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ARTICLES

Promoting Overall Health and Wellness Among Clients: The Relevance and Role of Professional Counselors

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Given the rise in health care costs and the premature morbidity and mortality rates in the United States, the authors discuss the relevant constructs of wellness and holistic health as they relate and apply to the profession of counseling. Implications and application of the Indivisible Self model of wellness (J. E. Myers & T. J. Sweeney, 2004) in counseling are highlighted.

A movement in the profession of counseling incorporates a wellness philosophy and wellness-oriented approach within the counseling change process. The construct of *wellness* pertains to an orientation of lifestyle in which body, mind, and spirit are fully integrated in efforts to achieve an optimal state of health and well-being (Myers, Sweeney, & Witmer, 2000). Wellness, according to Myers et al. (2000), involves the physical, social, psychological, emotional, intellectual, and environmental dimensions of life. According to Ardell and Langdon (1989), quality of life is an important aspect of wellness. Hence, the term *wellness* involves the intentional act of embracing health-enhancing values, motives, and behaviors in efforts to promote good health. Simply put, wellness involves an individual's ability to achieve and maintain healthy living.

Definitions of wellness and health diverge depending on the professional specialty (e.g., psychology, counseling, education, medicine; Compton, Smith, Cornish, & Qualls, 1996). To illustrate contemporary thinking about health and wellness, Arnold and Breen (1998) conceptualized health as an empowerment among communities, groups, and individuals as they strive to improve and advance their particular health aims. In this context, health care professionals equip individuals and groups to better function in and contribute to their communities and society as a whole. This concept is congruent with the

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counseling profession's overarching goal of assisting clients to maintain a lifestyle of optimal health and healthy living. Current models of wellness illustrate a shift from a set of restricted, narrow characteristics toward a more holistic, integrated perspective (Savolaine & Granello, 2002). Consequently, wellness paradigms represent a reevaluation of the traditional pathogenic biomedical model of health care and emphasize instead the entire spectrum of health that includes health-promoting variables (Gordon, 1981).

THE CONSTRUCT OF HOLISTIC HEALTH

Gross (1980) defined *holistic health* as "practices and philosophies that consider total individuals in their approaches to well-being" (p. 96). The major themes of this construct revolve around prevention of illness, the implementation of alternative methods in the treatment of illness, and ultimately the achievement of good health and personal fulfillment (Gross, 1980). In essence, the construct of holistic health includes the advocacy of the interconnectedness of mind and body, healthy living, and a balanced lifestyle (Ardell, 1985).

The term *wholeness* has historical roots within ancient Greece. Grounded in Greek philosophy, the word *holistic* is a derivative of *halo*, meaning "whole" (Gross, 1980; Witmer & Sweeney, 1992). A prominent aspect of the Greek medical tradition as well as the Jewish healing tradition was the notion of treating the whole person, thereby conceptualizing an interrelated, interdependent relationship between mind and body.

The concept of holistic health dates back thousands of years to ancient Middle Eastern religions. The idea of holism evolved into an accepted notion during the 1920s when Jan Smuts, a South African philosopher, conceptualized *holism* as the belief that the whole, as in a living entity, is more than the sum of its parts (Gordon, 1981; Gross, 1980; Tamm, 1993). Dunn (1961), the initiator of the contemporary wellness movement, further associated the concept of wellness with holism when he alluded to the significance of progress toward fostering high-level wellness; living life to one's fullest potential; and developing an integrated body, mind, and spirit. This integrated approach to health represents a deliberate effort to prevail over the long-standing mind–body duality in Western science and medicine. At present, Western society is experiencing a rebirth of the idea of holism as it pertains to the study, understanding, and cultivation of good health and well-being.

Dunn (1961) was not alone in advocating the importance of a holistic approach to health and wellness. Theorists from several mental health orientations have noted the importance of holism and the interdependent dynamism of wellness. Alfred Adler, Carl Jung, Abraham Maslow, and Carl Rogers have each contributed to the current understanding of holistic wellness (Britzman & Main, 1990; Myers, Sweeney, & Witmer, 2001). Each of these theorists recognized the importance of healthy functioning and identified a constellation of constructs (e.g.,

integration of the whole, individuation, self-actualization) deemed essential to healthy living. Their scholarly endeavors drew attention to individuals' inherent potential for change and positive, holistic growth (Seligman, 2001; Vecchione, 1999).

HEALTH CARE IN THE UNITED STATES: A CURRENT STATE OF AFFAIRS

At the start of the 20th century, the average life expectancy for individuals in the United States was 47 years (Hampl, Anderson, & Mullis, 2002). By 2004, life expectancy at birth had risen to approximately 77.8 years (Arias, 2007; Miniño, Heron, Murphy, & Kochanek, 2007). Advancements in preventive medicine, vaccinations, risk factor identification, medical treatments, and sanitation have all contributed to this increased longevity.

Although the rise in average life expectancy represents true progress, it has also presented new problems for the health field. At the same time that life expectancies are rising, the prevalence of chronic disease has reached epidemic levels. Currently, approximately 70% of all deaths in the United States are caused by chronic disease (Centers for Disease Control and Prevention [CDC], 2003, 2004). Recent estimates suggest that cardiovascular disease, including high blood pressure, coronary heart disease, heart failure, and stroke, affects approximately one out of every three American adults (Rosamond et al., 2008). In 2005, the incidence of diabetes was approximately 20.8 million, or 7% of the total population, including an estimated 6.2 million undiagnosed cases (CDC, 2005a). More than 125 million Americans (40%) live with at least one chronic condition, and roughly 30 million (10%) have major functional limitations resulting from chronic diseases, some to the extent that they can no longer perform basic activities of daily living (CDC, 2003).

Health care expenditures have also grown at an alarming rate. In 1970, $74.9 billion, or $356 per person, was spent on health care in the U.S. economy (government, personal, and employer health care expenses). This amounted to 7.2% of the gross domestic product (Catlin, Cowan, Hartman, Heffler, & National Health Expenditure Accounts Team, 2008). By 2006, $2.1 trillion dollars were allocated to health care, or approximately $7,026 per person. This equated to 16.0% of the gross domestic product for the country (Catlin et al., 2008). Collectively, these data suggest that even when taking population growth and inflation into account, the growth in health care spending has substantially outpaced the growth of the overall economy, and a larger percentage of our nation's resources are being allocated to providing medical care (Morgan, 2004).

Not surprisingly, there is a direct link between the growing problems of rising health care costs and chronic disease. It has been estimated that 75% of health care spending is on treating patients with chronic disease (Anderson & Horvath, 2004; CDC, 2003, 2004). In 2005, expenditures on heart disease and stroke

exceeded $394 billion, including $242 billion in direct costs and $152 billion in indirect costs (e.g., lost productivity, premature death), and $60 billion was spent on treating hypertension (American Heart Association, 2005). In 2002, diabetes cost the United States $92 billion in direct costs and $40 billion in indirect costs. Furthermore, average health care costs are five times higher for individuals with diabetes in comparison with costs for nondiabetic individuals ($13,243 vs. $2,560; CDC, 2005b). Finally, the total cost of obesity generally in the U.S. economy was estimated to be $117 billion in 2000, including $61 billion in direct and $56 billion in indirect costs (CDC, 2005c). These statistics highlight the tremendous potential of the prevention of chronic disease to alleviate both economic strain and human suffering. In recent years, the pressing realities of rising health care costs and alarming rates of premature morbidity and mortality have inspired a wellness movement nationwide (Cowen, 1994; Warner, 1984).

A NEED FOR CHANGE

Two key factors lie at the root of the current health crisis in the United States. The first is that the health care system has traditionally been reactive, rather than proactive. Professionals in the mental health field, for instance, have focused their efforts on the achievement of three goals: (a) to ameliorate psychopathology, (b) to understand the etiologies and processes that lead to psychopathology, and (c) to repair and restore mental health by means of psychotherapy (Cowen, 1994). From a historical perspective, mental health professionals have filled a reactive, remedial role that is reparative in nature. The historical roots of mental health were governed and driven by a desire to understand disorders of the psyche. Cowen (1994) best highlighted this point as he evaluated the current system of mental health and the need for a system change that underscores the promotion of long-term health and wellness from the start, rather than supporting efforts to repair well-established pathology. Cowen (1994) stated,

> Baldly put, the current mental health system is reactive, not proactive! Its time, efforts, and resources are allocated to visible, deeply rooted, change-resistant problems. Known limitations of this system raise the salience of a conceptually appealing alternative, that is, systematic effort to promote wellness from the start may prove to be a more humane, cost-effective, and successful strategy than struggling, however valiantly and compassionately, to undo established deficits in wellness. (p. 151)

Similar trends can be seen in the field of medicine, where the traditional focus has been on the development and implementation of treatments for exist-

ing chronic disease. Notably, although per capita health care spending in the United States is the highest in the world, the United States ranked only 19th in the world for life expectancy of women and 22nd for that of men as of 2000 (World Health Organization, 2002). Although there are many reasons for the inefficiencies in the U.S. health care system, a major factor is that tremendous sums of money are spent on expensive treatment of well-established diseases. However, the vast majority of deaths are attributable to five chronic, lifestyle-related diseases: heart disease, cancer, stroke, chronic obstructive pulmonary disease, and diabetes (National Center for Health Statistics, 2007). It has been estimated that approximately one third of all deaths in the United States are attributable to three key modifiable behaviors: smoking, lack of exercise, and poor nutritional habits (CDC, 2003). Alcohol, drug use, and poor stress management are also major contributors to premature morbidity and mortality in the United States (Hampl et al., 2002).

Since the first Surgeon General's report on smoking and health (Advisory Committee to the Surgeon General, 1964), tobacco use has been a major target of health promotion and wellness efforts. Despite impressive reductions in tobacco use, smoking remains the leading preventable cause of death in the United States. From 1995 to 1999, smoking caused approximately 440,000 premature deaths each year in the United States (CDC, 2002). About 8.6 million Americans have at least one chronic disease caused by smoking, including chronic pulmonary disease (i.e., emphysema and chronic bronchitis), coronary heart disease, stroke, and cancer. Considered from an economic perspective, smoking costs $96 billion in direct health care expenditures and $97 billion in lost productivity each year (CDC, 2008b). Currently, nearly 45.4 million American adults smoke, of whom close to 70% want to stop (CDC, 2005d).

Poor nutrition and lack of physical activity have also been causally linked to numerous chronic diseases. Exercise has been formally prescribed for health promotion since at least 2500 BC (MacAuley, 1994). Unfortunately, the increasingly industrialized and mechanized U.S. society and an abundance of sedentary forms of entertainment have made a sedentary lifestyle easy and comfortable. Reduced energy expenditure because of physical inactivity, coupled with an abundance of calorie-dense, inexpensive, and convenient food choices have led to an epidemic of obesity. Obesity has been linked to higher death rates in comparison with death rates for people of normal weight (Flegal, Graubard, Williamson, & Gail, 2005). In addition, epidemiological and physiological studies have consistently linked obesity with diabetes and hypertension. Currently, approximately two thirds of Americans are overweight or obese, with more than 34% obese (Ogden et al., 2006; Ogden, Carroll, McDowell, & Flegal, 2007). Even among those who are not overweight or obese, insufficient exercise increases the risk of cardiovascular disease, diabetes, osteoporosis, several forms of cancer, and depression. Although most people know that it is healthy to exercise and eat properly, less than 50% of Americans exercise enough to

improve their health, and 25% report no leisure-time physical activity. Similarly, in 2005, only one in three American adults ate at least two servings of fruit daily, and one in four reported consuming at least three servings of vegetables daily (CDC, 2008a).

Collectively, the aforementioned statistics highlight the tremendous harm that poor lifestyle choices have on physical health. Conversely, they also demonstrate the tremendous potential that primary prevention and improvement of lifestyle choices could have for reducing premature morbidity and mortality that result from chronic diseases and for slowing the growth in health care costs.

A second major factor that has contributed to the current health crisis is that traditionally, health education has more frequently been focused on physical wellness, whereas mental health counseling has been focused on promoting emotional, social, and occupational well-being (Chandler, Holden, & Kolander, 1992). Similarly, since the 17th century, scientific thinking has been dominated by a mechanistic focus of medicine, which split mind and spirit from the body. The medical profession operationalized the construct of health from the perspective of states of ill-health and disease. Consequently, the medical professions did not promote wellness and optimal functioning. Accordingly, prior philosophical efforts to understand the nature of human wellness did not achieve a central position in the understanding of the etiology of physical illness (Ryff & Singer, 1998).

An appreciation for the mental, emotional, social, and spiritual components, as well as the physical, biological, and physiological dimensions, of individuals represent a holistic paradigm for health care and medicine (Gordon, 1981; Ryff & Singer, 1998). Recent studies illustrate a growing national trend in individuals seeking integrated holistic approaches to health promotion and improvement in quality of life (Rakel, 1999). The target outcome has become the achievement of good health, not just the cure of pathology (Gordon, 1981).

THE ROLE OF WELLNESS COUNSELING

From a multifaceted, systems perspective, the delivery of wellness counseling on the part of professional counselors is fundamental in response to the rising health care expenditures in the United States for two primary reasons. First, wellness counseling focuses on the prevention of developing lifestyle-related, chronic disease, and second, the process of wellness counseling involves client education and identifying how clients can become proactive at improving their lifestyle and maintaining good health and well-being. Empowering individuals to take a proactive role in their own health choices and facilitating their progress toward a holistic and healthy lifestyle has the potential, therefore, to reduce chronic disease as well as health care costs.

Perhaps Granello (2000) best illuminated how the role and identity of professional counselors are integral with the goals of primary prevention and

the promotion of wellness when he stated that "mental health professionals may be uniquely suited to assisting clients with the psychological and social mediators that may effect health and wellness behaviors" (p. 13). Empowering people to make better lifestyle choices will undoubtedly require a multifaceted approach incorporating governmental, community-based, work site, school, and individual initiatives. Specifically, professional counselors who incorporate a wellness paradigm when counseling individuals can contribute to promoting change in health attitudes, beliefs, behaviors, and lifestyles to facilitate healthy, productive living (Pender, 1996), especially when they work in the settings of health-related services such as hospitals, clinics, and community mental health centers, as well as in private practice and schools. The challenge facing professional counselors, regardless of the setting in which they practice, is to assist clients in recognizing and identifying factors that contribute to as well as inhibit their advancement in achieving overall wellness (Cowen, 1991).

Threats to wellness and quality of life, as previously noted, vary from unhealthy lifestyle habits that consequently lead to states of ill-health, to significant social contexts (e.g., dysfunctional family environments), to disruptive life circumstances (e.g., divorce). Taking into consideration the myriad events and mediating variables that threaten individuals' sense of well-being, it is paramount that counselors embrace a systemic, team-oriented perspective in their wellness work by consulting with and referring clients to appropriate professionals on the basis of their clients' needs and areas of their lives that are deficient in wellness (Cowen, 1991).

THE INDIVISIBLE SELF MODEL: A CONCEPTUAL FRAMEWORK OF WELLNESS COUNSELING

According to Hartwig and Myers (2003), comprehensive models of holistic wellness underscore both healthy and unhealthy lifestyle-related behaviors and, accordingly, both build on and aspire to increase the strengths of individuals. Given the strength-based perspective that they incorporate, wellness paradigms are preferred to the traditional medical models in this endeavor. Regarding the construct of wellness, there is significant focus on the achievement of optimal health, empowerment, and the recognition of individual potential as well as strengths (Cowen, 1991; Hartwig & Myers, 2003).

During the past several decades, the profession of counseling has witnessed the emergence of several models of wellness that delineate specific psychological, physical, and sociological variables that contribute to wellness (Granello, 2000). The most commonly noted wellness paradigms in the counseling profession are those of Hettler (1980), Zimper (1992), and Sweeney and Witmer (1991), as well as Witmer and Sweeney's (1992) Wheel of Wellness and, more recently, Myers and Sweeney's (2004) Indivisible Self model of wellness. According to Myers et

al. (2000), a contemporary paradigm of wellness is offered as "an alternative to the traditional illness-based medical model for treatment of mental and physical disorders" (p. 251). Myers et al. (2000) proposed that wellness incorporates a state of optimal health and well-being wherein full integration of body, mind, and spirit lead to individuals living more fully and living well.

In 1992, Witmer and Sweeney created the Wheel of Wellness, the first model of wellness centered in counseling theory. Although existing ideas supported the concept of wellness, this model provided a unique and theory-based perspective, using Adler's Individual Psychology as a unifying theme of its explanation of well-being (Myers & Sweeney, 2004). In 2004, Myers and Sweeney presented a new evidence-based model of wellness based on the Wheel of Wellness—the Indivisible Self model—that represented a paradigm for conceptualizing wellness across the life span. The Indivisible Self model of wellness consists of 17 distinct dimensions of wellness, five second-order factors, and one higher order wellness factor. The five second-order factors are the Essential Self, Social Self, Creative Self, Physical Self, and Coping Self. The five second-order factors constitute the self, also referred to as the *indivisible self*. The 17 discrete dimensions of wellness are the following: spirituality, self-care, gender identity, cultural identity, thinking, emotions, control, positive humor, work, friendship, love, realistic beliefs, stress management, self-worth, leisure, exercise, and nutrition. The total score that is calculated from the sum of scores on the 17 subscales derived from the dimensions of wellness is the higher order wellness factor.

The second-order factors that form the basis of organization for the 17 dimensions of wellness are divided into five conceptual groups in the following manner: (a) the Essential Self comprises the dimensions of spirituality, self-care, gender identity, and cultural identity; (b) the Creative Self consists of the thinking, emotions, control, positive humor, and work dimensions; (c) the Social Self involves the dimensions of friendship and love; (d) the Coping Self is organized according to the four dimensions of realistic beliefs, stress management, self-worth, and leisure; and (e) the Physical Self consists of the exercise and nutrition dimensions (Myers & Sweeney, 2004).

Fundamental to the execution of wellness counseling is the introduction of the Indivisible Self model of wellness to clients with the hope that it will allow them to identify important lifestyle-related behaviors that either promote positive growth or detract from wellness. First, the counselor defines wellness, explains the wellness model, and describes how lifestyle behaviors either move individuals toward wellness or restrict their achievement of wellness. Next, clients' level of wellness is assessed on both an informal and a formal basis. Formal assessment of wellness occurs with the use of the Five Factor Wellness Inventory (5F-Wel; Myers, Sweeney, & Witmer, 2001). Then, clients identify wellness dimensions included in the Indivisible Self model of wellness in which they

desire greater wellness. Counselor and client collaborate to develop a written personal wellness plan specific to the acknowledged dimensions. The task is to develop a wellness plan that involves achievable, measurable, and realistic goals; timelines; concrete objectives; and techniques for outcome measurement. In doing so, the specific nature of such a wellness plan is to serve as a baseline to measure client progress as well as a starting point for clients to initiate making healthy lifestyle choices (Granello, 2000). It is important to note that wellness plans should only target one or two dimensions of wellness at a time that clients wish to modify and improve (Granello, 2000; Myers et al., 2000). The counseling process is then tailored to and focused on the one or two dimensions for which clients desire a change and enhanced wellness. As part of the educational process of wellness counseling, it is important that counselors inform clients of the reciprocal, interdependent relationships among the 17 dimensions of wellness identified in the Indivisible Self model. In other words, effecting change and influence in one or two areas of wellness, such as stress management and leisure, will create a ripple effect and inevitably bring about change in other areas of a client's life, with the ultimate hope of enhancing his or her overall quality of life.

COUNSELING INTERVENTIONS TO PROMOTE WELLNESS

The clinical formulation for promoting optimal functioning and wellness of body and mind in clients involves the implementation of various counseling skills and techniques throughout the counseling change process. The Indivisible Self model is a valuable asset in determining the most efficacious counseling interventions to achieve greater client wellness. As previously outlined, clients first assess, prioritize, and target one or two dimensions that they perceive as deficient in wellness, after which counselors choose the most effective therapeutic interventions related to the dimensions clients wish to change (Granello, 2000). According to Granello, clinical tools that counselors often incorporate in wellness work include education, cognitive behavioral interventions, behavioral change techniques, and various skills training for clients including relaxation and stress management and social skills.

IMPLICATIONS FOR PROFESSIONAL COUNSELORS

Wellness counseling can have far-reaching implications for improving clients' quality of life and enhancing their health promotion and optimal functioning. A well-structured, comprehensive wellness paradigm can serve as a departure from the costly remedial, reactive treatment approaches that are often used in traditional health care in the United States. Using a holistic wellness paradigm when counseling individuals provides a blueprint for distinguishing and assessing the multiple dimensions identified in the Indivisible Self model of wellness (e.g.,

self-care, self-worth, spirituality, and friendship) that converge in individuals' lives to either strengthen or weaken overall quality of life. Rather than simply targeting clients' presenting concerns, problems, and dysfunctions, counselors can conceptualize and assess the whole person. By counseling individuals as whole persons, counselors become skilled and efficacious at helping clients take inventory of the many aspects of their life, including the physical, intellectual, psychological, social, emotional, and environmental dimensions, that ultimately converge and influence their overall state of health and well-being.

Counseling from a wellness paradigm requires counselors to be holistic in their clinical practice and delivery of counseling techniques. It is important for counselors to be cognizant of practicing within the bounds of their competence when engaged in wellness work with clients. For instance, professional counselors should be cautious when advising clients on exercise regimens or nutritional plans. Collaboration with professionals in other specialties and making appropriate referrals to specialists such as certified nutritionists, physical fitness trainers, and physicians are essential components for counselors to incorporate when counseling clients within a wellness paradigm (Granello, 2000).

CONCLUSION

In the United States, the 21st century represents an era in which lifestyle choices have led to an epidemic of lifestyle-related illness and early mortality. The majority of premature illnesses and deaths in the United States are not the consequence of infectious diseases and famines, but a result of poor health habits, including excessive drinking, smoking, physical inactivity, and poor nutrition, that place people at risk for developing cardiovascular disease, stroke, diabetes, cancer, and other chronic diseases. The interconnectedness between poor health habits and development of chronic disease highlights the fact that many health-related behavioral choices have the potential to either increase or decrease overall well-being. A principal focal point of the paradigm of wellness continues to be primary prevention and the promotion of healthy living. Achieving wellness is conceptualized as a proactive approach that is reachable and inclusive of all persons. More than anything else, a counseling philosophy grounded in wellness challenges the long-established "fix it when it's not right approach" (Hatfield & Hatfield, 1992, p. 164) by focusing on prevention rather than remediation. When counselors embrace a wellness, holistic approach when counseling individuals, they apply the philosophy of systematically working with and tending to the whole person (Witmer & Sweeney, 1992). The implementation of such an approach to counseling represents a multidimensional perspective to assist clients in creating and achieving a wellness-oriented lifestyle.

As stated earlier, counseling from a wellness paradigm requires counselors to use an extensive holistic and broad-based approach to their work with clients. A wellness approach to counseling requires knowledge of a variety of theories

because wellness work involves use of a wide spectrum of counseling-related tasks that are tailored to the specific needs of individual clients. However, the themes of wellness counseling involve promoting good health and, ultimately, preventing lifestyle-related diseases by substituting poor health behaviors with health-enhancing behaviors. Hence, the direction of wellness counseling may diverge depending on whether one is counseling mentally healthy clients who wish to improve their overall quality of life or counseling clients who are diagnosed with mental illness and wish to alleviate or manage symptoms. Regardless, the premise of wellness counseling remains the initiation and pursuit of optimal functioning.

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