer for each item using this scale:

Strongly Agree: If it is true for you most or all of the time.

Agree: If it is true for you some of the time.

Disagree: If it is usually not true for you.

Strongly Disagree: If it is almost or never true for you.

1. I engage in a leisure activity in which I lose myself and feel like time stands still.
2. I am satisfied with how I cope with stress.
3. I eat a healthy amount of vitamins, minerals, and fiber eat day.
4. I often see humor even when doing a serious task.

Appendix D: Sample Questions for Work Environment Scale

They are statements about the place in which you work. The statements are intended to apply to all work environments. However, some words may not be quite suitable for your work environment. For example, the term ***supervisor*** is meant to refer to the boss, manager, department head, or the person or persons to whom an employee reports.

You are to decide which statements are true of your work environment and which are false. Please be sure to answer every statement.

If you think the statement is true or mostly true of your work environment, **select true.**

If you think the statement is false or mostly false of your work environment, **select false.**

The work is really challenging.

TRUE FALSE

People go out of their way to help a new employee feel comfortable.

TRUE FALSE

Appendix E: Permission to use COSE

From: Larson, Lisa M [PSYCH] [redacted]
Sent: Tuesday, February 11, 2020 11:23 AM
To: Ashley Davis
Subject: Re: permission to use COSE

Ms. Davis,

I appreciate your interest in the Counseling Self-Estimate Inventory (COSE). To purchase the inventory, the cost is $50 plus $1.50 in postage. You would receive a copy of the instrument and a scoring sheet as well as a description and reference list of publications using the COSE.

If you are interested in purchasing the COSE, please submit a check or money order to:

[redacted]

Sincerely,

Lisa M. Larson, Ph.D.

From: Ashley Davis [redacted]
Date: Sunday, February 9, 2020 at 1:09 PM
To: Lisa Larson [redacted]
Subject: permission to use COSE

Hi Dr. Larson,

My name is Ashley Davis and I am a doctoral student at Walden University in the Counselor Education and Supervision program. I am writing to you to request permission to use the COSE measure in my dissertation.