5-25-2024

# The Self-Perceived Level of Wellness Among Ghanaian Mental Health Counselors

Adwoa Bonney-Graves
*Walden University*

# Walden University

College of Social and Behavioral Health

This is to certify that the doctoral dissertation by

Adwoa K. Bonney-Graves

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

Review Committee
Dr. Cynthia Briggs, Committee Chairperson, Counselor Education and Supervision Faculty
Dr. Jasmine Willis, Committee Member, Counselor Education and Supervision Faculty

Chief Academic Officer and Provost
Sue Subocz, Ph.D.

Walden University
2024

Abstract

The Self-Perceived Level of Wellness Among Ghanaian Mental Health Counselors

by

Adwoa K. Bonney-Graves

MA, Texas Wesleyan University, 2013

BS, Texas Wesleyan University, 2010

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Counselor Education and Supervision

Walden University

May 2024

## Abstract

In Ghana, many people seek help for their mental health; however, despite the great need, there are often barriers or factors that can create unwellness among mental health counselors. There is a gap in the research literature addressing whether unwellness among Ghanaian mental health counselors is caused by external factors of counselor caseload, low funding, and minimal work staff. This quantitative study aimed to fill this gap by using predictive regression analysis to determine whether there is a correlation between Ghanaian counselors' unwellness and counselor caseload, low funding, and minimal work staff. The study participants ($N = 96$) were Ghanaian mental health counselors actively practicing in Ghana and providing mental health services. The results determined some correlation between the dependent variable (wellness) and independent variables (work staff, counselor caseload, and funding). The holistic wellness theory served as the theoretical framework for this study because it applies to multicultural research studies and diverse populations and allows for assessing various levels and dimensions of wellness. The Five Factor Wellness Inventory (5F-WEL) was used to assess participants' level of wellness and unwellness, and a survey was used to measure the impact of low funding, minimal work staff, and counselor caseload on participants. The study results could lend support for the need to create a revised training model that incorporates wellness practices for counselors in Ghana. Potential implications for positive social change include the awareness of addressing the importance of counselor wellness and unwellness and incorporating measures to implement a wellness program as part of counselor onboarding for Ghanaian mental health counselors.

# The Self-Perceived Level of Wellness Among Ghanian Mental Health Counselors

by

Adwoa K. Bonney-Graves

MA, Texas Wesleyan University, 2013

BS, Texas Wesleyan University, 2010

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Counselor Education and Supervision

Walden University

May 2024

# Dedication

I dedicate this to my late beloved grandmother, Madam Veronica Violet Bonney who showered me unconditionally with love, support, and guidance.

My auntie Rennie and cousin Esther (who I claim to be my younger sister), for their unwavering love, support, and prayers that have anchored and empowered me through this journey to believe in my abilities to accomplish my doctoral degree.

I also dedicate this to all the dreamers full of ambition, may you never give up on what you are destined to do and be inspired to grow through adversity.

# Acknowledgments

"I would have lost heart if I did not know the goodness of God in the land of the living. Wait on the Lord, be of good courage, and he shall strengthen your heart, wait, I say on the Lord." Psalm 27:13-14. This scripture captures how my faith in God has sustained me during one of the most challenging academic journeys of my life. I trusted God to direct my path and align me with the right people to support and guide me along this journey, and he did not fail me. I am filled with immense gratitude for how God has truly favored and blessed me during my doctoral journey.

Family & Friends:

I want to thank my late and beloved grandmother, who continues to be my inspiration and the wind beneath my wings during this time. I began my doctoral program five months after my grandmother passed away. I was inspired, motivated, and scared to begin this journey, yet I was more prepared to honor her for all her sacrifices in raising me, for instilling in me the significance of seeking education beyond limitations, for setting the example of a phenomenal woman, who without many resources, made sure to still rise above adversity. Grandma, we made it. I know you are so proud of me. I thank you for always believing and entrusting me with the gift of responsibility and always giving me room to flourish and shine. I deeply love you and I thank God for you. It is because of your dream for me and my life, is why I am here as the doctor you always said I would become, Dr. Adwoa K. Bonney-Graves.

To my auntie Rennie and my cousin Esther-Eno (I call my baby sis), I want to thank you for your unwavering prayers, overflow of support, and love. The times when I

just did not know whether to continue or give up, you anchored me with support. Your stories of being overcomers and your unshakeable faith demonstrated to me to keep pushing, praying, and believing that this day would come. I thank you for the times we still laughed even when we felt like crying and when you cheered me on to envision that then-distant graduation day and how we would celebrate. To be at this point and share this moment with you is one I do not take for granted. Thank you for being present at every single milestone, graduation, and life moment. Thank you for being my constants, prayer warriors, and best friends. I thank you for not ever doubting me and always knowing that I was destined to become Dr. Adwoa K. Bonney-Graves. I love you deeply and thank God for you. I thank the rest of my immediate and external family in Ghana for their continued support, encouraging words, and well wishes.

I want to thank all my friends whom I consider *fr-amily*. All of you are God's gift to me. Your support along the way has encouraged me in times when I did not feel empowered or wanted to give up. Each of you inspires me in your ways and motivates me with your own stories of triumph. Thank you for embracing me, pouring into me, and being in my corner.

Walden Faculty and Staff:

To my dissertation committee, Dr. Cyndi Briggs (chair) and Dr. Jasmine Willis (committee member), I could not have asked for a more thoughtful and dynamic team. Both of you were committed to helping me get to the finish line and anchored me with support, time, and dedication, your encouragement, and most of all cheering me on along the way with #OperationGraduation. Dr. Briggs, thank you for an exemplary

demonstration of allyship, mentorship, and support beyond measure. Thank you for always seeing me as more than capable of achieving this goal and the multiple opportunities you provided to me to help me grow professionally and academically. I look forward to finally meeting for coffee and tea from my special cup. Dr. Jasmine Willis, words cannot express my gratitude for your commitment to getting me to the finish line. Thank you for an exemplary demonstration of paying-it-forward that you would step in at the right time to get me to this point. In my most challenging times, you stepped in to push and motivate me, you prayed for me and with me and kept me accountable. I look forward to now collaborating and co-presenting with you.

To Dr. Ariel Harrison, thank you for the opportunity to submit my first manuscript for a textbook chapter. It is an opportunity I will cherish forever and will not take for granted. I also thank you for your guidance, leadership, and support of all members of Tapestry. Thank you for your willingness to always see us grow and flourish with the different opportunities you send our way. I look forward to future projects with you.

To Dr. Melinda Haley, I want to thank you for the opportunities you gave me as your Teacher's Assistant that helped develop my teaching skills and dedication as an educator. I thank you for your support during the start of my doctoral journey and for your continued support for my professional growth.

To my advisor Gabe Turner, thank you for your consistency in your term check-ups to ask how things were going and for helping me plan the next steps. I appreciated your honesty, guidance, and exceptional advisory service during my time at Walden.

My doctoral sisterhood:

I want to thank Dr. Jasmine Willis, Dr. PaQuita Pullen, and Dr. Rhemma Payne. I am honored to have each of you in my life and to share this milestone with each of you. I met each of you at key points during my doctoral journey and I can only thank God for aligning us in such a remarkable way. I am honored to join you as a collective that reflects why representation matters. For every prayer you said for me, every seed you sowed for my progress through this program, our laughs and sentiments in our group chat, and every time and commitment you extended to me, my cup runneth over with gratitude. I am excited to finally join you in this esteemed honor and cannot wait to see all the amazing things we are going to do in the field.

To Dr. Anita Neuer-Colburn, thank you for the opportunity to be on your team of university supervisors for graduate students. Beyond this opportunity, I sincerely thank you for your gentle guidance, support, and leadership. Thank you for your example of what empowering leadership looks like and for always being willing to pour into me as an emerging counselor educator. I am most grateful to call you a friend and be part of your circle.

Lastly, I want to thank myself for proving that I could complete this program and not give up. All the hurdles and setbacks I endured were steppingstones to get me to this point. I am so glad to make six-year-old me proud. I cannot believe I am here and now Dr. Adwoa K. Bonney-Graves. I thank God for this amazing journey.

Table of Contents

List of Tables

List of Figures

# Chapter 1: Introduction to the Study

Ghanaian mental health workers are enthusiastic about their work with clients within their communities. However, although they value their work as mental health workers, there are often barriers or factors that can present unwellness. There is limited empirical evidence about mental health in workplace settings in Africa (Asare-Doku et al., 2021). Specific to Ghana, mental health-related symptoms and factors contributing to those symptoms include working shifts of more than 12 hours, physical working conditions, and financial factors, which also impact psychological distress (Asare-Doku et al., 2021).

In Ghana, about 21.6 million people present with moderate to severe mental illness, out of which 650,000 are severe mental health cases and 2,166,000 are moderate to mild cases (Deborah et al., 2019), as a result, there is a need for Ghanaian mental health workers. However, despite the significant role of mental health professionals, including mental health nurses, several challenges in caring for consumers with severe conditions are prevalent and mostly influenced by personal qualities, professional skills, and environmental factors (Deborah et al., 2019). Mental health caregivers experience a burden of care in mental health that is associated with difficulties such as symptoms of anxiety, depression, and stress, which negatively affect their lifestyles and well-being (Ocansey et al., 2021).

Although studies have addressed some of the previously noted experiences of Ghanaian mental health workers, there are also gaps and limitations in the literature. In Ghana, several empirical studies about mental health services have focused on treatment

pathways and health system weaknesses; however, these studies have not explored the burden of care from the perspective of mental health caregivers (Deborah et al., 2019).

In considering unwellness among Ghanaian mental health workers, there is a gap in literature addressing whether unwellness is caused by external factors of counselor caseload, low funding, and minimal work staff. This research study aims to contribute to the gap in the literature, using a quantitative study to predict whether there is a correlation between counselor unwellness among Ghanaian counselors and counselor caseload, low funding, and minimal work staff. Potential implications for positive social change include the awareness of addressing the importance of counselor wellness and unwellness and incorporating measures to implement a wellness program as part of counselor onboarding for Ghanaian mental health counselors.

In Chapter 1, I present the background information on Ghanaian mental health workers experiencing unwellness and discuss each of the external factors of low funding, counselor caseload, and minimal work staff. I identify the problem statement, the purpose of the study, and the research questions and hypotheses. Additionally, I provide a brief description of the theoretical framework and nature of my study and provide definitions, assumptions, limitations, and delimitations. Lastly, I identify the significant and potential contributions of my study.

## Background

Due to limited current research on my topic, I referenced a few older research articles related to the scope of my research topic. From historical data, case studies, and observations, there is an unclear understanding of the benefits of counseling in Non-

Western countries like Ghana, due to the perception of mental health counselors, and psychiatrists, and the lack of quantitative research examining Ghanaian counselors' self-perceptions regarding their level of wellness through a quantitative measure (Lo & Dzokoto, 2005). By providing historical data on the mental health perspectives in Ghana, I provide insight and results that may impact funding for mental health services.

Kugbey et al. (2015) identified an apparent problem between factors affecting psychological well-being and the lack of social support for Ghanaian mental health staff and counselors. The association between low funding and limited qualified mental health staff in Ghana is due to the shortage of trained mental health professionals, unmet mental health care needs among their clientele, and the overall mental health care government-funded budget of only 0.5% of the total health care budget (Agyapong et al., 2015).

The lived experiences and reported burdens of caregivers of patients with mental disorders are related to funding, social exclusion, emotional depression, and inadequate time for social responsibilities (Ae-Ngibise et al., 2015). The lack of funding to support and provide a functional mental health information system for Ghanaian mental health staff has presented challenges such as an increased workload, poor staff involvement, and training (Kpobi et al., 2018). The mental help systems in Ghana are overwhelmed with severe and chronic mental health issues which present challenges for staff to provide services, as a result, mental health clients tend to seek services from lay counselors and religious groups (Osei-Tutu et al., 2019).

Concerning wellness, Thomas and Schmuldt (2012) addressed the correlation between wellness and counselor impairment and found that significant causes of

impairment include personal crises, burnout, mental and physical illnesses, and substance abuse. Awareness and wellness programs and counseling sessions help to overcome counselor unwellness among health professionals (Degheili et al., 2019). The wellness of counselors is important to ensure counselors provide the best services to their clients (Taylor et al., 2018). The gap in knowledge in the discipline I address through my study is that there is little research on whether there is a relationship between experiences of unwellness among Ghanaian mental health counselors and counselor caseload, low funding, and minimal work staff. This study is needed because although researchers have investigated this issue of unwellness among Ghanian counselors, the topic has not been explored in the same way as my study, to predict whether there is a relationship between counselor caseload, low funding, and limited work staff, and wellness.

## Problem Statement

The problem is that Ghanaian mental health workers are experiencing unwellness from counselor caseloads, low funding, and minimal work staff while providing mental health care and services to their clients. About 56.2%, 66.2%, and 78% of Ghanaian caregivers of clients with mental disorders have experienced severe anxiety, depression, and moderate to severe stress-related symptoms, respectively (Ocansey et al., 2021). The increased burden of care in mental health has presented difficulties related to the poor psychological well-being of caregivers, which has negatively impacted their lifestyles, relationships, and professional roles and responsibilities to clients (Ocansey et al., 2021).

Other factors that impact Ghanaian mental health workers are barriers that impact their clients from accessing mental health services. These barriers include general

attitudes and knowledge about mental health services, cost of treatment, access to transportation, and general proximity to receiving services (Badu et al., 2018). Additionally, factors within the health systems that add to these barriers are low priority and limited funding sources for mental health services, irregular medicine supply, limited services for marginalized groups, and poor state and management of psychiatric facilities and mental health cadres (Bade et al., 2018).

Ghanaian mental health professionals mostly experience challenges with managing clients exhibiting aggressive behavior, mostly from clients who have relapsed from treatment, which becomes burdensome for mental health professionals (Deborah et al., 2019). The burden experienced by Ghanaian mental health professionals is increased due to the limited training, knowledge, and skills to manage aggressive behaviors from clients (Deborah et al., 2019). As a result, further training in this area is recommended to help mental health professionals adequately manage these aggressive behaviors from their clients (Deborah et al., 2019). Though there is literature about the impact of low funding, counselor caseload, and minimal work staff on Ghanaian mental health counselors, there is no current research focused on whether these factors cause Ghanaian mental health counselors to experience unwellness. My research study is needed because although researchers have investigated this issue of unwellness among Ghanian counselors, the topic has not been explored in the same way as in my study, to predict whether there is a relationship between counselor caseload, low funding, and limited work staff, and wellness.

## Purpose of the Study

The purpose of my quantitative study was to predict whether there is a relationship between the independent variables (IVs)—external factors of counselor caseload, low funding, and limited work staff—and the dependent variable (DV), wellness, as determined by the Five Factor Wellness Inventory (5F-WEL).

## Research Questions and Hypotheses

RQ: Does counselor self-perceived levels of wellness of Ghanaian mental health counselors (as measured by the 5F-WEL assessment), counselor caseload (as measured by demographic questionnaire), low funding (as measured by demographic questionnaire), limited work staff (as measured by demographic questionnaire).

$H_0$: There is no predictive relationship between counselor self-perceived levels of wellness of Ghanaian mental health counselors (as measured by the 5F-WEL assessment), counselor caseload (as measured by demographic questionnaire), low funding (as measured by demographic questionnaire), limited work staff (as measured by demographic questionnaire), that predicts counselor levels of unwellness (as measured by demographic questionnaire).

$H_1$: There is a predictive relationship between counselor self-perceived levels of wellness of Ghanaian mental health counselors (as measured by the 5F-WEL assessment), counselor caseload (as measured by demographic questionnaire), low funding (as measured by demographic questionnaire), limited work staff (as measured by demographic questionnaire).

## Theoretical Framework

The holistic wellness theory provides the theoretical framework for my study. After an exhaustive literature review, I discovered conflicting information about the origin of the holistic wellness model. However, factors in the holistic wellness model are evident in current approaches to wellness. The modern concept of wellness is composed of holistic and positive health that emerged in academic research within the health sciences beginning in the late 1950s, from theorists such as Dunn in 1959-1961, Travis in 1972, Ardell in 1977, and Hettler in 1980 (Grénman, 2019). Other theorists from humanistic psychology (e.g., Rogers in 1961; Maslow in 1954), counseling (Myers et al., 2000; Sweeney & Witmer, 1991; Witmer & Sweeney, 1992;), positive psychology (e.g., Csikszentmihalyi in 2000 and Seligman in 2012), and transformative consumer research (e.g., Mick in 2006 and 2012) have also contributed to the theme of wellness and specifically holistic health (Grénman, 2019). Another source noted that the holistic wellness model was developed by Chandler et al. (1992) based on the six dimensions of wellness: intellectual, physical, spiritual, occupational, social, and emotional (Koo et al., 2021).

In holistic wellness theory, wellness is conceptualized as a multidimensional and synergistic construct that focuses primarily on the positive aspects of wellness (Mayer et al., 2020). Counselors' wellness is an important concept to ensure counselors are providing the best services to their clients (Taylor et al., 2018). Specific to my topic, I focused on the social, emotional, environmental, and physical dimensions of wellness. Within the various models of holistic wellness theory, there are two overarching

principles, holism, and optimal functioning, which are generally used to define and clarify the concept of holistic wellness in counseling (Moe et al., 2012). The first principle of holistic wellness is holism, which suggests that individuals are viewed as unified wholes and are more than the sum of their parts (Moe et al., 2012; Sweeney & Witmer, 1991), as a result, although there are different aspects of human functioning, such as mental or physical health, all aspects of an interrelated and emergent system that affect one part lead to change in the whole (Moe et al., 2012). Some documented examples that are evident in illustrating the principle of holism include the relationship between social relationships and overall well-being (Hartwig & Myers, 2003) and mental health and spirituality (Moe et al., 2012; Savolainen & Granello, 2002; Witmer & Sweeney, 1992).

The second principle of holistic wellness, optimal functioning, posits that human beings can continually develop in capacity and are resilient across interrelated domains over the lifespan (Moe et al., 2012; Sweeney & Witmer, 1991). Furthermore, optimal functioning notes that health and overall life satisfaction should not be only defined by the absence of illness but also by the presence of factors and characteristics that promote health (Moe et al., 2012; Sweeney & Witmer, 1991). These two principles of the holistic wellness model promote the adoption of a preventative, developmental, and strength-based approach that is the foundation for the collective professional identity of counselors and informs standard counseling practice (Moe et al., 2012; Myers, 1992; Remley & Herlihy, 2001). In Chapter 2, I will provide more in-depth information about the holistic wellness theory, identifying its relation to my study, and other wellness models.

## Nature of the Study

The specific research design for my study included a predictive regression analysis. I used the 5F-WEL as the instrument for assessment (i.e., based on five general factors of self: creative, coping, social, essential, and physical, as well as levels of impairment), surveys to measure and determine external factors, and a demographic questionnaire for data collection. I purchased the 5F-WEL assessment tool and implemented survey questions. The quantitative analysis helped me to determine the self-perceived level of wellness of the participants administered and collected at one time. I measured the external factors—counselor caseload, low funding, and minimal work staff—using a demographic questionnaire I composed in SurveyMonkey. I used the demographic questionnaire to determine the caseloads of the counselors by asking how many clients each counselor is currently serving daily, weekly, or monthly and what number of clients determines a high or low caseload. The counselors answered questions about their caseloads by selecting from choices such as 1–10, 11–20, 21–30, 40–50, or unlimited.

I recruited participants for my study by inviting all mental health counselors from a national directory, which stores a list of Ghanaian mental health counselors, psychologists, clinicians, and staff. I only recruited Ghanaian mental health counselors, currently practicing in Ghana, who agreed to participate in the study. If I was not able to recruit all participants from the directory, I would also invite participants from the clinical department at Ridge Hospital, a county hospital in the Greater Accra region of

Ghana. Additionally, if needed, I would also invite participants via social media outlets with Ghanaian mental health counselors' groups.

Participants included Ghanaian mental health counselors listed in a national directory. Participants participated in the study online by answering the survey questions created in SurveyMonkey and taking the 5F-WEL assessment. I did not collect any identifying information (i.e., names) and all results were in aggregate form. The data points I used to answer my research question include the results from the 5F-WEL assessment based on five general factors of self: creative, coping, social, essential, physical, and levels of impairment. Additional data points from the survey questions addressed the external factors: counselor caseload, low funding, and minimal work staff, to predict whether there is a relationship between these IVs and the DV, wellness.

## Definitions

*Counselor caseload*: Counselor caseload is the workload in the number of clients assigned to Ghanaian mental health counselors serving clients experiencing mental health issues (Kpobi et al., 2018).

*Limited work staff*: Limited work staff is a shortage of trained mental health professionals who are serving clients with significant unmet mental healthcare needs. (Agyapong et al., 2015).

*Low funding*: A lack of funding to support mental health systems in Ghana presents challenges to mental health staff (Kpobi et al., 2018).

*Unwellness*: Unwellness is defined as an outcome of counselor impairment caused by burnout, and mental and physical illnesses, causing a negative impact on a counselor's professional functioning (Thomas & Schmuldt, 2012).

*Wellness*: Wellness is defined as a multidimensional and holistic view of individuals' optimal health and well-being, and although viewed differently throughout helping professions, it is a growth-oriented and strength-based process, that extends beyond illness to optimal well-being (Blount & Lambie, 2017; Dillman et al., 2018; Fetter & Koch, 2009; Myers et al., 2000).

## Assumptions

I can identify several assumptions within my study. Some initial assumptions were that all participants would understand the survey questions, provide honest responses after receiving informed consent for participating in the study, and answer the survey questions without any bias. Additionally, I assumed that participants' responses would vary based on their individual experiences with unwellness impacted by the external factors of counselor caseload, low funding, and limited work staff. Lastly, another assumption was that data collection results would be accurate and reliable.

## Scope and Delimitations

In my study, I aimed to predict whether external factors such as counselor caseload, low funding, and minimal work staff cause unwellness within Ghanaian mental health counselors based on their self-perceived level of wellness using the 5F-WEL assessment scale and a demographic questionnaire. For my study, I targeted Ghanaian male and female mental health counselors, who are currently in private practice, working

in various settings such as hospitals or clinics, nonprofit agencies, and educational institutions, and are not inclusive of the general population or other health professionals.

## Limitations

The limitations of using survey research methods are the issue of nonrespondents creating a low response rate and providing inaccurate responses. Surveys that fail to collect data from every respondent in the sampling frame jeopardize representativeness and contain nonresponse bias (Fulton, 2018; Groves, 2006), as a result, low response rates undermine the external validity of the data (Fulton, 2018). Limitations of using this design include that retrospective data, which are often incomplete or difficult to obtain, may not meet all requirements to determine causality and may lack internal validity (Schweizer et al., 2017).

My research design did not allow me to make any claims regarding causality, as a result, I could only be able to demonstrate whether there is a relationship among the variables of my study and whether my IVs predict my DV. Low response rates from a large proportion of sampled respondents undermine the external validity of the data, increase the risk of variables containing nonresponse bias, and produce biased estimates and hypothesis tests (Fulton, 2018).

Consequently, even using pre-existing surveys should be re-evaluated for validity and reliability evidence because a lack of validity with using a pre-existing survey with new sampling information indicates a reason to edit the pre-existing survey or create a new one (Phillips, 2017). Additionally, the accuracy of survey data relies on the ability of respondents to accurately interpret the meaning of survey items and honestly report their

individual experiences and behaviors (Burkholder, 2016). The reasonable measures I used to address these limitations were to provide clear instructions, compose the demographic questionnaire and statements in a simple and short format, and avoid complicated skip patterns that can be difficult for respondents to follow (Burkholder et al., 2016).

## Significance

The results from my study could lend support for the need to create a revised training model that incorporates wellness practices for counselors in Ghana. Potential implications for positive social change include the awareness of addressing the importance of counselor wellness and unwellness and incorporating measures to implement a wellness program as part of counselor onboarding for Ghanaian mental health counselors. Previous research has only focused on the effect of low funding, minimum work staff, burdens on mental health workers, and the increased need for mental health services in Ghana.

There is limited research on the need for wellness programs for Ghanaian counselors experiencing unwellness and continued education or training for those experiencing wellness within their daily practice. Information from my study could assist mental health counselors in Ghana with specified recommendations to enhance wellness practices in the workplace and community.

## Summary

Ghanaian mental health counselors could be experiencing unwellness due to counselor caseloads, low funding, and minimal work staff. Through my study, I aim to

explore whether there is a relationship between these variables. In Chapter 1, I provided a background of some of the mental health concerns experienced by Ghanaian mental health counselors, addressed the significance of my study, provided definitions, identified my assumptions, and briefly described the theoretical approach for my study. In Chapter 2, I will provide a comprehensive review of the existing literature on counselor caseload, low funding, minimum work staff, wellness, and unwellness of Ghanaian mental health counselors.

# Chapter 2: Literature Review

Ghanaian counselors experience unwellness due to external factors, impacting their ability to effectively help their patients and clients. The burden of care on mental health counselors in Ghana attending to mental health patients and clients varies in degrees related to low funding and emotional depression (Ae-Ngibise et al., 2015). The specific research problem that I addressed in my study was to predict if Ghanaian mental health counselors experience unwellness due to external factors including counselor caseload, low funding, and minimal work staff. There is little or no literature on understanding whether there is a relationship between Ghanaian mental health counselors experiencing unwellness, counselor caseload, low funding, and minimal work staff.

Historical data, case studies, and observations ascertain that there are similarities and differences between Western and non-Western countries, such as Ghana and Taiwan, and the perception of counseling (Lo & Dzokoto, 2005). The benefits of counseling services are unclear in these countries due to the perception of mental health counselors, psychiatrists, and psychologists; as a result, providers cannot always aid people in solving their mental health problems (Lo & Dzokoto, 2005). Most recently, researchers concluded that counseling services have evolved in Ghanaian culture and there is a need to educate the public about the purpose of receiving counseling services and acknowledging Ghanaian mental health counselors who provide those services (Asante & Oppong, 2012).

There is a presenting problem between factors affecting the well-being of Ghanaian mental health counselors and the lack of social support for them; as a result, the

presence of depression and high-stress levels can impact their work performance (Kugbey et al., 2015). Among other factors, a shortage of trained mental health professionals results in unmet mental health care needs for the public, and the overall mental health care system in Ghana, although government funded, receives a budget of 0.5% of the entire health care budget, which impacts funding for staff development and training, as well as employment for more counseling staff (Agyapong et al., 2015). Additionally, low funding or lack thereof to support Ghanaian mental health counselors to provide mental health services and use a functioning mental health information system has presented challenges to Ghanaian mental health counselors due to an increased caseload, poor staff involvement, and lack of training opportunities (Kpobi et al., 2018).

Other factors that impact Ghanaian counselors are that their lived experiences and reported burdens from providing mental health services derive from low funding, social exclusion, emotional depression, and inadequate time for social responsibilities (Ae-Ngibise et al., 2015). Additionally, due to the overwhelming need to provide services for clients presenting with severe and chronic mental health issues, mental health counselors in Ghana are overwhelmed with high demand and minimal staff to provide services, and as a result, mental health clients tend to seek help and services from lay counselors or religious groups, who are inexperienced to fully provide the appropriate treatment (Dzokoto et al., 2019). With these factors in mind, Ghanaian mental health counselors may experience some events and circumstances that could impact their wellness, jobs, and livelihood.

There is a correlation between wellness and counselor impairment among counselors and members of the helping professionals (Thomas & Schmuldt, 2012). Counselor impairment alone can be a significant cause of personal crisis, burnout, mental and physical illnesses, and substance abuse (Thomas & Schmuldt, 2012). Although my study does not focus on counselor impairment, considering that a correlation can exist between wellness and impairment could lead to a future study or an extension of my current study. Another symptom of impairment is burnout. Although I do not include information about burnout in my current study, burnout impacts the wellness of counseling and health professionals, as a result, seeking help with burnout should be included in various wellness programs and counseling sessions (Degheili et al., 2019).

The perceived wellness levels among counseling trainees and their overall wellness are important concepts to ensure counselors are providing the best services to clients (Dillman et al., 2018). This supports my study in that the perceived level of wellness among counselors contributes to providing effective services to clients and counselors implementing best practices.

## Literature Search Strategy

I implemented an extensive literature search strategy using the following databases within Walden University's Library Database: ProQuest, ERIC, Academic Search Complete, Business Source Complete, APA PsycINFO, Complementary Index, IEEE Xplore Digital Library, Directory of Open Access Journals, Education Source, Research Gate, and Sage Journals. I also included dissertations from Walden University, as well as dissertations and theses from other institutions, that were similar to my

research topic or that used similar instruments, such as surveys and wellness assessments, such as the 5F-WEL. I used Google Scholar to search for articles on research design, theoretical framework, and wellness theories. I also used a snowball search approach by reviewing articles from the reference lists of some articles to find additional literature relevant to my study and key words included in my search.

My search included a Boolean search that permitted me to use search operators like “OR” and “AND” to combine my search words and terms. I primarily focused on peer-reviewed journal articles, then included a few book reviews, and excluded searches from websites. Initially, when searching specifically for literature on my selected theoretical framework, the holistic wellness model, I did not specify a specific date range because I wanted to find information on the origin of the holistic wellness model. Once I gathered sufficient historical information on my selected theoretical framework, I then specified my date range to be within 5 years of the anticipated publication of this study (2018–2023) to look for any current literature. However, because there is limited scope on parts of my topic, I maintained flexibility with using existing literature before the 5-year range, only if conducive to the development of my study.

The keywords that I searched were Ghanaian mental health counselors, counseling in Ghana, counseling, and wellness, wellness theory, holistic wellness model, holistic wellness theory, wellness models, five-factor wellness inventory, counselors, and caseload and unwellness, counselors and funding, counselors and funding and unwellness, counselors and limited work staff, counselors and limited work staff and unwellness, and counseling services and training in Ghana. There is not much current

research on my topic, so I also included a few older articles in my search. After a thorough review of previous and current literature, I determined that there is sparse literature on understanding whether there is a relationship between Ghanaian mental health counselors experiencing unwellness, counselor caseload, low funding, and minimal work staff.

## Theoretical Foundation

In the following sections, I describe the specific theory of wellness for my study, multicultural considerations, and its relation to my study.

### Holistic Wellness Theory

In Chapter 1, I noted that after an exhaustive literature review, I discovered conflicting information about the origin of the holistic wellness model. The modern concept of wellness is composed of holistic and positive health that emerged in academic research within the health sciences beginning in the late 1950s, from theorists such as Dunn in 1959-1961, Travis in 1972, Ardell in 1977, and Hettler in 1980(Grénman, 2019). Other theorists from humanistic psychology (e.g., Rogers in 1961 and Maslow in1954), counseling (Myers et al., 2000; Sweeney & Witmer, 1991; Witmer & Sweeney, 1992), positive psychology (e.g., Seligman in 2012 and Csikszentmihalyi in 2000), and transformative consumer research (e.g., Mick in 2006 and 2012) have also contributed to the theme of wellness and specifically holistic health (Grénman, 2019).

In holistic wellness theory, wellness is conceptualized as a multidimensional and synergistic construct that focuses primarily on the positive aspects of wellness (Mayer et al., 2020). Holistic wellness has concepts that inform best practices for counselors and

other mental health professionals (Moe et al., 2012; Myers et al., 2001). Within the holistic wellness theory are various models that exist due to different theorists' perspectives on the aspects of human experience such as mind, body, spirit, and community, which presents a multi-faceted concept (Moe et al., 2012). I will discuss these models and theorists later in this chapter.

After an exhaustive literature review, I could not find current literature on the development of holistic wellness theory; therefore, I cited older sources. Within the various models of holistic wellness theory, there are two overarching principles, holism, and optimal functioning, which are generally used to define and clarify the concept of holistic wellness in counseling (Moe et al., 2012). The first principle of holistic wellness is holism, which suggests that individuals are viewed as unified wholes and are more than the sum of their parts (Moe et al., 2012; Sweeney & Witmer, 1991); as a result, although there are different aspects of human functioning, such as mental or physical health, all aspects of an interrelated and emergent system that affect one part cause change in the whole (Moe et al., 2012). Some documented examples that are evident in illustrating the principle of holism include the relationship between social relationships and overall well-being (Hartwig & Myers, 2003), and mental health and spirituality (Moe et al., 2012; Savolaine & Granello, 2002; Witmer & Sweeney, 1992).

The second principle of holistic wellness, optimal functioning posits that human beings can continually develop in capacity and are resilient across interrelated domains over the lifespan (Moe et al., 2012; Sweeney & Witmer, 1991). Furthermore, optimal functioning notes that health and overall life satisfaction should not be only defined by

the absence of illness but also by the presence of factors and characteristics that promote health (Moe et al., 2012; Sweeney & Witmer, 1991). These two principles of the holistic wellness model promote the adoption of a preventative, developmental, and strength-based approach that is the foundation for the collective professional identity of counselors and informs standard counseling practice (Moe et al., 2012; Myers, 1992; Remley & Herlihy, 2001).

Based on the historical emphasis on holistic wellness in counseling, counselors are urged to integrate wellness concepts into conceptualization and treatment planning with their clients so that the connection between wellness, health, and life satisfaction is supported (Moe et al., 2012). By using a holistic approach in counseling, several influential components in an individual's life are addressed, including biological, psychological, social, and spiritual; therefore, balancing these components affects the overall health and well-being of individuals (Berry & Berry, 2018; Fullen, 2016).

**Multicultural Considerations**

Holistic wellness theory applies to conceptualizing the needs of culturally diverse people, including ethnically and sexually diverse groups (Moe et al., 2012). A study by Rayle and Myers (2004) documented a positive correlation between ethnic identity and overall wellness in adolescents belonging to ethno-racial minority groups, identified spirituality as an aspect of wellness that significantly correlated to both overall wellness and the ethnic identity development for African American adolescents (Moe et al., 2012).

In another study, Garret et al. (2008) described a group counseling technique in correlation with Native American beliefs and identified that promoting harmony between

different levels of mind, body, spirit, nature, and relationships is an essential component of Native American views on health and wellness (Moe et al., 2012). With these findings, it is informative to know that in holistic wellness theory domains that are emphasized as aspects of health by different cultures facilitate multicultural competency among counselors who engage with clients whose worldview is not based on traditional medicine or interventions (Moe et al., 2012).

### Relation to the Present Study

Holistic wellness theory is applicable to use in multicultural research studies and diverse populations; as a result, it is a fitting theory for my study to predict if Ghanaian mental health counselors experiencing unwellness is due to counselor caseload, low funding, and minimal work staff. Using a holistic approach addresses several influential components in an individual's life which include biological, psychological, social, and spiritual components (Berry & Berry, 2018). By using this theory for my study, I can assess the various levels and dimensions of wellness, specifically the social, emotional, environmental, and physical dimensions of wellness.

## Literature Review Related to Key Variables and Concepts

In this section, I will define and describe information related to the key variables and concepts of my study.

### Definition of Wellness

The word "wellness" was developed by Dunn (1961) from a combination of the words "well-being" and "wholeness" (Erzsebet & Zsuzsa, 2016). Wellness as defined by Myers et al. (2000) is a way of life oriented toward optimal health and well-being in

which the individual integrates body, mind, and spirit to live fully within the human and natural community (Branco & Patton, 2020). Wellness involves a coherent integration of human functioning to achieve a favorable level of health to meet the goal of optimum wellness (Pomeroy & Clark, 2015). It is important to note that, despite significant attention to wellness in the literature, there is little consensus on its actual definition due to researchers failing to agree on one definition or a dimensional structure of wellness (Roscoe, 2009).

Having a clear definition of wellness is difficult due to its subjective nature and the inherent value judgment about what wellness is and what it is not, and that an individual can either be well or not (Kelly, 2000; Roscoe, 2009; Sarason, 2000). Nevertheless, the World Health Organization's (WHO) definition of health provided the foundations for defining wellness by three dimensions: physical, mental, and social health; these dimensions, as a result, highlighted that wellness is not only comprised of individual aspects but an integrated whole (Bart et al., 2018). Furthermore, wellness results from a balance of dimensions to allow an individual to cope with life circumstances, achieve an optimal state of being, and practice lifestyle behaviors that surpass basic health (Bart et al., 2018).

The wheel of wellness theoretical framework developed in 1998 to better understand the concept of wellness, defined wellness as a way of life oriented towards optimal health and well-being which integrates mind, body, and spirit for an individual to live life fully (Bart et al., 2018). In 2004, the WHO Health Promotion Unit in Switzerland updated the definition of wellness in the Health Promotion Glossary as the optimal state

of health of individuals and groups, with two focal concerns: realizing an individual reaching their fullest potential physically, psychologically, socially, spiritually, and economically; the other being an individual's fulfillment of the expectations of their roles in the family, community, place of worship, workplace, and other settings (Bart et al., 2018). Other definitions of wellness assert that it is often considered the endpoint of physical, mental, or social interventions, as a result, to accurately assess wellness, comprehensive measurement methods that accurately identify and evaluate the various wellness dimensions are necessary (Bart et al., 2018).

## Theories and Models of Wellness

I will describe below various theories and models of wellness I found during my thorough literature review.

### *The Wheel of Wellness Model*

Witmer et al. (1998) first proposed the wheel of wellness, which evolved from the Adlerian principles of work, friendship, and love and included aspects of self and spirit (Berry & Berry, 2018). The symbol of the wheel shows how components of the wheel influence other components and sometimes disrupt the balance of the wheel, however, in this model, five life tasks are proposed and depicted on the wheel, these five life tasks are spirituality, work, leisure, friendship, love, and self-direction (Berry & Berry, 2018).

The intent of using this model is to bring awareness to the components of healthy functioning and to understand the interrelated and interconnected relationship of the components of wellness (Berry & Berry, 2018). It is essential to understand that, with the wheel of wellness model, if an individual attains fulfillment only in one area, such as

work, they will be lacking in other capacities of the wheel causing the achievement of an optimum state of health and well-being to become more remote (Pomeroy & Clark, 2015).

Berry and Berry (2018) explored themes from a wellness counseling group with aging adults using the wheel of wellness model to explore aspects of wellness counseling in group work. It is important to note that only participants who were their guardians and had no diagnoses of a cognitive disorder, such as dementia, were included in the study, as including those with such diagnoses would diminish the participants' capacity in the study and difficult to attain informed consent (Berry & Berry, 2018).

Using a snowball sampling procedure, participants recruited for the study were eight senior adults (ages 71-92), four males and four females, with diverse marital statuses (3 widowed, 3 divorced, 1 single, 1 married and living with a wife), and race and ethnicity (4 White, 2 African-American, 2 Hispanic) selected to participate in a group counseling program for 12-weeks; researchers used pseudonyms to conceal the real names of the participants for confidentiality (Berry & Berry, 2018).

Using a qualitative research method and grounded theory as the theoretical approach, researchers introduced the wheel of wellness model to senior adults participating in the study, to investigate aspects of wellness that may be more relevant in their lives and gain insight into their understanding of concepts of wellness (Berry & Berry, 2018). Researchers introduced the wheel of wellness model to participants at the start of the study and focused on specific aspects of the model during subsequent sessions (Berry & Berry, 2018). Participants reflected on their meaning of concepts of the model

and the model itself, this approach was implemented by asking participants the following research questions: (a) What aspects of the lives of the elderly are important to them as evidenced by the content of the group sessions? and (b) What anxieties and fears did the members have about aging and their current lives (Berry & Berry, 2018)? The counseling sessions were conducted by one of the researchers, a licensed professional counselor with 10 years of experience working with the target population selected for this study, in both inpatient and outpatient mental health settings (Berry & Berry, 2018).

The 12 group one-hour counseling sessions were recorded using a digital audio recorder and were transcribed by one of the researchers (Berry & Berry, 2018). After completing 12 group sessions with the participants and transcribing their responses, researchers identified the following themes in the results of their study: family and traditions, loneliness and isolation, control over choices, death and dying and the importance of humor were all aspects of wellness important to the aging population (Berry & Berry, 2018). From the results, researchers discussed that seniors have growing concerns about their loss of control and desire to make their own choices about their healthcare needs, as a result, researchers identified that psychoeducational content may be beneficial to the counseling experience with the elderly (Berry & Berry, 2018). Researchers identified that most of the participants expressed concerns about feeling isolated and lacking socialization, which confirms a correlation between isolation and loss of socialization and increases health and social well-being problems (Berry & Berry, 2018).

Researchers identified that limitations of the study were present in the group counseling sessions, participant selection, and the use of grounded theory (Berry & Berry, 2018). Researchers note that data collected from the group session would be different if the counseling sessions were individual sessions and with the same participants; additionally, participants had prior group counseling experience which limited researchers to gather new perspectives, rather than if participants had no experience with group sessions (Berry & Berry, 2018). Another limitation researchers identified in their study was selecting only participants who were willing and able to contribute to the study versus excluding potential participants who would have contributed immensely to the study (Berry & Berry, 2018). The last limitation researchers detected in their study was the use of grounded theory, which is criticized for not being sufficiently rigorous and difficult to report findings concisely (Berry & Berry, 2018; Fassinger, 2005). To overcome one of the limitations of Berry and Berry's (2018) study, my study aims to eliminate the use of group counseling sessions with participants who have prior experience with attending group counseling sessions. My study is a quantitative research survey study with participants who will complete a demographic questionnaire and a wellness assessment individually and not in a group setting. Participants for my study will not be limited to one-hour sessions, as demonstrated in the group counseling sessions in Berry and Berry's (2018) study.

### *Adlerian Theory and Wellness*

The theory of wellness relates to Adlerian theory in the context of holism (Myers & Sweeney, 2008; Pomeroy & Clark, 2015; Sweeney, 2009), in that, like holism, it

honors the whole person and the integrated expressions of the parts working as a whole (Fall et al., 2010; Pomeroy & Clark, 2015). The concept of holism in Adlerian theory relates to how an individual fully functions with feelings, beliefs, and actions as a whole unit, and how balancing all these functions presents a coherent and integrated level of experiencing life, and if one or more areas are lacking in an individual's life, the person will not feel whole or will function in a less integrated way (Pomeroy & Clark, 2015).

Wellness, then in the Adlerian theory, posits that since self-efficacy involves the self-perceptions of individuals and the world around them, to fully understand a person, it is necessary to perceive the self through interconnected patterns of functioning, as a result, for people to reach optimum well-being, all aspects of the functioning should be working together (Pomeroy & Clark, 2015).

### *Indivisible Self-Wellness Model*

This model of wellness represents the core self, and it is consistent with the concepts of the wheel of wellness and the Adlerian concepts of holism (Pomeroy & Clark, 2015). The core self in this model considers five second-order factors that are the creative self, coping self, social self, essential self, and physical self (Pomeroy & Clark, 2015; Sweeney, 2009). Like the wheel of wellness, a combination of the factors in this model makes up the core or whole self of an individual, as a result, changes in one aspect of the self-affect other areas that make up the whole self (Pomeroy & Clark, 2015). When using this model of wellness, counselors must understand the major concept of wellness as having many aspects that develop and maintain an individual's optimum health, and

these factors in wellness can be influenced by a person's self-efficacy can affect their overall emotional well-being of the individual (Pomeroy & Clark, 2015).

### *Systems Psychodynamic Wellness Model*

Henning and Cilliers (2012) constructed a systems psychodynamic wellness model (SPWM) which is composed of merging theory and concepts from systems psychodynamics and positive psychology (Henning & Cilliers, 2012). Researchers constructed the SPWM to understand psychological wellness at the individual, group, and organizational levels (Henning & Cilliers, 2012). Within the SPWM, are two psychological paradigms: systems psychodynamics and positive psychology. From the systems psychodynamic perspective, wellness is a relational concept that regards the psychological wellness of any person, group, or organization as an open system with numerous subsystems that interact across different system boundaries, as a result, psychological wellness is a result of constant interpersonal and intrapersonal change and variety (Henning & Cilliers, 2012; O'Connor & Lubin, 1990). From the positive psychology perspective, positive psychology aims to change the focus of theory and practice from a preoccupation with disease and healing to well-being and improving strengths and virtues (Henning & Cilliers, 2012). Positive psychology implies an active human is constantly adapting to the environment to ensure wellness (Henning & Cilliers, 2012; Lopez, 2008).

Henning and Cillers (2012) identified that there was no psychological wellness model that integrates the principles of systems psychodynamics, which focuses on negative behavior and positive psychology. Positive behavior as the purpose of their

research was to attempt to merge these perspectives to apply them to individual, group, and organizational behavior (Henning & Cillers, 2012).

Using a qualitative, descriptive, and conceptual research approach and method, they conducted an in-depth literature study to construct the SPWM model of wellness and redefined the model using a Listening Post comprised of experienced subject experts (Henning & Cillers, 2012). From their study, the researchers identified 39 themes and categorized them into three different levels: The first level included three themes: identity, hope, and love, rated at the highest level of integration; the second level included nine themes: sources of self, ego, boundary management, wisdom, transcendent, meaning, paradox, mirror glazing self, and window watching others, which were less complex and abstract than the first-level themes; the third level, was the least complex and consisted of 27 themes: evolution of self, self-image, narcissism, ego ideal, space, ego structure, ego defenses, time, task, open-mindedness, beyond boundaries, creativity, curiosity, aesthetics, connectedness, attachment, mastery, self-actualization, social actualization, goal-seeking, authenticity, reparation, optimism, self-knowledge, social integration, and social acceptance (Henning & Cillers, 2012).

Researchers created a graphic construction of the SPWM using fractal geometry, which is a visual way of understanding and displaying things on bigger and smaller scales, and how the whole is always within each part and each part of the whole (Henning & Cillers, 2012). Researchers chose to use the Sierpinski Triangle, named after Sierpinski, as their fractal symbol and graphic design, to display the 39 themes extracted from their study (Henning & Cillers, 2012). Using this graphic design allowed the

researchers to show the themes in one complete structure, making it appropriate to construct a complex theoretical model (Henning & Cillers, 2012).

Once this was accomplished, the researchers then renamed the graphic design as the SPWM Triangle and described that it integrates systems psychodynamic thinking and positive psychology to offer a more holistic and optimistic perspective on human behavior as opposed to other perspectives that focused on disease and pathology (Henning & Cillers, 2012). By using the SPWM Triangle, researchers identified a logical flow from simple to complex from the first, second, and third level themes, as a result, they determined that systems psychodynamics and positive psychology both contain themes to describe psychological wellness at the individual, group, and organizational levels (Henning & Cillers, 2012). This research challenged Wissing and Van Eeden's (1997) linear wellness continuum where illness and wellness are opposites extremes, in favor of the systems approach (Henning & Cillers, 2012).

Henning and Cillers (2012) concluded that the SPWM Triangle can be used as a conceptual qualitative tool to understand individual, group, and organizational wellness and can also be used in market research because its wellness concepts could reflect the social dynamics of a particular group or social context (Henning & Cillers, 2012). As a result, researchers concluded from this study that the SPWM can be applied as a qualitative diagnostic tool for understanding individual, group, and organizational wellness and for consulting systemic wellness.

From their study, Henning and Cillers (2012) recommended that consultants use the SPWM to guide discussions and interactive communication when collaborating with

people, groups, and organizations and that researchers should validate the model in both qualitative and quantitative research implemented in various organizational settings like individual and team coaching. A limitation researchers noted in their study is that although the SPWM is significant, it cannot fully capture the complexity of the topic of psychological wellness (Henning & Cillers, 2012). Another limitation is that, although researchers found substantial literature on psychodynamic systems, information on psychological wellness was extremely limited (Henning & Cillers, 2012). The last limitation researchers identified was that although they conceptualized the systems psychodynamic model, they did not explore the operational aspects of the model (Henning & Cillers, 2012). One of the limitations identified in Henning and Cillers' (2012) study that I hope my study aims to eliminate is to explore the operational aspects of the holistic wellness model I selected for my study.

***National Wellness Institute Model***

This model describes wellness as a process in which people become more alert and capable of making decisions to lead a more successful life (Wickramarathneet al., 2020). After Hettler (1977) introduced the six dimensions of wellness: emotional, spiritual, intellectual, social, physical, and occupational, this model was then renamed the six dimensions of the wellness model. This model may be used by policymakers in the field of education to extend students' overall wellness and help them create well-balanced personalities to serve society (Wickramarathne, et al., 2020).

### *Wellness Continuum/Illness–Wellness Continuum*

The wellness continuum, also known as the illness-wellness continuum, was developed by Tarris (1972) based on Lewis Robbins' health risk continuum the self-actualization concept of Abraham Maslow, and the theoretical foundations of the illness-wellness continuum (Wickramarthne et al., 2020). This model is composed of three wellness concepts: the iceberg model, the illness-wellness continuum, and the wellness energy system (Wickramarathne et al., 2020). These concepts summarize that individuals frequently encounter physical side effects due to exhaustion or discontent with their lives, which can heighten significant health problems, as a result, with this model, it is important to greatly consider an individual's physical self, use the mind positively, communicate feelings adequately, engage with people, and stop ruminating constantly about an individual's physical and mental situation (Wickramarathne, et al., 2020).

### *Transtheoretical Model/Stages of Change Model*

Prochaska and Decrement (1983) developed this model with the understanding that most people are unable to change their behaviors or attitudes decisively or quickly (Wickramarathne et al., 2020). This model posits that changes in behaviors that are habitual happen as a continuous process or cyclical, as a result, this model can be identified as a decision or choice-making model that shows the change in the intention of the individual (Wickramarathne et al., 2020). This model identifies five stages of change: pre-contemplation, contemplation, preparation, action and maintenance, subsequently, a sixth stage was added concerning health-related attitudes (Wickramarathne et al., 2020).

### *Comprehensive Whole Person Wellness Model*

Montague et al (2002) developed this model which positions personal wellness in the middle of multidirectional and dynamic interaction, reacts with the six dimensions of health, and individual dimensions interact with one another (Wickramarathne, et al., 2020). This model emphasizes humans as multidimensional beings, who with personal wellness concepts of optimism, self-responsibility, self-direction, and personal choice, are capable of reaching a higher and personal level of functioning and wellness (Wickramarathne, et al., 2020).

### *Ardell's Model of Wellness*

Ardell (1977) first introduced his high-level wellness model composed of five dimensions of wellness: nutritional awareness, environmental sensitivity, stress management, physical fitness, and self-responsibility (Wickramarathne, et al., 2020). In 1982, Ardell another wellness model which included dimensions such as meaning and purpose, self-responsibility, nutritional awareness, relationship dynamics, and physical fitness (Wickramarathne, et al., 2020). The latest version of wellness by Ardell (2011) consists of three domains mental, physical, and meaning and purpose. The domains of this model may be used in higher education to effectively enhance the academic performance and well-being of undergraduate students (Wickramarathne, et al., 2020).

After reviewing the wellness models I listed above, I chose to use the holistic wellness model for my study due to how the model assesses several influential components in an individual's life which include biological, psychological, social, and spiritual components (Berry & Berry, 2018). By using this theory for my study, I can

assess the various levels and dimensions of wellness, specifically the social, emotional, environmental, and physical dimensions of wellness.

**History of Wellness in Counselors**

As described in some literature, wellness, and counselor impairment across the continuum are described as counselors capable of either wellness or impairment, where wellness-like impairment is a state rather than a trait, and an individual can deliberately move towards either wellness or impairment (Thomas & Schmuldt, 2011). Researchers have demonstrated that counselors who are mentally unhealthy experience more difficulties professionally and personally than their healthy counterparts (Harris, 2010; Meyer & Ponton, 2006). Consequently, previous research has not only shown that unresolved psychological issues impact counselor wellness but also questions whether the perceived wellness of counselors might be due to delayed self-care (Harris, 2010; Meyer & Ponton, 2006). Counseling students often enter the profession with unresolved issues from their families of origin or past trauma that need to be addressed (Harris, 2010). Researchers argue that educators have a responsibility to identify and address problems with professional competence, however, counselor development programs do not have a systematic way of assessing potential threats to counselor competency or helping counseling students learn the importance of self-care (Harris, 2010; Johnson et al., 2008).

In recent years, there has been an increase in attention to wellness in counselor preparation (Wolf et al., 2012). Providing wellness strategies in counselor preparation helps to promote wellness practices at the onset and mitigates factors that put a counselor's well-being and professional competence at risk (Lawson et al., 2007; Wolf et

al., 2012). A prevailing belief about counselor educators and wellness is that counselor educators who are well produce counseling students who are well and in turn produce clients who are well (Branco & Patton-Scott, 2019; Myers et al., 2016). Overall, counselor educators who possessed higher levels of wellness, and who reported an increased level of stress, had a decrease in their sense of wellness (Branco & Patton-Scott, 2019; Wester et al., 2009).

In one counseling program, Schure et al. (2008) provided counselors-in-preparation with a 15-week elective mindfulness-based stress reduction course that introduced the students to self-care strategies like meditation and yoga (Wolf et al., 2012). Counseling students who completed the course reported benefits of increased energy and awareness of the mind-body-emotion connection, as well as professional benefits like advanced comfort with silence and an increased capacity to address the therapy process (Wolf et al., 2012). These outcomes suggested that the course had significant benefits for participants such as positive physical, emotional, mental, attitudinal, and interpersonal changes (Wolf et al., 2012).

A healthy acknowledgment of humanness is for counselors to admit that they need to be available for self-care, as a result, counselor educators and students must transition away from a deficit view of wellness and embrace self-care and fostering a healthy environment (Wolf et al., 2012). Counselors having a changed and positive mindset with a holistic view creates a foundation for counselors to integrate a holistic wellness paradigm in counselor preparation (Wolf et al., 2012). To encourage counselors-in-preparation to take individual steps to promote well-being, support from faculty and

the institution is critical to promoting wellness within counselor preparation (Wolf et al., 2012). Counselors-in-training are aware of the importance of maintaining an optimal level of personal wellness during their counseling education process to provide effective services to clients (Burck et al., 2014; Wolf et al, 2012).

Myers et al. (2003) examined the wellness levels of graduate counseling students and the researchers found higher levels of wellness for the graduate students than for the adults not enrolled in graduate school. Additionally, researchers also determined that students might have reported higher levels of wellness than they truly experienced (Dillman et al., 2018). In another study by Roach and Young (2007), researchers also found that master's-level counseling students exhibited higher levels of wellness than adults not enrolled in graduate school, however, they found no differences in wellness levels among three groups of counseling students: students at the beginning, middle, and the end of their counseling programs (Dillman et al., 2018).

From these studies it can be concluded that wellness is essential in the competency of helping professionals, however, little is known about factors to mitigate burnout or promote wellness (Dillman et al., 2018). Subsequently, researchers identified counselors' wellness as an important concept for research to ensure that counselors provide the best services for their clients, as a result, professional organizations, such as the American Counseling Association and Council for Accreditation of Counseling and Related Educational Programs, support the continued focus of wellness within the counseling profession (Dillman et al., 2018).

## Historical Factors Influencing Counselor Unwellness

Unwellness is the outcome of counselor impairment due to burnout and mental and physical illnesses, which harms a counselor's professional functioning (Thomas & Schmuldt, 2012). Previous researchers have demonstrated a link between unwellness and counselor effectiveness (Lawson et al., 2007; Mullen & Guiterrez, 2016; Taylor et al., 2018; Young & Lambie, 2007). To be more specific, there is a relationship between counselors' perceived wellness (Lawson et al., 2007), how effective they are, and their ability to maintain a positive point of view, as well as counselors experiencing burnout (Mullen & Gutierrez, 2016) and has an inverse relationship to the frequency in which they provide services ( Taylor et al., 2018). From the literature, I have determined that there is no specific definition for unwellness, however, there is a description of unwellness to be the outcome produced from burnout, counselor impairment, stress, depression, and lack of wellness practices. Specifically, in my study, I will describe some of these symptoms of unwellness, such as burnout, stress, and counselor impairment, in detail.

### *Burnout*

Burnout is a form of impairment that affects aspects of counselors' functioning their abilities, as a result, the consequences of burnout include therapeutic ineffectiveness, premature occupation attrition, and depression, which are potentially serious personally and professionally for counselors (Lambie, 2006). The process of burnout starts with the counselor experiencing a loss of caring and commitment and being unable to function fully due to a depletion of inner resources and emotional

exhaustion, as this continues, the counselor develops negative feelings and attitudes toward clients (Lambie, 2006).

Therapeutic impairment happens when there is a significant negative impact on the professional function of a counselor that compromises client care and potentially harms the client (Lawson & Vert, 2005). Impaired counselors are stressed or distressed counselors who experience significant stressors, but their work is not significantly affected, as a result, it can be assumed that impaired counselors have a significant level of clinical competence, however, impairment does not imply unethical behavior (Lawson & Vert, 2005).

In more current literature, many counselors increase the risk of burnout and risk harming clients being served due to struggling with practicing self-care regularly (Silva, 2019). Specifically, a quantitative survey research study conducted by Silva (2019) explored the relationship between counselor burnout, life balance, and self-compassion among fully and provisionally licensed counselors.

From the study, two canonical correlation analyses were conducted to determine if there was a relationship between measuring life balance and burnout and measuring burnout and self-compassion (Silva, 2019). Results from the study indicated a statistically significant relationship, which determined that professional counselors who experience burnout also experience poor work-life balance, however, professional counselors who do not experience burnout had higher levels of self-compassion (Silva, 2019).

Counseling professionals find it difficult at times to maintain a lifestyle of wellness in their lives regardless of the negative impact of burnout (Puig et al., 2012;

Silva, 2019). Additionally, counselors who are impaired are advised to not offer therapeutic services to individuals due to the negative impact on a client's treatment (Puig et al., 2012; Silva, 2019). Counselors who work in the counseling profession often do not recognize the degree to which caring for clients may have on their health and well-being (Bridgeman et al., 2018; Silva, 2019).

## Theories and Models of Unwellness

From the literature, there are no specific theories and models of unwellness, however, there are theories about burnout and other symptoms of unwellness. I discuss these theories below.

### *Conservation of Resources Theory*

The conservation of resources (COR) theory suggests that counseling professionals with high demands and few resources may experience maladaptive coping that leads to experiencing burnout (Silva, 2019). Additionally, the COR theory posits having resources helps people protect themselves from experiencing stress, anger, depression, anxiety, and burnout (Huang et al., 2016; Silva, 2019). A meta-analysis on the COR theory generated by Alarcon (2011) based on job demands, resources, and attitudes toward burnout, determined that all three factors are positively related to burnout, that the perceived control and autonomy at work negatively relate to burnout, and lastly, job satisfaction and organizational commitment negatively relate to burnout (Alarcon, 2011; Silva, 2019). The conclusion from Alarcon's (2011) meta-analysis determined that the COR theory is well suited for understanding burnout (Silva, 2019).

### *The Humanistic Existential Theoretical Model of Burnout*

The humanistic-existential model of burnout, although not exact, determines that real-life work environments are neither negative nor positive but rather are a complex combination of degrees of stress and support (Lambie, 2006). Therefore, counselors' feelings of occupational meaningfulness fluctuate based on their interactions within their environment, as a result, within this model, burnout is not stagnant (Lambie, 2006; Pines, 1993). Within this model, burnout is then considered a product of an interaction between the counselor's expectations of their occupational roles and work environment (Lambie, 2006).

### Counselor Caseload and Unwellness

Research about counselor burnout has focused on identifying external factors responsible for the occurrence of burnout, such as occupational stress, role ambiguity, and large caseloads, and how the influence of these external factors increases the susceptibility to burnout (Lambie, 2006; Lambie, 2002). A supportive environment reduces the likelihood of burnout rather than a stressful environment that provides conditions that may contribute to a sense of failure and burnout (Lambie, 2006). Burnout was determined to be negatively correlated with a sense of success, the ability to express oneself at work, and receiving a level of appreciation for work performance, as a result, people who have low expectations and do not care about their work generally do not experience burnout (Lambie, 2006; Pines & Aronson, 1983).

In Ghana, a task-shifting approach, a process of assigning other clinical and counseling duties to other staff like case managers, mental health techs, etc., is

recognized and used as an effective approach to reducing the workload for health and mental health professionals and makes seeking mental health services easily accessible (Badu et al., 2018). From the literature, I was unable to find a direct link on whether counselor caseload is a predictive cause of counselor unwellness. However, by including counselor caseload as one of the variables in my study, I can run a predictive analysis to determine if it is or can be a factor in unwellness.

Shillingford et al. (2013) specifically examined the wellness of female counselor educators of color, several factors noted such as challenges with students, overwhelming workloads, high expectations, and feelings of isolation, contributed negatively to their overall wellness (Branco & Patton-Scott, 2019). To address these factors, counselor educators who participated in the study used wellness strategies related to spirituality, self-care, and a positive support system (Branco & Patton-Scott, 2019).

Branco and Patton-Scott (2019) described how a small clinical mental health counseling master's program implemented a wellness initiative to benefit both students and faculty during their accreditation process. Researchers for this study began efforts for wellness instruction at the admissions interview through the end of internship training (Branco & Patton-Scott, 2019). Researchers presented all internship students and faculty with an empirically validated wellness inventory and a workbook (Branco & Patton-Scott, 2019). Participants in this study were recruited from a small northeastern, urban, not-for-profit teaching university, with all faculty on the non-tenure track with opportunities for promotion, five core faculty members identified as faculty of Color, and

50 master's level students in total, 37 of which identified as of Color (Branco & Patton-Scott, 2019).

Researchers used a cocurricular wellness approach to implement both self-care and wellness instruction throughout the Clinical Mental Health Counseling program (Branco & Patton-Scott, 2019). Researchers incorporated wellness at the admission interview by asking participants questions like: "Please share with us how you manage stress," and "What are your self-care and wellness strategies?" The next phase was at student orientation, where researchers asked each core faculty member to introduce themselves, include their wellness and self-care strategies, and mention courses taught and research agendas (Branco & Patton-Scott, 2019). Researchers then dispersed to students who could not attend orientation, a clinical mental health counseling newsletter with bios of core and adjunct faculty emphasizing self-care and wellness strategies (Branco & Patton-Scott, 2019).

Researchers noted that the institution prohibited programs from requiring services for personal counseling, as a result, to address this mandate, researchers promoted the institution's partnership with offsite free telehealth counseling services for students via email, newsletters, posted flyers, and in-class announcements (Branco & Patton-Scott, 2019). Researchers restored the institution's advising model to ascertain all students met with advisors at least twice a semester and aimed the objective of advising to provide academic and professional growth, including self-care and wellness guidance to promote optimal student development (Branco & Patton-Scott, 2019).

After completing all the preliminary steps mentioned above, researchers wanted to examine how to infuse wellness and self-care content in various core courses by developing an emergent wellness model, focusing on the following core courses: orientation to professional counseling and ethics, practicum readiness and assessment, helping relationships and counseling skills, practicum, and internship (Branco & Patton-Scott, 2019). Researchers then administered the 5F-WEL assessment to enrolled internship students and all clinical mental health counseling core and adjunct faculty (Branco & Patton-Scott, 2019).

Participants included 23 students enrolled in internship during the summer semester who were eligible to take the 5F-WEL, five core faculty members, and four adjunct faculty (Branco & Patton-Scott, 2019). After completing the assessment, researchers gave participants a post-assessment individual report about their wellness profile and also provided participants with the Five Factor Wellness Inventory and Habit Change Workbook authored by Myers and Sweeney in 2006, to aid participants in implementing self-care and wellness strategies throughout the internship experience (Branco & Patton-Scott, 2019). Researchers took measures to dispel any concerns faculty may have about student responses by recruiting the campus librarian to set up online accounts and send links to participants to take the 5F-WEL assessment (Branco & Patton-Scott, 2019).

Researchers noted that results related to cocurricular wellness-infused activities were difficult to measure, however, faculty observed an increase in student discourse about wellness and self-care efforts (Branco & Patton-Scott, 2019). Although results

were not quantifiable, researchers met their goal to infuse wellness within the CMHC program and revealed how smaller, non-accredited CMHC programs could incorporate wellness initiatives into their programs with research and creativity (Branco & Patton-Scott, 2019).

Researchers identified the following limitations and implications in their study: of the 23 eligible student participants, 16 students currently enrolled in internship, two of the five core faculty, and no adjunct faculty of the six participants completed the 5F-WEL assessment; there was high emphasis on instruction the first and final semesters, the content was not evenly distributed during the middle portion of the program, additionally, not all eligible students and faculty members participated due to the 5F-WEL being voluntary; faculty (core and adjunct) had poor participation rates, limiting their abilities to share their experiences with the inventory and workbook; faculty members noted the timing of the inventory distribution at the end of the semester created a challenge to complete due to teaching and advising duties (Branco & Patton-Scott, 2019).

Another limitation of Branco and Patton-Scott's (2019) study that my study aims to eliminate is the poor participation rate of most of the participants. Although I cannot guarantee a great or poor participation rate for my study, I will ensure to implement a plan to alleviate poor participation rate by considering the timing of my inventory and survey distribution, and also giving participants ample time to complete the instruments after distribution. Another thing I will take into consideration is the time difference between Ghana and Texas; there is a five-hour difference between both locations, where

Ghana is five hours ahead of Texas time, as a result, I would need to consider this time difference when I begin my study.

**Funding and Unwellness**

In the United States and worldwide, poverty is a pressing sociopolitical issue that presents experiences with a significant effect on the mental health and overall wellness of individuals (Clark et al., 2020). As a result, it is important for professional counselors to effectively serve clients experiencing poverty (Clark et al., 2020). A systematic review of parent-reported barriers to seeking mental health services for their children included structural barriers such as costs, trust, and confidence in professionals, the effectiveness of treatment, and understanding of mental health problems (Radez et al., 2019).

The World Economic Forum forecasted that by 2030, mental ill-health will encompass more than half of the global economic burden at $6 trillion (Knapp & Wong, 2020). Alternatively, economic disadvantage is linked to a greater likelihood of mental illness due to exposure to risk factors such as social exclusion, poverty, treatment costs, and challenges with employment (Knapp & Wong, 2020). Due to the scarcity of resources and the goal to maximize health and well-being, Knapp and Wong (2020), recommend that economic analyses are needed for decision-makers to identify the best options in using available resources.

Poorer countries spend a minimal portion of their health budget on mental health by allocating the budget less efficiently by using a large portion of the budget on building psychiatric hospitals (Saxena, 2019). Countries with low income should not wait for improvements in economic wealth before increasing their health budget for mental health

and allocating funds efficiently (Saxena, 2019). In Ghana, there is limited funding support for mental health services, and historically, mental health services have been funded through three main sources: government, international development partners, and internally generated funds (Badu et al., 2018).

The government funding support is restricted funds allocated to three psychiatric hospitals for mental health services, used for overhead costs, including basic medical supplies, and service maintenance (Badu et al., 2018). However, the funding fluctuates annually so hospitals sometimes supplement medicine shortages from operating costs, and there is no dedicated budget to support mental health even though there are existing Budget Management Centers for general health services, making it difficult to plan and deliver mental health services at a primary level (Badu et al., 2018).

An assessment conducted in 2012 of Ghana's mental health system revealed that the system was fraught with numerous challenges including low government spending and inequitable distribution of resources across geographical space with all services (Dankyi & Huang, 2021). In many low- and middle-income countries like Ghana, there is a paucity of mental health professionals, as a result, traditional and complementary medicine practitioners are used more frequently for mental disorders (Kpobi et al., 2019).

In Ghana specifically, efforts have been implemented to formalize and standardize the work of traditional medicine practitioners, which is a goal that is mostly unmet due to the lack of scientific knowledge of beliefs, methods, and practices in mental healthcare, with very few studies documenting this knowledge (Kpobi et al., 2019). Additionally, mental health services are not covered by the National Health Insurance

Scheme, as a result, uninsured clients presenting with mental health issues are expected to pay for treatment for co-morbid physical conditions (Badu et al., 2018; Ofori-Atta et al., 2010). Consequently, due to the inconsistency in the pre-payment policy, presents a huge financial burden for clients and service providers, due to a loss in earnings (Badu et al., 2018). In this regard, due to low funding for mental health services for the general population, many clients with mental illnesses turn to traditional healers for services, which in turn affects the employment and status of clinically trained staff and mental health workers.

Evidence suggests that mental health interventions are cost-effective, as a result, all countries must implement immediate actions to increase investments in mental health services and establish community-based service systems (Saxena, 2019). As an example, for eminently treated conditions, like major depressive disorder, there is a high treatment gap of 78% in high-income countries and 96% in low-income and lower-middle-income countries (Saxena, 2019). These percentages can be decreased with a higher investment in mental health services, improved development, and accurate methods of accounting for the health budget and allocating funding for mental health services (Saxena, 2019).

Addo et al. (2018) reviewed available evidence on the economic burden experienced by primary caregivers for persons with severe mental illness. Researchers noted that over the past two decades, the focus of mental health care shifted from institutionalization to community-based programs and short hospital stays which increased the role of caregivers, mostly family members of persons with mental illness (Addo et al., 2018). Researchers extracted and reviewed seven articles covering themes

such as physical, psychological, and socioeconomic burden, using keywords in the search such as “burden,” “cost of illness,” and “economic burden” (Addo et al., 2018, p. 1-2). The results of the study identified caregivers as mostly female with a mean age of 46.34 and unemployed (Addo et al., 2018). From the articles reviewed, researchers identified that five out of seven studies (71%) estimated the full economic burden of severe mental illness on caregivers and the remainder of the studies described the caregiver burden (Addo et al., 2018).

Further results noted by researchers informed that moderate to severe caregiver burden is due to financial constraint, productivity loss, and lost employment, as a result, the caregiver’s level of income and employment status, the severity of the patient’s condition, and duration of mental illness negatively affect the economic burden experienced by caregivers (Addo et al., 2018). To expound further, researchers noted that it is evident the direct and indirect costs incurred by caregivers are substantial due to about 71 % of caregivers of persons with mental illness in Ghana reporting a monthly income of less than $223, which is consistent with recent estimates of 94% of caregivers of elderly people reported monthly incomes of less than $224 (Addo et al., 2018).

Researchers conclude that failure to identify, measure, and quantify these costs leads to underestimation of the economic burden experienced by informal caregivers, and policymakers are misinformed of the exact burden on informal caregivers, which leads to failure of mental health planning to address the needs of the caregivers (Addo et al., 2018). The findings from this study support the claim that low funding can affect Ghanaian mental health workers and caregivers of persons with mental illness, with

surmountable economic burdens and financial instability. I hope my proposed study will confirm this as a predictive cause of counselor unwellness.

**Limited Work Staff and Unwellness**

One major challenge facing mental health in Ghana is a shortage of mental health workers (Asamoah et al., 2014). One way of responding to this shortage of mental health workers was to explore and engage the potential benefits of faith-based organizations, as a result, 70-80% of Ghanaians use traditional medicine as their front-line service, and about 45,000 traditional healers and many churches providing spiritual healing which is a blend of traditional medicine and Christianity (Asamoah et al., 2014; Akosah-Sarpong, 2007; Ministry of Health, 2005). In Ghana, it has been estimated that there is one psychiatrist for every 1.4 million people (Kpobi et al., 2019; Kpobi et al., 2014). Psychiatrists are predominately in urban areas like other mental health professionals (Kpobi et al., 2019). Alternatively, the estimate of traditional healers is one for every 200 people (Ae-Ngibise et al., 2010; Kpobi et al., 2019), this suggests that traditional healers would be the first point of contact to see approximately 70% of people needing mental health care (Kpobi et al., 2019; Ofori-Atta et al., 2010).

There is poor management of human resources for mental health services in Ghana, this indicates that the current strength of mental health professionals is limited to meet the increasing demand for mental health services (Badu et al., 2018). Health policy directors perceived that the number of mental health professionals in Ghana is completely inadequate due to an aging workforce and an increase in specialists migrating outside the country or to other specializations outside of mental health services (Badu et al., 2018).

Despite these factors, mental health workers have demonstrated an increased desire to change stigmatizing attitudes about mental health, correcting the misunderstandings that mental illness is treatable, and increasing respect for the field of mental health care (Badu et al., 2018). These are some of the instances experienced by mental health workers, however, from the literature I was unable to find a direct link if these cause or predict unwellness in counselors due to limited work staff. However, by including limited work staff as one of the variables in my study, I can run a predictive analysis to determine if it is or can be a factor in unwellness.

**History of Mental Health in Ghana**

In Ghana, there is a lack of mental health research to guide interventions or psychoeducational programs and policy planning (Dankyi & Huang, 2021). Previous literature suggests that mental health needs for people in Ghana are addressed by biomedical, traditional Indigenous medicine, and spiritual resources, however, this pattern of seeking help for mental health issues in Ghana is driven by belief systems and culture (Osei-Tutu et al., 2019). Traditionally in Ghana, resources for psychological and mental health care were available from extended family members, as well as, from elders who serve as community counselors (Esen, 1973; Osei-Tutu et al., 2019; Van der Geest, 2015). To expound further, help from either extended family members or elders in the community is mainly through advising on how to solve the issue and teaching life lessons based on elderly wisdom and knowledge (Osei-Tutu, 2019; Van der Geest, 2015).

Mental health has been acknowledged as a significant issue for national policy intervention (Asamoah et al., 2014). There is a discourse on the need to integrate

Indigenous practices of mental health care into formal systems which follows global concern for governments to be holistic in their approaches to the delivery of mental health care services (Asamoah et al., 2014). Scientific research on mental health in Ghana conducted by the Kintampo Health Research Centre (2012) indicated that about 80% of the population is suffering from different forms of depression, and according to the WHO (2011), over 2 million Ghanaians suffer from moderate to mild mental disorders and 650,000 suffer from severe illness (Asamoah et al., 2014). However, despite these findings and statistics, only 2% of Ghanaians have access to treatment for mental health problems, indicating a treatment gap of 98% (Asamoah et al., 2014; Dixon, 2012; WHO, 2011).

In a situational analysis of mental health care in Ghana conducted by Ofori-Atta et al.(2010), there were inadequate policies, legislation, and services for mental health in Ghana due to one of the major reasons being a weak mental health information system (Kpobi et al., 2018). The mental health information system in 2008 only collected information on four categories of mental illness: psychoses, neuroses, epilepsy, and substance use disorders (Kpobi et al, 2018). These disorders collectively made up less than 1 % of the data collected by the Ghana Health Service (Kpobi et al., 2018). Subsequently, the situational analysis by Ofori-Atta et al. (2010) revealed that these diagnoses were not standard and could not provide credible information on mental health needs and services in the country (Kpobi et al., 2018).

As part of the Mental Health Act (2012) in Ghana, a major policy intervention towards improving the mental health of indigenes admonished the establishment of a

community-based mental health system to holistically address the mental health needs of community members (Amu et al., 2021), which created opportunities for various studies in Ghana to assess mental health issues. In considering the state of mental health in Ghana, the Ghana mental health law (Act 846) of 2012 presents a new intention to improve the well-being of people with mental illness and has the potential and mandate to improve the quality of mental healthcare and protect the human rights of people seeking mental services (Badu et al., 2018). The government should prioritize the use of services through policies, financial incentives, infrastructure support, and adequate training of mental health professionals (Gyamfi et al., 2020).

Some of the challenges with mental health services include limited funding sources, high unmet service needs, limited services for marginalized groups, and the poor state of psychiatric facilities (Gyamfi et al., 2020). The Mental Health Authority in Ghana is responsible for coordinating and managing mental health services, by directly advising the Ministry of Health on mental health issues, particularly on policy formulation and implementation (Gyamfi et al., 2020). Additionally, the Government of Ghana is currently using a task-shifting policy to increase the number of mental health professionals required to facilitate mental health services, as a result, two new programs, Community Medicine and Clinical Psychiatry (CPOs) and Diploma in Community Mental Health (CMHOs) were developed in 2011 (Badu et al., 2018). CPO professionals are trained to work independently in facilities without a psychiatrist, and CMHO professionals are placed as frontline community-level mental health workers to assist Community Psychiatric Nurses (CPNs) (Badu et al., 2018).

**History of Counseling in Ghana**

In countries like Ghana, counseling is perceived as what counselors do, regardless of their training background, without formal and academic training, and engage in the areas of promoting healthy lifestyles, identification of individual stressors and personal levels of functioning, and preservation or restoration of mental health (Lo & Dzokoto, 2005). In Ghana, although there is an increase in the demand for Western-style psychological and counseling services, Western-style counseling continues to be the least typical definition of counseling (Lo & Dzokoto, 2005).

Many Ghanaians regardless of educational level are unclear about the role and value of counseling and perceive counseling professionals as experts who can explain all human behavior and as people who read minds (Lo & Dzokoto, 2005). A study conducted by Lo and Dzokoto (2005), reviewed the state of counseling in Taiwan and Ghana and revealed that although counseling is noted as a relatively new discipline to citizens of these countries, the concept of counseling is familiar in either country (Lo & Dzokoto, 2005). Each country as noted by the researchers has a variety of resources available for the preservation and restoration of mental health services and counseling practices, excluding religion, thus the idea of seeking Western-style counseling services is becoming more socially acceptable (Lo & Dzokoto, 2005).

Ghana's health system is classified as "inclusive" by the WHO based on the use of traditional, complementary, and alternative medicine within the health sector (Osafo, 2016). The concept of creating an integrative system of health care dates to the 1960s when the government at that time formed the Ghana Psychic and Traditional Healers

Association, to complement orthodox treatments of common diseases with traditional ones (Osafo, 2016). Since the implementation of this model, there have been several arguments regarding the roles of various groups of practitioners attending to mental health issues (Osafo, 2016). There has been some support for leveraging the services of religious groups, such as faith healers and the clergy, to bolster the under-resourced mental health system in Ghana (Osafo, 2016). Consequently, the functioning of the clergy and other religious leaders as frontline mental health workers demonstrates the relationship between religion and medicine (Koenig et al., 2012; Osafo, 2016). Currently, religious leaders continue to operate as informal frontline mental health workers who often refer cases to mental health professionals and other counseling resource centers (Bledsoe et al., 2013; Osafo, 2016; Weaver et al., 2003).

Mental health systems in Ghana are overwhelmed with severe and chronic mental health issues and due to a rapid rate of urbanization, providing mental health services is limited, as a result, religious organizations offer viable options through counseling ministries and groups (Osei-Tutu et al., 2019). With an increase in urbanization and more people moving into urban cities, away from their extended families, the presence of stress, overcrowding, interpersonal alienation, crime, and poverty has become prevalent, as a result, people seek help from religious organizations who have lay counselors on staff, such as pastors, cleric, elders, lay ministers, and laity (Osei-Tutu et al., 2019).

In a study by Osei-Tutu et al. (2019), researchers proposed to understand the role lay counseling plays in the mental help system in Ghana and interviewed one hundred lay counselors practicing mainly in Christian and Islamic religious contexts across urban

areas in Ghana (Osei-Tutu et al., 2019). The purpose of the study was to examine the reason people seek counseling and if receiving services from lay counselors is a legitimate part of the existing system of care in Ghana (Osei-Tutu et al., 2019). Results from the study revealed that most presenting problems were interpersonal, low-level, and non-threatening issues, and did not focus on mental disorders (Osei-Tutu et al., 2019).

Researchers examined presenting problems lay counselors encounter with clients in four specific areas: pre-marital and in-marriage problems, parenthood concerns, psychological problems, and academic and career issues (Osei-Tutu et al., 2019). In the area of psychological problems, researchers identified that a small number of the participants disclosed the psychological problems they encountered with clients including substance abuse and unspecified mental health issues, however, the area of marriage and parenthood had the highest responses and concluded those areas as the most prevalent presenting concerns (Osei-Tutu et al., 2019).

Additionally, researchers concluded in their findings that although lay counselors are presented with and work on psychological and mental health problems, they are unable to diagnose less obvious cases of disorders due to not having the required training (Osei-Tutu et al., 2019). Furthermore, researchers identified from their study that lay counselors provide a space for people to address social problems and personal issues; in Ghana specifically, religious groups have adopted the role of providing community counseling, to repurpose an old practice to have a new means to operate (Osei-Tutu et al., 2019).

Considering the findings noted above, it can be determined that in some instances, mental health workers are urged to form collaborations with healers to prevent human rights abuses and promote alternatives for treatment (Read, 2019). Additionally, mental health workers expected to collaborate with healers are asked to participate in sensitization of the traditional and faith healers who treat people with mental illness, as a key aspect of public health work inclusive of community engagement efforts with education on the signs and symptoms of disease and where to seek treatment (Read, 2019).

**History of Counselor Unwellness in Ghanaian Counselors**

In a study by Ae-Ngibise et al. (2015), researchers conducted a qualitative study to assess the burden of care on mental health caregivers of people living with serious mental disorders in rural Ghana (Ae-Ngibise et al., 2015). Researchers assessed the coping strategies and available support for mental health caregivers (Ae-Ngibise et al., 2015). Seventy-five mental health caregivers participated in the study and provided information about their experiences in providing care for clients with mental health disorders (Ae-Ngibise et al., 2015). The results of the study revealed that the caregivers reported various degrees of burden due to financial, social exclusion, emotional, depression, and inadequate time for other social responsibilities (Ae-Negibe et al., 2015). Participants reported that religious prayers and the anticipation of a cure were their main coping strategies and expecting new treatments to be discovered (Ae-Negibe et al., 2015).

As researchers noted in the study, in Ghana wide networks like church societies provide support to individuals and other groups, however, the same social support for

those who care for patients with mental disorders does not exist due to the stigma of mental illness (Ae-Negibe et al., 2015). As a result of this, caregivers of mentally ill patients feel they have no choice but to carry their physical, emotional, spiritual, and financial needs alone (Ae-Negibe et al., 2015). Researchers concluded that emotional distress, mental health stigma, financial burden, and social exclusion experienced by caregivers highlight the need for interventions to support them as caregivers and the clients they care for.

## Summary and Conclusions

Ghanaian counselors could be experiencing or not experiencing unwellness due to counselor caseload, low funding, and minimal work staff. In my study, I want to know if these variables predict counselor unwellness. From my findings in current and previous literature, there is research to support the key variables identified in my study: wellness, counselor caseload, low funding, and minimal work staff, which could have an impact on Ghanaian counselors. There is minimal literature to know if Ghanaian counselors experiencing unwellness is due to counselor caseload, low funding, and minimal work staff, therefore, the results of my study will fill the gap in the literature and could lend support to creating wellness practices and training for counselors in Ghana. Proceeding to Chapter 3, I will focus on the selected research design and rationale, methodology, the threat to validity, and data analysis of the study.

# Chapter 3: Research Method

There is a definitive gap in the literature predicting if the self-perceived level of wellness among Ghanaian mental health counselors is due to counselor caseload, low funding, and minimum work staff. Although previous research has primarily focused on counselor caseload, low funding, and minimum work staff in the mental health field in Ghana, researchers have not explored it in the same way as in my study, which was to identify whether there is a connection between these factors and wellness. The purpose of my quantitative study was to predict whether there was a relationship between Ghanaian mental health counselors experiencing unwellness, and the external factors of counselor caseload, low funding, and minimum work staff. In this chapter, I identify and explain the research design and rationale for my study and describe the methodology, threats to validity, and ethical procedures. I also describe my procedures for recruiting the participants for my study, my intended sampling processes, and methods for data collection.

## Research Design and Rationale

For my quantitative study, I used a nonexperimental research survey design using a linear multiple regression data analysis to determine whether there was a relationship between Ghanaian mental health counselors experiencing unwellness, counselor caseload, low funding, and minimal work staff. The purpose of my quantitative study was to predict whether there was a relationship between the IVs (external factors of counselor caseload, low funding, and limited work staff) and the DV (wellness, as determined by 5F-WEL).

Regression analysis provides the opportunity to determine whether there is a relationship between two variables and whether one variable can predict participants' scores on another variable (Crawford, 2014). Specifically for my study, using a predictive regression design was appropriate because the variables cannot be manipulated, thus allowing me to obtain results from a study as it occurs in everyday life (Crawford, 2014; Stangor, 2011). With this research design, I did not have any perceived time or resource constraints.

## Methodology

In this section, I identify the target population for my study, describe my sampling procedure, and discuss my procedures for recruiting the participants for my study and collecting my data.

### Population

The target population for my study was Ghanaian mental health counselors currently working in private practice and various settings such as hospitals or clinics, nonprofit agencies, and educational institutions. The population of mental health counselors in Ghana are all categorized as psychologists in the registry and database of the Ghana Psychological Council (Quarshie et al., 2016). As of 2016, per the registry, 166 trained mainstream psychologists were practicing in Ghana within the following specialties: clinical, sports, counseling, educational, industrial and organizational, and social work (Quarshie et al., 2016). Most recently, the current population of psychologists (i.e., counselors, therapists, and lay counselors), is 244; this does not include the number of mental health social workers at 362, and mental health nurses at 2,463 (WHO, 2022).

**Sampling and Sampling Procedures**

I recruited the participants for my study from a national registry, which stores a directory of Ghanaian mental health counselors, psychologists, clinicians, and staff. However, my sample frame included only Ghanaian mental health counselors who volunteered to participate. I used convenience sampling to recruit the participants and selected the appropriate sample size for my study. Convenience sampling is an easy and inexpensive way for researchers to gather initial data from individuals who are most accessible and, in a position, to provide the required information requested from the researcher. However, based on being a cost-effective and easy sampling method, there is no way to identify whether the sample is representative of the population, so it cannot produce generalizable results (Mweshi & Sakyi, 2020).

Mweshi and Sakyi (2020) explained that sampling strategies should identify inclusion and exclusion criteria to set boundaries on items selected and not selected from a study's population. For my study, the participants I recruited were Ghanaian mental health counselors who are from Ghana and currently practicing in Ghana, and who agreed to participate in the study. The inclusion criteria for my sample included counselors in both private practice and working in various settings such as hospitals or clinics, nonprofit agencies, and educational institutions, working at least part-time hours of 25 hours per week. The exclusionary criteria included school counselors, career counselors, marriage counselors, and mental health technicians.

To determine the desired sample size for my study, I used the G*Power statistical software, a power analysis program commonly used to conduct a set of statistical tests

(Faul et al., 2009). To obtain the sample size, I used a small effect size of .15 a power of .80, and an alpha of .05. Specifically for my study, I pulled my sample size of 100 participants from the population of 244 psychologists who specialize in clinical counseling and mental health. I conducted an a priori power analysis for a linear multiple regression considering four variables, which will provide a sample size of 100.

**Recruitment and Participation Procedures and Primary Data Collection**

I recruited participants for my study using convenience sampling from the national database, which stores a directory of Ghanaian mental health counselors, psychologists, clinicians, and staff. I asked permission to access the directory from the clinical administrator via email and keep a copy of the email as documentation. Upon receiving access to the directory, I invited participants via email to participate in the survey and I provided them with information about the study, informed consent, and a demographic questionnaire (see Appendix A) via email. I used the participants' survey responses, results from the 5F-WEL assessment, and demographic questionnaires to collect data for my study. I recruited only Ghanaian mental health counselors, currently practicing in Ghana, who agreed to participate in my study.

The informed consent form I presented to participants included my identification as the researcher and Walden University as the sponsoring institution, and information about the study, such as description and purpose of the study. Additionally, I ensured confidentiality and information about potential risks to participants. Lastly, I provided the inclusion and exclusion criteria to the participants. Participants reviewed and signed the informed consent form to consent to participate in the study by reviewing the agreement

section of the form, electronically signing the document, and selecting the option of "I consent to participate." Participants had the option to save a copy of the form as a PDF file or print it out for record-keeping purposes.

Participants then completed the provided demographic questionnaire and took the 5F-WEL assessment online. While completing the survey, participants had the option to exit or opt out of taking the survey at any time, and I did not include data obtained from participants who opted out of taking the survey in my study. After all survey entries were submitted, I exported the data into SPSS and analyzed the results. After participants completed and submitted the survey, they received an automated thank-you statement with my information as the researcher and contact information for Walden University to address questions, comments, or feedback from participants. No follow-up procedures were needed for my study.

## Instrumentation and Operationalization of Constructs

I used the following instruments to predict whether there was a relationship between Ghanaian mental health counselors experiencing unwellness, and the external factors of counselor caseload, low funding, and minimum work staff.

### *5F-WEL Assessment*

The 5F-WEL instrument was developed by Myers and Sweeney in 2004 to measure the level of a person's well-being (Bakar et al., 2019). The 5F-WEL is based on the idea that many elements of a person contribute to their holistic self and, as a result, the self cannot be divided into separate components (Meany-Walen et al., 2016). The 5F-WEL instrument measures five factors: Creative Self, Coping Self, Social Self, Essential

Self, and Physical Self, which makes it suitable to be used to encompass a human's self-wholeness (Bakar et al., 2019). These five factors are the key areas Myers and Sweeney (2005) focused on while creating and developing the 5F-WEL instrument (Meany-Walen et al., 2016).

The 5F-WEL instrument is available in paper or online format and includes 103 questions for participants to respond to choosing the options of *strongly agree*, *agree*, *disagree*, or *strongly disagree* (Meany-Walen et al., 2016). Participants for my study completed the online version of the 5F-WEL assessment. The assessment takes 10–20 minutes to complete, and results are provided to the administrator or the person who has permission to administer the assessment (Meany-Walen et al., 2016). There are no additional or specific requirements or tools needed to administer the assessment. I obtained permission from the developer to use the 5F-WEL instrument for my study before purchasing it (see Appendix B).

The 5F-WEL assessment tool demonstrates strong reliability values as noted in studies about wellness assessment tools (Bart et al., 2018). In a recent analysis and development of updated wellness instruments, the 5F-WEL has demonstrated significantly improved validity and reliability as compared to other wellness instruments (Bart et al., 2018). The 5F-WEL now has only 91 questions, has reliability with internal consistency, and alpha scores ranging from $r = 0.61$–$0.89$ across all domains (Bart et al., 2018).

In a study conducted about the validation of using the 5F-WEL instrument to examine the well-being of 52 Muslim converts in Malaysia, Bakar et al. (2019)

distributed the instrument among the participants, focusing on questions within the five categories of Creative Self, Coping Self, Social Self, Essential Self, and Physical Self, and using a Cronbach alpha as a method for reliability analysis to obtain the reliability value. The Cronbach alpha perceives the internal consistency of a test construct and measures internal consistency to determine how related an item is in a group and perceived as a measurement for reliability (Bakar et al., 2019). The overall reliability alpha for the construct needs to have a value of at least $r = 0.70$, however, $r = 0.80$ and above is best (Bakar et al., 2019; Creswell, 2005; Gable & Wolf, 1993). By using a Cronbach alpha, the researchers of the study obtained a very high-reliability level with a reliability index of $r = 0.945$ (Bakar et al., 2019).

In another study using the 5F-WEL assessment tool, Meany-Walen et al. (2016) assessed the impact of wellness-focused supervision on mental health counseling practicum students. The researchers' specific aim for the study was to improve participants' total wellness as measured on the 5F-WEL assessment (Meany-Walen et al., 2016). Participants took the online version of the 5F-WEL assessment, and researchers collected weekly data from participants' responses (Meany-Walen et al., 2016). The researchers found the reliability scores of the 5F-WEL assessment ranging between .89 and .96, to be satisfactory for their study; as a result, after collecting weekly data from four participants, they concluded that effect sizes greater than or equal to .90 indicate an effective treatment, effect sizes ranging between .70 and .89 indicate moderate effectiveness, whereas effective sizes ranging between .50 and .69 revealed debatable

effectiveness, and effective sizes less than .50 deemed ineffective (Meany-Walen et al., 2016).

### *Survey Research Method*

Survey research methods are considered the most widely used and best-known method in quantitative research that includes surveys that are exploratory, descriptive, and explanatory, and present multiple options to collect facts, opinions, and attitudes (Hackett, 1981). Currently, surveys are considered a critical source of data used to examine the relationships between nonresponse bias and response patterns in surveys (Fulton, 2018).

## Operationalization

The DV in my study was unwellness, and the IVs were the external factors: counselor caseload, low funding, and minimal work staff. I measured these variables using the following instruments:

### *5F-WEL*

I used the 5F-WEL assessment instrument to assess the DV unwellness. Participants completed the online assessment as instructed and administered. The quantitative analysis from the results of the assessment should help determine the self-perceived level of wellness of the participants administered and collected at one time, based on the range of scores of each participant.

### *Survey*

I measured the external factors (IVs: counselor caseload, low funding, and minimal work staff) using a demographic questionnaire I composed in SurveyMonkey. I

used the demographic questionnaire to determine the caseloads of the counselors by asking how many clients each counselor is currently serving daily, weekly, or monthly and what number of clients determined a high or low caseload. The counselors answered questions about their caseloads by selecting from choices such as 1–10, 11–20, 21–30, 40–50, or unlimited. Next, the counselors answered questions about low funding by selecting strongly agree or strongly disagree, agree or disagree, neutral or unsure, if it impacts their salaries, continued education, and supplies for work. Lastly, the counselors answered questions about minimal work staff by selecting choices that identify the number of staff attending to clients and patients, such as 1–10, 11–20, 21–30, 40–50, or unlimited.

Participants completed the survey online within the allotted period. While completing the survey, participants had the option to exit or opt out of taking the survey at any time, and I did not include data obtained from participants who opted out of taking the survey in my study. After all survey entries were submitted, I exported the data into SPSS and analyzed the results. After participants completed and submitted the survey, they received an automated thank-you statement with my information as the researcher and contact information for Walden University to address questions, comments, or feedback from participants. No follow-up procedures were needed for my study. Results from the survey should determine the impact of each of the external factors identified in the survey.

## Data Analysis Plan

I used the IBM SPSS Statistics (Version 29) software, a Statistical Package for the Social Sciences Standard, to analyze and implement data cleaning for my study. I exported the data entry through SPSS, and I randomly selected a small percentage of the data to perform a detailed screening to ensure data was entered correctly. Additionally, I used the SPSS software to analyze data, perform correlational coefficients between the identified variables, and reported the results and findings of my study. For data analysis, I screened and cleaned the data to increase the reliability and validity of the data for accuracy in the conclusions of my study (Cronk, 2017). I implemented this process by reviewing the demographic questionnaire by hand and filtering out those questions that have missing data and excluding them from my results to avoid getting skewed results. I made sure I gathered the minimum number of completed surveys before completing the data collection for my study.

I used the following measures to clean and screen the data I collected for my study: I did another review of the demographic questionnaire and eliminated any incomplete or unanswered questions. I used descriptive statistics as an output from version 29 of SPSS and used the SPSS software to create scatterplots and histograms to reveal any outlier datasets I needed to investigate later (SPSS, 2023). If there were any outlier datasets revealed, I used the tab called detect outliers in the software program to spot and change those outliers (IBM, 2012).

If I determined that the outlier data were less than the minimum value, I substituted the outlier data with the minimum value; however, if the outlier data were

greater than the maximum value, I substituted it with the maximum value. Additionally, to screen outlier datasets, I created a histogram, by using the data mining function in the software to define both my minimum and maximum range of values for my data and determined if any of the data is outside of my specified range (IBM, 2012), I then displayed any invalid or missing data using color coding to differentiate from the other data in the histogram.

To report the mean, standard deviation, and frequencies among the variables, I used descriptive statistics, and I employed regression analysis to generate both a correlation and an analysis of variance (ANOVA) table. When using multiple regression analysis as a research design, there are assumptions such as linearity, homoscedasticity, normality, multivariate normality, and no multicollinearity (Field, 2017). To assess linearity, which is when a linear relationship exists between both predictor and response variables, I used a scatterplot. If linearity was violated, I applied a nonlinear transformation to the predictor variable (Field, 2017). To evaluate for homoscedasticity, I used a scatterplot once again, and if there was a violation, I amended the response variable by taking the square root of the values. Next, I conducted a test to determine there is no multicollinearity by calculating the value of the variance inflation factor for my predictor variables and scanned for values greater than 5. If there was a violation of this assumption, I removed all the values that were greater than 5 (see Fields, 2017).

I used the Durbin-Watson Test to evaluate the independence of variables, which means that observation is independent (Field, 2017). If this was violated, I checked if a negative or positive serial correlation was produced, and then if there was a negative

outcome, I reviewed different variables. Consequently, if there was a positive outcome, I included lags of the IV or DV in the model and tested for multivariate normality using a Q-Q plot. If there was a violation of the test for multivariate normality, I checked for outlier datasets and removed them (Fields, 2017).

Additionally, I used The Durbin-Watson Test to detect autocorrelation in the residuals from the regression analysis of my study. I conducted the survey for my study using SurveyMonkey, reviewed the data through the online platform, and exported the data into SPSS-25. Additionally, I removed any incomplete or inaccurate data from the survey, and I did not finish the survey until the minimum number of participants answered all the questions and completed the survey.

I examined the following research question and analyzed the hypotheses through predictive regression analysis in my current study:

RQ: Does counselor self-perceived levels of wellness of Ghanaian mental health counselors (as measured by 5F-WEL assessment), counselor caseload (as measured by demographic questionnaire), low funding (as measured by demographic questionnaire), limited work staff (as measured by demographic questionnaire).

$H_0$: There is no predictive relationship between counselor self-perceived levels of wellness of Ghanaian mental health counselors (as measured by 5F-WEL assessment), counselor caseload (as measured by demographic questionnaire), low funding (as measured by demographic questionnaire), limited work staff (as measured by demographic questionnaire).

$H_1$: There is a predictive relationship between counselor self-perceived levels of wellness of Ghanaian mental health counselors (as measured by: 5F-WEL assessment), counselor caseload (as measured by demographic questionnaire), low funding (as measured by demographic questionnaire), limited work staff (as measured by demographic questionnaire).

I assumed that the results from my study showed a correlation between counselor unwellness (DV) and external factors (IV): counselor caseload, low funding, and minimum work staff and that based on the correlation, the IV predicted the DV. However, in predictive regression analysis, no variables can be manipulated to reveal a particular outcome, due to the nonexperimental design. Another assumption was that the survey responses were accurate and void of errors and non-responses and confirmed the validity of the IVs. Additionally, the results from the 5F-WEL assessment revealed scores that determined counselor unwellness or wellness.

## Threats to Validity

In this section, I discussed threats to the validity using my selected research methods and instruments.

### External Validity

Surveys that fail to collect data from every respondent in the sampling frame jeopardize representativeness and contain nonresponse bias (Fulton, 2018; Groves, 2006), as a result, low response rates undermine the external validity of the data (Fulton, 2018). Although I aimed to survey a larger sample size which could yield more reliable data,

there was a possibility that only a limited number of participants would complete the entire survey, which could pose a threat to external validity.

**Internal Validity**

Limitations of using a survey design include that retrospective data is often incomplete or difficult to obtain, may not meet all requirements to determine causality, and lacks internal validity (Schweizer et al., 2017). My research design did not allow me to make any claims regarding causality, as a result, I was only able to demonstrate if there was a relationship among the variables of my study and if my IVs predicted my DV. Additionally, there could be other factors than the variables I picked that could affect the prediction of the relationship between the variables for my study, which can also impact internal validity.

**Content, Criterion, and Face Validity**

The validity of using the 5F-WEL instrument is determined by content, criterion, and face validity (Sherri, 2003; Zainuddin et al., 2019), which determines its consistency. The content validity of the instrument confirms the systematic examination and measurement of the test content and whether it covers the represented samples of behavioral domains that will be measured (Sherri, 2003; Zainuddin et al., 2019). A threat to content validity would be if the content of the instrument did not cover all domains sampled within its system.

Criterion validity of the instrument determines how accurately it can predict the behavior or capability in certain areas and to what extent is the relation between the measured test items and exempted external criteria; while the face validity of the

instrument perceives if the test toll will measure what is supposed to be measured (Sherri, 2003; Zainuddin et al., 2019). If the instrument failed to measure any other factors than what was intended, this would pose a threat to its face validity and impact reliability, subsequently, if the instrument could not accurately predict behavior domains or the relation between measured test items and exempted external criteria, criterion validity can be impacted.

## Ethical Procedures

I followed the guidelines provided by the Institutional Review Board (IRB) by not contacting potential participants and not collecting any data before IRB approval. After I received IRB approval on 3/8/2024 (IRB approval number 03-08-24-0726919), I contacted prospective participants via email from the directory list I previously mentioned and provided participants with an informed consent document, information about the study, a confidentiality statement, and a written explanation of the risks and benefits of the study. Participants had the opportunity to review, read, and sign the informed consent before taking the survey and completing the demographic questionnaire. I did not include any identifying information about the participants in the demographic questionnaire and survey. My research study did not require or need me to access the protected health information of the participants, as a result, approval for this information was not required from the participants. As an extra level of protection for participants, I implemented anonymity in my study by not collecting any identifiable information and keeping my informed consent separate from my collected data. I stored the data on a designated flash drive and secured it with at least two layers of security, in a

secured file cabinet, in a locked home office. I stored the data for the period required by IRB regulations. I did not collect data from co-workers, friends, and family members.

## Summary

In Chapter 3, I described and explained the research design for my study was a nonexperimental research survey design using a linear multiple regression data analysis to determine if there was a relationship between Ghanaian mental health counselors experiencing unwellness, and counselor caseload, low funding, and minimal work staff. I informed that I recruited Ghanaian Mental Health Counselors from the Ghana Psychology Council Database, as participants for my study. I described the instruments I used for my study were the survey research method and the 5F-WEL assessments, and described the ethical procedures, sampling, and data collection processes of my study. In Chapter 4, I will discuss my process for data collection, period, and response rate, report the demographic and descriptive characteristics of my sample, present the results of both my statistical and research analyses, and summarize my findings to answer my research question.

# Chapter 4 Results

The purpose of my quantitative study was to predict if there was a relationship between the IVs (external factors of counselor caseload, low funding, and limited work staff) and the DV (wellness, as determined by 5F-WEL). The research question and hypotheses I attempted to answer with my study were:

RQ: Does counselor self-perceived levels of wellness of Ghanaian mental health counselors (as measured by the 5F-WEL assessment), counselor caseload (as measured by demographic questionnaire), low funding (as measured by demographic questionnaire), limited work staff (as measured by demographic questionnaire).

$H_0$: There is no predictive relationship between counselor self-perceived levels of wellness of Ghanaian mental health counselors (as measured by the 5F-WEL assessment), counselor caseload (as measured by demographic questionnaire), low funding (as measured by demographic questionnaire), limited work staff (as measured by demographic questionnaire), that predicts counselor levels of unwellness (as measured by demographic questionnaire).

$H_1$: There is a predictive relationship between counselor self-perceived levels of wellness of Ghanaian mental health counselors (as measured by the 5F-WEL assessment), counselor caseload (as measured by demographic questionnaire), low funding (as measured by demographic questionnaire), limited work staff (as measured by demographic questionnaire).

## Data Collection and Cleaning

After receiving IRB approval, I uploaded my demographic questionnaire and 5F-WEL assessment into SurveyMonkey. Before commencing the survey, participants read and agreed to informed consent by reading the informed consent document and clicking on the "begin survey" link to indicate consent. Once the survey was completed in SurveyMonkey, the survey was disseminated via email by an in-country Ghanaian mental health counselor. A total of 100 participants from the total population of 274 Ghanaian counselors listed in the national registry provided consent to participate. The on-ground colleague emailed the survey link to all 274 mental health counselors in the national registry. From that list, 100 mental health counseling participants in Ghana responded. My survey was opened for 3 weeks and when I reached my target goal of 100 responses, I closed the survey and ended data collection. I exported multiple versions of my survey report from SurveyMonkey into PDF, SPSS, and Excel formats and saved the data to a password-protected desktop folder on my computer that is kept in a private, locked office.

I used the following measures to clean and screen the data I collected for my study: I opened the Excel spreadsheet and began data cleaning by eliminating blank columns or columns I did not initially collect, such as name, email address, collector, and response ID numbers, and IP addresses. After reviewing the exported raw data, I discovered that out of the 100 participants who provided consent to participate in the study, I ended up with a sample size of ($N$ = 96) who fully completed the study. I did another review of the data and discovered that out of the sample size of ($N$ = 96), 43

participants completed the demographic questionnaire but not the 5F-WEL assessment, and 53 participants completed the entire study answering both the demographic questionnaire and 5F-WEL assessment. In Chapter 3, I discussed my initial plans to eliminate any incomplete or unanswered questions, however, when I discovered that almost half of the sample size did not complete the entire survey, I decided to keep all the data so that my results would not be greatly affected due to not having a larger sample size, to begin with. After completing data cleaning, I uploaded the raw data into SPSS, created codes for each variable, and created subscales for the IVs (minimum work staff, counselor caseload, and low funding) and the DV (wellness) before I started data analysis and retrieved my results.

**Descriptive and Demographic Characteristics and Statistics of Sample**

Participants of my study were Ghanaian mental health counselors who met the inclusion criteria for participation. Participants provided their informed consent online to participate in the study. There was a total of 100 participant responses, and of the 100 participants there were a total ($N$ = 96) who completed the survey; however, of the 96 participants, 43 completed the demographic questionnaire but not the 5F-WEL assessment, and 53 completed both the demographic questionnaire and 5F-WEL assessment, fully completing the study.

The 96 Ghanaian mental health counselors in the sample included 72 (75%) female participants and 24 (25%) male (see Table 1). I included the following age ranges in the demographic questionnaire, coded from 1 to 5: 18–24 (1), 25–34 (2), 35–45 (3), 46–59 (4), 60+ (5). The ages of the participants fell within these ranges as follows: 37

(38.5%) participants were 18–24, 36 (37.5%) were 25–34, 21 (21.9%) were 35–45, one (1.0%) was 46–59, and one (1.0%) was 60+ (see Table 2). The participants identified working in various settings by selecting the appropriate option from the demographic questionnaire, which I coded from 1 to 4, as follows: Private Practice (1), Psychiatric hospital (2), Nonprofit agencies/NGOs (3), and Private agencies/schools/institutions (4). Twenty-three (24.0%) participants worked in private practice, 19 (19.8%) worked in psychiatric hospitals, 13 (13.5%) worked in Nonprofit agencies/NGOs, and 41 (42.7%) worked in private agencies/schools/institutions (see Table 3). Participants identified the number of clients on their caseloads by choosing the appropriate option from the demographic questionnaire, which I coded from 1 to 5: 53 (55.2%) participants reported having 1–10 clients on their caseloads, 23 (24.0%) reported having 11–20 clients on their caseloads, nine (9.4%) reported having 21–30 clients on their caseloads, three (3.1%) reported having 31–40 clients on their caseloads, one (1.0%) reported having 41–50 clients on their caseload, and seven (7.3%) reported having an unlimited number of clients on their caseload (see Table 4).

**Table 1**

*Participant Gender*

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | Male | 24 | 24.0 | 25.0 | 25.0 |
| | Female | 72 | 72.0 | 75.0 | 100.0 |
| | Total | 96 | 96.0 | 100.0 | |
| Missing | System | 4 | 4.0 | | |
| Total | | 100 | 100.0 | | |

**Table 2**

*Participant Age*

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | 18-24 | 37 | 37.0 | 38.5 | 38.5 |
| | 25-34 | 36 | 36.0 | 37.5 | 76.0 |
| | 35-45 | 21 | 21.0 | 21.9 | 97.9 |
| | 46-59 | 1 | 1.0 | 1.0 | 99.0 |
| | 60+ | 1 | 1.0 | 1.0 | 100.0 |
| | Total | 96 | 96.0 | 100.0 | |
| Missing | System | 4 | 4.0 | | |
| Total | | 100 | 100.0 | | |

**Table 3**

*Participant Workplace Settings*

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | Private practice | 23 | 23.0 | 24.0 | 24.0 |
| | Psychiatric hospital | 19 | 19.0 | 19.8 | 43.8 |
| | Non-profit agencies/NGO | 13 | 13.0 | 13.5 | 57.3 |
| | Private agencies, schools, or institutions | 41 | 41.0 | 42.7 | 100.0 |
| | Total | 96 | 96.0 | 100.0 | |
| Missing | System | 4 | 4.0 | | |
| Total | | 100 | 100.0 | | |

**Table 4**

*Counselor Caseload*

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | 1-10 | 53 | 53.0 | 55.2 | 55.2 |
| | 11-20 | 23 | 23.0 | 24.0 | 79.2 |
| | 21-30 | 9 | 9.0 | 9.4 | 88.5 |
| | 31-40 | 3 | 3.0 | 3.1 | 91.7 |
| | 41-50 | 1 | 1.0 | 1.0 | 92.7 |
| | Unlimited/Varied number | 7 | 7.0 | 7.3 | 100.0 |
| | Total | 96 | 96.0 | 100.0 | |
| Missing | System | 4 | 4.0 | | |
| Total | | 100 | 100.0 | | |

**Descriptive Statistics of IV**

The IVs I included in the sample were minimum work staff, counselor caseload, and low funding. Participants answered questions from the demographic questionnaire which provided results for each of the IVs. I created three subscales from the question items from the demographic questionnaire and labeled them in all caps as WORKSTAFF, CASELOAD, and FUNDING. I calculated each item within each of the subscales to obtain the total of each of them. Table 5 provides an overview of the IV subscales.

**Table 5**

*Independent Variable Descriptive Statistics*

| | N | Minimum | Maximum | Mean | Std. Deviation | Skewness | | Kurtosis | |
|---|---|---|---|---|---|---|---|---|---|
| | Statistic | Statistic | Statistic | Statistic | Statistic | Statistic | Std. Error | Statistic | Std. Error |
| WORKSTAFF | 96 | 1 | 5 | 1.59 | 1.202 | 2.173 | .246 | 3.532 | .488 |
| CASELOAD | 96 | 3 | 11 | 5.47 | 1.635 | 1.407 | .246 | 2.106 | .488 |
| FUNDING | 96 | 3 | 13 | 7.82 | 2.575 | .042 | .246 | -.757 | .488 |
| Valid N (listwise) | 96 | | | | | | | | |

**Descriptive Statistics for DV**

The DV included in my sample was wellness, and I used the 5F-WEL instrument to assess the participants' level of wellness. Participants for my study completed the online version of the 5F-WEL assessment, which takes 10–20 minutes to complete. There are no additional or specific requirements or tools needed to administer the assessment. As the administrator, I received the results of the assessment, and I purchased the manual for further instructions to score and interpret the results. The 5F-WEL has 91 questions or items, has reliability with internal consistency, and has alpha scores ranging from $r$ = 0.61–0.89 across all domains (Bart et al., 2018). Each item of the 5F-WEL is a statement answered by respondents using a four-point Likert scale (strongly agree, agree, disagree, and strongly disagree) with each response being converted into numerical scores from 4 (*strongly agree*) to 1 (*strongly disagree*) and summed for each subscale (5FWEL manual, 2024; Myers & Sweeney, 2005, 2014). Some of the items are reverse scored to achieve consistent reporting with other scales.

I used the formula provided in the 5F-WEL manual to place all scales onto a common metric, then converted to a core ranging from 25 to 100 by dividing the mean score for each scale by the number of items and then multiplying by 25 (FFWEL manual, 2024; Myers & Sweeney, 2005, 2014). Following this formula, transformed the scale to be more meaningful for interpretation purposes; as a result, for scoring purposes, missing data are considered because a minimum of three item responses per scale is required for a scale to be scored. Individual scores are composed of 17 third-order factor scores that are grouped according to the five second-order factors (creative self, coping self, social self,

essential self, and physical self), plus Total Wellness, each of the four context scores, and a one-item Life Satisfaction score (FFWEL manual, 2024; Myers & Sweeney, 2005, 2014). I created five subscales from the 91 items from the assessment and labeled them in all caps to match the five areas assessed: CREATIVE SELF, COPING SELF, SOCIAL SELF, ESSENTIAL SELF, and PHYSICAL SELF. To get the Total Wellness score, I added the sum of the total scores of all five areas, divided by the 91 items in the scale, and multiplied by 25.

## Results

In this section, I present the results from the study and describe the characteristics of my sample. I explain the statistical assumptions, describe the statistics of the two instruments I used for my study, the demographic questionnaire created in SurveyMonkey and the 5F-WEL instrument, and report statistical analysis findings.

### Testing Assumptions

When using multiple regression analysis as a research design, there are assumptions such as linearity, homoscedasticity, normality, multivariate normality, and no multicollinearity (Field, 2017). To assess linearity, which is when a linear relationship exists between both predictor and response variables, I used a scatterplot. If linearity was violated, I applied a nonlinear transformation to the predictor variable (see Field, 2017). To evaluate for homoscedasticity, I used a scatterplot once again, and if there was a violation, I amended the response variable by taking the square root of the values. Next, I conducted a test to determine that there is no multicollinearity by calculating the value of the variance inflation factor for my predictor variables and scanned for values greater

than 5. If there was a violation of this assumption, I removed all the values that were greater than 5 (see Fields, 2017).

I used the Durbin-Watson Test to evaluate the independence of variables, which means that observation is independent (Field, 2017). If this was violated, I checked if a negative or positive serial correlation was produced, and then if there was a negative outcome, I reviewed different variables. Consequently, if there was a positive outcome, I included lags of the IV or DV in the model and tested for multivariate normality using a Q-Q plot. If there was a violation of the test for multivariate normality, I checked for outlier datasets and removed them (Fields, 2017). Additionally, I used The Durbin-Watson Test to detect autocorrelation in the residuals from the regression analysis of my study. Table 6 provides an overview of the collinearity statistics and Figure 1 provides an overview of the scatterplots for testing assumptions of homoscedasticity.

**Table 6**

*Collinearity Diagnostics*

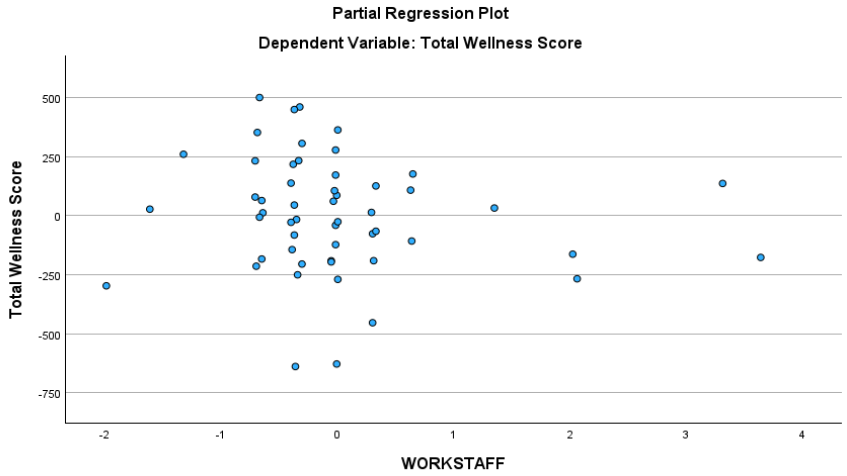
**Collinearity Diagnostics[a]**

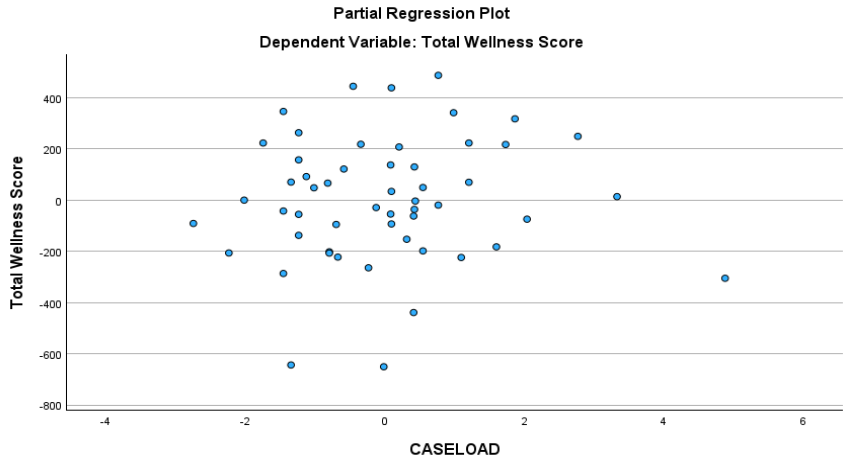
| Model | Dimension | Eigenvalue | Condition Index | Variance Proportions | | | |
|---|---|---|---|---|---|---|---|
| | | | | (Constant) | WORKSTAFF | CASELOAD | FUNDING |
| 1 | 1 | 3.613 | 1.000 | .00 | .02 | .00 | .01 |
| | 2 | .280 | 3.595 | .01 | .67 | .00 | .07 |
| | 3 | .084 | 6.541 | .01 | .27 | .35 | .42 |
| | 4 | .023 | 12.496 | .97 | .04 | .65 | .50 |

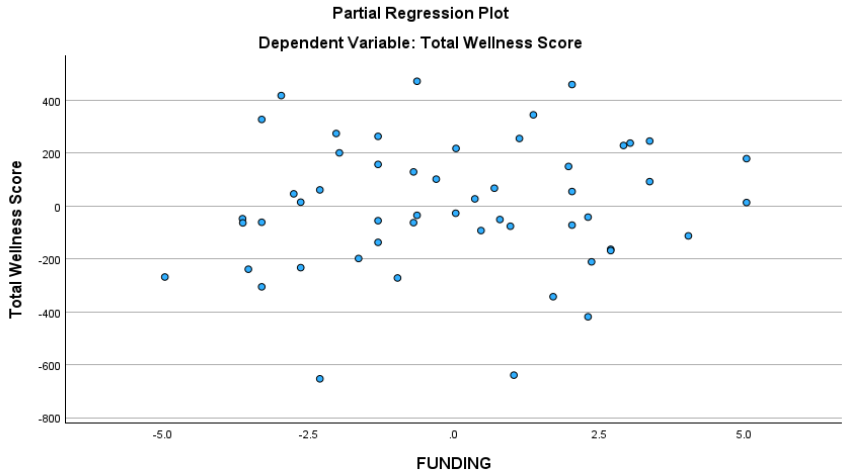
a. Dependent Variable: Total Wellness Score

**Figure 1**

*Scatterplots Testing for Homoscedasticity*



**Survey Results**

In my demographic questionnaire, I included questions related to the IVs (minimum work staff, counselor caseload, low funding). I obtained survey results from the participants' responses to the questions related to the IVs. I focused on the participants' responses about counselor caseload and low funding. I first asked questions about whether the participants felt overwhelmed or fulfilled by their counselor caseload by providing the following options for them to select always, sometimes, not really/not at all. Twelve (12.5%) participants reported feeling overwhelmed by their caseload, while 52 (54.2%) participants reported feeling fulfilled by their role as a counselor. Sixty-seven (69.8%) participants reported sometimes feeling overwhelmed by their caseload, while 41 (42.7%) participants reported feeling sometimes fulfilled by their role as a counselor. Seventeen (17.7%) participants reported not really/not at all feeling overwhelmed by their caseload, while 3 (3.1%) participants reported not really/not at all feeling fulfilled in their role as a counselor.

Next, I asked questions about funding whether there should be more funding resources for professional experiences for counselors in Ghana, promotions and salary increases, and overall satisfaction with their salaries. Participants answered the questions by selecting from the following options: agree, disagree, strongly agree, strongly disagree, unsure/prefer not to answer. Forty-nine (51.%) of participants agreed that more funding resources should be available, one (1%) participant disagreed to more funding, 43 (44.8%) of participants strongly agreed to more funding, three (3.1%) participants strongly disagreed to more funding, 0 respondents were unsure to more funding. The

results for funding to support the needs of counselors such as promotions, training, and salary increases are as follows, 14 (14.6%) of participants agree that funding should be available to support the needs of counselors, 45 (46.9%) of participants disagree that funding should be available to support counselors, two (2.0%) participants strongly agree that funding should be available to support counselors, 20 (20.8%) strongly disagree that funding should be available to support counselors, 15 (15.6%) were unsure/prefer not to answer if funding should be available to support counselors. For current salary satisfaction as a Ghanaian mental health counselor, six (6.3%) participants agree to salary satisfaction as a counselor, 43 (44.8%) participants disagree with salary satisfaction, two (2.1%) strongly agree to salary satisfaction, 29 (30.2%) participants strongly disagree to salary satisfaction, and 16 (16.7%) participants were unsure/prefer not to answer about salary satisfaction.

I also included a question to identify the overall counselor experiences for the participants based on those IVs. I aimed to assess the overall experiences of the counselors in their roles and to identify if there is any correlation between them. Participants answered the question choosing from four options, coded from one to four: fulfilled/stress-free (1), stressed/overwhelmed (2), depressed/isolated (3), and unknown/no experience (4). The results revealed that 27 (28.1 %) of participants reported feeling fulfilled/stress-free by counselor experiences, 59 (61.5 %) of participants reported feeling overwhelmed by counselor experiences, nine (9.4 %) participants reported feeling depressed/isolated by counselor experiences, and one (1.0 %) participant reported

unknown/no experiences by counselor experiences. An overview of these results is presented in Tables 7 and 8.

**Table 7**

*Counselor Experiences*

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|---|---|---|---|---|---|
| Valid | Fulfilled/Stress-free | 27 | 27.0 | 28.1 | 28.1 |
| | Stressed/Overwhelmed | 59 | 59.0 | 61.5 | 89.6 |
| | Depressed/Isolated | 9 | 9.0 | 9.4 | 99.0 |
| | Unknown/No experience | 1 | 1.0 | 1.0 | 100.0 |
| | Total | 96 | 96.0 | 100.0 | |
| Missing | System | 4 | 4.0 | | |
| Total | | 100 | 100.0 | | |

**Table 8**

*Correlations*

| | | Counselor experiences | WORKSTAFF | CASELOAD | FUNDING |
|---|---|---|---|---|---|
| Counselor experiences | Pearson Correlation | 1 | .161 | .005 | .105 |
| | Sig. (2-tailed) | | .118 | .960 | .307 |
| | N | 96 | 96 | 96 | 96 |
| WORKSTAFF | Pearson Correlation | .161 | 1 | .409** | -.017 |
| | Sig. (2-tailed) | .118 | | <.001 | .872 |
| | N | 96 | 96 | 96 | 96 |
| CASELOAD | Pearson Correlation | .005 | .409** | 1 | -.015 |
| | Sig. (2-tailed) | .960 | <.001 | | .884 |
| | N | 96 | 96 | 96 | 96 |
| FUNDING | Pearson Correlation | .105 | -.017 | -.015 | 1 |
| | Sig. (2-tailed) | .307 | .872 | .884 | |
| | N | 96 | 96 | 96 | 96 |

**. Correlation is significant at the 0.01 level (2-tailed).

## 5F-WEL Results

In Chapter 3, I noted that the quantitative analysis from the results of the 5F-WEL assessment should help determine the self-perceived level of wellness of the participants

administered based on the range of scores for each participant. However, I am uncertain if I achieved this because although I used the formula provided to get the sum for each of the subscales created, the results appeared high for the creative self, coping self, social self, essential self, physical self, and total wellness, whereas the sum for the contextual variables and the life satisfaction index was low. I created a histogram to demonstrate the Total Wellness score obtained from the sum of the five subscales (creative self, coping self, social self, essential self, and physical self). Tables 9–13 and Figure 2 provide an overview of the 5F-WEL results.

**Table 9**

*Statistics*

| | | CREATIVE SELF | COPING SELF | SOCIAL SELF | ESSENTIAL SELF | PHYSICAL SELF | Total Wellness Score | Local Context | Institutional Context | Global Context | Chronometric Context | Life Satisfaction Index |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| N | Valid | 53 | 53 | 53 | 53 | 53 | 53 | 53 | 53 | 53 | 53 | 53 |
| | Missing | 47 | 47 | 47 | 47 | 47 | 47 | 47 | 47 | 47 | 47 | 47 |
| Mean | | 469.91 | 407.42 | 530.29 | 525.13 | 379.95 | 4974.85 | 73.30 | 72.41 | 77.99 | 83.73 | 79.72 |
| Std. Error of Mean | | 5.536 | 4.653 | 9.374 | 7.844 | 8.285 | 33.951 | 1.340 | 1.592 | 1.958 | 1.500 | 2.699 |
| Median | | 468.25 | 405.15 | 546.88 | 532.55 | 387.50 | 4960.11 | 70.00 | 68.75 | 83.33 | 87.50 | 75.00 |
| Mode | | 433[a] | 405 | 469 | 469[a] | 388[a] | 4326[a] | 70 | 69 | 83 | 75 | 75 |
| Std. Deviation | | 40.304 | 33.872 | 68.241 | 57.102 | 60.315 | 247.170 | 9.754 | 11.592 | 14.256 | 10.918 | 19.646 |
| Variance | | 1624.414 | 1147.335 | 4656.810 | 3260.675 | 3637.858 | 61092.860 | 95.138 | 134.366 | 203.243 | 119.200 | 385.976 |
| Skewness | | .067 | -.218 | -.589 | -.617 | -.637 | -.321 | .952 | -.074 | -.420 | -.416 | -.846 |
| Std. Error of Skewness | | .327 | .327 | .327 | .327 | .327 | .327 | .327 | .327 | .327 | .327 | .327 |
| Kurtosis | | .081 | -.507 | -.268 | .769 | .095 | .362 | .853 | .953 | -.068 | .101 | .586 |
| Std. Error of Kurtosis | | .644 | .644 | .644 | .644 | .644 | .644 | .644 | .644 | .644 | .644 | .644 |
| Range | | 205 | 142 | 273 | 281 | 250 | 1141 | 45 | 63 | 58 | 50 | 75 |
| Minimum | | 367 | 326 | 352 | 344 | 238 | 4326 | 55 | 38 | 42 | 50 | 25 |
| Maximum | | 571 | 468 | 625 | 625 | 488 | 5467 | 100 | 100 | 100 | 100 | 100 |
| Sum | | 24905 | 21593 | 28105 | 27832 | 20138 | 263667 | 3885 | 3838 | 4133 | 4438 | 4225 |
| Percentiles | 25 | 444.44 | 378.56 | 468.75 | 493.16 | 350.00 | 4810.32 | 65.00 | 68.75 | 66.67 | 75.00 | 75.00 |
| | 50 | 468.25 | 405.15 | 546.88 | 532.55 | 387.50 | 4960.11 | 70.00 | 68.75 | 83.33 | 87.50 | 75.00 |
| | 75 | 499.26 | 434.21 | 585.94 | 564.45 | 437.50 | 5151.73 | 80.00 | 81.25 | 83.33 | 93.75 | 100.00 |

a. Multiple modes exist. The smallest value is shown

**Figure 2**

*Histogram for Total Wellness Score*

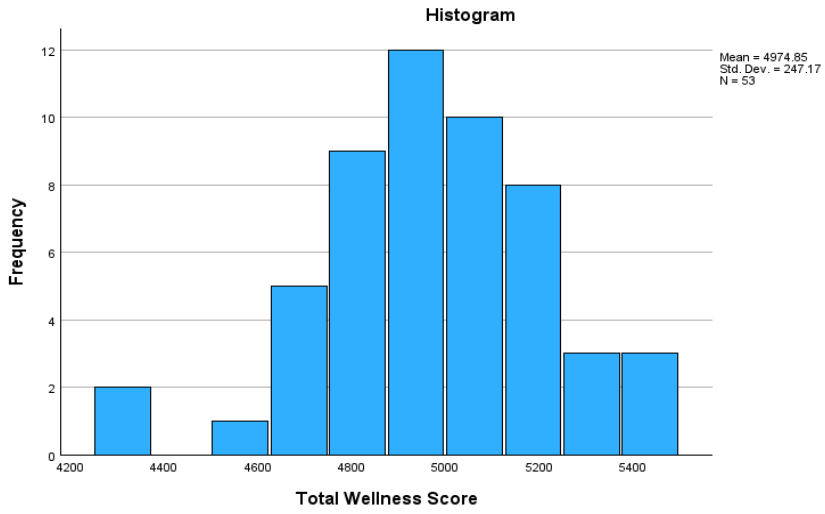



**Table 10**

*Statistics for Total Wellness Score*

Total Wellness Score

| | | |
|---|---|---|
| N | Valid | 53 |
| | Missing | 47 |
| Mean | | 4974.85 |
| Std. Error of Mean | | 33.951 |
| Median | | 4960.11 |
| Mode | | 4326[a] |
| Std. Deviation | | 247.170 |
| Variance | | 61092.860 |
| Skewness | | -.321 |
| Std. Error of Skewness | | .327 |
| Kurtosis | | .362 |
| Std. Error of Kurtosis | | .644 |
| Range | | 1141 |
| Minimum | | 4326 |
| Maximum | | 5467 |
| Sum | | 263667 |
| Percentiles | 25 | 4810.32 |
| | 50 | 4960.11 |
| | 75 | 5151.73 |

a. Multiple modes exist. The smallest value is shown

**Table 11**

*Correlations*

| | | Total Wellness Score | WORKSTAFF | CASELOAD | FUNDING |
|---|---|---|---|---|---|
| Total Wellness Score | Pearson Correlation | 1 | -.118 | -.016 | .107 |
| | Sig. (2-tailed) | | .399 | .911 | .448 |
| | N | 53 | 53 | 53 | 53 |
| WORKSTAFF | Pearson Correlation | -.118 | 1 | .409** | -.017 |
| | Sig. (2-tailed) | .399 | | <.001 | .872 |
| | N | 53 | 96 | 96 | 96 |
| CASELOAD | Pearson Correlation | -.016 | .409** | 1 | -.015 |
| | Sig. (2-tailed) | .911 | <.001 | | .884 |
| | N | 53 | 96 | 96 | 96 |
| FUNDING | Pearson Correlation | .107 | -.017 | -.015 | 1 |
| | Sig. (2-tailed) | .448 | .872 | .884 | |
| | N | 53 | 96 | 96 | 96 |

**. Correlation is significant at the 0.01 level (2-tailed).

**Table 12**

*Correlations: Counselor Experiences and Total Wellness Score*

| | | Counselor experiences | Total Wellness Score |
|---|---|---|---|
| Counselor experiences | Pearson Correlation | 1 | -.288* |
| | Sig. (2-tailed) | | .036 |
| | N | 96 | 53 |
| Total Wellness Score | Pearson Correlation | -.288* | 1 |
| | Sig. (2-tailed) | .036 | |
| | N | 53 | 53 |

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

**Table 13**

*Correlations*

| | | Total Wellness Score | WORKSTAFF | CASELOAD | FUNDING |
|---|---|---|---|---|---|
| Pearson Correlation | Total Wellness Score | 1.000 | -.118 | -.016 | .107 |
| | WORKSTAFF | -.118 | 1.000 | .477 | -.077 |
| | CASELOAD | -.016 | .477 | 1.000 | -.205 |
| | FUNDING | .107 | -.077 | -.205 | 1.000 |
| Sig. (1-tailed) | Total Wellness Score | . | .199 | .455 | .224 |
| | WORKSTAFF | .199 | . | .000 | .291 |
| | CASELOAD | .455 | .000 | . | .071 |
| | FUNDING | .224 | .291 | .071 | . |
| N | Total Wellness Score | 53 | 53 | 53 | 53 |
| | WORKSTAFF | 53 | 53 | 53 | 53 |
| | CASELOAD | 53 | 53 | 53 | 53 |
| | FUNDING | 53 | 53 | 53 | 53 |

**Results of the Multiple Regression**

A linear multiple regression analysis was used in this study to examine the relationship between the DV and IVs. The following research question were examined in SPSS: Does counselors self-perceived levels of wellness of Ghanaian mental health counselors (as measured by the 5F-WEL assessment), counselor caseload (as measured by demographic questionnaire), low funding (as measured by demographic questionnaire), limited work staff (as measured by demographic questionnaire).

$H_0$: There is no predictive relationship between counselor self-perceived levels of wellness of Ghanaian mental health counselors (as measured by the 5F-WEL assessment), counselor caseload (as measured by demographic questionnaire), low funding (as measured by demographic questionnaire), limited work staff (as measured by

demographic questionnaire), that predicts counselor levels of unwellness (as measured by demographic questionnaire).

$H_1$: There is a predictive relationship between counselor self-perceived levels of wellness of Ghanaian mental health counselors (as measured by the 5F-WEL assessment), counselor caseload (as measured by demographic questionnaire), low funding (as measured by demographic questionnaire), limited work staff (as measured by demographic questionnaire).

Since I could not determine if the scores from the 5F-WEL predicted the self-perceived level of wellness from the participants, I proceeded to run a correlation between the DV (wellness) and the IV (minimum work staff, counselor caseload, low funding) to assess if there was any correlation between them. To do this, I analyzed a correlation between the Total Wellness score and the three IV subscales (work staff, caseload, funding). With correlation, I am seeking to find the strength, nature, and significance between DV and IV. The strength of the correlation is determined by using the following guidelines, strong correlation is between 0.7 to 1, moderate correlation is between 0.3 to 0.7, and weak correlation is less than 0.3. The nature of the correlation is determined by positive or negative, it is negative if there is a negative sign before the number. The significance of the correlation is either significant ($p < .05$) or insignificant ($p > .05$).

The results determined that the correlation between total wellness and work staff was weak, negative, and insignificant. The correlation between total wellness and caseload was strong, positive, and significant. The correlation between total wellness and

funding was moderate, negative, and insignificant. I then ran a correlation between total wellness and counselor experience. The correlation between total wellness and overall counselor experience is moderate, negative, and significant in Tables 14–16.

**Table 14**

*Model Summary*

**Model Summary[b]**

| Model | R | R Square | Adjusted R Square | Std. Error of the Estimate | Change Statistics | | | | | Durbin-Watson |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | R Square Change | F Change | df1 | df2 | Sig. F Change | |
| 1 | .167[a] | .028 | -.032 | 251.044 | .028 | .469 | 3 | 49 | .705 | 1.665 |

a. Predictors: (Constant), FUNDING, WORKSTAFF, CASELOAD

b. Dependent Variable: Total Wellness Score

**Table 15**

*Analysis of Variance*

**ANOVA[a]**

| Model | | Sum of Squares | df | Mean Square | F | Sig. |
|---|---|---|---|---|---|---|
| 1 | Regression | 88700.928 | 3 | 29566.976 | .469 | .705[b] |
| | Residual | 3088127.801 | 49 | 63023.016 | | |
| | Total | 3176828.729 | 52 | | | |

a. Dependent Variable: Total Wellness Score

b. Predictors: (Constant), FUNDING, WORKSTAFF, CASELOAD

**Table 16**

*Coefficients*

**Coefficients[a]**

| Model | | Unstandardized Coefficients | | Standardized Coefficients | t | Sig. | 95.0% Confidence Interval for B | | Correlations | | | Collinearity Statistics | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | B | Std. Error | Beta | | | Lower Bound | Upper Bound | Zero-order | Partial | Part | Tolerance | VIF |
| 1 | (Constant) | 4875.886 | 180.930 | | 26.949 | <.001 | 4512.295 | 5239.478 | | | | | |
| | WORKSTAFF | -32.277 | 35.364 | -.146 | -.913 | .366 | -103.343 | 38.788 | -.118 | -.129 | -.129 | .772 | 1.295 |
| | CASELOAD | 11.495 | 24.482 | .077 | .470 | .641 | -37.704 | 60.695 | -.016 | .067 | .066 | .744 | 1.343 |
| | FUNDING | 10.800 | 14.007 | .111 | .771 | .444 | -17.349 | 38.948 | .107 | .109 | .109 | .958 | 1.044 |

a. Dependent Variable: Total Wellness Score

## Summary

A multiple regression was completed to assess my research question in this study. The hypothesis for my study was confirmed and my null hypothesis was rejected. However, total wellness and work staff results presented a weak, negative, and insignificant correlation. I used descriptive statistics as an output from version 29 of SPSS and used the SPSS software to create scatterplots and histograms to reveal any outlier datasets I needed to investigate later (SPSS, 2023). To report the mean, standard deviation, and frequencies among the variables, I used descriptive statistics, and I employed regression analysis to generate both a correlation and an ANOVA table.

I described the data collection processes for my study and discussed the results and findings from analyzing my data. I added charts and tables of the descriptive statistics of my study, including the variables from my demographic questionnaire. Additionally, I included chats from the results and output of the 5F-WEL assessment instrument. In Chapter 5, I will provide an overview of the implications of the findings of my study, interpret the findings, and explain the limitations identified from my study. Additionally, I will make recommendations for future studies using the 5F-WEL instrument or implementing a qualitative study to assess counselor wellness. I also will discuss the implications of the study related to positive and social change and provide a conclusion to this study.

# Chapter 5 Findings

The purpose of my quantitative study was to predict if there was a relationship between the IVs (external factors of counselor caseload, low funding, and limited work staff) and the DV (wellness, as determined by 5F-WEL). The specific research design for my study included a predictive regression analysis. I used the 5F-WEL as the instrument for assessment (i.e., based on five general factors of self: creative, coping, social, essential, and physical, as well as levels of impairment), surveys to measure and determine external factors, and a demographic questionnaire for data collection. The data points I used to answer my research question included the results from the 5F-WEL assessment based on five general factors of self: creative, coping, social, essential, physical, and levels of impairment. Additional data points from the survey questions addressed the external factors (i.e., counselor caseload, low funding, and minimal work staff) to predict whether there was a relationship between these IVs and the DV, wellness.

## Interpretation of the Findings

The research question examined in my study was the relationship between wellness and external factors (work staff, counselor caseload, low funding) among Ghanaian mental health counselors. The three IVs (work staff, counselor caseload, and low funding) were assessed to determine whether they predict DV (wellness). The total sum of the scale items from the 5F-WEL instrument composed a total wellness score which represented the DV. As a result, the IVs were assessed with the total wellness score, and the results varied from the total wellness score and each of the IVs. Some of the results showed a correlation between low funding or lack of more funding and an

increased level of stress and overwhelm among 59 respondents. Of the 59 respondents, 32 of them reported having 1–10 clients or patients on their caseload. This outcome determined that total wellness and funding had moderate, negative, and insignificant correlation. Insignificance in correlation means the variables are going in different directions, meaning that the respondents felt the opposite of total wellness, which is unwellness due to low funding in their role as a counselor. This finding supports the point addressed by Ae-Negibe et al. (2015) that the various degrees of burden reported by caregivers of mental health patients included financial burdens, which caused emotional distress. Addo et al. (2018) also reported that caregiver burden transitions from moderate to severe levels due to financial constraints which creates an economic burden for them.

The results for total wellness and counselor caseload determined a strong, positive, and significant correlation. Significance in this instance means that total wellness and counselor caseload are in the same direction, there is no difference or impact on counselor wellness. Total wellness and work staff results presented a weak, negative, and insignificant correlation. So although the two variables were insignificant, there was no impact on the participants' wellness or unwellness. As mentioned in Chapter 4, I assessed total wellness and counselor experience to determine a possible correlation. The results determined that the correlation between total wellness and counselor experience was moderate, negative, and significant. Both total wellness and counselor experience are significant, and there is no difference in impact on counselors' wellness. Based on these results and findings, I disprove my null hypothesis and determine that my

hypothesis is correct, that there is a predictive relationship between the DV (wellness) and the IVs (work staff, counselor caseload, and low funding).

## Limitations of the Study

The limitations that arose from the execution of my study included having more responses from female participants than male participants. I sent reminders weekly to the designated mental health colleague to encourage participants to complete the survey with soft deadlines and timeframes for completion. The response rate was slow at first, possibly due to low motivation from participants to complete the study; as a result, in future studies, offering a small compensation or reward might be motivating to participants. I used convenience sampling to recruit participants due to being an easy and inexpensive method to gather data; however, with this method, there is no way to identify whether the sample is representative of the data, which can impact the generalizability of results (Mweshi & Sakyi, 2020). Another limitation to generalizability was my sample size. As noted by Kirchner (2014), a larger sample size can increase generalizability and would answer the research question more adequately. I would consider using a lesser number of subscales from the 5F-WEL assessment than using the full number of subscales due to time restraints and having an overload of questions. Kirchner (2014) stated that by nature individuals are multifaceted and may require deep investigation into many aspects of individuals' lives to determine predictive variables for wellness. Content, criterion, and face validity determine the validity of the 5F-WEL instrument (Sherri, 2003; Zainuddin et al., 2019). Criterion validity of the instrument determines how accurately it can predict the behavior or capability in certain areas and to what extent

is the relation between the measured test items and exempted external criteria (Sherri, 2003; Zainuddin et al., 2019), although the face and content validity was not a limitation, the criterion validity was impacted due to only $n = 53$ participants completing the 5F-WEL assessment and not the entire sample size of $N = 96$. Other limitations include the natural limitations of quantitative research, such as the possibility that participants may have had insights to share that were not possible in a survey format.

## Recommendations for Future Practice

The recommendations for further research grounded in the strengths and limitations of the current study include conducting this study as a qualitative study to address the limitations identified from this study. Using different research instruments, such as conducting interviews and facilitating focus groups with participants, could yield different results that identify the lived experiences of mental health counselors in Ghana. Most of the literature referenced in my study about Ghanaian mental health counselors are qualitative studies that showcase their lived experiences, and participants share more dialogue. The theoretical framework I used for the current study was holistic theory. For further research, I would consider using the wellness continuum/illness–wellness continuum, which is composed of three wellness concepts (i.e., the iceberg model, the illness-wellness continuum, and the wellness energy system), and summarizes that individuals frequently experience physical side effects due to exhaustion with their lives (Wickramarthne et al., 2020). With this model, it is important to consider an individual's physical self, using the mind positively, adequately communicating feelings, engaging with people, and minimizing constant rumination of an individual's physical and mental

situation (Wickramarthne et al., 2020). For future practice, I recommend implementing a qualitative research study on wellness, using the 5F-WEL instrument, and developing a wellness plan, as suggested in the instrument's manual. Other considerations could be to use a modified version of the instrument with lesser subscales, rather than the full scale due to time restraints for participant completion and researchers completing data analysis and results.

## Implications

In this section, I discuss the impact of positive social change and the methodological and theoretical implications for my study.

### Positive Social Change

The potential impact for positive social change at the organizational level is that the onboarding process and training for new mental health counselors can incorporate informational resources on wellness practices to improve staff well-being, productivity, and effectiveness. Badu et al. (2018) stated that Ghana uses a task-shifting approach to assign clinical and counseling duties to alternative staff like case managers and mental health technicians is an effective way to reduce the workload for counselors. The implementation of positive social change can eliminate the task-shifting approach and designate tasks for the appropriate staff. Continued professional development training and education about wellness practices in the workplace and applying tools to target unwellness and burnout can contribute to staff development and overall improvement in job performance. The potential impact for positive social change at the societal and policy level can include additions to improve overall funding for budget increases for

mental health services, salary increases for current and new clinical staff, and improve the overall budget for training and continued education for all staff.

### Methodological and Theoretical Implications

I used convenience sampling as an easy and inexpensive way to gather data from participants who are accessible and able to provide the required information requested, however, an implication of using this method is that although is a cost-effective and easy sampling method, it is impossible to identify if the sample is representative of the population and generalizable results cannot be produced (Mweshi & Sakyi, 2020). I used holistic theory as the theoretical framework for my study because it is more accessible to multicultural groups and considers the components of the whole person, social, emotional, psychological, and biological. Although this theory was fitting for my study, assessing the holistic components yielded time restraints with participants answering multiple questions at once.

## Conclusion

This study aimed to identify the gap in the literature about Ghanaian mental health counselors experiencing unwellness due to minimum work staff, low funding, and client caseload. The results of the study aimed to predict whether these external factors affected counselor wellness or unwellness and could lend to support the improvement of onboarding and training of current and new clinical staff in various mental health settings in Ghana.

# References

Abrahams, S., & Balkin, R. (2018, October). *Review of the Five-Factor Wellness Inventory (5F-WEL).* https://www.researchgate.net/publication/267969724_Review_of_the_Five_Factor_Wellness_Inventory_5F-WEL

Addo R., Agyemang, S. A., Tozan Y., & Nonvignon, J. (2018). Economic burden of caregiving for persons with severe mental illness in sub-Saharan Africa: A systematic review. *PLoS ONE 13*(8), Article e0199830. https://doi.org/10.1371/journal.pone.0199830

Ae-Ngibise, K. A., Doku, V. C. K., Asante, K. P., & Owusu-Agyei, S. (2015). The experience of caregivers of people living with serious mental disorders: A study from rural Ghana. *Global Health Action*, *8*(1), 1–9. https://doi.org/10.3402/gha.v8.26957

Agyemang, S. O., Ninnoni, J. P., & Enyan, N. I. E. (2022). Prevalence and determinants of depression, anxiety, and stress among psychiatric nurses in Ghana: A cross-sectional study. *BMC Nursing*, *21*, Article 179. https://doi.org/10.1186/s12912-022-00964-5

Agyapong, V. I. O., Akwasi, O., Farren, C. K., & McAuliffe, E. (2015). Task shifting – Ghana's community mental health workers' experiences and perceptions of their roles and scope of practice. *Global Health Action*, *8*(1), 1–16. https://doi.org10.3402/gha.v8.28955

Akosah-Sarpong, K. (2007, May 8). Ghana: Striking health workers and traditional medicine. Africa Conservation Foundation. *Accra Daily Mail*.

Alarcon, G. M. (2011). A meta-analysis of burnout with job demands, resources, and attitudes. *Journal of Vocational Behavior, 79*(2), 549–562. https://doi.org/10.1016/j.jvb.2011.03.007

Amu, H., Osei, E., Kofie, P., Owusu, R., Bosoka S. A., Konlan K. D., Kim, E., Orish, V. N., Maalman, R. S.-E., Manu, E., Parbey, P. A., Saah, F. I., Mumuni, H., Appiah, P. K., Komesuor, J., Ayanore, M. A., Amenuvegbe, G. K., Kim, S., Jung, H., … Gyapong, J. O. (2021). Prevalence and predictors of depression, anxiety, and stress among adults in Ghana: A community-based cross-sectional study. *PLoS ONE*, *16*(10), Article e0258105. https://doi.org/10.1371/journal. pone.0258105

Asamoah, M. K., Osafo, J., & Agyapong, I. (2014). The role of Pentecostal clergy in mental health-care delivery in Ghana. *Mental Health, Religion & Culture, 17*(6), 601–614. https://doi.org/10.1080/13674676.2013.871628

Asante, K. O., & Oppong, S. (2012). Psychology in Ghana. *Journal of Psychology in Africa, 22*(3), 473–478. https://doi.org/10.1080/14330237.2012.10820557

Asare-Doku, W., Rich, J. L., Kelly, B., Amponsah-Tawiah, K., & James, C. (2021, June). Mental health and mining: the Ghanaian gold mining story. *International Archives of Occupational and Environmental Health*, *94*, 1353–1362. https://doi.org/10.1007/s00420-021-01726-7

Badu, E., O'Brien, A. P., & Mitchell, R. (2018). An integrative review of potential enablers and barriers to accessing mental health services in Ghana. *Health*

*Research Policy and Systems, 16,* Article 110. https://doi.org/10.1186/s12961-018-0382-1

Bart, R., Ishak, W. W. W., Ganjian, S., Jaffer, K. Y., Abdelmesseh, M., Hanna, S., Gohar, Y., Azar, G., Vanle, B., Dang, J., & Danovitch, I. (2018). The assessment and measurement of wellness in the clinical medical setting: A systematic review. *Innovations in Clinical Neuroscience*, *15*(9-10), 14–23.

Berry, J. J. & Berry, K. (2018). Emerging themes from wellness counseling group sessions with aging adults. *The Wisconsin Counseling Journal*, 57–67.

Bledsoe, T. S., Setterlund, K., Adams, C. J., Fok-Trela, A., & Connolly, M. (2013). Addressing pastoral knowledge and attitudes about clergy/mental health practitioner collaboration. *Social Work and Christianity*, *40*(1), 23–45.

Blount, A. J., & Lambie, G. W. (2017). The helping professional wellness discrepancy scale: Development and validation. *Measurement and Evaluation in Counseling and Development, 51*(3), 1-19. http://dx.doi.org/10.1080/07481756.2017.1358060

Branco, S. F. & Patton-Scott, V. (2020). Creating space for connection: Creativity in the classroom. *Journal of Creativity in Mental Health*, *15*(3), 405–412. https://doi.org/10.1080/15401383.2019.1696260

Burck, A. M., Bruneau, L., Baker, L., & Ellison, L. (2014). Emerging counselors' perception of wellness: Implications for counselor development. *Counseling Outcome Research and Evaluation*, *5*(1), 39–51. https://doi.org/10.1177/2150137813518554

Clark, M., Ausloos, C., Delaney, C., Waters, L., Salpietro, L., & Tippett, H. (2020). Best practices for counseling clients experiencing poverty: A grounded theory. *Journal of Counseling & Development*, *98*(3), 283–294. https://doi.org/10.1002/jcad.12323

Cronk, B. C. (2017). *How to use SPSS®: A step-by-step guide to analysis and interpretation*. Routledge.

Burkholder, G. J., Cox, K. A., & Crawford, L. M. (Eds.). (2016). *The scholar-practitioner's guide to research design*. Chapter 13, "Survey Research" (pp. 215–226). Laureate Publishing.

Chandler, C., Holden, J., & Kolander, C. (1992). Counseling for spiritual wellness: Theory and practice. *Journal of Counseling and Development*, *71*, 168–175. https://doi.org/10.1002/j.1556-6676.1992.tb02193.x

Crawford, M. A. (2014). *Strengths and limitations of correlational design*. https://doi.org/10.13140/RG.2.1.4195.7920

Dankyi, E., & Huang, K. Y. (2022). Street children in Ghana's golden triangle cities: Mental health needs and associated risks. *Child Psychiatry and Human Development*, *53*(4), 840–851. https://doi.org/10.1007/s10578-021-01223-5

Deborah, T. D., Anthony, E. K., Badu, E., Amy, B. A., Gyamfi, N., Josephine, A. N., & Opoku, M. P. (2020). The burden of caregiving among mental health nurses providing services to consumers with depression in Ghana. *Perspectives in psychiatric care*, *56*(1), 72–80. https://doi.org/10.1111/ppc.12377

Degheili, J. A., Yacoubian, A. A., Dargham, R. A., & El-Hout, Y. Z. (2020). Burnout of residents: Overview from various medical institutions- A suggested model for improvement. *Urology Annals, 12*(1), 9–14. http://www.urologyannals.com

Dillman Taylor, D., Gungor, A., Blount, A. J., & Mullen, P. R. (2018). Personality priorities and perceived wellness among counseling trainees. *The Journal of Individual Psychology, 74*(2), 188–208. https://doi.org/10.1353/JIP.2018.0012

Dixon, J. (2012, September). Improving the mental health treatment gap in Ghana. *Backgrounder, 39*. https://africaportal.org/wp-content/uploads/2023/05/Africa_Portal_Backgrounder_No_39.pdf

El-Masri, M. M. (2017). Probability sampling: The process of randomly selecting research participants from a target population. *The Research File, 113*(2), 26.

Erzsebet, P. M., & Zsuzsa, I. H. (2016). Applicability of American wellness research methods in case of Central-European countries. https://www.researchgate.net/publication/321082697

Fall, K. A., Holden, J. M., & Marquis, A. (2010). *Theoretical models of counseling and psychotherapy* (2nd ed.). Routledge.

Fetter, H., & Koch, D. W. (2009). Promoting overall health and wellness among clients: The relevance and role of professional counselors. *Adultspan Journal, 8*(1), 4–17. https://doi.org/10.1002/j.2161-0029.2009.tb00053

Fullen, M. C. (2016). Counseling for wellness with older adults. *Adultspan Journal, 15*(2), 109–123. https://doi.org/10.1002/adsp.12025

Fulton, B. R. (2018). Organizations and survey research: Implementing response enhancing strategies and conducting nonresponse analyses. *Sociological Methods & Research, 47*(2), 240–276. https://doi.org10.1177/0049124115626169

Garrett, M., Brubaker, M., Torres-Rivera, E., West-Olatunji, C., & Conwill, W. (2008). The medicine of coming to center: Use of the Native American Centering Technique— Ayeli—to promote wellness and healing in group work. *Journal for Specialists in Group Work, 33*, 179–198.

Grénman, Miia. (2019). *In quest of the optimal self: Wellness consumption and lifestyle - A superficial marketing fad or a powerful means for transforming and branding oneself?* [Thesis, University of Jyväskylä]. https://www.researchgate.net/publication/335339647

Groves, Robert M. 2006. Nonresponse rates and nonresponse bias in household surveys. *Public Opinion Quarterly, 70*, 646–675

Gyamfi, N., Badu, E., Mprah, W.K. *et al.* (2020). Recovery services and expectation of consumers and mental health professionals in community-based residential facilities of Ghana. *BMC Psychiatry* 20, 355. https://doi.org/10.1186/s12888-020-02768-w

Hackett, G. (1981). Survey research methods. *The Personnel and Guidance Journal*, 599–604. Retrieved from Walden Library Resources.

Harris, M. R. (2010). *The relationship between psychological well-being and perceived wellness in graduate-level counseling students*[Doctoral dissertation, Walden

University]. Walden Dissertations and Doctoral Studies. https://scholarworks.waldenu.edu/dissertations/778

Hartwig, H., & Myers, J. (2003). A different approach: Applying a wellness paradigm to adolescent female delinquents and offenders. *Journal of Mental Health Counseling*, *25*, 57–75.

Henning, S., & Cilliers, F. (2012). Constructing a systems psychodynamic wellness model. *SA Journal of Industrial Psychology/SA Tydskrif vir Bedryfsielkunde, 38*(2), Art. #989, 9 pages. http://dx.doi.org/10.4102/ sajip.v38i2.989

Kirchner, E. (2014). *Occupational demographics, professional quality of life, and wellness levels among public school educators*. Walden Dissertation and Doctoral Studies Collection. https://scholarworks.waldenu.edu/dissertations

Knapp, M. & Wong, G. (2020). Economics and mental health: The current scenario. *World Psychiatry, 19*, 3–14. https://doi.org/10.1002/wps.20692

Koenig, H. G., King, D. E., & Carson, V. B. (2012). *Handbook of religion and health*. Oxford University Press.

Koo, K., Kim, Y. W., Lee, J. & Nyunt, G. (2021). "It's my fault": Exploring experiences and mental wellness among Korean international graduate students. *Journal of International Students, 11*(4), 790–811. https://doi.org/ 10.32674/jis.v11i4.2801

Kpobi, L., Swartz, L., & Ofori-Atta, A. L. (2018). Challenges in the use of the mental health information system in a resource-limited setting: Lessons from Ghana. *BMC Health Services Research, 18*(98), 1–9. https://doi.org/10.1186/s12913-019-2887-2

Kugbey, N., Osei-Boadi, S., & Atefoe, E. A. (2015). The influence of social support on levels of depression, anxiety, and stress among students in Ghana. *Journal of Education and Practice, 6*(25), 135–140. http://iiste.org/Journals/index.php/JEP

Lambie, G. W. (2006). Burnout prevention: A humanistic perspective and structured group supervision activity. *Journal of Humanistic Counseling, Education and Development*, 45, 32–44.

Lawson, G. & Venart, B. (2005). *Preventing counselor impairment: Vulnerability, wellness, and resilience.* Retrieved from http://www.counseling.org/docs/default-source/vistas/vistas_2005_article_53.

Lawson, G., Venart, E., Hazler, R. J., & Kottler, J. A. (2007). Toward a culture of counselor wellness. *Journal of Humanistic Counseling, 46*(1), 5–19. http://dx.doi.org/10.1002/j.2161-1939.2007.tb00022.x

Lo, H. W., & Dzokoto, V. (2005). Talking to the master: Intersections of religion, culture, and counseling in Taiwan and Ghana. *Journal of Mental Health Counseling*, *27*(2), 117–128. https://doi.org/10.17744/mehc.27.2.gx7d7thlvgkju4pd

Meany-Walen, K. K., Davis-Gage, D., & Lindo, N. A. (2016). The impact of wellness-focused supervision on mental health counseling practicum students. *Journal of Counseling & Development*, *94*, 464–472. https://doi.org/10.1002/jcad.12105

Moe, J. L., Perera-Diltz, D. M., & Rodriguez, T. (2012). Counseling for wholeness: Integrating holistic wellness into case conceptualization and treatment planning.

*Ideas and Research You Can Use, 1*, 1–10. http://counselingoutfitters.com/vistas/VISTAS_Home.htm

Mullen, P. R. & Gutierrez, D. (2016). Burnout, perceived stress, and direct student services among school counselors. *The Professional Counselor, 6*(4), 344–359. https://doi.org/10.15241/pm.6.4.344

Mweshi, G. K., & Sakyi, K. (2020). Application of sampling method for the research design. *Archives of Business Review, 8*(11), 180–193. https://doi.org/10.14738/abr.811.9042

Myers, J. E., Sweeney, T. J., & Witmer, J. M. (2000). The wheel of wellness counseling for wellness: A holistic model for treatment planning. *APPA and Well-Being 207 Journal of Counseling & Development, 78*(3), 251–266. https://doi.org/10.1002/j.1556-6676.2000.tb01906.x

Myers, J. (1992). Wellness, prevention, development: The cornerstone of the profession. *Journal of Counseling & Development, 7*, 136–139. Retrieved from http://www.counseling.org/Publications/Journals.aspx

Ocansey, P. M. E., Kretchy, I. A., Aryeetey, G. C., Agyabeng, K., & Nonvignon, J. (2021). Anxiety, depression, and stress in caregivers of children and adolescents with mental disorders in Ghana and implications for medication adherence. *Ghana Med Journal, 55*(3), 173–182. https://doi.org/10.4314/gmj.v55i3.1

Osafo, J. (2016). Seeking paths for collaboration between religious leaders and mental health professionals in Ghana. *Pastoral Psychol, 65*, 493–508. https://doi.org/10.1007/s11089-016-0703-7

Osei-Tutu, A., Dzokoto, V. A., & Affram, A. A. (2019). Common presenting problems in religious lay counseling practice in Ghana. *Mental Health, Religion & Culture, 22*(8), 819–831. https://doi.org/10.1080/13674676.2019.1666096

Phillips, A. W. (2017). Proper application of surveys as a study methodology. *Western Journal of Emergency Medicine: Integrating Emergency Care with Population Health, 18*(1), 8–11. https://doi.org/10.5811/westjem.2016.11.32000

Pomeroy, H. & Clark, A. J. (2015). Self-efficacy and early recollections in the context of Adlerian and wellness theory. *The Journal of Individual Psychology*, *71*(1), 24–33.

Quarshie, E. N., Annor, F., Andoh-Arthur, J., Tagoe, T. et al. (2016). Psychologists in Ghana: Analysis of the standing register. *New Voices on Psychology*, *12*(1), 55–69. https://doi.org/10.25159/1812-6371/1627

Radez, J., Reardon, T., Creswell, C., Lawrence, P. J. et al. (2021). Why do children and adolescents (not) seek and access professional help for their mental health problems? A systemic review of quantitative and qualitative studies. *European Child & Adolescent Psychiatry*, *30*, 183–211. https://doi.org/10.1007/s00787-019-01469-4

Read, U. M. (2019). Rights as relationships: Collaborating with faith healers in community mental health in Ghana. *Cult Med Psychiatry, 43*, 613–635. https://doi.org/10.1007/s11013-019-09648-3

Remley, T. P., Jr., & Herlihy, B. (2001). *Ethical, legal, and professional issues in counseling.* Prentice-Hall.

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

Savolaine, J., & Granello, P. (2002). The function of meaning and purpose for individual wellness. *Journal of Humanistic Counseling, Education & Development, 41*, 178–189.

Saxena, S. (2019). Disparity between burden and budget for mental health. *The Lancet Public Health, 4*(2), 75–76. https://doi.org/10.1016/S2468-2667(18)30238-X

Schweizer, M. L., Braun, B. I., & Milstone, A. M. (2016). Research methods in healthcare epidemiology and antimicrobial stewardship- Quasi-experimental designs. *Infection control and hospital epidemiology, 37*(10), 1135–1140. https://doi.org/10.1017/ice.2016.117

Schure, M. B., Christopher, J., & Christopher, S. (2008). Mind–body medicine and the art of self–care: Teaching mindfulness to counseling students through yoga, meditation, and qigong. *Journal of Counseling and Development, 86*(1), 47–56. http://www.counseling.org /Publications/Journals.aspx

Sherri, L. J. (2003). *Research methods and statistics: A critical thinking approach*. Belmot, CA: Thomson Learning.

Stangor, C. (2011). *Research methods for the behavioral sciences*. (Laureate Education, Inc., custom ed.). Boston: Houghton Mifflin Company

Sweeney, T., & Witmer, J. M. (1991). Beyond social interest: Striving towards optimum health and wellness. *Individual Psychology: The Journal of Adlerian Theory,*

*Research, and Practice, 47,* 527–540. http://www.utexas.edu/utpress/journals/jip.html

Taylor, D. D., Gungor, A., Blount, A. J., & Mullen, P. R. (2018). Personality priorities and perceived wellness among counseling trainees. *The Journal of Individual Psychology, 74*(2), 188–208.

Thomas, D. A & Schmuldt, L. (2012). Creatively training wellness-minded counselors. http://www.counseling.org/docs/default-source/vistas/vistas_2012_article_20

Wester, K. L., Trepal, H. C, & Myers, J. E. (2009). Wellness of counselor educators: An initial look. *Journal of Humanistic Counseling, Education, and Development, 48*, 91–109. http://www.counseling.org/Publications/Journals.aspx

Wickramarathne, P. D. V. C., Phuoc, J. C., & Albattat, A. R. S. (2020). A review of wellness dimension models: For the advancement of the society. *European Journal of Social Sciences Studies, 5*(1), 185–198. https://doi.org/10.5281/zenodo.3841434

Witmer, J. M., & Sweeney, T. (1992). A holistic model for wellness and prevention over the life span. *Journal of Counseling & Development, 71*, 140–148. Retrieved from http://www.counseling.org/Publications /Journals.aspx

Wolf, C. P., Thompson, I. A., & Smith-Adcock, S. (2012). Wellness in counselor preparation: Promoting individual well-being. *The Journal of Individual Psychology, 68*(2), 164–80.

World Health Organization. (2022). Ghana WHO special initiative for mental health situational assessment. Global Mental Health, University of Washington.

https://www.who.int/publications/m/item/ghana---who-special-initiative-for-mental-health

Young, M. E., & Lambie, G. W. (2007). Wellness in school and mental health systems: Organizational influences. *Journal of Humanistic Counseling, 46*(1), 98–113. https://doi.org/10.1002/j.2161-1939.2007.tb00028.x

Zainuddin, A., Amat, S., Ishak, N. M., Karim, D. N. F. M., & Bakar, A. Y. A. (2019). The validation of 5F-WEL instrument to examine the Well-Being of Muslim converts in Malaysia. *Religation. Journal of Social Sciences and Humanities, 4*(21), 174-179. ISSN 2477-9083.

# Appendix A: Demographic Questionnaire

Please complete this demographic questionnaire. Please answer each question carefully and accurately.

1. What gender do you identify as?
    a. Female
    b. Male
    c. Prefer not to answer

2. What is your age group?
    a. 25 – 35
    b. 35–45
    c. 45–55
    d. 65– plus

3. What is your current year as a mental health counselor? In other words, how long have you been a mental health counselor in Ghana?
    a. 1–3 years
    b. 3–5 years
    c. 5–10 years
    d. 10–15years
    e. Retired

4. In what settings do you currently practice or provide mental health services as a mental health counselor in Ghana?
    a. Private practice
    b. Psychiatric hospital
    c. Non-profit agencies/NGO
    d. Private agencies, schools, or institutions

5. Based on the setting you selected in the previous question, how many counseling staff or colleagues do you work with?
    a. 1–10
    b. 10–20
    c. 20–30
    d. 40–50
    e. Unknown/Unlimited

6. How many clients or patients do you have on your caseload per week?
    a. 1–10
    b. 10–20
    c. 20–30
    d. 40–50
    e. Unlimited number
    f. None

7. Is there funding available for promotions, training, salary increases or other needs to support your role as a mental health counselor in Ghana?
    a. Yes
    b. No
    c. Unknown

8. Are you satisfied with your salary as a mental health counselor in Ghana?
    a. Yes
    b. No
    c. Unsure
    d. Prefer not to answer

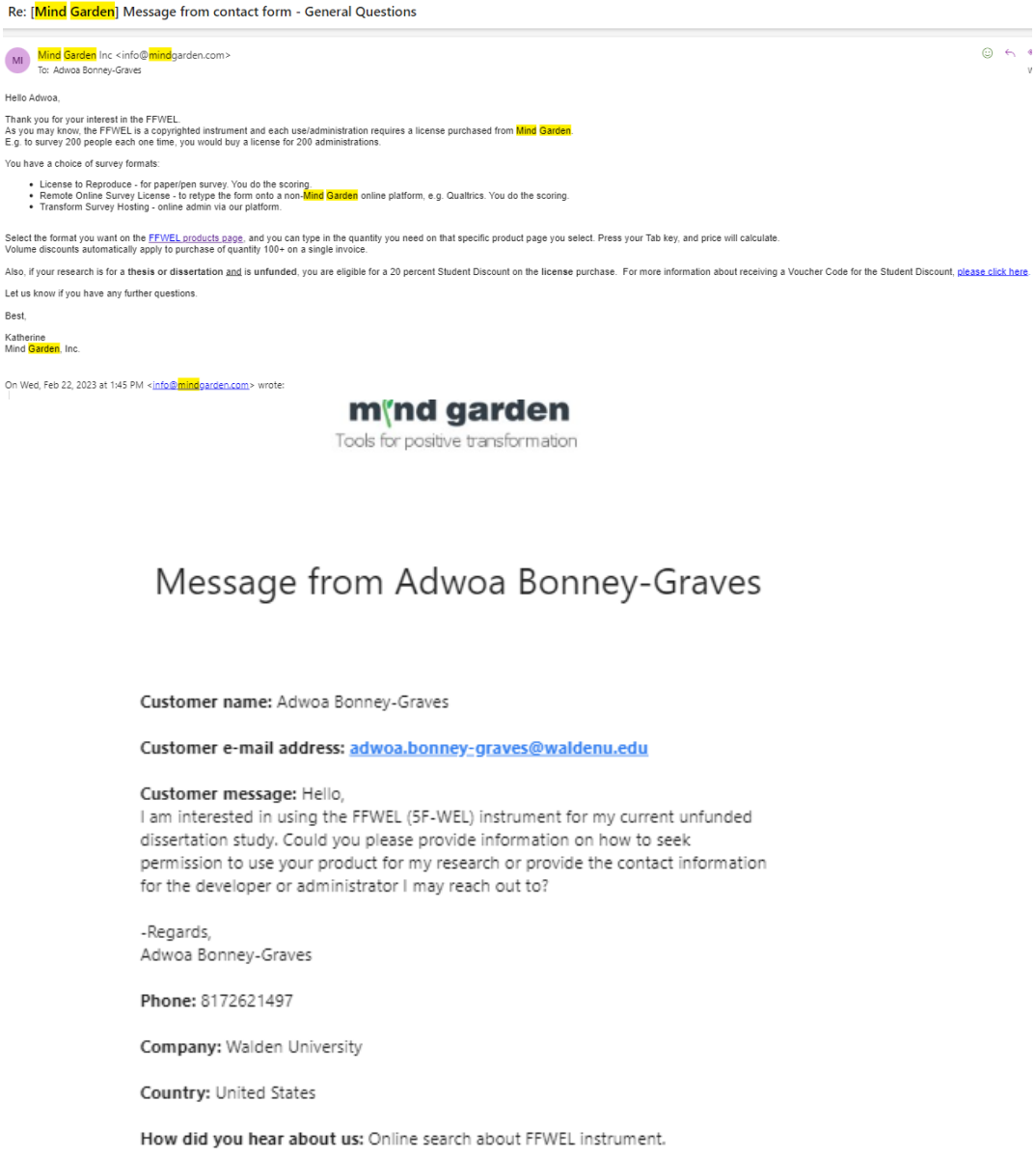
9. Based on your professional experience as a mental health counselor in Ghana, should there be more financial resources available to support mental health counselors in Ghana?
    a. Yes
    b. No
    c. Prefer not to answer

10. Based on your workload or caseload, do you feel overwhelmed by your role as a mental health counselor in Ghana?
    a. Always
    b. Sometimes
    c. Not really/Not at all
    d. Unknown

11. Based on your workload or caseload, do you feel fulfilled by your role as a mental health counselor in Ghana?
    a. Always
    b. Sometimes
    c. Not really/Not at all
    d. Unknown

12. Please indicate the type of experiences you have had in your role as a mental health counselor in Ghana?
    a. Fulfilled/Stress-free
    b. Stressed/Overwhelmed
    c. Depressed/Isolated
    d. Unknown/No experience

# Appendix B: Permission to use 5F-WEL



Re: [Mind Garden] Message from contact form - General Questions

MI Mind Garden Inc <info@mindgarden.com>
To: Adwoa Bonney-Graves

Hello Adwoa,

Thank you for your interest in the FFWEL.
As you may know, the FFWEL is a copyrighted instrument and each use/administration requires a license purchased from Mind Garden.
E.g. to survey 200 people each one time, you would buy a license for 200 administrations.

You have a choice of survey formats:

- License to Reproduce - for paper/pen survey. You do the scoring.
- Remote Online Survey License - to retype the form onto a non-Mind Garden online platform, e.g. Qualtrics. You do the scoring.
- Transform Survey Hosting - online admin via our platform.

Select the format you want on the FFWEL products page, and you can type in the quantity you need on that specific product page you select. Press your Tab key, and price will calculate.
Volume discounts automatically apply to purchase of quantity 100+ on a single invoice.

Also, if your research is for a **thesis or dissertation** and is **unfunded**, you are eligible for a 20 percent Student Discount on the **license** purchase. For more information about receiving a Voucher Code for the Student Discount, please click here.

Let us know if you have any further questions.

Best,

Katherine
Mind Garden, Inc.

On Wed, Feb 22, 2023 at 1:45 PM <info@mindgarden.com> wrote:

mind garden
Tools for positive transformation

## Message from Adwoa Bonney-Graves

**Customer name:** Adwoa Bonney-Graves

**Customer e-mail address:** adwoa.bonney-graves@waldenu.edu

**Customer message:** Hello,
I am interested in using the FFWEL (5F-WEL) instrument for my current unfunded dissertation study. Could you please provide information on how to seek permission to use your product for my research or provide the contact information for the developer or administrator I may reach out to?

-Regards,
Adwoa Bonney-Graves

**Phone:** 8172621497

**Company:** Walden University

**Country:** United States

**How did you hear about us:** Online search about FFWEL instrument.

# Appendix C: 5F-WEL Sample Questions

transform
by mind garden.com

**Five Factor Wellness Inventory Adult Form - Sample Items Form**

*Below are directions and a few sample items of the Five Factor Wellness Inventory. Both online and paper reproduction licenses are available. Click on the Translations tab for available languages.*

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.

Strongly Agree | Agree | Disagree | Strongly Disagree

* 2. I am satisfied with how I cope with stress.

Strongly Agree | Agree | Disagree | Strongly Disagree

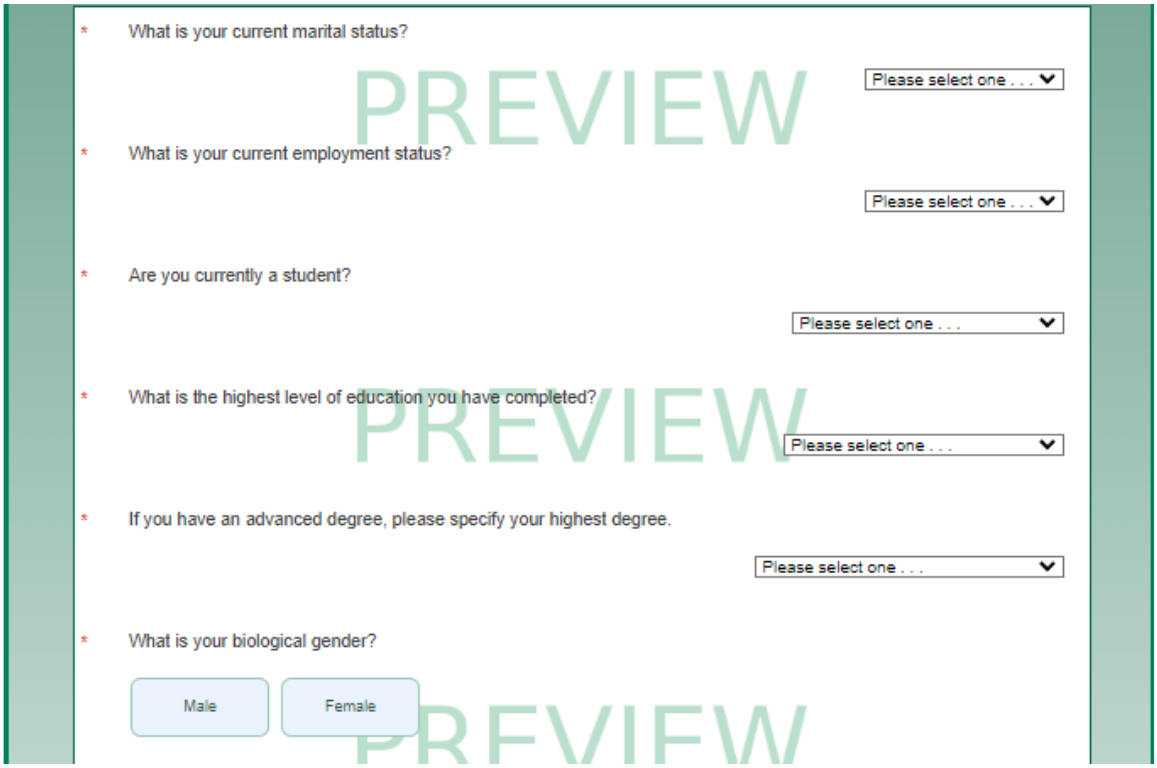
* 3. I eat a healthy amount of vitamins, minerals, and fiber each day.

Strongly Agree | Agree | Disagree | Strongly Disagree

* 4. I often see humor even when doing a serious task.

Strongly Agree | Agree | Disagree | Strongly Disagree

Items marked by * are required.


* What is your current marital status?
Please select one . . .
PREVIEW
* What is your current employment status?
Please select one . . .
* Are you currently a student?
Please select one . . .
* What is the highest level of education you have completed?
Please select one . . .
PREVIEW
* If you have an advanced degree, please specify your highest degree.
Please select one . . .
* What is your biological gender?
Male
Female
PREVIEW