THE IDENTIFICATION AND ANALYSIS OF SELECTED WELLNESS PROGRAMS IN EDUCATIONAL INSTITUTIONS IN THE STATE OF TEXAS

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PREFACE

A Wellness Program Questionnaire was designed to survey educational institutions in Texas as to the definition, goals, components, and services of their wellness programs. Through the pilot study and full study, 11 independent school districts, 13 junior/community colleges, and 8 universities were identified as having wellness programs.

I am very grateful to the faculty and graduate students in the School of Health, Physical Education, and Leisure Science for their support and encouragement throughout my graduate program. I would like to thank my committee chairman, Dr. Steven Edwards, for his guidance during this research project. Additionally, I would like to thank the other committee members: Dr. Betty Edgley, Dr. Mac McCrory, and Dr. Robert Kamm for their advisement in the course of this work.

Appreciation is extended to several individuals at Austin College for their assistance in completing this study. They are: Dr. Janet Lowry, Dr. Anne Fuller, Dr. John White, and Vivian Neeley. Special attention must also be given to Gigi Lawson for her artistic assistance.

Special thanks, love, and deepest appreciation are extended to my husband Sig for his love, support, and inspiration without which I would never have succeeded.

This dissertation is dedicated to my father, Ralph E. Wilcoxon, and in loving memory of my mother, Marian B. Wilcoxon. Their strong belief in education and loving guidance provided the foundation for this achievement.

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CHAPTER I

INTRODUCTION

The fitness craze in America is no longer a fad but a deep-rooted concern for healthy living. The medical community has, in the past, primarily been concerned with illness or the negative aspects of health. The growing public concern for improved quality of life represents a shift from this negative aspect to a more positive, preventative approach to health or wellness.

Coronary heart disease accounts for 100,000 deaths in the United States each year. Heart attacks alone account for nearly 35% of all deaths. The three major risk factors for coronary heart disease are hypertension, elevated serum cholesterol, and cigarette smoking; and a combination of all three leads to a 3.8 times greater risk of heart attack. Hypertension is present in 25 million people and can lead to death or disability through stroke, heart failure, and kidney failure (Pollock, Wilmore, and Fox, 1978).

These risk factors represent lifestyle diseases caused by specific individual behaviors. Awareness of the relationship between lifestyle behaviors and disease is the leading reason for the emergence of the current fitness

craze and the development of disease prevention/health promotion and wellness programs.

Wellness has become a major financial concern as well as a benefit for both business and industry. There are over 500 companies that have fitness programs with full time directors spending $5-$7 billion annually (Cooper and Collingwood, 1984). Due to premature deaths, American industry has spent more than $25 billion, with 132 million workdays lost. Of those lost workdays, 52 million were directly related to heart disease (Crase, Hamrick, and Rosato, 1979).

Dr. Kenneth Cooper, director of The Aerobics Center in Dallas, Texas, has predicted that one in six hospitals will close within the next decade due to the decreased number of patients. Consequently, some hospitals are reversing their outlook from an illness orientation to preventative education for their patients and the community.

The educational community is slowly following the lead of business and industry. The Dallas Independent School District, with the Institute for Aerobics Research, initiated a wellness pilot program for five schools with 160 participants in 1982. A medical screening and fitness assessment were required for membership in the Aerobics Wellness Center for maintenance and recreation programs. Activities included wellness seminars, aerobic dance classes, weight-training classes, intramural programs, and special events. It was described by Dr. Linus Wright

(cited in Collingwood, 1982), superintendent, as the "most positive and successful program that I have seen in 34 years of my involvement with education" (p. 6). The results demonstrated a significant improvement in both physiological and psychological components, provided a data base for program justification, and resulted in the development of a district-wide wellness program (Collingwood, 1982).

The rapid growth of concern for health and fitness has resulted in diverse interpretations of the basic premise of healthy living. The development of this healthy living lifestyle has been called wellness, holistic health, total well-being, positive health behavior, health promotion, disease prevention, and quality of life, to name a few. Their definitions overlap, occasionally conflict, and run the gamut from philosophical points of view to specific statistical health descriptions. The programs that have been implemented are varied, ranging from structured, comprehensive programs to haphazard single component concerns. Employee wellness programs have been established, but very little has been reported in the literature. Therefore, there is a need to discover what is actually occurring in employee health and fitness in the educational sector.

Need for Study

Halbert L. Dunn, considered the "Father of Wellness,"

believed that wellness has meaning for many subject fields and that the philosophy was not complete but needed to be explored, probed, tested, questioned, and added to (Dunn, 1961). Vierke (1980) explored wellness programs and felt that success was dependent upon "establishing a common language of terms and concepts in holistic health" (p. 241). He also stated that the workplace is an important environment for a program in which the "social milieu" could lead to changes in behavior. Petosa (1984) examined health promotion programs and stated that "much work needs to be done on philosophical, research and program issues related to wellness" (p. 39). Baranowski (1981) studied the role of health professionals and concluded that "more must be learned about health and wellness since each concept implies a slightly different focus for a variety of health professionals" (p. 255).

Definitions

The following are conceptual definitions which will be used in this study:

Health. "Health is a state of complete mental and social well-being and not merely the absence of disease or infirmity" (World Health Organization, 1947, p. 29).

Wellness.

> An integrated method of functioning which is oriented toward maximizing the potential of which an individual is capable . . . within the environment where he is functioning (Dunn, 1961, pp. 4-5).

Physical Fitness. "The ability to perform daily tasks vigorously and alertly, with energy left over for enjoying leisure-time activities and meeting emergency demands" (President's Council on Physical Fitness and Sports, 1984, p. 1).

Stress. "The nonspecific response of the body to any demand made upon it" (Selye, 1974, p. 27).

The following are functional definitions which will be used in this study:

Wellness Program. A program that attempts to improve the health status of those it serves.

Program Component. The dimensions or topics identified as properties of healthy living.

Program Services. Activities that "systematically attempt to focus and control behavior change" (Cooper and Collingwood, 1984, p. 36).

Goals. The stated beliefs accrued by the individual and the institution upon participation in or administration of the wellness program.

Statement of the Problem

The purpose of this study was to survey selected educational institutions in the State of Texas in order to define wellness, to determine the goals and objectives for each participant and the institution, and to identify program components and services.

Delimitations

The following are delimitations of this study:

1. The research was delimited to selected educational institutions in the State of Texas which provide wellness programs for their employees.

2. Since wellness programs are currently found in larger institutions where there are more personnel, administration, and financial support, larger public K-12 school districts, junior/community colleges, and colleges and universities were surveyed.

Limitations

The following are limitations of this study:

1. The respondent may have been limited by his/her understanding of the institution's program.

2. The respondent's role in designing the program may have affected responses to specific questions.

3. The respondents may not have had similar definitions of wellness and wellness components and services.

4. Evaluation and interpretation of open-ended responses may have been influenced by the subjectivity of the researcher.

Assumptions

The following are the assumptions of this study:

1. The respondent was involved in the development process or had an understanding of the process for his/ her program.

2. The respondent is knowledgeable about wellness and positive health promotion.

3. The respondent is actively involved with all phases of the wellness program at the institution.

4. Wellness programs tend to be found in larger educational institutions.

5. Wellness programs tend to be found in or near larger cities where influenced by corporate fitness programs and sports medicine and research institutions.

6. Health services of an institution will have some role in any wellness program, whether it be in medical screening, risk assessment, blood pressure screen, or other.

Pertinent Questions

The following are questions which are pertinent to this study:

1. Which educational institutions in the State of Texas provide wellness programs for their employees?

2. What is the operational definition of wellness used in wellness programs in the educational sector?

3. What components of wellness are incorporated in the wellness program?

4. What are the goals and objectives for both the individual and the institution?

5. What are the services provided by the program administrators for the participants?

Research Design

Qualitative research of a descriptive nature was used to determine the nature of wellness programs in educational institutions in Texas. Survey methods of the social sciences for instrument design and mail-out procedures were used to obtain program information. For the analysis of data, frequency distributions were used for program services and components, as well as for key words found in open-ended responses. Likert-scale means and ranks were determined for components and services. Documentary analysis and description were used to summarize open-ended responses for wellness definitions and goals.

CHAPTER II

REVIEW OF LITERATURE

Introduction

Wellness, as a concept and as a program, is a new idea. To understand its current place in educational institutions one must examine its definitional roots, the models portraying the definitions and dimensions of the concept, and the programs that promote the concept. For application in educational settings one must also explore the need for wellness programs as well as the components and services of these programs. Research on wellness in educational institutions is limited. Some research on corporate programs has been directed toward employee wellness and wellness at the worksite.

Wellness Definitions

Wellness has come to mean many things to many people. This diversity can be observed by examining wellness definitions as well as several other related terms and their definitions. Research on wellness programs in educational institutions is very limited; therefore, most definitions emerge from allied health fields and corporate fitness programs.

Generally, definitions of health and wellness derive their basic concepts from the definition of health as defined in 1947 by the World Health Organization (p. 29): "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." To expand upon that basic concept, health has been defined as "that biological well-functioning that provides the body with the physical capacities to fulfill all higher order tasks" (Baranowski, 1981, p. 251). Carter (1984) has determined that health is a status and he has defined it as "a dynamic status that results from an interaction between hereditary potential, environmental circumstances, and lifestyle education" (p. 35). In laymen's terms, health is "where you feel great and look great, to do well whatever you want to do" (Allen, 1981, p. 13).

The term "wellness" was first used in the 1950's in lectures and articles by a retired public health service physician. According to Dunn (1961), generally considered the founding Father of Wellness, high level of wellness is:

> . . . 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 functioninging (pp. 4-5).

Dunn (1961) also designed a symbol for High Level Wellness (Figure 1):

> The three interlocking orbits represent the human body as a manifestation of organized energy, and also symbolize the body, mind and spirit of man as an interrelated and

> interpendent whole. The dart symbolizes the life cycle of the individual as he strives to achieve his purpose in living and grows in wholeness toward the maturity of self-fulfillment (p. vi).

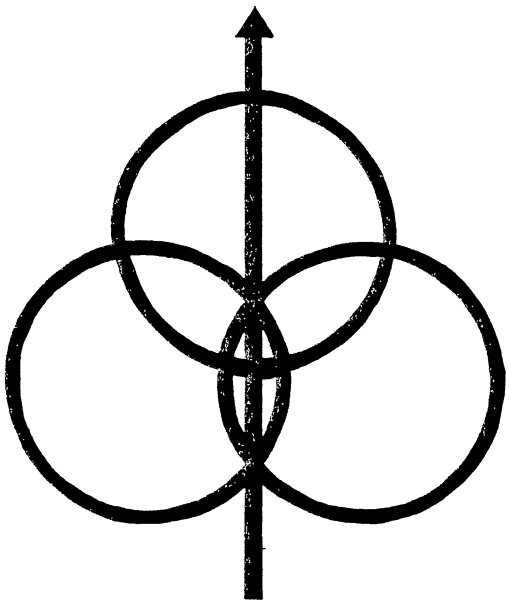

Figure 1. High Level Wellness

Ardell (1982) felt that the word "health" was not complete and that wellness "embodies new parameters and expectations of well-being" (p. 17). He has defined high level wellness as "a lifestyle approach to realizing your best potentials for well-being" (Ardell, 1979, p. 17) and included the dimensions of wellness (Ardell, 1982) (Figure 2):

1. Self-responsibility
2. Nutritional awareness
3. Physical fitness
4. Stress awareness and management
5. Environmental sensitivity

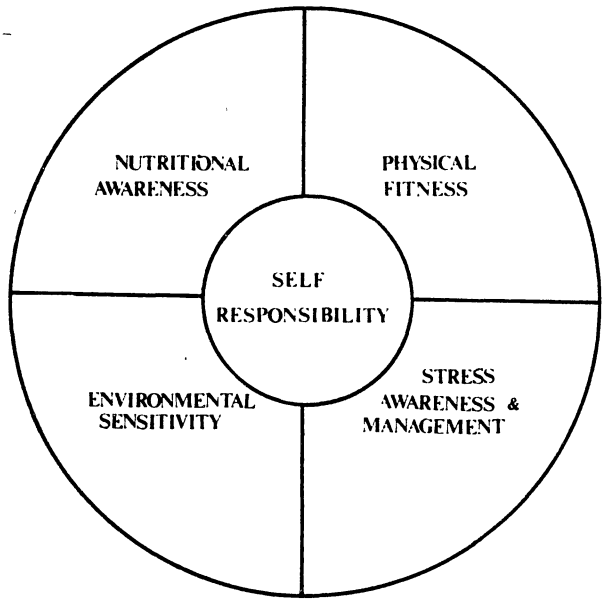

Figure 2. Dimensions of Wellness

Hettler (1983), at the University of Wisconsin at Stephens Point, has defined wellness as "an active process through which people become aware of, and then make choices toward, a more successful existence" (p. 31). He further described it as a "unique lifestyle that changes daily in

the reflection of his or her intellectual, emotional, physical, social, occupational, and spiritual dimensions" (1980, p. 77) (Figure 3). The program at the University of Nebraska-Omaha (Wellness Council of the Midlands, WELCOM) has adopted a similar definition, indicating that wellness "describes a lifestyle aimed at optimizing one's total health and productivity" (Flynn and Berg, 1984, p. 38).

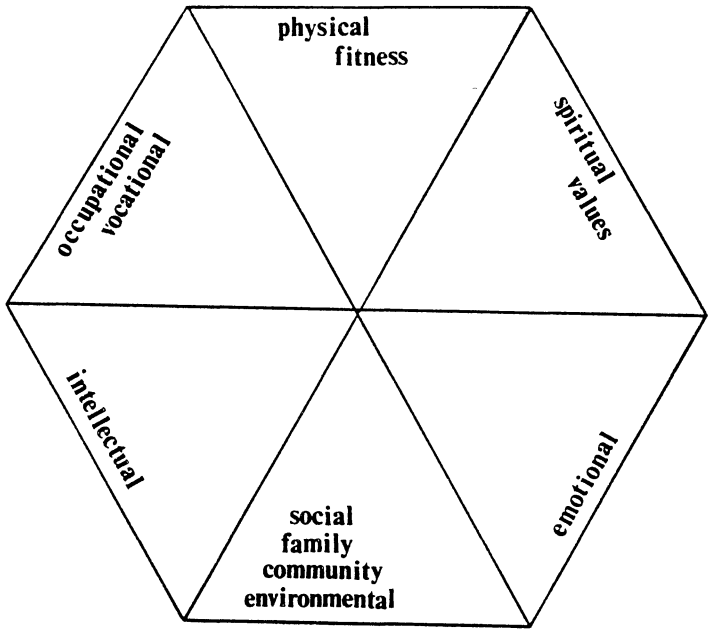

Figure 3. Six Dimensions of Wellness

Ryan and Travis (1981) developed key phrases to define wellness. To summarize, wellness is a choice; a way of life; a process; an efficient channelling of

energy; the integration of body, mind, and spirit; and the loving acceptance of yourself.

Others have defined wellness in similar and briefer terms. The Texas Education Agency (Fulbright and Harris, 1982, p. 2) called wellness "a lifestyle one shapes for himself that maximizes all his potential." Allen (1981, p. 13) believed it to be a "feeling of total well-being, exhilaration, a genuine zest for being alive." Englehardt (1980, p. iii) noted that wellness was a "dynamic way of life designed to encourage the development of personal potential." Similarly, Baranowski (1981, p. 251) indicated the concept of wellness as "the capacity of the person to fulfill personal goals and perform socially defined role tasks." Wellness as a movement has been described by Tager (1983, p. 24) as an "organized systems-approach for creating healthier lifestyles."

The individual is the center of the wellness model, according to Goldstein (1983, p. 36), having "primary responsibility for achieving and sustaining an optimum level of well-being." For her and many others, the key word of wellness is "lifestyle," and prevention is critical to success for the individual. The key words for Hettler (1983, p. 31) are "become aware" and "make choices."

Within the holistic health framework, Cmich (1984, p. 31) stated "wellness is an attitude as well as a lifestyle." "Holism, holistic health and wellness are fast becoming popular words in a variety of settings" (Cmich,

1984, p. 30). She believed wellness "focuses on degrees of health and well-being . . . and emphasizes each individual's challenge to live at a fuller potential and enjoy the highest level of health possible" (p. 31). The concept of holistic health "entails the integration of a wellness lifestyle into one's personal life journey" (p. 32). Other terms for health include: well-being, wellness, state of being, feeling good, and quality of living (Carter, 1984).

There is controversy and conflict concerning wellness definitions. Carlyon (1984) described the "gap" between disease prevention/health promotion and wellness. His position is that the former was primarily risk reduction types of activities and that "wellness promotion tasks are primarily social, philosophical and spiritual" leading to "self-actualization and personal fulfillment" (p. 28).

All the definitions of wellness contain some word to indicate "action" on the part of the individual by selecting "behaviors" that lead to the goal of "positive health."

Wellness Models

Wellness models have been developed by several researchers to identify the components of wellness and exemplify their interrelatedness to each other and the relationship to the individual. We have already seen the models of Dunn (1961), Ardell (1982), and Hettler (1983), though some discussion is in order. Ardell (1977a) considered self-responsibility the keystone to high level

wellness (see Figure 2). It gives one a sense of accountability and motivation. Hettler (1980) felt that the stability of the individual depends upon the integrity of each dimension (see Figure 3). Curtis and Detert (1981) portrayed self-responsibility as a commitment to health and included mental emotional stability as a part of their wellness wheel (Figure 4).

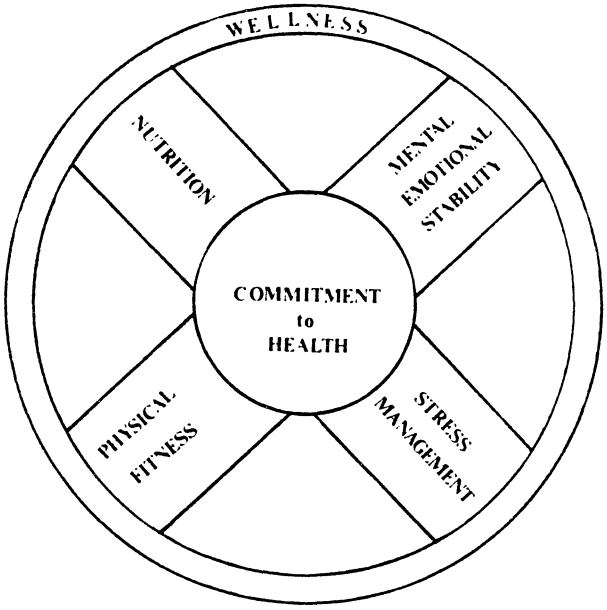

Figure 4. The Wellness Wheel

A more detailed wellness model has been designed by McCrory and Baker (1984), indicating elements of control and elements of influence. All of these are affected by

the attitudes, intellect, and values of the individual with a healthy body, mind, and spirit as the goal (Figure 5).

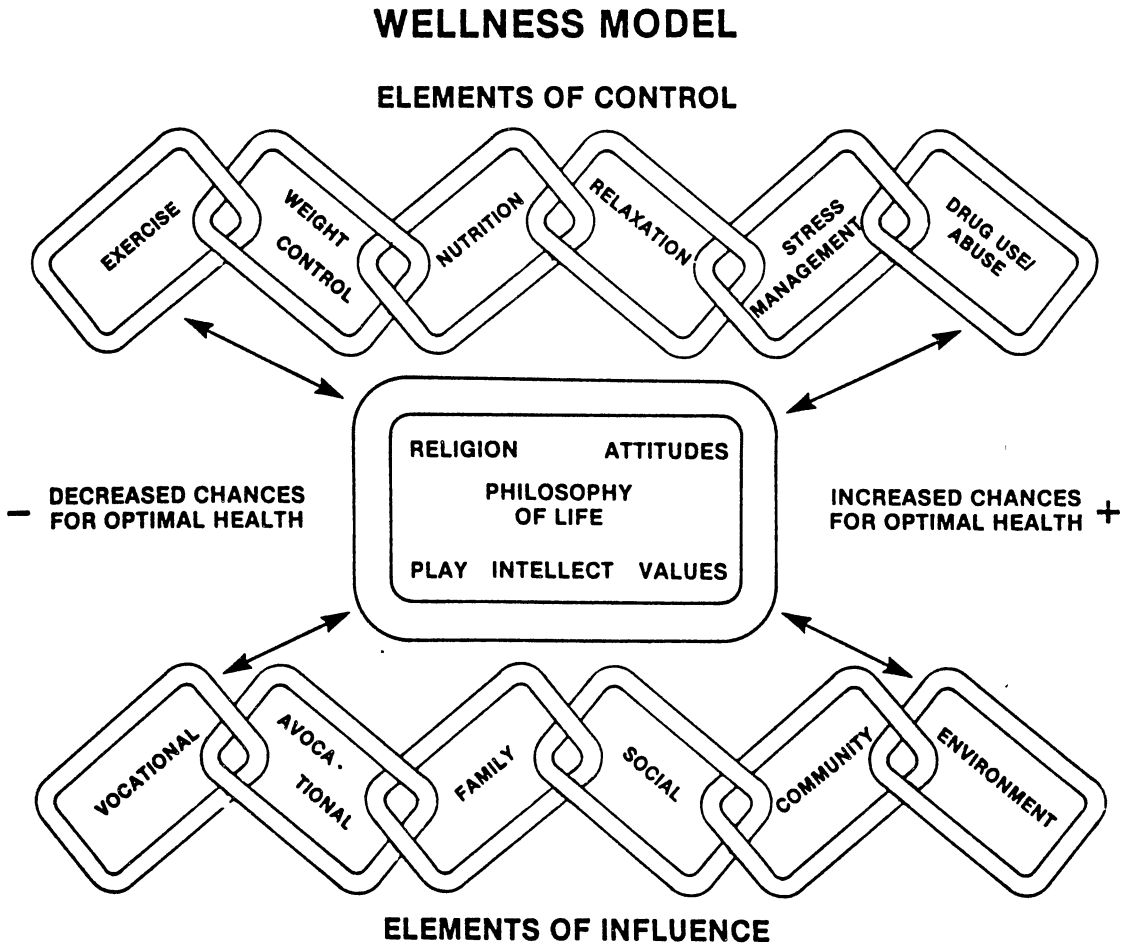

Figure 5. McCrory/Baker Wellness Model

Wellness Components

The components of wellness identify different life-style behaviors that are important to success in achieving the goal of high-level wellness. There are three commonly accepted components of wellness: physical fitness, nutrition, and stress management. There are also a variety of other components or dimensions whose terms are related and whose definitions tend to overlap. Typically, the roots of the author and program are reflected in the emphasis of each component.

Physical fitness has been a part of every model of wellness found by this researcher. Physical fitness, as defined by the President's Council on Physical Fitness and Sports (PCPFS) (1984, p. 1), is "the ability to perform daily tasks vigorously and alertly, with energy left over for enjoying leisure-time activities and meeting emergency demands." The three components of physical fitness are: cardiorespiratory endurance, muscular strength and endurance, and flexibility. Cardiorespiratory endurance is the "ability to deliver oxygen and nutrients to tissues, and to remove wastes, over sustained periods of time" (PCPFS, 1984, p. 2). According to Cooper and Collingwood (1984), this may be referred to as cardiovascular endurance, aerobic capacity, or just fitness. The fitness level, as determined by a treadmill test, has been proven to be a highly significant predictor of coronary risk and disease (Cooper and Collingwood, 1984).

The PCPFS's (1984) definition of flexibility is "the ability to move joints and use muscles through their full range of motion" (p. 2). Muscular strength and endurance is the ability to "exert force for a brief period" and "to sustain repeated contractions" (p. 2).

Nutrition, diet, and weight control are the key terms used to describe this wellness component. Nutrition is the study of basic food groups and their effect on body metabolism. A balanced diet from the basic four food groups should consist of calories distributed as follows: 50% complex carbohydrates, 20% proteins, and 30% fats. Weight control is the balance of calories consumed and the calories metabolized in daily living. Determinaton of ideal weight and body composition can assist in designing a positive eating plan and exercise plan to lose, gain, or maintain weight (Cooper, 1982).

Stress awareness and stress management are usually included in wellness. Stress is a hazard of modern living Selye (1974 has defined stress as "the nonspecific response of the body to any demand made upon it" (p. 27). "Damaging or unpleasant stress is distress" (p. 31). Eustress is positive or "extremely pleasant" stress (p. 33). Benson (1975) defined stress as the "environmental conditions that require behavior adjustment" (p. 59). Exercise, relaxation techniques, and time management are the methods most often mentioned for coping, managing, or reducing stress.

Emotional and mental stability are affected by stress and are sometimes a part of stress management or, in other models, are separate components. The descriptors of these areas tend to overlap. This component could also include social, intellectual, and spiritual dimensions of living, as Hettler (1980) proposed with his six dimensions of wellness. Other descriptors are: peace of mind, positive outlook, contented spirit, absence of envy and jealousy, cheerful disposition, love of mankind, and faith (Ardell, 1977a).

The spiritual dimension has been defined as a result of research by Banks (1980). She identified the following as descriptors of this dimension: (1) a unifying force integrating all the other dimensions, (2) that which is meaningful and purposeful in life, (3) common bonds between individuals, and (4) individual perceptions and faith.

Ardell (1977a) emphasized physical, social, and personal environment in environmental sensitivity. The air, water, and land are our physical environment. Our social environment is the economy, and governmental and cultural contexts with which we interact. Our personal environment is the design and shape of the space we inhabit, referring to all that stimulates one's senses. He advocated personal assertiveness and social action to control the environment. The occupational and vocational dimensions are referred to as one's satisfaction with one's work (Hettler, 1980).

Cooper (1982) identified habit control or controller substances in total well-being. The cessation of smoking, control of alcohol consumption, and awareness and control of legal and illegal drugs are key dimensions of the component.

As one can see, in addition to three components of physical fitness, nutrition, and stress management, there are a multitude of terms for the remaining components concerning the other facets of life.

Wellness Programs

Wellness programs rarely exist in educational institutions. "In the majority of school settings the health of employees has been disproportionally ignored" (Falck and Kilcoyne, 1984, p. 239). Dr. Linus Wright (cited in Holroyd, 1983), superintendent of the Dallas Independent School District (DISD), stated that "many of the same principles used by businesses could be applied to employees of his school district" (p. 17). The DISD, beginning in 1982 with a pilot program, has established the first comprehensive fitness program of its type in public school education. They have "broken the ice for other school districts throughout the state . . . to inspire employees and their families to better health" (Holroyd, 1983, p. 17).

Need in Education

A wellness lifestyle affects the quality of life of

the individual. "The ultimate aim of education is the improvement of the human condition and therefore, the quality of life" (Engelhardt, 1980, p. 10). Drolet and Davis (1984), Mitchell (1984), Reynolds (1984), Cmich (1984), the U.S. Department of Health, Education and Welfare (HEW) (1979a), and Perry (1984) all reported the importance of teachers and other school personnel serving as role models for students. Drolet and Davis (p. 32) believed that "school personnel are perceived as more important role models now than in the past." "Modeling is an important factor in the educational process . . . teachers should always model the behavior they are trying to develop" (Nakamura and Lescault, 1983, p. 557).

There is also an "increasing recognition of children's abilities to motivate . . . school personnel . . . to change their behavior" (Perry, 1984, p. 145). Perry also suggested that intervention activities in the school "integrate the students, teachers, and community" (p. 147). Associate Superintendent Collins (cited in Holroyd, 1983) of the DISD, in response to the wellness program, stated that "children react favorably to seeing their teachers trying to improve their well-being. There is definitely a positive effect on their environment and instructional quality" (p. 18).

Performance of teachers is of great concern in achieving quality education. Mitchell (1984), with the Personalized Aerobics Lifestyle Systems (PALS), felt that the

program had the "potential to affect significant change in teacher classroom performance and student learning" (p. 4). The Texas Education Agency (TEA) (cited in Fulbright and Harris, 1982), having sponsored wellness workshops around the state, stated that "once personal awareness levels are aroused, then perhaps exciting, dramatic classroom teaching and learning experiences will follow" (p. 34). This will not occur "until school personnel understand the importance of good health habits within their own lives and present themselves as positive role models" (p. 33). Collingwood, Blair, Reynolds, Sterling, and Collins (1983) reported that employee wellness programs have "not been applied fully and systematically for public school teachers" (p. 2). Their studies indicated the stress symptoms of teachers can be altered by improving physical fitness. In analyzing a short-term study of the DISD, teachers in treatment schools were found to have increased participation in vigorous exercise, improved physical fitness, lost weight, lowered blood pressure, reported higher level of well-being, and were better able to handle job stress (Blair, Collingwood, Reynolds, Smith, Hagan, and Sterling, 1984).

The challenge made by the U.S. Department of Health and Human Services (cited in Iverson and Kolb, 1983) in Promoting Health/Preventing Disease: Objectives for the Nation in 1980 was the "health officials and health providers must be joined by employees . . . school teachers . . . in efforts to prevent disease and promote health"

(p. 297). The Surgeon General's Report (U.S. Department of HEW, 1979a) suggested that the "worksite may provide an appropriate setting for health promotion as well as health protection activities" (p. 11).

In Texas, there is a growing recognition of the importance of health education reflected in new state regulations. After studying Texas' health education programs, Glover (1984, p. 310) reported that "If Texas, a leader in Health Education, is to keep abreast of the growing national interest in health promotion, existing Health Education programs need improvement."

Higher education has also found a place for wellness within their structure. Lovett (1978) believed a wellness resource center was a "concept whose time has come for adoption by university and college health services" (p. 170). He felt that this type of program could best be presented to the campus and community "through the health services in the community colleges" (p. 179). Taub (1983) believed that the role of the university is to formulate a position statement, provide a state-of-the-art report, and guidelines for further action in health promotion in industry. The wellness movement with its strength in the corporate sector, has found its way into higher education through the efforts of the Student Life Program at the University of Wisconsin at Stephens Point. Wellness promotion "can only enhance the academic and programming functions of a university," according to it's director, Bill

Hettler (cited in Warner, 1984, p. 33). Hettler (1980) also believed the university to be "an ideal location to attempt a wellness promotion program" (p. 90).

At the community college, Whitaker (1977) determined that 20% of the students dropped out of college for medical reasons and concluded that it was "appropriate that community colleges provide health programs for their students" (p. 5) and that faculty and staff be "eligible for services and encouraged to participate" (p. 14).

Goals for Wellness Programs

Goals for wellness programs have been identified in the literature for both the individual and the institution. In many cases, the goals have not been separated into these two categories. The resulting benefits of participation in established programs have been minimally reported in the research and that which is available has not necessarily substantiated the claims of the promoters. Perceptions and personal feelings have provided much of the justification for programs and have generally been reported.

Philosophical Goals

Individual goals are reflected in the goals of health, well-being, and wellness as presented in the definitions of wellness and the wellness models. The challenge put forth by the Surgeon General's Report (cited in Iverson and Kolb, 1983) was to "promote a safer and healthier environment for

all Americans at home, at work, and at play" (p. 295). From this came much of the support for employee programs.

The terms "health promotion, "health intervention," and "wellness" tend to be used to describe similar program goals. Brennan (1981) believed positive health changes would occur from health promotion at the workplace. His goal for health promotion was "to facilitate behavioral and environmental adaptations that will improve the existing state of health" (p. 66). He designated health promotion as any activities that attempted to bring about that goal.

In his article, Taub (1983) reported several definitions of health promotion and wellness. Health promotion, as defined by Parkinson (cited in Taub, 1983, p. 10), is a "combination of educational, organizational and environmental activities designed to support behavior conducive to the health of employees and their families." Wellness was defined by Wharton and Davis (cited in Taub, 1983) as the health intervention programs to meet this goal. Health promotion, according to Perry (1984, p. 142) included "efforts to change particular health practices or health-related behaviors."

Petosa (1984) reported that the wellness movement tries to promote the "acquisition of skills that promote wellness" (p. 38). Wellness programs have formed to "enable people to accomplish self-chosen tasks with a corresponding increase in their enjoyment of living" (p. 38). He reported wellness as a new name for the old concept of

prevention. However, Goldstein (1983) believed prevention to be a critical concept in wellness. According to Hettler (1983, p. 35), "the health promotion movement may go under lots of names and it really isn't important what name you choose; the concept is important."

Wellness in the workplace as being the responsibility of the employer, was encouraged by Shields (1984, p. 32) to "motivate, educate, and direct employees toward healthful living." The ultimate goals were to reduce risk to disease and premature death and enhance the quality of life. These goals are also reported by Gross (1980), Dinkmeyer and Dinkmeyer, 1979), Ardell (1977a), Sorenson (1979), Craig (1983), Baun (1983), and the U.S. Department of HEW (1979b).

Individual and Institutional Goals

Individual and more specific goals are explained through benefits for the individual and for the sponsoring agency. Chen and Jones (1982) identified the following goals: (1) improve morale, (2) increase productivity, (3) reduce health care costs, and (4) promote healthier work forces. These are supported by Collingwood (1981), Baun (1983), Tager (1983), Richard (1984), Edington (1983), and the U.S. Department of HEW (1979b). In a survey of small businesses, they were more "apt to establish wellness programs to improve morale than reduce health care cost"

(Clark, 1984, p. 4). This may be true in education as well.

At Tenneco in Houston, Baun (1983) more specifically identified the goals of: (1) increasing cardiovascular fitness, (2) increasing health knowledge and reduction of coronary risk factors, (3) encouragement of self-responsibility and program ownership, (4) motivation to improve/maintain optimal health, and (5) development of support groups. Adding to these, Phillips and Allen (1979) included goals of developing good relationships with community health resources and establishing effective screening mechanisms. Additionally, cost containment strategies and medical alternatives should be explored (Tager, 1983).

The educational setting is a "natural" for wellness programs. In a Region IV TEA survey, Falck and Kilcoyne (1984) stated several assumptions to demonstrate this belief: (1) public schools have qualified personnel (nurses, dietitians, physical and health educators), (2) they have physical facilities (gymnasiums, tracks, equipment), and (3) on-site programs are more convenient and supportive than ones at outside facilities. They concluded that the key components for success of the program were the building facilitator and the importance of the program to the school administrator. Tager (1983) supported these assumptions and added that professional conferences and in-service programs provided opportunities for wellness program activities.

Mitchell (1984) identified the goals for the DISD: (1) to assist teachers in better managing stress, (2) to reduce absenteeism, and (3) to apply the health/fitness promotion model to education. From an administration standpoint, the goal was to maintain the functional ability of teachers. The belief was "a physically fit, energetic teacher who possesses a positive attitude about self and teaching, can make a greater impact on student learning" (p. 2). There is a "growing acceptance that it is an administrative responsibility to define and deliver programs to affect these goals" (p. 2).

At the University of South Carolina (South Carolina Department of Health Education, 1984, p. 1) their goal was "to provide supportive environment, encouragement, information and dynamic enrichment programs" for both students and faculty and staff in their "Open Door" program. Specifically, the aims were to: (1) improve health knowledge, (2) improve self-responsibility, and (3) adopt health-promoting behaviors (Love, Morphis, and Page, 1981).

Edington (1983) has developed a model for program validity to understand the gains for the individual and the organization (Figure 6).

Program Components

Wellness components tend to be identified as the subjects or content for the program. Wellness and health promotion programs incorporate different components with

a varying level of emphasis according to their goals, resources, and facilities. The targets for health promotion from the U.S. Department of HEW (1979a) are: smoking, alcohol and drug use, nutrition, exercise and fitness, and stress management. Most programs reflect these basic components of wellness in their goals, programs, and services. Environmental awareness (Richard, 1984; Ardell, 1977a), interpersonal relations, safety, dental wellness, and blood pressure screening (Hettler, 1980) are additional components mentioned in the literature.

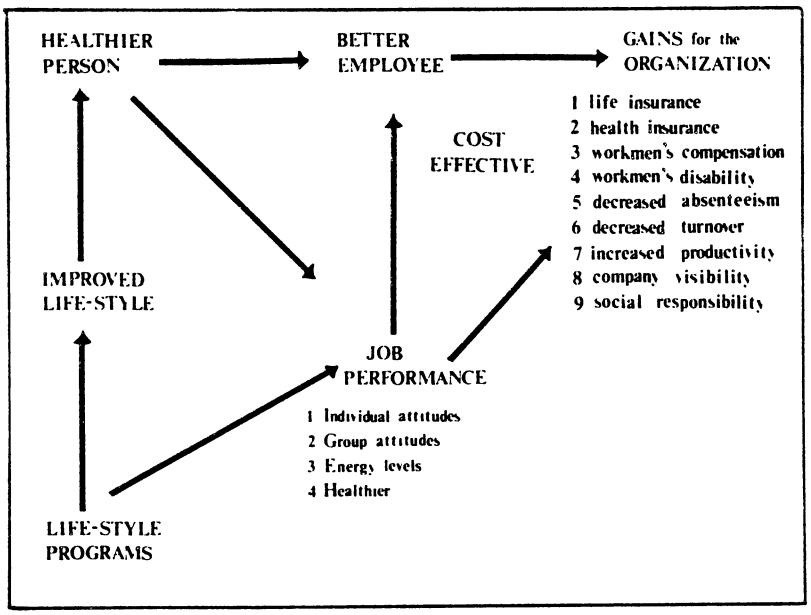

Figure 6. Model of Program Validity

By examining wellness as a process, levels of change have been incorporated in PALS. In a progressive ladder, these are: (1) knowledge, (2) activity, (3) healthy lifestyles, (4) health and fitness status, (5) attitudes, (6) stress management, and (7) job-related functioning (Mitchell, 1984).

Program Services

Program services tend to mirror components and are sometimes difficult to separate. The services are usually the activities sponsored by the program administrator for the employee.

The generic services for any program have been established by Cooper and Collingwood (1984). These include: (1) medical screening, (2) fitness and lifestyle assessment, (3) individual goal setting, (4) exercise and nutrition prescription, (5) supervised group starter programs, (6) educational classes, (7) structured motivation and reinforcement system, and (8) ongoing feedback.

A broader service structure is presented by Vierke (1980). He suggested educational presentations, individual consultation, behavior change groups, and workshops as services in a lifestyling program. Hettler (1984) suggested the services of information, group activities, and confidential personal assistance. For student-oriented programs, the University of Wisconsin at Stephens Point (Hettler, 1980) included contraception. Southern Illinois

University (Cohen, 1980) included: (1) lifestyle programs, (2) human sexuality services, (3) a health activation programs, and (4) alcohol education projects.

The services provided at the University of South Carolina were termed "strategies" and included: (1) psychophysical assessments, (2) one-on-one consultations, (3) group programs, (4) mass media contact, and (5) wellness-oriented social events (Love, Morphis, and Page, 1981).

The Sunbelt Executive (1984), in a national magazine survey, stated that an employee wellness program provided one or more of the following: (1) health education programs, (2) health intervention programs, (3) health screening, and (4) physical fitness programs. In the "Industrial Health Model" (Phillips, 1979), services offered were lifestyle risk analysis, lecture-discussions, group strategies, medical laboratory screening, and evaluation.

Summary

Through this review, we have examined the diversity of terminology, understandings, and practices involved in the wellness movement. There are also some consistencies in the overall concept of wellness and program design.

Wellness definitions, using a great variety of words, generally identified a striving for optimal health and indicated some choice or action on the part of the individual to meet his/her potential. No one definition has been found to be commonly used by educational institutions. The

wellness models expressing the interrelationships of wellness components were generally found in a circle, indicating the continuity of wellness and the "wholeness" of the individual within the wellness concept.

The need for wellness programs in education for the employee has been demonstrated. Where programs do exist, there have been improvements in a variety of health concerns as well as reports of positive perceptions of the participants and the administrators.

The goals which have been identified were generally broad, altruistic goals for the individual and very specific concerning the financial aspects of the institution. Though terminology changed, goals consistently reported were: better health, increased productivity and morale for the individual, and reduced health care costs for the institution.

The components serving as "topics" for program activities, varied according to the institution and the resource personnel. Specific component emphases have not been identified nor has the level of emphasis within the programs been reported.

Program services have been grouped with components or listed as activities. Consistently, health assessments, educational classes, and group support systems have been reported as services provided within the program design. Some form of motivation or goal setting was also recognized as an important service or strategy.

With the limited research on concept structures of wellness programs in educational institutions and with the diversity of definitions, goals, components, and services within the few programs that do exist, it is necessary to survey the field to uncover what is being done in Texas, and to determine where these programs are and how they are functioning within the wellness framework.

CHAPTER III

METHODOLOGY

The philosophical and organizational structure of wellness programs in educational institutions in Texas were researched according to qualitative research designs (Wiersma, 1975). The survey instrument, cover letter, follow-up letter, and reminder postcard, as well as the operational procedures, were designed and implemented according to formats from social science methodology (Bailey, 1982). Analysis of data included frequency of distributions for general information, program components, and services. A "key words" list was developed from open-ended responses for the wellness definitions and the goals and objectives.

Instrument Development

Questionnaire

The wellness program questionnaire was divided into three sections: general information, concept information, and program information (Appendix A). The first section was designed to identify the type of institution, the title and age of the program, the employee group for which the program existed, the number of potential and actual

participants, the position of the director, and the department under which the program was administered. The response methods were either a category to be checked or a short line on which to fill-in-the-blank.

Concept information was requested through open-ended questions which allowed for creative expression to define wellness and list goals for the individual and the institution. A request to cite the reference for the definition, if not original, was made.

A Likert-type scale was used to obtain program information on components and services. The emphasis of the component in the program offerings was responded to on a 1-5 scale, with 1 being never, 2 rarely, 3 sometimes, 4 often, and 5 always a part of the program. Opportunity was given for the respondent to add other components not listed. The services were identified in a similar manner. The role of the service was based on a 1-5 scale, with 1 being never, 2 rarely, 3 sometimes, 4 often, and 5 always a part of the program. Opportunity was again given to add services not listed.

There were several opportunities for the respondent to add additional information concerning the organization, conceptual bases, and "special" aspects of their program.

Support Materials

The cover letter included a definition of a wellness program, the purpose of the research, the need for the

research, and the motivation for responding to the questionnaire (Appendix B). A memo (Appendix B) was designed to guide the person opening the envelope to route the questionnaire to the appropriate person(s) or to return the questionnaire in the stamped, self-addressed envelope if there was no wellness program. Personal confidentiality of responses was guaranteed. Institutional confidentiality was also guaranteed; however, permission to describe their program and to identify the institution was requested.

A follow-up letter (Appendix B), similar to the cover letter, was used to insure receipt of the materials. The questionnaire was included in case the first packet was lost in the mail or misplaced by the individual.

Validity of Instrument

The questionnaire and letters were submitted to three college professors: Dr. Janet Lowry, sociology professor, who specializes in questionnaires for research in the social siences and who supervises a social sciences laboratory; Dr. Anne Fuller, dean of academic affairs at a small, liberal arts college; and Dr. John White, education professor and former public school English teacher. They were asked to evaluate the format and clarity of directions and terminology of the questionnaire. They also examined the support materials for clarity and appropriateness of content. Minor changes were made in the layout of the

categories and the Likert-scale sections. Other grammar and punctuation errors were corrected.

The questionnaire was then submitted to a panel of six experts in the field of wellness to determine the content validity of the instrument. Experts were defined as those persons who are teachers of wellness or health or persons who are currently directors of wellness programs in educational institutions. The six experts included three university health professors and three directors of wellness programs (one K-12 public school director, one junior college director, and one university director). They were: Melanie Packwood, wellness Facilitator, Mesquite Independent School District; Bob Stock, Wellness Director, Brookhaven Community College; Dr. Linda King, Wellness Director, Texas Woman's University; Dr. Glenn Richardson, Professor of Health Education, Texas A & M University; Dr. Mac McCrory, Director, Health and Fitness Center, Oklahoma State University; and Dr. Betty Edgley, Chairman, Department of Health Education, Oklahoma State University. One individual indicated that it was not necessary to validate the instrument, as it was a survey. However, the researcher believed it important that the components and services were the accepted terminology and that they were comprehensive and complete. A few components were reworded and services were regrouped. The wellness program definition in the cover letter was adjusted to be more precise.

Pilot Study

Purposes. A pilot study was conducted to field test the wellness program questionnaire, to test the operational/mail-out procedures, and to analyze the data with a small group.

Sample. Fifteen institutions were selected to receive the pilot study, five from each type of institution--public school, junior college, and college or university. At least three of the five selected institutions were known to have wellness programs and the name of the director had been identified. One or two institution(s) of each type was/were selected, not knowing the name of the director or whether or not a program existed. This was necessary to examine the routing procedure. Total selection reflected different geographical locations throughout the state.

Mail-Out Procedures. The questionnaire packet was mailed November 2, 1984. After three weeks, the follow-up letter and questionnaire were sent as a reminder and to insure receipt of materials. After two more weeks, nonrespondents received a post-card reminder (Appendix B).

Analysis of Pilot Study. The response to the pilot study was very good. Of the 15 institutions, 13 responded, with 10 (N=10) indicating that a wellness program was in existence. This included three independent school districts, three junior colleges, and four universities. The

questions involving category checks were tallied by hand on a master matrix which was divided by type of institution. This was then developed into a frequency distribution table. The Likert-scale ratings were used to determine the means for each component and service for the whole group as well as by type of institution. Open-ended question responses were listed by institution type with key words listed separately.

In reviewing the response to the general information, several changes were made in the questionnaire. The institutional grouping was reduced from six to five categories. The public and private designations for the colleges and universities were not necessary. To clarify the age of the wellness program, a selection of years was given to the respondent for the researcher to be more precise in the classification of this information. The number of eligible participants and actual participants was not clear nor consistent among the respondents. The researcher determined that the number of participants would change from fall semester to spring semester and would not, in fact, be necessary to answer the research questions. These two questions were eliminated.

The wellness definitions were all original definitions; therefore, the request to cite the reference was deleted. More space was then allowed for the concept information responses.

No changes were made in the list of components or services. There were some multiple category checks from a few respondents in both components and services. This was deemed not to be a problem of the instrument, but of the respondent attempting to interpret their program emphasis in some areas. No one listed any "other" components or services. This option was dropped from the lists.

At the end of the questionnaire, permission to identify programs with institutions was requested. Nine of the 10 responded positively to this request. All 10 wished to receive a summary of the results of the research. Confidentiality of responses was guaranteed, as coding of questionnaires was necessary for follow-up and research records.

With 13 of 15 responses (86.6%), operational procedures were deemed successful. Six questionnaires were returned after the first mail-out, four questionnaires after the second, and three more questionnaires were returned after the post-card reminder.

A content analysis was performed using "key words" for the definitions and the goals of the program. The results of the pilot study are reflected in, and similar to, the results of the final study. The open-ended responses were clear statements using many of the key words found in the literature. Health enhancement, well-being, and happiness were found in more than two definitions.

The goals of improving employee health, increasing awareness of healthful living, assessing risks, increasing

productivity, and providing low-cost resources were most often listed. Some respondents combined the goals for the individual and the institution.

The most-emphasized program-offered components were: physical fitness, nutrition awareness, stress awareness, stress management, and relaxation techniques. The least emphasized components were environmental awareness and the values/spiritual awareness components.

The services provided most often included personal evaluation and feedback, group exercise program, and program evaluation. The services of medical screening and educational classes followed closely behind. The means of services, all 3.0 or higher, indicated that all the services were important and were included in the wellness programs.

The researcher noted that the responses in the pilot study should lead the researcher toward answering the research questions through the full study. The method of recording the open-ended question responses was changed from an institution summary sheet to a note-card system for each question with institutional code or name where permission to identify the program was granted.

Wellness Program Study

Sample Selection

Educational institutions in Texas were selected for

the study with the following criteria. All institutions known by the researcher to have wellness programs were included in the study. The TEA sponsored four wellness workshops in different regions of the state in 1982-1983. All the participants from AAAAA (5A) and AAAA (4A) independent school districts were included in the study. Other 5A school districts listed in the Texas School Directory, 1983-84 (TEA, 1983) in or near major urban centers were added to the list. All junior/community colleges with an enrollment of 3,000 students or more and colleges/universities with an enrollment of 5,000 students or more were included in the study (Texas Sports Guide of High Schools and Colleges, 1984-85, 1984).

The sample included 47 5A and 12 4A independent school districts, 26 junior/community colleges, and 27 colleges/universities. Questionnaire packets were sent to 112 educational institutions in Texas.

Operational Procedures

Mailing labels were addressed to the wellness director by name or to the wellness director/health services director if no name was known. Included in the number 10 envelope were the memo (if no name was known); the cover letter; the Wellness Program Questionnaire; and a stamped, number 9, self-addressed envelope. The four-page questionnaire was printed on a single sheet of 11" x 17" yellow paper, folded in half.

The questionnaire packet was mailed January 5, 1985. The follow-up/questionnaire packet was mailed on January 26, 1985, to 64 institutions and the reminder post card was mailed to 48 nonrespondents on February 9, 1985.

The responses were dated and checked off the master coding list. There were 48 responses after the first mail-out, 17 responses after the second mail-out, and 12 responses after the post-card reminder. This resulted in 77 responses (68.7%), with 22 indicating that a wellness program existed. A master list of wellness programs and their directors was developed (Appendix C).

Compilation of Data

The questionnaires were separated according to type of institution. Type I institutions were the 5A and 4A independent school districts. There was only one 4A independent school district responding who had a wellness program. Junior and community colleges were classified as Type II and universities were classified as Type III. Few colleges were included in the sample because of enrollment figures; this may have affected the number of colleges identified in the study. However, the researcher, through inquiries at professional meetings, had determined that smaller colleges generally do not have structured wellness programs.

All tabulations were recorded by type and then combined for summarization. A listing was made of the title and age of each program. A matrix was developed to tally

all categorical information in the general information section and for the components and the services sections. A second matrix was used for reliability in tallying. Each section was tallied at two different times by the researcher. Any section with a total number discrepancy was tallied a third time. The means were calculated for each component and service for the whole group and by type.

The open-ended responses were recorded on 5 x 8 cards. The operational definition was recorded with the institutional code. The goals for the individual and the institution were combined on another 5 x 8 card, again with the code number. These were then filed by type of institution. A comprehensive "key word" list was developed from responses from all the institutions for the definitions, individual goals, and institutional goals.

It was necessary for the researcher to interpret some notes of clarification by the respondent to determine a categorical response. Multiple answers were reported for the auspices of the program. Several respondents enclosed their wellness program literature which was used by the respondent to reference answers to questions on definitions and goals. This resulted in some interpretation by the researcher to identify their answers to those specific questions.

Several respondents did not check some components and services. Where there were two checks in one component,

the average of the two scores was recorded (for example, 3 and 5 was recorded as 4). Where there were two checks in one services, the average of the two scores was recorded (for example, 4 and 5 was recorded as 4.5).

CHAPTER IV

RESULTS AND DISCUSSION

The Wellness Program Questionnaire was mailed to 112 educational institutions in Texas. Of these, 77 (68.7%) responded, with 22 indicating that a wellness program was in operation. Fifty other respondents had no wellness program and five indicated on the questionnaire that their program was: (1) not in operation this year, (2) a student-required course, or (3) a single component or one-time-only activity. These five programs were deemed not to be wellness programs as defined by the researcher and were not included in the study.

Respondents included 8 independent school districts (Type I), 10 junior/community colleges (Type II), and 4 colleges/universities (Type III). Therefore, the total number of wellness programs identified was 22.

General Information Results

Program Title

The wellness programs are entitled using three general styles. The first style includes the word wellness within the title. Ten programs used this style, with five of these

using their school name with it. Four others used the term employee to designate the program participants. Typical titles of this style are "DISD Wellness Program" and "Cedar Valley Employee Wellness."

The second style includes the use of initials. "W.O.W." ("Working on Wellness" and "LIFE" ("Live in Fitness Everyday") are examples of this style found in Type I institutions. One Type II institution used "N.E.W." for "Northeast Wellness."

The third style includes other wellness-related terms, catchy phrases, or the use of subtitles. "Project Lifestyle," "Shape Up," and "Your Heart is in Your Hands" exemplify this style. Subtitles help to describe some of the programs. "Wellness: Morning Madness and Exercise a Bunch for Lunch" gives more specific information about the program's activities.

Age of Program

Programs in educational institutions are truly in the infancy stages. The oldest is a five-year university program followed by another at three years of age. One junior college program has been in existence for four years while three junior colleges are in their third year of operation The rest are in their first or second year of operation. The DISD Wellness Program at the Institute for Aerobics Research is three years old and seems to be the leader and guide for other public school programs. It began with a

pilot study during the 1983-83 school year and has continued to grow in program offerings and participants to the point of providing a data base for the justification of wellness programs in public education for the nation. The rest of the independent school district programs are in their first or second year of operation.

Seven respondents who had no wellness program indicated that they were in the planning stages of program development and would be very interested in the results of this research, since it might assist them in the process.

Program Participants

The wellness programs are primarily designed for the faculty, staff, and administrators of the institution. However, 6 of 10 junior colleges included the students in their program, and a few Type II and III schools included people from the local community. The community-oriented schools exemplify one mission of higher education; that is, community service. The spouse and family were generally not included on a regular basis but were included on some special occasion activities.

Administrative Responsibility

Department. Various departments were designated as being responsible for the administration of a wellness program. In several cases, more than one department was involved in the administration. The physical education

department was cited most often. The physical education departments alone or jointly administered 14 programs. The college health services department was cited for 6 of 10 Type II institutions. In all the Type III programs, the leadership came primarily from the physical education department with support of the health education and recreation departments.

The most diverse administration was found in Type I schools where the physical education department carries out the program but the organizational structure comes from a variety of offices within the general administration office. This leadership includes the superintendent's office, employee relations department, adult education office, interdepartmental task forces, and steering committees. The personnel office and student services were mentioned in only two programs.

Program Director. This individual was referred to as a director, coordinator, and facilitator. There was great disparity in the status of the director. The position ranged from voluntary to part-time to full-time status. This may include release time or additional duties for a full-time employee. Such diversity was found across all respondents with no one status predominating.

Wellness Definition Results

The definition of wellness as reported by the respondents ranged from key word listings and brief statements to

in-depth statements and thorough statements of philosophy. Some respondents referred the researcher to brochures and reports accompanying the questionnaire. Upon reading the materials, the researcher identified those sections which were pertinent to specific questions from the questionnaire. Where different terms were used as headings, similar concepts were grouped together. For example, a statement of philosophy incorporated a definition of wellness but was not specifically referred to as such.

Key Word Analysis

Key words found in wellness definitions were used to determine the most commonly occurring terms used to define wellness. Similar terms were then grouped to identify the basic concepts portrayed in the definitions.

Key Words. The words physical and fitness were each used six times and were not necessarily used together. Emotional and mental were used four times, along with the word maximizing or maximum potential. Quality of life, well-being, health, optimal, and spiritual were used three times each and self-responsibility, positive state of health, moving to and learning each appeared twice. Other terms used at least once were: health awareness, lifestyle improvement, health promotion, body-mind-spirit, state of wellness, social psychological, positive living habits, healthy lifestyle choices, health improvement, disease

prevention, stress, nutrition, lifestyle change, whole person, good health habits, enjoy life, cope, health related, and lifetime commitment.

Only two definitions were quoted and referenced. Tarrant County College identified Hettler's (1984) definition and the Six Dimensions of Wellness as their program model. Another university respondent quoted O'Connell and Ainsworth, Health Promotion in the Workplace, defining wellness as "an attitude, an approach to life, work, and even to the way one copes with illness and injury."

Word Groups. Upon combining similar terms, the researcher identified four main groupings. There were more specific references to health and health-related terms than any other concept term. This included knowledge of health, establishing healthy habits, and/or improving health status.

A second concept referred to the possible end product or objective. Common terms were the quality of life, well-being, and level of wellness, indicating the possible outcomes of wellness lifestyles. Closely related to the second concept is the third concept of lifestyle. This is the process or method of achieving the end product. The terms lifestyle enhancement, improvement, change, and choices suggests a decision or action on the part of the individual. This concept is a behavior-oriented process to achieve the end product of wellness.

The fourth concept expressed in the grouping of key words is one of the dimensions or components of wellness. Physical occurred most often, with emotional, mental, and spiritual also being included. Stress and nutrition were also mentioned. The terms self-responsibility and lifetime commitment suggested action on the part of the individual throughout one's life as a broad component or dimension of wellness.

Key Word Summary. Health and fitness are used to describe the substance of wellness. The goal or objective of wellness is to achieve well-being or a quality of life. The action descriptors of optimal, maximizing, and maximum potential were used to identify the level of wellness. The process for achieving wellness is through lifestyle choices and changes in behavior. The components of wellness are important to the understanding of the wellness concept. The physical, emotional, mental, and spiritual designations indicated which aspects of life were affected by, and integral to, developing and achieving high level wellness.

According to these four key concepts, a definition of wellness was designed to represent wellness in educational institutions in Texas. Wellness is optimal health and fitness involving the physical, emotional, mental, and spiritual self, through lifestyle choices, to maximize the quality of life or well-being of the individual.

Definition Discussion

The key word analysis suggests that the educational institutions' definitions of wellness generally follow the definitions as found in the review of literature. Ardell's (1979, p. 17) "lifestyle approach . . . potentials for well-being" compares favorably with this study's lifestyle choices, optimal health and fitness, and well-being. This study's definition also follows Hettler's (1983, p. 31) definition of making "choices toward a more successful existence." However, the definition reported here is more specific than the philosophic definition of Dunn (1961). There is similarity in his "method of functioning" as process or lifestyle and "maximizing the potential" as optimal and to maximize (pp. 4-5). From there, though, Dunn discusses the "continuum of balance and purposeful direction" which does not appear in this study's definition.

The equal importance and emphasis of components as implied in the wellness models (equal sections in circular models for each component) are supported in the definitions reported by the respondents but are not equally emphasized in actual program offerings. The results indicate a lesser emphasis on the role of the individual toward self-responsibility and commitment. The individual is key in the definitions and models of Goldstein (1983), Ardell (1982), Hettler (1980), and Curtis and Detert (1981). This individual emphasis was not portrayed as strongly in the

operational definitions in this study. Some definitions do imply action on the part of the individual but rarely was it emphasized as a key component to the success of achieving wellness.

Goal Results

The goals and objectives listed by the respondents were composed of both very broad, general statements for the individual and the institution and very specific, measurable goals for each area. Some respondents combined their goals in one listing, not designating whether the goal was specific to the individual or the institution. Others referred the researcher to enclosed materials wherein tbe researcher had to interpret the goal categories. Due to this diversity of response patterns, some of the respondents' goals were organized into individual and institutional categories.

Individual Goals

Key Word Analysis. The primary goal for six of the wellness programs was to increase one's level of wellness. Coping with stress was mentioned five times, with awareness of healthy living or health consciousness being mentioned in four programs. Equally important was assessing risks and promoting change for the individual. Reducing risk factors, weight control/diet, and nutrition were mentioned three times. Another identified goal was for the

individual to participate in a health promotion program. Learning factual information, enhancing self-esteem, improving the quality of life, and smoking cessation were also listed.

Goal Groups. By combining similar goals together, the researcher identified several very specific goals. The strongest, most identifiable goal was the idea of increasing the level of wellness. This concept combined optimal health and fitness, achieving wellness, and improving the quality of life. These goals, combined with the idea of promoting change, indicate that a positive change in the health status of the individual was the predominant goal for developing wellness programs.

The second area of emphasis for the individual included assessing risks, lifestyle and physical fitness, and reducing those risk factors. The third area of emphasis, related closely to the second area, was an awareness of healthy living. Through assessments of the second area and the educational aspects of the programs, one may develop greater awareness of healthy living.

More narrow, single concept goals follow distantly behind the three predominant goals. These goals include nutrition, diet and weight control, managing stress, and smoking cessation.

Ironically, the key to the success in wellness is self-responsibility, as identified in the review of lit-

erature and the definition discussion. This was only briefly mentioned by two respondents as goals for the individual. Accepting responsibility and making choices were the phrases used to indicate this goal. Other similar goals may imply action and responsibility but the concept of self-responsibility was specifically stated by only one respondent.

Relating to education, only two respondents listed becoming role models and more effective teachers as an important outcome of their wellness program. The concept of effective teaching may be a part of being more productive, as can be seen below.

Institutional Goals

The goals for the institution were found to be more consistent and specific than for the individual. There was a consensus that the key goals were to increase productivity, reduce health care costs, reduce absenteeism, and increase morale. Another related goal was to reduce turnover and replacement/retraining costs.

Key Word Analysis. Promoting health education and a wellness attitude, providing wellness programs and educational opportunities for employees, and enhancing community image were also a concern for the institution. More altruistic goals included improving employee health and developing a sense of spirit/camaraderie.

Goal Groups. When combining similar goals, four goal groupings can be established. The first group ultimately relates to a financial goal; that is, increased productivity, reduced health care costs, reduced absenteeism, and reduced turnover are the primary concerns for the institution.

The altruistic goals can also be grouped together. Improved employee health, promotion of a wellness attitude, and developing a sense of spirit/comaraderie can be related to the third goal of institutional image. Improved employer-employee relationship, improved benefit package, easier recruitment of new employees, and enhanced community image were all image-oriented goals.

The fourth goal area was that of providing opportunities. This includes providing qualified instructors, educational opportunities, offering a variety of activities, and generally providing a wellness program for employees.

Goal Discussion

The goals and objectives of wellness programs described in the literature have not been separated specifically as to individual or institutional goals. By examining two of the three goals of the DISD, for teachers to better manage stress and reduce absenteeism, the typical combination of individual and institutional goals can be seen (Mitchell, 1984). By identifying whether the benefit is for the individual or for the program sponsor--the

institution--one can designate one category or the other for the majority of the goals.

The dominant goals for the institution support Chen and Jones (1982), Collingwood (1981), and others. However, there is little research to support the achievement of these financial goals in educational institutions. The DISD reported a statistically significant reduction in health care claim costs as well as reduced absenteeism (Mitchell, 1984). They reported a 35% reduction in absenteeism in 1982 (Mitchell, 1984) and a savings of $400,000 for absenteeism in 1983 (Holroyd, 1983). Otherwise, there is no long-term research to support the financial benefits of wellness programs in educational institutions.

The individual goals identified in this study are found throughout the literature. Specific health component improvements, that is, physical fitness, weight control, and so forth, are documented in the research and are realistic goals for wellness programs. Long-term general health and well-being goals are not yet substantiated and may or may not be realistic as program goals.

The identified goals of wellness programs need to be evaluated according to the ability of program participants and institutions to succeed in achieving the goals. This may then give support for the realistic identification of goals for both the individual and the institution. As noted here, the goals can be designated according to who

benefits from the goal, and this division of goals should be incorporated in selecting goals for future programs and further research.

Component Results

The components were identified according to the amount of emphasis in program offerings. Table I indicates the means and ranks of the various components for each type of institution and for the group. The most predominant component was physical fitness, which was emphasized often-always at all responding institutions. The group means resulted in physical fitness, nutritional awareness, weight control, and diet programs being ranked one, two, three, and four, respectively. In Type III programs, there was a four-way tie for these components.

The next-most emphasized components were also very similar among the different types of institutions. Type I emphasized the emotional component (ranked fourth), with stress awareness and stress management ranked fifth and sixth. For Type II program diet programs, stress awareness and stress management were tied for fifth position. Type III program rankings were stress awareness (fifth), with stress management and smoking cessation tied for sixth. Of the top six components, none was reported to not be emphasized at all.

Although the emotional component was emphasized in Type I programs, the group rank was eighth. Habit control

TABLE I

WELLNESS COMPONENTS--LIKERT-SCALE MEANS AND RANKS

Components	Type I Mean	Type I Rank	Type II Mean	Type II Rank	Type III Mean	Type III Rank	Mean	Rank
Physical Fitness	4.63	1	4.80	1	5.00	2.5	4.76	1
Nutritional Awareness	4.38	2	4.50	2	5.00	2.5	4.52	2
Weight Control	4.00	3	4.30	3	5.00	2.5	4.29	3
Diet Programs	3.50	7	4.00	5	5.00	2.5	3.95	4
Stress Awareness	3.75	5	4.00	5	4.00	5	3.91	5
Stress Management	3.63	6	4.00	5	3.75	6.5	3.82	6.5
Habit: Smoking	3.38	8	3.70	9	3.75	6.5	3.82	6.5
Emotional	3.88	4	3.50	12	3.25	11.5	3.59	8
Relaxation Techniques	3.25	9	3.60	10.5	3.67	8	3.48	9
Habit: Alcohol	3.14	10.5	3.80	8	2.50	19	3.42	10
Habit: Drug	3.14	10.5	3.60	10.5	2.50	19	3.32	11
Medical Resources/Services	2.75	16	3.89	7	3.00	15.5	3.29	12
Safety	3.00	12	3.10	14.5	3.50	9	3.14	13
Occupational	2.50	19.5	3.33	13	3.00	15.5	2.95	14
Intellectual	2.50	19.5	3.10	14.5	3.25	11.5	2.90	15
Social	2.88	13.5	2.70	17	3.25	11.5	2.86	16
Environment	2.63	18	2.80	16	3.25	11.5	2.82	17
Values	2.75	16	2.67	18	3.00	15.5	2.76	18
Community	2.75	16	2.56	19	3.00	15.5	2.71	19
Time Management	2.88	13.5	2.40	20	2.50	19	2.59	20

of smoking was consistent among the respondents, but alcohol and drug control rankings were quite diverse. The Type I and Type II program rankings were similar, but the Type III alcohol and drugs ranked nineteenth.

Although there was great similarity of response, the range of response in the rest of the components was from "not at all" to "always." A mean of 3.0 was used to indicate which components are being emphasized at least sometimes by the group. The components of medical resources and services and safety are sometimes found in wellness programs. Surprising to this researcher are the components that fell at the lower end of the rankings. This included the occupational, intellectual, social, environmental, values/spiritual, and community components. Time management was ranked last. As a stress management strategy, this may have been too narrow a topic for program emphasis.

Component Discussion

The components emphasized in educational institutions in Texas do not follow the dimensions of wellness of Ardell (1982) nor Hettler (1980) but more closely resemble the Wellness Wheel of Curtis and Detert (1981). The top components of physical fitness, nutrition, and stress management reflect their emphases. Even though the mental-emotional stability was not ranked at the top, there is some strength for it by the emphasis in Type I programs.

The lowest-ranked components which are found in Hettler's (1980) model are the less structured, difficult-to-identify-and-measure components. They are, however, reported in the literature to be equally important with physical fitness in the total concept of wellness. This was not indicated in this study. These components are more philosophical, which may have affected the outcome in this study.

The emphasis in program offerings was, however, in conflict with the definitions of wellness reported earlier. The wellness definitions, goals, and objectives incorporated the quality of life and physical, emotional, mental, and spiritual components, whereas the program offerings do not indicate this importance.

Service Results

The services are recognized as essential in their role of importance to the administration and success of wellness programs. There was a small range of means between and among institutions, indicating a common ground for services provided within the programs, as seen in Table II. A mean of 3.0 was used to indicate whether a service had a role in the programs sometimes, often, or always. All the listed services were above this minimal standard, indicating a common base of services provided by educational institutions in Texas.

TABLE II

WELLNESS SERVICES--LIKERT-SCALE MEANS AND RANKS

Components	Type I Mean	Type I Rank	Type II Mean	Type II Rank	Type III Mean	Type III Rank	Mean	Rank
Fitness Assessment	4.50	2	4.60	1	5.00	3.5	4.64	1
Group Exercise Program	4.63	1	4.30	5	5.00	3.5	4.55	2
Exercise Prescription	4.00	6	4.40	2	5.00	3.5	4.35	3
Medical Screening	3.88	10	4.30	5	5.00	3.5	4.27	4.5
Personal Evaluation/Feedback	4.25	3	4.30	5	4.25	10	4.27	4.5
Risk Assessment	3.57	12	4.30	5	5.00	3.5	4.19	6
Educational Classes	3.88	10	4.20	8	4.75	7	4.18	7
Reinforcement	4.00	5	4.30	5	4.00	12	4.14	8
Feedback	4.00	5	3.90	12.5	4.50	8.5	4.05	9
Motivational Incentives	4.00	5	4.00	10	4.00	12	4.00	10
Nutrition Prescription	3.43	13	4.00	10	5.00	3.5	3.95	11.5
Program Evaluation	4.00	5	3.90	12.5	4.00	12	3.95	11.5
Monitoring Participation	3.88	10	3.40	14	4.50	8.5	3.77	13
Goal Setting	3.38	14	4.00	10	3.86	14	3.75	14

Fitness assessment, group exercise programs, and exercise prescription were ranked one, two, and three, respectively. Medical screening and personal evaluation and feedback were tied at the fourth position. Risk assessment, educational classes, reinforcement, feedback, and motivational incentives ranked as often playing a role in the program.

Group exercise programs were most often a part of the program for Type I programs. Fitness assessment and exercise prescription led the list in Type II programs. All forms of health assessment, tied with group exercise programs, were ranked highest in Type III programs. This included medical screening, risk and fitness assessment, exercise, and nutrition prescriptions.

Risk assessment was the only service identified by more than one type as not being offered at all. However, where this was mentioned, respondents indicated that they were planning to include it in the future.

Services Discussion

This research demonstrates support for the generic services identified by Cooper and Collingwood (1984). Having used their list of services primarily for the questionnaire, this is not unexpected. The services supported by this study are: fitness assessment, exercise prescription, medical screening, ongoing feedback, and reinforcement. Individual goal setting was ranked last. However, it is

also an important part of personal evaluation, feedback, and reinforcement which gives importance to the service within the total program. The high rankings of these three services gives importance to goal setting as a strategy for evaluation.

The top three services indicate the importance of the physical component in the program. The top three services and the number one component are emphasized the most and indicate a common starting point for individuals in the wellness process. The top eight ranked services indicate the importance of the individual and the personal touch within a wellness lifestyle.

Type III institutions emphasized all forms of health assessment. They tend to have greater access to personnel and equipment to administer the more complete assessment services than Type I and Type II institutions. It may also reflect the orientation of the leadership--from physical education to health services and research.

CHAPTER V

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

Summary

The purpose of this study was to identify and examine employee wellness programs in public schools, junior/community colleges, and colleges/universities. The objective was to identify the operational definition of wellness, goals, and objectives for the individual and the institution, components emphasized in program offerings, and services provided within the program. The Wellness Program Questionnaire was mailed to 112 educational institutions in Texas. Of the 77 respondents, 22 indicated that a wellness program was in operation and completed the questionnaire. A brief summary for each responding institution appears in Appendix D. The conceptual bases for wellness programs were identified through key word analyses. By combining key words, wellness is defined as optimal health and fitness involving the physical, emotional, mental, and spiritual self, through lifestyle choices, to maximize the quality of life or well-being of the individual.

Specific goals for the individual were to increase the level of wellness; assess risks, lifestyle and

physical fitness; reduce those risk factors; and develop an awareness of healthy living. Primary institutional goals were to increase productivity, reduce health care costs, reduce absenteeism, and reduce turnover.

Physical fitness, nutritional awareness, and weight control were ranked one, two, and three, respectively, as components emphasized in program offerings. The services provided were: fitness assessment, group exercise programs, exercise prescription, medical screening, and personal evaluation/feedback. Risk assessment, educational classes, and reinforcement were also found to be a part of the program.

Conclusions

Wellness programs were found at all types of educational institutions in Texas. Combining the pilot study and the full study, wellness programs were identified in 11 independent school districts, 13 junior/community colleges, and 8 colleges/universities. Especially encouraging was the number of programs in independent school districts and community colleges.

The independent school district programs tend to be found in and around the cities of Dallas and Houston. It is this researcher's contention that the influence of the Institute for Aerobics Research in Dallas and the corporate fitness programs in Dallas and Houston have been instrumental in promoting program development in these

two areas of the state. The TEA Wellness Workshops also encouraged and guided this program development.

The junior/community colleges have been most prolific in incorporating wellness programs into their structure. The close ties of the college to the community and the active role of the health services department may have combined forces for this phenomenon to occur.

The medium-sized and/or private university, where there tends to be more concern for the individual, have led the way toward wellness on their campuses. The small number of colleges/universities responding may be misleading. The delimitation of university enrollment may have excluded colleges where programs may be in operation.

Program design, in most cases, appeared to be thoroughly researched, planned, and organized. A few programs seemed to be less organized, involving fewer components and services with less structure. This may indicate that development of programs may have been spontaneous, resulting in less structure. If such is the case, more planning is needed to further develop and enhance the structure and to be able to call the program "wellness." As it is very important to evaluate the success of wellness programs, the goals and objectives need to be identified more specifically for both the individual and the institution. The reported goals for the institution followed this general format. They could

be stated more specifically, though, by using numbers or percentages of reduction. The goals for the individual, however, were too broad and general to be easily measured and evaluated to monitor success for the individual. For educators to espouse measurable and specific performance and behavioral objectives and not design them for their own programs indicates a lack of planning or lack of commitment to the concept of goal setting.

Although the definitions express the holistic concept, the actual topical offerings do not. In reality, it is difficult to separate some of the components. Physical fitness, nutrition, weight control, and even stress management can be linked to one another in the pursuit of wellness. It is important to convey this holistic approach in our program model, program offerings, and services. If we are concerned with the "whole person," we should develop program offerings with more philosophical concepts in mind. Recognizing that these concepts may be a part of other components in an existential way, we still could do more to develop an awareness of the whole self within this framework.

The researcher has designed "The Wellness Umbrella" to express the top 10 components that are emphasized in wellness programs in Texas educational institutions (Figure 7). Physical fitness has been identified as the standard component for all wellness models and programs. Nutritional awareness follows closely in importance.

Weight control and diet programs could easily come under either of these headings and are actually related to both components. Stress awareness and stress management are included in wellness, with relaxation techniques as one mode for management. Habit control, primarily smoking and alcohol, are important for so many people to be healthy and to achieve wellness, both physically and emotionally. Emotional well-being of the individual is affected by all the dimensions, with self-responsibility as the supporting structure to achieve high level wellness. This "Wellness Umbrella" provides protection of the individual in his/her quest for wellness.

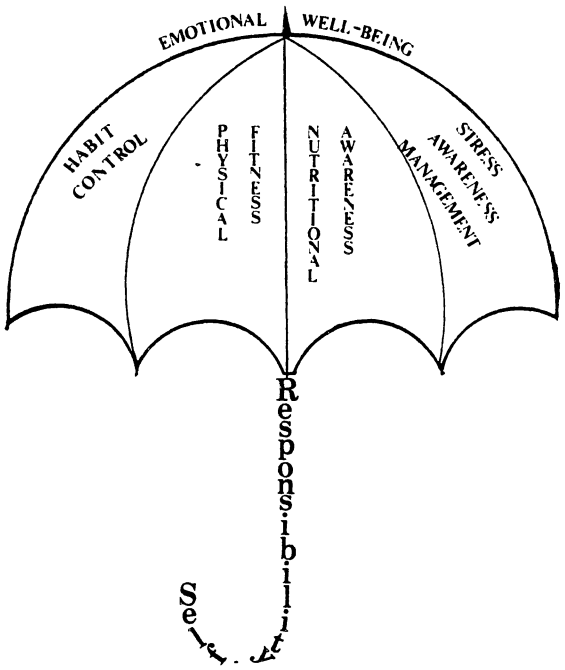

Figure 7. The Wellness Umbrella

There seems to be little doubt as to the services that should be incorporated within a wellness program. The size of the institution, financial resources, and a wellness commitment by the administration may be the key factors to implement all the services indicated. Benefit packages for employees could be attractive for future teacher bargaining. Private funding and combining resources with local businesses may be another alternative to establishing wellness programs in educational institutions where funding may be limited.

From the definitions, models, and components reported in the literature and identified in this study, one can recognize the all-encompassing concept of wellness. However, the present wellness programs in Texas are not carrying out this concept as completely as they could or should. This may be the consequence of young programs, wherein depth will be added as the programs mature and our understanding of wellness becomes greater. We must work toward this expansion of the wellness concept within the program design to truly be identified as wellness programs. Wellness, however, is not only the ultimate goal but also a process. It can easily be seen as a continuum or hierarchy with basic physical health leading to emotional well-being and high level wellness. There are many small component steps individuals may take at different times in their lives, with varying degrees of intensity, to be living a wellness lifestyle.

Anything and everything we do within all the different components are, in fact, a part of wellness and ultimately may lead to a higher level of wellness.

Recommendations

This study has provided a knowledge base for Texas educational institutions. It is recommended that a support network be developed for planning and implementation of employee wellness programs at all educational levels. The Wellness Directory may provide wellness leaders with assistance in program planning. The TEA should continue to offer wellness workshops for district teams. Higher education, by providing research bases, needs to share their program ideas and lend support to all agencies wishing to sponsor wellness programs.

Educational curricula needs to be designed for the less emphasized, but important, components of wellness. Teaching and marketing strategies need to be developed for the intellectual, social, spiritual, and emotional components. By including them in program offerings, one would demonstrate their importance in the holistic concept of wellness.

The program offerings need to be broadened, also, to meet the needs and interests of more employees. Not all people respond to exercise programs but may respond to an intellectually challenging experience. This may provide

one with new awarenesses that could lead to other wellness components.

The conceptual bases of wellness programs have been examined in this study. Extended research is needed in program evaluation to justify the program. By evaluating the program through the established goals, one may provide the impetus for further development of wellness programs in other educational institutions.

The diversity of definitions reported here should lead others to investigate further the all-encompassing aspects of wellness. More needs to be done to better clarify the similarities and differences between, and among, the concepts of wellness, health promotion, and holistic health.

What educational institutions in Texas are doing within their wellness programs can provide a starting point for further investigation in other venues, in other states, and around the world. The wellness movement, as a new standard for healthy living, has only just begun. With educational institutions' influence of future generations, starting with the employee as a model, the wellness lifestyle may become an accepted way of life.

A SELECTED BIBLIOGRAPHY

Allen, R. F. Lifegain. New York: Appleton-Century-Crofts, 1981.

Ardell, D. B. 14 Days to a Wellness Lifestyle. Mill Valley, California: Whatever, 1982.

Ardell, D. B. High Level Wellness: An Alternative to Doctors, Drugs and Disease. Emmaus, Pennsylvania: Rodale, 1977a.

Ardell, D. B. "High Level Wellness Strategies." Health Education, 8 (July/August, 1977b), pp. 2-4.

Ardell, D. B. "The Nature and Implications of High Level Wellness, or Why 'Normal Health' is a Rather Sorry State of Existence." Health Values: Achieving High Level Wellness, 3 (January/February, 1979), pp. 17-24.

Bailey, K. D. Methods of Social Research, 2nd ed. New York: Free Press, 1982.

Banks, R. "Health and the Spiritual Dimension: Relationships and Interpretations for Professional Preparation Programs." Journal of School Health, 50 (April, 1980), pp. 195-202.

Baranowski, T. "Toward the Definition of Concepts of Health and Disease, Wellness and Illness." Health Values: Achieving High Level Wellness, 5 (November/December, 1981), pp. 246-256.

Baun, W. B. "Tenneco Health and Fitness." JOPERD, 54 (October, 1983), pp. 40-41.

Benson, H. The Relaxation Response. New York: Avon, 1975.

Blair, S. N., Collingwood, T. R., Reynolds, R., Smith, M., Hagan, R. D., and Sterling, C. L. "Health Promotion for Educators: Impact on Health Behaviors, Satisfaction and General Well-Being." American Journal of Public Health, 74 (February, 1984), pp. 147-149.

Brennan, A. J. "Health Promotion at the Worksite." Journal of School Health, 51 (January, 1981), pp. 65-66.

Carlyon, W. H. "Reflections: Disease Prevention/Health Promotion--Bridging the Gap to Wellness." Health Values: Achieving High Level Wellness, 8 (May/June, 1984), pp. 27-30.

Carter, G. F. "Health is a Status." Health Education, 15 (January/February, 1984), pp. 33-35.

Chen, M. S. and Jones, R. M. "Preparing Health Educators for the Workplace: A University Health Insurance Co. Alliance." Health Values: Achieving High Level Wellness, 6 (November/December, 1982), pp. 9-12.

Clark, C. C., Ed. "Wellness in the Workplace." The Wellness Newsletter, 5 (September/October, 1984), pp. 4-5.

Cmich, D. E. "Theoretical Perspectives of Holistic Health." Journal of School Health, 54 (January, 1984), pp. 30-32.

Cohen, M. S. "The Student Wellness Resource Center: A Holistic Approach to Student Health." Health Values: Achieving High Level Wellness, 4 (September/October, 1980), pp. 209-212.

Collingwood, T. R. "The Aerobics Fitness and Well-Being Program." (Unpub. manuscript, Dallas Independent School District and the Institute for Aerobics Research, Dallas, Texas, 1982.)

Collingwood, T. R. "Fledgling Programs Prove Good Business." Business Insurance (February 2, 1981), p. 21.

Collingwood, T. R., Blair, S. N., Reynolds, R., Sterling, C., and Collins, R. "Health and Fitness Promotion to Affect Teacher Stress and Absenteeism." (Unpub. manuscript, Institute for Aerobics Research, Dallas, Texas, 1983.)

Cooper, K. H. The Aerobics Program for Total Well-Being. New York: M. Evans, 1982.

Cooper, K. H. and Collingwood, T. R. "Physical Fitness: Programming Issues for Total Well-Being." JOPERD, 55 (March, 1984), pp. 35-36.

Craig, D. H. "Healthy Planet, Healthy People." Health Education, 14 (September/October, 1983), pp. 9-11.

Crase, D., Hamrick, M. H., and Rosato, F. D. "Emerging Consciousness: Health, Wellness and a Quality of Life." Health Education, 10 (September/October, 1979), pp. 4-7.

Curtis, J. D. and Detert, R. A. How to Relax: A Holistic Approach to Stress Management. Palo Alto, California: Mayfield, 1981.

Dinkmeyer, D. and Dinkmeyer, D., Jr. "Holistic Approaches to Health." Elementary School Guidance and Counseling, 14 (December, 1979), pp. 108-112.

Drolet, J. C. and Davis, L. G. "Seaside--A Model for School Health Education Inservice." Health Education, 15 (May/June, 1984), pp. 25-32.

Dunn, H. L. High Level Wellness. Arlington, Virginia: R. W. Beatty, 1961.

Edington, D. W. "Models of Validity." Corporate Fitness and Recreation (October/November, 1983), p. 44.

Engelhardt, L. J. "Wellness Models for Self Regulation, Nutrition and Self-Discovery." (Unpub. Ph.D. dissertation, University of Northern Colorado, 1980.)

Falck, V. T. and Kilcoyne, M. E., Jr. "A Health Promotion Program for School Personnel." Journal of School Health, 54 (August, 1984), pp. 239-243.

Flynn, R. B. and Berg, K. "Community Health Promotion and Wellness." JOPERD, 55 (March, 1984), pp. 37-39.

Fulbright, C. S. and Harris, B. M. "Evaluating the Wellness Lifestyle Conference." (Unpub. manuscript, Texas Education Agency, Austin, Texas, 1982.)

Glover, E. D. "Health Education in Texas." Journal of School Health, 54 (September, 1984), pp. 310-311.

Goldstein, J. E. "Fitness=Wellness: The New Military Equation." Parks and Recreation, 18 (December, 1983, pp. 36-37.

Gross, S. J. "The Holistic Health Movement." Personnel and Guidance Journal, 59 (October, 1980), pp. 96-100.

Hettler, B. "Wellness: Encouraging a Lifetime Pursuit of Excellence." Health Values: Achieving High Level Wellness, 8 (July/August, 1984), pp. 13-17.

Hettler, B. "Wellness Promotion on a University Campus." Family and Community Health, 3 (1980), pp. 77-95.

Hettler, G. W., III. "High Level Wellness: A Quality of Life." Health Values: Achieving High Level Wellness, 7 (November/December, 1983), pp. 31-35.

Holroyd, R. T. "Aerobics in the Classroom." Parkway (August, 1983), pp. 17-18.

Howell, J. "Wellness for the Practitioners." JOPERD, 54 (October, 1983), pp. 37-55.

Iverson, D. C. and Kolbe, L. J. "Evolution of the National Disease Prevention and Health Promotion Strategy: Establishing a Role for the Schools." Journal of School Health, 53 (May, 1983), pp. 294-302.

Love, M., Morphis, L., and Page, P. "Model for an Employee Wellness Project." Journal of the American College Health Association, 29 (February, 1981), pp. 171-173.

Lovett, E. D. "The Wellness Resource Center." Journal of the American College Health Association, 26 (February, 1978), pp. 178-182.

McCrory, M. and Baker, B. Class notes, Oklahoma State University, Summer, 1984.

Mitchell B. "Personalized Aerobics Lifestyle System." (Unpub. manuscript, Institute for Aerobics Research, Dallas, Texas, 1984.)

Nakamura, R. M. and Lescault, C. M. "Health Behavior Survey of California School Health Educators." Journal of School Health, 53 (November, 1983), pp. 557-560.

Perry, C. "Health Promotion at School: Expanding the Potential for Prevention." School Psychology Review, 13 (Winter, 1984), pp. 141-149.

Petosa, R. "Wellness: An Emerging Opportunity for Health Education." Health Education, 15 (October/November, 1984), pp. 37-39.

Phillips, J., Jr. and Allen, G. E. "Industrial Health Education: A Model." Health Values: Achieving High Level Wellness, 3 (March/April, 1979), pp. 95-98.

Pollock, M. L., Wilmore, J. H., and Fox, S. M. Health and Fitness Through Physical Activity. New York: John Wiley, 1978.

President's Council on Physical Fitness and Sports (PCPFS). Fitness Fundamentals: Guidelines for Personal Exercise Programs. Washington, D.C.: U.S. Government Printing Office, 1984.

Reynolds, R. "Student Lifestyle and Wellness--A Process for Change." (Paper presented at the TAHPERD Convenion, San Antonio, Texas, November, 1984.)

Richard, E. "A Rationale for Incorporating Wellness Programs Into Existing Occupational Health Programs." Occupational Health Nursing, 32 (August, 1984), pp. 412-415.

Ryan, R. S. and Travis, J. W. The Wellness Workbook. Berkeley: Ten Speed, 1981.

Selye, H. Stress Without Distress. Philadelphia: J. B. Lippincott, 1974.

Shields, S. L. "The Physical Education Profession in the Corporate Sector." JOPERD, 55 (March, 1984), pp. 32-34.

Sorenson, R. E. "Wellness: A Virtue for Medical Cost Containment." Health Education, 10 (September/October, 1979), pp. 19-22.

South Caroline Department of Health Education. "Open Door: A Peer Health Enrichment Center." (Unpub. manuscript, Columbia, South Carolina, 1984.)

Tager, M. J. "Creating Wellness in Your Schools." School Administrator, 40 (October, 1983), pp. 24-26.

Taub, A. "Health Promotion in Industry: The Role of the University." Health Education, 14 (July/August, 1983), pp. 9-11.

Texas Education Agency (TEA). Texas School Directory, 1984-84. Austin: Texas Education Agency, October, 1983.

Texas Sports Guide of High Schools and Colleges, 1984-85. El Paso: Craftsman, 1984.

U.S. Department of Health, Education and Welfare. Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention. Washington, D.C.: U.S. Government Printing Office, 1979a.

U.S. Department of Health, Education and Welfare. Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention. Background Papers. Washington, D.C.: U.S. Government Printing Office, 1979b.

Vierke, S. "The Lifestyle Program: Moving Toward High Level Wellness." Health Values: Achieving High Level Wellness, 4 (September/October, 1980), pp. 237-241.

Warner, M. J. "Wellness Promotion in Higher Education." NASPA Journal, 21 (Winter, 1984), pp. 32-38.

Whitaker, L. A. "Student Health and the Community College." ERIC, ED 151030 (December, 1977).

Wiersma, W. Research Methods in Education. Itasca, Illinois: Peacock, 1975.

World Health Organization. "Constitution of the World Health Organization." Chronicle of the World Health Organization, I(1-2) (1947), pp. 29-43.

APPENDIXES

APPENDIX A

WELLNESS PROGRAM QUESTIONNAIRE

WELLNESS PROGRAM QUESTIONNAIRE

Instructions: Check the appropriate category or fill in the blank.

I. General Information

Educational Institution:

_____Independent School District

_____AAAAA _____AAAA _____Other:(please specify)_____.

_____Jr./Community College

_____Public College

_____Private College

_____Public University

_____Private University

Our wellness program is entitled_____.

The program was first implemented in _____Semester 19_____.

Our wellness program is designed for: (Check all that apply)

_____Administration

_____Faculty

_____Staff

_____Student's

_____Spouse

_____Family

_____Community

_____Other:(please specify)_____

The total number of faculty/staff/students eligible for the wellness program are: _____faculty _____staff _____students

The total number of participants in the wellness program are:

_____faculty _____staff _____students _____other

The wellness program is under the auspices of the:

_____Health Services Dept.

_____Health Dept.

_____Physical Education Dept.

_____Recreation Dept.

_____Student Services

_____Personnel Dept.

_____Other:(please specify)_____

The position of director is a:

_____part-time position

_____full-time position

_____volunteer position

_____other:(please specify)_____

II. Concept Information

There are many definitions of wellness being used in the general research literature today. Our operational definition of wellness is:(please be complete)

Is this an original definition?_____Yes/No If no, please cite the reference:_____

_____

Goals and objectives are an important part of educational planning. The stated goals for the individual participant are:

The stated goals for the institution are:

Please list any other basic concepts under which you operate your wellness program.

III. Program Information

Recognizing that all the following components are important to wellness, which ones do you emphasize through program offerings? Please check the appropriate column for the components as to their emphasis in your program.

1-never a part of program offerings
2-rarely a part of program offerings
3-sometimes a part of program offerings
4-often a part of program offerings
5-always a part of program offerings

Component	Never 1	Rarely 2	Sometimes 3	Often 4	Always 5
physical fitness					
nutritional awareness					
diet programs					
weight control					
stress awareness					
stress management					
time management					
relaxation techniques					
habit control: smoking					
alcohol					
drugs					
safety					
environmental awareness					
medical resources/services					

Realizing the following components are less structured, more philosophical, which ones do you emphasize through specific program offerings?

intellectual challenges					
emotional well-being					
occupational satisfaction					
values/spiritual awareness					
social relationships					
community involvement					
other:_____					
other:_____					

Please identify the following services as to their role in your program. Please check the appropriate column.

1-never a part of the program
2-rarely a part of the program
3-sometimes a part of the program
4-often a part of the program
5-always a part of the program

Service	Never 1	Rarely 2	Sometimes 3	Often 4	Always 5
medical screening					
fitness assessment					
risk assessment					
goal setting/contracting					
exercise prescription					
nutrition prescription					
group exercise programs					
educational classes					
motivation/incentives					
reinforcement					
personal evaluation/feedback					
program evaluation					
feedback					
monitoring participation					
other:_____					

Is there any aspect of your program that is special that you would like to share.(please make additional comments on back)

_____Please sign here if you grant permission to the researcher to identify your program and institution in the research report.

_____Please check here if you wish to receive a summary of the results of the research.

Thank you for your time and effort. The questionnaire is coded for response records, however, confidentiality is guaranteed.

WELLNESS PROGRAM QUESTIONNAIRE

Instructions: Check the appropriate category or fill in the blank.

I. General Information

Educational Institution

_____5A Independent School District
_____4A Independent School District
_____Jr./Community College
_____College
_____University

Our wellness program is entitled_____.

The program has been in operation for:

_____0-1Year _____2 Years _____3 Years _____4 Years _____5 Years

Our wellness program is designed for: (Check all that apply)

_____Administration
_____Faculty
_____Staff
_____Students
_____Spouse
_____Family
_____Community
_____Other:(please specify)_____

The wellness program is under the auspices of the:

_____Health Services Dept.
_____Health Dept.
_____Physical Education Dept.
_____Recreation Dept.
_____Student Services
_____Personnel Dept.
_____Other:(please specify)_____

The position of director is a:

_____part-time position

_____full-time position

_____volunteer position

_____other:(please specify)_____

II. Concept Information

There are many definitions of wellness being used in the general research literature today. Our operational definition of wellness is:(please be complete)

Goals and objectives are an important part of educational planning. The stated goals for the individual participant are:

The stated goals for the institution are:

Please list any other basic concepts under which you operate your wellness program.

III. Program Information

Recognizing that all the following components are important to wellness, which ones do you emphasize through program offerings? Please check the appropriate column for the components as to their emphasis in your program.

1-never a part of program offerings
2-rarely a part of program offerings
3-sometimes a part of program offerings
4-often a part of program offerings
5-always a part of program offerings

Component	Never 1	Rarely 2	Sometimes 3	Often 4	Always 5
physical fitness					
nutritional awareness					
diet programs					
weight control					
stress awareness					
stress management					
time management					
relaxation techniques					
habit control: smoking					
alcohol					
drugs					
safety					
environmental awareness					
medical resources/services					

Realizing the following components are less structured, more philosophical, which ones do you emphasize through specific program offerings?

intellectual challenges					
emotional well-being					
occupational satisfaction					
values/spiritual awareness					
social relationships					
community involvement					

Programs may be described according to the services provided. Please identify the following services as to their role in your program. Please check the appropriate column.

1-never a part of the program
2-rarely a part of the program
3-sometimes a part of the program
4-often a part of the program
5-always a part of the program

Service	Never 1	Rarely 2	Sometimes 3	Often 4	Always 5
medical screening					
fitness assessment					
risk assessment					
goal setting/contracting					
exercise prescription					
nutrition prescription					
group exercise programs					
educational classes					
motivation/incentives					
reinforcement					
personal evaluation/feedback					
program evaluation					
feedback					
monitoring participation					

Is there any aspect of your program that is special that you would like to share with others?

_____Please sign here if you grant permission to the researcher to identify your program and institution in the research report.

_____Please check here if you wish to receive a summary of the results.

Thank you for your time and effort. The questionnaire is coded for response records, however, confidentiality is guaranteed.

APPENDIX B

CORRESPONDENCE

November 5, 1984

Dear Wellness Director:

We are in the midst of a wellness revolution. Through an increased concern for optimal health and total well-being, Texas has become a leader in establishing wellness programs in business and in educational institutions. A wellness program is defined as a program that attempts to improve the health status of those it serves. Your educational institution has been identified as being a leader in this movement. Your expertise is needed to assist others in establishing quality programs in wellness.

As a doctoral candidate at Oklahoma State University and member of the American Alliance for Health, Physical Education, Recreation and Dance's Task Force on Wellness, I am asking for your help in defining wellness and in identifying the goals, components, and services of your program on the enclosed questionnaire. Although the questionnaire looks rather lengthy, it will only take about 20 minutes to complete. There are no right or wrong answers. You will not personally be identified and your answers will be treated confidentially. Institutional confidentiality will be maintained unless you grant permission to describe your program and identify it with your institution.

Please answer all the questions to the best of your ability and return in the stamped, self-addressed envelope. I would appreciate any printed materials describing your program; however, this is not necessary for my research.

Please return the questionnaire as soon as possible. Thank you for your assistance in this research endeavor.

Sincerely,

Barbara R. Lawson
913 Valentine Dr.
Sherman, Texas 75090
(214) 892-4865

Memo

Date: November 5, 1984

To: Wellness Director/Director of Health Services

From: Barbara R. Lawson, Wellness Researcher

We are in the midst of a wellness revolution. Educational institutions in Texas are leading the way in providing wellness programs for employees and students. A wellness program is defined as a program that attempts to improve the health status of those it serves. Are you involved in one of these programs?

If you are directly involved in the leadership of a wellness program, please respond to the enclosed questionnaire; if not, please route it to the individual(s) most responsible for the program. If there is no structured program in process, please return the enclosed questionnaire in the stamped, self-addressed envelope so I will not send follow-up information.

Your assistance in identifying model programs and directors will be valuable to me in my research and later to the development of future programs in Texas and nationwide.

If routing to another person, please remove this memo. Thank you for your assistance in this research endeavor.

November 26, 1984

Dear Wellness Director:

A few weeks ago I mailed you a questionnaire concerning the wellness program in your institution. I wonder if you received it? In the event you did not, I am enclosing another. Your institution has been identified as a leader in the wellness movement and your expertise in wellness is needed to promote positive health throughout our educational system. A wellness program is defined as a program that attempts to improve the health status of those it serves.

As a doctoral candidate at Oklahoma State University and member of the American Alliance for Health, Physical Education, Recreation and Dance's Task Force on Wellness, I am asking for your help in defining wellness and in identifying the goals, components, and services of your program. You will not personally be identified and your answers will be treated confidentially.

Will you please take the time now to complete the questionnaire and return it in the stamped, self-addressed envelope? I would appreciate any printed materials describing your problem; however, this is not necessary for my research. If there is no structured program in process, please return the enclosed questionnaire in the stamped, self-addressed envelope so I will not send follow-up information.

Thank you for your time and effort in this research endeavor.

Sincerely,

Barbara R. Lawson
913 Valentine Dr.
Sherman, Texas 75090
(214) 892-4865

A REMINDER

You are responsible for your quest for wellness. You are also special to me in my quest for information on your wellness program. Would you please fill in the Wellness Program Questionnaire and return it today?

If you have already responded, thank you and please disregard this notice.

Sincerely,

Barbara R. Lawson
913 Valentine Dr.
Sherman, Texas 75090
(214) 892-4865

APPENDIX C

WELLNESS PROGRAM DIRECTORY

WELLNESS DIRECTORY

Doug Monaghen
Alief ISD
P. O. Box 68
Alief, Tx 77411

Carol Champion
Allen ISD
Box 13
Allen, Tx 75002

Gayle Jones
Amarillo ISD
910 W. 8th
Amarillo, Tx 79101

Dean Watson
Dallas ISD
3700 Ross Ave.
Dallas, Tx 75204

Billie McCann
El Paso ISD
Box 20100
El Paso, Tx 79998

Betty Blakely
HPER Director
Houstin ISD
3830 Richmond Ave.
Houston, Tx 77027

Pam Erwin
Hurst/Euless/Bedford ISD
1849 Central Dr.
Bedford, Tx 76021

Marcella Porter
Elementary PE Consult.
Irving ISD
Box 2637
Irving, Tx 75061

Lillian Morava
LaPorte ISD
301 E. Fairmont Pkwy.
LaPorte, Tx 77571

Melanie Packwood
Mesquite ISD
405 E. Davis
Mesquite, Tx 75149

Jake Swan
Plano ISD
1517 Ave. H
Plano, Tx 75074

Joe McDaniel
Spring Branch ISD
955 Campbell Rd.Box 19432
Houston, Tx 77024

Bob Stock
Brookhaven CC
3939 Valley View Ln.
Farmers Branch, Tx 75244

Donnine Ballance
Cedar Valley CC
3030 N. Dallas Ave.
Lancaster, Tx 75134

Cheri Reynolds
Eastfield CC
3737 Motley Dr.
Mesquite, Tx 75150

John Hutchingson
El Centro CC
Main and Lamar Sts.
Dallas, Tx 75202

Rose Mary Valladaled
El Paso CC
P. O. Box 20500
El Paso, Tx 79998

McLennan CC
1400 College Dr.
Waco, Tx 76708

Leon Dulin
Midland College
3600 N. Garfield
Midland, Tx 79701

Robert S. Williams
No. Harris CC
2700 W Thorne Dr.
Houston, Tx 77073

Wellness Directory, cont.

Karen Iannicilli
North Lake CC
5001 N. MacArthur Blvd.
Irving, Tx 75038

Ms Lawrence
Odessa College
201 W. University
Odessa, Tx 79764

Paula Vastine
Tarrant CC
828 Harwood Rd.
Hurst, Tx 76053

Don Woods
Texarkana CC
1024 Tucker
Texarkana, Tx 75501

Marvene Wallace
Texas Southmost College
80 Fort BRown
Brownsville, Tx 78520

Nancy Patton
Box 13857
Phys. Ed. Division
North Texas State University
Denton, Tx 76203

Dr. Neil Hattlestad
Dept. of P.E.
Sam Houston State University
Huntsville, Tx 77341

Dr. Berdie Barr
SMU WEllness Program-Personnel Services
Southern Methodist University
Dallas, Tx 75275

Dr. Tinker Murry
Southwest Texas State University
San Marcos, Tx 78666

Dr. Charolette Gibbons
Dept. of Health and P.E.
160 E. Kyle
Texas A & M University
College Station, Tx 77843

Dr. Linda King
Director of the Wellness Center
P. O. Box 23717
TWU Station
Denton, Tx 76204

Dr. Grover(Rusty) Pippin
Dept. Of HPER
The University of Texas at Arlington
Arlington, Tx 76019

Dr. Keith McCoy
University of Texas at Tyler
3900 University Blvd.
Tyler, Tx 75701

Dr. Mary Hill
Dept. of Health and P.E.
West Texas State University
Box 216
Canyon, Tx 79015

APPENDIX D

INSTITUTIONAL RESPONSE SUMMARY

INSTITUTIONAL RESPONSE SUMMARY

The institutional responses are briefly summarized here for their definitions, goals, components and services. Key words are used where appropriate and components and services are coded according to the following:

Components: (C)

1. Physical fitness
2. Nutritional awareness
3. Weight control
4. Diet programs
5. Stress awareness
6. Stress management
7. Habit: smoking
8. Emotional
9. Relaxation techniques
10. Habit: alcohol
11. Habit: drugs
12. Medical resources/services
13. Safety
14. Occupational
15. Intellectual
16. Social
17. Environmental
18. Values/spiritual awareness
19. Community
20. Time management

Services: (S)

1. Fitness assessment
2. Group ex. program
3. Exercise prescription
4. Medical screening
5. Personal evaluation
6. Risk assessment
7. Ed. classes
8. Reinforcement
9. Feedback
10. Motivational incentives
11. Nutrition prescription
12. Program evaluation
13. Monitoring participation
14. Goal setting/contracting

Components and services are listed by those which were selected as "always a part of the program" on the Likert scale. Individual goals will be "I" and institutional goals will be "II".

TYPE I INDEPENDENT SCHOOL DISTRICTS

Def: healthy lifestyle choices, promote health improvement/ disease prevention, increase quality of life
I. achieve high level wellness, participate in health promotion programs
II. enhance productivity, reduce health care costs
C. 1,2,3
S. 1-6, 14
*****
Def: Good care: physical self, use mind constructively, express emotions effectively, creatively involved, concern for physical, psychological and spiritual environment
I. increase level of wellness, more effective teachers
II. more productivity, reduced absences
C. 1-8, 10-12, 16, 19
S. 1,2, 5-10, 12, 13
*****

Def: Justification: rationale and benefits
I. improve health knowledge and attitude, reduce risks, improve quality of life, enhance self esteem and problem-solving capacities
II. reduce medical care costs, improve morale and productivity, reduce absenteeism and turnover, increase ease of recruitment, enhance community image
C. 1,2
S. 1-13
*****
I. improve health/fitness, to change unhealthy behavior and accept responsibility for health, provide fun programs for social environment
II. improve employee morale, reduce absenteeism, reduce insurance utilyzation, increase productivity, improve image
C./S. none ranked "always"
*****
Def: enhance productivity through fitness and health awareness program
I./II. educational opportunities, improve health, decrease absenteeism, reduce health care costs, offer variety of activities, improve employee/employer relationship, appreciate vital role of exercise, sense of camaraderie/team spirit
C. 1,2,8,13,15,
S. 1,2,4,5,9,10,12-14
*****
Def: program which seeks to improve lifestyle
I. become more active through exercise
II. reduce absenteeism, improve morale, improve benefit package, gather health data
C. 1
S. 2
*****
Def: stress, fitness, nutrition, self responsibility
I/II. improve fitness and health, reduce absenteeism, reduce health care costs, improve morale
C./S. none ranked "always"
*****
C. 3
S. 1,2,5
*****

TYPE II COMMUNITY COLLEGES

Def: optimal physical, mental, emotional, spiritual well-being
C. 1,2,5,8,12,14
S. 1,2,4-10,11,12,14
*****

Def: positive state of health, maximizing the quality of life
I. determine health risks, learn how to reduce risks, formulate lifestyle changes
II. encourage health consciousness, provide programs to improve health status
C. 1-3,5-7,9-13,17
S. 6
*****
Def: total fitness, unity of spirit, mind, body, functional to maximum potential
I. recognize interrelationship of physical fitness to lifetime components, weight control and reduction of stress
C. 1-7,9-11,15,16,18
S. 1-3,5,7,8,10,11
*****
Def: maximal physical and mental well-being
I. knowledge of nutrition, effective exercise program, maintain health, body weight and % body fat
II. improve efficiency and morale, reduce insurance claims
C. none ranked "always"
S. 8
*****
Def: positive state of health, taking responsibility, whole person
I. achieve and maintain optimal health and fitness
C. 1,2
S. 1,4,6
*****
Def: active process, aware of and make choices, more successful existence(Hettler)
I. provide lifestyle behavior information,assess risks, health consciousness, wellness role models
C. all
S. all
*****
I. reach target goals(cv, flexibility,strength,body composition)
II. reach students and community to start on road to fitness
C. 1,7,10,11
S. 1,3,14
*****
Def: develop physical and emotional fitness to enjoy life to its fullest
I. enhance self worth, develop physical fitness, relieve stress, develop nutritional awareness, social relationships, diet programs
II. provide for individual needs, exercise stress, nutrition
C. 1,2,5-9,12,14
S. 1-13
*****

Def: living to one's fullest possible mental, physical, and spiritual health
I. physical, assessment, fitness prescription, present programs
II. increase employee morale, increase productivity, decrease health care costs
C. 1-4
S. 1-3,5-8,11
*****
C./S. none ranked "always"
*****

TYPE III UNIVERSITIES

Def: interrelationship of emotional, mental, physical, and social dimensions, improve quality of life, strive for optimal well-being
I. improve quality of life: reduce cv disease, smoking cessation, decrease stress, improve nutritional awareness, increase safety awareness
C. none ranked "always"
S. 1,2,4,6
*****
Def: an attitude, an approach to life, work(O'Connell and Ainsworth)
I. aware of health fitness practices, behavioral changes
II. identify risk factors, maintain health costs at current level, maintain occurance and frequency of absenteeism, maintain functional capacity of employee
C. 1-4
S. 1-9,11-14
*****
Def: program utilyzing components of health related fitness, lifetime commitment
I. educate participants on wellness, encourage adoption of lifetime program
C. 1-6,19
S. 1-4,6,7,11,14
*****
Def: movement toward optimal health
I. individual health program
II. research, professional experiences for students, discretionary money for department, community modeling
C. 1-4,8,12,15,16
S. 1-7,9,11,13
*****

VITA 2

Barbara Ruth Lawson

Candidate for the Degree of

Doctor of Education

Thesis: THE IDENTIFICATION AND ANALYSIS OF SELECTED WELLNESS PROGRAMS IN EDUCATIONAL INSTITUTIONS IN THE STATE OF TEXAS

Major Field: Higher Education

Minor Field: Health, Physical Education and Leisure Services

Biographical:

Personal Data: Born in East Cleveland, Ohio, February 19, 1945, the daughter of Ralph E. Wilcoxon and Marian B. Wilcoxon. Married to Sylvan L. Lawson on March 2, 1980.

Education: Graduated from Euclid Senior High School, Euclid, Ohio, in June, 1963: received Bachelor of Science in Education degree from Miami University in August, 1967: received Master of Science degree from Arizona State University in August, 1977: completed requirements for the Doctor of Education degree at Oklahoma State University in July, 1985.

Professional Experience: Physical Education Instructor, Wheaton North High School, August, 1967 to June, 1969, and at Elmwood Park High School, August, 1969 to June, 1976; Graduate Assistant, Department of Physical Education, Arizona State University, August, 1976 to June, 1977; Assistant Professor of Physical Education at Austin College, August, 1977 to July, 1984; Wellness Consultant, July, 1984 to present.

Professional Associations: American Alliance for Health, Physical Education, Recreation and

Health, Physical Education, Recreation, and Dance; National Association for Physical Education in Higher Education; Womens' Sports Foundation; United States Volleyball Association; American Red Cross.

Honors: Notable Women of Texas, 1984-85; Texas Intercollegiate Athletic Association, Tennis Coach of the Year, 1983.

Scholarly Endeavors: Psychological Aspects of Female College Athletes, Master's Thesis; Competency-Based Physical Education, Austin College Curriculum Study; Office Stress Management Project, J. C. Penney, Dallas Accounting Center.