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The influence of Korean counselors' personal wellness on client-perceived counseling effectiveness: the moderating effects of empathy

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THE INFLUENCE OF KOREAN COUNSELORS' PERSONAL WELLNESS ON CLIENT-PERCEIVED COUNSELING EFFECTIVENESS: THE MODERATING EFFECTS OF EMPATHY

by

Yoo Jin Jang

An Abstract

Of a thesis submitted in partial fulfillment of the
requirements for the Doctor of Philosophy degree in
Counseling, Rehabilitation and Student Development
(Counselor Education and Supervision) in the Graduate College of
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Thesis Supervisor: Associate Professor Tarrell Awe Agahe Portman

ABSTRACT

Wellness is defined as an individual's lifestyle, choices, and habits as a way to achieve optimal health and well-being. Professional organizations and literature in the counseling field underscored the importance of enhancing personal wellness of professional counselors and counselors-in-training. The assumption underlying this movement was that counselors' personal wellness would be directly translated into their effectiveness with clients in counseling practice. However, this assumption has received little empirical attention. In addition, the review of counselor wellness literature illustrated the need for addressing potential moderators in the relationship of counselor wellness to counseling effectiveness as an attempt to provide an elaborated knowledge base for wellness interventions in counselor training. Thus, this study investigated the relationship of Korean counselors' personal wellness to their clients' perceptions of counseling effectiveness and the moderating effects of counselor empathy on this relationship.

Participants in this study were 133 counselor-client dyads who had engaged in face-to-face individual counseling at university counseling centers or youth counseling institutes located in Seoul and Gyeonggi Province, South Korea. Survey measures for counselors were used for the assessment of personal wellness, empathy, and social desirability. Client survey measures were used to assess counseling effectiveness variables: (a) satisfaction with counselors' in-session behavior, (b) evaluation about the session impact, and (c) perception of the working alliance.

The results from correlation and multiple regression analyses indicated that Korean counselors' personal wellness scores were not significantly related to their clients' ratings of counseling effectiveness. However, a series of hierarchical regression analyses revealed that Korean counselors' cognitive empathy moderated the relationships of their personal wellness to client-perceived counseling effectiveness. Specifically, the findings suggested that, for Korean counselors with lower levels of cognitive empathy,

wellness in Essential Self had a positive influence on client-perceived session smoothness, but wellness in Coping Self had a negative effect on client-rated working alliance. Also, wellness in Creative Self was found to have a negative influence on client-perceived session smoothness only among Korean counselors with higher levels of cognitive empathy.

These findings call into question the supposition that well counselors are more likely to be effective with their clients, suggesting that a more complicated interplay between counselor wellness and other potential moderators should be considered as a determinant of counseling effectiveness. Future research is warranted to see if this study's findings are replicated with American counselor samples. Limitations are presented with a focus on range restrictions on the counseling effectiveness variables and small effect sizes associated with the interactions. In light of these limitations, future research directions are also discussed.

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PH.D. THESIS

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CHAPTER I

INTRODUCTION

In spite of little consensus on the definition of wellness, there is some agreement on its nature. In a comprehensive review of wellness theories and assessment measurements, Roscoe (2009) concluded that wellness had been commonly described as (a) the integration and balance of multiple dimensions, (b) self-choices or determination toward optimal functioning, (c) a continuum, not an end state, and (d) not merely the absence of illness. Given these common factors across wellness theories and models, wellness is conceptualized as an individual's lifestyle, choices, and habits as ways to achieve optimal and balanced functioning of body, mind, and spirit. Although the term of *well-being* has been used interchangeably with wellness in the counseling literature (Oguz-Duran & Tezer, 2009), well-being has been used to represent a state of general mental health or life satisfaction and happiness (Ryff & Keyes, 1995), whereas wellness highlights an individual's effort toward optimal functioning of body, mind, and spirit in a holistic sense (Myers, 1992). As the positive psychology movement (Seligman & Csikszentmihalyi, 2000), which advocated for the paradigm shift in theory, research, and practice from individuals' problems and areas of weakness to their strengths and interests, emerged in the psychology and education fields, attention to the wellness of both clients and counselors has also increased in the counseling field.

During the past two decades, professional organizations in the counseling field (American Counseling Association [ACA], 2005; Association for Counselor Education and Supervision [ACES], 1995; Council for Accreditation of Counseling and Related Programs [CACREP], 2001) and the counselor education literature have placed an emphasis on wellness of professional counselors and counseling students (Myers, Mobley, & Booth, 2003; Roach & Young, 2007; Smith, Robinson, & Young, 2007). In response to a strong call for embracing a wellness philosophy in counselor education, several scholars (Granello, 2000; Hermon, 2005; Myers & Williard, 2003; Roach & Young;

Venart, Vassos, & Pitcher-Heft, 2007; Witmer & Granello, 2005; Witmer & Young, 1996) suggested training models and general guidelines for implementing the wellness philosophy in counselor training and curriculum. For instance, Witmer and Granello claimed that a wellness paradigm should be integrated into every facet of the program from faculty participation, student admissions, and course work to co-curricular activities and field-work experiences.

An emphasis on personal wellness of the counselor comes from a long tradition in counseling claiming a counselor's personal characteristics such as personality, coping patterns, well-being, empathic ability, values, attitudes, and beliefs (Beutler, Machado, & Neufeldt, 1994) are vital to his or her ability to help others (Rogers, 1961). Magnuson, Norem, and Wilcoxon (2002) noted that distinguished counseling professionals committed themselves to personal growth and development to avoid professional burnout and promote success in working with clients. Hanna and Bemak (1997) argued that counselor effectiveness depends more on the personal characteristics of the counselor than on school, training, or theory. The counselor education literature has acknowledged that the practice of counseling places counselors at risk of experiencing impairment, such as compassion fatigue, vicarious trauma, and burnout (Cummins, Massey, & Jones, 2007; Lawson, Venart, Hazler, & Kottler, 2007; Rogers, 1995). The literature also has well documented that counselors who are stressed, distressed, or impaired may not be able to offer the highest level of counseling services to their clients (Lawson, 2007). This view has been supported with numerous empirical studies (e.g., Hazler & Kottler, 1996; Sheffield, 1998; Young & Lambie, 2007). Thus, the importance of a counselor's personal qualities in their counseling effectiveness and the inherent danger of impairment in counseling services provide compelling reasons to monitor and promote counselors' personal wellness.

Statement of the Problem

The rationale for promoting a counselor's wellness is that it provides the foundation of her or his work with clients (Venart et al., 2007; Yager & Tovar-Blank, 2007). For instance, Hill (2004) believed that healthy counselors are more likely to produce healthy clients. Roach (2005) also found that both faculty and students in counseling programs believed their personal wellness was essential for their effectiveness with clients. In brief, assumptions have been made in the literature that a counselor's personal development and well-being is translated into his or her effectiveness with clients (Young & Lambie, 2007).

These assumptions of a connection between counselor wellness and effectiveness have led to little research. Furthermore, two recent empirical studies (Curry, 2007; O'Brien, 2007) investigating this relationship did not find a significant correlation between these two variables. Based on the data from 88 master's level internship students in counseling programs, Curry reported no statistically significant relationship between counseling students' wellness and their counseling self-efficacy. Also, in the study exploring the relationship between master's level counseling practicum students' wellness and client outcomes, O'Brien found that 70 counseling students' wellness was not related to client progress in terms of an alleviation of symptoms or distress. However, because this line of research examining the relationships between counselor wellness and effectiveness variables is in its infancy, more empirical efforts are needed to identify how levels of wellness in counselors might influence their effectiveness with clients in counseling.

In addition, given that a handful of wellness research studies using samples of counselors-in-training, professional counselors, or counselor educators addressed relatively preliminary inquiries, a more sophisticated research agenda is needed to provide practical implications for counselor training and practice. Prior studies on counselor wellness can be divided into two categories: (a) within- or between-group

comparisons of average wellness scores, and (b) demonstration of correlations between counselor wellness and other single variables. An example of the former category was the study conducted by Myers et al. (2003) showing that wellness levels of doctoral students in counseling programs were higher than those of master's students and that average wellness scores of counseling students were higher than those of non-student adults. Likewise, Wester, Trepal, and Myers (in press) examined counselor educators' wellness and reported higher levels of wellness in their sample than Myers et al.'s (2003) data on counseling students. Two recently conducted doctoral dissertation studies (Riley, 2005; Smith, 2006) exemplified the latter category of wellness research by sampling counselor groups. Riley examined the relationship between wellness of counselor education students and attitudes toward personal counseling, reporting a significant positive correlation between these two variables. Smith investigated the relationship between wellness of entry-level counseling students versus social desirability and psychological disturbance, demonstrating a significant negative relationship between wellness and psychological disturbance and no significant relationship between wellness and social desirability.

The preceding, brief review of wellness literature illustrates that prior research on counselor wellness has focused on how various counselor groups differed in personal wellness and how counselor wellness correlated with another single variable. However, little is known about whether or not the relationship of counselor wellness to another variable (e.g., client outcome) would differ based on certain conditions. Aguinis, Boik, and Pierce (2001) claimed that identifying a moderating variable contributes to existing knowledge in scientific inquiry because the direction or strength of the relationship between two variables changes according to levels or types of moderators. In this regard, the lack of research examining potential moderators in the relationship of counselor wellness to counseling effectiveness may lead to an insufficient knowledge base for counselor wellness interventions. Thus, determining the conditions that affect the

relationship between counselor wellness and counseling effectiveness may provide counselor educators with a more elaborated idea on those interventions.

Although counselors need to seek a healthy lifestyle in order to achieve the holistic wellness of body, mind, and spirit (Myers & Sweeney, 2005a), they must pay attention to the client's life to be empathic with his or her suffering or internal frame of reference (Batson, Ahmad, Lishner, & Tsang, 2002). In other words, promoting personal wellness may require counselors to become self-oriented, but, in contrast, empathizing with clients may demand that counselors become client-oriented. Given the empirical evidence of the relationship of empathy to counseling effectiveness (Duan & Hill, 1996), the difference in orientation between pursuing personal wellness and seeking empathy allows for the possibility that the relationship between counselor wellness and counseling effectiveness would differ depending on empathy. For instance, counselors who have high levels of both personal wellness and empathic ability may demonstrate different levels of counseling effectiveness as compared with those who have high levels of personal wellness but low levels of empathic ability. Thus, in this study, counselor empathy was posited as a hypothesized moderator that may alter the relationship between counselor wellness and counseling effectiveness.

In summary, a review of existing wellness literature involving counselor populations illustrated the need for continuing to conduct empirical studies examining the influence of counselor wellness on counseling effectiveness and for exploring potential variables moderating the relationship between counselor wellness and effectiveness. In addition, in a comprehensive review of wellness counseling literature, Myers and Sweeney (2008) claimed new empirical studies were needed to explore the applicability of wellness models in countries other than the United States for a better understanding of the characteristics of people from varied cultural and geographic backgrounds. The Korean data from this study may provide the foundation for further cross-cultural

investigations to compare the wellness levels of Korean and American counselors and patterns of the relationship between counselor wellness and effectiveness in each group.

Purpose of the Study

The purpose of this study was to investigate the relationship of Korean counselors' personal wellness to their clients' perceptions of counseling effectiveness and to assess the moderating effects of counselor empathy on that relationship. Specifically, this study examined the relationship between Korean counselors' personal wellness and their clients' perceived counseling effectiveness and the moderating effects of counselor empathy on the relationship between these two variables. Clients' perceptions of counseling effectiveness were measured by three different variables: (a) satisfaction with counselors' in-session behavior, (b) evaluation of the impact of the counseling session, and (c) perception of the working alliance.

Determining the nature of the relationship between Korean counselors' wellness and effectiveness and the moderating role of counselors' empathic ability in this relationship may provide Korean counselor educators and supervisors with critical insights into how to address counselor trainees' personal wellness and empathy in their training courses. The field of counseling in Korea has recently begun to consider counselors' ethical responsibility and accountability as a high professional priority (Seo, Kim, & Kim, 2007). In 2003, the Korean Counseling Psychological Association (KCPA), the largest professional organization of counselors in Korea, enacted professional ethical codes that resembled those of the ACA and the American Psychological Association in many aspects. The KCPA code of ethics did not make an explicit statement requiring counselors to further enhance their personal wellness, but implied that counselors should pursue sustained efforts for personal growth and development. Also, given that empirical inquiry concerning counselor wellness has been lacking in the Korean counseling literature, it is hoped that conducting this study will stimulate future research on the

relationship between Korean counselors' personal wellness and counseling outcome variables such as counseling effectiveness and client outcomes.

In addition, future replication studies of this Korean study with a sample of American counselors examining the relationship between counselor wellness and counseling effectiveness may provide important implications for counselor educators who endeavor to adopt wellness strategies in counselor training programs. Moreover, the results of this study about the moderating role of empathy in the relationship between counselor wellness and effectiveness may stimulate future empirical efforts to explore other moderating variables that may alter the strength or direction of the relationship between the two variables. Eventually, the identification of important moderators affecting the relationship between counselor wellness and effectiveness or outcome variables may contribute to the maturity and sophistication of a field of inquiry regarding counselors' personal wellness.

Research Questions

The purpose of this study was to investigate the relationship of Korean counselors' personal wellness to their clients' perceptions of counseling effectiveness and to assess the moderating effects of counselor empathy on that relationship. Thus, two sets of questions were of interest in this investigation. The specific research questions guiding this investigation were as follows.

Research Question 1

What is the relation of Korean counselors' personal wellness to their clients' perceptions of counseling effectiveness in terms of satisfaction with the counselor's in-session behavior, evaluation of the session impact, and perception of the working alliance?

Research Question 2

Do the effects of Korean counselors' personal wellness on their clients' perceptions of counseling effectiveness vary as a function of their empathic ability?

Definition of Terms

This section presents the conceptual and operational definitions of the major terms necessary to conduct this study. The major terms used in this study are defined in the following. These terms represent independent and dependent variables used in this study.

Wellness

In this study, wellness refers to "a way of life oriented toward optimal health and well-being, in which body, mind, and spirit are integrated by the individual to live life more fully within the human and natural community" (Myers, Sweeney, & Witmer, 2000, p. 252). Operationalized in this study, it is considered as the Total Wellness scores measured by the Korean version of the Five Factor Wellness Inventory (5F-Wel-K; Hong, 2008). Each of the five second-order factors are defined as follows, as measured by the corresponding subscale of the 5F-Wel-K.

1. *Creative Self* refers to "the combination of attributes that each of us forms to make a unique place among others in our social interactions and to interpret our world" (Myers & Sweeney, 2005a, p. 33).
2. *Coping Self* refers to "the combination of elements that regulate our responses to life events and provide a means for transcending their negative effects" (Myers & Sweeney, 2005a, p. 33).
3. *Social Self* refers to "social support through connections with others in our friendships and intimate relationships, including family ties" (Myers & Sweeney, 2005a, p. 33).
4. *Essential Self* refers to "our essential meaning-making processes in relation to life, self, and others" (Myers & Sweeney, 2005a, p. 33).

5. *Physical Self* refers to "the biological and physiological processes that comprise the physical aspects of our development and functioning" (Myers & Sweeney, 2005a, p. 33).

Empathy

According to Duan and Hill's (1996) suggestion to investigate cognitive or affective elements of empathy as distinct phenomena, the researcher measured both affective and cognitive components of empathy in this study. Empathy is defined as a multidimensional construct that includes both affective responding to the feelings of the other and cognitive understanding of another person's situation (Davis, 1983a). For the purpose of this study, affective empathy represents the ability to feel warmth, compassion, and concern for others, as measured by the Empathic Concern subscale in the Interpersonal Reactivity Index (IRI; Davis, 1980). In contrast, cognitive empathy is defined as the ability to intellectually assume the perspective of another person, as assessed by the Perspective Taking subscale in the IRI.

Counseling Effectiveness

The term, "counseling effectiveness" or "counselor effectiveness," has been widely used in the counseling literature. Other similar terms, such as counseling outcome and client outcome, often have been used interchangeably with this term. In general, counseling effectiveness has referred to short-term effects of counseling sessions or immediate effects of a given counseling session, distinct from long-term outcome such as improvement in the client's presenting problems or targeted symptoms and change in the client's psychosocial functioning. For the purpose of this study, counseling effectiveness represented the relatively immediate effects of a specific counseling session. Specifically, it was operationalized in terms of clients' ratings on the following three variables;

1. A client's satisfaction with a counselor's in-session behaviors refers to a client's global ratings of satisfaction with the counselor's behaviors in a counseling session in terms of three attribute dimensions, including

attractiveness, expertness, and trustworthiness, as measured by the Counselor Rating Form – Short (Corrigan & Schmidt, 1983).

2. Session impact refers to a counseling session's immediate effects, including clients' evaluations of what happened and their post-session affective state (Stiles & Snow, 1984). A client's perceived impact of the session was measured by the scores from the client's ratings on the Session Evaluation Questionnaire (Stiles, 1980).
3. The working alliance refers to the active relational element in counselor-client relationships that fosters change processes (Bordin, 1979). Bordin defined the working alliance using three components: (a) emotional bonds, (b) goals, and (c) tasks. The emotional bonds refer to trust and attachment between counselor and client. Goals refer to an agreement about focus of treatment. Tasks refer to agreement about actions required to achieve goals. For the purpose of this study, only a client's overall perception of the working alliance was measured by the Working Alliance Inventory – Short (Horvath & Greenberg, 1986).

CHAPTER II

LITERATURE REVIEW

Chapter II presents a literature review of the variables of this study. The purpose of this study was to examine the relationship between Korean counselors' personal wellness and their clients' perceptions of counseling effectiveness and to assess the moderating role of counselor empathy on that relationship. Thus, the major variables examined within this chapter are wellness, empathy, and working alliance as counseling effectiveness indicators. Lastly, in this chapter the Korean literature is briefly reviewed to describe the current status of the Korean counseling field and illustrate the need for this study in a Korean context.

Wellness

Definitions of Wellness

The World Health Organization (1964) defined optimal health as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity" (p. 1). This definition indicated that a healthy individual must strive to achieve health or wellness in multiple dimensions of human functioning (Savolaine & Granello, 2002). However, this definition did not reflect a dynamic aspect of wellness by depicting it as a static construct. In the modern wellness movement, wellness has been widely viewed as a dynamic process of maximizing an individual's potential (Myers & Sweeney, 2005a).

Dunn (1977), who is known as the "architect" of the modern wellness movement (Myers & Sweeney, 2005a), characterized wellness as an individual's dynamic striving for achieving his or her highest potential within the social environments by integrating personal strengths and interests. Dunn highlighted a dynamic and personalized process of enhancing and balancing one's physical, mental, and spiritual well-being. Dunn also delineated "health" as merely the absence of illness by differentiating it from the concept of wellness. Similarly, other authors (e.g., Antonovsky, 1979; Travis, 1972) describing

the concept of wellness differentiated between health and wellness by defining health as a neutral point on a continuum that ranges from wellness at the upper end of the continuum to illness on the lower end. The idea of conceptualizing illness, health, and wellness on a continuum was sharply contrasted with the health-illness dichotomy that existed in the medical model (Harari, Waehler, & Rogers, 2005).

Hettler (1984) was another well-known wellness theorist who defined wellness as individuals' purposeful endeavor to enhance their life quality. He emphasized the multidimentional aspect of wellness by proposing its six components of wellness: (a) physical, (b) emotional, (c) occupational, (d) social, (e) intellectual, and (f) spiritual. He also stressed the holistic nature of wellness, positing it as an integrated and balanced function across the six life domains. Hettler made significant contributions to the growth of the modern wellness movement because he established the National Wellness Institute in the 1970s which provided a variety of resources for professionals who engaged in wellness promotion activities.

More recently, after a multidisciplinary literature review, Myers, Sweeney, and Witmer (2000) defined wellness as

> a way of life oriented toward optimal health and well-being, in which body, mind, and spirit are integrated by the individual to live life more fully within the human and natural community. Ideally, it is the optimum state of health and well-being that each individual is capable of achieving. (p. 252)

Myers et al. (2000) explained that wellness can be seen as both an outcome and a process. In other words, wellness can be depicted as a state of achieving optimal health and well-being in a holistic sense or also as an ongoing effort to achieve that state by lifestyles, choices, and habits.

The definitions of wellness mentioned previously were used to create a foundation for wellness models that are described in the next section. For the purpose of this study, the researcher used Myers et al.'s (2000) definition because it seems to

represent aptly the holistic and dynamic nature of wellness and the active individualized process of enhancing it, which were reflected in most of modern wellness definitions.

Wellness Models

Early wellness models evolved within a medical field in an attempt to provide an alternative to the traditional view that health is just absence of illness (Harari et al., 2005). Dunn (1977) coined the term wellness and introduced the concept of high-level wellness as opposed to a passive concept of health as being free from illness. He described wellness as a lifestyle approach for pursuing elevated states of physical, psychological, and spiritual well-being. In his view, wellness entails a conscious commitment to positive initiatives for optimal, balanced functioning in these three areas.

Travis and Ryan (1981) opposed the idea that the absence of illness could represent wellness. Instead, they depicted a wellness model graphically as a continuum with illness on one end and wellness on the other end. In this model, illness was described as being initiated with medical signs and symptoms and gradually progressing toward premature death. In contrast, they described high-level wellness as a person's state of optimal health and highest potential achieved by his or her way of life. The midpoint of this continuum health is a neutral state wherein neither illness nor wellness is present.

Hettler (1984) developed a model of wellness that included six specific dimensions: intellectual, emotional, physical, social, occupational, and spiritual health. Intellectual wellness can be evidenced by continuous acquisition and development of critical thinking, expressive/intuitive skills and abilities focused on the achievement of a more satisfying existence, and a demonstrated commitment to life-long learning. Emotionally well persons are both aware of and accept a wide range of feelings in themselves and others. People experiencing wellness in the physical dimension tend to work toward investing time each week in the pursuit of endurance, flexibility, and strength. Socially well persons contribute to their human and physical environment for

the common welfare of the community. Occupationally well individuals contribute their unique skills and talents to meaningful and rewarding work. Individuals who maintain a high level of spiritual wellness are willing and able to transcend the self in order to question the meaning and purpose of their lives and the lives of others. Hettler emphasized that the allocation of time and energy to these six dimensions should be balanced.

Unlike the other models grounded in physical health sciences described above, Sweeney and Witmer (1991) developed the first theoretical model of wellness, *the Wheel of Wellness,* grounded in Adler's (1954) *Individual Psychology* and counseling theory. Through a literature review across multiple disciplines, including behavioral medicine, anthropology, sociology, ecology, and various psychology specialties, they attempted to identify the core characteristics of healthy people over the life span. Those characteristics were a basis for the Wheel of Wellness model and Adler's theory was used as a theoretical framework to explain why people strive to achieve wellness (Myers & Sweeney, 2005a). This model included the three basic life tasks (work, friendship, and love) and the two additional tasks (self-regulation and spirituality). Spirituality was regarded as the most important component in this model that might strengthen wellness in the other tasks. However, the importance of gender and cultural differences in the conceptualization of individual wellness across the life span has been recognized through analyses of the database (Witmer, Sweeney, & Myers, 1998) and thus the revision of this model ensued.

In the revised Wheel of Wellness model (Witmer et al., 1998), the five major life tasks (i.e., spirituality, self-direction, work and leisure, friendship, love), which were included in the original Wheel of Wellness model (Sweeney & Witmer, 1991), remained identical. Also, spirituality, conceptualized as the core characteristic of healthy people, was still placed in the center of the Wheel. The term "self-regulation" was replaced with the new term "self-direction" to reflect a more active connotation (Myers & Sweeney,

2005a). Also, given the need for including gender and cultural components, the subtasks of self-direction, which constituted the spokes of the Wheel, were expanded into the 12 factors: (a) sense of worth, (b) sense of control, (c) realistic beliefs, (d) emotional awareness and coping, (e) problem solving and creativity, (f) sense of humor, (g) nutrition, (h) exercise, (i) self-care, (j) stress management, (k) gender identity, and (l) cultural identity. Work, friendship, and love were considered three major life tasks that would be achieved through these 12 self-direction subtasks. Based on this model, *the Wellness Evaluation of Lifestyle* (WEL; Witmer et al. , 1998) inventory was developed to assess each of the individual characteristics in the Wheel of Wellness. However, statistical analyses of the database accumulated over the years using the Wheel of Wellness model and the WEL failed to confirm the hypothesized structure of the model and the centrality of spirituality in relation to other wellness components (Hattie, Myers, & Sweeney, 2004). Consequently, a new evidence-based wellness model emerged.

Through continued research and extensive factor analyses using a large database gathered on the Wheel of Wellness model, a new evidence-based wellness model and instrument, called *the Indivisible Self Model of Wellness* (IS-Wel) and *the Five Factor Wellness Inventory* (5F-Wel), respectively, were developed (Myers, & Sweeney, 2005b; Myers & Sweeney, 2004). As illustrated in Figure 1, Adler's (1954) belief in the unity and indivisibility of the self became the theoretical framework of this new model, thereby the self being at the core of wellness and depicted as indivisible (Myers & Sweeney, 2008). In the IS-Wel model, Total Wellness, a measure of general well-being, is composed of five second-order factors (Creative Self, Coping Self, Social Self, Essential Self, and Physical Self), which were derived from structural equation modeling (Hattie et al., 2004). Also, 17 third-order factors were grouped within the five second-order factors as follows: Creative Self (thinking, emotions, control, work, positive humor), Coping Self (leisure, stress management, self-worth, realistic beliefs), Social Self (friendship, love),

Essential Self (spirituality, gender identity, cultural identity, self-care), and Physical Self (nutrition, exercise).

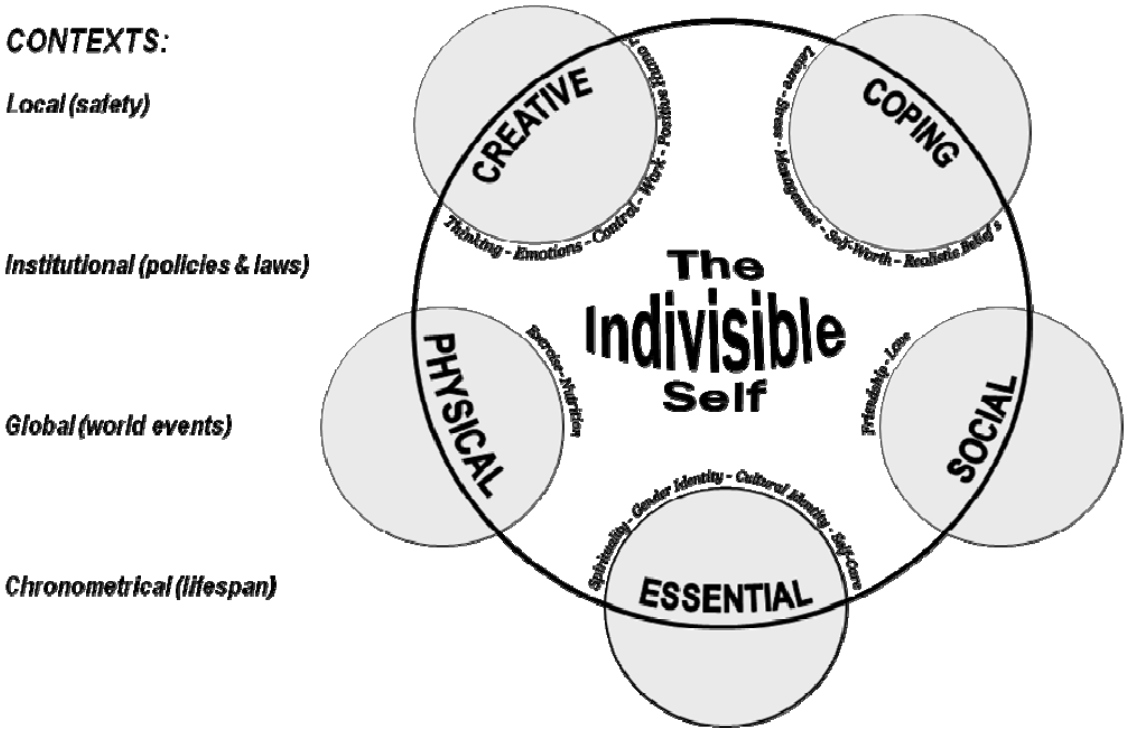

Figure 1. The Indivisible Self Wellness Model

Source: Myers, J. E., & Sweeney, T. J. (2005a, p. 32), *Counseling for wellness: Theory, research, and practice.* Alexandria, VA: American Counseling Association.

The Creative Self refers to the combination of those qualities that make an individual a unique being among others, comprising the five third-order factors: thinking, emotions, control, work, and positive humor (Myers & Sweeney, 2005b). Individuals with higher levels of wellness in thinking engage in intellectually stimulating activities and make efforts to expand their knowledge and skills. Emotionally well people are able to experience and express their feelings appropriately. People experiencing wellness in their work are able to handle and manage work stress. Positive humor allows people to laugh at their foibles and contradictions and to retain a healthy perspective even in the

face of adverse circumstances. In brief, the Creative Self represents a person's unique way of interpreting the world.

The Coping Self is defined as the combination of elements that direct an individual's responses to life events and provide a means to overcome the negative consequences of those events (Myers & Sweeney, 2005b). The Coping Self includes the four components of leisure, stress management, self-worth, and realistic beliefs. Leisure provides relief from stress and helps people better cope with life demands. To successfully manage stress, people should be able to find available coping resources and use healthy coping strategies. Self-worth refers to one's overall sense of value, goodness, and deservedness about oneself. Realistic beliefs allow people to adjust perceptions that do not conform to the realities of the situation and to avoid irrational or distorted thoughts.

The Social Self represents an individual's social connections with others in friendships and intimate relationships (Myers, & Sweeney, 2005b). This component comprises the two third-order factors: friendship and love. Friendships provide a key outlet for one's emotions and a meaningful network of support. Healthy people also can build and sustain a genuine and trusting relationship with another person which contributes to meeting their personal and social needs.

The Essential Self refers to a person's essential meaning-making processes in relation to life, self, and others (Myers, & Sweeney, 2005b). The Essential Self comprises the four third-order factors: spirituality, gender identity, cultural identity, and self-care. Spirituality, conceptualized as central to holistic wellness by Adler (1954), is rooted in being connected with others and with the world and provides a sense of meaning and purpose in life. Satisfaction with one's gender and cultural identity enhances a sense of meaningfulness, thus enhancing the overall quality of life. Self-care includes active efforts to live long and well by incorporating healthy habits in everyday life.

Lastly, the Physical Self is described as individuals' biological and physiological processes that comprise the physical aspects of their development and functioning (Myers

& Sweeney, 2005b). This component includes the two third-order factors: exercise and nutrition. Engaging in regular physical exercise is a critical component of self-care. Also, eating a nutritionally balanced diet is important for one's physical well-being over the life span.

Myers and Sweeney (2005b) emphasized that each component in the IS-Wel model interacts with all others to contribute to holistic functioning. They noted that strengths in one area can enhance functioning in other areas and help to overcome negative forces affecting wellness in other life domains. Similarly, according to Myers et al. (2000), all factors in the model also interact with local, institutional, global, and chronometrical ecological contexts because people are both affected by and have an influence on their environment. Local contexts include people's families, neighborhoods, and communities. For instance, the issue of personal safety within one's neighborhood is of great importance. Institutional contexts comprise education, religion, government, business and industry, and the media. The influence of policies and laws on personal wellness is an important part of this contextual variable. Global contexts include politics, culture, and global events. The impact of world events on wellness is the central concept for this context. The final context, chronometrical, refers to the fact that people change over time in both expected and unexpected ways.

For the purpose of this study, the IS-Wel and its up-to-date instrument, the 5F-Wel, were used to conceptualize and measure Korean counselors' personal wellness. The main reasons the IS-Wel and the 5F-Wel were chosen for this study were that the model was developed based on both theoretical and empirical support and the instrument has been widely used and updated in the counseling research literature for a variety of counselor and non-counselor populations. In addition, the IS-Wel seemed to best represent the holistic and dynamic nature of the wellness concept, positing it as integrated and balanced functioning of an individual's body, mind, and spirit. The model conceptualizes wellness as a multidimensional construct that emphasizes an individual's

functioning on multiple life domains but also recognizes the existence of a single, broad construct of wellness that is viewed as a single score indicating how well an individual's functioning on multiple dimensions is balanced and integrated. Furthermore, the 5F-Wel has been translated into or adapted for the Korean language (Chang, 1998; Hong, 2008), providing the opportunity for cross-cultural or cross-national research studies. Through the translation and adaptation processes as recommended by the International Test Commission's guidelines (Hambleton, 2001), several modifications, including changing the response choices and finding out more culturally relevant words in items, have been made to reflect linguistic and cultural differences between the English and Korean languages (Chang, Hays, & Tatar, 2005; Hong, 2008).

Counselor Wellness

With the premise that a counselor's wellness provides the foundation of her or his work with clients, transforming the wellness of clients and the profession of counseling as a whole comes down to individual counselors taking responsibility for their own wellness (Venart et al., 2007). The essence of counseling is to consistently draw on the energy to deal with the sufferings of another human being while at the same time struggling with the challenges associated with one's own life outside of the counseling setting (Cummins et al., 2007). The nature of counseling places counselors at risk for compassion fatigue, vicarious trauma, and burnout (Lawson et al., 2007). Counselors who are stressed, distressed, or impaired may not be able to offer the highest level of counseling services to their clients, and they are likely to begin experiencing a deterioration of the quality of their personal lives as well (Lawson, 2007). The inherent danger of impairment provides a strong rationale for the necessity of promoting and monitoring wellness in counselors and counselors-in-training.

During the past two decades, professional organizations in the counseling field (ACA, 2005; ACES, 1995; CACREP, 2001) have underscored the importance of counselors' personal wellness. Also, counselor educators have begun to advocate for the

incorporation of a wellness model in counselor education by identifying effective strategies for selecting students with higher levels of wellness, evaluating student wellness, or promoting the wellness of counseling students currently enrolled in counselor education programs (Myers, Mobley, & Booth, 2003; Witmer & Young, 1996). The underlying assumption is that by achieving and maintaining a greater sense of wellness, counseling students may enhance their personal growth and development. As a result, the students should be more able to meet the demands of their training and future work environments by dealing more effectively with stress, thereby reducing impairment and burnout (Roach & Young, 2007).

In response to a strong call for embracing a wellness philosophy in counselor education, several scholars (Granello, 2000; Hermon, 2005; Myers & Williard, 2003; Roach & Young, 2007; Venart et al., 2007; Witmer & Granello, 2005; Witmer & Young, 1996) suggested training models and general guidelines for implementing the philosophy of counselor training and curriculum. Witmer and Granello claimed that the commitment of all members including faculty, students, and site supervisors to a wellness paradigm would be the first step to creating a wellness community in a counselor education program. According to Hermon, faculty members, as role models, should demonstrate a healthy lifestyle and optimize their personal healthy approach to teaching, research, and service. Each student should participate in personal self-disclosure and self-growth as part of the wellness goals of the training. In addition, Hermon argued that students should engage in extracurricular activities such as workshops on health topics or a wellness fair. Both faculty and students should develop an individual wellness plan in which they would establish goals and priorities for their own wellness lifestyle. Granello (2000) claimed that field supervisors should nurture their supervisees' strengths and virtues and encourage them to recognize their clients' strengths and virtues as essential elements in intervention planning.

Regarding the curriculum of a counselor education program, Witmer and Granello (2005) presented three different models in terms of the extent of the infusion of a wellness philosophy as a guiding force. *The course-specific model* involves the creation of a single, stand-alone course on wellness. *The infusion model* seeks to alter the curriculum by inserting wellness objectives and assignments into existing course work. *The holistic wellness model* for which Witmer and Granello advocated over the other models incorporates wellness into both the course work and the non-curricular and lifestyle experiences of the faculty and students. Under this model, a wellness philosophy would be integrated into every facet of the program from faculty participation, student admissions, and course work to co-curricular activities and field-work experiences.

In summary, consistent with the wellness movement embracing a developmental, strengths-based perspective in counseling approaches, a number of counselor educators (e.g., Witmer & Granello, 2005; Myers & Sweeney, 2008) and major professional organizations (e.g., ACA, 2005; CACREP, 2001) in the counseling field have begun to strongly advocate for the inclusion of the wellness philosophy in counselor training and education programs. They seem to believe that counselors' personal wellness is an essential condition for effective counseling with their clients. However, little empirical evidence linking counselor wellness with counseling process and outcome variables exists. Thus, empirical studies paying attention to the relationships of counselor wellness to counseling process and outcome variables are necessary to provide valuable evidence-based input into the current wellness movement in the counseling field.

Empirical Studies on Counselor Wellness

Although a number of research studies on non-counselor populations' wellness exist, limited research has been undertaken on counselors' and counseling students' wellness. To date, there have been two major lines of research regarding counseling students' wellness. One line of research (Myers et al., 2003; Roach & Young, 2007) sought to investigate whether graduate training programs would increase the wellness

levels of counseling students. In a study of 263 counseling graduate students including both doctoral and master's level, Myers et al. (2003) found that doctoral students reported greater wellness scores than master's students while both groups indicated higher levels of wellness than the general population in the most factors measured by the Wellness Evaluation of Lifestyle (Myers et al., 1998), a prior version of the Five Factor Wellness Inventory (5F-Wel; Myers & Sweeney, 2004). On the basis of these results, they concluded that counseling students' wellness would increase in proportion to the duration of stay in counseling programs. However, more recently, using the 5F-Wel, Roach and Young (2004) presented the contradictory findings to Myers et al. (2003). Roach and Young compared mean wellness scores of three different groups of master's-level students at the beginning, middle, and end of their program based on hours completed in graduate counseling programs. The results indicated that no matter how long a student had been in the program, wellness was not differentiated. In spite of the limitations associated with sampling, both studies provided the baseline data for personal wellness of counselors-in-training, thereby allowing future researchers to utilize the results to evaluate the wellness levels of their own samples.

The other line of research (Curry, 2007; O'Brien, 2007) concerned the relationship between counselor wellness and effectiveness. Two recent doctoral dissertation studies did not support the connection between these two variables. Based on the data from 70 master's level internship students in counseling programs, Curry reported no statistically significant relationship between master's-level counseling students' wellness and their counseling self-efficacy. Also, in a study to explore the relationship between master's level counseling practicum students' wellness and client outcomes, O'Brien found that counseling students' wellness was not related to client progress in terms of the alleviation of symptoms or distress. However, as this line of research examining the relationships between counselor wellness and effectiveness is still in its infancy, more empirical efforts are necessary to determine how the levels of

wellness in counselors influence their effectiveness with clients in actual counseling sessions.

Empathy

Definitions of Empathy

There has been the endless debate about the nature of empathy. The first debate concerns whether empathy is an affective or cognitive phenomenon. Empathy has been identified by some as primarily an affective phenomenon (e.g., Allport, 1961; Eisenberg, Shea, Carlo, & Knight, 1991; Langer, 1967; Lennon & Eisenberg, 1987; Mehrabian & Epstein, 1972; Stotland, 1969) referring to the emotional experiencing of the emotions of another person. For example, Lennon and Eisenberg represented this perspective by identifying three types of affective empathy: (a) personal distress, (b) emotional contagion, and (c) genuine concern for others. Personal distress refers to the personal feelings of anxiety or discomfort that results from observing another's pain or sufferings. Emotional contagion refers to responding with the same emotion as another person's emotion. Genuine concern refers to feeling an emotion of concern for another, not having the same feeling. In contrast, others view empathy as primarily a cognitive construct (e.g., Barrett-Lennard, 1962 , 1981; Borke, 1971; Deutsch & Madle, 1975; de Waal, 1996; Ickes, 1993; Kalliopuska, 1986; Katz, 1963; Kohut, 1971; Rogers, 1986; Woodall & Kogler-Hill, 1982) referring to the intellectual understanding of another's experience. From this perspective, empathy is conceptualized as a cognitive understanding of the internal frame of reference of another person. A third view holds that empathy contains both cognitive and affective components (e.g., Brems, 1989; Hoffman, 1977; Shantz, 1975; Strayer, 1987). Those holding this view argue that being authentically empathic requires both the cognitive understanding of the worldview of another and the emotional response to that person (Watson, 2002). They believe that the affective and cognitive components of empathy are inseparable and reciprocal with each other.

Regardless of whether empathy is an experience in one's affect, cognition, or both, it appears the counseling literature has differentiated the two aspects of empathy. Gladstein (1983) noted that the two separate and distinct types of empathy were identifiable in the social, developmental, and counseling psychology literature although the terms had not been actually used. Duan and Hill (1996) acknowledged the utility of this differentiation in conducting research even though research evidence showed that cognitive and affective processes unavoidably influence each other (e.g., Bower, 1981). They claimed the definitional differentiation would allow researchers more freedom of investigating cognitive or affective elements of empathy as distinct phenomena without being caught in the endless debate about the nature of empathy. Thus, this study considered Korean counselors' empathy to have both emotional and cognitive components regardless of the degree to which they overlap.

Another major debate regarding the concept of empathy concerns whether empathy is a trait or a state (Duan & Hill, 1996). Some theorists, including psychoanalytic theorists (e.g., Buie, 1981; Sawyer, 1975), counseling researchers (e.g., Johnson, 1990; Mehrabian & Epstein, 1972; Rogers, 1957), and social and developmental psychologists (e.g., Davis, 1983a; Kestenbaum, Farber, & Sroufe, 1989), believed that empathy is a personality trait or general ability to understand another person's inner experience or to share feelings of others. In this view, some individuals may be more empathic than others and the empathic ability of an individual will be stable over time and not fluctuate across situations. This conceptualization allowed counseling researchers to explore the influence of the developmental process or other personal characteristics on a counselor empathic ability. Other writers claimed empathy is a situation-specific state (e.g., Barrett-Lennard, 1962; Hoffman, 1984; Rogers, 1949, 1951, 1957, 1959). From this perspective, empathic experience varies by the situation regardless of a person's developmental level of empathy. This perspective allowed for studying situational factors promoting or hindering empathic experience and counselors' intra-individual differences

in empathy. Although no consensus exists among scholars from several disciplines, empirical evidence in the counseling literature appears to support the idea that inter-counselor variability in empathy overrides intra-counselor variability (Lafferty, Beutler, & Crago, 1989). Thus, this study considered empathy as a personality trait rather than a situation specific state, assuming that a Korean counselor's empathic ability would be relatively stable over time and across situations.

Although the construct of empathy has been addressed mainly in a general context in the two debates described above, Clark (2007) conceptually organized it into three modes in a counseling context: (a) experiential, (b) communication, and (c) observational modes. With regard to an experiential mode of empathy, Rogers (1951) and other person-centered theorists supported the idea that a counselor assumes a transitory engagement with a client in an attempt to understand the client's inner experience. Rogers (1951) recognized empathy as a way of being or an attitude and believed that it is of utmost importance for a counselor to grasp the implicit and explicit meanings of a client's verbal and nonverbal disclosures.

The communication mode, conceptualized by Clark (2007), emphasized that empathy must be communicated to a client or made visible in some form to produce therapeutic gain (Barrett-Lennard, 1981). In this mode, empathy is conceptualized as primarily the technological qualities of a communication skill or technique rather than a way of being or an attitude. Particularly, the technique of reflection came to be equated with empathic understanding (Bohart & Greenberg, 1997). The interactive aspect of empathy is highlighted in the communication mode.

Finally, Clark's (2007) observational mode of empathy provides a method for a counselor to acquire psychological data with respect to a client. This information-gathering activity is subsequently transformed and communicated to the client through an interpretation or related interventions (Poland, 1984). In this view, the acquisition of knowledge about a client enables a counselor to provide informed therapeutic

interventions that serve to broaden and deepen the client's self-insight. Unlike the experiential or communication mode, which tends to focus on the immediate functioning of a counselor, the observational mode of empathy involves a counselor's prolonged immersion in a broader perspective of a client's life (Ornstein, 1979).

Clark's (2007) conceptualization of empathy in a counseling setting appears to suggest that both affective and cognitive components of empathy should be considered in addressing a counselor's empathic ability. It seems that all three modes are necessary in order for a counselor to use empathy as a therapeutic tool. To transition from one mode to another, it is apparent that counselors should be able to understand their client's feelings and internal world. In this regard, this study's conceptualization of empathy as having both affective and cognitive components appears relevant to the counseling context.

Empirical Studies on Empathy

The concept of empathy generated much research after Rogers's (1949, 1951, 1957, 1959) writings regarding its role in counseling. Most of all, the primary focus of counseling researchers has been on how empathy assessed by either counselor or observer measures was related to client outcome assessed by client's self-report, counselor, observer, or objective test methods. A large number of research studies (e.g., Blalock, 2006; Jones, Wynne, & Watson, 1986; Kolb, Beutler, Davis, Crago, & Shanfield, 1985; Lafferty, Beutler, & Crago, 1989; Luborsky, Chandler, Auerbach, Cohen, & Bachrach, 1971; Martz, 2001; Miller, Taylor, & West, 1980; Truax & Carkhuff, 1967) and meta-analytic studies (e.g., Bohart, Elliott, Greenberg, & Watson, 2002; Lafferty et al., 1981; Patterson, 1984) provided empirical evidence of the relationship of empathy to counseling effectiveness and client change. However, the majority of evidence in the counseling literature has been established with regard to correlations between counselors' cognitive empathy and counseling outcomes, resulting in little research into counselors' affective empathy (Duan & Hill, 1996). Although a number of empirical studies in the social and developmental psychology literature addressed affective empathy as a study

variable, they found evidence connecting affective empathy only with helping or altruistic behaviors (Batson, Fultz, & Schoenrade, 1987; Mehrabian, Young, & Sato, 1988). Thus, there is a need for future studies to pay more attention to the role of counselors' affective empathy as it relates to counseling outcomes.

The literature on predictors of empathy is much smaller than that on the role of empathy. It has been mainly concerned with individual differences in empathic ability (Duan & Hill, 1996). Accordingly, the assumption that some individuals are more empathic than others has clearly guided most of the research in this area. Therefore, effort has been directed toward finding the relationships of counselor demographics, such as gender (Carlozzi & Hurlburt, 1982), or relatively stable variables, such as personality type (Jenkins, Stephens, Chew, & Downs, 1992) with counselor-perceived empathy, most often measured in various empathy scales as the degree of the counselor's understanding of the client (Sexton & Whiston, 1994).

It may be reasonable to conceptualize personal wellness as a potential variable which might reflect individual differences as it relates to empathy, but only one research study examining the relationship between empathy and wellness could be found in the counseling literature which used either the Five Factor Wellness Inventory (5F-Wel; Myers & Sweeney, 2004) or, its prior version, the Wellness Evaluation of Lifestyle (WEL; Witmer, Sweeney, & Myers, 1998). Using the WEL for a sample of 100 American undergraduate students, Granello (1996) examined the relationship between wellness and empathy. Granello hypothesized an individual's wellness would be significantly predicted by empathic ability. However, the results did not support this hypothesis. Unfortunately, there have been no empirical efforts to examine the relationship of personal wellness to empathy using counselor samples. In this study, counselor empathy was posited as a moderator between counselor wellness and client-rated counseling effectiveness, and thus, the research question addressing the direct relationship between counselor wellness and empathy was not established. However,

given the lack of sufficient empirical evidence on this relationship, the results of this study may provide more knowledge on how counselors' personal wellness is related to their empathic ability.

Working Alliance

The Concept of Working Alliance

The concept of the working alliance has had a controversial history (Horvath, 2001). Freud (1958) was one of the first clinicians to underscore the importance of the relationship between counseling and client. He described three distinct forms of the therapeutic relationship: (a) transference, that is, the client's unconscious projections of unresolved conflicts or feelings with significant others from the past on the counselor; (b) countertransference, the counselor's unconscious linking of the client with significant figures or unresolved conflicts from the past; and (c) the client's friendly and positive linking of the counselor with benevolent and kind persons from the past (Bachelor & Horvath, 1999). Later, Rogers (1951) claimed the ideal therapeutic relationship is an existential encounter rather than a psychodynamic one, as argued by Freud, between counselor and client. He hypothesized that empathy, genuineness, and unconditional positive regard on the part of the counselor are necessary and sufficient for making the relationship therapeutic and further bringing about change in a client (Horvath, 2001).

In reaction to Rogers' (1951) model, which focused exclusively on the counselor's contribution to the relationship, social influence theorists (e.g., LaCrosse, 1980; Strong, 1968) recognized the client's role in the relationship by highlighting the client's perception of the counselor's power to influence the client's thinking, feeling and behavior, and thus to promote therapeutic change. This new formulation of the alliance concept directed attention to the collaborative and interactive elements in the relationship between counselor and client (Bachelor & Horvath, 1999).

In the mid-seventies, major meta-analytic findings suggested the therapeutic elements common to all forms of counseling (Horvath, 2001). As a consequence, the

relationship between counselor and client received great attention again because it was regarded as one of the core common factors that were found to contribute to successful counseling outcomes. Two major theorists (Bordin, 1979; Luborsky, 1976) suggested new ways of conceptualizing the alliance as positive, reality-based component of the therapeutic relationship and the universal element in all successful counseling work (Horvath).

Luborsky (1976, 2000) proposed a two-stage concept of the alliance. The first stage consisted of issues of mutual liking and a counselor's support to make a client feel safe, and the second involved collaboration and cooperation of the client with the counselor in the tasks of counseling sessions. Bordin (1979, 1994) developed a similar pan-theoretical concept of the effective components of the therapeutic relationship, which he named *the working alliance*. For Bordin, the alliance was fundamentally a collaborative entity and had three essential components: (a) interpersonal bonds, (b) agreement on the goals of counseling, and (c) collaboration on therapeutic tasks (Bordin, 1979). Bordin (1994) believed that the positive development and maintenance of the alliance is, in itself, therapeutic.

Bordin's (1979, 1994) concept has been the foundation for the current conceptualization of the working alliance as a conscious and purposeful aspect of the counselor-client relationship (Horvath & Bedi, 2002). As a consequence, the current definition of the working alliance emphasizes the affective or bond elements such as liking, respect, and trust as well as the quality of the collaboration between counselor and client in establishing the tasks and goals of treatment (Fitzpatrick & Irannejad, 2008). Consistent with the current concept of the working alliance, this study was based on Bordin's conceptualization of the counselor-client working alliance.

Empirical Research on Working Alliance

In spite of the debate on a definition of the therapeutic relationship and on its fundamental components, there has been strong agreement on the proposition that the

counselor-client relationship plays a central role in the process and outcomes of counseling (Bachelor & Horvath, 1999). The quality of the therapeutic relationship has been shown to be a significant determinant of beneficial outcome across diverse counseling approaches, and it has been seen by many to represent a common factor accounting for therapeutic success (Horvath, 2001). Specifically, the therapeutic alliance has been found to play an important role among behavioral, eclectic, and dynamically oriented therapies (Gaston, Marmar, Thompson, & Gallagher, 1991; Hovarth, 1994). It also has been found to have a significant impact on counseling outcomes in a variety of treatment environments and across a range of client problems (Beutler et al., 1994; Horvath & Symonds, 1991; Luborsky, Critis-Christoph, Mintz, & Auerbach, 1988). By adopting the relational focus and identifying the positive collaboration between counselor and client as one of the most essential components for success in counseling, the working alliance has bridged the long-standing dichotomy between process and outcome (Teyber & McClure, 2000).

In their comprehensive research review, Sexton and Whiston (1994) concluded that the therapeutic relationship consistently contributed more to treatment success than counselors' and clients' characteristics. Similarly, Orlinsky, Grawe, and Parks (1994) found a strong relationship between the quality of the therapeutic relationship and positive client outcome in 80% of their reviewed studies. Lambert and Bergin's (1994) review also concluded one of the major factors in discriminating helpful from less helpful counselors was the quality of the counselor-client relationship. Horvath and Symonds (1991) conducted a meta-analysis examining the relationship between working alliance and client outcomes. Their examination of 24 studies revealed that the working alliance was the most predictive measure of successful client outcomes. More recently, in their comprehensive review of 79 existing empirical studies relating alliance to outcome, Martin, Garske, and Davis (2000) found that therapeutic alliance was moderately but

consistently associated with outcome, regardless of the moderating or mediating variables posited.

A review of the literature has also shown that clients and counselors differ in their perceptions of the therapeutic relationship (Horvath, 2001). Comparisons of clients' and counselors' ratings of the relationship have consistently indicated lack of congruence (e.g., Golden & Robbins, 1990; Horvath & Marx, 1990; Tichenor & Hill, 1989). From the results indicating that counselor and client ratings of the alliance were only moderately correlated, Mallinckrodt (1991) speculated that counselors may evaluate the alliance based on their theoretical orientations whereas clients may use other close personal relationships as a reference. Empirical investigations have confirmed that, across different modalities of treatment, clients' markers of a strong positive alliance were relatively homogeneous, in contrast to the counselor's positive alliance markers, which appeared to be more theory specific (Horvath, 1994; Horvath & Luborsky, 1993). Interestingly, a number of research (e.g., Mallinckrodt, 1993; Safran & Wallner, 1991; Tichenor & Hill, 1989) and meta-analytic studies (e.g., Orlinsky & Howard, 1986) revealed clients' ratings on the working alliance were most predictive of positive outcome, rather than counselor or third party assessments.

To date, no empirical studies exist investigating the relationship between counselor wellness and the working alliance rated by either counselors or clients. Given the established relationship of working alliance to a variety of indicators of successful counseling outcome, empirical studies investigating the relationship between counselor wellness and working alliance would provide new insight into the role of counselors' personal wellness in counseling process and outcomes. Based on previous studies indicating that counselors' perception of the alliance did not match clients' perception and that clients' evaluation of the alliance was most predictive of positive outcome in counseling, this study measured only clients' perception of the working alliance posited as an indicator of counseling effectiveness.

Korean Literature Review

Counseling in Korea

Since the introduction of the Western model of counseling by American delegates of education in the 1950s, the counseling field in Korea has witnessed tremendous growth in various aspects (Seo et al., 2007). The number of those who want to study counseling as well as the number of counseling programs and faculty positions has dramatically increased during the last few decades (Korean Department of Education, 2005). Also, since the 1990s, there have been an increasing number of regional and national conferences related to the practice of counseling (Seo et al.). These conferences have provided opportunities for an exchange of information and ideas as well as organized training in counseling practice. Increased efforts to integrate traditional counseling techniques from Buddhism, Taoism, and Korean shamanism into counseling practices may be another indicator of the growth of the counseling field in Korea (Joo, 1993).

Furthermore, the places where counselors are employed have become more diverse than before as the public's demand for mental health services has increased and diversified (Seo et al., 2007). Graduates of counseling programs now occupy positions in a variety of settings, including local youth counseling centers, educational settings, and leading business companies such as Samsung and LG. In addition, counseling has increasingly been accepted as a profession by the Korean government. As a result, a growing number of government-sponsored public counseling institutions have been established (Bae, 2001). The central and local governments in Korea have also encouraged middle and high schools to hire school counselors for students with career and psychological problems (Lee, 2003). This expansion of work settings may indicate enhanced recognition of the utility of counseling services by Korean society.

Counselor Training in Korea

The Korean Counseling and Psychological Association (KCPA), the largest professional organization of counselors in Korea, now has more than 5,000 members

(KCPA, 2008) and publishes a professional journal, the *Korean Journal of Counseling and Psychotherapy* (KJCP). The KCPA has a rigorous certification system that has been believed to contribute to producing quality counselors. Currently, the certification board and its certification criteria demand a relatively high level of training and competence (Joo, 2009). The certification board requires the candidates who pass the written exam to submit documented evidence of counseling-related training experiences, including the names and qualifications of their clinical supervisors, total hours of clinical supervision, total number of case presentations, total hours of individual and group counseling, and total hours of test administration and interpretation (KCPA, 2003). Audiotapes and transcriptions of counseling sessions are also required as a proof of counseling competence. Furthermore, the KCPA launched its ethics committee (Seo et al., 2007), indicating its commitment to fostering counselors' accountability in counseling practices.

Despite the relatively rigorous credentialing system of the KCPA, there are no training standards. For example, the KCPA board specifies neither semester/quarter hour nor content area requirements for counselor training programs in colleges and universities. Recently, a number of scholars in the counseling field have argued for the need to set up a formal training model (e.g., Ahn, 2003; Lee, 1996; Lee & Kim, 2002). Lee (1996) argued that one cannot justify claiming the high competence of graduates to the public if the content and quality of training vary widely from program to program. Indeed, Lee found that the graduate level counseling programs surveyed for his study varied widely in the minimum number of courses required and the topics covered by the curriculum. One strategy to accumulate the knowledge base for creating standards for counselor training may be to identify the personal qualities and professional capabilities of counselors which might be related to their effectiveness with clients in counseling sessions. Empirical evidence in this area will serve as a solid foundation for standardizing counselor training programs because it will provide counselor educators with the knowledge of what should be nurtured and enhanced among their trainees.

To date, the majority of empirical studies examining the relations of counselor variables to counseling outcomes that have been published in Korean counseling journals have exclusively focused on Korean counselors' professional capabilities such as techniques or skills rather than their personal qualities (Lee, 1996). In considering that American counseling literature has consistently recognized counselors' personal qualities as critical factors in determining successful counseling outcomes (Wampold, 2001), there is a strong need for future studies investigating the relationships between Korean counselors' personal qualities and counseling outcomes. In this regard, personal wellness may be considered one of the Korean counselor's personal quality variables that have an influence on his or her effectiveness with clients. Given that Korean counselors are facing difficulties and challenges such as limited employment opportunities (Bae, 2001), lower income compared with other professions (Yoo & Park, 2002), and a variety of occupational stresses (Choi, Yang, & Lee, 2002; Park, 2006), it is imperative for researchers to pay attention to the current wellness status of Korean counselors and to investigate how their personal wellness influences their counseling effectiveness.

Summary

The preceding review of the literature has provided a broad view of the variables examined in this study. This chapter has also presented a brief review of the Korean literature with regard to the current status of counseling and counselor education in Korea. It was evident after reviewing the literature that there was a need to study the wellness of Korean counselors and to investigate if Korean counselors' personal wellness would affect their counseling effectiveness. Also, the review of the American literature pertinent to wellness, empathy, and the working alliance has illustrated the need for future studies examining the relationship among these variables. Chapter III will delineate how this study was conducted.

CHAPTER III

METHODOLOGY

Chapter II presented an overview of the theoretical and research background of wellness, empathy, the working alliance, and a review of the relevant Korean literature. Chapter III presents the methodological details of this study. Specifically, this chapter describes the participants of this study, the instruments used to collect data, data collecting procedures, and the design and statistical analysis of the data. In addition, the translation procedure for the instrument is described.

Participants

Data in this study were gathered from both counselors and clients, that is, counselor-client dyads in South Korea. However, the target population, which is defined as "the group to which the study's results will be generalized" (Heppner, Kivlighan, & Wampold, 1999, p. 322), was Korean counselors. This was due to the major purpose of the study to examine the effects of Korean counselors' personal wellness and empathy on their effectiveness in working with clients. Specifically, the target population was counselors who have engaged in face-to-face individual counseling in any type of position (e.g., practicum, internship, part-time, full-time) at university counseling centers or youth counseling institutes located in Seoul and Gyeonggi Province, South Korea. Seoul, the capital city, and Gyeonggi Province, the largest of nine Provinces, represent the most populated urban areas in Korea. The exact number of university counseling centers in Seoul and Gyeonggi Province is not known, yet the number may be larger than other regions given that the vast majority of universities and colleges are located in these two areas. Also, of the total of 146 youth counseling institutes in Korea, 16 and 32 centers are established in Seoul and Gyeonggi Province, respectively (Korean Youth Counseling Institute, 2008).

To be included in this study, a counselor was required to have a client on his or her caseload who met the following criteria: (a) had attended a minimum of three face-to-

face individual counseling sessions; (b) was over 18 years of age; and (c) had adequate levels of self-awareness needed for responding to the survey and appropriate levels of self-determination for deciding on participation (neither being mentally retarded nor psychotic) as determined by the counselor's judgment. If counselors had more than one eligible client on their caseload, they were asked to choose only one, following ascending alphabetical order by last name. The age criterion for selecting non-minor clients was applied to avoid potential complications in informed consent procedures and to ensure full comprehension of survey items and adequate levels of self-awareness needed for responding to the survey. The minimum three session restriction was imposed because assessing the working alliance between counselor and client after a minimum of three sessions was considered valid for predicting outcome in counseling (Horvath & Symonds, 1991) and a working alliance is commonly believed to develop by the third counseling session (Suh, Strupp, & O'Malley, 1986).

Counselors

The counselor sample consisted of 124 women (93.2%) and 9 men (6.8%) with a mean age of 35.67 years (SD=6.56). Given that women comprise the predominant proportion of certified counselors in Korea, this ratio of female to male counselors appears to represent the gender composition of the Korean counselor populations (KCPA, 2008). Among 133 counselors, 86 (64.7%) were working in Seoul and 47 (35.3%) in Gyeonggi Province. The majority of participants (91%) were counselors working in university counseling settings, and only a small number of participants (9%) were those in youth counseling institutes. Their counseling experiences ranged from 1 month to 17 years and averaged 5.06 years (SD=4.24). The entire sample had obtained at least a Bachelor's degree; 29 (21.8%) and 26 (19.5%) counselors were currently enrolled in master's and doctoral counseling programs, respectively. Sixty counselors (45.1%) had obtained a master's degree, and 18 (13.5%) had received a doctoral degree in counseling-related majors. At the time of the survey, 38 counselors (28.6%) were in practicum or

internship, 44 (33.1%) were part-time workers, and 50 (37.6%) were working in full-time status. Practicum or internship is rarely required as part of graduate-level counseling programs in South Korea (Seo et al., 2007), but the majority of students seek these opportunities outside of their academic programs as an attempt to meet the certification requirements. Over half of the participants (n=70; 52.6%) were married, with the remaining participants (n=63; 47.4%) being single.

Table 1. Demographic Characteristics of Counselor Participants

Demographic Variable	Categories	Frequency	Percent
City	Seoul	86	64.7
	Gyeonggi	47	35.3
Work Setting	University Counseling	121	91.0
	Youth Counseling	12	9.0
Gender	Male	9	6.8
	Female	124	93.2
Age	20-29	26	19.5
	30-39	72	54.2
	40 and over	35	26.3
Marital Status	Married/Partnered	63	47.4
	Single	70	52.6
Sexual Orientation	Homosexual	1	0.8
	Heterosexual	122	91.7
	Bisexual	10	7.5
Position in the Work Setting	Practicum/Internship	38	28.6
	Part-Time	44	33.1
	Full-Time	50	37.6
Counseling-Related Education	In Master's Program	29	21.8
	Master's Degree Earned	60	45.1
	In Doctoral Program	26	19.5
	Doctoral Degree Earned	18	13.5
Individual Counseling Experience	- 3 years	59	44.4
	- 8 years	45	33.8
	Over 8 years	29	21.8

Table 2. Demographic Characteristics of Client Participants

Variables	Categories	Frequency	Percent
Gender	Male	23	17.29
	Female	110	82.71
Age	19-20	8	6.0
	21-25	94	70.7
	26-30	22	16.5
	30 and over	9	6.8
Marital Status	Married/Partnered	11	8.3
	Single	122	91.7
Sexual Orientation	Homosexual	5	3.7
	Heterosexual	119	89.5
	Bisexual	9	6.8
Education Completed	High school graduate	95	71.4
	Bachelor's Degree	33	24.8
	Master's Degree	5	3.8
Fee Payment	Yes	5	3.8
	No	128	96.2
Prior Counseling Experience	Yes	41	30.8
	No	92	69.2

Clients

The client sample consisted of 23 men (17.29%) and 110 women (82.71%), averaging 25.24 years of age (SD=5.52), ranging from 19 to 50 years old. Forty-one clients (30.8%) indicated they had engaged in previous counseling with a different counselor. There were only 5 clients (3.8%; 3 at university counseling centers, 2 at youth counseling centers) who had paid counseling fees, with the majority (n=128; 96.2%) receiving counseling services for free. This was because counseling services are provided as a free student service at universities and colleges in South Korea. Also, youth counseling institutes in Korea do not receive counseling fees from clients who are under the age of 25 years because the agencies are funded by central and local governments. The predominant proportion of the clients were single (n=122; 91.7%), which makes

sense considering that most clients participating in this study were college students; of the total of 133 dyads, 121 dyads were engaging in individual counseling sessions in university counseling centers. However, 33 clients (24.8%) had completed a Bachelor's degree and the remaining 5 (3.8%) held a master's degree.

Procedure

Translation of the Instruments

Since the Interpersonal Reactivity Index (IRI; Davis, 1980) was the only instrument with Korean translation unavailable, this scale was translated into the Korean language through the back translation method (Brislin, 1986) by three individuals who were bilingual in Korean and English. Specifically, the IRI was first translated from the original (English) to the target language (Korean). This translation was then translated back into the original language (English). This translation was done by a professional translator who did not refer back to the original scale. Following this back-translation, another bilingual speaker assessed the adequacy of the translation by comparing the back-translated version with the original English version. Based on this evaluation, the researcher modified the Korean translations of any items that were slightly different in their meaning. Finally, other bilingual speakers reviewed the revised translation to assess if it represented the original items accurately. It was the last version that served as the final Korean version of the IRI (see Appendix A3).

Data Collection

The researcher contacted via email the directors of 25 university counseling centers and five youth counseling institutes in Seoul and Gyeonggi Province, in the vicinity of Seoul, South Korea, requesting them to forward two consent letters (one for the counselor, the other for the client) attached to the email to all counselors who were providing face-to-face individual counseling services. At this time, a brief explanation was provided, including an overview of the study, its procedures, the selection criteria for qualified counselors and clients, and time expectations for completing the survey. The

consent letter for counselors instructed the counselors to review the letter and then decide whether or not to participate. Those counselors who were willing to participate were instructed to give the consent letter for clients to their eligible client. If counselors had more than one eligible client on their caseload, they were asked to choose only one following ascending alphabetical order by last name. Then, clients were asked to make their own decision on participation and inform their counselor of their decision. If the first eligible client on a counselor's list did not wish to participate in the study, the counselor asked the next client on the list.

A total of 151 counselors who mutually agreed with the client to participate in this study sent an email to the researcher indicating the dyad's willingness to participate, their name, and the agency address. Upon receipt of their email, a large envelope enclosing both counselor and client survey packets, labeled as "Counselor Packet" and "Client Packet," respectively, was mailed to the address they indicated. The Counselor Packet included the consent letter for counselors, the Korean versions of the Five Factor Wellness Inventory (Myers & Sweeney, 2004), the Interpersonal Reactivity Index (Davis, 1980), the Marlowe-Crowne Social Desirability Scale (Crowne & Marlowe, 1960), a demographic questionnaire, and a prestamped, addressed return envelope. The Client Packet included the consent letter for clients, the Korean versions of the Counselor Rating Form-Short (Corrigan & Schmidt, 1983), the Session Evaluation Questionnaire (Stiles & Snow, 1984), the Working Alliance Inventory-Client Form (Horvath & Greenberg, 1986), a demographic questionnaire, an email address request form, and a prestamped, addressed return envelope.

Counselors were asked to complete a set of survey questionnaires enclosed in the Counselor Packet, put them in a prestamped, addressed return envelope, seal, and return the envelope to the researcher within 1 week after receiving the packet. Counselors also were instructed to give the Client Packet to their client before the next scheduled session began and to ask the client to complete the survey immediately after the termination of

the session. At this time, counselors were asked to reassure the client that participation would be completely voluntary, and the client could decline participation without any negative consequences. Counselors also were instructed to provide privacy while the client filled out the survey questionnaires.

Clients were asked to complete the email address request form along with the survey. On this form, clients were asked to write the email address at which they would like to receive a gift certificate as compensation for the participation. If clients did not have an email account, they were asked to indicate their mailing address and name so a hard copy of a five-dollar value gift certificate could be sent to them. The gift certificate could be redeemed both offline and online for purchasing a variety of merchandise and services (e.g., books, apparel, movie tickets, restaurants, shopping malls). Finally, the clients were instructed to put both the completed survey and email address request form in a prestamped, addressed return envelope, seal, and return it directly to the researcher as soon as it was completed.

Completing the survey was estimated to take approximately 15 to 25 minutes for counselors and 10 to 20 minutes for clients. Both counselors and clients were instructed to not write their names and addresses on the return envelope. Email reminders were sent to counselors when the completed survey packet from either the counselor or the client was not returned within 3 weeks from the date when the packets were sent. This reminder stated that the researcher would consider it a withdrawal from participation if the completed packet was not received within 2 weeks after the reminder was sent. Given that the researcher did not have clients' email addresses, counselors were asked to forward this reminder to their clients only if a client did not return the packet to the researcher. Counselors were asked to send a response email to this reminder indicating when they and/or their client could return the packets if there were any reasons for delay. Again, counselors were informed that if the packet was not returned and a response email

to the reminder was not received in 2 weeks after the reminder was sent, there would be no further contact.

Finally, a total of 140 surveys were returned (92.7% return rate). Of the 140 returned surveys, 7 cases were eliminated from analysis because significant portions of data from either counselor or client were missing. Thus, the final sample consisted of 133 counselor-client dyads, and data from their surveys were included for data analysis.

Survey Measures

The following section presents the instruments used within this study. For the purpose of this study, two different sets of questionnaires were administered. One set of questionnaires for Korean counselors included (a) the Five Factor Wellness Inventory, (b) the Interpersonal Reactivity Index, and (c) the Marlowe-Crowne Social Desirability Scale, and (d) the Demographic Questionnaire. The other set of questionnaires for Korean clients included (a) the Counselor Rating Form – Short, (b) the Session Evaluation Questionnaire, (c) the Working Alliance Inventory – Client Form, and (d) the Demographic Questionnaire. The measures in a survey set were counterbalanced to control for possible ordering effects.

Measures for Counselors

Five Factor Wellness Inventory – Korean Version (5F-Wel-K)

The Five Factor Wellness Inventory – Korean Version (Hong, 2008) was used to measure Korean counselors' personal wellness for this study. The 5F-Wel-K is composed of 105 items (73 scored and 32 experimental) on a 4-point Likert scale. The original version of the 5F-Wel (Myers & Sweeney, 2004) was composed of 73 scored and 19 experimental items. In the original version, the 19 experimental items were included to measure the four contexts, including local, institutional, global, and chronometrical. During the translation and cultural adaptation of the original scale, Hong created an additional 14 items to reflect the unique aspects of the Korean culture.

Korean counselors were asked to answer each item that was the most representative and descriptive of them on a 4-point Likert scale that ranged from *strongly agree* to *strongly disagree*. Each item was written in the form of a self-statement (e.g., "I am satisfied with how I cope with stress" and "I eat a nutritionally balanced diet"). The 5F-Wel-K yielded one score for Total Wellness, five second-order factor scores, and 17 third-order factor scores. The five second-order factors encompassed the 17 third-order factors as follows: Creative Self (Thinking, Emotions, Control, Work, Positive Humor), Coping Self (Leisure, Stress Management, Self-Worth, Realistic Beliefs), Social Self (Friendship, Love), Essential Self (Spirituality, Gender Identity, Cultural Identity, Self-Care), and Physical Self (Nutrition, Exercise). Total Wellness scores were determined by the sum of 73 scored items on the inventory. In order to place all scales on a common metric, Myers and Sweeney (2004) advised that Total Wellness and all second-order factor scores be converted to a score ranging from 25 to 100 by dividing the mean score for each scale by the numbers of items and then multiplying by 25. Thus, the highest score is 100 and the lowest is 20. Higher scores indicate greater levels of wellness.

Using the original 5F-Wel, Myers and Sweeney (2004) reported the internal consistency estimates of .90 for Total Wellness, .92 for Creative Self, .88 for Essential Self and Physical Self, and .85 for the Coping Self and Social Self. These were derived from a sample of 3,343 Americans: 52% males and 48% females; ages 18 to 101; 52% of Caucasian, 29% African American, 4.3% Asian Pacific Islander, and 3.2% Hispanic; 11.8% with less than a high school education, 39% with a high school education, 12% with a bachelor's degree, and 13.4% with a master's or doctoral degree. However, they found the internal consistency estimates of the 17 third-order factors became much more variable, ranging from .66 to .91. Thus, the researcher of the current study used Total Wellness and five second-order factor scores only for data analysis of this study, excluding 17 third-order factor scores.

The original 5F-Wel has evidenced both convergent and divergent validity of the scales relative to constructs such as ethnic identity, acculturation, body image, self-esteem, and gender role conflict in multiple dissertations and other studies (Myers & Sweeney, 2005b). A recent doctoral dissertation study (Bigbee, 2008) using the 5F-Wel with a sample of 125 American university faculty, staff, and students demonstrated that participants' wellness had a significant positive relationship with their religious and social interest levels. After assessing the criterion-related validity of the 5F-Wel, Myers and Sweeney (2004) reported a high correlation between the variables of life satisfaction and Total Wellness scores. Because the reliability and validity information about the Five Factor Wellness Inventory – Korean Version was not available, the internal consistency estimates were calculated for the data of this study.

Interpersonal Reactivity Index (IRI)

To assess Korean counselors' empathic ability in this study, the researcher used the Interpersonal Reactivity Index (Davis, 1980, 1983a). The IRI was chosen because this scale assumes empathy as being a personality trait and measures both affective and cognitive components, which is consistent with this study's conceptualization of empathy as described in the previous chapter.

The IRI is designed to measure a dispositional, multidimensional empathy in social situations. Davis operationalized empathy as a set of related constructs including both emotional and cognitive components. Although the *Questionnaire Measure of Emotional Empathy* (QMEE; Mehrabian & Epstein, 1972) and the *Empathic Understanding Scale* (EUS; Carkhuff, 1969) have been widely used in empathy research (Zhou et al., 2003), the IRI has a unique strength. Specifically, the IRI resolved a major problem with Mehrabian and Epstein's QMEE that tapped various aspects of empathy-related responding such as sympathy, susceptibility to emotional arousal, perspective taking, and personal distress because the IRI contained separate subscales designed to differentiate among these aspects. Also, in comparison to Carkhuff's EUS, which

measured only the cognitive aspect of empathy, the IRI considered both emotional and cognitive aspects of empathy. Indeed, the IRI has been recognized as the most widely researched and comprehensive multidimensional assessment of empathy available (Cliffordson, 2001).

The IRI is a 28-item measure consisting of four 7-item subscales (Perspective Taking, Empathic Concern, Fantasy, Personal Distress), each measuring different underlying constructs of empathy. Korean counselors rated each item on a 5-point Likert scale ranging from 0 (*does not describe me well*) to 4 (*describes me very well*), and subscale scores were obtained by summing item responses. Subscale scores range from 0 to 28, and higher scores suggest greater levels of empathy.

The Perspective Taking (PT) subscale assesses the inclination to adopt the point of view of others. Davis (1980) explained that this subscale would clearly tap the cognitive aspect of empathy. An example of an item is, "I sometimes try to understand my friends better by imagining how things look from their perspective." The Empathic Concern (EC) subscale taps the tendency to have feelings of warmth, compassion, and concern for others. According to Davis (1980), the EC subscale was clearly a measure of the affective aspect of empathy in contrast to the PT subscale. An example of an item from this subscale is, "I often have tender, concerned feelings for people less fortunate than me." The Fantasy Scale (FS) is a measure of the extent to which an individual related to the psychological or emotional experience of characters in books, movies, and plays. A sample item is, "I really get involved with the feelings of the characteristics in a novel." Finally, the Personal Distress (PD) subscale measures personal distress or unease in reaction to the emotions of another individual. This is a more self-centered reaction than that characterized by the EC subscale. A sample item is, "Being in an intense emotional situation scares me."

Davis (1980) suggested the EC and PT subscales reflected the most advanced levels of empathy. In addition, a review of subscale items indicated that the EC and PT

subscales corresponded more directly with conceptual definitions of empathy (Bohort et al., 2002; Ridley & Lingle, 1996), whereas the FS and PD subscales did not correspond with recognized conceptualizations of empathy (Constantine, 2000; Hayes & Erkis, 2000; Pulos, Elison, & Lennon, 2004). Thus, paralleling this line of past research, the EC and PT subscales were the only subscales used for this study.

The internal reliability measures of the EC and PT subscales have been consistently reported as acceptable in a number of research studies (e.g., Britton & Fuendeling, 2005; Burkard & Knox, 2004; Constantine, 2000; Davis, 1980; Davis, Frazier & Kaler, 2006; Pulos et al., 2004). For example, Pulos et al. reported a coefficient alpha of .80 for the EC subscale and .79 for the PT subscale. Test-retest reliabilities were reported as .62 and .71 over a 2-month period (Davis, 1980) and .50 and .62 over a 2-year period, for EC and PT, respectively (Davis & Franzoi, 1991). Also, the construct validity of the EC and PT subscales has been demonstrated in a number of settings with a variety of populations, including undergraduate students (Beitel, Ferrer, & Cecero, 2004; Joireman, Needham, & Cummings, 2002; Joireman, Parrott, & Hammersla, 2002), medical personnel (Bellini & Shea, 2005; Galantino, Baime, Maguire, Szapary, & Farrar, 2005; Shanafelt et al., 2005), and counselors (Constantine & Gainor, 2001; Hatcher et al., 2005).

The EC and PT subscales have been found to be related but largely independent. Davis (1980) reported that the EC subscale showed a strong correlation with the QMEE (Mehrabian & Epstein, 1972), which measured affective empathy, whereas the PT subscale was highly related to the Hogan Empathy Scale (Hogan, 1969), which measured cognitive empathy. In another study, Davis (1983b) reported that the EC subscale displayed a significant positive correlation with emotional reactions whereas the PT subscale was unrelated to them. Davis, Hull, Young, and Warren (1987) reported the EC and PT subscales were associated with clearly different patterns of affective response to the stimulus tapes.

A Korean version of the IRI was not available and any studies using the IRI could not be identified in the Korean counseling literature. As previously discussed, given that the EC and PT subscale scores were used for this study, only these two subscales in the original IRI were translated into the Korean language through the back translation method (Brislin, 1986). Total scores were not obtained for this study because the EC and PT subscales have been reported to assess different aspects of empathy.

The Marlowe-Crowne Social Desirability Scale (MCSDS)

Social desirability bias is defined as "the inclination to respond in a way that will make the respondent look good" (Beretvas, Meyers, & Leite, 2002, p. 1). This bias in responding to items on psychological questionnaires has been an area of concern for survey researchers for a long time (Paulhus, 1991). Because positive statements are predominant in the 5F-Wel instrument previously described, it is highly probable that counselors' responses in this scale would be confounded by their need to appear socially desirable. Thus, the researcher chose to use the MCSDS (Crowne & Marlowe, 1960) to detect Korean counselors' social desirability bias in responding to the other instruments included in the survey for counselors.

The MCSDS (Crowne & Marlowe, 1960) consists of 33 forced-choice, true-false statements, 18 keyed true and 15 false. The 18 keyed true items describe socially desirable but uncommon behaviors whereas the 15 keyed false items represent socially undesirable but common behaviors. The selection of "true" response for the 18 true items was assigned one point. Conversely, a "false" response for the 15 false items was scored as one point. An example of the true items is, "I have never intensely disliked anyone." A sample statement of the false items is, "I like to gossip at times." All items were dichotomously scored, and a Korean counselor's score was yielded by summing all points earned in 33 items. Higher scores indicate a strong tendency to respond to the survey in a socially desirable manner.

Since its development, the MCSDS has been the most frequently used instrument to assess social desirability bias. Primarily, it has been used to provide evidence supporting the responses in the focal instruments (Beretvas et al., 2002). Testing with college students, Crowne and Marlowe (1960) reported the internal consistency estimate of .88 and a test-retest correlation of .89, based on the scores of participants who took the test 1 month later. They conceptualized the socially desirable responses as representing a personality trait, that is, the individual's habitual response style that is aroused in situations of self-evaluation.

This study used the Korean version of the MCSDS that was translated by Seol (2007). He used the back translation method and reported high convergence between the original and the translated versions. In the study of 248 undergraduate and 134 graduate students in Korea, he provided evidence of the MCSDS's unidimensionality.

Demographic Questionnaire for Counselors (DQ-CO)

The DQ-CO was administered to the Korean counselors for the purposes of (a) describing demographic configurations of the counselors of the study, (b) conducting the preliminary data analysis, and (c) judging the generalizability of the results of the study. The DQ-CO addressed the questions regarding the Korean counselor's personal and professional background information, including age, gender, marital status, sexual orientation, work setting, position in the work setting, counseling-related education, and individual counseling experience. The counselor's real name was not asked to ensure anonymity.

Measures for Clients

Counselor Rating Form - Short (CRF-S)

The Counselor Rating Form - Short (Corrigan & Schmidt, 1983) was used to measure Korean clients' evaluation of their counselor's in-session behavior. This scale is composed of 12 adjectives that describe counselor behavior based on the perception of three dimensions of the counselor's behavior: (a) attractiveness, (b) expertness, and (c)

trustworthiness. Based on Strong's (1968) interpersonal influence model, these three dimensions are purported to have a significant effect on counselor effectiveness (Barak & LaCrosse, 1975). The clients were asked to rate items on a 7-point Likert scale ranging from 1 (*not very*) to 7 (*very)*. Scores for a global rating of satisfaction with the counselor's in-session behavior range from 12 to 84. Mean scores were derived for the global scale, with higher scores indicating more positive impressions of the counselor's in-session behavior.

The global satisfaction score in the CRF-S was viewed as a unitary, positive evaluation factor of the counselor's effectiveness in session (Lawson & Brossart, 2003; Heppner et al., 1999). Also, factor-analytic studies largely have revealed that the three subscales (attractiveness, expertness, and trustworthiness) were too highly correlated with each other and supported a single-factor solution for the CRF-S (Corrigan & Schmidt, 1983; Kokotovic & Tracey, 1987; Tracey, Glidden, & Kokotovic, 1988). Thus, the global satisfaction score was used for this study. The global measure of CRF-S has consistently evidenced high levels of the internal consistency estimates through a great number of studies in counseling literature (e.g., Corrigan & Schmidt, 1983; Lawson & Brossart; Tracey et al.). For instance, Tracey et al. found the internal consistency estimate on the global satisfaction scale of .94 for an American client sample.

The original version of the CRF (Barak & LaCrosse, 1975) consisting of 40 items has been translated and widely used in counseling studies in Korea (e.g., Cho & Lee, 2003; Kim, 1988; Lee, 1990; Song & Ko, 2001). These studies also found the CRF to be a highly reliable scale with clinical and non-clinical samples in Korea. For instance, Cho and Lee reported the internal consistency estimate of the global satisfaction factor as .97. The CRF-S, a short version of the original CRF, has not been used in counseling related studies in Korea. However, because the 12 adjective items in the CRF-S were selected from the original CRF (Corrigan & Schmidt, 1983), the researcher selected and used

those items that comprise the CRF-S out of the 40 items of the original CRF translated by Kim (1988).

Session Evaluation Questionnaire (SEQ)

The Session Evaluation Questionnaire (Stiles & Snow, 1984) was used to measure Korean clients' perception of the session impact. This scale includes twenty-four 7-point bipolar adjective scales, divided into two sections of 12 items for each. The first section is designed to assess clients' session evaluation and consists of two subscales: Depth and Smoothness. The second section is intended to assess clients' post-session mood and is comprised of two subscales: Positivity and Arousal. The clients were instructed to circle the appropriate number to show how they felt about the counseling session. Mean scores were yielded for each of four subscales, with higher scores indicating more positive evaluation of the session impact.

Depth was measured as the average rating on the scales "valuable–worthless,", "deep–shallow", "full–empty", "powerful–weak", and "special–ordinary." Smoothness was measured as the average rating on the scales "easy–difficult", "relaxed–tense", "pleasant–unpleasant", "smooth–rough", and "comfortable–uncomfortable." Positivity was measured as the average rating on the scales "happy–sad", "pleased–angry", "definite–uncertain", "confident–afraid", and "friendly–unfriendly." Arousal was measured as the average rating on the scales "moving–still", "excited–calm", "fast–slow", "energetic–peaceful", and "aroused–quiet."

The SEQ's four subscales have evidenced sound reliability and validity. In a study with the sample of 117 American clients, Reynolds et al. (1996) reported the internal consistency estimates for Depth, Smoothness, Positivity, and Arousal of .90, .93, .90, and .81, respectively. Also, previous factor-analytic studies (e.g., Reynolds et al.; Stiles & Snow, 1984; Stiles et al., 1994) have demonstrated sound construct validity of each subscale, showing statistically significant associations with other similar measures.

Choi (1987) translated the SEQ into Korean and factor-analyzed the items based on 26 Korean clients' ratings for 64 counseling sessions. In this study, all four subscales were found to be appropriate factors in clients' ratings on the questionnaire. Choi reported that the internal consistency estimates for four subscales ranged from .90 to .95. In this study, the researcher used the Korean version of the SEQ that was translated by Choi. Only four subscale scores were used for data analysis in this study because the original scale (Stiles & Snow, 1984) did not intend to score the sum of all items.

Working Alliance Inventory – Client Form (WAI-C)

The Working Alliance Inventory – Client Form (Horvath & Greenberg, 1986) was used to measure Korean clients' perception of the working alliance in this study. This measure consists of 36 questions and included three subscales: (a) emotional bonds, (b) tasks, and (c) goals, each of which was based on Bordin's (1979) theoretical concept of the working relationship between counselor and client. Each subscale is scored on a 7-point Likert scale ranging from 1 (*never*) to 7 (*always*) and has 12 non-overlapping items. Subscale scores range from 12 to 84 and total scores range from 36 to 252. Higher scores reflect more positive and stronger ratings of the working alliance.

Based on initial validation samples of 29 and 25 American clients, Horvath and Greenberg (1986) reported that the internal consistency estimates of the three subscales ranged from .85 to .92 and those of the total scores were .93. The recent study conducted by Hanson, Curry, and Bandalos (2002) supported the high reliability of the WAI-C, reporting that internal consistency estimates of the three subscale scores ranged from .77 to .97 and those of the total scores ranged from .83 to .97. Validity also has been established through significant correlations between WAI ratings and counseling outcome (Horvath & Greenberg; Horvath & Symonds, 1991), client characteristics (Kokotovic & Tracey, 1990), and counselor technical activity (Kivlighan, 1990).

Despite high reliability estimates of the three subscales of the WAI-C reported in previous research, some recently conducted studies (Hatcher & Barends, 1996; Salvio,

Beutler, Wood, & Engle, 1992) found the high overlap among the three subscale scores and concluded that a single general alliance factor (the overall alliance score) accounted for most of the explainable variance in alliance scores. Thus, for the purposes of this study, the subscales scores (emotional bonds, tasks, and goals) were combined to calculate a total working alliance score. The total score on the WAI-C represents an client's overall rating of the working alliance.

Jun (2000) found the WAI-C had been translated into Korean and widely used in a number of counseling research studies in Korea. In this study, the researcher used the WAI-C translated by Kang (1995), who reported the internal consistency estimate for the total scores of .92. By using the same translated version of the WAI-C, Koo (1999) reported that the internal consistency estimate of the total scores was .94.

Demographic Questionnaire for Clients (DQ-CL)

The DQ-CL was administered to collect the Korean clients' personal and counseling-related information, including age, gender, sexual orientation, martial status, educational levels, payment of counseling fee, and prior counseling experience. This information was used to describe demographic configurations of the clients participating in this study. In this questionnaire, any identifying information about the client was not collected to ensure anonymity.

Design and Analysis

According to Heppner et al. (1999), this study can be categorized as a *descriptive field study* because the study was characterized by the use of real counselor and client samples and no randomization or manipulation of variables. Because this study was conducted in real counseling settings, not in a laboratory, high external validity was expected. To ensure truly high external validity, it was important that the data-gathering procedures should not have sufficient impact on both counselors and clients to disrupt their normal set of actions in counseling sessions. However, no randomization or manipulation of variables might have resulted in low internal validity.

As indicated earlier, all the instruments used in this study were originally developed in the United States and then translated into the Korean language. Thus, the reliability coefficient for each scale in the current sample was examined to check its cultural validity. On the basis of the results of reliability estimates, only scales and subscales that demonstrated adequate internal consistency (>.60) were used in data analysis. In addition, skewness and kurtosis for each variable were examined to detect any substantial deviation from normality.

Descriptive statistics were used to present the demographic configurations of Korean counselors and clients who participated in this study. Also, a series of t-tests were conducted to compare the means of the current sample with that of the American norm and the American counseling student sample reported in prior research. This comparison provided a cross-cultural understanding of the levels of personal wellness of Korean counselors.

Preliminary analyses using bivariate correlations, t-tests, and one-way ANOVAs allowed the researcher to examine any significant differences on the independent and the dependent variables based on the demographic variables of counselors and clients. The demographic variable, which was found to cause a significant difference in either the independent or the dependent variables, was included as a control variable in subsequent multiple regression analyses to eliminate its effects on the relationship between the independent variable and the dependent variable.

To determine the relationship between counselor wellness and client-perceived counseling effectiveness as indicated in Research Question 1, the bivariate correlations were calculated and a series of multiple regression analyses were carried out. Although the bivariate correlation indicated no significant relationship between two variables, a hierarchical multiple regression predicting the dependent variable was carried out to see if the insignificant result remained unchanged even after partialing out the effects of control variables (counselor age and social desirability in this study). This was

necessary because suppression effects of the control variables might mask the true relationship between counselor wellness and client-perceived counseling effectiveness.

Among several different types of multiple regression methods, hierarchical multiple regression has been recognized as the preferred statistical method when moderating effects were tested (Frazier, Tix, & Barron, 2004). Thus, this method was chosen to examine the moderating effects of Korean counselors' empathy on the relationship between their personal wellness and clients' perceptions of counseling effectiveness as stated in Research Question 2. Specifically, the amount of incremental variance explained by the interaction above and beyond the main effects was examined to determine if the interaction term was significant. Statistically significant interaction effects would support the moderating effects of empathy.

Given that this study was designed to examine the effects of multiple predictor variables, including control variables, the independent variable, and the moderator, on each of dependent (or criterion) variables, multiple regression was an appropriate statistical method for analyzing the data from this study (Petrocelli, 2003). Also, traditionally, multiple regression was originally developed for the analysis of nonexperimental observational and survey data whereas the analysis of variance (ANOVA) method was developed for the analysis of experimental data (Aiken & West, 1991). Given that the analysis of variance requires categorization of variables, this study addressing the majority of continuous variables might be susceptible to the problems associated with the ANOVA strategy such as loss of information and a new source of measurement error if it was used instead of multiple regression.

Summary

Chapter III presented an overview of the research design, measurements, and methods that structured this study. Translation procedures for the Korean version of the IRI were also described. In addition, this chapter provided a description of the potential research participants, instruments used and their reliability and validity information

reported by previous research, and the statistical analyses that were used to answer the research questions.

CHAPTER IV

RESULTS

To report the findings of the research questions, this chapter contains the results of the data analyses in four sections: (a) reliability of the measures, (b) descriptive data for Korean counselors' wellness, (c) preliminary analyses, (d) the relation of Korean counselors' wellness to client-perceived counseling effectiveness, and (e) moderating effects of Korean counselors' empathic ability in the relationship between their personal wellness and client-perceived counseling effectiveness. Descriptive statistics on counselor wellness are provided to give an overview of Korean counselors' average wellness scores in comparison with those of the American samples. The results of preliminary analyses are mainly used to select covariates that may affect the relationships between counselor wellness and counseling effectiveness variables, thus being controlled in subsequent multiple regression analyses. The remaining two sections present the results to answer the two research questions.

Reliability of the Measures

The internal consistency reliability for all the scales used in this study was estimated using Cronbach's alpha. Most of the scales were found to be sufficiently reliable for the current sample, achieving an acceptable level of reliability (>.60; DeVellis, 1991). The results of the reliability coefficients are presented in Table 5.

The internal consistency estimates of the 5F-Wel (Myers & Sweeney, 2004) were .91 for Total Wellness, .85 for the Creative Self, .76 for the Coping Self, .85 for the Social Self, .77 for the Essential Self, and .62 for the Physical Self, indicating acceptable reliability. However, the alphas for the current sample were not as high as those of the U.S. norm reported by Myers and Sweeney (2005b), all of which were more than .85. With regard to the Interpersonal Reactivity Index (IRS; Davis, 1980, 1983a), the current study yielded the coefficient alphas of .42 and .72 for the Empathic Concern (EC) and the Perspective Taking (PT) subscale, respectively. Emotional empathy as measured by the

EC subscale was excluded in subsequent analyses due to its low internal consistency, and thus, only the PT subscale was used for data analysis to represent a Korean counselor's empathic ability. Using the current sample of Korean counselors, the Marlowe-Crowne Social Desirability Scale (MCSDS; Crowne & Marlowe, 1960) yielded a coefficient of .82, indicating high reliability.

In regard to the client measures, all scales demonstrated an acceptable level of internal consistency. In this study, the alpha coefficients for both the Counselor Rating Form - Short (CRF-S; Corrigan & Schmidt, 1983) and the Working Alliance Inventory-Client Form (WAI-C; Horvath & Greenberg, 1986) were found to be very high, yielding .94 and .95, respectively. As for the Session Evaluation Questionnaire (SEQ; Stiles & Snow, 1984), the internal consistency estimates calculated from the current sample of Korean clients were .80 for the Depth, .84 for the Smoothness, .85 for the Positivity, and .70 for the Arousal subscales.

Descriptive Data for Korean Counselors' Personal Wellness

Given that comparable data was not available regarding Korean counselors' personal wellness in the literature, the mean scores of the current sample were compared through two independent sample *t*-test with those of the American norm, which was published in the 5F-Wel's manual (Myers & Sweeney, 2004). Given that the two samples were derived from different populations, the t-test for two independent samples was chosen. As shown in Table 3, substantial differences in the standard deviations between the two groups indicated that the American norm was more heterogenous than the current sample. This makes sense because the former consisted of a wide range of people in terms of occupations whereas the latter comprised people in the counseling profession only. In addition, the sample size of the American norm was much larger than the Korean sample in this study. Thus, tests were carried out to determine if the variances of the two samples were significantly different. The results of these tests indicated the heterogeneity of the variances in all wellness measures, requiring corrections to degree of freedom for

each t-test. Consequently, based on the modified degree of freedom, the *t*-value for each comparison was calculated.

As presented in Table 3, the mean differences on all wellness scales reached statistical significance, indicating that the average wellness scores of this study's sample was significantly lower than those of the American norm. These results demonstrated that the Korean counselors felt less well than average American people in their overall personal lives and in all life domains.

Table 3. Comparisons of Mean Differences on Personal Wellness Measures between the Current Sample (N = 133) and the American Norm (N =1,899)

	Current Sample		American Norm		
	M	SD	M	SD	*t* (df)
Total Wellness	74.16	5.27	76.22	12.51	3.82(254.00)*
Creative	75.30	6.52	77.80	12.99	3.91(214.44)*
Coping	70.98	5.65	72.36	10.63	2.52(204.67)*
Social	81.34	9.43	84.06	17.82	2.98(205.39)*
Essential	76.57	8.45	78.90	16.15	2.84(207.24)*
Physical	68.27	8.00	70.98	17.00	3.41(227.12)*

Note. Given that the mean scores of the American norm were higher than those of the current sample, a one-tailed probability was used to determine the significance of the mean difference.

* $p < .01$.

Similarly, the group of master's-level counseling students selected from the current sample (n=29; 21.8%) reported lower levels of mean wellness scores overall and in all the five second-order factors when compared with the equivalent American group used by O'Brien (2007). The sample from O'Brien was chosen because it consisted of master's counseling students only, which was comparable to part of the current sample. The results of two independent sample *t*-tests comparing mean wellness scores for the

master's-level Korean counseling students as a subset of the present study's sample with those for the American counterparts in O'Brien's study are presented in Table 4.

Table 4. Means and Standard Deviations of Personal Wellness Measures for Master's-Level Counseling Students from the Current Sample (N = 29) and those from O'Brien's Study[a] (N =70)

	Current Sample (Master's Students Only)		O'Brien's Sample		
	M	SD	M	SD	t (df)
Total Wellness	73.74	5.62	83.65	8.22	6.91(75.55)*
Creative	75.83	7.00	85.39	9.52	5.53(70.54)*
Coping	70.28	6.17	78.63	9.35	5.22(77.98)*
Social	80.50	8.71	93.58	9.48	6.62(56.69)*
Essential	76.99	8.97	87.25	10.45	4.93(60.57)*
Physical	65.52	7.24	75.64	15.33	4.45(95.26)*

Note. Given that the mean scores of O'Brien's sample were higher than those of the subset of the current sample, a one-tailed probability was used to determine the significance of the mean difference.

[a] O'Brien, E. R. (2007). *The relationship between master's level counseling practicum students' wellness and client outcomes*. Unpublished doctoral dissertation. University of Central Florida.

* $p < .001$.

Preliminary Analyses

Means, standard deviations, skewness, and kurtosis for all independent and dependent variables in the study are presented in Table 5. Also, Pearson product-moment correlations among the major study variables were calculated and presented in Table 6. As can be seen in Table 6, the Arousal subscale was not related to either the other three subscales (Depth, Smoothness, and Positivity) in the SEQ or the other two counseling effectiveness variables (clients' satisfaction and perception of working alliance). It

appeared that the Arousal subscale did not represent the client's perception of counseling effectiveness. Thus, this subscale was not used as a dependent variable in subsequent analyses.

Table 5. Descriptive Statistics and Values of Coefficient Alpha for Scale Scores

Variable	Number of Items	M	SD	Skewness	Kurtosis	α
Counselor Variables						
Total wellness	73	74.16	5.27	.21	-.04	.91
Creative	20	75.30	6.52	.54	.71	.85
Coping	19	70.98	5.65	.17	1.14	.76
Social	8	81.34	9.43	.10	.03	.85
Essential	16	76.57	8.45	-.13	-.43	.77
Physical	10	68.27	8.00	.30	-.02	.62
Emotional empathy	7	3.83	.39	.05	-.28	.42
Cognitive empathy	7	3.59	.50	-.20	-.47	.71
Social desirability	33	13.71	5.85	-.17	-.69	.82
Client Variables						
Client-perceived counseling effectiveness						
Satisfaction	12	5.82	.82	-.69	.30	.94
Session impact						
Session depth	5	5.12	1.02	-.44	.84	.80
Session smoothness	5	5.21	1.12	-.21	-.95	.84
Post-session positivity	5	4.92	1.03	.02	-.63	.85
Arousal	5	3.52	1.03	.36	-.18	.70
Working alliance	36	5.65	.67	-.21	-.53	.95

Note. The means and standard deviations presented were derived from the nonstandardized variables.

Table 6. Pearson Correlations among Study Variables

Variable	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
1. Total Wellness	–	.													
2. Creative Self	.81***	–													
3. Coping Self	.72***	.57***	–												
4. Social Self	.77***	.63***	.48**	–											
5. Essential Self	.74***	.40***	.29***	.46***	–										
6. Physical Self	.55***	.25**	.23**	.33***	.37***	–									
7. Cognitive empathy	.37***	.33***	.18*	.41***	.25**	.17	–								
8. Counselor age	-.14	-.20*	-.09	-.16	-.06	.01	-.07	–							
9. Social desirability	.25**	.22**	.13	.20*	.25**	.04	.19*	-.08	–						
10. Client satisfaction	-.11	-.06	-.13	-.09	-.10	-.03	-.01	.23**	-.00	–					
11. Session depth	-.14	-.10	-.05	-.11	-.12	-.12	-.03	.12	-.13	.61***	–				
12. Session smoothness	-.06	-.14	-.10	-.08	.07	.04	-.14	.09	-.06	.54***	.39***	–			
13. Positivity	-.15	-.15	-.10	-.13	-.08	-.09	-.05	.15	-.10	.53***	.60***	.65***	–		
14. Arousal	-.09	-.04	-.04	-.07	-.06	-.16	-.07	.12	.09	-.08	-.01	.03	.08	–	
15. Working alliance	-.13	-.06	-.09	-.06	-.14	-.13	.06	.12	-.03	.80***	.66***	.52***	.60***	-.10	–

Note. $N = 133$. The correlation coefficients presented were derived from the nonstandardized variables.

$^{*}p < .05$. $^{**}p < .01$. $^{***}p < .001$

The results of the correlations were also used to determine possible control variables used in subsequent multiple regression analyses. The relationships between the three independent variables (i.e., wellness variables, cognitive empathy, and social desirability) and each of the counselor demographic variables were first examined. As shown in Table 6, Korean counselors' social desirability scores were positively related to their cognitive empathy ($r = .19$, $p < .05$), Total Wellness ($r = .25$, $p < .01$), Creative Self ($r = .22$, $p < .01$), Essential Self ($r = .25$, $p < .01$), and Social Self scores ($r = .20$, $p < .05$). In addition, it was found that counselor age was negatively associated with the Creative Self scores ($r = -.20$, $p < .05$), indicating younger counselors reported themselves as more well in the domain of the Creative Self, which represents the characteristic of making oneself a unique being in social interactions. No significant relationships were observed between either Total Wellness or any of the five second-order factors versus individual counseling experience. Also, a series of *t*-tests and one-way analyses of variance (ANOVA) were conducted to examine the mean differences across types and locations of the work setting, marital status, sexual orientation, position status at the work setting, and levels of counseling-related education, all of which were categorical variables. A test-wise alpha value based on the Bonferroni correction (Hays, 1994) was adopted to control for conducting a set of multiple *t*-tests. Results revealed that there were no significant differences on counselor wellness (i.e., Total Wellness and five second-order factors), cognitive empathy, and social desirability according to these counselor demographic variables (see Appendix D for details).

Additional analyses were conducted to determine if there were significant differences in the dependent variables in terms of counselor demographic indicators. Given that counselor age, individual counseling experience, and the number of sessions completed with the client were measured by continuous variables, bivariate correlations between each of these variables and the dependent variables were examined. Only the counselor's age was found to be significantly related to clients' satisfaction ($r = .23$, p

< .01). Also, a series of *t*-tests and one-way analyses of variance (ANOVA) were performed to detect the mean differences across types and locations of the work setting, marital status, sexual orientation, position status at the work setting, and levels of counseling-related education. However, results indicated that there were no significant differences on the dependent variables according to these demographic variables (see Appendix D for details).

Similarly, either bivariate correlations or t-tests were conducted to examine differences in the dependent variables (client-perceived counseling effectiveness variables) according to client demographics. Results indicated that significant differences on counseling effectiveness measures did not exist in relation to client gender, age, marital status, sexual orientation, education levels, and prior counseling experience (see Appendix D for details). However, one-way ANOVAs could not be performed for clients' sexual orientation because sample sizes of subgroups were too small (<10) for valid mean comparisons as can be seen in Table 2. For the same reason, t-tests could not be carried out according to whether or not a client paid for counseling services. Finally, no ordering effects were observed in either counselor or client survey sets.

As a result of preliminary analyses, counselor age and social desirability were found to correlate significantly with some of the study variables. Even though these two variables did not account for a significant portion of unique variance in all dependent variables, they were still controlled across all regression analyses to keep consistency. For instance, even though counselor age had no significant relationship with client-perceived working alliance, it was used as a control variable in hierarchical regression analyses involving the working alliance as a dependent variable. Further, counselors' social desirability was significantly related not to any of the dependent variables but to some of the independent ones, yet it was included as a control variable in all regression analyses because of potential possibility of its suppression effect in the relationships between the independent and dependent variables. In conclusion, counselor age and

social desirability were simultaneously entered at the first step in all subsequent hierarchical multiple regression models.

Hierarchical multiple regression analyses, which will be summarized in the following sections, involved the six independent variables on each of the five dependent variables while controlling for the effects of counselor age and social desirability. The independent variables included Total Wellness and the five second-order factors: (a) Creative Self, (b) Coping Self, (c) Essential Self, (d) Social Self, and (e) Physical Self. The dependent variables were (a) client's satisfaction, (b) session depth, (c) session smoothness, (d) post-session positivity, and (e) working alliance, all of which represented client's perceptions of counseling effectiveness.

Regression Diagnostics

It was examined whether the data met regression assumptions of normality, linearity, and homoscedasticity (Cohen, Cohen, West, & Aiken, 2003). For each hierarchical regression analysis, the distribution of the ordinary and the standardized residuals was inspected to detect substantial departures from normality for the model. Also, the scatterplot of the standardized residuals against the standardized predicted values of each dependent variable based on the model was examined for evidence of substantial heteroscedasticity and nonlinearity, and for outliers. These diagnostic inspections indicated that there was no violation of the assumptions of normality, linearity, and residual homoscedasticity. Also, no extreme outlying values were observed.

Relation of Personal Wellness to Counseling Effectiveness

Research Question 1 was: What is the relation of Korean counselors' personal wellness to their clients' perceptions of counseling effectiveness in terms of satisfaction with the counselor's in-session behavior, evaluation of the session impact, and perception of the working alliance? Evaluation of the session impact was measured by the three subscales of the SEQ: (a) Depth, (b) Smoothness, and (c) Positivity. As presented in Table 6, the bivariate correlations indicated that Korean counselors' Total Wellness

scores were not significantly correlated with any indicators of counseling effectiveness rated by the client (*r*s ranged from -.09 to -.15, *ns)*. To examine if Total Wellness does not contribute significant variance to counseling effectiveness variables even when the effects of counselor age and social desirability are held constant, both counselor social desirability and age were entered as a set of control variables in the first step and then Total Wellness in the second step in a regression equation that predicts each of the dependent variables. Consistent with correlation results, however, Total Wellness did not increase the amount of variance explained in any dependent variable above and beyond the effects of counselor age and social desirability ($\Delta R^2 = .008$, $F(1, 129) = 1.09$, *ns*). The contribution of counselor age was significant for clients' satisfaction even after controlling for the effects of social desirability ($\beta = .22$, $p < .05$).

Second, the bivariate correlations among the five second-order wellness factors and client-perceived counseling effectiveness variables were examined. As shown in Table 6, all of these five factors were not significantly related to each of the client-perceived counseling effectiveness variables (*r*s ranged from -.06 to -.14, *ns*). Also, a series of hierarchical regression analyses were conducted to examine whether the contribution of each of the five second-order wellness factors to variance in each of the dependent variables of client-perceived counseling effectiveness variables would remain insignificant while controlling for counselor age and social desirability scores. In a separate analysis, counselor age and social desirability were included as control variables in the first step and each second-order wellness factor was entered in the second step. Results indicated that each second-order factor did not add a significant incremental change in variance of each client-perceived counseling effectiveness variable. However, counselor age remained a significant predictor for the dependent measure of clients' satisfaction with counselors' in-session behavior even when the effects of social desirability were partialed out ($\beta = .22$, $p < .05$). In conclusion, there was no significant

relationship between personal wellness and client-perceived counseling effectiveness among Korean counselors.

Moderating Effects of Counselor Empathy

Research Question 2 was: Does the relation of Korean counselors' personal wellness to their clients' perceptions of counseling effectiveness vary as a function of their empathic ability? A series of hierarchical multiple regression analyses were conducted to examine the moderating effect of Korean counselors' cognitive empathy on the relationship between counselor wellness and each of the seven dependent variables while controlling for the effects of counselors' age and social desirability tendency. As recommended by Aiken and West (1991) and Frazier et al. (2004), the predictors and moderator variable were standardized in an attempt to reduce multicollinearity between the main effects and the interaction term. In addition, for each hierarchical multiple analysis, tolerance was checked to measure the proportion of variance that the independent variable did not have in common with other independent variables. Results indicated that the variable's tolerance value for each model was acceptable, that is, more than 0.90 (Myers, 1990).

In each analysis, a two-way interaction term was created by multiplying the standardized values of the predictor and the moderator. In a separate analysis predicting each dependent variable, counselor age and social desirability were entered as a set of control variables in the first step, and the counselor wellness variable and cognitive empathy were entered in the second step. Finally, the corresponding product-term variable (i.e. each of counselor wellness variables × cognitive empathy) was added in the third step to evaluate whether the interaction made the significant incremental change in R^2 above and beyond that explained by the first two steps. The use of a more liberal criterion in non-experimental research when testing the significance of interaction effects was recommended because it is hard to detect interaction effects, and the contribution of interaction effects over and above the main effects is typically small (Frazier et al., 2004;

Pedhazur & Schmelkin, 1991; Wampold & Freund, 1987). Therefore, no correction was made to alpha even though multiple analyses were conducted. Instead, the criterion of the alpha level of .05 was used to evaluate the significance level of the interaction effects.

For each significant interaction determined from the hierarchical multiple regression, the regression lines were plotted using predicted values for the dependent variable derived from representative groups at one standard deviation above the mean and one standard deviation below the mean on the independent variable (i.e., Total Wellness, each of the five second-order wellness factors) and the moderator term (i.e., cognitive empathy). Following procedures recommended by Frazier et al. (2004), these predicted values were obtained by multiplying the unstandardized regression coefficients for each regression variable by appropriate value (i.e., -1 and 1 for standardized variables), summing the products, and then adding the constant value. In addition, for each regression line, an analysis of the simple slopes (Aiken & West, 1991) was conducted to test whether the regression of the dependent variable on the independent variable in the low and high conditions of cognitive empathy was significantly different from zero.

Total Wellness and Cognitive Empathy

Results indicated that the interaction term between Korean counselors' cognitive empathy and Total Wellness was not statistically significant for client-perceived session depth, $\Delta R^2 = .006$, $F(1, 128) = .74$, *ns*; post-session positivity, $\Delta R^2 = .001$, $F(1, 128) = .16$, *ns*; client satisfaction, $\Delta R^2 = .002$, $F(1, 128) = .25$, *ns*; and working alliance, $\Delta R^2 = .001$, $F(1, 128) = .07$, *ns*. However, the interaction was statistically significant for client-perceived session smoothness, $\Delta R^2 = .034$, $F(1, 128) = 4.80$, $p < .05$ (see Table 7). To illustrate this, the regression lines were plotted using predicted values for client-perceived session smoothness derived from representative groups at one standard deviation above the mean and one standard deviation below the mean on Total Wellness and the moderator term, that is, cognitive empathy.

In addition, for each regression line shown in Figure 2, an analysis of the simple slopes (Aiken & West, 1991) was conducted to test whether the regression of session smoothness on Total Wellness at low and high levels of cognitive empathy was significantly different from zero. As presented in Table 11, the simple slope analysis indicated that the relationship between counselors' Total Wellness and client-perceived session smoothness was not significant at high and low levels of counselor cognitive empathy, b = - 0.19, t = - 1.43, *ns* and b = 0.18, t = 1.31, *ns*, respectively. In other words, the slopes were different as indicated by a significant interaction, but each slope was not steep enough to be significantly different from zero.

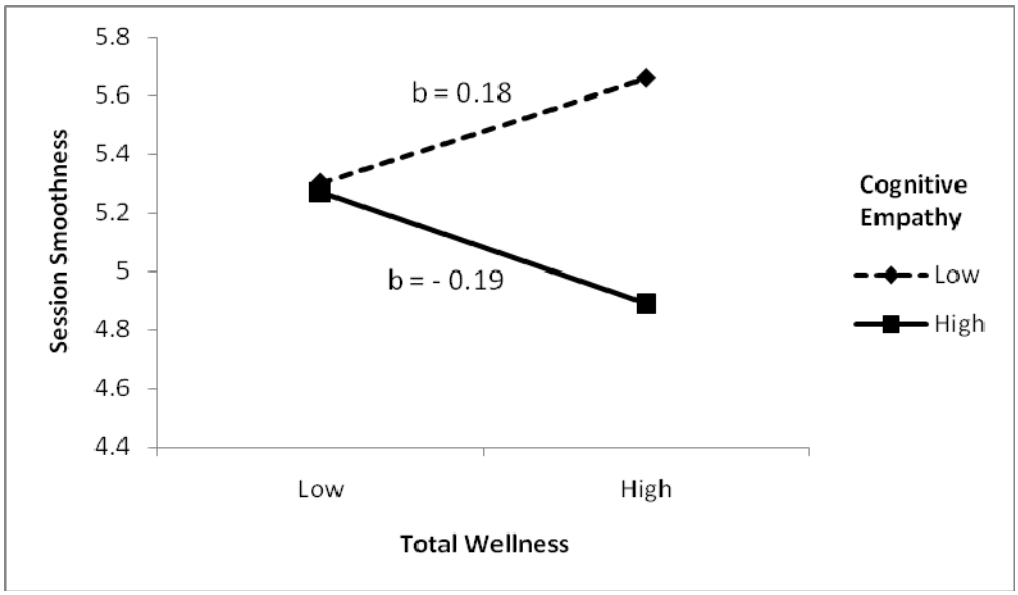

Figure 2. Relationship of Total Wellness with Client-Perceived Session Smoothness at High and Low Levels of Cognitive Empathy

Note. Regression slopes at low level of cognitive empathy (one standard deviation below the mean) and high level of cognitive empathy (one standard deviation above the mean).

Table 7. A Hierarchical Multiple Regression Analysis Predicting Client-Perceived Session Smoothness from Total Wellness, Cognitive Empathy, and Their Interaction (N = 133)

	Session smoothness [a]			
Predictor Variable	r	Part r	β	Δ R^2
Step 1:				.011
Counselor age	.09	.08	.08	
Social desirability	-.06	-.06	-.06	
Step 2:				.015
Counselor age	.09	.08	.08	
Social desirability	-.06	-.03	-.03	
Total Wellness	-.06	.01	.01	
Cognitive empathy	-.14	-.12	-.13	
Step 3:				.034*
Counselor age	.09	.06	.07	
Social desirability	-.06	-.05	-.05	
Total Wellness	-.06	.01	.01	
Cognitive empathy	-.14	-.16	-.17	
Total Wellness × Cognitive empathy	-.15	-.18	-.19*	

Note. N = 133.

[a] R^2 = .06

* p < .05.

Creative Self and Cognitive Empathy

In the third step of each analysis in which the product terms of Creative Wellness and cognitive empathy were entered, results indicated that the two-way interaction did not add significant increments in the explained variance of the most dependent variables beyond the main effects of session depth, Δ R^2 = .000, F(1, 128) = .03, *ns*; post-session positivity, Δ R^2 = .007, F(1, 128) = .89, *ns*; overall satisfaction, Δ R^2 = .007, F(1, 128) = .89, *ns*; and working alliance, Δ R^2 = .004, F(1, 128) = .51, *ns*. However, the interaction

significantly predicted the session smoothness, $\Delta R^2 = .053$, $F(1, 128) = 4.80$, $p < .05$ (see Table 8). To further explore the nature of the interaction between counselor cognitive empathy and Creative Self, the relation between the predictor variable (Creative Self) and the dependent variable (session smoothness) was plotted when levels of the moderator (cognitive empathy) was one standard deviation below and one standard deviation above the mean for that variable (see Figure 3).

Table 8. A Hierarchical Multiple Regression Analysis Predicting Client-Perceived Session Smoothness from Creative Self, Cognitive Empathy, and Their Interaction ($N = 133$)

	Session smoothness [a]			
Predictor Variable	r	Part r	β	ΔR^2
Step 1:				.011
Counselor age	.09	.08	.08	
Social desirability	-.06	-.06	-.06	
Step 2:				.022
Counselor age	.09	.06	.06	
Social desirability	-.06	-.02	-.02	
Creative Self	-.14	-.08	-.09	
Cognitive empathy	-.14	-.09	-.10	
Step 3:				.053*
Counselor age	.09	.05	.05	
Social desirability	-.06	-.05	-.05	
Creative Self	-.14	-.05	-.06	
Cognitive empathy	-.14	-.15	-.17	
Creative Self × Cognitive empathy	-.20*	-.23*	-.24*	

Note. $N = 133$.

[a] $R^2 = .09$

* $p < .05$.

Figure 3. Relationship of Creative Self with Client-Perceived Session Smoothness at High and Low Levels of Cognitive Empathy

Note. Regression slopes at low level of cognitive empathy (one standard deviation below the mean) and high level of cognitive empathy (one standard deviation above the mean).

* $p < .05$

The statistical significance of each of these two slopes was also tested (Aiken & West, 1991; Cohen, Cohen, West, & Aiken, 2003), which represents the simple effect of the predictor variable at two levels of the moderator variable (see Table 11). As illustrated in Figure 3, the result of a simple-effect analysis indicated that the negative relationship between Korean counselors' Creative Self and client-rated session smoothness was significant at a high level of counselors' cognitive empathy (b = - 0.34, t = - 2.64, $p < .01$). However, the association between counselors' Creative Self and client-perceived session smoothness was not statistically significant at a low level of counselors' cognitive empathy (b = 0.17, t = - 1.14, *ns*). These results indicated that Creative Self had a negative effect on clients' perception of session smoothness only for Korean counselors who had higher levels of cognitive empathy. In contrast, it mattered

little in the client's perception of session smoothness for counselors who had lower levels of cognitive empathy.

Coping Self and Cognitive Empathy

No interaction effects were significant for session depth, $\Delta R^2 = .010$, $F(1, 128) = 1.30$, *ns*; session smoothness, $\Delta R^2 = .001$, $F(1, 128) = .12$, *ns*; post-session positivity, $\Delta R^2 = .004$, $F(1, 128) = .49$, *ns*; or overall satisfaction, $\Delta R^2 = .001$, $F(1, 128) = .19$, *ns*. The interaction term was significant only for client-rated working alliance, $\Delta R^2 = .031$, $F(1, 128) = 3.76$, $p < .05$ (see Table 9), providing support for a moderated relationship. The plot of the Coping Self by cognitive empathy, as illustrated in Figure 4, indicated that Coping Self was significantly negatively related to client-rated working alliance for Korean counselors who had lower levels of cognitive empathy (b = - 0.20, t = - 2.23, $p < .01$), not for those who had higher levels of cognitive empathy (b = 0.01, t = 0.11, ns).

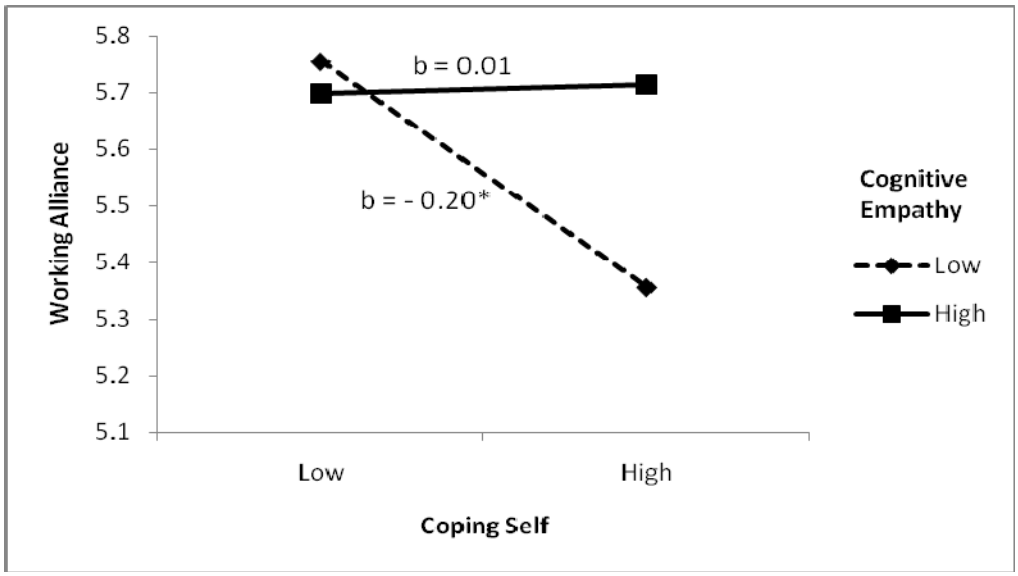

Figure 4. Relationship of Coping Self with Client-Perceived Working Alliance at High and Low Levels of Cognitive Empathy

Note. Regression slopes at low level of cognitive empathy (one standard deviation below the mean) and high level of cognitive empathy (one standard deviation above the mean).

* $p < .05$

Table 9. A Hierarchical Multiple Regression Analysis Predicting Client-Perceived Working Alliance from Coping Self, Cognitive Empathy, and Their Interaction *N* = 133)

	Working alliance [a]			
Predictor Variable	*r*	Part *r*	β	Δ R^2
Step 1:				.014
Counselor age	.12	.12	.12	
Social desirability	-.03	-.02	-.02	
Step 2:				.012
Counselor age	.12	.11	.11	
Social desirability	-.03	-.02	-.02	
Coping Self	-.09	-.09	-.09	
Cognitive empathy	.06	.08	.09	
Step 3:				.031*
Counselor age	.12	.13	.13	
Social desirability	-.03	-.00	-.00	
Coping Self	-.09	-.13	-.14	
Cognitive empathy	.06	.12	.12	
Coping Self × Cognitive empathy	.13	.18*	.19*	

Note. *N* = 133.

[a] $R^2 = .06$

* $p < .05$.

Essential Self and Cognitive Empathy

Results showed that the interaction terms were not statistically significant for most of the dependent variables: session depth, Δ $R^2 = .007$, $F(1, 128) = .93$, *ns*; post-session positivity, Δ $R^2 = .001$, $F(1, 128) = .15$, *ns*; overall satisfaction, Δ $R^2 = .001$, $F(1, 128) = .10$, *ns*; or working alliance, Δ $R^2 = .008$, $F(1, 128) = 1.09$, *ns*. Session smoothness was the only dependent variable for which the interaction effect was significant, Δ $R^2 = .039$, $F(1, 128) = 5.46$, $p < .05$. Table 10 summarizes the result of the hierarchical regression analysis.

As seen in Figure 5, the plot showed that Korean counselors who had relatively lower levels of cognitive empathy were likely to receive positive evaluation from their clients in terms of session smoothness as their level of Essential Self increases. In contrast, among those who had higher levels of cognitive empathy, the association between their client's perception of session smoothness and their Essential Self scores was not significant.

Table 10. A Hierarchical Multiple Regression Analysis Predicting Client-Perceived Session Smoothness from Essential Self, Cognitive Empathy, and Their Interaction (N = 133)

	Session smoothness [a]			
Predictor Variable	r	Part r	β	Δ R^2
Step 1:				.011
Counselor age	.09	.08	.08	
Social desirability	-.06	-.06	-.06	
Step 2:				.029
Counselor age	.09	.08	.08	
Social desirability	-.06	-.06	-.06	
Essential Self	.07	.12	.13	
Cognitive empathy	-.14	-.15	-.15	
Step 3:				.039*
Counselor age	.09	.08	.08	
Social desirability	-.06	-.05	-.06	
Essential Self	.07	.11	.12	
Cognitive empathy	-.14	-.18	-.19	
Essential Self × Cognitive empathy	-.17	-.20*	-.20*	

Note. N = 133.

[a] R^2 = .08

* $p < .05$.

Figure 5. Relationship of Essential Self with Client-Perceived Session Smoothness at High and Low Levels of Cognitive Empathy

Note. Regression slopes at low level of cognitive empathy (one standard deviation below the mean) and high level of cognitive empathy (one standard deviation above the mean).

* p < .05

Social Self and Cognitive Empathy

The Social Self by cognitive empathy interaction term did not account for a significant portion of additional variance in any of the dependent variables: session depth, $\Delta R^2 = .007$, $F(1, 128) = .96$, *ns*; session smoothness, $\Delta R^2 = .026$, $F(1, 128) = 3.53$, *ns*; post-session positivity, $\Delta R^2 = .000$, $F(1, 128) = .01$, *ns*; overall satisfaction, $\Delta R^2 = .000$, $F(1, 128) = .03$, *ns*; or working alliance, $\Delta R^2 = .000$, $F(1, 128) = .06$, *ns*.

Physical Self and Cognitive Empathy

The interaction term of Physical Self with Cognitive Empathy at the third step did not explain a significant incremental variance in all dependent variables: session depth, $\Delta R^2 = .000$, $F(1, 128) = .00$, *ns*; session smoothness, $\Delta R^2 = .010$, $F(1, 128) = 1.32$, *ns*;

post-session positivity, $\Delta R^2 = .004$, $F(1, 128) = .48$, *ns*; client satisfaction, $\Delta R^2 = .003$, $F(1, 128) = .42$, *ns*; or working alliance, $\Delta R^2 = .015$, $F(1, 128) = 1.98$, *ns*.

Table 11. Analysis of the Slopes of the Regression Lines Associated with the Significant Moderator Interactions ($N = 133$)

Variable	b	*t*
Dependent variable : Client-perceived session smoothness		
Total Wellness × Cognitive Empathy		
1*SD* below Mean	.18	1.31
1*SD* above Mean	-.19	-1.43
Creative Self × Cognitive Empathy		
1*SD* below Mean	.17	1.14
1*SD* above Mean	-.34	-2.64*
Essential Self × Cognitive Empathy		
1*SD* below Mean	-.10	-.72
1*SD* above Mean	.34	2.52*
Dependent variable : Client-perceived working alliance		
Coping Self × Cognitive Empathy		
1*SD* below Mean	-.20	-2.23*
1*SD* above Mean	.01	.11

Note. The results presented in this table represent the values associated with the regression slopes plotted for each significant moderator. 1*SD* below Mean = the low condition of the moderator when compared with zero; 1*SD* above Mean = the high condition of the moderator when compared with zero. For each analysis, $df = 129$ for *t*.

* $p < .05$.

Summary

The results of the mean comparisons with the American norm and previous studies' samples of master's-level counseling students indicated that Korean counselors in the current sample reported lower levels of personal wellness overall and in the major domains of their life. Also, bivariate correlation and multiple regression analyses

revealed that neither overall wellness nor five second-order wellness scores of Korean counselors had a significant influence on their clients' evaluation of counseling effectiveness in terms of satisfaction, session impact, and working alliance. As for the moderating role of counselor empathy, the results of hierarchical multiple regression analyses showed that Korean counselors' cognitive empathy moderated the effects of Creative Self and Essential Self on clients' perception of session smoothness and the effects of Coping Self on clients' ratings on working alliance. These findings, along with the implications for counseling education and the cautions which should be taken in interpretation, will be discussed in more detail in the following chapter.

CHAPTER V

DISCUSSION

Chapter V will provide a summary of the findings of this study with possible explanations. Further, this chapter will present the implications for counselor training and review limitations of the study. Finally, the chapter will conclude with suggestions for future studies.

Discussion of Findings

The purpose of this study was to examine the relationship between Korean counselors' personal wellness and their client's perceived counseling effectiveness. Another goal of the present study was to determine if counselors' empathic ability would moderate the relationship of counselor personal wellness with clients' perception of counseling effectiveness. In addition, the descriptions of Korean counselors' mean wellness scores in comparison with those of American samples in prior research were to provide baseline knowledge about the current status of Korean counselors' wellness levels.

Research participants were counselor-client dyads who had engaged in at least three sessions of face-to-face individual counseling in university counseling centers or youth counseling institutes located in Seoul and Gyeonggi Province, South Korea. Through the mail-out survey method, a total of 133 valid survey sets were collected from 25 university counseling centers and 5 youth counseling institutes. Counselor participants completed the survey instruments to assess the three major variables of interest: (a) personal wellness, (b) empathy, and (c) social desirability. Client participants responded to the survey designed to measure the three indicators of counseling effectiveness: (a) overall satisfaction, (b) session impact, and (c) working alliance. The counselor's survey set was matched with the client's based on the pre-coded identification number, and thus, a counselor-client dyad constituted a unit of data analysis.

Korean Counselors' Personal Wellness

Although exact equivalency between the original 5F-Wel and its Korean translation could not be guaranteed, it appeared clear that Korean counselors in the current sample reported lower levels of personal wellness overall and in the major domains of their lives when compared with the general American population used by Myers and Sweeney (2004). Also, the subgroup of master's level counseling students in this study reported lower levels of overall wellness and all five second-order wellness factors than the American counterparts sampled in previous studies (O'Brien, 2007; Roach & Young, 2007). These results are consistent with Yu et al. (2008), who reported higher levels of burnout in Korean counselors as compared with American counterparts. They also provided empirical support for a number of recent reports (Bae, 2001; Choi et al., 2002; Park, 2006; Yoo & Park, 2002) describing a variety of risk factors for Korean counselor groups that may affect their personal well-being. Due to the lack of more equivalent comparison groups between the current sample and the American samples used in previous wellness studies, further cross-national comparisons in mean wellness scores could not be made. For instance, the terms professional counselors and counselor educators, which were categorizing terms widely used in American wellness studies, are not used in the counseling field in South Korea; therefore, these terms were not included as choices in the counseling-related education question in the demographic questionnaire. For this reason, comparisons of the subgroups of professional counselors or counselor educators in terms of mean wellness scores could not be done.

It was noteworthy that no significant differences in average wellness scores of Korean counselors were found according to their counseling-related education levels and individual counseling experience because some of the findings from recent studies using American counseling student samples showed different results. Myers et al. (2003) reported that doctoral students in counseling programs exhibited higher levels of wellness than did master's-level students. Also, Wester et al. (in press) found that counselor

educators in their study showed greater wellness than Myers et al.'s (2003) counseling student samples. Instead, this study demonstrated that Korean counselors' age was inversely correlated with the Creative Self scores, indicating that younger counselors are more well in efforts to make themselves a unique being in their personal lives. This makes sense in considering that younger generations are more inclined to make themselves distinct from others.

Korean Counselors' Personal Wellness and Clients' Perceptions of Counseling Effectiveness

The present study indicates that levels of Korean counselors' personal wellness are not associated with their client's perceptions of counseling effectiveness. These results concur with O'Brien (2007), who found no significant relationship between master's-level students' personal wellness in American counseling programs and client outcome such as symptom reduction. Given that clients' evaluation of counseling effectiveness was measured by three different instruments and neither overall wellness nor five second-order wellness factors demonstrated significant relations to scores on these three scales, it is hard to say that the null results may have come from random or measurement errors. In conclusion, there was no clear and direct link between counselors' personal wellness and client-rated counseling effectiveness found in this study. Thus, the findings of this study would seem to call into question the prevalent assumption that well counselors are more likely to be successful with their clients.

It may be easy to find counselors who are keeping high levels of well-being in their personal lives but struggling with difficulties in addressing client issues in counseling sessions. It also may be possible to observe those who are struggling with aspects of their personal lives, such as marriage and physical health, but are doing very well in dealing with clients' presenting problems. Another speculation is that it may be rare for counselors' personal wellness to be manifested or communicated to the client in counseling sessions. Unless the counselor shares a lot of personal information, whether or

not it is intentional, clients may have few chances to see clues indicating counselor wellness. In fact, too much self-disclosure on the part of the counselor, especially when it is irrelevant to a client's issue, is regarded as unprofessional and inappropriate in counseling practice. Given the possibility that clients may have had few chances to gauge the wellness of their counselor, it makes sense that counselors-perceived wellness did not influence client-rated counseling effectiveness.

However, restricted ranges on all counseling effectiveness variables allow for another explanation of the null results with regard to the relations of counselor wellness to client-perceived counseling effectiveness. It was noteworthy that average scores of counseling effectiveness variables were pretty high and the majority of the clients rated higher than the midpoint on these measures, thereby resulting in all central tendency indices (i.e., mean, median, mode) falling much higher than the midpoint of the scales. These apparently restricted ranges of counseling effectiveness measures in the sample might have led to insignificant relationships between counselor wellness scores and counseling effectiveness scores rated by clients. Thus, the results of this study examining the relationship between counselor wellness and counseling effectiveness should be considered exploratory rather than confirmatory, warranting further investigations.

Although it was not established as a research question, one unexpected finding was that Korean counselors' cognitive empathy was not related to their clients' perceptions of counseling effectiveness. Although the majority of empirical evidence supports the critical role of counselor cognitive empathy in counseling outcome, this finding lends partial support to some scholars' claims that it was not counselors' self-reported ratings but clients' perceptions of empathy that would predict client outcome (Barrett-Lennard, 1981; Orlinsky et al., 1994).

In fact, the Perspective Taking (PT) subscale of IRI, which was used to measure counselors' cognitive empathy in this study, was developed to measure empathy as a general tendency within a person rather than as a specific ability within a counseling

context. The PT subscale might not have represented how successful counselors were in communicating their understanding of the client's world. Thus, Korean counselors' rating on their cognitive empathy may not be associated with clients' feelings of counselor empathy in counseling sessions. It was also possible that if the Empathic Concern subscale of IRI measuring Korean counselors' emotional empathy, which represents caring for others' welfare, had been reliable enough, results might have been different. In fact, the two subscales were found to tap different aspects of empathy and demonstrate differential relationships with a variety of psychological measures (Davis, 1983b).

The significant, positive correlations of counselors' social desirability tendency to personal wellness and cognitive empathy indicated that Korean counselors with a higher need to respond in a socially desirable manner gave higher ratings of wellness and empathy. It may not be surprising that the participants who were inclined to respond in a way that would depict them in a more favorable manner would give more favorable ratings on the wellness and empathy scores because the items on these measures were relatively transparent. In addition, participants were informed that this investigation would examine the factors affecting counseling effectiveness. The relationship between social desirability and empathy, as measured by the same scale (i.e., IRI) as in this study, was also found in a study with the American practicing psychologists (Burkard & Knox, 2004). In the more directly related research regarding counselor wellness, however, O'Brien (2007) found that social desirability was not significantly correlated with counselor wellness among master's-level counseling students. Perhaps one implication of these results is that social desirability may be a primary concern generally in counseling research involving Korean counselors. Consequently, future researchers may need to account for social desirability influences in their research designs.

Another notable finding was the statistically significant relationship between wellness variables, except for the Physical Self factor, and cognitive empathy, indicating that Korean counselors with a higher level of personal wellness reported higher ratings of

cognitive empathy. Previous studies using American samples demonstrated that the construct of wellness was positively correlated with numerous indicators of healthy interpersonal functioning, including social interest (Makinson, 2001), sense of belonging (Connolly, 2000; Rayle & Myers, 2004), and healthy love styles (Shurts & Myers, 2008). Considering that cognitive empathy, that is, perspective taking is an important element for positive social interactions, the results of the current study showing an association between counselor wellness and cognitive empathy seemed consistent with the findings of these previous studies.

Moderating Effects of Counselor Empathy on the Relationship between Counselor Wellness and Client-Rated Counseling Effectiveness

As presented in the Introduction section, it was speculated that counselor wellness and clients' rated counseling effectiveness might be conditional on the counselor's empathy levels. This speculation received partial support by the findings of the current study. Although the interaction between counselor wellness and cognitive empathy was found to be statistically insignificant for most of the dependent variables, some interesting interactions emerged from the multiple regression analyses using either client-perceived session smoothness or working alliance as a dependent variable.

Specifically, Korean counselors' cognitive empathy moderated the effects of Creative Self and Essential Self on clients' perception of session smoothness. Counselors' perceived wellness in Creative Self had a negative effect on their clients' perception of session smoothness only for counselors who had higher levels of cognitive empathy. In other words, for Korean counselors with higher levels of cognitive empathy, the more wellness they experience in Creative Self, the less likely are their clients to perceive the counseling session as smooth. In contrast, counselor wellness in the Creative Self factor did not affect how clients perceived session smoothness for counselors who had lower levels of cognitive empathy. Also, perceived counselor wellness in the

Essential Self domain was positively related to their clients' ratings of session smoothness among counselors with lower levels of cognitive empathy, whereas the significant relationship between wellness and session smoothness was not found among counselors with higher levels of cognitive empathy. That is, if counselors have lower levels of cognitive empathy, increased wellness in Essential Self is likely to result in clients' perception that the counseling session goes smooth.

The interaction pattern that appeared in the analysis involving Coping Self as the predictor and the client-perceived working alliance as the dependent variable was different from the product terms (Creative Self × cognitive empathy, Essential Self × cognitive empathy) discussed above. Counselors' perceived wellness in Coping Self had a negative influence on their clients' evaluation of the working alliance only among counselors with lower levels of cognitive empathy. However, counselor wellness in the domain of Coping Self did not affect client-rated working alliance when counselors had higher levels of cognitive wellness.

In this study, the significant interaction terms of cognitive empathy with Creative Self and Essential Self accounted for 5.3% and 3.9% of incremental variance in client-perceived session smoothness, respectively. The cognitive empathy by Coping Wellness interaction explained an additional 3.1% of the variance in client-perceived working alliance. Although these R^2 values indicate a small effect size according to Cohen et al's (1992) classification, many scholars (Frazier et al., 2004; Pedhazur & Schmelkin, 1991; Wampold & Freund, 1987) noted that in non-experimental social science studies, interaction effects contributed to only a small proportion of the variance (typically 1% to 3%) over and above the main effects. It was also noted that weak relations between predictor and outcome (i.e., dependent) variables may further contribute to small effect sizes of interactions (Chaplin, 1991). Given that a significant relationship did not appear in any combinations of the wellness variables (i.e., predictor variables) and the counseling effectiveness variables (i.e., dependent variables), other true interaction

effects may have gone undetected due to the low power. Taken together, the results of interaction effects in this study suggest the possibility that the influence of counselors' personal wellness on counseling outcomes would be conditional on the levels of counselor empathy. That is, cognitive empathy appeared to serve to change the direction or strength of the relationship between counselor wellness and client-perceived counseling effectiveness.

In spite of the statistically significant moderation effects of counselors' cognitive empathy found in this study, it is difficult to make sense of these results. In summary, the findings of this study indicate that, for counselors with lower levels of cognitive empathy, wellness in Essential Self had a positive influence on client-perceived session smoothness, but wellness in Coping Self had a negative effect on client-rated working alliance. Also, results suggest that wellness in Creative Self had a negative influence on client-perceived session smoothness among counselors with higher levels of cognitive empathy. However, the lack of empirical evidence of different functions of the wellness factors appears to make it more difficult to provide possible explanations of the interaction results presented above. For instance, it seems somewhat counterintuitive that counselors who have a high level of cognitive empathy are more likely to receive a negative evaluation on session smoothness from their client as their wellness in Creative Self increases. Similarly, it seems unfathomable that counselors with lower levels of cognitive empathy are likely to establish good relationships with clients as their personal wellness decreases. Thus, given the small effect sizes in conjunction with the relatively small size of sample and measurement error, the interpretations of the significant interaction effects should be made with extreme caution. Further empirical evidence will help to understand these results with reasonable explanations.

Implications for Counselor Educators

Although a growing awareness of counselor impairment in the counseling field has led to a strong emphasis on monitoring and enhancing personal wellness of

professional counselors or counselors-in-training, many scholars have suggested incorporating the wellness philosophy into counselor education or training. Promoting an individual counselor's personal wellness has been underscored as one of the best ways to prevent the counselor from being impaired. The reasoning behind this belief is that there should be a direct connection between counselor wellness and impairment. In other words, it is believed that counselors will be able to guard themselves against impairment by increasing their levels of wellness as they would fall on the single continuum from "well" to "impaired." Given that counselor impairment is defined as a problem occurring in a counselor's professional functioning such as client care (Lawson & Venart, 2006), it can be reasoned that a counselor's wellness would be directly related to his or her counseling effectiveness. Because research has been lagging in exploring the relationship between counselor wellness and counseling effectiveness, this study aimed to investigate this relationship with a sample of Korean counselors.

Interestingly, the findings of this study indicated that counselors' personal wellness did not correlate with all three variables of client-perceived counseling effectiveness. These results are in line with prior research demonstrating that counselor wellness was not significantly associated with client outcome (O'Brien, 2007). Thus, this study provides empirical evidence challenging the supposition that well counselors will be more effective with their clients in counseling sessions. It also challenges counselor educators who plan to incorporate a conceptualization of wellness into course work, co-curricular activities, and field-based training to reexamine their beliefs underlying these efforts.

With the small effect sizes and a somewhat unexplainable nature of the moderation effects observed in this study, it is difficult to make definitive claims, but it may be possible to make a tentative statement that the influence of counselor wellness on client-perceived counseling effectiveness varies as a function of counselors' cognitive empathy. Thus, counselor educators should be able to monitor the empathic ability of

counseling students or trainees along with their personal wellness to predict how effective they would be in actual counseling sessions. However, this is not to say promoting wellness among professional counselors or counselors-in-training should be abandoned, but rather that there might be a variety of moderating factors determining how counselors' personal wellness would be related to counseling effectiveness. Thus, attention must be paid to understanding the more complicated interplay between counselor wellness and other counselor characteristics such as empathy.

As it pertains to Korean counselor educators and supervisors, the comparisons of mean wellness scores demonstrated that Korean counselors experienced lower well-being in their personal lives when compared with American counterparts and American people in general. Coupled with prior research indicating that Korean counselors are exposed to numerous sources of burnout, this finding illustrates a need for additional awareness regarding the well-being of counselors-in-training among Korean counselor educators and supervisors. Particularly, the lowest average score of Physical Self suggests that counseling programs and employers need to pay attention to improving awareness of self-care strategies among their students or employees. However, cultural considerations may provide a different explanation on these results. Because of the cultural nature of the wellness construct, the value judgment of Korean counselors about what is wellness and what is not might be different than that inherent in the wellness scale used in this study. In other words, the items on the 5F-Wel may not have captured the way in which wellness is conceptualized by Korean counselors.

Limitations of the Study

Several limitations should be taken into account when considering the foregoing interpretation of the results. The first limitation of the study concerns the cultural validity of the 5F-Wel. Since a large size sample is required to factor analyze this scale consisting of 73 scored items, neither exploratory nor confirmatory factor analysis could be performed in this study. Instead, the internal consistency of the overall wellness and

subscale scores was checked carefully with the current Korean counselor sample. Although this study evidenced acceptable reliability of the 5F-Wel (αs ranged from .62 to. 92), the alphas for the current sample were not as high as those of the U.S. study reported by Myers and Sweeney (2004), which indicated more than .90 across the scale and all subscales. Given that the validity of the Korean version of the 5F-Wel (Hong, 2008) was not fully confirmed, perhaps the relatively lower alphas for the Physical, Coping, and Essential Self subscales were due to translation problems or to differences in the concept of wellness in both cultures (Hambleton, 2001). The latter seems to be more plausible considering that the highly individualistic nature of wellness might not fit collectivistic cultures (Harari et al., 2005) like Korean. Specifically, there is no guarantee that the concept of wellness is understood in the same way by Korean counselors as by American counterparts because differences in language, family structure, religion, lifestyle, and values may exist between the two cultures (van de Vijver & Leung, 1997). Thus, the expansion of the Korean wellness scale in a large size of non-counselor samples is warranted to determine whether the existing factor structure is replicated or the factor structure emerges in the Korean culture. Furthermore, as Chang et al. (2005) recommended, qualitative methods such as interviewing and observation might be employed to examine the conceptualizations of wellness in the Korean culture.

A second limitation was that the reliability of clients' responses on counseling outcome measures may be questionable. There were multiple layers of safeguards to protect the client's right to voluntarily choose whether or not to participate in this study, but, some cultural factors may have led to the clients' biased responses in the survey. Relationships in Korea are highly hierarchical in general, and the counselor-client relationship is no exception (Joo, 2009). Thus, Korean clients tend to view their counselor as an authority figure who can teach them the ways to solve their presenting problems (Kim, Atkinson, & Umemoto, 2001). For these reasons, the clients may have felt pressure to participate and to evaluate the counselor and the counseling session much

more favorably than they authentically perceived. Another possibility was that the counselors may have been tempted to choose a client who they believed would rate on the survey items in positive ways rather than choose a client whose last name came first in alphabetical order as instructed in the consent letter. The clients' response biases in favor of their counselor and counseling sessions were reflected in remarkably high average scores and range restrictions on almost all counseling effectiveness measures.

An additional limitation had to do with the self-report nature of the data. The accuracy of self-report measures is limited by human perception errors. As seen in the significant correlations of Korean counselors' social desirability scores with their wellness and empathy scores, social desirability may have affected a counselor's ratings on the wellness and empathy scales. This issue may be more salient to Korean subjects because maintaining one's social face by behaving in a manner befitting the social values is an important cultural characteristic of Korean people (Choi & Lee, 2002). Therefore, alternative methodological approaches, such as observation methods or peers' and supervisors' reports of the counselor's wellness, may be beneficial in future research endeavors.

Finally, a single time assessment of all study variables may not have been accurate in grasping the real relationships among the variables because of the possible fluidity of the constructs measured and influence of other factors that may have affected the participants' responding at the given time. In particular, counselors' perception of their own personal wellness may be different according to the time they respond to the scale. Likewise, a client's reports on counseling effectiveness may have been influenced by other factors such as mood (Gurman, 1977) or stage of change (Prochaska, DiClemente, & Norcross, 1992). For instance, perceptions of the working alliance may have fluctuated in some clients (Gaston & Marmar, 1994). Moreover, the client's report on the working alliance scale may have been based on the accumulative experience with the counselor rather than on the client's resultant thoughts and feelings from the session

after which the survey occurred. Thus, tracking changes in the study variables across multiple sessions during a specific duration of time could make up for these limitations associated with a single time measurement by capturing a more dynamic interplay among the variables.

Directions for Future Research

As for research implications, because this research is still in its infancy, additional studies should be conducted to further examine the relations of counselor wellness to counseling effectiveness or outcome by using both Korean and American counselor samples. To this end, different measures of counselor wellness and counseling effectiveness could be used. A simpler and brief instrument such as The Perceived Wellness Survey (PWS; Adams, Bezner, & Steinhardt, 1997), which attempts to include the balance of multiple life dimensions in its evaluation of an individual's wellness, may lend some different perspectives on the relationship between counselor wellness and counseling outcome from the client's view. Given that the counseling effectiveness measures used in this study purported to capture short-term effects, such as session impact, future research may address long-term effects, such as symptom reduction and improvement in psychosocial functioning, by including different measures of client outcomes.

Also, future studies should obtain a large representative sample of Korean counselors with a more balanced composition in terms of several demographic indicators, such as types and locations of work settings and gender. The counselor-client dyads who chose to participate in this study were limited to university counseling centers and youth counseling institutes and were recruited only from Seoul and the Gyeonggi Province. Even though there is no theoretical basis to believe that participants from other work settings, such as private counseling clinics, and other areas, including suburban and rural areas, may have shown different results, the expansion of the sample to other work settings or regions might be more representative of Korean counselor populations, thus

making findings more generalizable. In addition, given that the majority of the current sample comprises female counselors in university counseling centers, an approximately equal size of participants from youth counseling institutes and a large number of male counselors will help to further explore whether there are any preexisting differences in the study variables on the basis of counselors' work settings and gender. Considering the small effect sizes detected in this study, a larger sample size would also result in sufficient power levels to allow readers to interpret the findings with reasonable assurance.

Additionally, future studies should continue to determine the moderating effects of counselors' empathic ability in the relationship between counselor wellness and counseling outcome. The results of the interaction effects in this study did not provide clear evidence on the role of counselor empathy, possibly due to the small effect sizes and the inconsistent interaction patterns that appeared in the hierarchical multiple regression analyses with different combinations of the wellness factors and the counseling effectiveness variables. Because emotional empathy as measured by the Empathic Concern subscale of the IRI (Davis, 1980) was excluded in data analysis due to its lower internal consistency, the question regarding how different aspects of empathy would function as a moderator still remains unanswered. Thus, efforts should be made to ensure that the measure of empathy used in future research has sound psychometric properties and minimal measurement error. Also, the client's feelings of being empathized with could be measured and tested as a moderator instead of the counselor's rating of the experience of empathizing. This might make the construct of empathy more relevant to counseling settings, thereby providing a more practical insight into counseling. Furthermore, researchers should explore other potential moderators which might affect the relationship pattern of counselor wellness to client outcome. Addressing other potential moderating variables would contribute additional insights to the existing literature on counselor wellness by extending the findings of the current study.

Finally, the current results highlighting Korean counselors' tendency to respond in a socially desirable way should be taken into consideration, especially when future studies using a sample of Korean counselors include the measures of positive psychological characteristics, such as wellness and empathy as in this study. Caution should be taken to select the scales that may be less susceptible to social desirable responding. Perhaps researchers might choose scales that consist of the equal number of positive and negative statement items or those that comprise the items less transparent to responders. For instance, the Empathic Understanding Scale (Carkhuff, 1969), which measures counselors' abilities to accurately discriminate between various levels of empathic responses, may be an alternative option because it was designed to assess counselor empathy in an objective manner rather than relying on counselors' self-rating.

Conclusion

The construct of wellness has been recently recognized as one of the personal qualities of counselors that facilitates their success with clients. In spite of strong calls for increased efforts to develop wellness strategies in the arena of counselor education, there exists little empirical evidence supporting the direct influence of counselors' personal wellness on client or counseling outcome. Personal wellness may be of utmost importance to everyone, not only to counselors or counselors-in-training. The rationale for embracing the wellness philosophy as a dominating principle in counselor education programs should be that promoting counselor wellness will, immediately or at least ultimately, benefit counseling services provided to clients. Without assurance of its link with counseling outcome, the wellness movement within counseling education should be reconsidered. Also, if the influence of counselor wellness on counseling outcome changes based on other factors, then exploring these moderating variables takes on importance. Increased knowledge of the moderators provides more complex understanding of counselor wellness for counselor educators.

Overall, this study was one of the first studies in the field of counseling in Korea to connect personal wellness of Korean counselors with client-perceived counseling effectiveness and to further explore a potential moderator in the relationship between these two constructs. This study presented evidence that wellness of Korean counselors was not related to clients' perceptions of counseling effectiveness and some of the relationships between counselor wellness factors and counseling effectiveness variables differed as a function of counselors' cognitive empathy scores.

Most important, this finding could serve as a stimulant for future empirical work to replicate and extend the current study to larger and more representative Korean or American counselor samples, other measures of counseling outcome, and other moderators. These efforts may add further insights into how counselor educators should address the issues of their trainees' personal wellness as related to their professional functioning such as effectiveness with clients. It is hoped that, as more knowledge regarding counselor wellness is accumulated through future studies, counselor educators will be able to clarify ways to enhance both the personal wellness and the professional functioning of their trainees.

APPENDIX A

SURVEY MEASURES FOR COUNSELORS

A1. Five Factor Wel Inventory (5F-Wel)

Directions: The items are statements that describe you. Answer each item in a way that is true for you most of the time. Think about how you most often see yourself, feel, or behave. Answer all the items. Do not spend too much time on any one item.

Mark only one answer for each item using this scale:

Answer **Strongly Agree** if it is true for you most of the time.

Answer **Agree** if it is true for you some of the time.

Answer **Disagree** if it is mostly not true for you.

Answer **Strongly Disagree** if it is never true for you.

		Strongly Disagree	Disagree	Agree	Strongly Agree
1	I engage in a leisure activity in which I lose myself and feel like time stands still.	1	2	3	4
2	I am satisfied with how I cope with stress.	1	2	3	4
3	I eat a healthy amount of vitamins, minerals, and fiber each day.	1	2	3	4
4	I often see humor even when doing a serious task.	1	2	3	4
5	I am satisfied with the quality and quantity of foods in my diet.	1	2	3	4
6	Being a male/female is a source of satisfaction and pride to me.	1	2	3	4
7	When I have a problem, I study my choices and possible outcomes before acting.	1	2	3	4
8	I do not drink alcohol or drink less than two drinks per day.	1	2	3	4
9	I get some form of exercise for 20 minutes at least three times a week.	1	2	3	4
10	I value myself as a unique person.	1	2	3	4
11	I have friends who would do most anything for me if I were in need.	1	2	3	4
12	I feel like I need to keep other people happy.	1	2	3	4
13	I can express both my good and bad feelings appropriately.	1	2	3	4

14	I eat a healthy diet.	1	2	3	4
15	I do not use tobacco.	1	2	3	4
16	My cultural background enhances the quality of my life.	1	2	3	4
17	I have a lot of control over conditions affecting the work or schoolwork I do.	1	2	3	4
18	I am able to manage my stress.	1	2	3	4
19	I use a seat belt when riding in a car.	1	2	3	4
20	I can take charge and manage a situation when it is appropriate.	1	2	3	4
21	I can laugh at myself.	1	2	3	4
22	Being male/female has a positive affect on my life.	1	2	3	4
23	My free time activities are an important part of my life.	1	2	3	4
24	My work or schoolwork allows me to use my abilities and skills.	1	2	3	4
25	I have friends and/or relatives who would provide help for me if I were in need.	1	2	3	4
26	I have at least one close relationship that is secure and lasting.	1	2	3	4
27	I seek ways to stimulate my thinking and increase my learning.	1	2	3	4
28	I am often unhappy because my expectations are not met.	1	2	3	4
29	I look forward to the work or schoolwork I do each day.	1	2	3	4
30	I usually achieve the goals I set for myself.	1	2	3	4
31	I have sources of support with respect to my race, color, or culture.	1	2	3	4
32	I can find creative solutions to hard problems.	1	2	3	4
33	I think I am an active person.	1	2	3	4
34	I take part in leisure activities that satisfy me.	1	2	3	4

35	Prayer or spiritual study is a regular part of my life.	1	2	3	4
36	I accept how I look even though I am not perfect.	1	2	3	4
37	I take part in organized religious or spiritual practices.	1	2	3	4
38	I am usually aware of how I feel about things.	1	2	3	4
39	I jump to conclusions that affect me negatively, and that turn out to be untrue.	1	2	3	4
40	I can show my feelings anytime.	1	2	3	4
41	I make time for leisure activities that I enjoy.	1	2	3	4
42	Others say I have a good sense of humor.	1	2	3	4
43	I make it a point to seek the views of others in a variety of ways.	1	2	3	4
44	I believe that I am a worthwhile person.	1	2	3	4
45	I feel support from others for being a male/female.	1	2	3	4
46	It is important for me to be liked or loved by everyone I meet.	1	2	3	4
47	I have at least one person who is interested in my growth and well being.	1	2	3	4
48	I am good at using my imagination, knowledge, and skills to solve problems.	1	2	3	4
49	I can start and keep relationships that are satisfying to me.	1	2	3	4
50	I can cope with the thoughts that cause me stress.	1	2	3	4
51	I have spiritual beliefs that guide me in my daily life.	1	2	3	4
52	I have at least one person with whom I am close emotionally.	1	2	3	4
53	I am physically active most of the time.	1	2	3	4
54	I use humor to gain new insights on the problems in my life.	1	2	3	4
55	I can put my work or schoolwork aside for leisure without feeling guilty.	1	2	3	4

56	I have to do all things well in order to feel worthwhile.	1	2	3	4
57	I feel a positive identity with others of my gender.	1	2	3	4
58	I am appreciated by those around me at work or school.	1	2	3	4
59	I plan ahead to achieve the goals in my life.	1	2	3	4
60	I like myself even through I am not perfect.	1	2	3	4
61	I am satisfied with my free time activities.	1	2	3	4
62	I do some form of stretching activity at least three times a week.	1	2	3	4
63	I eat at least three meals a day including breakfast.	1	2	3	4
64	I do not use illegal drugs.	1	2	3	4
65	I believe in God or a spiritual being greater than myself.	1	2	3	4
66	I can experience a full range of emotions, both positive and negative.	1	2	3	4
67	I am able to relax when I need to do so to relieve my stress.	1	2	3	4
68	I eat fruits, vegetables, and whole grains daily.	1	2	3	4
69	My spiritual growth is essential to me.	1	2	3	4
70	When I need information, I have friends whom I can ask for help.	1	2	3	4
71	I am proud of my cultural heritage.	1	2	3	4
72	I like to be physically fit.	1	2	3	4
73	I have at least one person in whom I can confide my thoughts and feelings.	1	2	3	4
74	I am satisfied with my life.	1	2	3	4
75	I have enough money to do the things I need to do.	1	2	3	4
76	I feel safe in my home.	1	2	3	4

77	I feel safe in my workplace or school.	1	2	3	4
78	I feel safe in my neighborhood.	1	2	3	4
79	I feel safe in my daily life.	1	2	3	4
80	I am afraid that I or my family will be hurt by terrorists.	1	2	3	4
81	I am optimistic about the future.	1	2	3	4
82	My government helps me be more well.	1	2	3	4
83	My education has helped me be more well.	1	2	3	4
84	My religion helps my well being.	1	2	3	4
85	I know I can get a suitable job when I need one.	1	2	3	4
86	I watch TV less than two hours each day.	1	2	3	4
87	World peace is important to my well being.	1	2	3	4
88	Other cultures add to my well being.	1	2	3	4
89	I look forward to growing older.	1	2	3	4
90	I like to plan the changes in my life.	1	2	3	4
91	Changes in life are normal.	1	2	3	4

A2. Interpersonal Reactivity Index

The following 14 statements inquire about your thoughts and feelings in a variety of situations.

For each item, indicate how well it describes you by circling the appropriate number on the scale:

1, 2, 3, 4, or 5. Reach each item carefully before responding. Answer as honestly as you can.

		Does not describe well				Describes well
1	I often have tender, concerned feelings for people less fortunate than me.	1	2	3	4	5
2	I sometimes find it difficult to see things from the "other guy's" point of view.	1	2	3	4	5
3	Sometimes I don't feel very sorry for other people when they are having problems.	1	2	3	4	5
4	I try to look at everybody's side of a disagreement before I make a decision.	1	2	3	4	5
5	When I see someone being taken advantage of, I feel kind of protective towards them.	1	2	3	4	5
6	I sometimes try to understand my friends better by imagining how things look from their perspective.	1	2	3	4	5
7	I am often quite touched by things that I see happen.	1	2	3	4	5
8	Other people's misfortunes do not usually disturb me a great deal.	1	2	3	4	5
9	If I'm sure I'm right about something, I don't waste much time listening to other people's arguments.	1	2	3	4	5
10	When I see someone being treated unfairly, I sometimes don't feel very much pity for them.	1	2	3	4	5
11	I believe that there are two sides to every question and try to look at them both.	1	2	3	4	5
12	I would describe myself as a pretty soft-hearted person.	1	2	3	4	5
13	When I'm upset at someone, I usually try to "put myself in his shoes" for a while.	1	2	3	4	5
14	Before criticizing somebody, I try to imagine how I would feel if I were in their place.	1	2	3	4	5

A3. Interpersonal Reactivity Index (Korean Version)

다음 문장들은 여러 상황에서 자신이 어떻게 느끼고 생각하는지를 묻는 문항들입니다. 각 문항에 대해, 여러분을 가장 잘 표현하는 번호를 골라 O 나 V 표 해 주세요. 각 문항을 꼼꼼히 읽으시고 솔직하게 답해 주세요.

		전혀 그렇지 않다				매우 그렇다
1	나보다 불행한 사람들을 볼 때 애처롭고 안됐다는 마음이 든다.	1	2	3	4	5
2	때때로 “상대편”의 관점에서 상황을 바라보는게 쉽지 않다.	1	2	3	4	5
3	때때로 다른 사람들에게 문제가 있는 걸 봐도 안됐다는 느낌이 들지 않을 때가 있다.	1	2	3	4	5
4	어떤 결정을 내리기 전에 다른 의견을 가진 모든 사람들의 입장을 고려하려고 노력한다.	1	2	3	4	5
5	누군가가 이용당하고 있는 것을 보면, 그 사람을 보호하고 싶어진다.	1	2	3	4	5
6	때때로 나의 친구들의 관점에서 보면 어떨 지를 생각해 보면서 그들을 더 잘 이해하려고 노력한다.	1	2	3	4	5
7	내 눈 앞에서 벌어지는 일들로 인해 마음이 움직일 때가 많다.	1	2	3	4	5
8	다른 사람의 불행을 봐도 마음이 크게 흔들리지는 않는다.	1	2	3	4	5
9	어떤 문제에 대해 옳다고 확신하면, 다른 사람의 의견을 듣기 위해 시간을 낭비하지 않는다.	1	2	3	4	5
10	누군가가 부당하게 대우받는 것을 보아도 그들에게 동정심이 들지 않을 때가 더러 있다.	1	2	3	4	5
11	모든 문제에는 두 가지 측면이 있다고 믿고 두 측면 모두를 보려고 노력한다	1	2	3	4	5
12	나는 스스로를 매우 부드러운 마음의 소유자라고 생각한다.	1	2	3	4	5

13	누군가에게 화가 나면 잠시라도 그 사람의 입장에서 생각해 보려고 노력한다.	1	2	3	4	5
14	남을 비난하기 전에, 내가 만일 그 사람이었다면 어떨지를 생각해 보려고 노력한다.	1	2	3	4	5

A4. Marlowe-Crowne Social Desirability Scale

Listed below are a number of statements concerning personal attitudes and traits. Read each item and decide whether the statement is true or false as it pertains to you personally.

		Yes	No
1	Before voting I thoroughly investigate the qualifications of all the candidates.	1	2
2	I never hesitate to go out of my way to help someone in trouble.	1	2
3	It is sometimes hard for me to go on with my work if I am not encouraged.	1	2
4	I have never intensely disliked anyone.	1	2
5	On occasion I have had doubts about my ability to succeed in life.	1	2
6	I sometimes feel resentful when I don't get my way.	1	2
7	I am always careful about my manner of dress.	1	2
8	My table manners at home are as good as when I eat out in a restaurant.	1	2
9	If I could get into a movie without paying and be sure I was not seen I would probably do it.	1	2
10	On a few occasions, I have given up doing something because I thought too little of my ability.	1	2
11	I like to gossip at times.	1	2
12	There have been times when I felt like rebelling against people in authority even though I knew they were right.	1	2
13	No matter who I'm talking to, I'm always a good listener.	1	2
14	I can remember "playing sick" to get out of something.	1	2
15	There have been occasions when I took advantage of someone.	1	2
16	I'm always willing to admit it when I make a mistake.	1	2
17	I always try to practice what I preach.	1	2

18	I don't find it particularly difficult to get along with loud mouthed, obnoxious people.	1	2
19	I sometimes try to get even rather than forgive and forget.	1	2
20	When I don't know something I don't at all mind admitting it.	1	2
21	I am always courteous, even to people who are disagreeable.	1	2
22.	At times I have really insisted on having things my own way.	1	2
23.	There have been occasions when I felt like smashing things.	1	2
24.	I would never think of letting someone else be punished for my wrong-doings.	1	2
25.	I never resent being asked to return a favor.	1	2
26.	I have never been irked when people expressed ideas very different from my own.	1	2
27.	I never make a long trip without checking the safety of my car.	1	2
28.	There have been times when I was quite jealous of the good fortune of others.	1	2
29.	I have almost never felt the urge to tell someone off.	1	2
30.	I am sometimes irritated by people who ask favors of me.	1	2
31.	I have never felt that I was punished without cause.	1	2
32.	I sometimes think when people have a misfortune they only got what they deserved.	1	2
33.	I have never deliberately said something that hurt someone's feelings.	1	2

A5. Demographic Questionnaire for Counselors

Please circle the answer or write your answers in the space provided.

1. Gender : 1) Male 2) Female

2. Age : _____ years old

3. What is your current marital status?

    1) married/partnered

    2) single

    3) separated

    4) divorced

    5) widowed

4. What is the highest level of education you have completed?

    1) Less than high school

    2) High school graduate

    3) Bachelor's Degree

    4) Master's Degree

    5) Doctoral Degree

5. What is your sexual orientation?

    1) homosexual

    2) bisexual

    3) heterosexual

6. Current work or training setting (Please choose only one):

    1) University Counseling Center (Please list the name of the agency) :

    2) Youth Counseling Institute (Please list the name of the agency) :

7. Current status in the work or training setting you chose above:

    1) Practicum Student

    2) Internship Student

    3) Part-time counselor

4) Full-time counselor

8. Current counseling-related educational status:

1) In Master's Program _____ Years in Program

2) In Doctoral Program _____ Years in Program

3) Bachelor's Degree

4) Master's Degree

5) Doctoral Degree

9. Please list counseling-related certifications or licensures you have.

1) _____ granted from _____

2) _____ granted from _____

3) _____ granted from _____

4) _____ granted from _____

5) _____ granted from _____

10. Total years and months of face-to-face individual counseling experiences:

_____ years _____ months

Approximate number of sessions _____

Approximate number of clients _____

(Please include practicum or internship periods at graduate level)

11. Total years and months of supervision experiences for your face-to-face individual counseling cases:

_____ years _____ months

(Please include supervised practicum or internship periods at graduate level)

(Please also include both individual and group supervision experiences)

12. How many sessions have you had with the client who you asked to complete the survey?

_____ sessions

APPENDIX B

SURVEY MEASURES FOR CLIENTS

B1. Counselor Rating Form – Short

We would like to rate several characteristics of the counselor from the session you just finished. For each characteristic on the following page, there is a seven-point scale that ranges from "not very" to "very." Please mark an "X" at the point on the scale that best represents how you perceived the counselor from the session.

For example:

FUNNY

Not Very : ___X____ : _____ : _____ : _____ : _____ : _____ : _____ : Very

WELL DRESSED

Not Very : _____ : _____ : _____ : _____ : _____ : ____X___ : _____ : Very

These ratings might show that the counselor did not joke around much, but dresses wisely.

Though all of the following characteristics we ask you to rate are desirable, counselors differ in their strengths. We are interested in know how you view the counselor from the session you just finished.

Please indicate your responses on the next page.

FRIENDLY

Not Very : _____ : _____ : _____ : _____ : _____ : _____ : _____ : Very

EXPERIENCED

Not Very : _____ : _____ : _____ : _____ : _____ : _____ : _____ : Very

HONEST

Not Very : _____ : _____ : _____ : _____ : _____ : _____ : _____ : Very

LIKABLE

Not Very : _____ : _____ : _____ : _____ : _____ : _____ : _____ : Very

EXPERT

Not Very : _____ : _____ : _____ : _____ : _____ : _____ : _____ : Very

RELIABLE

Not Very : _____ : _____ : _____ : _____ : _____ : _____ : _____ : Very

SOCIABLE

Not Very : _____ : _____ : _____ : _____ : _____ : _____ : _____ : Very

PREPARED

Not Very : _____ : _____ : _____ : _____ : _____ : _____ : _____ : Very

SINCERE

Not Very : _____ : _____ : _____ : _____ : _____ : _____ : _____ : Very

WARM

Not Very : _____ : _____ : _____ : _____ : _____ : _____ : _____ : Very

SKILLFUL

Not Very : _____ : _____ : _____ : _____ : _____ : _____ : _____ : Very

TRUSTWORTHY

Not Very : _____ : _____ : _____ : _____ : _____ : _____ : _____ : Very

B2. Session Evaluation Questionnaire

Please circle the number that most closely depicts your view.

In recalling the past session, it was:

Bad	1	2	3	4	5	6	7	Good
Safe	1	2	3	4	5	6	7	Dangerous
Difficult	1	2	3	4	5	6	7	Easy
Valuable	1	2	3	4	5	6	7	Worthless
Shallow	1	2	3	4	5	6	7	Deep
Relaxed	1	2	3	4	5	6	7	Tense
Unpleasant	1	2	3	4	5	6	7	Pleasant
Full	1	2	3	4	5	6	7	Empty
Weak	1	2	3	4	5	6	7	Powerful
Special	1	2	3	4	5	6	7	Ordinary
Rough	1	2	3	4	5	6	7	Smooth
Comfortable	1	2	3	4	5	6	7	Uncomfortable

In recalling this past session, I presently feel:

Happy	1	2	3	4	5	6	7	Sad
Angry	1	2	3	4	5	6	7	Pleased
Moving	1	2	3	4	5	6	7	Still
Uncertain	1	2	3	4	5	6	7	Definite
Calm	1	2	3	4	5	6	7	Excited
Confident	1	2	3	4	5	6	7	Afraid
Wakeful	1	2	3	4	5	6	7	Sleepy
Friendly	1	2	3	4	5	6	7	Unfriendly
Slow	1	2	3	4	5	6	7	Fast
Energetic	1	2	3	4	5	6	7	Peaceful
Involved	1	2	3	4	5	6	7	Detached
Quiet	1	2	3	4	5	6	7	Aroused

B3. Working Alliance Inventory – Client Form

On the following pages are the sentences that describe some of the different ways you might think or feel about your counselor. As you read the sentences mentally insert the name of your counselor in place of _____ in the text. To the right of each statement there is a seven point scale:

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

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

1	I feel uncomfortable with _____	1	2	3	4	5	6	7
2	_____ and I agree about the things I will need to do in counseling to help improve my situation.	1	2	3	4	5	6	7
3	I am worried about the outcome of these sessions.	1	2	3	4	5	6	7
4.	What I am doing in counseling gives me new ways of looking at my problems.	1	2	3	4	5	6	7
5.	_____ and I understand each other.	1	2	3	4	5	6	7
6.	_____ and I have a common perception of my goals.	1	2	3	4	5	6	7
7.	I find what I am doing in counseling confusing.	1	2	3	4	5	6	7

8.	I believe _____ likes me.	1	2	3	4	5	6	7
9.	I wish _____ and I could clarify the purpose of our sessions.	1	2	3	4	5	6	7
10.	I disagree with _____ about what I ought to get out of counseling.	1	2	3	4	5	6	7
11.	I believe the time _____ and I are spending together is not spent efficiently.	1	2	3	4	5	6	7
12.	_____ does not understand what I am trying to accomplish in counseling.	1	2	3	4	5	6	7
13.	I am clear on what my responsibilities are in counseling.	1	2	3	4	5	6	7
14.	The goals of these sessions are important for me.	1	2	3	4	5	6	7
15.	I find what _____ and I are doing in counseling is unrelated to my concerns.	1	2	3	4	5	6	7
16.	I feel that the things I do in counseling will help me to accomplish the changes that I want.	1	2	3	4	5	6	7
17.	I believe _____ is genuinely concerned for my welfare.	1	2	3	4	5	6	7
18.	I am clear as to what _____ wants me to do in these sessions.	1	2	3	4	5	6	7
19.	_____ and I respect each other.	1	2	3	4	5	6	7
20.	I feel that _____ is not totally honest about his/her feelings toward me.	1	2	3	4	5	6	7
21.	I am confident in _____'s ability to help me.	1	2	3	4	5	6	7
22.	_____ and I are working towards mutually agreed upon goals.	1	2	3	4	5	6	7

23.	I feel that _____ appreciates me.	1	2	3	4	5	6	7
24.	We agree on what is important for me to work on.	1	2	3	4	5	6	7
25.	As a result of these sessions, I am clearer as to how I might be able to change.	1	2	3	4	5	6	7
26.	_____ and I trust each other.	1	2	3	4	5	6	7
27.	_____ and I have different ideas on what my problems are.	1	2	3	4	5	6	7
28.	My relationship with _____ is very important to me.	1	2	3	4	5	6	7
29.	I have the feeling that if I say or do the wrong things, _____ will stop working with me.	1	2	3	4	5	6	7
30.	_____ and I collaborate on setting goals for these sessions.	1	2	3	4	5	6	7
31.	I am frustrated by the things I am doing in counseling.	1	2	3	4	5	6	7
32.	We have established a good understanding of the kind of changes that would be good for me.	1	2	3	4	5	6	7
33.	The things that _____ is asking me to do don't make sense.	1	2	3	4	5	6	7
34.	I don't know what to expect as the result of counseling.	1	2	3	4	5	6	7
35.	I believe the way we are working with my problem is correct.	1	2	3	4	5	6	7
36.	I feel _____ cares about me even when I do things that he/she does not approve of.	1	2	3	4	5	6	7

B4. Demographic Questionnaire for Clients

Please circle the answer or write your answers in the space provided.

1. Gender : 1) Male 2) Female

2. Age : _____ years old

3. What is your current marital status?

1) married/partnered

2) single

3) separated

4) divorced

5) widowed

4. What is your sexual orientation?

1) homosexual

2) bisexual

3) heterosexual

5. What is the highest level of education you have completed?

1) Less than high school

2) High school graduate

3) Bachelor's Degree

4) Master's Degree

5) Doctoral Degree

6. What kind of problem (or complaint) brought you to this center for individual counseling?

_____

7. Have you been paying for individual counseling services you have received from the counselor who gave this packet to you?

1) Yes

2) No

8. Have you ever received face-to-face individual counseling services before?

1) Yes

2) No

If yes,

1) How many times? _____

2) How many counselors did you see in the past? _____

3) How many sessions did you attend? _____

APPENDIX C

INVITATION AND CONSENT LETTERS

C1. Consent Letter for Counselors

Date

Dear Counselor:

We are writing to invite you to participate in a research study. The purpose of the study is to examine the factors affecting counseling effectiveness.

We are inviting you to be in this study because you are a counselor who is working at a university counseling center or a youth counseling institute in Seoul or Gyeonggi Province, South Korea. We requested the director of your agency to distribute this letter to you. Your name was not given to us. Approximately 150 counselors and 150 clients will take part in this study.

Since this study requires the input from both you and your client, we are also requesting you to solicit the voluntary participation of your clients who meet the following criteria: (a) have attended a minimum of three face-to-face individual counseling sessions; (b) be over 18 years of age; and (c) have adequate levels of self-awareness needed for responding to the survey and appropriate levels of self-determination for deciding on the participation (neither being mentally retarded nor psychotic). If you have a client who meets all three criteria described above, you are eligible for participating in this study. If you have more than one eligible client on your caseload, please choose only one following ascending alphabetical order by last name.

Please understand that this study requires agreement from both you and your eligible client for participation in the study. Thus, we would like to request you first to decide whether or not to participate in this study within one week after your director distributes this email to you and then contact your eligible client to ask if they are interested in being in the study. If the first eligible client on your list does not wish to participate in the study, you may ask the next client on the list.

If both you and a client agree to be in the study, we would like you to give the *Consent Letter for Clients* attached to this email to your eligible client. The consent letter

will instruct your client to carefully review it, decide whether or not to participate, and then inform you of his/her decision within one week after receiving the letter from you. If your client decides to participate, we would like you to send an email at yoojin-jang@uiowa.edu indicating your and your client's willingness to participate and your name and agency address. Upon receipt of your response email, we will send a large envelope enclosing both counselor and client survey packets to you at the address of your agency. If you open the envelope, you will see two separate sealed packets, labeled as "Counselor Packet" and "Client Packet," respectively. Please do not open the "Client Packet."

After you receive the survey packets from us, we would like you to do (or know) the following things.

1. You will complete a set of survey questionnaires enclosed in the "Counselor Packet" at a convenient time for you. You will be asked a number of questions including your age, gender, marital status, sexual orientation, level of education, and questions regarding your feelings or thoughts about your personal lifestyles. You will be asked to choose the appropriate number on a scale, indicating how well each statement describes you. Examples of the statements are "I engage in a leisure activity in which I lose myself and feel like time stands still" and "I often have tender, concerned feelings for people less fortunate than me." You are free to not answer any questions you would prefer not to answer. Completing the questionnaire will take approximately 15 to 25 minutes. Then, you will put the completed packet in a prestamped, addressed return envelope, seal, and return it to us within one week after receiving the packet from us (Note: Please DO NOT WRITE THE YOUR NAME OR ADDRESS ON THIS RETURN ENVELOPE).

2. You will give the "Client Packet" to your client before the next scheduled session begins and ask the client to complete the survey immediately after the termination of the session. At this time, you will reassure the client that participation will be completely voluntary and the client can decline participation without any negative

consequences. You should leave the client alone while he or she fills out the survey questionnaires. This is especially important because your absence will ensure that your client will respond to the survey questionnaires in a secure and honest way. The survey for clients will require approximately 10 to 20 minutes. The client will be instructed to put the completed packet in a prestamped, addressed return envelope, seal, and return it directly to us separately from you.

We will send an email reminder to you if the completed survey packet from either you or your client is not returned within three weeks from the date when we send the packets. This reminder will state that we will consider it a withdrawal from the participation if the completed packet is not received in two more weeks after the reminder is sent. Since we do not have your client's email address, we will request you to pass this reminder on to your client if you believe your client did not return the packet to us. If you send a response email to this reminder indicating when you and/or your client can return the packets, we will wait until then. If the packet is not returned and we do not receive a response email to this reminder from you in two more weeks after the reminder is sent, there will be no further contact.

We will keep the information you provide confidential; however, federal regulatory agencies and the University of Iowa Institutional Review Board (a committee that reviews and approves research studies) may inspect and copy records pertaining to this research. Your survey responses will be linked with your client's survey responses by a pre-coded numeric ID on survey packets. Your name will be used only for sending survey packets to you. Your email address will be used only for sending an email reminder and a gift certificate as compensation for your participation. All identifying information about you, including name, email address, and email correspondence will be destroyed immediately after this study is over. We will not keep your name, any identifying information, or any links to information that would identify you. If we write a report about this study, we will do so in such a way that you cannot be identified.

There are no known risks from being in this study, and you will not benefit personally. However, we hope that others may benefit in the future from what we learn as a result of this study.

You will not have any costs for being in this research study.

You will be offered via email a five-dollar value gift certificate ("Dosu-Munwha" gift certificate issued by www.booknlife.com) as a token of our appreciation if we receive the completed survey packet from you by a designated date which will be indicated in an email reminder just in case your return of the packet is delayed. Even if your client does not return his/her own packet to us, you will receive the gift certificate if you return your own packet. The gift certificate can be redeemed both offline and online. This can be used for purchasing a variety of merchandise and services (e.g., books, apparel, movie tickets, restaurants, shopping malls) at thousands of offline stores and hundreds of online stores just like using cash or a credit card.

Taking part in this research study is completely voluntary. If you decide not to be in this study, or if you stop participating at any time, you won't be penalized or lose any benefits for which you otherwise qualify.

If you have any questions about the research study itself or experience a research-related injury, please email Yoo Jin Jang at yoojin-jang@uiowa.edu or Dr. Tarrell Portman at tarrell-portman@uiowa.edu, or call Yoo Jin Jang at [Number in Korea]. If you have questions about the rights of research subjects, please contact the Human Subjects Office, 300 College of Medicine Administration Building, The University of Iowa, Iowa City, IA 52242, (319) 335-6564, or e-mail irb@uiowa.edu. To offer input about your experiences as a research subject or to speak to someone other than the research staff, call the Human Subjects Office at the number above.

Thank you very much for your consideration. Returning the completed survey to us will indicate your willingness to participate in the study.

Sincerely,

Yoo Jin Jang,

Doctoral Candidate
Department of Counseling, Rehabilitation and Student Development
College of Education
The University of Iowa

C2. Consent Letter for Clients

Date

Dear Client:

We are writing to invite you to participate in a research study. The purpose of the study is to examine the factors affecting counseling effectiveness.

We are inviting you to be in this study because you are a client who has been receiving face-to-face individual counseling services at a university counseling center or a youth counseling institute in Seoul or Gyeonggi Province, South Korea, from a counselor who interested in being in this study. To be included in this study, you must be over 18 years of age and have attended a minimum of three face-to-face individual counseling sessions with your counselor. We requested your counselor to give this letter to you. Your name was not given to us. Approximately 150 counselors and 150 clients will take part in this study.

Please carefully review this letter, decide whether or not to participate in this study, and then inform your counselor of your decision within one week after receiving this letter from your counselor. If you agree to participate, we would like you to complete a set of survey questionnaires, which will be filled out without your counselor's presence. You will be asked your age, gender, marital status, sexual orientation, level of education, problem for which you are seeking counseling, and a number of questions regarding your feelings or thoughts about the counseling session. You will be asked to choose the appropriate number on a scale, indicating how well each statement describes your feelings and thoughts. A sample statement is "What I am doing in counseling gives me new ways of looking at my problems." You are free to not answer any questions you would prefer not to answer. It will take approximately 10 to 20 minutes.

As soon as we hear from your counselor that both you and your counselor want to participate in this study, we will send survey packets to your counselor. Your counselor will give a sealed envelope labeled as "Client Packet" to you before the next scheduled

session begins and ask you to complete the survey immediately after the termination of the session. This packet includes a set of survey questionnaires, an email address request form, and a prestamped, addressed return envelope. You will fill out the survey questionnaires without your counselor's presence so you can respond in a secure and honest way. On the email address request form, you may indicate your email address at which you would like to receive a gift certificate as compensation for your participation. If you do not have any email accounts, you may indicate your name and mailing address so we can send a hard copy of a gift certificate to you. Finally, you will put both the completed survey and the email address request form in a prestamped, addressed return envelope, seal, and return it directly to us as soon as it is done (Note: PLEASE DO NOT WRITE YOUR NAME OR ADDRESS ON THIS RETURN ENVELOPE).

We will send an email reminder to your counselor if the completed survey packet from either you or your counselor is not returned within three weeks from the date when we send the packets. This reminder will state that we will consider it a withdrawal from the participation if the completed packet is not received in two more weeks after the reminder is sent. Since we do not have your email address, we will request your counselor to pass this reminder on to you if he/she believes you did not return the packet to us. If your counselor sends a response email to this reminder indicating when you and/or your counselor can return the packets, we will wait until then. If the packet is not returned and we do not receive a response email to this reminder from your counselor in two more weeks after the reminder is sent, there will be no further contact.

We will keep the information you provide confidential; however, federal regulatory agencies and the University of Iowa Institutional Review Board (a committee that reviews and approves research studies) may inspect and copy records pertaining to this research. Your survey responses will be linked with your counselor's survey responses by a pre-coded numeric ID on survey packets. We will obtain your name and email or mailing address only for the purpose of sending a gift certificate as

compensation for your participation. Your email, mailing address, or name won't be linked with your survey responses. The email address request form will be separated from your returned envelope immediately after we receive it and will be destroyed immediately after we send a gift certificate to you. We will not keep your name, any identifying information, or any links to information that would identify you. If we write a report about this study, we will do so in such a way that you cannot be identified.

There are no known risks from being in this study, and you will not benefit personally. However, we hope that others may benefit in the future from what we learn as a result of this study.

You will not have any costs for being in this research study.

You will be offered via email a five-dollar value gift certificate ("Dosu-Munwha" gift certificate issued by www.booknlife.com) as a token of our appreciation if we receive the completed survey packet from you by a designated date which will be indicated in an email reminder just in case your return of the packet is delayed. Even if your counselor does not return his/her own packet to us, you will receive the gift certificate if you return your own packet. The gift certificate can be redeemed both offline and online. This can be used for purchasing a variety of merchandise and services (e.g., books, apparel, movie tickets, restaurants, shopping malls) at thousands of offline stores and hundreds of online stores just like using cash or a credit card.

Taking part in this research study is completely voluntary. If you decide not to be in this study, or if you stop participating at any time, you won't be penalized or lose any benefits for which you otherwise qualify.

If you have any questions about the research study itself or experience a research-related injury, please email Yoo Jin Jang at yoojin-jang@uiowa.edu or Dr. Tarrell Portman at tarrell-portman@uiowa.edu, or call Yoo Jin Jang at [Number in Korea]. If you have questions about the rights of research subjects, please contact the Human Subjects Office, 300 College of Medicine Administration Building, The University of

Iowa, Iowa City, IA 52242, (319) 335-6564, or e-mail irb@uiowa.edu. To offer input about your experiences as a research subject or to speak to someone other than the research staff, call the Human Subjects Office at the number above.

Thank you very much for your consideration. Returning the completed survey to us will indicate your willingness to participate in the study.

Sincerely,

Yoo Jin Jang,

Doctoral Candidate
Department of Counseling, Rehabilitation and Student Development
College of Education
The University of Iowa

C3. Invitation Letter for Directors of Counseling Centers

Date:

Email Address:

Dear Directors,

My name is Yoo Jin Jang and I am currently a doctoral candidate at the University of Iowa. In order to complete my doctoral studies, I will be conducting research on the factors affecting counseling effectiveness.

I am writing to request your assistance for my research study. I am inviting counselor-client dyads who have been engaging in face-to-face individual counseling at a university counseling center or a youth counseling institute in Seoul or Gyeonggi Province, South Korea. In the *Consent Letter for Counselors* attached to this email, we will request counselors to solicit the voluntary participation of their clients who meet the following criteria (a) have attended a minimum of three face-to-face individual counseling sessions; (b) be over 18 years of age; and (c) have adequate levels of self-awareness needed for responding to the survey and appropriate levels of self-determination for deciding on the participation (neither being mentally retarded nor psychotic). If a counselor has more than one eligible client on his/her caseload, he/she will choose only one following ascending alphabetical order by last name. If the first eligible client on his/her list does not wish to participate in the study, he/she may ask the next client on the list.

Since this study requires the input from both counselor and client, the data set will not be complete should either the counselor or his/her client decline to participate. Thus, we will request counselors first to decide whether or not to participate in this study. Those counselors who are willing to participate will give the *Consent Letter for Clients* attached to this email to their eligible client. Then, clients will make their own decision about the participation and inform their counselor of their decision.

Only those counselor-client dyads who mutually agree to participate in this study will be asked to complete a set of survey questionnaires. The survey will take approximately 15-25 minutes for counselors and 10-20 minutes for clients, respectively. Those counselors and clients who return their respective survey packets to us will be offered a five-dollar value gift certificate ("Dosu-Munwha" gift certificate issued by www.booknlife.com) as a token of our appreciation.

If you wish to assist in the study, would you please distribute two documents (Consent Letter for Counselors, Consent Letter for Clients) attached to this email to all counselors who are providing face-to-face individual counseling services at your agency regardless of their position (part-time, full-time, interns, practicum students, etc.). If you want to see more details of the procedures and conditions of this study, please refer to the attached consent letters.

If you have any questions about the research study itself, please email Yoo Jin Jang at yoojin-jang@uiowa.edu or Dr. Tarrell Portman at tarrell-portman@uiowa.edu, or call Yoo Jin Jang at [Number in Korea].

Thank you for your time and consideration.

Sincerely,

Yoo Jin Jang,

Doctoral Candidate
Department of Counseling, Rehabilitation and Student Development
College of Education
The University of Iowa

C4. Email Address Request Form for Clients

Email Address Request Form

Please indicate your email address below at which you would like us to send a five dollar value gift certificate as compensation for your participation. Only if you do not have any email accounts, please provide your mailing address instead. Your email, mailing address, and name will be used only for sending a gift certificate as compensation for your participation. Your email, mailing address, or name won't be linked with your survey responses. The email address request form will be separated from your returned envelope immediately after we receive it and will be destroyed immediately after we send a gift certificate to you)

Email Address : _____ @ _____

OR

Mailing Address (Only if you do not have an email address) :

_____

Name:

_____

C5. Email Reminder for Counselors

Date

Email Address :

This letter is a follow up to the survey packets we sent to you a few weeks ago. Our record indicates that we have not received the completed packets from (you / your client / you and your client) so far.

If you and/or your client have some reasons for delayed return, please send a response email as soon as possible indicating when you and/or your client can return the packets. We will wait until then. If the packet is not returned and we do not receive a response email to this reminder by [Date], we will consider it a withdrawal from the participation. There will be no further contact after that date.

Since we do not have your client's email address, we are requesting you to pass this reminder on to your client only if your client did not return the packet to us.

If you have any questions or concerns about this reminder, please email Yoo Jin Jang at yoojin-jang@uiowa.edu or Dr. Tarrell Portman at tarrell-portman@uiowa.edu, or call Yoo Jin Jang at [Number in Korea].

Thank you.

Sincerely,

Yoo Jin Jang,

Doctoral Candidate
Department of Counseling, Rehabilitation and Student Development
College of Education
The University of Iowa

APPENDIX D

SUPPLEMENTAL ANALYSES: TABLES

Table D1. Means and Standard Deviations of Counselor Variables by Location of Work Setting

Counselor Variable	Location of Work Setting				
	Seoul (*N* = 86)		Gyeonggi (*N* = 47)		
	M	SD	M	SD	*t* (df)
Total Wellness	74.75	4.95	73.07	5.71	1.77(131)
Creative Self	75.69	5.85	74.60	7.63	.92(131)
Coping Self	71.40	4.96	70.21	6.71	1.16(131)
Social Self	82.49	9.14	79.26	9.70	1.91(131)
Essential Self	77.56	8.64	74.77	7.87	1.84(131)
Physical Self	68.55	7.94	67.77	8.18	0.54(131)
Cognitive empathy	3.65	.49	3.49	.50	1.81(131)
Social desirability	14.53	5.91	12.19	5.48	2.24(131)

Table D2. Means and Standard Deviations of Counselor Variables by Type of Work Setting

Counselor Variable	Type of Work Setting				
	University Counseling Center (*N* = 121)		Youth Counseling Institutes (*N* = 12)		
	M	SD	M	SD	*t* (df)
Total Wellness	74.02	5.20	75.49	6.02	-.92(131)
Creative Self	75.38	6.58	74.48	6.13	.46(131)
Coping Self	70.81	5.67	72.70	5.30	-1.11(131)
Social Self	80.97	9.51	85.16	7.90	-1.48(131)
Essential Self	76.38	8.23	78.52	10.68	-.83(131)
Physical Self	68.08	8.03	70.21	7.79	-.88(131)
Cognitive empathy	3.60	.49	3.58	.60	.08(131)
Social desirability	13.45	5.76	16.25	6.43	-1.59(131)

Table D3. Means and Standard Deviations of Counselor Variables by Marital Status

Counselor Variable	Marital Status				
	Married/Partnered (*N* = 63)		Single (*N* = 70)		
	M	SD	M	SD	*t* (df)
Total Wellness	74.90	6.34	73.48	5.15	1.56(131)
Creative Self	76.28	6.53	74.43	6.44	1.64(131)
Coping Self	71.47	6.44	70.54	4.82	.95(131)
Social Self	82.59	9.94	80.22	8.87	1.45(131)
Essential Self	77.26	8.58	75.96	8.35	.88(131)
Physical Self	68.77	8.27	67.82	7.79	.68(131)
Cognitive empathy	3.60	.50	3.59	.50	.10(131)
Social desirability	14.05	5.45	13.40	6.21	.64(131)

Table D4. Means and Standard Deviations of Counselor Variables by Sexual Orientation

Counselor Variable	Sexual Orientation				
	Bisexual (*N* = 10)		Heterosexual (*N* = 123)		
	M	SD	M	SD	*t* (df)
Total Wellness	71.71	3.71	74.39	5.35	-1.55(131)
Creative Self	71.50	5.61	75.58	6.53	-1.92(131)
Coping Self	68.42	2.32	71.27	5.73	-1.56(131)
Social Self	76.56	6.79	81.74	9.57	-1.67(131)
Essential Self	76.72	6.65	76.61	8.62	.04(131)
Physical Self	66.50	3.76	68.50	8.22	-.76(131)
Cognitive empathy	3.26	.45	3.62	.49	-2.25(131)
Social desirability	14.00	6.55	13.69	5.84	.61(131)

Note. Only one counselor in this study's sample identified himself/herself as homosexual. Thus, the homosexual category was excluded from this comparison.

Table D5. Means and Standard Deviations of Counselor Variables by Position in Work Setting

Counselor Variable	Position in Work Setting						
	Practicum/ Internship (N = 38)		Part-Time (N = 44)		Full-Time (N = 50)		
	M	SD	M	SD	M	SD	F (df_1, df_2)
Total Wellness	72.94	5.93	74.43	5.14	74.95	4.75	1.64(2,129)
Creative Self	74.71	7.50	74.86	6.46	76.18	5.85	.70(2,129)
Coping Self	69.97	6.75	71.23	5.78	71.66	4.47	1.02(2,129)
Social Self	81.17	10.47	81.39	8.23	81.56	9.83	.02(2,129)
Essential Self	74.75	8.92	77.49	7.92	77.38	8.42	1.37(2,129)
Physical Self	65.59	7.94	69.20	8.81	69.55	6.97	3.15(2,129)
Cognitive empathy	3.49	.48	3.73	.44	3.57	.54	2.66(2,129)
Social desirability	14.71	4.66	13.89	5.91	12.90	6.56	1.05(2,129)

Table D6. Means and Standard Deviations of Counselor Variables by Counseling-Related Education

Counselor Variable	Counseling-Related Education								
	In Master's Program (N = 29)		In Doctoral Program (N = 26)		Master's Degree (N = 60)		Doctoral Degree (N = 18)		
	M	SD	M	SD	M	SD	M	SD	F (df_1, df_2)
Total Wellness	73.74	5.62	72.62	4.76	74.51	5.47	75.86	4.36	1.53(3,129)
Creative Self	75.83	7.00	73.51	6.28	75.04	6.39	77.92	6.11	1.74(3,129)
Coping Self	70.28	6.17	70.63	4.38	71.21	6.37	71.86	3.70	.53(3,129)
Social Self	80.50	8.71	79.81	9.97	81.82	9.64	83.33	9.34	.62(3,129)
Essential Self	76.99	8.97	74.10	8.86	76.98	8.29	78.13	7.46	1.02(3,129)
Physical Self	65.52	7.24	66.54	6.60	69.92	8.82	69.72	6.91	2.69(3,129)
Cognitive empathy	3.54	.51	3.61	.43	3.57	.55	3.74	.38	.68(3,129)
Social desirability	15.03	4.52	12.50	5.97	13.68	6.50	13.39	5.28	.88(3,129)

Table D7. Means and Standard Deviations of Dependent Variables by Counselors' Work Setting Location

Counselor Variable	Counselors' Work Setting Location				
	Seoul (*N* = 86)		Gyeonggi (*N* = 47)		
	M	SD	M	SD	*t* (df)
Client satisfaction	5.75	.82	5.96	.82	-1.38(131)
Session depth	5.02	1.01	5.30	1.02	-1.53(131)
Session smoothness	5.21	1.11	5.21	1.16	.00(131)
Positivity	4.85	.93	5.06	1.19	-1.08(131)
Working alliance	5.60	.65	5.72	.71	-.99(131)

Table D8. Means and Standard Deviations of Dependent Variables by Counselors' Work Setting Type

Counselor Variable	Counselors' Work Setting Type				
	University Counseling Center (*N* = 121)		Youth Counseling Institutes (*N* = 12)		
	M	SD	M	SD	*t* (df)
Client satisfaction	5.86	.77	5.44	1.21	1.71(131)
Session depth	5.14	1.02	4.83	1.04	1.01(131)
Session smoothness	5.22	1.10	5.10	1.39	.36(131)
Positivity	4.95	1.02	4.65	1.11	.97(131)
Working alliance	5.66	.64	5.49	.98	.85(131)

Table D9. Means and Standard Deviations of Dependent Variables by Counselors' Marital Status

Counselor Variable	Counselors' Marital Status				
	Married/Partnered (N = 63)		Single (N = 70)		
	M	SD	M	SD	t (df)
Client satisfaction	5.69	.80	5.94	.83	-1.77(131)
Session depth	5.12	.97	5.11	1.06	.05(131)
Session smoothness	5.09	1.17	5.32	1.08	-1.17(131)
Positivity	4.75	1.05	5.08	1.00	-1.85(131)
Working alliance	5.57	.71	5.71	.63	-1.25(131)

Table D10. Means and Standard Deviations of Dependent Variables by Counselors' Sexual Orientation

Counselor Variable	Counselors' Sexual Orientation				
	Bisexual (N = 10)		Heterosexual (N = 123)		
	M	SD	M	SD	t (df)
Client satisfaction	6.07	.67	5.80	.83	.99(131)
Session depth	5.32	1.24	5.10	1.00	.64(131)
Session smoothness	5.90	.93	5.17	1.12	2.01(131)
Positivity	5.30	1.22	4.90	1.02	1.19(131)
Working alliance	5.63	.49	5.64	.69	-.05(131)

Note. Only one counselor in this study's sample identified himself/herself as homosexual. Thus, the homosexual category was excluded from this comparison.

Table D11. Means and Standard Deviations of Dependent Variables by Counselors' Position in Work Setting

Counselor Variable	Counselors' Position in Work Setting						
	Practicum/ Internship (N = 38)		Part-Time (N = 44)		Full-Time (N = 50)		
	M	SD	M	SD	M	SD	F (df_1, df_2)
Client satisfaction	5.84	.76	5.95	.71	5.68	.95	1.29(2,129)
Session depth	5.11	1.06	5.05	.94	5.17	1.06	.17(2,129)
Session smoothness	5.19	1.13	5.32	1.08	5.10	1.05	.49(2,129)
Positivity	5.00	.99	4.77	1.05	4.98	1.05	.64(2,129)
Working alliance	5.66	.57	5.65	.56	5.63	.83	.03(2,129)

Table D12. Means and Standard Deviations of Dependent Variables by Counselors' Counseling-Related Education

Counselor Variable	Counselors' Counseling-Related Education								
	In Master's Program (N = 29)		In Doctoral Program (N = 26)		Master's Degree (N = 60)		Doctoral Degree (N = 18)		
	M	SD	M	SD	M	SD	M	SD	F (df_1, df_2)
Client satisfaction	5.91	.83	5.76	.77	5.75	.84	6.00	.84	.57(3,129)
Session depth	5.13	1.17	5.19	.84	5.00	1.03	5.38	.96	.72(3,129)
Session smoothness	5.33	1.19	5.05	1.27	5.23	1.03	5.18	1.16	.29(3,129)
Positivity	5.04	1.08	4.86	.96	4.83	.98	5.14	1.22	.59(3,129)
Working alliance	5.71	.56	5.61	.62	5.59	.70	5.78	.83	.49(3,129)

Table D13. Means and Standard Deviations of Dependent Variables by Clients' Gender

Counselor Variable	Client Gender				
	Male (N = 23)		Female (N = 110)		
	M	SD	M	SD	t (df)
Client satisfaction	5.84	.87	5.83	.81	.06(131)
Session depth	5.16	1.07	5.12	1.02	.19(131)
Session smoothness	5.49	1.14	5.17	1.11	1.19(131)
Positivity	5.16	1.11	4.88	1.01	1.15(131)
Working alliance	5.62	.63	5.66	.68	-.21(131)

Table D14. Means and Standard Deviations of Dependent Variables by Clients' Marital Status

Counselor Variable	Clients' Marital Status				
	Single (N = 122)		Married/Partnered (N = 11)		
	M	SD	M	SD	t (df)
Client satisfaction	5.79	.82	6.16	.83	-1.42(131)
Session depth	5.11	1.02	5.22	1.03	-.35(131)
Session smoothness	5.16	1.11	5.77	1.15	-1.73(131)
Positivity	4.90	1.02	5.20	1.14	-.92(131)
Working alliance	5.63	.66	5.83	.78	-.97(131)

Table D15. Means and Standard Deviations of Dependent Variables by Clients' Education Levels

Counselor Variable	Clients' Education Levels				
	High School Diploma (N = 95)		Bachelor's Degree (N = 33)		
	M	SD	M	SD	t (df)
Client satisfaction	5.82	.80	5.89	.75	-.48(126)
Session depth	5.06	.93	5.39	.98	-1.76(126)
Session smoothness	5.21	1.14	5.18	1.11	.16(126)
Positivity	4.86	1.07	5.08	.92	-1.09(126)
Working alliance	5.58	.66	5.84	.63	-1.92(126)

Note. Because only five clients in this study's sample reported they had a master's degree, they were excluded from this comparison.

Table D16. Means and Standard Deviations of Dependent Variables by Clients' Prior Counseling Experience

Counselor Variable	Clients' Prior Counseling Experience				
	Yes (N = 41)		No (N = 92)		
	M	SD	M	SD	t (df)
Client satisfaction	5.79	.73	5.84	.87	-.32(131)
Session depth	5.28	.84	5.04	1.08	1.27(131)
Session smoothness	4.93	1.11	5.34	1.11	-1.98(131)
Positivity	4.86	1.05	4.95	1.03	-.49(131)
Working alliance	5.55	.62	5.69	.69	-1.08(131)

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