WELLNESS OF KANSAS PRINCIPALS: SELF-PERCEPTION

A Dissertation by

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To my wife, Susan, and my five children,

Randi, Gabriel, Hannah, Emily, and Jedidiah

I love you and thank God for each of you
The journey is the reward.

While I am aware of the time and cost this process has exacted,

I pray that it will be valued and remembered in a positive light,

inspiring my family to pursue their dreams.

May our journey through life benefit in its destinations

from the paths this trek has taken us

to the experiences yet to be.

At the same time, I shall never forget my dad’s humbling,

yet meaningful statement,

“It still takes a dollar with that dissertation to buy a cup of coffee.”
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ABSTRACT

This quantitative study examined the perceived wellness of Kansas K-12 public school building principals. Increased expectations at national, state, and local levels such as No Child Left Behind, budget cuts primarily due to declining enrollments, and funding issues have added to the pressures of stress involved with education today. Principals, as building leaders, feel these very real responsibilities as they represent the front line of their respective buildings dealing with these issues on a daily basis. This study investigated personal and professional factors to determine if they contributed to the overall wellness of these principals.

A questionnaire was administered to a population of 310 Kansas principals. The questionnaire consisted of demographic items that asked for personal and professional factors and the Perceived Wellness Survey developed by Dr. Troy Adams, Arizona State University. The responses from the questionnaire were analyzed to answer the research questions.

Major findings included significance between various aspects of perceived wellness with the following variables: (a) gender and psychological, social, and intellectual wellness, (b) age and spiritual, emotional, and intellectual wellness, (c) race/ethnicity with spiritual wellness and wellness composite scores, (d) marital status and wellness composite scores, (e) building enrollment and emotional wellness, and (f) building levels and emotional wellness.
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Chapter 1

Introduction

The issue of wellness has been overlooked when it comes to considering the principals who serve as the leaders of our public school facilities. It is interesting to note that an entire discipline of study exists concerning the health and wellness of students. At the same time, little attention has addressed school employee health (Directors of Health Promotion and Education, 2004). Specifically, the role of the school principal has become one of the most complex management positions within the entire public sector (Australian Government Primary Principals’ Association, 2004), yet little concern has been directed toward the wellness of that individual. Ballard (1991) supported this discrepancy noting, “Administrators in schools are expected to cope with high stress, low pay, and few health services because of an altruistic interest in children” (p. 111). The need for an awareness of the wellness of principals has never been greater than it is presently.

Increased expectations from state and federal legislation have caused Kansas K-12 public school building principals to experience increasing demands for their positions. Since the report, A Nation at Risk (United States National
Commission on Excellence in Education (USNCEE), 1983), educators at all levels have been subjected to intense scrutiny and extensive measures of accountability. The report, A Nation at Risk, authorized by the Reagan administration, claimed “a ‘rising tide of mediocrity’ in American public education” (Rothstein, 1998, p. 30). Education in America became a political issue as the report created alarm and concern among stakeholders in American education. The report contributed to the belief that American education was in a state of crisis (Berliner & Biddle, 1995). This report, followed by the involvement of legislators, business leaders, journalists, and concerned citizens, only added pressure for increased accountability on school personnel, especially teachers and administrators.

National attention to education led many states to evaluate the quality and content of their educational programs. In 1992, the Kansas Legislature passed the School District Finance and Quality Performance Act (Kansas Statute Annotated [K.S.A.] 72-6401 et seq.). This act required all public schools in Kansas to have a performance accreditation system in place for the 1995-1996 school year. In this act the legislature directed the Kansas State Board of Education to provide statewide assessments in core academic areas including mathematics, reading, writing, science, and social studies. The assessments were to be assessed at three different grade levels, and they were to establish curriculum standards for each discipline as well as determine performance levels for individual students and buildings (Kansas State Department of
Education, 2000). More recently, the “No Child Left Behind Act” was signed into federal law on January 8, 2002. This federal mandate represented a significant reform plan for elementary and secondary education that created legal accountability for all 50 states (Lewis, 2002).

Kansas acted in accordance with this legislation to provide leadership for the supervision of educational interests under its jurisdiction. The recent legislation included accountability components that demand performance at the individual and, ultimately, building principal level. To implement this legislation, the Kansas State Board of Education (KSBE) in 2001, committed to action that supported NCLB. The KSBE developed goals that directly connected Kansas public school education with No Child Left Behind legislation.

The Kansas State Board of Education (KSBE) adopted three goals to implement the No Child Left Behind legislation. The first goal identified by the KSBE was to “help all students meet or exceed academic standards” (Kansas State Board of Education, 2001). This goal demonstrated the direct correlation between state and federal mandates and expectations held by Kansas State Board of Education for all attendance centers. The second goal developed by the KSBE made a direct connection to the issue of wellness. This goal stated the responsibility to “recruit, prepare, support and retain a competent, caring and qualified teacher for every classroom and a leader for every school” (Kansas State Board of Education, 2001). This goal can only be reached if one considers the importance of wellness for educational staff. The third goal established by
KSBE demonstrated the connection between the increased expectations and the responsibilities of educators. This goal charged the state to “design a new delivery system that ensures the opportunity for all to learn” (Kansas State Board of Education, 2001). Together all three goals represented the focus created by the Kansas State Board of Education on the issues of education that relate to roles of educators and direct connection to the performance of students.

Educational administration by itself is not easy and the more stress that comes with the job, the harder it is to be productive, satisfied, and able to perform at a high level (Kennedy, 2002). Research in the area of wellness suggested a strong link between job retention and occupational wellness (Dorn, 1992). Furthermore, Gmelch, Koch, Swent and Tung (1982) stated that stress caused by the educational administrator’s role is linked adversely to productivity, job satisfaction, and performance. It is reasonable then to conclude that, the issue of wellness has to be considered in light of these changes and challenges. The next section discusses the background of this research on the principal’s perceptions of wellness.

**Background of the Study**

Kansas K-12 public school building principals face a wide range of duties and responsibilities. Recent emphasis on school reform; accountability; compliance with federal, state and organizational rules; and budgetary restrictions has burdened an already long list of job descriptors (Gorton, 1982). Since time is finite, these additional responsibilities can add stress to an
already demanding position (Gmelch & Chan, 1995). The simple fact is that a broader array of duties is being expected of principals today (Bloom, 1999; Henrickson, 1979; Hoerr, 1996). Principals’ duties nationwide, including those of Kansas K-12 public school building principals, involve increasing attention to issues of school improvement, financial constraints, and violence among students (Williamson & Campbell, 1987).

The initiatives that were developed with the purpose of school improvement brought with them unexpected negative side effects. The role of the building principal changed from manager to instructional leader. The principal was no longer only expected to simply run the day-to-day operations of a school, but now they must be knowledgeable in curriculum, instruction, and assessment (Hurley, 2001). It is no longer acceptable for the principal to only manage, budget, and deal with problems. The school improvement model of building principals requires them to do more by involving all stakeholders in the improvement process (Hoerr, 1996). Principals must measure and raise student progress, develop community involvement, and achieve vision for their buildings.

The negative fallout of the increases in expectations, brought on by school improvement initiatives, is demonstrated by the lack of administrators nationwide. In 2002, for instance, the state of Colorado reported in its 176 school districts 740 openings for principal positions (Whaley, 2002). In fact, the number of schools across the nation reporting a shortage of principals was
staggering. In 2001, the state of New York reported starting the year with 163 temporary principals (Groff, 2001). In the same report, the Vermont Department of Education identified 1 out of every 5 principals from the previous school year as having either retired or resigned. The state of Washington reported 15% of its principals in the same situation. This highlights what many consider a national crisis (Groff, 2001).

A Texas principal provided insight about the magnitude of school reform and retirement on his school district,

When I became a principal, I saw it as the best way to help students. I took the job because I loved the job, and I still do. Unfortunately, the job has changed so much that a lot of principals don't love it anymore. Many of my peers are choosing to retire. In fact, half of the principals in my school district will retire at the end of the year (Whaley, 2002, p. 2).

These examples demonstrate how the issues of educational reform over the last several years have been focused on improving schools. This new focus has been achieved by increasing attention on student performance, working to improve teacher quality, and increasing the number of teachers in the classroom (Matthews, 2002). At the same time, persistent criticisms from parents and taxpayers have centered on student performance and expenses related to tax increases. Consequently, many communities have faced budget shortfalls that have caused school districts to reduce or even eliminate administrators (Hurley, 2001). As a result, funds that were once allocated to
administration were redirected to cover other critical areas of the budget shortfall. While an obvious need exists to cover other areas of the budget, the need for sufficient principals to lead schools remains evermore critical.

Schools are continually asked to do more with less money. Principals and other school officials feel the financial constraint caused by the loss of capital. Morgan (1997) stated that as demand increases for all schools to do more with less money, administrators must become entrepreneurial. Site-based management, in addition to tighter budgets, has placed greater financial responsibility on principals. Shortt (1994) claimed that site-based management places more responsibility on the principal for budgeting and management of financial resources. As a result of site-based management, teacher involvement in budgetary matters creates an additional workload for the principals (Shortt, 1994).

A third area of added stress for principals is escalation of violence among students in schools. Safety, then becomes a central issue. Tragic incidents such as Columbine, Colorado and Paducah, Kentucky cause patrons as well as educators to be concerned about schools being a safe place to learn and work (Covino, 2003; Lickel, Schmader, & Hamilton, 2003). Principals, especially, feel the pressure of ensuring safety as they add this responsibility to a growing list of responsibilities (Doring, 1993). Principals are not only responsible for the academic outcomes in a school, but also for the safe passage to, and from school,
as well as safety at school (Henrickson, 1979). Violence and related safety measures have created additional work hours and stress on principals.

The impact these issues have on principals is difficult to measure. As the role of principals is considered stressful (Stewart, 1980), the causation must be investigated. A vast amount of research concluded that occupational stress has an adverse effect on principals and their performance, job satisfaction, and health (Doring, 1993; Dorn, 1992; Gmelch et al., 1982; Gmelch & Swert, 1984; Swent & Gmelch, 1977). Some research has considered the sources of stress and its effects, but little research has been conducted on how principals themselves evaluate their own levels of wellness (Smith, Bibeau, Altschuld, & Heit, 1988). The literature further indicated a lack of information on educator wellness (Sackney & Miller, 2000). The absence of literature on educator wellness and the lack of information on principals’ self-evaluation of wellness beg for research in these areas. The next section discusses the rationale used for this study.

Rationale

This study was based upon two basic assumptions about the perceptions of wellness for Kansas K-12 public school building principals. The assumptions included (a) perceptions of health and wellness are valid indicators of wellness, and (b) wellness is a multi-dimensional lifetime process. The following information explored these assumptions in selected literature.
Perceptions

A plethora of literature supported the concept that health and wellness perceptions are valid indicators of wellness. The literature suggested individual perceptions of wellness were accurate measures with highly stable agreement of future health outcomes (Adams, Bezner, & Steinhardt, 1997; Idler, 1995; Kane, 1996; Lepper, 1998; Palombi, 1992). Another study of perceptions related to wellness status (Wilson & Cleary, 1995), found that issues related to wellness perceptions lead to powerful predictors of future health outcomes.

Because perceptions are a state of mind, empirical research was conducted in many other fields including social, stress, and medical research (Adams et al., 1997). The literature supported the belief that the mind works with the body in an interactive way to influence and understand overall health and wellness (Adams, Bezner, Garner, & Woodruff, 1998; Crose, Nicholas, Gobble, & Frank, 1992). Furthermore, the literature promoted perceptions as being a mental state that had a very real and powerful influence over the health of a person (Goleman, 1995). This research suggested a strong correlation between the measurement of wellness perceptions and the actual conditions.

A number of factors were found to help determine an individual’s overall wellness (Palombi, 1992). Several indicators contributed to each individual’s distinction of their state of wellness. These distinctions of individual states of wellness were found to vary as well (Kane, 1996). The research indicated that many people adapt their perception of wellness to create a new level of
understanding depending on their existing steady state (Adams, 2003; Greenburg, 1985; Kane, 1996). Other research went so far as to suggest that individuals could accurately indicate or predict their current state of wellness, often better than professionals (Kane, 1996). Kane also supported the use of a simple continuum from one extreme of wellness to the other pole as an effective measure of wellness (p. 2).

Wellness

The literature supported the second assumption that wellness was a lifetime process. This idea started when Halbert Dunn defined the term of wellness as “an integrated method of functioning which is oriented toward maximizing the potential of which the individual is capable” (Dunn, 1961, p. 4). Many definitions of wellness have since been created (Danna & Griffin, 1999). Of these definitions, common ground existed where they describe wellness as a lifetime process with no definite end or beginning. Rather, it was seen as an ongoing process with the primary purpose to increase the likelihood of a healthier life (Ardell, 1986; Palombi, 1992; Robbins, Powers, & Burgess, 1991). These definitions encompassed the individual’s role as an active participant in the acquisition of desired levels of wellness.

Many definitions existed for wellness, and just as many of those definitions included dimensions of wellness, indicating its multifaceted characteristics. The recurring theme for wellness was that the term covered many dimensions of a person’s life (Sackney & Miller, 2000). This author refined
his explanation by stating that wellness “involves a lifestyle with an integrated pattern of living focused on six dimensions” (p. 43).

The dimensions of wellness viewed in a holistic model consisted of six dimensions including physical, spiritual, psychological, social, emotional, and intellectual domains (Adams et al., 1997; Connolly & Myers, 2003; Hettler, 1984). Another author depicted the dimensions of wellness by defining wellness as “giving care to the physical self, using mind constructively, channeling stress energies positively, expressing emotions effectively, becoming creatively involved with others and staying in touch with the environment.” (Ardell, 1986, p. 46). This narrative described clearly dimensions that create the existence of wellness. For clarity of the research, the six dimensions selected for this study were based on theoretical support that substantiated their inclusion (Adams et al., 1997).

The literature established quite clearly that being well required a multidimensional approach (Kitko, 2001). Wellness, therefore, involved a balance of each dimension for overall effectiveness allowing people to maintain a balance in their life (Powers, 1994). This balance required individuals to focus on the whole or holistic aspect of wellness. This focus directed attention to each dimension of wellness, the dependence on balance, and the ongoing process that is a part of lifelong wellness.

Assumptions discussed have provided research literature that supported the rationale for this study. In summary, perceptions were found to provide a
valid measure for determining individual states of wellness. Perceptions could be measured effectively using a self-reporting scale on a simple rating continuum to establish a perceived state of being. Also, wellness was described by literature as a multi-dimensional process (Adams et al., 1997; Ardell, 1986; Bezner, Adams, & Whistler, 1999; Dobbs, 1994; Hettler, 1984; Hoeger, 1989). The research suggested that a number of dimensions make up a person’s life. These dimensions of wellness are integrated and require a balance in order to reach a high level of wellness (Morris & Devane, 1994; Robbins, Powers, & Burgess, 1999; Witmer & Sweeney, 1992). Research literature also found wellness to be a process that is continual for each individual in their attempt to maintain health. This incorporated a constant and intentional focus that highlighted the importance of the perceptions of wellness by all individuals including educators.

Conceptual Framework

Based on the literature previously discussed, the conceptual framework for this study has evolved from related theories. The need for this study has been demonstrated through literature that indicated perceptions are a viable means of wellness assessment as well as a shortage of information on educator wellness. The term wellness has been considered a synonym with health, “intended to mean good health, a balanced life, and well being” (Sackney & Miller, 2000, p. 42). Recent researchers have developed the understanding of
wellness to include a lifestyle involving a continual attempt to reach a higher level of wellness in all areas of one's life (Robbins et al., 1999).

The overarching point of the various definitions of wellness is that it covers many aspects of a person's life. While the literature has defined wellness with some differences, the main concept has been that wellness involves multi-dimensional properties (Adams, 2003).

For purposes of this research, wellness is salutogenic or health causing in nature. This aspect originated from Antonovsky (1988) who suggested that practices and research need to be directed to identify and reinforce causes of wellness instead of just illness, sickness, or disease. Wellness is proactive in the salutogenic arena for each dimension. The balance of each dimension creates the unique quality that each individual demonstrates. The dimensions that receive salutogenic attention vary for every individual in scope and depth (Wilson & Cleary, 1995).

Balance becomes a key to wellness in understanding, measuring, and describing wellness for individuals (Sackney & Miller, 2000). This enhances the importance of perceptions to describe the balance of wellness (Adams, 2003). Perception of wellness provided the core of the basis for this research.

The use of the Perceived Wellness Survey (PWS), developed by Troy B. Adams and associates, provided an instrument that enabled this researcher to measure the perceived wellness of Kansas principals for this study. The PWS was developed as a salutogenically-oriented, multidimensional measure of
perceived wellness (Adams & Bezner, 2000). It uses the perceptions of the physical, spiritual, psychological, social, emotional, and intellectual dimensions. Each dimension has six items for the respondent to identify their perception of wellness. The questions range from the poles of 1, for “strongly disagree” to 6, for “strongly agree”. The scoring of this instrument allows the researcher to observe the balance, magnitude, and overall score for each respondent. Combined with the data provided from the demographic information, the framework for this research was established.

Statement of the Problem

Increasing responsibilities and challenges face Kansas K-12 public school building principals today. The ability to shoulder these responsibilities can be measured by their overall job performance. Because wellness can affect job performance and ultimately impact student achievement, it is important to identify the extent to which Kansas K-12 public school building principals perceive their own personal wellness. Across the nation principals are leaving their positions in record number. Unable to meet expectations and increasing demands have, no doubt, taken their toll on the profession. The number of principal vacancies across the nation is expected to grow 10 to 20% by 2008 (Groff, 2001). This research highlights the direct relationship between principals’ perceptions of wellness and the increasing complexities of their occupations.
Purpose of the Study

The purpose of this study was to examine Kansas K-12 public school building principals’ perceptions of their own wellness. The study further investigated the effect that various personal and professional variables had on these perceptions.

The insights gained from this research will inform Kansas K-12 public school building principals, as well as legislative and local administrative bodies by identifying benefits of holistic wellness. These benefits include links between principals’ wellness and the way in which they need to work to promote and encourage holistic wellness among their staffs and their students. This research provides a clearer understanding of the needs of holistic wellness and the benefits that can be gained by all participants.

Research Questions

This research investigated Kansas K-12 public school building principals’ perceptions of their own wellness. Three specific research questions are addressed:

1. How do Kansas K-12 public school building principals perceive their own wellness?

2. To what extent do personal factors contribute to Kansas K-12 public school building principals’ perceptions of wellness?

3. To what extent do professional factors contribute to Kansas K-12 public school building principals’ perceptions of wellness?
Significance of the Research

The results of this research provide Kansas K-12 public school building principals, their administrators, board members, and other school district stakeholders with knowledge about perceptions of specific stressors and the effects of these stressors on their attendance center (building) principals. This knowledge presents Kansas administrators, Kansas State Board of Education, the Kansas State Legislature, and other governing school board bodies awareness of the link between wellness, occupational performance, and job satisfaction. Researchers to date have not focused on rural states' public school principals and their perceptions of wellness, and no research is available specifically about Kansas K-12 school building principals.

The information gathered by this research ascertained the areas in which Kansas K-12 school building principals must recognize in order to enjoy holistic wellness. For the purpose of this research, holistic wellness included physical, spiritual, psychological, social, emotional, and intellectual wellness, all of which contribute to occupational success and job satisfaction. Results of this research will provide the data to encourage and inspire Kansas K-12 public school building principals to address the issue of wellness and to take the necessary steps to be responsible for their own well-being.

Limitations

This research was limited to Kansas K-12 public school building principals. The population from which the random sample was selected included
principals of public elementary, middle school/junior high, and high schools in Kansas. The research does not include private or parochial educational settings.

The research is further limited by the wellness dimensions used in the Perceived Wellness Survey (PWS) (Adams et al., 1997). Other researchers may wish to include or exclude any of these dimensions, or may wish to define wellness in different ways. A phone conversation with Dr. Adams led to understanding of the PWS as an instrument to assess perceived wellness (T. A. Adams, personal communication, January, 2002). The omission of descriptors, except for the poles, on labels for the 6-point Leikert scale was purposely developed to avoid the confusion of having to accurately depict a definition for perceptions of each label. Adams noted the need for caution when comparing variables stating, “what one person believes to be an acceptable form of wellness, may vary greatly with another person’s assessment of wellness with similar conditions” (Adams, 2002). This factor of the PWS design precludes researchers from categorizing an individual’s wellness. The PWS instrument, therefore, does not allow for determination of individual wellness. The PWS instrument does, however, allow researchers to measure individual’s perceptions of their own wellness and provides data for researchers to compare perceptions of wellness among related groups.

Finally, this research may be limited as it does not fully explore occupational factors that affect Kansas K-12 public school building principals,
including, perhaps, the distinctions between rural Kansas schools and more urban Kansas schools.

**Overview of the Methodology**

This research used quantitative methods to collect data from a statewide sampling of principals. Three hundred ten randomly selected principals of K-12 public school attendance centers were mailed a questionnaire titled, Principal Wellness Questionnaire. They were asked to complete items relating to personal data, professional data, and perceptions of their own individual wellness. Of the 310 selected principals, 236 returned usable results for a response rate of 76%.

This Principal Wellness Questionnaire consisted of two sections. The first section consisted of nine demographic questions. The second section used the Perceived Wellness Survey developed by Troy B. Adams, Ph. D., and associates. The Perceived Wellness Survey consisted of 36 questions that asked respondents for perceptions of their wellness. The survey consisted of six questions for each of six dimensions of wellness surveyed. These dimensions included physical, spiritual, psychological, social, emotional, and intellectual domains.

Questionnaire and survey data were gathered for analysis with the use of the Statistical Package for the Social Sciences (SPSS), version 11.0. Measurements of central tendency provided statistical results. Descriptive and inferential statistics were also used for data analysis including t-tests, Spearman rho correlation coefficients, and one-way analysis of variance. A more
in-depth account of data analysis procedures, as well as the sample selection, can be found in Chapter 3.

**Definition of terms**

For purposes of clarity, the following terms used in the research require definition:

**KSBE** – KSBE refers to the Kansas State Board of Education that consists of ten elected members charged with supervision of public education and its interests.

**Attendance center** – An attendance center is a location for the purpose of attending school. An attendance center may house one or more configurations, such as an elementary, middle/junior high, high school, or some other variation of such formations such as a K-12 setting. Attendance centers are often referred to as “buildings.”

**Kansas’s K-12 public school building principals** – These principals are the subjects of this research. The subjects represent the leaders of their respective attendance centers that are a part of the K-12 public school system made up of Kansas’ 303 unified school districts.

**Wellness** – Wellness is an integrated and dynamic level of functioning, which is oriented toward maximizing potential, dependent upon self-responsibility (Robbins et al., 1991).

**Holistic wellness** – Holistic wellness refers to “viewing a person and his/her wellness from every possible perspective” (Ardell, 1986, p. 5)
In this research, the concept of wellness includes a variety of dimensions:

**Physical wellness** – Physical wellness involves operational functions of the body including, but not limited to, blood pressure, coronary heart disease, diet, exercise, and sleep (Powers, 1994).

**Spiritual wellness** – Spiritual wellness centers on the meaning and philosophy of life. Morality, values, ethics, and religion are all components of this dimension (Powers, 1994).

**Psychological wellness** – Psychological wellness refers to the perception one has of the outcomes to the events and circumstances that make up one’s life (Ardell, 1986).

**Social wellness** – Social wellness involves having support from family and friends in times of need (Adams et al., 1997). It also encompasses the day-to-day dealings with other people (Powers, 1994).

**Emotional wellness** – Emotional wellness involves an ability to cope, accept, and adjust to change, as well as maintaining relationships (Powers, 1994). A facet most commonly connected with emotional wellness is self-esteem, (that is, “a secure self-identity and a positive sense of self-regard”) (Adams et al., 1997).

**Intellectual wellness** – Intellectual wellness involves using the mind as well as one’s ability to use his mind (Powers, 1994). Intellectual wellness includes active participation in scholastic, cultural, and other learning activities for the purpose of expanding knowledge and improvement of skills.
Perceived Wellness Survey (PWS) - (Adams et al., 1997) The Perceived Wellness Survey is a multidimensional measure of wellness perceptions including six dimensions of wellness: physical, spiritual, psychological, social, emotional, and intellectual domains.

Organization of the Study

This study follows a five-chapter format. Chapter 1 provides an overview of the research with particular emphasis on the purpose of the study and the research questions considered. Chapter 2 presents a review of the relevant literature including historical perspectives of wellness, definitions of wellness, and dimensions of wellness considered in this research. It further includes the theoretical framework for the research and the hypotheses considered in this research. Chapter 3 details the methodology used in this research. Chapter 4 describes the data, analyses of the data, and the findings. Finally, Chapter 5 contains a statement of the findings, presents the conclusions, and addresses the implications of the research.
Chapter 2

Review of the Literature

Wellness has become a popular topic in recent years as it has addressed many factors that affect peoples’ lives such as relationships, diets, and stress, to name a few. Recently, corporations have implemented programs that highlight the value of wellness with many of those companies finding decreases in sick leave, workers compensation costs, and disability days while at the same time finding increases in their investment (Swanger, 2002). Added to that, national attention has shifted to wellness as a result of rising health care costs (Lachnit, 2002). The educational sector has been lacking, or slow at best, in the exploration of the value wellness could provide (Sackney & Miller, 2000). With available knowledge on benefits of wellness in the business sector, wellness must become a part of all educational circles.

Most educators recognize the increase in expectations, pressure, and ultimately, stress, that recent achievement mandates have created on public education at the federal, state, and local levels (Kennedy, 2002; Richardson, 1998; Sternberg, 2001). These issues have started to take their toll on administrators. Ripley (1997) addressed this topic directly stating:

Principals today are pulled in different directions and some are breaking under the stress. They are pressured to do this by one group, to do that by another; they find the needs of some students conflicting with the needs
of others; the must deal with parents who want one thing while the staff wants another. Principals must deal with tension every day. (p. 55)

Yet, while this added pressure is understood, budget cuts and funding deficits have only complicated the issue by compounding the lack of wellness in the educational setting (Gilman & Lanman-Givens, 2001; Hurley, 2001; Thomas, 1999; Whaley, 2002).

Because of the leadership role that principals inherit, it is important for a school district to help its principals develop an understanding of wellness that, ultimately, will allow them to become more effective leaders (Sackney & Miller, 2000). This will not only benefit administrators, but it will also have a positive impact on other administrators, teachers, support staff, and students.

The review of the literature in this chapter is framed around several important and related areas, including (1) historical perspective of wellness, (2) defining wellness, (3) the dimensions of wellness, (4) perceptions, (5) the principal’s role, (6) the impact that wellness has on job performance, and (7) wellness initiatives. The chapter concludes with a summary of these areas.

**Historical Perspectives of Wellness**

Certainly two of man’s earliest wellness concerns were the need to survive in hostile environments, involving finding shelter and keeping safe from predators, as well as the constant need to find food (Matarazzo, Weiss, Herd, Miller, & Weiss, 1984). From the ‘forbidden fruit’ of Biblical times to herbs and spices even today, people continually seek the height of potential wellness.
Greek Civilization had a philosophy of wellness that linked the wholeness of mind and body (Mackin & Shillingford, 1991). More recent philosophers and cultures added to the Greek idea of wellness by adding the component of spirit to mind and body wholeness (Morris & Devane, 1994).

One ancient system of healthcare involving the mind and body was known as Ayurveda. According to Gormley (2000), Ayurveda was considered to be the oldest healing science and was a holistic approach to health care that was intended to help people live long, healthy, and well-balanced lives. Ayurvedic medicine began in India about 5,000 years ago and is still being practiced around the world today (Neimark, 2004; Weber, 1998).

Ayurvedic tradition believed that each person had basic biological energies. The biological energies, also known as doshas, determined emotional traits, the kinds of foods a person should eat, and the kinds of activities that in which to partake (Gormley, 2000). The main guideline of Ayurveda was to avoid illness by maintaining a dosha balance throughout the body, mind, and consciousness. This was usually achieved by the use of herbal remedies, meditation, yoga, proper diet and life-enhancing lifestyle (Kessler & Goodkind, 1998).

Moses Ben Maimon, generally known by his Greek name Maimonides, developed the biopsychosocial approach during the 12th century (Maimonides, 1958). He believed that a person functions as a combined process encompassing the spiritual, natural, and physical. Maimonides promoted practices such as
avoiding areas of polluted air, living in places with an open horizon that allows the north winds and sun to penetrate, doing bodily exercise that involves movement, bathing at least once every ten days, and maintaining a reasonable weight. He also believed that when negative emotional states persisted, a person was more likely to become ill (Maimonides, 1958).

Similar to other ancient healing systems, Native American medicine used a holistic approach to medicine that focused on the treatment of the whole person, including the spiritual, physical, mental, and emotional aspects (Davis, 2000). The medicine men, medicine women, and shamans who were the Native American healers believed that individual health must work together with the natural and spiritual world. Therefore, they used symbolic healing rituals, ceremonies, and herbal remedies. Native American medical interventions also included medical herbs and healing plants. Seven out of the ten top-selling herbal remedies still being used in the U.S. today were first used by Native Americans (Davis, 2000).

A number of citizens formed the Popular Health Movement during the 1830’s and 1840’s. Supporters of the Popular Health Movement utilized approaches that midwives and lay practitioners had long used to heal their patients. These approaches included herbal remedies, proper nutrition, clean water, exercise, disease prevention, the body’s innate ability to heal itself, and health education. The Popular Health Movement and herbalists such as Samuel Thompson and Wooster Beach petitioned states to allow for certain
complementary and alternative medicine therapies to be incorporated into everyday health care. As a result, 69% of Americans still use at least one form of complementary and alternative medicine during any given year (Miller, 1999).

Andrew Taylor Still, MD, a physician at the time of the Civil War, was very dissatisfied with the medical profession during that era. He had personally lost three of his own children due to spinal meningitis and wanted to find better ways to treat patients. He noticed that his patients had areas of soreness, swelling, tightness and other physical problems. After working with them manually and achieving better results than with his medicines, he determined that bodily function and structural abnormalities were closely related. The body was made to heal itself, and manipulating the body and restoring it to original alignment normalized the nerve and blood supply, which promoted the body’s normal healing process (Magoun, 2000). His ideas were not accepted by medicine, so he established the new medical philosophy of osteopathy. Osteopathy supports the holistic medical philosophy (Magoun, 2000).

Since the Industrial Revolution some 300 years ago, significant improvements in maintaining and measuring wellness have occurred. McKay (1984) identified improvements in hygiene, public health control of the environment, and the increased production of food as contributions to improving mortality rates.

Anthroposophic medicine was founded by Rudolf Steiner in the early 20th century (Incao, 1997). Anthroposophic medicine blended mainstream medicine
with a holistic understanding of human beings having a spirit, soul, life forces, and a physical body. The Anthroposophic physician’s goal was to develop his or her intuitive grasp of the spiritual dynamic at work in every illness (Incao, 1997).

Continued advances and improvements led to changes in patterns such as illness, longevity, and death. As early as the 1920’s companies began developing health programs that stressed training and health education of workers (Crump & Gebhardt, 1990). Most of these programs were described as instructional in nature but the programs did not provide a change of routine (Crump & Gebhardt, 1990). However primitive, these programs demonstrated early attempts at improving the overall well-being of individuals.

The idea of health and wellness has evolved. The World Health Organization (WHO) created a definition of health around 1940. Prior to that time a person was viewed as healthy when they presented no indication of disease. WHO’s definition of health was, “a state of physical, mental, and social well-being and not merely the absence of disease.” (Kitko, 2001). This definition expressed the relationship between health, wellness and the whole person. This link has prevailed to the present time.

Meanwhile, A. H. Maslow (1943) was developing his hierarchy of basic needs. He understood that man was at his best when he had such values as truth, goodness, beauty, unity, transcendence, aliveness, uniqueness, perfection, justice, order, and simplicity. This thinking led Maslow to develop a universal
model for basic human needs, including physiological needs, safety needs, love needs, esteem needs, need for self-actualization, and, finally, the desire to know and understand. In Maslow’s model, a person’s basic human needs had to be met before he or she, could work in higher levels of the hierarchy like knowing and understanding (Maslow, 1943).

Businesses came to link productivity with healthy workers in the 1950’s. McGregor (McGregor, 1957) wrote that if workers’ basic needs were not met, then in the workplace they would perform with “indolence, passivity, resistance to change, [and] lack of responsibility” (p. 112).

Wellness was introduced in the United States as a health concept around 1960. Dr. Halbert Dunn, the first director of the United States National Office of Vital Statistics has been credited with the modern era concept of wellness (Ardell, 1986; Dobbs, 1994; Powers, 1994; Sackney & Miller, 2000). Dunn emphasized the importance of achieving a high level wellness that went beyond the mere status of “disease free” (Ardell, 1986). Dunn pioneered a new vision by promoting health “as an elevated [emphasis in original] state of superb well-being” (Powers, 1994). This became a springboard for future research and studies involving wellness. The President’s Council on Physical Fitness and Sports (PCPFS) was established in the 1960s to help school age students develop and maintain a physically fit lifestyle (Morris & Devane, 1994). Along with Dr. Dunn’s emphasis on wellness, the PCPFS exemplified the interest the United States was demonstrating in the arena of wellness.
The literature revealed a link with wellness to premature deaths. Julius B Richmond, M.D., United States Surgeon General in the 1970s reported in *Healthy People: The Surgeon General’s Report on Health Promotion and Disease Prevention* (1979) that, “20% of all premature deaths and a vast amount of disease and disability could be eliminated by protecting our people from environmental hazards” (p. 151). This was supported by Benson & Stuart, (Benson & Stuart, 1992) who stated, “as many as half the premature deaths in the United States may be due to unhealthy behaviors or lifestyles” (Benson & Stuart, 1992 p. 12). This was one of the first links between wellness and lifestyle. Alderfer (1972) built on this linkage by developing a relationship between Maslow’s hierarchy of needs and workers’ motivation and job design. Alderfer wrote,

... individuals are motivated to seek need fulfillment primarily from their job or task environment, motivation, positive job attitudes, and increased performance result from providing individuals settings in which their needs can be fulfilled through effective work performance. (p. 34)

More recently, wellness has become a major money making industry. Companies have continually developed, promoted, and sold ways for individual to achieve a higher level of wellness (Matarazzo et al., 1984). Thousands of products were developed because of the desire to achieve wellness (Ardell, 1986). The weight-loss industry alone has been estimated to be a “$33-billion-a-
year-industry” (Bertman, 1998). While the importance of wellness has seen recent growth in popularity, wellness in education is a relatively new concept.

During the 1990s and into the new century, development of wellness programs was included as a standard component of most businesses. More than 500 corporations in the United States had multifaceted wellness programs for the benefit of their employees in 1985 (Plowman & Bischoff, 1985). Wellness programs existed in more than two-thirds of America’s businesses that had more than 50 employees (Fisher & Hill, 1992). The success of these programs contributed to the continued development of wellness in the workplace. Swanger (2002) found that companies providing wellness programs and incentives for wellness lifestyles not only improved employee morale, reduced absenteeism, and created safer work environments, but they also increased their production.

In spite of increased awareness and programs in business, public education has not given wellness the same emphasis as the private business sector. A significant amount of research has been conducted for the business world related to wellness, but in the arena of education, very little research has been conducted involving the health status of administrators (Smith et al., 1988).

**Defining Wellness**

The literature lists several approaches that contribute to the working definition of wellness. Each of these approaches added another dimension to the concept of wellness.
Dr. Halbert Dunn (1961) defined wellness as, “an integrated method of functioning which is oriented toward maximizing the potential of which the individual is capable. It requires that the individual maintain a continuum of balance and purposeful direction within the environment where he is functioning” (pp. 4-5). He suggested an ongoing process involved the whole person who was striving to achieve his/her potential with what resources were available.

Greenburg (1985) defined wellness as the integration of five dimensions at any level of health or illness. Identified dimensions included physical, mental, social, emotional, and spiritual. Greenburg’s definition of wellness considered these dimensions as separate but important factors to wellness. He suggested that one dimension could be very fit or healthy while another dimension could be poor or ill. Morris and DeVane (Morris & Devane, 1994) also described wellness with five dimensions which included social, mental, emotional, spiritual, and physical health but considered wellness as the integration of these five dimensions.

Leonard Horowitz developed The Self-Care Motivation Model that utilized as many human functions in the educational process as possible. This holistic model included emotion-feelings, impulse-desire, thoughts, intuition, imagination, and body-sensations in terms of the essential self. Personal awareness was at the center of physical, mental, and emotional functions. As individuals developed awareness, they became less inhibited by physical,
mental, or emotional changes in terms of both health and disease (Horowitz, 1985).

While Greenburg’s definition included five dimensions as key ingredients to complete wellness, Hettler’s (1984) definition provided an additional dimension, the occupational domain. Hettler’s model defined wellness as “an active process through which individuals become aware of and make choices toward a more successful existence” (p. 1118). Here wellness was dependent upon balancing lifestyle choices in all aspects of life. Hettler theorized that awareness of each component allowed individuals to actively involve themselves in the process of their own wellness.

Hoeger (1989) defined wellness as, “the constant and deliberate effort to stay healthy and achieve the highest potential for total well-being” (p. 4). His concept incorporated eight key components: physical fitness, proper nutrition, stress management, health education counseling, medical-physical screening, alcohol and drug abuse control, smoking cessation, and diet/weight management – all related to lifestyle issues. Like Dunn and Hettler, he specifically emphasized balance as a necessity to wellness. He used a continuum that placed wellness in the balance of adequate fitness and environmental supports, leading to the goal of total well-being. At one end of the continuum was premature death; at the other end was high-level wellness. The model named certain behaviors such as smoking cessation and health education counseling as ingredients to the concept of wellness.
Richard Eberst’s Health Cube Model included six sides or dimensions of health. His dimensions included mental, physical, vocational, spiritual, emotional, and social. Total wellness would be illustrated when all six dimensions were in the same situation. When one dimension was exercised, the changes would also affect the other five dimensions. So, health professionals were to keep in mind the whole person rather than focusing only on individual aspects of health. Consequently, this model also promoted a holistic view of health (Eberst, 1984).

Adams, Bezner, and Steinhardt (1997) discussed the power of perceptions in wellness, and concluded that the study of wellness perceptions interfaced well with an overall model of health. Individual perceptions were important to the discussion of holistic wellness because one’s personal perceptions often preceded actual illness as well as wellness. Adams’ subsequent Perceived Wellness Survey (Adams et al., 1997) introduced a multidimensional measure of perceived wellness perceptions as they related to physical, spiritual, psychological, social, emotional, and intellectual dimensions of holistic wellness. Figure 1 represents Adams’ model.
Figure 1, Adams’ Perceived Wellness Model.


Robbins, Powers, and Burgess (Robbins et al., 1999) of Ball State University defined wellness as “an integrated and dynamic level of functioning oriented toward maximizing potential, dependent upon self responsibility” (p. 4). This definition described wellness as a participatory action, a lifestyle in which the participant was involved in an “ongoing attempt to reach a full potential” (Powers, 1994, p. 6). Robbins, Powers, and Burgess built upon the work of Dunn and defined wellness almost identically with the difference being
the dependence upon self-responsibility (Robbins et al., 1991). Six dimensions emerged in this definition: emotional, intellectual, occupational, physical, social, and spiritual.

Robbins et al. (1999) encompassed wellness as an on-going process that involved making choices through self-responsibility. Decisions people made had a direct impact on the quality of life those individuals chose (Powers, 1994). Powers (1994) stated that people need to manage an equal balance among all dimensions of their lives in order to achieve wellness.

The National Wellness Institute (2002) provided a similar definition using the themes of process and individual choice. Its definition stated that “Wellness is an active process of becoming aware of and making choices toward a more successful existence.” While balance was not included in this definition it was implied in the choices one must make in all dimensions of life. This created the balance that leads to wellness.

A strong linkage existed between balance and wellness. When a person’s perceptions of wellness were out of balance, the person described himself as ill, isolated, depressed, less tolerant of other people, easy to anger, or unable to focus (Clark-Reynolds, 2002). Clark-Reynolds (2002) suggested that being out of balance was being in chaos.

Chaos theory (Gleick, 1987; Wheatley, 1992) addressed the concept of balance. In this theory chaos occurred from the dynamics of living: order (or balance) was described as the mirror image of chaos (or imbalance), and within
the state of chaos, a system was held by boundaries that were well-ordered and predictable, that is, the definition of holistic wellness (Wheatley, 1992). The clear link between Clark’s conception of chaos and the chaos theory described by Gleick and Wheatley was the importance of maintaining an orderly, prioritized life. When this occurred, a person achieved a sustained, high level of personal wellness throughout his or her personal lifespan.

According to Robbins et al. (Robbins et al., 1991), all one had to do was perceive being out of balance and then make choices to bring oneself back into balance. This potentially involved new ways of thinking, behaving, and interacting with others (Robbins et al., 1999). Robbins’ findings indicated the importance of a person being alert and making corresponding life adjustments to achieve balance and ultimately a high level of personal wellness. Wellness involved a person becoming the best he can be in all dimensions of life.

**Dimensions of Wellness**

Each definition of wellness involved a number of areas, or dimensions. While there was variation in the number of these dimensions, most definitions concluded that wellness was multidimensional (Robbins et al., 1999). According to Corbin and Pangrazi (2001), the physical, social, intellectual, emotional, and spiritual dimensions were the most common areas used to describe wellness (p. 2).

Adams, Bezner, and Steinhardt’s (1997) definition of wellness encompassed all aspects of a person’s life, including professional and personal
characteristics referred to as dimensions (Ardell, 1986; Hettler, 1984; Powers, 1994). Identified wellness dimensions included: physical, spiritual, psychological, social, emotional, and intellectual.

**Physical Dimension**

Researchers reported that the physical dimension of wellness received the most attention (Greenburg, 1985; Hoeger, 1989). Physical wellness included the functional operation of the body itself, including exercise, diet, drugs, smoking, sleeping, and medical needs. Many reported benefits came from participation in a regular physical fitness program. One of the most noted benefits of this practice was improved quality of life (Hoeger, 1989).

Corporations developed wellness and fitness programs for this reason. Plowman (1985) suggested that educators should be encouraged to incorporate physical wellness into their lives. Physical vitality was found to be worth the effort. Decreased job frustrations, improved teacher creativity, better student tolerance, and increased quality of life were some of the rewards the study found to materialize.

**Spiritual Dimension**

The spiritual dimension of wellness involved developing the inner self and soul. The need to find meaning and purpose in one’s existence and an appreciation of life contributed to spiritual wellness (Ardell, 1986; McGuire & Snow, 1994). Ethics, values, and purposes or needs were also part of this component of wellness (Powers, 1994). Spiritual wellness was not limited to
religious beliefs. Spiritual wellness included concepts such as character, morals, and values, as well as beliefs (Kolander & Chandler, 1990). Dyer (2001) wrote that religion was something people come into and was the foundation to how they were raised to obey a set of customs and traditions. While these customs were outside the person, they dealt with expectations of spirituality. Dyer (2001) further explained, “spirituality is from within, the result of recognition, realization, and reverence” (p. 10). This definition offered a distinct difference between religion and spirituality.

Attitudes, beliefs, and philosophies were examples of work site behaviors that could have an important connection for the spiritual wellness of educators. Dyer (2001) stated that every person was at some state of spiritual wellness, varying from poor to well. The higher the level of wellness component of spirituality, the more likely that person was able to help with the inner well-being of those they encountered.

**Psychological Dimension**

The psychological dimension of wellness referred to the perception one had of outcomes to events and circumstances that make up one’s life (Ardell, 1986). Herman and Hazler (1999) defined this dimension as an “internal focused method of attaching value to the quality of life and affective experience generally accepted as a . . . construct with long-term . . . [and] short-term components similar in design to the trait/state distinction in anxiety” (p. 2).
Consequently optimism was considered to be the basis of psychological wellness (Adams & Bezner, 2000).

David Dwyer (1984) wrote an application example of the psychological dimension of wellness when he described successful principals. Successful school principals were aware of the restrictions and problems posed by their respective communities. “Whether their schools served poor or wealthy neighborhoods, these leaders found opportunities to extend the available human and material resources to their schools” (Dwyer, 1984, p. 34). Successful principals were able to find opportunities where others saw only problems. The principals made their schools community focal points in their neighborhoods while acquiring valuable resources and security.

Mental health was identified as a large component of psychological wellness. McGuire and Snow (1994) defined mental health as:

a crucial component necessary for high-level wellness because sound mental health involves a positive self-concept, a strong sense of feeling worthwhile and liking oneself, a strong sense of realism, self acceptance, self identity, and the ability to be honestly introspective about personal values, desires, obligations, and feelings of the past, present and for the future. (p. 14)

Another aspect of psychological wellness included how one dealt with his job or career. Sometimes referred to as occupational wellness (Dorn, 1992), psychological wellness involved balancing a career with personal life and
dealing with the work environment. Balancing a career included the identification of internal and external rewards needed in a career and the awareness of personal motivations and/or challenges that an occupation might bring. A strong body of evidence supported a relationship between experiences from a work environment and an individual’s health (Dorn, 1992). The work environment was also identified as a factor of the occupational dimension. Physical factors such as lighting, air quality, safety, and comfort were all a part of the work environment (Sackney & Miller, 2000 and Dorn, 1992).

Jahoda, Pert, Squire, and Trower did a brain research study in 1998 about the comparison of the predicted responses and self-concepts of aggressive and non-aggressive people with an intellectual disability when faced with stress and conflict. They found that some people gained status from being aggressive and some of the participants wanted to appear tough. These findings did not support the idea of working to improve self-perceptions. However, some of the aggressive males may have discovered that aggression was the only way that they could progress towards desired goals (Jahoda, Pert, Squire, & Trower, 1998). The participants may have also felt powerless to affect many aspects of their lives (Jahoda et al., 1998). Challenges associated with balancing career with personal life could make individuals such as high profile school administrators feel powerless as well when facing stress and conflict (Ripley, 1997).
Candace Pert (1997) explained the emotional aspect of psychological wellness in this way: “when emotions are expressed ... all systems are united and made whole. When emotions are repressed, denied, not allowed to be whatever they may be, our network pathways get blocked, stopping the flow of the vital feel-good unifying chemicals that run both our biology and our behavior” (Pert, 1997, p. 273). This further demonstrated the connection psychological wellness had with optimism.

Social Dimension

The social dimension of wellness involved interactions with other people. Characteristics of this dimension included accepting differences, getting along, and showing concern, fairness, and concern for all humans and the environment (Powers, 1994). Social wellness encompassed community involvement in improving the social surroundings (Sackney & Miller, 2000). Healthy relationships with other people contributed to the ability of people to achieve a lifestyle of high-level wellness (Ardell, 1986).

Putnam (2000) addressed the value of social wellness and the importance it plays in overall wellness by describing this dimension as “social capital.” He said it “calls attention to the fact that civic virtue is most powerful when embedded in a dense network of reciprocal, social relations. A society of many virtuous but isolated individuals is not necessarily rich” (p. 19). Putnam underscored the value of social wellness by suggesting that it was profitable for the individual who participates in social capital as well as for the public that
benefits from social involvement. Rotary and Lions Clubs were examples of social organizations that had social capital. These organizations had the potential to benefit a community while at the same time providing members with friendships and connections that have individual value.

Kouzes and Posner (1990) vividly described the impact of relationship upon effectiveness. When explaining what followers expect from their leaders, Kouzes and Posner indicated that being able to lead successfully depends more upon the follower’s view of the leader’s capabilities than upon the leader’s own perceptions. “Leadership is in the eye of the follower” (1990, p. 29).

Researchers also understood the importance of the relationship and accompanying perceptions. Werner (1990) noted three characteristics of children and their environments that were linked to positive school outcomes despite being confronted with risk. The characteristics included: external support network characteristics, individual temperamental qualities, and family affective characteristics. Protective factors seemed to buffer or override the negative consequences of risk factors. Approaches incorporating these factors included linking a child to a mentor, teaching an involved parent how to encourage academic achievement at home, and helping a teacher increase the occurrence rate of supportive behaviors toward a student in the classroom (Werner, 1990).

Whelage and Rutter (1986) studied whether positive advisor/advisee relationships would increase at-risk student attendance, demeanor, and grades
at Lely High School in Naples, Florida for students whose grade point averages were 1.5 or less on a four-point scale. The results indicated that 41% in the control group dropped out as opposed to only 17% in the group with advisors. Students with advisors were absent significantly fewer days during the twenty-one week study. The mean grade-point average of students with advisors was 1.05 as compared to 0.66 for the group without advisors. The positive changes noticed by advisors were more consistent attendance, increased studying, more interest in schoolwork, less sleeping in class, and friendlier, happier advisees, even though advisors spent most of their time discussing grades and other school-related matters (Werner, 1990).

Relationship continued to be the important factor in the Bowen and Bowen study (1998). This study found that teacher support positively and significantly affected grades and educational engagement. Students who thought that teachers had high levels of respect and concern and received teacher encouragement had higher grades and educational interest (Bowen & Bowen, 1998).

Garbarino and Asp (1981) found evidence that student motivation was more important than ability when dealing with the academic demands of schooling. Over half of all dropouts, according to this research, had the ability to be successful in school but chose to drop out instead. Therefore, adequate academic ability and performance did not guarantee that students would persevere and finish school (Garbarino & Asp, 1981). The research consistently
indicated that genuine, caring relationships between individuals were the
determiner between success and failure. Schools and businesses needed to
consider the benefits of social wellness through cultivated relationships between
leaders and followers to maximize their effectiveness (Bowen & Bowen, 1998).

Other benefits from social wellness allowing individuals to achieve high-
level wellness were documented. People who had a social network of support
were found to have fewer occurrences of minor illness and absenteeism
(Swanger, 2002). Another study even found workers to have less heart disease
(Benson & Stuart, 1992). This research suggested that social wellness has a
major impact on the work place, and therefore, it would be beneficial in the
educational setting.

The social dimension was related to the school context by educators’
involvement with students, families, and community. Leithwood and Jantzi
(1990) provided one example of how an educator could become involved in a
community project that not only benefits the community but also
unintentionally provides a positive perspective on the involved party. The
benefits allowed for an individual to feel good about doing something good. The
study involved a qualitative and quantitative assessment of twelve schools in
Ontario, Canada in which school administrators used six strategies to influence
school culture. They included: bureaucratic provision of money, planning, and
scheduling; collaborative decision-making and reducing teacher isolation;
strengthening the school’s culture by stressing shared goals; staff development
that recognizes that one can learn from one’s colleagues; direct and frequent communication; and the use of ways to celebrate and recognize the work of staff and students. These strategies helped build shared meaning among school staff and created high levels of commitment to accomplish goals.

**Emotional Dimension**

The emotional dimension addressed the management of one’s awareness, control, and acceptance of emotions. It involved understanding personal strengths and limitations. The development and maintenance of intimate relationships was also a part of this dimension (Duttweiler, 1986). This dimension had obvious implications for educators in the research. New teachers and administrators had obvious needs involved with emotional wellness. In addition, relationships involving educators had a wide range of age levels, from students as young as 3 to adults, some who may have retired. Duttweiler (1986) stated that “educational excellence requires a leader who has the ability to motivate others to change or improve—the ability to gain commitment of others to organizational goals” (p. 371).

Glatthorn (1987) asserted that strong school leadership was necessary if cooperative professional development was to succeed. The principal engaged in leadership practices to encourage collegiality, cooperation, and collaboration and made structural changes, if needed, to encourage this teambuilding.

The emotional dimension received a large amount of attention since the turn of the 21st Century. According to Bagshaw, (2000) understanding of
emotions was an essential in day-to-day work. This understanding was coined, “emotional intelligence” (Goleman, 1995).

Clark-Reynolds (2002) described emotional intelligence as a high level of emotional wellness. Attributes described with emotional intelligence include self-confidence, optimism, influence, and leadership. This research also explained that emotions produce energy. Positive emotions created positive energy, and, conversely, negative emotions had a negative effect on the energy produced.

Goleman (1995) contended that the emotional dimension may be the most important when dealing with personal relationships. The importance of dealing with people of all ages and their perceptions of self-worth could not be overstated (McGuire & Snow, 1994). The value of emotional wellness was cited as the opportunity to help others develop positive self worth as well (Goleman, 1995).

**Intellectual Dimension**

The intellectual dimension of wellness incorporated the use of the mind in such tasks as the ongoing pursuit of knowledge, staying up-to-date on current events, applying information in critical thinking formats, and reading (Ardell & Tager, 1982). This dimension was not limited to any particular field. In education, the fundamental insight into the concept of education was that the pursuit of knowledge was more important than the knowledge being pursued
(Powers, 1994). Educators needed to have great care and concern with regard to intellectual wellness.

Schein (1990) indicated that culture was a shared set of norms, values, beliefs, and assumptions that affect the way members look at the world. Wherever groups formed, cultures existed. Schools had their own culture and school cultures differ (Schein, 1990). Globalization was one example in today’s society of impacting our culture and intellectual wellness.

Friedman (2000), discussed the impact globalization was having on the importance of intellectual wellness. He stressed the urgency of this saying,

The best thing parents (and educators) can do to prepare their kids for the Internet age is not to teach them more whiz-bang, high-tech skills, or buy their kids faster modems and computers, but rather to stress more old-fashioned fundamentals. The faster your kids’ modems, the faster they can get online, the stronger must be their own personal software, if you want to see them thrive. And personal software can only be built the old-fashioned way: by stressing reading, writing, and arithmetic, church, synagogue, temple, mosque, and family. Those things can’t be downloaded from the Internet; they can only be uploaded by parents and teachers, priests and rabbis. (p. 472)

Just as the internet has impacted our students in both positive and negative ways, the culture of a school influences all of a school’s entities.

Firestone and Wilson (1985) stated that the culture of a school affects how
teachers view their work. Included in these views were how teachers look at in-service training and supervision, whether and how much they talk about teaching practices, and how much principals were allowed to affect curriculum and instruction. Therefore, if school improvement was to occur for both teachers and students, leaders needed to consider their culture and their corresponding intellectual wellness.

In summarizing the six dimensions and the integration of the six dimensions, it is important that we review their relationship. Each dimension of wellness was individually distinct and functioned somewhat interdependently. The difficulty of high levels of wellness was that each dimension must be integrated with the other five. In Powers’ (1994) this integration created a wellness package. This package provided a balance that, when each dimension was allowed to nourish, foster, and to grow, high-level wellness would occur. It allowed a lifestyle that provided wellness through life choices. In addition, this model of wellness assumed salutogenesis; wellness was factor causing health rather than illness (Adams & Bezner, 2000). This six-dimensional model created a powerful framework for the understanding of wellness.

Perceptions

Perceptions help individuals to see what dimensions of their lives contribute to overall wellness (Adams & Bezner, 2000). Perceptions are subjective, in that they related only to the individual’s view of these dimensions in his/her own life. They were also relative as one’s perceptions can be altered
by time and place as well as by the influence of outside factors (such as professional and personal characteristics). Measuring perceptions has been viewed as problematic.

Because one perceives his/her world through one’s own lenses that filter and select according to what one wants to see, the subjectivity of perception has typically been seen as not measurable (Wheatley, 1992). However, social psychologists have formulated an understanding of perception to be one’s own subjective view of all external phenomena (Gmelch, 1988). Further, perceptions led to one’s attitudes about these phenomena. Attitudes were generically defined as evaluative judgments formed from perceptions. Attitude/perception measurement involved gathering information “about a person’s attitude by examining his/her reactions to attitude relevant statements” (O'Keefe, 1990).

Thurstone (1931) and Liekert (1932) developed reliable and consistent scales of responses ranging from total disagreement to total agreement with no neutral responses. This technique for measuring perceptions was widely used by psychologists and sociologists, as well as medical professionals, for the last sixty years or so (McMillan & Schumacher, 2001).

Adams and Bezner (2000) cited very strong and consistent data indicating that subjective perceptions were valid indicators of objective health. The researchers attempted to view wellness as causing good health, rather than viewing wellness as the absence of disease (Adams & Bezner, 2000). The role of principals is discussed in the next section.
The Principal’s Role

The role of the school principal has become increasingly demanding with more facets to the job description. According to Ferrandino (2001), “the principalship today is a much more demanding job than it used to be” (p. 440). It was important for principals to understand the differences. This section will describe the link between principal wellness and job performance, the various roles of the school principal, the increasing workload of the school principal, recent legislation such as No Child Left Behind (NCLB), financial cuts, funding limitations, and increased public scrutiny of school administrators.

Principal Wellness and Job Performance

Stress among principals has become more prevalent (Gmelch, 1978). In one study, stress was analyzed to determine which factors contributed significantly. According to Williamson and Campbell (1987), four major factors were identified. They were management of time, relations with supervisors, relations with subordinates, and matters of finance.

Coping with stress is dependent upon each individual principal. No one technique for coping is appropriate for everybody (Allison, 1997). Gmelch (1995) discussed holistic methods to deal with stress in administration noting the need for individual coping strategies. The effectiveness of coping has an obvious effect on the principal’s view of stress (Swent & Gmelch, 1977).

Effective principals were described as people who were oriented and interactional, networked with other principals, and had administrative
practitioners who mentored them (Smith & Andrews, 1989). They tended to be visible and accessible. According to Whitaker (1997), to be effective, principals needed to visit classrooms daily. They would have participated and interacted with students if the situation permitted. Foster (1997) described this as a “presence” in the building, noting that students had positive images of their principal when he/she saw students between class periods, walking the halls, during lunch, or taking time to visit. When the principal was involved in class discussions or helping students work on assignments, it promoted the impression that the principal believed in the importance of learning. The principal was also to take the time to write a note to the teacher as feedback about the informal observation (Whitaker, 1997). Effective principals needed be involved with students and faculty in a visible fashion.

The Belloc and Breslow (1972) study evaluated the proportion of principals practicing seven health behaviors. The behaviors included: (a) sleeping seven or eight hours per night; (b) eating a good breakfast each day; (c) avoiding eating snacks between meals; (d) maintaining a good body weight; (e) getting at least thirty minutes of strenuous physical activity two or more times a week; (f) having two or less alcoholic drinks per day; and (g) avoiding smoking or chewing tobacco. People ages fifty-five to seventy-five that practiced all seven health habits had an average physical health status of individuals thirty years younger who practiced less than three of the habits.
The Belloc and Breslow study found that most principals tended to skip breakfast (65%), eat snacks between meals (85%), and exercise only sometimes or rarely (54%). In addition, some principals also reported always or often consuming more than two alcoholic beverages per day (7%) and smoking or chewing tobacco (15%) (Belloc & Breslow, 1972). These results suggested that principals had physical conditions equal to older adults practicing all seven habits.

The building principal’s job description appeared to promote other concerns in terms of wellness. Wheeler (1984) used the General Well-Being Questionnaire to examine the basic health of principals. Wheeler found that the principals’ most common physical complaints were feeling exhausted or fatigued, having colds or other illnesses, headaches, constipation or diarrhea, and bothered by pains. Fifty-eight percent of principals had at least one cold or other illness per month. Seventy-two percent of the principals felt exhausted or fatigued at least one time per month. Sixty-three percent of the principals had at least one headache per month. Constipation or diarrhea was a physical complaint for 44% of the principals. Last of all, 48% of the principals were bothered by pain at least once per month (Wheeler, 1984).

In addition to the physical ailments noted, principals experienced other types of job-related stress. It was common for inexperienced principals to have a fear of failure. Lovely (2004) indicated that incredible stress for first-time principals resulted from three concerns: “(1) absorbing volumes of information;
(2) working for change despite significant resistance; and (3) proving oneself to others” (p. 11).

**Increasing Workload and Expectations**

A significant facet of the role of the principal was to meet the expectations of the teachers in his or her building. Barbara Brock and Marilyn Grady (1998) studied beginning teacher induction programs in Nebraska. Forty-nine second year teachers from public and non-public schools in Nebraska described their expectations of principals in the study. The most frequently stated expectation for principals by the teachers was to communicate their criteria for good teaching. Other expectations included knowing the principal’s philosophy and expectations for the teacher. Teachers also wanted to be aware of the principal’s values for education, students, and quality teaching. The teachers wanted their principal to be highly visible, visit their classes, and give feedback. They also saw the need for a yearlong induction program that included mentors. This study’s list of teacher expectations of principals revealed that the principal provides a vital role of successful socialization and first-year induction of beginning teachers (Brock & Grady, 1998). The principal was viewed as a key source of guidance and support.

The principal’s role was more difficult when the expectations of others did not match the job requirements. The University of Windsor’s study by Awender (1978) examined the “two hat syndrome” of the building principal. Principals, teachers, and superintendents in 105 school jurisdictions in Ontario, Canada
were asked to rank-order eleven items that addressed the principal’s actual and ideal role. The questionnaire found that principals preferred viewing their role more like the superintendents’ idealism of the role of a principal rather than the view the teachers held concerning their perspective of the principals’ role. This was despite the fact that building principals tend to spend more time working with their teachers than they do with their superintendents. The superintendents thought that academic programming and supervision were the most important items followed by counseling and discipline. Teachers thought that counseling and discipline were most important, with decision making and supervision following closely behind in importance (Awender, 1978).

This conflicted view of the principal’s role made the principal’s role more challenging in terms of wellness when working with teachers. However, with the emphasis on increasing student achievement, principals needed to learn to effectively collaborate professionally with teachers.

The principal’s role was affected by other factors that contributed to stress as well. Certain characteristics of a schools size was associated to stress, according to Williamson and Campbell (1987), principals of large high schools experienced more stress in time management, while conversely, the principals of smaller high schools felt more stress in dealing with subordinates.

Yin Cheong Chang (1993) found that stronger school cultures had better motivated teachers. Schools that had strong organizational ideology, charismatic leadership and intimacy, and shared leadership tended to have
teachers experiencing higher job satisfaction and increased productivity. Stronger school cultures created a more efficient and stable learning environment (Chang, 1993). Personal and social relationships among educational workers have an impact on school culture and have been identified as being important (Sackney & Miller, 2000). Ultimately, the principal bore the brunt of the responsibility for setting expectations and outcomes in building climate and culture (Foster, 1997). Principals were required to maintain strong school cultures in order to have a motivated staff that produced the enhanced student achievement required.

In another study involving student achievement and the principal’s role, Smith and Andrews (Smith & Andrews, 1989) identified four areas of strategic interaction conducted by principals that led to higher levels of student achievement. The four areas of interaction included being a resource provider, an instructional resource, a communicator, and having a visible presence. Teachers needed recognition for exemplary teaching and encouragement to share with others. The principal showed genuine concern for the teachers’ health, welfare, and professional growth. This approach resulted in a faculty that was willing to approach change positively and to take risks (Smith & Andrews, 1989).

Educating students with special educational needs was a requirement for school principals, since these students now attend the local school in the community instead of being bused to a special day school elsewhere. Therefore,
mainstreaming special needs children was yet another challenge for principals. Most building principals do not have extensive training or experience in special education (Kennedy, 2002). Yet, according to Gage (1979), the following practices should be incorporated by effective principals:

- Know what staff members are doing . . .
- Encourage respect for children . .
- Emphasize positive self-concepts . . .
- Exhibit positive attitudes toward the school and all its programs . . .
- Provide alternative learning opportunities for all students . . .
- Reinforce effective home-school relationships . . .
- Familiarize yourself and your staff with the identification process for securing special education assistance . . .
- Encourage expansion of activities with the affective domain . . .
- Become attuned to teacher anxiety regarding special education students . . .
- Develop a sense of team planning between general and special educators . . .
- Avoid instant expertise. (Gage, 1979, pp. 575-577)

**Effects of NCLB on Principals**

Designing schools that meet the needs of all types of learners was essential if the principal planned to meet the No Child Left Behind (NCLB) Act’s requirements for accountability. Many principals reported that teachers in tested grades have become reluctant to have special education students in their classes to avoid inclusion of student scores in assessment results (Malveaux, 2004). This directly interfered with the principal’s responsibility to help guide the building to achieve the NCLB benchmarks or adequate yearly progress.
(AYP). School leaders monitored their NCLB compliance state plans meticulously so that they knew what additional data would be required of them. Yeagley (2003) stated, “Assuming a proactive posture in collecting accurate data could mean the difference between meeting or not meeting AYP in you schools” (p. 25).

Principals necessarily dealt with the demands of NCLB as an academic priority. Adam Kernan-Schloss (2004) indicated that principals and superintendents can strengthen and preserve public education by making demonstrable, consistent progress in reading, writing, and math and be able to communicate that progress to parents, taxpayers, and voters. Principals promoted wellness by being pro-active and taking advantage of multiple teachable moments. They helped parents and the community members understand how their schools were doing and how parents and the community could help. Administrators shared a complete picture of performance and tried to work closely with their local media to cultivate good relationships. Some other good strategies were to celebrate when appropriate, use messages that resonate with the community, build a group of key communicators, stay positive, and think long term (Kernan-Schloss, 2004).

The NCLB requirements have caused, and will continue to cause, every public school administrator to feel the pressure of being considered a winner or a loser. James Popham (2003) contended that the assessment requirements for the NCLB mandates will significantly increase in comprehensiveness before the
end of the 2005-2006 school year. Students’ scores on these tests classified many 
schools as failing because the schools did not meet the adequate yearly progress 
on test performance requirement.

Popham (2003) further asserted that administrators have three choices in 
how they decide to deal with NCLB. First, they could give up and choose to exit 
the school administration profession. Second, they could stay in the profession 
and just wait for the inevitable to happen without taking a pro-active stance. 
Third, they could choose to demand tools like instructionally sensitive tests to 
deal with NCLB. Clear descriptions of the content standards being assessed 
would be in place so educators could really understand what skills and 
knowledge were going to be measured. The tests would also provide 
instructionally informative results. “An instructionally sensitive NCLB test 
then will satisfy all three of these requirements by providing clear descriptions 
of what’s assessed, focusing on a few significant curricular aims and reporting 
its results in an instructionally informative manner. If an NCLB test falls down 
on one or more of these three requirements, it will be instructionally 
insensitive” (Popham, 2003, p. 12). The principals’ role clearly includes the 
significant requirements that NCLB testing has brought to the educational 
forefront.

**Budget Cuts and Financial Limitations**

Another obstacle for the building principal serving effectively in his or 
her role was dealing with the funding limitations of today’s schools. All
principals have to divide their time between what is viewed as most important. Williamson (1987) noted, “principals, as instructional leaders of the school, must devote the majority of their effort and energy to ensure the best possible education for the students” (p. 110). Concentrating on academics leaves little time for finances.

Paul Houston (2004) indicated that for many years, schools have supposedly been given more money and yet student achievement has regressed or stayed steady. But, he said that this statement was not true.

Spending for other systems such as prisons has increased at a faster rate than spending for schools. Most of the increases in education have been to fund special education. Therefore, mainstream education has struggled to achieve some improvement in overall scores despite the stagnant level of funding. (p, 38)

Public Scrutiny

Another role that was significant to principals and their effectiveness was the importance of public relations and the scrutiny that exists among staff and the community. Gary Bloom (2004) believed that principals must develop a new level of impulse control and keep in mind how comments, decisions, or actions, will be processed by others. The principal lost some freedom and privacy in his or her celebrity-like role. However, he or she realized that the role does require letting go of perfection and strict control. Delegation of some duties with some
allowances for minor implementation changes was required of successful principals and other administrators (Bloom, 2004).

The Impact that Wellness has on Job Performance

Wellness has impacted job performance. Principals and other administrators needed to address the need for improved physical and emotional wellness. James Burgett (2001) provided some tips for getting and staying physically healthy. He believed that administrators should include exercise for thirty minutes a day. He also recommended that administrators avoid smoking, drink alcohol only in moderation, eat a balanced diet, maintain a healthy body weight, and buckle their seatbelts. According to Burgett, to stay mentally and emotionally healthy, administrators needed to engage in some mental activity every day, stay connected with family and friends, maintain a spiritual connection, and think positively. The administrator required sufficient rest and took a fifteen-minute nap if needed or took a walk when having trouble staying awake. The administrator was more productive, did a better job, and gave the school district higher-quality work (Burgett, 2001). Physical, mental, social, spiritual, and professional wellness were incorporated into an administrator’s improvement plan.

Suzette Lovely (2004) suggested that a principal coach, who could serve 12-15 clients, could bring about increased professional wellness to an inexperienced or struggling administrator. The coach deciphered whether the principal utilized opportunities or resisted them; to what extent the principal
distinguished between systematic and superficial causes of problems; the principal’s level of optimism; and how the principal conducted himself and responded towards others. Coaches who were available during the school day and came from outside the district were more likely to have a neutral perspective and created more impact upon job performance. A coaching program created higher productivity, more confidence, and less turnover in the principalship (Lovely, 2004).

Lovely (2004) indicated that the emotional wellness of principals could be improved by using tools such as computer based simulation programs. Military installations and flight schools provided virtual reality training for many years extensively using simulation programs. One such program was created for business managers who provided a series of real-life business scenarios through an e-based format. The managers’ experienced doing day-to-day business operational tasks as well as dealing with staff interpersonal conflicts while learning from electronic mentors. People learned by making mistakes and practicing. This business scenario program allowed users to try different approaches and discover which approaches were more effective for them. Since the education leaders and business leaders faced many similar issues, a program developed specifically addressing educational administration had useful benefits (Lovely, 2004).
Wellness Initiatives in Schools

Recent initiatives focused on wellness expanded the role and responsibilities of every public school administrator. With approximately 53 million students attending primary and secondary schools each day, (U. S. Department of Education, 2002) the opportunities for administrators and teachers to influence students were obvious. This section investigated national and state initiatives followed by a look at the role local institutions provided.

National. The U.S. Department of Health and Human Services published a report titled, Healthy People 2010 (2000). The report provided a blueprint with two overarching goals: (1) to increase quality and years of healthy life and (2) to eliminate health disparities (Centers for Disease Control and Prevention et al., 2004b).

Healthy People 2010 was a comprehensive set of measures designed to promote health and prevent disease for all Americans (Centers for Disease Control and Prevention et al., 2004a). The two primary goals of Healthy People 2010 were to increase the quality and years of healthy life and to eliminate health disparities for all Americans (Gray & Oslin, 2003). These goals were monitored through 467 objectives, of which 107 were related to adolescents and young adults, and 10 concentrated on the role of schools in improving the health of young people (Fisher et al., 2003). Because public schools had the opportunity to reach so many youth, they were saddled with the expectation to improve not only the education but the health of these students as well. Consequently, the
responsibility of implementing these objectives fell upon administrators and building principals.

Fisher et al. (2003) identified the following 10 objectives related to adolescents and young adults that focus on the role schools have in improving the health of young people.

Objective 07-02: Increase the proportion of middle, junior high, and senior high schools that provide school health education to prevent health problems in the following area: unintentional injury; violence; suicide; tobacco use and addiction; alcohol or other drug use; unintended pregnancy, HIV/AIDS, and STD infection; unhealthy dietary patterns; inadequate physical activity; and environmental health.

Objective 07-04: Increase the proportion of elementary, middle, junior high, and senior high schools that have a nurse-to-student at least 1:750.

Objective 15-31: Increase the proportion of public and private schools that require use of appropriate head, face, eye, and mouth protection for students participating in school-sponsored physical activities.

Objective 19-15: Increase the proportion of children and adolescents aged 6 to 19 years whose intake of meals and snacks at schools contributes proportionally to good overall dietary quality.

Objective 21-13: Increase the proportion of school-based health centers with an oral health component.
Objective 22-08: Increase the proportion of public and private schools that require daily physical education for all students.

Objective 22-09: Increase the proportion of adolescents who participate in daily school physical education.

Objective 22-10: Increase the proportion of adolescents who spend at least 50% of school physical education class time being physically active.

Objective 22-12: Increase the proportion of public and private schools that provide access to their physical activity spaces and facilities for all persons outside of normal school hours (that is, before and after the school day, on weekends, and during summer and other vacations).

Objective 27-11: Increase smoke-free and tobacco-free environments in schools, including all school facilities, property, and vehicles and at all school events. (Fisher et al., 2003, (pp. 3-4))

These ten goals were identified to focus on the role of schools in improving the health of young people. This further demonstrated the importance of elementary and secondary schools for providing health services (APHA School Health Education and Services, 2004). It also substantiated the need for each state to develop initiatives that prepared schools and their staff to provide health resources and information to benefit students.

State. The importance of schools combining health and education led to the development of school health programs at state and local levels. Health education leaders developed a multi-faceted approach known as coordinated
school health programs (CSHP). The CSHP was designed to combine the resources and efforts of education, health and social agencies without duplicating or fragmenting services (APHA School Health Education and Services, 2004).

The CSHP included eight components: 1) health services; 2) health education; 3) healthy school environments; 4) nutrition services; 5) physical education and other physical activities; 6) counseling, psychological, and social services; 7) health promotion for faculty and staff; and 8) family and community involvement (Fisher et al., 2003). The administrator needed to recognize the importance of and the implementation of each component plus the understanding of how each component reinforces the other.

A working definition of the eight components previously identified was developed by the Centers for Disease Control and Prevention (2004).

1. Health Services. Services provided for students designed to provide access or referrals to primary health care. This included school-based or linked access to preventative services, emergency care, and chronic disease management. These services were to be provided by qualified professionals such as nurses, dentists, physicians, optometrists, and others.

2. Health Education. A K-12 curriculum addressing physical, mental, emotional, and social dimensions of health. This allows students to develop increased understanding of health-related knowledge. Topics include personal health, family health, community health, consumer health, environmental
health, sexuality education, mental and emotional health, injury prevention, disease prevention, and substance abuse.

3. Healthy School Environment. School buildings and the area surrounding them are safe. This included the physical environment as well as the psychological environment. It involved a constant assessment of the facility related to safety, health, climate and culture.

4. Nutrition Services. Providing appealing meals that were nutritious and reflected the U.S. Dietary Guidelines for Americans. The meals were to be affordable, available to all, and provided nutrition education into the classroom.

5. Physical Education. A K-12 curriculum that provides cognitive material with learning experiences in various activities. The program enhances physical fitness, promotes lifelong physical activity, and was taught by trained physical educators.

6. Counseling, Psychological, and Social Services. Professionals including counselors, psychologists, and social workers that provided services to focus on mental, emotional, and social health. This helped provide positive learning and healthy behavior to enhance development, prevention, and address problems.

7. Health Promotion for Faculty and Staff. This involved the maintenance and improvement of employees by assessment, education and fitness opportunities. This commitment can transfer to the health and involvement of students and creates positive role models. Health promotion activities help to
promote productivity, decreased absenteeism, and reduced health insurance costs.

8. Family and Community Involvement. A collaborative approach that enhanced the health and well-being of students. This involved partnerships designed to utilize resources and expertise in the area of health.

The CSHP incorporated all eight components involving a school's instruction, services, and physical and social environments. The leadership role served by principals and other administrators was evident in the partnerships, coordination, and cooperation involved in pulling the various pieces together to form the complete process.

The Kansas State Board of Education first recognized the value of the CSHP when it was presented in January of 2000. In that presentation, advantages of a CSHP were identified. Advantages included:

[R] reduced school absenteeism, fewer classroom behavior problems, improved student performance, new levels of cooperation among parents, teachers and organizations, a more positive spirit among educators and students, integration of health awareness by students, and young people more prepared to become productive members of society. (Kansas State Board of Education, 2000, pp. 3-4)

On March 1, 2002 the state of Kansas was awarded a grant from the Centers for Disease Control and Prevention for the implementation of the CSHP to interested schools offering cooperative services between schools and
community partners (Brooks, 2004). This represented the beginning of health related programs to be presented to school districts.

On June 30, 2004 President Bush signed the Child Nutrition and Women, Infants, and Children (WIC) Reauthorization Act of 2004 into law (P.L. 108-265) (Food Research & Action Center, 2004). The legislation reauthorized several programs including the School Lunch Program, School Breakfast Program, Summer Food Service Program, Child and Adult Care Food Program and WIC for five additional years. An additional feature to the updated reauthorization included a provision requiring a Local Wellness Policy (Gigliotti & Fellow, 2004). The Local Wellness Policy required local educational agencies to develop a local school wellness policy for schools. The issue of wellness was implemented into the school systems nationally with this legislation. This in itself made the wellness of principals an important factor as they lead their buildings into this federal mandate.

The Child Nutrition and WIC Reauthorization Act of 2004 required: (1) goals for nutrition education, physical activity, and other school-centered activities; (2) nutrition guidelines for all foods available during the day for each campus involved; (3) assurance that guidelines for reimbursable meals were at the minimum standards set by the USDA; (4) created a plan for measuring implementation of the local wellness policy; and (5) included a number of community members in the development of the school wellness policy (Gigliotti
& Fellow, 2004). The development of a school wellness policy required state involvement on a national scale.

According to Peggy McAdoo, Child Nutrition Consultant, KSDE, (2005), the state of Kansas was developing a prototype local wellness policy to meet the federal mandate. The prototype policy would serve as a model for local educational agencies to adopt and modify to suit their specific needs. Currently, KSDE was looking to other state agencies to determine what was working and how it was being devised to alleviate the growing pains of creating something new (McAdoo, 2005). Clearly, the federal law required state initiatives that had a far-reaching impact on all local educational agencies that would elevate the importance of wellness for all students and employees, not just principals.

Local. The importance of the role schools had on improvement of young people's health status had never been greater. In the report, Healthy People 2010, only parents and families were ranked higher than public schools as societal institutions that have a major influence on adolescent health (U. S. Department of Health and Human Services, 2000). It was widely recognized that organizations and institutions must work together to bring about significant change.

Many other opportunities existed from a school setting that administrators needed to recognize. The Centers for Disease Control and Prevention, et al. (2004b) identified the following characteristics that make an impact on reaching young people: providing academic knowledge, physical
shelter, establishing social values, developing social skills, and preparing children to become productive contributing members of society (p. 7). The need for adult involvement and the responsibility for adolescent wellness magnified the importance of schools providing role models.

Administrators needed to recognize the wellness opportunities their academic settings provide for young people. One of the primary points was that schools provide role models that influence youth (Centers for Disease Control and Prevention et al., 2004a). The American Public Health Association (2004) identified elementary and secondary schools as valuable settings for providing young people, who may not otherwise have the opportunity, to receive information and guidance from well-prepared and supportive faculty (APHA School Health Education and Services, 2004). Schools also provided peer influences due to the nature of their settings. The influence that faculty members, as role models, offered on students of all ages was not underestimated.

**Summary**

The purpose of this study was to examine Kansas K-12 public school attendance center principals’ perceptions of their own wellness. It further investigated the effect that selected personal and professional variables have on these perceptions.

This review of the literature discussed six important areas, including (1) a historical perspective of wellness, (2) a definition of wellness, (3) the...
dimensions of wellness used in this study, (4) the principal’s role, (5) the impact that wellness has on job performance, and (6) wellness initiatives. The literature highlighted factors, issues, and programs directly involved with the topic of wellness for school principals as leaders of their buildings. It behooves school administrators, school boards, and higher education institutions to consider this material as the efforts to educate children continues to grow more complicated. In Chapter 3, the discussion turns to methodology.
Chapter 3
Methodology

The literature review in Chapter 2 presented information about wellness, perceptions, the role of the principal, and the impact that wellness can have on job performance. Together these items potentially have a major influence on education and provide the foundation for the research. This chapter describes the research methodology used to answer the research questions. The study examined the perceived wellness of Kansas K-12 public school attendance center principals. Further, the study attempted to determine the effect that selected personal and professional factors have on the overall wellness and the six dimensions of wellness.

The methodology chapter begins with a description of the quantitative research design used to gather information to answer the research questions. It then describes the defined population and the sample used for the survey. Next, information is presented about the survey instrument, including development, implementation, and response rate. The next section describes the data analysis procedures used to interpret the data. The chapter concludes with a model that explains procedures used to answer the research questions.

Research Design

The study used a quantitative paradigm to answer the research questions through the use of a survey. This method of research enabled the researcher to collect data from a random sample of participants in order to make inferences to
a population (Patton, 1990). The quantitative approach relied on the description of findings through the use of numerical data (Crowl, 1993). It also enabled the researcher to survey a sample of the population and use data collected from the surveys were used to make inferences to the population and answer the research questions.

Creswell (2003) noted a quantitative design was utilized most effectively when it identified the influences of specified outcomes, the usefulness of an intervention, or for understanding the best predictors of an outcome. Creswell further stated a quantitative approach used strategies of investigation such as experiments and surveys. Researchers then collected data on predetermined instruments that yielded statistical data to make meaning of the research context.

The research design for this study involved framing research in terms of the research questions. The specific research questions were:

1. How do Kansas K-12 public school building principals perceive their own wellness?
2. What extent do personal factors contribute to Kansas K-12 public school building principals’ perceptions of wellness?
3. What extent do professional factors contribute to Kansas K-12 public school building principals’ perceptions of wellness?
The research design developed to answer the research question used a survey that was sent to randomly selected K-12 building principals across the state of Kansas. The population and sample are described in the next section.

**Population and Sample Selection**

The population from which the sample for this study was drawn included a database of principals from public school buildings. Given that the study was designed to determine perceptions of Kansas K-12 public school building principals in relation to the issues of wellness, the survey was designated for eligible principals in Kansas. The Kansas State Department of Education (KSDE) identified, in its 2002-2003 Kansas Educational Directory, a total number of 1,415 Kansas K-12 public school buildings, also called attendance centers. Included were 846 grade schools, 214 middle school/junior high schools, and 355 high schools. The elements of the sample were drawn by attendance center not by principal’s name. Parameters of the sample selection narrowed the field to principals who were identified as being in charge, or designated as having the lead role of an attendance center.

The configurations of Kansas public education attendance centers varied widely from district to district. Attendance centers were identified only once when the configuration housed more than one attendance center combination. An example would be a K-12 building. A school district of the example configuration would only have one attendance center listed in the 2002-2003 directory. Stratified sampling was not used.
The research design used a random selection procedure for distribution of the quantitative survey. Selection of the random sample was generated using a technique, random sampling without replacement, recommended by Gay and Airasian (2003). These authors stated that when selecting a sample, the researcher should proceed “in such a way that all individuals in the selected population have an equal and independent chance to be selected for the sample” (p. 103). Due to the varied design of Kansas’ public attendance centers, further steps were necessary to ensure that each individual had an equal and independent chance to be selected. Many school districts in Kansas had one principal in charge of more than one attendance center. Because the principal being selected was first identified by the attendance center he or she served, it was necessary to conduct random sampling without replacement. This method asserted that a sample size is drawn so that each possible element has the same chance of being drawn (Wolf, 1962). To achieve equal chance for participation, a principal’s name and that attendance center were removed from the list if that principal had already been identified with another attendance center. Measures were also taken to withdraw attendance centers that were not being administered by a principal. Random sampling without replacement enabled the researcher to select a sample from the population of Kansas’ public school principals with each element having the same chance to be selected.

Duplicated elements in the population, principals having more than one attendance center, were deleted from the Kansas Educational Directory. The
remaining elements were identified numerically. This criterion narrowed the potential population to 1,312.

The next issue addressed in this process was sample size. Measures were taken to ensure that the sampling measures used provided methods to avoid sampling error and sample bias (Sommer & Sommer, 1997). Once the entire potential population was identified, it was imperative to determine the sample size to be surveyed. Four variables that contributed to the calculation of sample size included: (1) size of population; (2) level of significance; (3) power; and (4) prior knowledge (McNamara, 1994).

Population size was the first variable in selecting sample size. The population size for this research was 1,312 principals of Kansas public K-12 attendance centers listed in the 2002-2003 Kansas Educational Directory.

Level of significance was the second variable in determining sample size. Researchers determined the level of significance for their research by assuming a certain probability that there was a non-error in measuring the association of sample data (Babbie, 2001). For this research, the level of significance was set at a probability of .05 (p < .05). This substantiated that the odds of a difference due to chance are less than 5 in 100 when the level of significance is .05 or less.

The third variable considered was power. Power was “the probability that the test will correctly lead to the conclusion that there is [italicized in text] a difference when, in fact, a difference exists” (Fraenkel & Wallen, 2000). In other
words, a powerful test was highly likely to indicate a significant difference when there was one. The statistical power for this research was .95.

The fourth variable in determining sample size was prior knowledge about the outcomes of the topic being studied. The researcher was provided maximum sample size when no prior knowledge of the outcome of the research existed (McNamara, 1994). This researcher claimed no prior knowledge concerning outcomes of results for this research.

A computerized formula developed by Wichita State University Associate Professor of the College of Education, Randy Turk, was implemented to compute sample size. The formula was developed from McNamara (1994). By using the four variables previously described and parameters discussed, the number of elements needed for this random sample was 306. Krejcie’s (1970) chart for determining sample size verified the sample to be at a substantive level. The chart suggested minimums for sample size with a given population. Using this chart, a minimum sample size for a population between 1,400 and 1,600 elements was between 302-310. Gay and Airasian (2003), using Krejcie’s chart, noted that the sample size “should be as large as possible; in general, the larger the sample, the more representative it is likely to be” (p. 118). This criterion provided the basis for the researcher to establish the sample size at 310.

Determination of sample size at 310 elements led to the next step in the sampling process. A table of random numbers was used to ensure equal probability during the selection process. Using a random table of numbers
eliminated researcher bias (Babbie, 2001). The table of random numbers used in this study was found in Borg and Gall’s *Educational Research: An Introduction* (1989). The researcher identified the first 310 usable numbers derived from the table of random numbers. Each number extrapolated from the table with a value of the last four digits of 1,312 or less, was selected. Each of these numbers was transposed to the corresponding numbered list of attendance centers from which the principals were identified in the Kansas Educational Directory.

This procedure led to a compiled list of numbers from which sample was generated. From this, a pool of principal’s names, attendance centers, and addresses was created.

This list of names, attendance centers, and addresses were organized in a Microsoft Word file database that provided a mailing list. The mailing list was used to send the survey instrument to the sample. The next section discusses the survey instrument aspect.

**The Survey Instrument**

A survey was the primary data collection source. Creswell (2003) noted that surveys provide quantitative descriptions of trends, attitudes, or opinions of a population. “Surveys are done to describe, compare, and predict knowledge, attitudes, and behavior” (Fink, 1995). Further, a survey allowed the study of variables as they existed in a natural setting, requiring that no experimental variables were manipulated (Wiersma, 2000). Since numerical data were needed from as many as 310 building principals, a survey was the best instrument to
gather it. Data from the survey were used to answer the three research questions.

The survey instrument named in this research, “Principal Wellness Questionnaire,” was composed of two sections (see Appendix A). The first section, demographic information, consisted of two sets of items, one relating to personal factors, and the second relating to professional factors. This researcher developed both sets of items. The personal factors, the first set, included age, gender, marital status, race, and ethnicity. Professional factors, the second set, included years in administration, years as principal in current position, building enrollment, building level, and school setting, which identified the attendance center as a rural or urban setting. These factors were determined to be characteristics that may or may not have an impact on principal wellness.

The second section of the instrument developed to measure principal wellness used the Perceived Wellness Survey (PWS). Instructions from the dissertation committee during the proposal phase were for the researcher to locate a survey that measured wellness and had already been developed. This would avoid having to write questions and to avoid biases.

It was determined by the dissertation Chairperson, Randy Turk, the Perceived Wellness Survey satisfactorily met the requirements established by the committee. Permission for the use of the PWS was solicited. The architect of the Perceived Wellness Survey, Dr. Troy B. Adams, granted permission in
writing to the researcher for use, with no alterations, of his PWS instrument (see Appendix B).

The PWS was designed by Dr. Troy Adams and associates as an instrument to measure perceived wellness that correlates with various health indexes (Adams et al., 1997). The Perceived Wellness Survey consisted of six dimensions of wellness that have been proven to be positively correlated (p < .05) with the Perceived Wellness Survey composite score (Adams et al., 1998). The Perceived Wellness Survey is a multidimensional measure of perceived wellness perceptions in six separate sub-scales, which included physical, spiritual, psychological, social, emotional, and intellectual dimensions.

The authors of the Perceived Wellness Survey provided verification of an acceptable reliability coefficient for the procedures of analyses. Adams and associates (Adams et al., 1998), reporting the independent scale reliabilities at Mu = .7, claimed these reliability scales were “more than adequate” (p. 3). Adams reported in several manuscripts that the Perceived Wellness Survey has a computed power of .85 (Adams & Bezner, 2000; Adams et al., 1998; Adams et al., 1997). In other words, a high probability existed that the test would correctly lead to the conclusion that a difference existed when, in fact, a difference exists. In addition, the internal consistency of alpha was reported as ranging from .88 to .93. The estimated face validity was statistically significant at p=.05 (Adams & Bezner, 2000; Adams et al., 1998). Adams and associates (Adams et al., 1998) reported “temporal stability estimates ranged from r = .73
to $r = .81$” (p. 3), indicating “reasonable stability” (p. 3). The related information provided supporting evidence of the construct validity and reliability for the PWS. It also authenticated the PWS as a valid instrument to use as a research tool (Adams et al., 1998).

The Perceived Wellness Survey section of the survey instrument was made up of 36 closed-ended response items. These items were presented as 6-point Likert scale items. The research participant read each item and responded on the scale ranging from 1 to 6. The six-point scale of this instrument was grounded, or labeled, only at the poles. These pole labels were identified as 1, “very strongly disagree,” and 6, “very strongly agree.” The Chairperson of this research discussed the possibility of using a different Likert scale, possibly a 5-point, to provide easier scoring procedures. As a result of this conversation, it was decided that the author of the PWS was to be contacted.

Dr. Troy Adams, in a personal communication with this researcher, stated that by using a 6-point Likert scale, he did not want to create a neutral field, as one would using a 5-point scale. The only categories on the 6-point scale that were to be labeled were the poles, “very strongly disagree,” and “very strongly agree” (personal communication, November 20, 2002). This enabled each respondent to construe the intervals as equivalent thus facilitating the use of parametric methods. Another concern that the Chair for this research had was the lack of labels for the positions inside the poles.
In a follow-up communication with Dr. Adams (2002), the issue of only labeling the poles was addressed. Dr. Adams indicated that labeling levels 2, 3, 4, and 5, was “problematic” simply because such labels are hard to define. Furthermore he indicated that labeling the in-between labels debunked the assumption that the intervals are equal. The levels at which one perceives or feels were very individualistic and by not labeling those levels, the format provided a method of continuous data using parametric methods (personal communication, December 2002).

The Principal Wellness Questionnaire instrument consisted of two sections previously described. Steps were taken to provide an instrument that would be well received and, thereby, to establish a high level of professionalism. A large sheet (11” x 17”) of light green paper was used, folded length-wise to create a four-page, 8 1/2” x 11”, booklet which made up the survey. Light green paper has been found to produce a higher response rate than other colors, including white paper (Fox, Crask, & Kim, 1988).

Attention was given to the question order and formatting procedures. The length of the survey was kept brief to prevent the potential respondent from feeling the request was too time consuming (Patten, 2001). A cover letter was written, complete with official Wichita State University letterhead, to promote sponsorship (see Appendix C). The final component included a return addressed, stamped envelope. To avoid folding of the survey, the researcher used a large envelope for mailing. These steps were taken to provide the most optimal
response rate possible (McNamara, 1994; Patten, 2001). The next section addresses the response rate.

**Response Rate**

The response rate of a survey has been correlated to the validity of that survey. A low response rate would have an adverse affect on the validity of the survey (Bernard, 2000, p.279). This information dramatized the importance of paying attention to many details that might help increase the overall response rate.

The dissertation committee for this research established a goal for a response rate of 70%. The researcher mailed 310 surveys on February 4, 2003 to Kansas public attendance center principals that were identified through the random sampling strategy. A 70% return rate of 310 required a return of 217 surveys. Results were compiled 20 days after mailing the surveys. A response rate of 76% was received for this research with 236 surveys returned. The 76% return rate exceeded the minimum desired rate of 70% by the research committee.

A high response rate was important to the accuracy of the research results as well as the assurance of proper representation of the identified population (Johnson & Christensen, 2000; Wiersma, 2000). While Patten (2001) suggested that a mail survey would have a large number of non-respondents, Wiersma (2000) stated, “when surveying a professional population, 70% is considered a minimum response rate” (p. 176). Babbie (2001) was less stringent...
in his opinion of response rate stating a 50% response rate is “acceptable,” 60% is “good,” and a response rate of 70% is “very good” (p. 70). A 76% return rate provided a high degree of accuracy for the research results.

Data Analysis

The purpose of analyzing data was to gather supporting evidence for responding to the research questions. All data gathered were analyzed with the intent to develop meaningful research that would uncover relationships, discover patterns, and substantiate findings (Babbie, 2001). Data were gathered from the respondents of the Principal Wellness Questionnaire of Kansas K-12 public school building principals.

Surveys were analyzed using appropriate descriptive and inferential statistics. The advantage of descriptive statistics was that they enable the investigator to use one or two numbers to represent all of the individual scores in a sample (Borg & Gall, 1989). In using descriptive statistics, readers derived their own meaning from the data. This technique provided the researcher with data that allowed for inferences to the population.

The data analysis portion of the research design provided the researcher with procedures to obtain significant information regarding wellness issues related to the six dimensions of wellness. Initially, the Principal Wellness Questionnaire response sheets were carefully scored, coded, and transferred to process the data for analysis.
The first step in the analysis of the data was to take the stack of scored and coded surveys and present the raw data in a manner that made sense. This was accomplished by summarizing the findings of the research using descriptive and inferential statistics.

Initially, numerical descriptions of the data were calculated providing frequency distributions along the range of personal and professional data. This allowed some direction for answering the research questions.

The measures of mean, median, mode, and standard deviation were calculated for each of the 36 Likert scale responses that made up the Perceived Wellness Survey as well as for the demographic responses. Mean, median, and mode were measures of central tendency that are used to describe average, typical or representative scores (Glass & Hopkins, 1984). Standard deviation scores provided a sense of the spread of scores across the responses (Wiersma, 2000). The smaller the standard deviation statistic, the closer the scores were grouped around a particular response (Vockell, 1983).

Data collected from the Principal Wellness Questionnaires were analyzed further by calculating sub-scores for each of the six dimensions of wellness. Deeper analysis involved examining the relationships between the personal data factors and the professional factors. Correlation matrices were constructed to determine significant relationships among the demographic variables and the six wellness dimensions. In addition, Perceived Wellness Composite scores were calculated to determine (a) Perceived Wellness Composite for the entire sample;
(b) composite scores for any of the personal factors and professional factors; and
(c) any significant differences between demographic, personal and professional, variables and Perceived Wellness Composite scores. An example of this would be comparing men to women, age group, or total number of years in administration as the variables relate to the Perceived Wellness Composite score or any of the 6-dimension sub-scores. This provided inferential statistics that assessed the significance, or lack thereof, between the means of the two groups of scores being compared.

Electronic scoring procedures were employed for the scoring of the Perceived Wellness Survey. Data were transcribed onto a Microsoft Excel® spreadsheet that had itemized listings of all 236 respondents and the corresponding codes for each item. This spreadsheet was then imported onto the computerized software program: **Statistical Package for the Social Sciences** (SPSS), version 11. This facilitated the implementation of the scoring procedures outlined by Dr. Troy Adams, the author of the Perceived Wellness Survey.

Dr. Adams outlined the following steps to score the Perceived Wellness Composite score (Adams et al., 1997). Perceptions of wellness were quantified in the form of sub-scores for perceived wellness. Each of the six dimensions of perceived wellness including psychological, emotional, social, physical, spiritual, and intellectual domains had six individual questions dedicated to the respective dimensions. A sub-scale mean was computed by adding each of the
six responses identified for each sub-scale and divided by six. The sum of all sub-scale means made up the Wellness Magnitude score. The Wellness Magnitude was divided by six to create an “xbar”. This term “xbar” was an average of the sum of the sub-score averages. The “xbar” provided an average score of the sub-scales. Then each sub-scale mean minus the appropriate “xbar” was squared (sub-scale mean – xbar)². The result created a sub-scale deviation. Summing all of the sub-scale deviations and dividing by five then created a variance. Using the formula [(square root of the variance)+1.25] gave a Wellness Balance. Adding 1.25 to the denominator prevented a Wellness Balance of 0, which would be an invalid score, since the balance should range between 1 and 6. Finally, the Wellness Composite score was computed by dividing the Wellness Magnitude by the calculated Wellness Balance.

The analysis of relationships between personal factors and professional factors to the perceived wellness composite was calculated using descriptive and inferential statistics. The nature of the variables required a variety of statistics to be used in order to determine possible relationships to the means. Calculations were performed using the Statistical Package for the Social Sciences (SPSS), version 11. This package provided a large selection of programs that easily allowed the researcher to access data and interpret results for the statistical procedures (Bryman & Cramer, 2001).

A correlation coefficient was calculated for rank ordered independent variables with the wellness composite scores, including the sub-scale scores of
the six dimensions of wellness. Correlation measures were used to describe the degree of relationship between two variables (Glass & Hopkins, 1984). A correlation coefficient was used to summarize the magnitude and direction of the relationship between two variables (Johnson & Christensen, 2000; Wiersma, 1991). The relationship between two variables could vary from –1.0 to +1.0 (Babbie, 2001; Wiersma, 2000). A correlation coefficient of 0.0 would indicate that no correlation existed between two variables.

A Spearman rho correlation coefficient was selected because much of the data collected involved rank or ordinal data (Gay & Airasian, 2003; Urdan, 2001). The Spearman rho correlation was performed on several independent variables to determine if a relationship existed between selected variables and the wellness composite score or the six dimensions of wellness sub-scale scores. The variables of age, total years in administration, years at current position, and building enrollment were used to perform a Spearman rho correlation coefficient to determine if a relationship did exist. For the correlation study a coefficient was set statistically significant at the .05 level on a two-tailed test (Wiersma, 2000).

A t-test was calculated for each of the dichotomous independent variables to determine if a statistically significant difference existed between the various means. The t-test was a statistical test used to determine the difference between two means (Creswell, 1998; Huck & Cormier, 1996) and was figured using a .05 level of significance. This was referenced statistically as p < .05. This
meant that the probability (p) due to chance was less than 5% (.05) (Wiersma, 2000).

The independent variables for which t-tests were utilized, included gender, race/ethnicity, marital status, and school setting. The gender response provided a perspective for the number of male and female respondents. Race/ethnicity became a dichotomous variable due to the low number of minority respondents. This independent variable was recoded as “majority” for the White/Caucasian respondent and “minority” for all other race/ethnicity classifications. The next variable to provide dichotomous means was for marital status. This variable was described as “married” or “single.” The last independent variable for which a t-test was used included the school setting. This variable asked the respondent to describe their particular situation as a “rural” setting or an “urban” setting. The United States Census Bureau defined the distinction of these two settings as rural, having a population of less than 50,000 and urban, having more than 50,000 inhabitants (U.S. Census Bureau, 1995).

A one way analysis of variance (ANOVA) was performed on the independent variable of building level. The ANOVA is an effective tool when the means of more than two samples are being tested to see if the means are significantly different from each other (Urdan, 2001). This variable asked the respondent to describe the grade levels of their building providing seven choices.
An ANOVA was the appropriate measure to use because the variable required determining the difference among the means of the seven groups.

**Wellness Model**

Consideration of the research design led the researcher to develop a model that helped depict the research objectives (Appendix D). The model on which this study was based, “Model for K-12 Public School Attendance Center Principals’ Perceived Wellness,” illustrated how the three research questions were processed. It illuminated the movement from the study’s sample, Kansas K-12 public school attendance center principals, to considering two selected groups of demographic factors. These factors were made up of both personal and professional data that may have had a direct impact on respondents’ perceptions of their own wellness. This perception was defined in a perceived wellness magnitude denoted in the model as the six dimensions of wellness. The magnitude could have described dimension-by-dimension as sub-scales, as well as a summation of the six dimensions to an overall wellness sum. The Perceived Wellness Composite score provided this overall sum. The model also included a predicted outcomes goal that was not covered in this study.

The first of two groups of demographic factors involved personal data such as age (Age), gender (Gen), marital status (MS), and race and ethnicity (R/E). These factors impacted Kansas K-12 public school building principals’ perceived wellness (PW).
The second group of demographic factors involved professional data. These factors included the total number of years in administration (TYA), number of years in current position as principal (YCP), building enrollment (BE), building level (BL), and school setting (SS) that impacted Kansas K-12 public school attendance center principals’ perceived wellness (PW).

Personal and professional data factors were analyzed among the same six perceived wellness dimensions: psychological (PsyW), spiritual (SpiW), physical (PhyW), social (SocW), emotional (EmoW), and intellectual (IntW). While the six perceived wellness dimensions were considered one-by-one as sub-scales, a mean score of all six sub-scales constituted the wellness composite score (WCS). This wellness composite score in turn should have led to predicted outcomes, which were not part of this study. The examination of the relationship between personal and professional factors to the perceived wellness scores allowed for the following analysis:

1. The impact personal data had on each of the numbered dimensions of perceived wellness was examined. This included a comparison of men and women along any single dimension of wellness or all six dimensions (the Perceived Wellness Magnitude). The same analysis was used to examine the sample on the basis of marital status, race/ethnicity, and age.

2. The impact of professional data on each of the numbered dimensions of perceived wellness was reviewed. This included comparing the total number of years in administration along any single dimension of wellness
or all six dimensions (the Perceived Wellness Magnitude). The same analysis was used to examine the sample on the basis of the number of years as principal at current position, enrollment of building, building level, and school setting.

3. The six perceived wellness dimensions were considered one-by-one as sub-scales, and a mean score of all six sub-scales constituted the total wellness score. This score was identified as the Perceived Wellness Composite (PWC) in the model.

Summary

The study examined the perceptions of wellness held by Kansas K-12 public school attendance center principals and what extent personal and professional factors may have contributed to that perception. Quantitative techniques were used in the research design.

To collect information efficiently from a large population, a survey was developed and administered to randomly selected principals of attendance centers in Kansas ($N=310$). A return of 236 surveys resulted in a response rate of 76%. The survey consisted of two sections. The first was a set of nine demographic questions. The second section used a 6-point Likert scale survey known as the Perceived Wellness Survey.

The data from the survey questions was analyzed using descriptive and inferential statistical methods. The “Model for K-12 Public School Attendance Center Principals’ Perceived Wellness” was developed to illustrate the possible
relationships between the personal and professional factors and the Perceived Wellness Composite score. The information gleaned from these procedures provided data that enabled the researcher to explore the research questions. Chapter 3 explained the methodology used to conduct this study. Next, chapter 4 discusses the data analysis and findings.
Chapter 4

Findings

This research examined Kansas K-12 public school building principals’ perceptions of their own wellness. Personal and professional variables were investigated to determine their effect on the principals’ perceived wellness. Chapter 3 described the design and methodology for this research; a detailed explanation of the research findings is reported in this chapter.

To inform the reader, this chapter begins with an overview of research design and methodology. The second section provides a description of the independent and dependent variables used in the research. The third section includes an analysis of data using descriptive and inferential statistics applied with the variables involved in this research. The final section contains a findings summary.

Overview of Research Design and Methodology

The researcher used the Principal Wellness Questionnaire to collect quantitative data. The survey consisted of two sections. The first section contained items that collected demographic data, which included personal and professional characteristics of the respondents. The second section of the questionnaire was the Perceived Wellness Survey, developed by Dr. Troy Adams and associates (1997).
The research addressed three overarching questions that focused on the perceived wellness of Kansas K-12 public school building principals. The research questions asked:

1. How do Kansas K-12 public school building principals perceive their own wellness?
2. To what extent do personal factors contribute to Kansas K-12 public school building principal perceptions of wellness?
3. To what extent do professional factors contribute to Kansas K-12 public school building principal perceptions of wellness?

Examination of the dependent and independent variables was required to answer the research questions.

Independent and Dependent Variables

The research included nine independent variables, one dependent variable, and six dependent “sub-scale” variables. The nine independent variables were developed by the researcher to collect demographic data. The dependent variable was the wellness composite score of the Perceived Wellness Survey. The six dependent sub-scale variables consisted of each dimension of wellness that contributed to the wellness composite score. These dependent sub-scale variables included physical, spiritual, psychological, social, emotional, and intellectual wellness scores.

The independent variables consisted of the personal and professional factors from the Principal Wellness Questionnaire. Personal factors included
age, gender, marital status, and race/ethnicity. Professional factors included years in administration, years as principal in current position, building enrollment, building level, and rural or urban setting.

The dependent variable for this research was the wellness composite score. This score was derived using six sub-scales, one each for the six dimensions of wellness used in this research. Sub-scale scores for each dimension of wellness were computed by adding the appropriate responses from the six-point Likert scale. The sum of the six responses for each dimension determined the sub-scale score, which indicated perceived wellness of the associated domain.

The wellness composite score was derived from a mathematical formula (Adams et al., 1997). The first step of the formula was to compute the means for each sub-scale. The second step was to add the six sub-scale means. The third step was to compute the combined standard deviation of the six sub-scales. The fourth step was to add the constant 1.25 to the composite standard deviation. This constant eliminated the possibility of computing a score of 0. This new value of the sum of composite standard deviation and the constant, 1.25, became the denominator of the formula.

The final step was to divide the sum of the six means by the numerical value resulting from the sum of the composite standard deviation plus 1.25. The resulting score from this mathematical procedure determined the wellness.
composite score (Adams et al., 1998). Adams further credited this procedure with providing simultaneous accounts for both magnitude and balance (p.2).

The six components that made up the “sub-scale” dependent variables were used in determining the wellness composite score. These components included the physical, spiritual, psychological, social, emotional, and intellectual dimensions. Table 1 shows the variables of the research, the type of variable, and the abbreviation for each variable.
Table 1

Dependent, Dependent Sub-scale, and Independent Variables

<table>
<thead>
<tr>
<th>Variable Name</th>
<th>Type of Variable</th>
<th>Abbreviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wellness Composite</td>
<td>Dependent</td>
<td>WC</td>
</tr>
<tr>
<td>Physical Wellness</td>
<td>Dependent Sub-scale</td>
<td>PhyW</td>
</tr>
<tr>
<td>Spiritual Wellness</td>
<td>Dependent Sub-scale</td>
<td>SpiW</td>
</tr>
<tr>
<td>Psychological Wellness</td>
<td>Dependent Sub-scale</td>
<td>PsyW</td>
</tr>
<tr>
<td>Social Wellness</td>
<td>Dependent Sub-scale</td>
<td>SocW</td>
</tr>
<tr>
<td>Emotional Wellness</td>
<td>Dependent Sub-scale</td>
<td>EmoW</td>
</tr>
<tr>
<td>Intellectual Wellness</td>
<td>Dependent Sub-scale</td>
<td>IntW</td>
</tr>
<tr>
<td>Age of Respondent</td>
<td>Independent</td>
<td>Age</td>
</tr>
<tr>
<td>Gender</td>
<td>Independent</td>
<td>Gen</td>
</tr>
<tr>
<td>Marital Status</td>
<td>Independent</td>
<td>MS</td>
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<tr>
<td>Race/Ethnicity</td>
<td>Independent</td>
<td>R/E</td>
</tr>
<tr>
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<td>Independent</td>
<td>YA</td>
</tr>
<tr>
<td>Years at Current Position</td>
<td>Independent</td>
<td>YCP</td>
</tr>
<tr>
<td>Building Enrollment</td>
<td>Independent</td>
<td>BE</td>
</tr>
<tr>
<td>Building Level</td>
<td>Independent</td>
<td>BL</td>
</tr>
<tr>
<td>School Setting (Rural/Urban)</td>
<td>Independent</td>
<td>SS</td>
</tr>
</tbody>
</table>

Analysis of Data

Principal Wellness Questionnaires were sent to a randomly selected sample (N = 310) of Kansas K-12 public school building principals. Two hundred thirty six Principal Wellness Questionnaires were returned to the researcher.
All returned surveys were in usable condition. The return rate for usable surveys was 76.1%.

All data were analyzed using descriptive and inferential statistics. When appropriate, descriptive data included such information as frequency distribution; statistics of central tendency including mean, median, mode; and distributions including range and standard deviation to help describe each independent variable.

The analysis of the six-point Likert scale used on the Perceived Wellness Survey results produced mean and standard deviation for the six dimensions of wellness that were then used to compute the wellness composite score. It further provided means and standard deviations for the six dimensions of wellness including physical, social, psychological, spiritual, emotional, and intellectual wellness domains. These descriptive measures were then used to perform correlation coefficients, t-tests, or one way analysis of variance to determine relationships between variables.

Table 2 showed descriptive statistics including the means and standard deviations for the six dimensions of wellness and the wellness composite score of the sample.
Table 2

Means and Standard Deviations

<table>
<thead>
<tr>
<th>Wellness Variable</th>
<th>N</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical</td>
<td>236</td>
<td>28.78</td>
<td>5.02</td>
</tr>
<tr>
<td>Spiritual</td>
<td>236</td>
<td>32.00</td>
<td>3.82</td>
</tr>
<tr>
<td>Psychological</td>
<td>236</td>
<td>30.25</td>
<td>3.97</td>
</tr>
<tr>
<td>Social</td>
<td>236</td>
<td>30.71</td>
<td>4.10</td>
</tr>
<tr>
<td>Emotional</td>
<td>236</td>
<td>29.20</td>
<td>4.26</td>
</tr>
<tr>
<td>Intellectual</td>
<td>236</td>
<td>29.01</td>
<td>3.72</td>
</tr>
<tr>
<td>Wellness Composite</td>
<td>236</td>
<td>17.52</td>
<td>3.05</td>
</tr>
</tbody>
</table>

The means for the six dimensions were figured using the sum of the six responses for each designated dimension divided by six. The wellness composite score involved a more involved computation that used the dimensional scores by combining the mean, or magnitude, of each dimension with the standard deviation, or balance, among the dimensions (Adams & Bezner, 2000). Wellness composite scores ranged from 3 to 29 with “higher scores indicating greater wellness” (p. 172).

The intellectual wellness dimension had the lowest standard deviation (3.72) among the six dimensions suggesting more consistency in scores between
the respondents. Conversely, the physical dimension had the largest standard deviation (5.02) that indicated a wider range of scores for that dimension.

A correlation was calculated between selected independent variables and the dependent variable of wellness including the six dimensions and the wellness composite score. The variables involved with rank data required a specific type of correlation to be used (Gay & Airasian, 2003). The correlation statistic was generated using the Spearman $\rho$ coefficient applied to data derived from the Perceived Wellness Survey scores and the independent variables. These data were reported using the Spearman $\rho$ coefficient. The Spearman $\rho$ was calculated to determine if a relationship existed. This correlation coefficient was also checked with the six sub-scales of the independent variable, the six dimensions of wellness.

Statistical significance between means was determined through the use of t-tests (Ferguson, 1981). Ferguson stated that t-tests were appropriate whenever the means of two groups were being compared. The t-tests were conducted to determine statistical significance. Each independent variable was subsequently measured through the same t-test procedure with sub-scales of the dependent variable. Means were compared to determine if the difference between means was statistically significant, that is, if the difference was due to chance or reflected a true relationship between the variables, as opposed to sampling error. For the t-tests, a statistically significant difference between the
means of independent variables was observed at the p < .05 and p < .01 level (Wiersma, 2000).

For t-tests, the critical value of t on a two-tailed test, with a sample size of greater than 120, needed to be 1.960 for statistical significance at the .05 level, and 2.576 at the .01 level (Wiersma, 2000). The .01 level indicated an even smaller probability due to chance. For the correlation study, a coefficient of .139 was needed to be statistically significant at the .05 level on a two-tailed test with a sample size greater than 200, and, for the .01 level, .182 was set (Wiersma, 2000).

For data involving group means, the one-way analysis of variance (ANOVA) was used. The one-way ANOVA is an appropriate technique to use for multiple means (Gay & Airasian, 2003). The one-way ANOVA requires categorical variables with at least two independent groups (Urdan, 2001). One variable, building levels, required the use of this technique to determine if statistical significance existed between the group of mean scores.

The next section provides descriptive and inferential analyses of the findings for the research sample. The findings are organized by independent variables as they appeared on the survey. When possible, tables are provided for each variable depicting necessary information. This section begins with the personal factors.
Personal Factors

The first four questions on the Principal Wellness Questionnaire made up the section personal factors. Gender, age, race/ethnicity, and marital status were included in this section of the questionnaire. These areas are described in further detail to provide understanding of the data analysis.

Gender

Of the 236 principals responding, 159 (67%) were male and 77 (33%) were female. Efforts were made by the researcher to determine if the sample was a fair representation of the population. Two sources were searched for a comparison of these data. In a report provided by the Kansas Association of School Boards (2004), administration figures included data providing gender, age, and years of experience from the state figures. This information revealed the actual percentage of male and female principals across Kansas to be 63% male and 37% female. A second source, provided by the Kansas State Department of Education (2004), revealed a ratio of 67% males to 33% females building administrators. Each indicated a reasonable proximity from actual numbers to the research, with the KSDE numbers providing an exact match. Table 3 provided the data analysis for gender. Data representing the total number for each group, mean, and standard deviation were included.
Table 3

Data Analysis for Gender

<table>
<thead>
<tr>
<th>Wellness Dimension</th>
<th>Gender</th>
<th>N</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>PhyW</td>
<td>Male</td>
<td>159</td>
<td>28.69</td>
<td>4.84</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>77</td>
<td>28.97</td>
<td>5.39</td>
</tr>
<tr>
<td>SpiW</td>
<td>Male</td>
<td>159</td>
<td>31.68</td>
<td>3.95</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>77</td>
<td>32.65</td>
<td>3.46</td>
</tr>
<tr>
<td>PsyW</td>
<td>Male</td>
<td>159</td>
<td>29.89</td>
<td>4.10</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>77</td>
<td>30.97</td>
<td>3.61</td>
</tr>
<tr>
<td>SocW</td>
<td>Male</td>
<td>159</td>
<td>30.34</td>
<td>4.27</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>77</td>
<td>31.47</td>
<td>3.62</td>
</tr>
<tr>
<td>EmoW</td>
<td>Male</td>
<td>159</td>
<td>29.01</td>
<td>4.36</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>77</td>
<td>29.60</td>
<td>4.04</td>
</tr>
<tr>
<td>IntW</td>
<td>Male</td>
<td>159</td>
<td>28.52</td>
<td>3.65</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>77</td>
<td>30.03</td>
<td>3.67</td>
</tr>
<tr>
<td>WC</td>
<td>Male</td>
<td>159</td>
<td>17.42</td>
<td>3.15</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>77</td>
<td>17.70</td>
<td>2.85</td>
</tr>
</tbody>
</table>

Using the Table 3 information, Table 4 provided data analysis information from a t-test, including the critical value of t, the degrees of freedom, the .05 level of statistical significance coded with an asterisk and the .01 level of statistical significance coded with a double asterisk.
Table 4

Gender t-test

<table>
<thead>
<tr>
<th>Wellness Variables</th>
<th>t</th>
<th>df</th>
<th>Mean Dif</th>
</tr>
</thead>
<tbody>
<tr>
<td>PhyW</td>
<td>-0.405</td>
<td>234</td>
<td>-0.282</td>
</tr>
<tr>
<td>SpiW</td>
<td>-1.925</td>
<td>234</td>
<td>0.056</td>
</tr>
<tr>
<td>PsyW</td>
<td>-1.972*</td>
<td>234</td>
<td>-1.081</td>
</tr>
<tr>
<td>SocW</td>
<td>-1.995*</td>
<td>234</td>
<td>-1.128</td>
</tr>
<tr>
<td>EmoW</td>
<td>-0.988</td>
<td>234</td>
<td>-0.585</td>
</tr>
<tr>
<td>IntW</td>
<td>-2.976**</td>
<td>234</td>
<td>-1.510</td>
</tr>
<tr>
<td>WC</td>
<td>-0.661</td>
<td>234</td>
<td>-0.281</td>
</tr>
</tbody>
</table>

*p < .05; **p < .01

Research Findings for Gender

Findings that represent statistical significance between gender and the various dimensions of wellness and the wellness composite are included in this section. For understanding, the researcher identified the variable with the higher perception of wellness first. This was done to avoid the appearance of bias of findings. Mean differences were reported in parentheses. Findings also indicate statistical significance at the p < .05 or p < .01 level. The sample of 236
principals represented 159 (67%) males and 77 (33%) females. This compared closely to state data.

- Females perceived their own psychological wellness higher (1.081) than males, statistically significant at \( p < .05 \) level.
- Females perceived their own social wellness higher (1.128) than males, statistically significant at \( p < .05 \) level.
- Females perceived their own intellectual wellness higher (1.510) than males, statistically significant at \( p < .01 \) level.

Statistical significance was not found between the differences in means for the independent variable of gender with the dependent variables of physical wellness, psychological wellness, emotional wellness, or the wellness composite score.

**Age**

The range of the respondents’ age in years was from 30 to 67. The mean age of principals from the sample was 46.6 with a median age of 48. The principals’ mean age was lower than the median, which indicated the principal age skewed very slightly to the younger age. Three of the 236 respondents did not indicate an age. Looking at state data, the mean age for principals in Kansas for 2003-2004 was 47.3 years old (KASB, 2004).

Table 5 summarized the distribution of age for the sample. The table displayed categories with the range, frequency, percent and total percentages. The categories were depicted merely to facilitate clarity and understanding of
the presented data. Data were not analyzed in accordance with the depicted categories.

Table 5

<table>
<thead>
<tr>
<th>Range</th>
<th>Frequency</th>
<th>Percent</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>30-39</td>
<td>50</td>
<td>21.2</td>
<td>21.2</td>
</tr>
<tr>
<td>40-49</td>
<td>84</td>
<td>35.6</td>
<td>56.8</td>
</tr>
<tr>
<td>50-59</td>
<td>88</td>
<td>37.3</td>
<td>94.1</td>
</tr>
<tr>
<td>60-67</td>
<td>11</td>
<td>4.7</td>
<td>98.8</td>
</tr>
<tr>
<td>No response</td>
<td>3</td>
<td>1.3</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>236</td>
<td>100</td>
<td></td>
</tr>
</tbody>
</table>

The personal factor of age was correlated with the wellness composite score and the six dimensions of wellness to determine if a relationship existed. The Spearman rho coefficient was computed for each of the wellness scores, the dependent variables, and the age group variables. Table 6 displayed the Spearman rho correlation statistics. A correlation was considered statistically significant at the .05 level on a two-tailed test with a sample size of greater than 200 (Wiersma, 2000).
Table 6

Correlation Comparing Wellness Variables with Age

<table>
<thead>
<tr>
<th>Wellness Variable</th>
<th>n</th>
<th>Sig. (2-tailed)</th>
<th>rho</th>
</tr>
</thead>
<tbody>
<tr>
<td>PhyWell</td>
<td>233</td>
<td>.999</td>
<td>.000</td>
</tr>
<tr>
<td>SpiWell</td>
<td>233</td>
<td>.009</td>
<td>.171**</td>
</tr>
<tr>
<td>PsyWell</td>
<td>233</td>
<td>.106</td>
<td>.106</td>
</tr>
<tr>
<td>SocWell</td>
<td>233</td>
<td>.323</td>
<td>.065</td>
</tr>
<tr>
<td>EmoWell</td>
<td>233</td>
<td>.038</td>
<td>.136*</td>
</tr>
<tr>
<td>IntWell</td>
<td>233</td>
<td>.008</td>
<td>.173*</td>
</tr>
<tr>
<td>WC</td>
<td>233</td>
<td>.546</td>
<td>.040</td>
</tr>
</tbody>
</table>

* p < .05; ** p < .01

Research Findings for Age

Findings that represented correlation between age and the dimensions of wellness as well as the wellness composite are included in this section. Age for respondents ranged from 30-67 with a mean of 46.6 and a median of 48 years old.

- The correlation between spiritual wellness scores and age was statistically significant ($rho = .171$, $p < .01$).
• The correlation between emotional wellness scores and age was statistically significant \((rho = .136, p < .05)\).

• The correlation between intellectual wellness scores and age was statistically significant \((rho = .173, p < .01)\).

The significant findings of Spearman \(rho\) should be considered with caution since the effect size, also known as coefficient of determination \((rho^2)\), is low. The correlation between physical wellness, psychological wellness, social wellness, and wellness composite scores with age were not statistically significant.

**Race/Ethnicity**

The next personal factor involved the race/ethnicity of the sample. Respondents were given five choices from which to select the race/ethnicity description that most accurately described themselves. The choices included: (a) Asian/Pacific Islander, (b) Black/African American, (c) Native/Indian American, (d) White/Caucasian, and (e) other.

The White/Caucasian category accounted for 225 respondents, or 95.3% of the sample. The remaining eleven respondents selected three other categories. These eleven respondents made up 4.7% of the sample. Of that group, nine were females and two were male. The researcher attempted to compare these data with Kansas data similar to the age and gender sequence. Speaking with Veryl Peter (personal communication, November 1, 2004), School Finance Director, with the Kansas State Department of Education, Mr. Peter stated the
percentage of minority administrators across Kansas was “probably around 5%.”
This was verified in checking the state database, provided by the Teacher
Education and Licensure division of KSDE. The data showed 1,459 principals
registered in the state. Eighty-seven listed a race/ethnicity other than white for
5.9% of the principals in Kansas (personal communication, November 1, 2004).
<table>
<thead>
<tr>
<th>Wellness Score</th>
<th>Race Ethnicity</th>
<th>N</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>PhyW Majority</td>
<td>225</td>
<td>28.85</td>
<td>4.72</td>
<td></td>
</tr>
<tr>
<td>Minority</td>
<td>11</td>
<td>27.36</td>
<td>9.46</td>
<td></td>
</tr>
<tr>
<td>SpiW Majority</td>
<td>225</td>
<td>31.88</td>
<td>3.85</td>
<td></td>
</tr>
<tr>
<td>Minority</td>
<td>11</td>
<td>34.27</td>
<td>2.20</td>
<td></td>
</tr>
<tr>
<td>PsyW Majority</td>
<td>225</td>
<td>30.23</td>
<td>3.99</td>
<td></td>
</tr>
<tr>
<td>Minority</td>
<td>11</td>
<td>30.64</td>
<td>3.67</td>
<td></td>
</tr>
<tr>
<td>SocW Majority</td>
<td>225</td>
<td>30.65</td>
<td>4.05</td>
<td></td>
</tr>
<tr>
<td>Minority</td>
<td>11</td>
<td>31.82</td>
<td>5.04</td>
<td></td>
</tr>
<tr>
<td>EmoW Majority</td>
<td>225</td>
<td>29.18</td>
<td>4.25</td>
<td></td>
</tr>
<tr>
<td>Minority</td>
<td>11</td>
<td>29.72</td>
<td>4.69</td>
<td></td>
</tr>
<tr>
<td>IntW Majority</td>
<td>225</td>
<td>28.92</td>
<td>3.74</td>
<td></td>
</tr>
<tr>
<td>Minority</td>
<td>11</td>
<td>30.73</td>
<td>2.80</td>
<td></td>
</tr>
<tr>
<td>WC Majority</td>
<td>225</td>
<td>17.60</td>
<td>3.01</td>
<td></td>
</tr>
<tr>
<td>Minority</td>
<td>11</td>
<td>15.72</td>
<td>3.57</td>
<td></td>
</tr>
</tbody>
</table>

Based on these preliminary findings, the race/ethnicity variable was used in the analyses as a dichotomous variable with the categories “majority” and
“minority” reported. Table 7 provided the data analysis for race/ethnicity. Data representing the total number for each group, mean, and standard deviation were included.

Using information from Table 7, Table 8 provided data analysis information for the variables of race/ethnicity and wellness, including the six dimensions and the wellness composite score. Data analysis derived from a t-test included the critical value of t, the degrees of freedom, the .05 level of statistical significance coded with an asterisk. The .01 level of statistical significance coded with a double asterisk.

Table 8

<table>
<thead>
<tr>
<th>Wellness Variables</th>
<th>t</th>
<th>df</th>
<th>Mean Dif</th>
</tr>
</thead>
<tbody>
<tr>
<td>PhyW</td>
<td>-0.519</td>
<td>234</td>
<td>-1.490</td>
</tr>
<tr>
<td>SpiW</td>
<td>2.039*</td>
<td>234</td>
<td>2.388</td>
</tr>
<tr>
<td>PsyW</td>
<td>0.333</td>
<td>234</td>
<td>0.410</td>
</tr>
<tr>
<td>SocW</td>
<td>0.920</td>
<td>234</td>
<td>1.165</td>
</tr>
<tr>
<td>EmoW</td>
<td>0.417</td>
<td>234</td>
<td>0.550</td>
</tr>
<tr>
<td>IntW</td>
<td>1.576</td>
<td>234</td>
<td>1.803</td>
</tr>
<tr>
<td>WC</td>
<td>-2.012*</td>
<td>234</td>
<td>-1.885</td>
</tr>
</tbody>
</table>

*p < .05; **p < .01
Research Findings for Race/Ethnicity

Findings that represent statistical significance between race/ethnicity and the various dimensions of wellness and the wellness composite are included in this section. For understanding, the researcher identified the variable with the higher perception of wellness first. This was done to avoid the appearance of bias of findings. Mean differences were reported in parentheses. Findings also indicate statistical significance at the $p < .05$ or $p < .01$ level. Only 4.7% of the respondents identified a race other than White/Caucasian compared to state data indicating 5.9% of Kansas principals were of another race/ethnicity.

- The minority race/ethnicity principals perceived their spiritual wellness higher (2.388) than majority race/ethnicity principals, statistically significant at the .05 level.

- The majority race/ethnicity principals perceived their wellness composite higher (1.885) than minority race/ethnicity principals, statistically significant at the .05 level.

Statistical significance was not found between the differences in means for the independent variable of race/ethnicity with the dependent variables of physical wellness, psychological wellness, social wellness, emotional wellness, intellectual wellness, or the wellness composite score.

Marital Status

The final independent variable included in the personal factors’ section was marital status. The respondents were given choices that consisted of (a)
single, (b) married, (c) divorced, (e) separated, and (f) widowed. Table 9 depicted the marital status in terms of frequency and percentage of sample.

Table 9

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>9</td>
<td>3.8</td>
</tr>
<tr>
<td>Married</td>
<td>204</td>
<td>86.4</td>
</tr>
<tr>
<td>Divorced</td>
<td>17</td>
<td>7.2</td>
</tr>
<tr>
<td>Separated</td>
<td>3</td>
<td>1.3</td>
</tr>
<tr>
<td>Widowed</td>
<td>3</td>
<td>1.3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>236</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

Total respondent frequencies indicated that, in descending order, married, divorced, single, separated, and widowed described the sample. Two hundred four respondents reported being married at the time the survey was completed, accounting for 86.4% of the sample. Seventeen principals identified their marital status as divorced, which represented 7.2% of the respondents. The third highest response for marital status was the single category that made
up 3.8%. Three respondents reported being separated. There were also three widowed respondents. These accounted for 1.3% of the sample respectively.

Due to the low percentage of categories selected other than married for this variable, the sample was grouped by the researcher into two categories, “married” and “single” to balance the data for analysis. Table 9 provided the data analysis for marital status using married and single for categorization. Data representing the total number for each group, mean and standard deviation were included in Table 10.
Table 10

Data Analysis for Marital Status

<table>
<thead>
<tr>
<th>Wellness Score</th>
<th>Marital Status</th>
<th>N</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>PhyW Married</td>
<td></td>
<td>204</td>
<td>28.89</td>
<td>4.83</td>
</tr>
<tr>
<td>PhyW Single</td>
<td></td>
<td>32</td>
<td>28.09</td>
<td>6.10</td>
</tr>
<tr>
<td>SpiW Married</td>
<td></td>
<td>204</td>
<td>31.99</td>
<td>3.94</td>
</tr>
<tr>
<td>SpiW Single</td>
<td></td>
<td>32</td>
<td>32.06</td>
<td>2.93</td>
</tr>
<tr>
<td>PsyW Married</td>
<td></td>
<td>204</td>
<td>30.38</td>
<td>3.95</td>
</tr>
<tr>
<td>PsyW Single</td>
<td></td>
<td>32</td>
<td>29.41</td>
<td>4.06</td>
</tr>
<tr>
<td>SocW Married</td>
<td></td>
<td>204</td>
<td>30.86</td>
<td>3.94</td>
</tr>
<tr>
<td>SocW Single</td>
<td></td>
<td>32</td>
<td>29.72</td>
<td>4.94</td>
</tr>
<tr>
<td>EmoW Married</td>
<td></td>
<td>204</td>
<td>29.20</td>
<td>4.32</td>
</tr>
<tr>
<td>EmoW Single</td>
<td></td>
<td>32</td>
<td>29.25</td>
<td>3.92</td>
</tr>
<tr>
<td>IntW Married</td>
<td></td>
<td>204</td>
<td>28.99</td>
<td>3.77</td>
</tr>
<tr>
<td>IntW Single</td>
<td></td>
<td>32</td>
<td>29.13</td>
<td>3.42</td>
</tr>
<tr>
<td>WC Married</td>
<td></td>
<td>204</td>
<td>17.70</td>
<td>3.06</td>
</tr>
<tr>
<td>WC Single</td>
<td></td>
<td>32</td>
<td>16.37</td>
<td>2.79</td>
</tr>
</tbody>
</table>

Using information from Table 10, Table 11 provided data analysis information for the variables of marital status and wellness including the six dimensions and the wellness composite score. Data analysis derived from a t-
test, included the critical value of $t$, the degrees of freedom, the .05 level of statistical significance coded with an asterisk and the .01 level of statistical significance coded with a double asterisk.

Table 11

Marital Status t-test

<table>
<thead>
<tr>
<th>Wellness Variables</th>
<th>t</th>
<th>df</th>
<th>Mean Dif</th>
</tr>
</thead>
<tbody>
<tr>
<td>PhyW</td>
<td>-0.837</td>
<td>234</td>
<td>-0.798</td>
</tr>
<tr>
<td>SpiW</td>
<td>0.106</td>
<td>234</td>
<td>0.077</td>
</tr>
<tr>
<td>PsyW</td>
<td>-1.287</td>
<td>234</td>
<td>-0.971</td>
</tr>
<tr>
<td>SocW</td>
<td>-1.472</td>
<td>234</td>
<td>-1.144</td>
</tr>
<tr>
<td>EmoW</td>
<td>0.066</td>
<td>234</td>
<td>0.054</td>
</tr>
<tr>
<td>IntW</td>
<td>0.190</td>
<td>234</td>
<td>0.135</td>
</tr>
<tr>
<td>WC</td>
<td>-2.313*</td>
<td>234</td>
<td>-1.330</td>
</tr>
</tbody>
</table>

*p < .05; **p < .01

Research Findings for Marital Status

Findings that represent statistical significance between marital status and the various dimensions of wellness and the wellness composite are included in this section. For understanding, the researcher identified the variable with
the higher perception of wellness first. This was done to avoid the appearance of bias of findings. Mean differences were reported in parentheses. Findings also indicate statistical significance at the \( p < .05 \) or \( p < .01 \) level. A majority of the sample (86.4\%) identified their marital status as married.

- The married principal perceived his or her wellness composite higher (1.330) than single principals did by a statistically significant amount at the \( p < .05 \) level.

Statistical significance was not found between the differences in means for the independent variable of race/ethnicity with the dependent variables of physical wellness, spiritual wellness, psychological wellness, social wellness, emotional wellness, or intellectual wellness.

Professional Factors

The second set of independent variables that comprised the demographic section of the Principal Wellness Questionnaire contained professional factors. Questions in this section looked at total years in administration, years at current position, building level, building enrollment, and school setting. The descriptive analyses continued with an in depth look at these professional factors.

Total Years in Administration

This professional factor allowed the researcher to acquire the total years each respondent had spent in administration. All 236 respondents provided a
response. The range was from 1 to 38 (years). The median for total years in administration was 9 with a mean of 10.76.

The professional factor of total years in administration was correlated with the wellness composite score and the six dimensions of wellness to determined if there was a relationship. A Spearman $rho$ coefficient was figured for each of the wellness scores, the dependent variables, and the variable total years in administration. Table 12 displayed the Spearman $rho$ correlation statistics. A correlation was considered statistically significant at the .05 level on a two-tailed test with a sample size of greater than 200 (Wiersma, 2000).

Table 12

Spearman $rho$ Correlation Coefficients Total Years in Administration

<table>
<thead>
<tr>
<th>Wellness Variable</th>
<th>Significance (2-tailed)</th>
<th>$rho$</th>
</tr>
</thead>
<tbody>
<tr>
<td>PhyWell</td>
<td>.437</td>
<td>.051</td>
</tr>
<tr>
<td>SpiWell</td>
<td>.054</td>
<td>.126</td>
</tr>
<tr>
<td>PsyWell</td>
<td>.316</td>
<td>.066</td>
</tr>
<tr>
<td>SocWell</td>
<td>.516</td>
<td>-.042</td>
</tr>
<tr>
<td>EmoWell</td>
<td>.180</td>
<td>.088</td>
</tr>
<tr>
<td>IntWell</td>
<td>.190</td>
<td>.086</td>
</tr>
<tr>
<td>WC</td>
<td>.990</td>
<td>-.001</td>
</tr>
</tbody>
</table>

* p < .05; ** p < .01
Research Findings for Total Years in Administration

Statistical significance was not found with the correlation for the independent variable of years in administration with the dependent variables of physical wellness, spiritual wellness, psychological wellness, social wellness, emotional wellness, intellectual wellness, or the wellness composite.

Demographic data for the independent variable of total years in administration ranged from 1-38 years with a mean of 10.76 and a median of 9 total years.

Years at Current Position

The next professional factor determined how many years the principal responding had served in his or her current position. One survey respondent left this question blank. The median of total years at current position for the respondents was 4 (n=235). The mean was 5.84 years. The reported range varied for years at current position from 1 year to 27 years. The mode for total years in current position was two years. The number of principals serving in the second year of their current position equaled 41 (17%). Data from surveys also indicated 55.9% of the principals had served 4 years or less in their current positions. Eighty-eight point six percent (209) principals had served in their current position for ten years or less.

The professional factor, years at current position, was correlated with the wellness composite score and the six dimensions of wellness to determine if a relationship existed. A Spearman $\rho$ coefficient was figured for each of the wellness scores, the dependent variables, and the age groups variables. Table 13
displayed the Spearman rho correlation statistics. A correlation was considered statistically significant at the .05 level on a two-tailed test with a sample size of greater than (Wiersma, 2000).

Table 13

Spearman rho Coefficients with Years at Current Position

<table>
<thead>
<tr>
<th>Wellness Variable</th>
<th>Significance (2-tailed)</th>
<th>rho</th>
</tr>
</thead>
<tbody>
<tr>
<td>PhyWell</td>
<td>.124</td>
<td>.101</td>
</tr>
<tr>
<td>SpiWell</td>
<td>.260</td>
<td>.074</td>
</tr>
<tr>
<td>PsyWell</td>
<td>.407</td>
<td>.054</td>
</tr>
<tr>
<td>SocWell</td>
<td>.386</td>
<td>.057</td>
</tr>
<tr>
<td>EmoWell</td>
<td>.768</td>
<td>.019</td>
</tr>
<tr>
<td>IntWell</td>
<td>.931</td>
<td>-.006</td>
</tr>
<tr>
<td>WC</td>
<td>.412</td>
<td>.054</td>
</tr>
</tbody>
</table>

p < .05; ** p < .01

Research Findings for Years at Current Position

Statistical significance was not found with the correlation for the independent variable of years at current position with the dependent variables of physical wellness, spiritual wellness, psychological wellness, social wellness,
emotional wellness, intellectual wellness, or the wellness composite score.  
Demographic data for the independent variable of years at current position ranged from 1-27 years with a mean of 5.84 and a median of 4 years.

**Enrollment of Building**

This professional factor determined if the perceptions of wellness differed by size of the building for each principal. A great disparity was reported for the enrollment of buildings. The range in building enrollment was from 33-2100 students. The two lowest reported building enrollments were 33 and 34 students. Two principals had building enrollments of 2,100 students.

The professional factor of building enrollment was correlated with the wellness composite score and the six dimensions of wellness to determine if a relationship existed. A Spearman \( \rho \) coefficient was figured for each of the wellness scores, the dependent variables, and the building enrollment variables. Table 14 displayed the Spearman \( \rho \) correlation statistics. A correlation was considered statistically significant at the .05 level on a two-tailed test with a sample size of greater than 200 (Wiersma, 2000).
Table 14
Spearman rho Correlation Coefficients with Building Enrollment

<table>
<thead>
<tr>
<th>Wellness Variable</th>
<th>Significance (2-tailed)</th>
<th>rho</th>
</tr>
</thead>
<tbody>
<tr>
<td>PhyWell</td>
<td>.301</td>
<td>.068</td>
</tr>
<tr>
<td>SpiWell</td>
<td>.717</td>
<td>.024</td>
</tr>
<tr>
<td>PsyWell</td>
<td>.691</td>
<td>.026</td>
</tr>
<tr>
<td>SocWell</td>
<td>.390</td>
<td>-.056</td>
</tr>
<tr>
<td>EmoWell</td>
<td>.031</td>
<td>.141*</td>
</tr>
<tr>
<td>IntWell</td>
<td>.500</td>
<td>.044</td>
</tr>
<tr>
<td>WC</td>
<td>.270</td>
<td>.072</td>
</tr>
</tbody>
</table>

* p < .05; ** p < .01

Research Findings for Building Enrollment
Findings that represented correlation between building enrollment and the dimensions of wellness as well as the wellness composite are included in this section. Building enrollment ranged from 33-2100 students for the respondents.

- The correlation between principals’ perceptions of emotional wellness and building enrollment was statistically significant (rho = .141, p < .05).
The significant finding of Spearman rho should be considered with caution since the effect size, also known as coefficient of determination \((\rho^2)\), is low. Statistical significance was not found with the correlation for the independent variable of building enrollment with the dependent variables of physical wellness, spiritual wellness, psychological wellness, social wellness, intellectual wellness, or the wellness composite score.

Building Level

The next professional factor studied was building level. This category indicated the principal’s building grade level. The survey offered several choices of building level to capture as closely as possible the numerous configurations of Kansas schools. They included elementary/grade school; middle school/jr. high; junior/senior high (7-12); high school; K-8; K-12; and other. An open-ended response was included to allow the principal to identify a level not included on the survey. Three respondents (1.3%) did not identify a building level.

Table 15 provided a frequency chart to depict the building levels represented for this survey. Table 15 clarified the variable by depicting building level, frequency and percentage of sample that made up each category.
Eleven respondents listed “other” as their building level. These respondents used the open response item to describe their particular situation. The following descriptions were quoted from the open-ended portion of the “other” category for building configurations: Pre-k-K; K-5+9-12; K with 5-6; 3rd-5th; 3rd-8th; 5th grade; three principals identified 5th-6th; 5-12; and, 6-12 buildings.

Data representing the total number of respondents, mean, and standard deviation for each age group were included in Table 16. It provided the data
analysis for the variable of building level with the dependent variables, the six
dimensions of wellness and the wellness composite score.

Table 16
Data Analysis for Building Level

<table>
<thead>
<tr>
<th>Bld. Level</th>
<th>n</th>
<th>PhyW</th>
<th>SpiW</th>
<th>PsyW</th>
<th>SocW</th>
<th>EmW</th>
<th>IntW</th>
<th>WC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elem/Grade</td>
<td>106</td>
<td>M 28.83</td>
<td>32.03</td>
<td>30.84</td>
<td>31.15</td>
<td>29.34</td>
<td>29.38</td>
<td>17.72</td>
</tr>
<tr>
<td></td>
<td>SD 5.51</td>
<td>3.86</td>
<td>3.76</td>
<td>3.85</td>
<td>3.98</td>
<td>3.75</td>
<td>3.09</td>
<td></td>
</tr>
<tr>
<td>MS/JH</td>
<td>30</td>
<td>M 28.63</td>
<td>32.60</td>
<td>30.57</td>
<td>31.20</td>
<td>30.77</td>
<td>29.07</td>
<td>17.38</td>
</tr>
<tr>
<td></td>
<td>SD 4.53</td>
<td>2.98</td>
<td>3.35</td>
<td>3.42</td>
<td>3.18</td>
<td>2.72</td>
<td>2.14</td>
<td></td>
</tr>
<tr>
<td>Jr/Sr High</td>
<td>15</td>
<td>M 27.6</td>
<td>30.67</td>
<td>28.60</td>
<td>29.53</td>
<td>26.60</td>
<td>28.33</td>
<td>16.50</td>
</tr>
<tr>
<td></td>
<td>SD 5.01</td>
<td>4.13</td>
<td>3.87</td>
<td>4.63</td>
<td>4.53</td>
<td>3.31</td>
<td>3.08</td>
<td></td>
</tr>
<tr>
<td>High Sch.</td>
<td>44</td>
<td>M 29.32</td>
<td>32.20</td>
<td>29.95</td>
<td>30.52</td>
<td>29.91</td>
<td>28.86</td>
<td>18.15</td>
</tr>
<tr>
<td></td>
<td>SD 4.75</td>
<td>4.21</td>
<td>4.13</td>
<td>4.07</td>
<td>4.11</td>
<td>3.91</td>
<td>3.38</td>
<td></td>
</tr>
<tr>
<td>K-8</td>
<td>13</td>
<td>M 28.15</td>
<td>31.31</td>
<td>29.77</td>
<td>29.54</td>
<td>27.31</td>
<td>27.62</td>
<td>16.30</td>
</tr>
<tr>
<td></td>
<td>SD 4.60</td>
<td>3.77</td>
<td>4.04</td>
<td>3.97</td>
<td>5.25</td>
<td>4.52</td>
<td>3.04</td>
<td></td>
</tr>
<tr>
<td></td>
<td>SD 3.57</td>
<td>3.73</td>
<td>4.25</td>
<td>5.21</td>
<td>5.27</td>
<td>4.47</td>
<td>3.13</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>11</td>
<td>M 28.92</td>
<td>31.69</td>
<td>29.23</td>
<td>30.69</td>
<td>27.31</td>
<td>29.15</td>
<td>16.91</td>
</tr>
<tr>
<td></td>
<td>SD 5.28</td>
<td>4.05</td>
<td>5.43</td>
<td>5.53</td>
<td>4.63</td>
<td>3.67</td>
<td>2.87</td>
<td></td>
</tr>
</tbody>
</table>
The professional factor of building level was analyzed with the wellness composite score and the six dimensions of wellness to determine if a difference in the means existed. A one-way analysis of variance (ANOVA) was used with the seven categories of building level and the dependent variables. The one-way ANOVA divided up the variance into two groups, those attributed to differences between-groups and variance attributed to differences within-group (Urdan, 2001). The ANOVA determined if a statistically significant difference existed at the .05 level. Table 17 depicted the ANOVA results with the first column identifying the dependent variables followed by the levels for between groups, within groups, and total. The following columns contained: (a) sum of squares (SS); (b) degrees of freedom (df); (c) mean squares (MS); (d) F-score (F); and (e) level of significance (Sig.).
Table 17

One-way ANOVA Comparing Building Level with Wellness Variables

<table>
<thead>
<tr>
<th>Variable</th>
<th>Groups</th>
<th>SS</th>
<th>df</th>
<th>MS</th>
<th>F</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Between</td>
<td>40.492</td>
<td>6</td>
<td>6.749</td>
<td>.263</td>
<td>.954</td>
</tr>
<tr>
<td></td>
<td>Within</td>
<td>5859.099</td>
<td>228</td>
<td>25.698</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>5899.591</td>
<td>234</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Between</td>
<td>46.857</td>
<td>6</td>
<td>7.810</td>
<td>.529</td>
<td>.786</td>
</tr>
<tr>
<td></td>
<td>Within</td>
<td>3369.075</td>
<td>228</td>
<td>14.777</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>3415.932</td>
<td>234</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Between</td>
<td>133.872</td>
<td>6</td>
<td>22.312</td>
<td>1.436</td>
<td>.202</td>
</tr>
<tr>
<td></td>
<td>Within</td>
<td>3542.622</td>
<td>228</td>
<td>15.538</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>3676.494</td>
<td>234</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Between</td>
<td>112.299</td>
<td>6</td>
<td>18.717</td>
<td>1.118</td>
<td>.352</td>
</tr>
<tr>
<td></td>
<td>Within</td>
<td>3816.024</td>
<td>228</td>
<td>16.737</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>3928.323</td>
<td>234</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Between</td>
<td>300.503</td>
<td>6</td>
<td>50.084</td>
<td>2.911</td>
<td>.009*</td>
</tr>
<tr>
<td></td>
<td>Within</td>
<td>3923.344</td>
<td>228</td>
<td>17.208</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>4223.847</td>
<td>234</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Between</td>
<td>58.212</td>
<td>6</td>
<td>9.702</td>
<td>.698</td>
<td>.652</td>
</tr>
<tr>
<td></td>
<td>Within</td>
<td>3169.771</td>
<td>228</td>
<td>13.903</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>3227.983</td>
<td>234</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Between</td>
<td>71.048</td>
<td>6</td>
<td>11.841</td>
<td>1.290</td>
<td>.263</td>
</tr>
<tr>
<td></td>
<td>Within</td>
<td>2093.702</td>
<td>228</td>
<td>9.183</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>2164.751</td>
<td>234</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* p < .05

Table 17 indicated the emotional wellness variable had a statistically significant difference between the group means. In order to determine which groups significantly differ, a post-hoc test needed to be conducted (Urdan, 2001).
The post-hoc test of Least Significant Differences was performed to determine which groups differed significantly.

The dependent variable of emotional wellness was used to compare the differences between the means of the seven building levels identified on the questionnaire. The post-hoc test of Least Significant Differences (LSD) found five pairs of means that indicated differences that were statistically significant at the .05 level. Using information from Table 17, Table 18 provided data analysis information from a post-hoc test, including the building levels identified with a statistical significance at the .05 level, the mean difference (MD), standard error (SE), and the level of significance (Sig.).
Table 18

Post-hoc Test of Multiple Comparisons

<table>
<thead>
<tr>
<th>Building Level (a)</th>
<th>Building Level (b)</th>
<th>MD (a-b)</th>
<th>SE</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Junior/Senior High (7-12)</td>
<td>Elem/grade</td>
<td>-2.73962*</td>
<td>1.14434</td>
<td>.017</td>
</tr>
<tr>
<td></td>
<td>Middle/jr. high</td>
<td>-4.16667*</td>
<td>1.31178</td>
<td>.002</td>
</tr>
<tr>
<td></td>
<td>High school</td>
<td>-3.30909*</td>
<td>1.24027</td>
<td>.008</td>
</tr>
<tr>
<td>K-8</td>
<td>Middle school/jr high</td>
<td>-3.45897*</td>
<td>1.37741</td>
<td>.013</td>
</tr>
<tr>
<td></td>
<td>High school</td>
<td>-2.60140*</td>
<td>1.30948</td>
<td>.048</td>
</tr>
</tbody>
</table>

Table 18 indicated significant differences between the means of junior/senior high principals, identified as working in a 7-12 building, with the means of elementary, middle school, and high school principals. Negative differences were also indicated by Table 17 with the wellness means of K-8 principals compared to middle school/junior high and high school principals.

**Research Findings for Building Levels**

Findings that represented statistical significance between group means for building level and the various dimensions of wellness and the wellness composite are included in this section. Findings also indicated whether the
difference was statistically significant at the p < .05 level. The one-way ANOVA provided the following findings.

- The differences between the means for principals’ perceptions of emotional wellness and building levels were statistically significant (p < .05).

- Post-hoc procedures of the one-way ANOVA revealed statistically significant differences between junior/senior high (7-12) building principal’s perceptions of lower emotional wellness when compared to building principals of elementary/grade school (-2.74), middle/jr. high (-4.17), and high school (-3.31). All levels were significant at the p < .05.

- Post-hoc procedures of the one-way ANOVA revealed statistically significant differences between K-8 building principal’s perceptions of lower emotional wellness when compared to building principals of middle school/junior high (-3.46), and high school (-2.60). All levels were significant at the p < .05.

The one-way ANOVA found no statistical significance between the group means of building level with the dependent variables of physical wellness, spiritual wellness, psychological wellness, social wellness, intellectual wellness, or the wellness composite score.

School Setting

The last question in the demographic section involved the independent variable of school setting. The purpose of this variable was to identify whether
the respondent was from a rural or urban setting. The United States Census Bureau classified “urban” as all territory, population, and housing units located within an urbanized area (U.S. Census Bureau, 1995). The United States Census Bureau defined residency as either rural, less than 50,000 population, or urban, more than 50,000. The choice of “suburban” was no longer listed, narrowing the selection to either rural or urban.

Forty-one respondents reported serving at a school setting in an “urban” area. This represented 17.4% of the sample. There were 191 or 80.9% principals that listed “rural” as their school setting. Four respondents did not answer this question, causing the researcher to question the clarity of the item.

Table 19 provided the data analysis for school setting. Data representing the total number for each group, mean, and standard deviation were included.
Table 19

Data Analysis for School Setting

<table>
<thead>
<tr>
<th>Wellness Score</th>
<th>School Setting</th>
<th>N</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>PhyW</td>
<td>Rural</td>
<td>191</td>
<td>28.98</td>
<td>4.85</td>
</tr>
<tr>
<td></td>
<td>Urban</td>
<td>41</td>
<td>27.88</td>
<td>5.87</td>
</tr>
<tr>
<td>SpiW</td>
<td>Rural</td>
<td>191</td>
<td>32.06</td>
<td>3.60</td>
</tr>
<tr>
<td></td>
<td>Urban</td>
<td>41</td>
<td>31.56</td>
<td>4.77</td>
</tr>
<tr>
<td>PsyW</td>
<td>Rural</td>
<td>191</td>
<td>30.31</td>
<td>4.04</td>
</tr>
<tr>
<td></td>
<td>Urban</td>
<td>41</td>
<td>30.10</td>
<td>3.72</td>
</tr>
<tr>
<td>SocW</td>
<td>Rural</td>
<td>191</td>
<td>30.79</td>
<td>4.07</td>
</tr>
<tr>
<td></td>
<td>Urban</td>
<td>41</td>
<td>29.98</td>
<td>4.23</td>
</tr>
<tr>
<td>EmoW</td>
<td>Rural</td>
<td>191</td>
<td>29.02</td>
<td>4.14</td>
</tr>
<tr>
<td></td>
<td>Urban</td>
<td>41</td>
<td>30.00</td>
<td>4.78</td>
</tr>
<tr>
<td>IntW</td>
<td>Rural</td>
<td>191</td>
<td>29.01</td>
<td>3.66</td>
</tr>
<tr>
<td></td>
<td>Urban</td>
<td>41</td>
<td>28.95</td>
<td>4.02</td>
</tr>
<tr>
<td>WC</td>
<td>Rural</td>
<td>191</td>
<td>17.58</td>
<td>3.03</td>
</tr>
<tr>
<td></td>
<td>Urban</td>
<td>41</td>
<td>17.29</td>
<td>3.26</td>
</tr>
</tbody>
</table>

Using information from Table 19, Table 20 provided data analysis information from a t-test, including the critical value of t, the degrees of
freedom, the .05 level of statistical significance coded with an asterisk, and the .01 level of statistical significance coded with a double asterisk.

Table 20

**School Setting t-test**

<table>
<thead>
<tr>
<th>Wellness Variables</th>
<th>t</th>
<th>df</th>
<th>Mean Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>PhyW</td>
<td>1.274</td>
<td>230</td>
<td>1.106</td>
</tr>
<tr>
<td>SpiW</td>
<td>0.753</td>
<td>230</td>
<td>0.497</td>
</tr>
<tr>
<td>PsyW</td>
<td>0.316</td>
<td>230</td>
<td>0.217</td>
</tr>
<tr>
<td>SocW</td>
<td>1.148</td>
<td>230</td>
<td>0.810</td>
</tr>
<tr>
<td>EmoW</td>
<td>-1.328</td>
<td>230</td>
<td>-0.974</td>
</tr>
<tr>
<td>IntW</td>
<td>0.092</td>
<td>230</td>
<td>0.059</td>
</tr>
<tr>
<td>WC</td>
<td>0.544</td>
<td>230</td>
<td>0.288</td>
</tr>
</tbody>
</table>

*p < .05; **p < .01

**Research Findings for School Setting**

Statistical significance was not found between the differences in means for the independent variable of school setting with the dependent variables of physical wellness, psychological wellness, social wellness, emotional wellness, intellectual wellness, or the wellness composite score. Almost 81% of the respondents identified their school setting as being rural.
Findings Summary

Chapter 4 presented the data analysis and findings for the research. The analysis of data from the Principal Wellness Questionnaire identified findings about the perceptions of wellness for Kansas K-12 public school building principals. The random survey was sent to 310 randomly selected participants to provide answers to the three research questions. The six dimensions of wellness (physical, spiritual, psychological, social, emotional, and intellectual domains) along with the wellness composite score provided insight into the perceptions of principals when compared to personal and professional factors.

The Perceived Wellness Score had a possible composite wellness range from 3-29. The wellness composite scores were correlated with the level of perceived wellness. The higher the score was, the higher the perceived wellness (Adams et al., 1998). The next chapter provides a brief overview of the study followed by conclusions and implications based on the findings presented in this chapter.
Chapter 5

Findings, Conclusions, and Implications

The wellness of public school principals is an issue worth consideration for the benefit of all involved in education. Specifically, the administrative role of the principal is increasingly demanding with a wide range of duties and expectations that have continually increasing responsibilities (Allison, 1997; Williamson & Campbell, 1987). The quest is to develop a balance between wellness needs of the leadership role and expectations and duties that are job requirements.

Several issues recently have brought wellness to the front stage of education. President Bush’s landmark legislation to achieve 100% success of all students at the proficient or above levels by 2014, known as “No Child Left Behind (NCLB)” has added scrutiny and legal accountability to all school officials, especially building principals (Lewis, 2002). The demands of NCLB weigh heavily as parents, citizens, media, and legislators assess individual schools by this mandate. The state of Kansas has responded to the federal mandate by revising its school improvement procedures, known as Quality Performance Accreditation (QPA) to coincide with the requirements of NCLB (Kansas State Department of Education, 2000). QPA requires all public school buildings to assess reading and math annually at various grade levels, along with writing, science, and social studies once every two years to establish criteria consistent with the federal requirements. Other measures of required
accountability for QPA include attendance, dropout rate, and percent of highly qualified teaching staff. NCLB and QPA are two examples of pressures building principals face today that add to their workload. In addition, principals are still expected to run the daily operations of a school, including managing budgets, dealing with students, being a collaborative decision maker, developing teachers, improving student progress, and achieving vision for their buildings (Hoerr, 1996; Hurley, 2001).

Lack of financial resources has added stress to principals. School districts facing budget shortfalls nationally have forced principals to make cuts in staff and programs, consequently, having to do more with less (Morgan, 1997). The decrease in resources due to financial management has added to the oversight and responsibilities of those principals involved (Shortt, 1994).

Violence is another area of increased stress for building principals. No greater pressure exists than the duty every principal feels in trying to ensure the safety of all students (Doring, 1993). While this aspect may have never been taken for granted, recent incidents have changed the perspectives that all principals feel responsible to the students, parents, and communities.

This increase in workload has come with a price. Evidence of a shortage of qualified administrators exists for open positions nationwide (Whaley, 2002). More and more principals are deciding it is just not worth the time, stress, and demands required of the job. These issues have made wellness an essential element for principals.
At the same time, attention is focused on the need for schools to be more directly involved in improvement of health of young people. The concept of the Coordinated School Health Program (CSHP) recognizes that schools, more than any other societal agency, could provide more help and understanding to the health, welfare, and longevity of young people (Allensworth & Kolbe, 1987). This youth health issue, combined with the Healthy People 2010 initiative, a national campaign with the primary goals of increasing the quality and years of life and eliminate health disparities, has served to establish a new focus on health and wellness (Fisher et al., 2003). Included in the eight components that make up the CSHP is the idea of developing school programs that improve and protect the wellness of faculty and staff (APHA School Health Education and Services, 2004).

Chapter 5 concludes this study. It begins with a brief description of the study and methodology. The final two sections provide (a) the conclusions of the research and (b) implications of the study.

Overview of Study

Two basic assumptions, based on literature study, guided this research. The first assumption was that perceptions of health and wellness are valid indicators of wellness (Adams et al., 1997). The second assumption was that wellness is a multidimensional lifetime process (Sackney & Miller, 2000).

Wellness perceptions as valid indicators of wellness were supported by literature. According to Wilson (1995), perceptions of wellness have been found
to be powerful predictors of future health outcomes. Perceptions are viewed as mental states that have real and powerful influence over the health of a person (Goleman, 1995). As a result, perceptions, albeit a state of mind, are supported by literature as an accurate measure of how the mind works interactively with the body to influence health outcomes.

Several definitions exist that describe wellness. For the purpose of this study, wellness is described by the literature as a multidimensional process that involve a balance of each dimension for overall effectiveness in maintaining health (Powers, 1994; Sackney & Miller, 2000). Wellness also requires the participant’s active role in acquiring desired levels of wellness (Ardell, 1986; Robbins et al., 1991). The six dimensions of wellness identified for this study include the physical, spiritual, psychological, social, emotional, and intellectual domains (Adams et al., 1997).

The six dimensions of wellness are part of a holistic model in which balance of each dimension becomes an individual component. Wellness, therefore, involves an ongoing balance of every individual focusing attention on each dimension as an ongoing process for lifelong wellness (Powers, 1994).

Statement of the Problem

Kansas K-12 public school building principals are faced with increased demands responsibilities and challenges today. Their overall job performance will be measured as they assume responsibilities and shoulder liabilities of increased workload. It is important to identify the extent to which Kansas K-12
public school building principals perceive their own wellness because of its impact on job performance and, ultimately, student achievement. In a draft report prepared by the Directors of Health Promotion and Education (2004) an extensive study of research led them to identify the health of school employees and students as “inseparable” (p. 1). They conclude by noting:

[H]ealth promotion in schools holds the promise of far greater impact than health promotion at any other worksite. As one of the nation’s largest employers, schools reach more than 4.5 million adults. . . . [T]hey also have the potential of affecting the academic achievement and well-being of the more than 16 million students. A comprehensive school employee wellness program, as an integral and equal component of a coordinated school health program, can be key to maintaining a healthy, optimistic environment where students and staff alike thrive. (Directors of Health Promotion and Education, 2004, p. 113)

School districts must develop an understanding of the importance of the wellness of building principals to provide necessary leadership for a healthy staff and student lifestyle.

Research Questions

The research examined the perceived wellness of Kansas K-12 public school building principals. Three research questions guided the study:

1. How do Kansas K-12 public school building principals perceive their own wellness?
2. To what extent do personal factors contribute to Kansas K-12 public school building principal’s perceptions of wellness?

3. To what extent do professional factors contribute to Kansas K-12 public school building principal’s perceptions of wellness?

These three research questions guided the study’s research design and methodology for data collection.

**Methodology**

This quantitative study explored the perceived wellness of Kansas K-12 public school building principals. This section describes data collection procedures and data analysis used in the study.

**Data Collection Procedures**

This study’s population consisted of 1,312 Kansas K-12 public school building principals identified in the 2002-2003 Kansas Educational Directory. The Kansas State Department of Education provided this directory after duplications, buildings without identifiable principals, and alternative settings were extracted. A sample size was established using a formula (McNamara, 1994). The determined sample size required inclusion of 310 elements selected through a random table of numbers to eliminate researcher bias (Babbie, 2001). This sample of 310 provided a confidence level of 95%.

The survey instrument titled, Principal Wellness Questionnaire, was developed to collect quantitative data. The survey consisted of two sections. The first section contained items that collected demographic data. This included
personal and professional characteristics of the respondents. The second section of the questionnaire included the Perceived Wellness Survey developed by Dr. Troy Adams and associates. The Perceived Wellness Survey was a multidimensional measure of perceived wellness consisting of six separate sub-scales including physical, spiritual, psychological, social, emotional, and intellectual dimensions. Each sub-scale was made up of six questions for a total of 36 items. The Perceived Wellness Survey used a 6-point Likert scale with only the poles labeled with, “very strongly disagree” for 1 and “very strongly agree” for 6. This enabled the respondent to construe the value of each interval. The survey instrument was then mailed to each selected sample element. Several strategies were used to maximize the rate of return (Fox et al., 1988; Patten, 2001).

The respondents returned 236 of the 310 mailed surveys for a response rate of 76%. This relatively high rate of return met the requirement of the dissertation committee, which established a goal of at least 70%.

Data Analysis

The first step in analysis of data was to score and code returned surveys. The researcher analyzed demographic information from section one of the Principal Wellness Questionnaire and reported findings in nine categories. They were: (a) gender, (b) marital status, (c) race/ethnicity, (d) age, (e) number of years in administration, (f) number of years as principal at your current position, (g) enrollment of building, (h) building level, and (i) school setting.
Data collected from the Perceived Wellness Survey were analyzed by deriving sub-scores for each of the six dimensions of wellness along with a Perceived Wellness Composite (PWC). Additionally, correlation matrices were constructed to determine significant relationships that may exist between demographic variables and the six dimensions of wellness. Significance between demographic, personal, and professional variables, along with the PWC scores was also examined.

Data were then statistically examined using the Spearman \( \rho \) coefficient to determine if a relationship existed. A t-test was calculated for each dichotomous independent variable to determine if a statistically significant difference existed between the various means. The one-way ANOVA was required for variables with more than two groups of means.

The results of the data analysis identified the findings. Conclusions and recommendations are discussed in the remainder of the chapter.

**Conclusions**

The analysis of data led to the findings. The study found data establishing the relationships of personal and professional factors to the six dimensions of wellness. Conclusions are derived from the findings and supported by literature as applicable. Conclusions are categorized around the variables of gender, time, ethnicity, marital status, and building characteristics.

Female principals perceive their psychological, emotional, and intellectual wellness to be higher than their male counterparts. Research
addresses the importance of each of these three wellness dimensions in principal’s performance. The literature describes psychological wellness as balancing a career with personal life (Dorn, 1992). Emotional wellness translates to understanding limitations and abilities for the purpose of building and maintaining relationships (Glatthorn, 1987). Intellectual wellness deals with the pursuit of knowledge, critical thinking, and current events (Powers, 1994). Research recognizes female principals as being as more inclined to be relationship builders than their male colleagues (Shakeshaft, 1989). Research by Peterson and Beekley (1997) found that female principals reported a higher level of active engagement with staff than male principals. Using the Leadership Practices Inventory to assess administrator’s self-perceptions, Boone (1997) found a statistical significance that females rated themselves higher than males to be willing to work with others to facilitate change process and work with colleagues. This conclusion suggests that female principals perceive their ability to better balance career and personal life, maintain relationships, and pursue knowledge than their male colleagues.

Age is the lone factor relating to time that influences wellness. In considering the variable of time, the only factor that has significance is age. Length of time in administration and length of time in current position did not reveal a bearing on perception of wellness. Age of principal, however, is a factor in the perceptions of a positive influence on wellness in the spiritual, emotional, and intellectual dimensions. Literature identifies ethics, values, and purpose in
life as virtues of spiritual wellness (McGuire & Snow, 1994; Powers, 1994). Combined with the emotional and intellectual dimensions previously described, older principals perceive their wellness with a sense of meaning. This conclusion suggests that with increased age principals perceive an increase in values and purpose, and are more able to maintain relationships and pursue knowledge.

Minority race/ethnicity principals perceive their spiritual wellness to be higher than their majority race/ethnicity colleagues, whereas, the majority principals perceive their wellness composite to be higher than their minority colleagues. It is interesting to note minority principals perceive a distinct difference in their spiritual wellness compared to their other wellness dimensions and wellness composite. This suggests a strong perception of minority principals about a high spiritual wellness. The number of minority respondents (n=11) of 4.7%, even though approximates the state percentage of 5.9% minority principals, suggests caution of this conclusion. Researchers claim spiritual wellness includes a sense of ethics, values, and purpose in life (McGuire & Snow, 1994; Powers, 1994). Adams defined wellness composite as the balance and magnitude of the combined wellness dimensions (Adams et al., 1997). This conclusion suggests that minority principals perceive themselves to be higher in ethics, values, and purpose in life than their majority colleague. It further suggests that the majority principals have stronger balance of their overall wellness.
Married principals perceive their wellness composite to be higher than their unmarried colleagues do. Higher wellness composite indicates a measurable difference between the balance and magnitude of the means for the six dimensions of wellness when compared to others (Adams et al., 1997). The researcher was unable to link the literature about marital differences to the wellness composite. This conclusion suggests that married principals have a higher balance among the six dimensions of wellness than their unmarried colleagues.

Configuration and enrollment are the only building characteristics that influence wellness. Building level configuration and building enrollment are factors in the principals’ perceptions of emotional wellness, where as school setting, rural or urban, reveals no difference in principals’ perceptions of wellness. Principals of K-8 and 7-12 buildings were found to have lower emotional wellness perceptions. Schools of this category may not have assistant administrators or other administrative personnel. The factor prevalent for both building levels is the wide range of grade levels. The literature identified increased job demands due to multiple activities and too many hats to wear as factors in wellness (Awender, 1978). Results of this research determined principals of schools with larger enrollments had higher levels of emotional wellness. The literature supports this conclusion by claiming that principals of smaller high schools feel more stress in dealing with subordinates (Williamson & Campbell, 1987). Conversely, principals of large high schools experienced
more stress in time management (Williamson & Campbell, 1987). Glatthorn (1987) suggested that emotional wellness focuses on building and maintaining relationships. Goleman (1995) added to the Glatthorn definition by stating that emotional wellness includes the opportunity to help others develop positive self-worth. This conclusion suggests that principals of buildings containing a wide range of grades perceived they were less able to build and maintain relationships. Principals of larger schools, however, perceived a stronger propensity towards relationships building positive self-worth in others.

The findings of research results contained in Chapter 4 provided data to establish the conclusions. The conclusions were grouped into the categories of gender, time, ethnicity, marital status, and building characteristics. Literature supported the conclusions as applicable.

Implications

The findings and conclusions, with support from appropriate literature, led to implications. Implications provide guidance to appropriate individuals and groups or agencies to consider in the development of higher wellness among Kansas principals.

Additional research should be conducted to more closely examine wellness of principals in Kansas. Literature reports a lack of information on the wellness of educators including principals (Sackney & Miller, 2000). General wellness of Kansas principals, as well as narrative descriptions of individual health, should be addressed in the research. The research should answer the
questions: (a) What impact does the principal’s work load have on his or her wellness? (b) How do increased demands in student performance affect principals? and (c) What other factors to contribute to the wellness of principals?

To facilitate the research, a web-based instrument could be developed to collect data and provide timely feedback about principal wellness. The feedback should include the individual’s wellness and comparison to the wellness of the population of Kansas principals. Literature supports this concept suggesting that a web-based assessment tool could provide confidential information as well as feedback for improvement (Lovely, 2004).

School districts should strongly consider the magnitude of administration in buildings that have a wide range of grade levels. Range of grade level within a building, because of the complexity of dealing with a wide-range of student age, requires unique support. The wide range of grade levels may induce complications due to age span, activities, and other variations (Chang, 1993). Recent declines in enrollment, funding shortfalls, and budget cuts have caused many districts to restructure administrative duties. Such changes have caused school districts to reduce or even eliminate administrators (Hurley, 2001).

Principals should take actions to ensure that they remain intellectually challenged for the duration of their tenure in building leadership. Pursuit of knowledge through professional development, professional conferences, reading,
and other appropriate strategies should be maintained to remain effective throughout the principals’ career (Ardell & Tager, 1982).

Staff from Kansas State Department of Education, educational service centers, school districts, and other appropriate agencies should support principal wellness by providing professional development, support groups, and resources. Professional development is associated with successful leadership (Glatthorn, 1987). The literature describes effective principals as people who, among other things, networked with other principals, and had administrative practitioners who mentored them (Smith & Andrews, 1989). Principals provide a vital role in encouraging and supporting staff in their pursuit of professionalism (Brock & Grady, 1998). Principals need the same support in their pursuit of professional knowledge. Professional learning communities and support groups allow principals to grow professionally and to have peers to share challenges, frustrations, experiences, and other job issues.

Realistic job descriptions and expectations congruent with described duties are key components of support. The demands on the administrative role of the principal involve a wide range of duties and expectations that are only increasing in terms of responsibilities (Allison, 1997; Williamson & Campbell, 1987). The stress of budget cuts and increased responsibilities are other reasons to justify the need for support groups to relieve stress (Morgan, 1997).
Summary

Principals are confronted with issues of school reform, accountability, compliance with mandates, and reduced budgets (Gorton, 1982). The stressfulness of the principalship, as a result of these issues, has increased significantly during the last decade (Ballard, 1991). Principal wellness has become an issue with increased stress, workload, and job expectations. This research examined the wellness of principals in Kansas. Data from this research identified several areas of concern for principal wellness. It appears that the principalship will become even more stressful in the future. The pursuit of principal wellness is essential to maintain the high level of job performance and longevity among our building level leaders.
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APPENDIX A: Principal Wellness Questionnaire

The purpose of this research is to determine the perceived wellness of Kansas' principals. The research is being conducted by a student for completion of a doctorate degree in Educational Administration at Wichita State University. All participants are granted anonymity.

This survey contains a section of demographic data and a section of perceived wellness. The demographic section is divided into the areas of personal data and professional data. The second section, the Perceived Wellness Survey, contains 36 items requiring a forced response on a scale of 1 through 6.

When completed, please return this packet in the stamped, self-addressed envelope. Thank you for your time and willingness to participate in this research.

**Demographic Information**

**Personal Data.** In the personal data area, for items 1, 2, and 3 please check (✓) the applicable response. Respond to item 4 by providing the appropriate number in the blank provided.

1. **Gender**
   - Male _____
   - Female _____

2. **Marital Status**
   - Single _____
   - Married _____
   - Divorced _____
   - Separated _____
   - Widowed _____

3. **Race/Ethnicity**
   - Asian/Pacific Islander _____
   - Black/African American _____
   - Hispanic/Latino _____
   - Native/Indian American _____
   - White/Caucasian _____
   - Other _____
4. Age (years) _____

Professional Data. In the professional data area, respond to items 5, 6, and 7 by providing the appropriate number in the blank provided. For items 8 and 9, please check (√) the applicable response.

5. **Total number of years in administration** (including this year) __________

6. **Number of years as principal at your current position** (including this year) __________

7. **Enrollment of Building(s)** __________

8. **Building Level.**
   - Elementary/Grade School _____
   - Middle School/Junior High _____
   - Junior High/Senior High (7 - 12) _____
   - High School _____
   - K-8 _____
   - K-12 _____
   - Other _____ (specify) __________

9. **School Setting.**
   - Rural (community < 50,000 population) _____
   - Urban (community> 50,000 population) _____
### Perceived Wellness Survey

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

<table>
<thead>
<tr>
<th>Very Strongly Disagree</th>
<th>Very Strongly Agree</th>
</tr>
</thead>
</table>

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

Please return this survey in the self-addressed stamped envelope. Thank you for your time and cooperation.
APPENDIX B: Permission Letter

6 January 2004

I hereby provide my written permission for Fred Dierksen to use the Perceived Wellness Survey in unaltered form for his dissertation.

Troy B. Adams, Ph.D.
Arizona State University
Dear Principal:

You are invited to participate in a study of the wellness of Kansas' principals. I hope to learn the extent to which building principals believe their state of wellness exists in a holistic model. Over 300 principals were randomly selected for this study from a list including every school building in the state. I would like you to complete the enclosed survey. The survey will take approximately 15 minutes to complete.

Your participation in this research will provide meaningful information about the status of wellness for Kansas' principals. You will also add valuable insight into the various conditions and settings that may contribute to the factors connected with wellness.

All survey data will remain anonymous. Respondents will not be identified in any way in the written report. Also, surveys and envelopes are not coded to identify respondents and non-respondents. If a follow-up mailing is required, all members of the sample will receive the follow-up mailing.

You are under no obligation to participate in this study. Your decision whether or not to participate will not affect your future relations with Wichita State University. Completion of and returning the survey will be taken as evidence of your willingness to participate and your consent to have the data used for this research.

Please complete the survey and return it in the enclosed postage paid envelope. If you have any questions about this research, I will be glad to answer them. Feel free to contact me by phone at 620-278-3112. You may contact me by mail at: Fred Dierksen, 204 N. Broadway Sterling, KS 67579. If you have any questions pertaining to your rights as a research participant, you can contact the Office of Research Administration at Wichita State University, Wichita, KS 67260-0007, 316-978-3285.

Sincerely,
Fred Dierksen
Doctoral Student, WSU
APPENDIX D: Wellness Model

Kansas K-12 Principals

Personal Factors
- Age
- Gender
- Race/Ethnicity
- Marital Status

Professional Factors
- Years in admin
- Years in current pos.
- Building enrollment
- Building level
- School setting

Dimensions of Wellness
- Physical (PhyW)
- Spiritual (SpiW)
- Psychological (PsyW)
- Social (SocW)
- Emotional (EmoW)
- Intellectual (IntW)

Perceived Wellness Composite

Predicted outcomes