Best Practices

Wellness Counseling: The Evidence Base for Practice

Jane E. Myers and Thomas J. Sweeney

Wellness conceptualized as *the* paradigm for counseling provides strength-based strategies for assessing clients, conceptualizing issues developmentally, and planning interventions to remediate dysfunction and optimize growth. Wellness counseling models have stimulated significant research that helps to form the evidence base for practice in the counseling field. The development of these models is explained, results of studies using the models are reviewed, and implications for research needed to further inform clinical practice and advocacy efforts are discussed.

> WHEREAS, optimum physical, intellectual, social, occupational, emotional, and spiritual development are worthy goals for all individuals within our society; and
> WHEREAS, research in virtually every discipline concerned with human development supports the benefits of wellness for both longevity and quality of life over the life span; and
> WHEREAS, the AACD [ACA] membership subscribe to values which promote optimum health and wellness;
> THEREFORE BE IT RESOLVED that the Governing Council of AACD [ACA] declare a position for the profession as advocates for policies and programs in all segments of our society which promote and support optimum health and wellness; and
> BE IT FURTHER RESOLVED that AACD [ACA] support the counseling . . . professions' position as an advocate toward a goal of optimum health and wellness within our society.
>
> —*Resolution of the Governing Council of the American Association for Counseling and Development (AACD), now the American Counseling Association (ACA)*

This resolution, titled *The Counseling Profession as Advocates for Optimum Health and Wellness,* was adopted by the Governing Council of the American Association for Counseling and Development (AACD), now the American Counseling Association (ACA), July 13, 1989. Rather than being a radical departure from prior goals, the resolution represented a renewed commitment to the history and philosophical foundations of the counseling profession as a whole. Sweeney (1995, 2001) reviewed the evolution of counseling as a profession and underscored its roots in a developmental guidance approach. These roots go back almost a century to seminal writings such as those of Jones (1934), who stated that "guidance is based upon the fact that human beings need help… in order that decisions may be made wisely" (p. 3). Today, concern in the profession for helping people make wise decisions is reflected in a philosophy variously defined in terms such as *prevention* (Derzon, 2006), *development* (American School Counselor Association [ASCA], 2003), and *wellness* (Myers & Sweeney, 2005a), terms that share common tenets and, as a consequence, are often used interchangeably (Myers, 1992).

In contrast to counseling, the roots of wellness go back almost 2,000 years. The Greek philosopher Aristotle, writing in the 5th century B.C., was perhaps the first person to write about wellness. His goal in doing so was to offer a scientific explanation for health and illness and to define a model of good health in which one seeks for "nothing in excess." During the Middle Ages, Descartes and others who defined the scientific revolution proposed a duality of mind and body that resulted in a fragmented approach to interpreting human functioning. Only within the latter half of the 20th century has a new paradigm in medicine emerged in which body, mind, and spirit are seen as integral to understanding both health and wellness (Larson, 1999). This new paradigm is consistent with the World Health Organization's (WHO) definition of health as "physical, mental, and social well-being, not merely the absence of disease" (1958, p. 1). Health in this context is a neutral concept, with wellness defined as a positive state of well-being on a continuum that ranges from illness at one extreme, through health in the middle, to high-level wellness at the other extreme (Travis & Ryan, 1988).

Professional counselors seek to encourage wellness, a positive state of well-being, through developmental, preventive, and wellness-enhancing interventions. Although these interventions are based in a philosophy of care, ethical practice requires the use of evidence-based techniques. In fact, the *ACA Code of Ethics* (ACA, 2005) states clearly that "counselors have a responsibility to the

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public to engage in counseling practices that are based on rigorous research methodologies" (p. 9). Following a review of research in the counseling field, Sexton (2001) noted the urgent need for evidence-based models to inform clinical practice and remarked that "moving toward evidence-based counseling practice … has been, and continues to be, a struggle within counseling" (p. 499). The purpose of this article was to address that struggle in a positive manner, by presenting both wellness models based in counseling and a review of the evidence underlying those models.

Although several models of wellness have been proposed in the counseling literature (e.g., Chandler, Holden, & Kolander, 1992), in our search, we were able to locate empirical studies in support of only two counseling-based wellness models, the Wheel of Wellness (Myers, Sweeney, & Witmer, 2000; Sweeney & Witmer, 1991; Witmer & Sweeney, 1992) and the Indivisible Self (Myers & Sweeney, 2005a, 2005e). The sources reviewed included 29 completed doctoral dissertations, several dissertations currently in progress, 19 published studies that were not based on dissertation research, and several additional studies in print or in press in counseling journals. Studies using other models and related assessment instruments (e.g., The Lifestyle Assessment Questionnaire and Testwell, both National Wellness Institute [1983] instruments based in Hettler's [1984] hexagon model) were excluded from this review because of their academic base in disciplines other than counseling. Implications for research needed to inform clinical practice in counseling with the goal of enhancing wellness and advocacy for greater wellness in various client populations are discussed.

The Wheel of Wellness: A Theoretical Model

The first wellness model was developed by Hettler, who is widely viewed as "the father" of the modern wellness movement. Although models such as Hettler's (1984) hexagon were presented as holistic, in practical use their emphasis was primarily on physical health. In addition, the concept of life span development was not included in these early models (B. Hettler, personal communication, December 1992). In a move away from the predominant models that were based in physical health sciences, Sweeney and Witmer (1991) and Witmer and Sweeney (1992) developed the first model of wellness that is based in counseling.

Myers et al. (2000) defined wellness as

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

This definition is the basis for the Wheel of Wellness (Sweeney & Witmer, 1991; Witmer & Sweeney, 1992), a theoretical model that emerged from reviews of cross-disciplinary studies in which we sought to identify correlates of health, quality of life, and longevity. Using Adlerian Individual Psychology (Adler, 1927/1954; Ansbacher & Ansbacher, 1967; Sweeney, 1998) as an organizing principle, Myers et al. (2000) proposed relationships among 12 components of wellness depicted graphically in a wheel. Following early research with this model, it was expanded and refined, with 17 components depicted in the final version of the Wheel of Wellness (see Figure 1; Myers et al., 2000) that interact with contextual and global forces to influence holistic well-being.

As shown in Figure 1, spirituality is depicted as the center of the wheel and the most important characteristic of well-being. The components of spirituality include having a sense of meaning in life in addition to religious or spiritual beliefs and practices. Radiating from the center of the Wheel of Wellness is a series of 12 spokes in the life task of self-direction: sense of worth, sense of control, realistic beliefs, emotional awareness and coping, sense of humor, nutrition, exercise, self-care, stress management, gender identity, and cultural identity. These spokes help to regulate or direct the self as a person responds to the Adlerian life tasks of work and leisure, friendship, and love. The model is proposed as an ecological one in that life forces, such as the media and the government, are shown as affecting the wellness of individuals. In addition, we hypothesized that all of the components of wellness are interactive and that change in one area causes or contributes to changes in other areas of the model as well.

The Wheel of Wellness is the basis of an assessment instrument, the Wellness Evaluation of Lifestyle (WEL; Myers, Sweeney, & Witmer, 1998), and has been widely used in workshops, seminars, and empirical studies. The Wheel of Wellness remains a useful tool

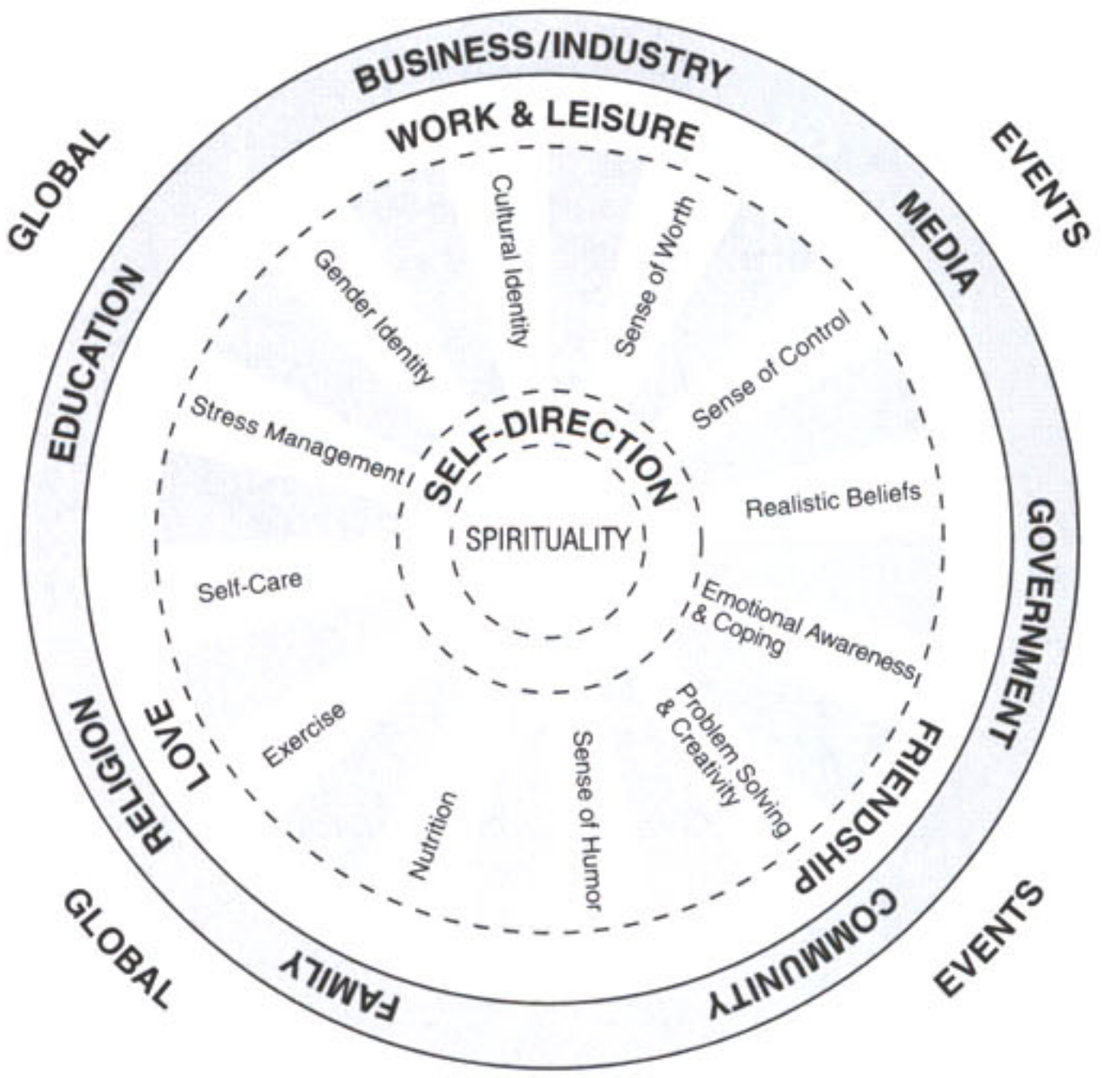

FIGURE 1

The Wheel of Wellness

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for professional counselors as a guide for both formal and informal assessment and for wellness-oriented counseling. Feedback we have received from professional counselors in the United States and other countries suggests that the placement of spirituality as the core characteristic of a well person has an intuitive and almost universal appeal. However, after years of study using the Wheel of Wellness model and the WEL, statistical analyses failed to support the hypothesized circumplex structure and the centrality of spirituality relative to other components of wellness.

The Indivisible Self: An Evidence-Based Model of Wellness

Hattie, Myers, and Sweeney (2004) analyzed the database of 5,380 persons that was developed during 7 years using the WEL inventory. Through structural equation modeling, they determined a three-level factor structure that included a single higher order wellness factor that was based on the total number of items in the WEL inventory and five second-order factors. Hattie et al. confirmed the original 17 components of the Wheel of Wellness as discrete third-order factors; however, the components did not fall into groups as originally hypothesized. After additional study, Myers and Sweeney (2005a, 2005e) developed the Indivisible Self (IS-Wel) model, shown in Figure 2 as an evidence-based model of wellness.

Nearly 6 years spanned the time between the development of the structural model by Hattie et al. (2004) and an explanation of the factors that defined the model. During that time, we sought to make sense of the difference between the theory and the empirical findings, particularly the emergence of Wellness as a single, preeminent factor. Eventually, using Adlerian theory as an organizing principle proved to be the key both to providing continuity with the earlier, theoretical Wheel of Wellness model and to providing a coherent explanation of the new structural model. Adler (1927/1954) was emphatic in his belief in the unity and indivisibility of the self, observing that human beings, are more than the sum of our parts and cannot be divided. This foundation of holism became the explanation of the new model in which the self is at the core of wellness and is depicted graphically (and ultimately statistically) as indivisible.

It was difficult to make sense of the five second-order factors of the self—Creative, Coping, Social, Essential, and Physical—because, as do most researchers, we found it hard to abandon the original theoretical groupings of the 17 components of wellness. These same 17 components were now clearly defined as third-order factors but with different interrelationships than we had originally hypothesized. Defining the second-order factors required (a) a new study of the third-order factors and the new groupings of these factors within the second-order factor structure and (b) a return to Adlerian theory. Myers and

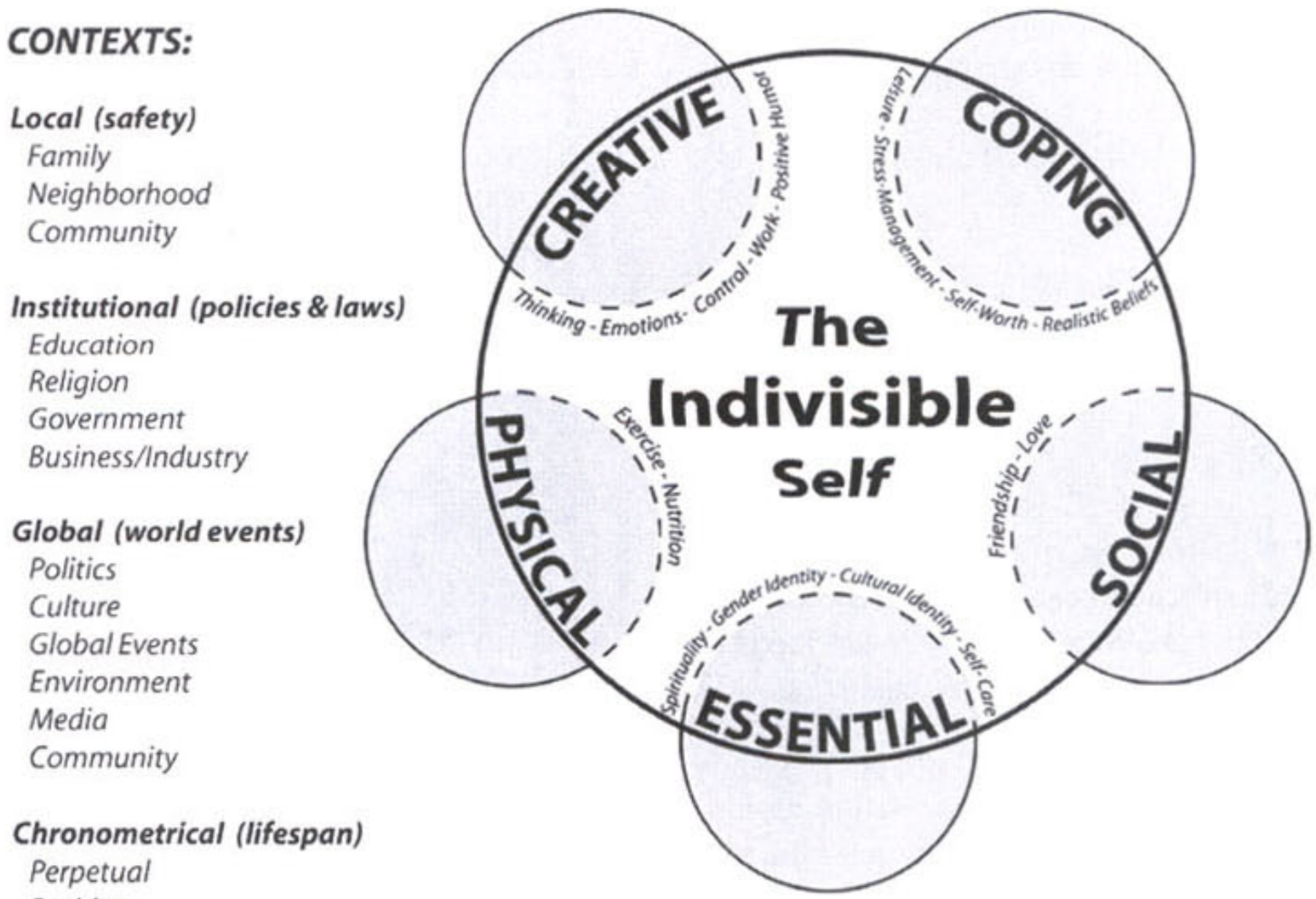

FIGURE 2

The Indivisible Self: An Evidence-Based Model of Wellness

Note. Creative = Creative Self; Coping = Coping Self; Social = Social Self; Essential = Essential Self; Physical = Physical Self. From *The Indivisible Self: An Evidence-Based Model of Wellness,* by T. J. Sweeney and J. E. Myers, 2003, Greensboro, NC: Author. Copyright 2003 by T. J. Sweeney and J. E. Myers. Reprinted with permission.

Sweeney (2005a) provided an extensive description of the factors and their grounding in Adlerian concepts (see Table 1 for an abbreviated description of each factor).

In a way that is similar to the Wheel of Wellness's use, the IS-Wel model can help counseling clients to assess their wellness and consider behaviors and choices to increase their wellness in multiple areas. Unlike the Wheel of Wellness, the interaction of components in the IS-Wel model is not hypothetical, but empirical. We can state with some certainty that the factors in the IS-Wel model do indeed interact, that change in one area will contribute to or cause change in other areas, and that change can be for better or for worse. The IS-Wel model also is ecological, with four contexts presented as integral to individual wellness: *local*, *instructional*, *global*, and *chronometrical*. To date, however, empirical studies have been conducted only on the local context, with outcomes supporting the importance of this factor for overall wellness (Tatar & Myers, in press). The components of the IS-Wel model are measured using the Five Factor Wellness Inventory (5F-Wel; Myers, Sweeney, & Witmer, 1998; Myers & Sweeney, 2005b, 2005f), with versions

TABLE 1

Abbreviated Definitions of Components of the Indivisible Self Model

Wellness Factor	Definition
Total Wellness	The sum of all items on the 5F-Wel; a measure of one's general well-being or total wellness
Creative Self	The combination of attributes that each of us forms to make a unique place among others in our social interactions and to positively interpret our world
Thinking	Being mentally active, open-minded; having the ability to be creative and experimental; having a sense of curiosity, a need to know and to learn; the ability to solve problems
Emotions	Being aware of or in touch with one's feelings; being able to experience and express one's feelings appropriately, both positive and negative
Control	Belief that one can usually achieve the goals one sets for oneself; having a sense of planfulness in life; being able to be assertive in expressing one's needs
Work	Being satisfied with one's work; having adequate financial security; feeling that one's skills are used appropriately; the ability to cope with workplace stress
Positive Humor	Being able to laugh at one's own mistakes and the unexpected things that happen; the ability to use humor to accomplish even serious tasks
Coping Self	The combination of elements that regulate one's responses to life events and provide a means to transcend the negative effects of these events
Leisure	Activities done in one's free time; satisfaction with one's leisure activities; having at least one activity in which "I lose myself and time stands still"
Stress Management	General perception of one's own self-management or self-regulation; seeing change as an opportunity for growth; ongoing self-monitoring and assessment of one's coping resources
Self-Worth	Accepting who and what one is, positive qualities along with imperfections; valuing oneself as a unique individual
Realistic Beliefs	Understanding that perfection and being loved by everyone are impossible goals, and having the courage to be imperfect
Social Self	Social support through connections with others in friendships and intimate relationships, including family ties
Friendship	Social relationships that involve a connection with others individually or in community, but that do not have a marital, sexual, or familial commitment; having friends in whom one can trust and who can provide emotional, material, or informational support when needed
Love	The ability to be intimate, trusting, and self-disclosing with another person; having a family or family-like support system characterized by shared spiritual values, the ability to solve conflict in a mutually respectful way, healthy communication styles, and mutual appreciation
Essential Self	Essential meaning-making processes in relation to life, self, and others
Spirituality	Personal beliefs and behaviors that are practiced as part of the recognition that a person is more than the material aspects of mind and body
Gender Identity	Satisfaction with one's gender; feeling supported in one's gender; transcendence of gender identity (i.e., ability to be androgynous)
Cultural Identity	Satisfaction with one's cultural identity; feeling supported in one's cultural identity; transcendence of one's cultural identity
Self-Care	Taking responsibility for one's wellness through self-care and safety habits that are preventive in nature; minimizing the harmful effects of pollution in one's environment
Physical Self	The biological and physiological processes that compose the physical aspects of a person's development and functioning
Exercise	Engaging in sufficient physical activity to keep in good physical condition; maintaining flexibility through stretching
Nutrition	Eating a nutritionally balanced diet, maintaining a normal weight (i.e., within 15% of the ideal), and avoiding overeating
Contexts	
Local context	Systems in which one lives most often—families, neighborhoods, and communities—and one's perceptions of safety in these systems
Institutional context	Social and political systems that affect one's daily functioning and serve to empower or limit development in obvious and subtle ways, including education, religion, government, and the media
Global context	Factors such as politics, culture, global events, and the environment that connect one to others around the world
Chronometrical context	Growth, movement, and change in the time dimension that are perpetual, of necessity positive, and purposeful

Note. 5F-Wel = Five Factor Wellness Inventory.

for adults (5F-Wel-A; Myers & Sweeney, 2005b), for middle school students (5F-Wel-T; Myers & Sweeney, 2005d), and for elementary school students (5F-Wel-E; Myers & Sweeney, 2005c), as well as several cultural adaptations in languages other than English (see the Wellness Counseling Research section). As has its predecessor the WEL, the 5F-Wel has been used extensively in counseling research.

Wellness Counseling Research

The WEL and the 5F-Wel have been used in multiple studies over the past 15 years, primarily as outcome measures or dependent variables, and have been used to study wellness in relation to diverse psychological constructs and demographic indices. They have also been used for program evaluation and to examine the success of wellness counseling interventions. In this section, studies of wellness are organized into five main sections: wellness of noncounselor populations; wellness of counselors-in-training, professional counselors, and counselor educators; correlates of wellness; cross-cultural and cross-national studies; and outcome research. (*Note.* Doctoral dissertations are listed in Table 2 and referenced in the text by date and with the identifier DD but are not included in the reference list because of space limitations.) Additional research and published studies on wellness using the Wheel of Wellness and IS-Wel models were reviewed. These studies were obtained through searches of the PsycINFO database, using the Web-based search engine Google Scholar, and through personal communication with study authors. Because of the large number of studies, only a brief mention of major findings is included in this article. A more extensive review of wellness counseling research and analysis of studies may be found in Myers and Sweeney (2005a).

Wellness of Various Noncounselor Populations

Participants in studies of wellness have included elementary school students in the third through sixth grades and middle and high school students (adolescents); undergraduates; graduate students (described in the next section); and young, midlife, and older adults. Populations of interest have included members of various ethnic groups, gay men and lesbian women, and clinical samples.

Children and adolescents. Villalba and Myers (2008) have been conducting research to assess levels of wellness among elementary, middle, and high school students and among teachers and staff in all three school settings. An initial study using the 5F-Wel-E with 55 elementary school students validated the usefulness of this measure with young children (Villalba & Myers, 2008). An additional dissertation study is currently being designed to examine "social, emotional, and academic gains of children paired with mentors from the same race versus children paired with mentors from a different race" (R. Mason, personal communication, May 11, 2006).

Studies of adolescents completed by Dixon Rayle (DD, 2002), Mitchell (DD, 2001), and Moorhead (published as Hartwig, DD, 2003) have demonstrated the usefulness of studying wellness factors in this age group. Both Dixon Rayle and Mitchell studied minority populations. Dixon Rayle, in a study of 462 adolescents, found significant differences in wellness across ethnic groups. Mitchell determined that both acculturation and wellness were significant factors affecting the self-concept of 200 Caribbean American adolescents.

Undergraduates. The preponderance of research studies on wellness have used undergraduate students as participants. Osborn (2005) completed a comprehensive review of these studies and concluded that physical and social aspects of wellness received primary attention in the literature, yet spirituality and coping behaviors were areas in which undergraduates consistently experienced lower wellness levels. On the basis of data from 511 freshman students, Enochs (DD, 2002) concluded that their level of wellness can be positively affected by participation in a residence hall program designed specifically for freshman. Such studies are encouraging, because Myers and Mobley's (2004) analysis of data for 1,567 students revealed that undergraduates experienced lower wellness levels than nonstudent adults in most areas. Moreover, nontraditional students of color scored lower than Caucasian students on a majority of the wellness scales in that study.

Myers and Bechtel (2004) found significant differences (based on age and gender) in wellness levels of 179 1st-year cadets at West Point, with younger cadets and men reporting higher wellness levels for multiple wellness factors. Gibson and Myers (2006) replicated this study with 234 cadets at The Citadel, a military college in South Carolina. Few differences were found between the sets of cadets (from West Point and The Citadel) in these two studies; however, in both studies, cadets scored higher than available norm groups on a majority of wellness factors.

Nonstudent adults across the life span. Studies with nonstudent adult populations are described in other sections of this review; these include doctoral dissertation studies by Amery (DD, 2005), Connolly (DD, 2000), Degges-White (DD, 2003), Dew (DD, 2000), Dice (DD, 2002), Gill (DD, 2005), Hutchinson (DD, 1996), Mobley (DD, 2005), and Tanigoshi (DD, 2004). Recently Myers and Degges-White (2007) completed a study of 142 older adults, with an average age of 83 years, who were living in an upscale retirement community in the Southeast. They observed that the wellness scores for their study participants were higher than the wellness scores for a comparable norm group of younger adults, and they underscored the need for more studies of wellness for individuals both in later life and across the life span. Harwell (DD, in preparation) examined teacher effectiveness and wellness and found no relationship between these variables in a small sample of 54 student teachers.

Ethnic groups. Several studies of wellness in minority populations have established the usefulness of the WEL and the 5F-Wel in cultural studies. These studies have examined wellness in relation to factors such as ethnic identity and acculturation of Native Americans (Garrett, DD, 1996), Korean Americans (Korean translation; Chang, DD, 1998), African Americans (Spurgeon, DD, 2002), and Caribbean American adolescents

TABLE 2

Doctoral Dissertations Using the Wheel of Wellness and Wellness Evaluation Lifestyle Inventory and the Indivisible Self and Five Factor Wellness Inventory Sorted by Date

Institution	Author and Date		Dissertation Title
Ohio University	Granello, P.	1995	Wellness as a function of perceived social support network and ability to empathize
Ohio University	Hermon, D.	1995	An examination of the relationship between college students' subjective well-being and adherence to a holistic wellness model
University of North Carolina, Greensboro	Garrett, M.	1996	Cultural values and wellness of Native American high school students
University of North Carolina, Greensboro	Hutchinson, G.	1996	The relationship of wellness factors to work performance and job satisfaction among managers
University of North Carolina, Greensboro	Chang, C. Y.	1998	The role of distinctiveness in acculturation, ethnic identity, and wellness in Korean-American adolescents and young adults
Ohio University	Vecchione, T.	1999	An examination of the relationship between career development and holistic wellness among college students
University of North Carolina, Greensboro	Connolly, K.	2000	The relationship among wellness, mattering, and job satisfaction
University of North Carolina, Greensboro	Dew, B. J.	2000	The relationship among internalized homophobia, self-disclosure, self-disclosure to parents, and wellness in adult gay males
Ohio University	Steigerwald, F.	2000	The relationship of family-of-origin structure and family conflict resolution tactics to holistic wellness in college-age offspring
University of North Carolina, Greensboro	Makinson, L.	2001	The relationship of moral identity, social interest, gender, and wellness among adolescents
University of North Carolina, Greensboro	Mitchell, N.	2001	The relationship among acculturation, wellness, and academic self-concept in Caribbean American adolescents
University of North Carolina, Greensboro	Sinclair, S.	2001	Objectification experiences, sociocultural attitudes toward appearance, objectified body consciousness, and wellness in heterosexual Caucasian college women
University of North Carolina, Greensboro	Dice, D.	2002	The relationship among coping resources, wellness, and attachment to companion animals in older persons
University of North Carolina, Greensboro	Dixon Rayle, A.	2002	The relationship among ethnic identity, acculturation, mattering, and wellness in minority and non-minority adolescents
University of Arkansas	Enochs, W.	2002	Wellness and adjustment to college based on type of residence hall and gender
University of North Carolina, Greensboro	Spurgeon, S.	2002	A comparative analysis between a historically Black college and university and a predominately White institution of the relationship among racial identity, self-esteem, and wellness for African American male college juniors and seniors
University of North Carolina, Greensboro	Degges-White, S.	2003	The relationships among transitions, chronological age, subjective age, wellness, and life satisfaction in women at midlife
University of North Carolina, Greensboro	Hartwig, H. J.	2003	The relationship among individual factors of wellness, family environment, and delinquency among adolescent females
University of North Carolina, Greensboro	Shurts, M.	2004	The relationships among marital messages received, marital attitudes, relationship self-efficacy, and wellness among never-married traditional-aged undergraduate students
University of New Orleans	Tanigoshi, H.	2004	The effectiveness of individual wellness counseling on the wellness of law enforcement officers
University of Florida	Webster, S.	2004	Toward a lexicon for holistic health: An empirical analysis of theories of health, wellness, and spirituality
Nelson Mandela Metropolitan University, Port Elizabeth, South Africa	Amery, S.	2005	The wellness of nurses working in oncology
University of North Carolina, Greensboro	Booth, C. S.	2005	The relationship among career aspiration, multiple role planning attitudes, and wellness in African-American and Caucasian undergraduate women
Heceteppe University, Ankara, Turkey	Dogan, T.	2005	Wellness of undergraduate students in Turkey and translation of 5F-Wel into Turkish
University of North Carolina, Greensboro	Gill, C.	2005	The relationship among spirituality, religiosity, and wellness for poor, rural women
University of North Carolina, Greensboro	Mobley, K.	2005	The relationship among gender role conflict, counselor training, and wellness in professional male counselors
Capella University	Phillips, J.	2005	Hollistic wellness: A study of lifestyle choices in adults

(*Continued on next page*)

TABLE 2 (*Continued*)

Doctoral Dissertations Using the Wheel of Wellness and Wellness Evaluation Lifestyle Inventory and the Indivisible Self and Five Factor Wellness Inventory Sorted by Date

Institution	Author and Date		Dissertation Title
University of South Carolina	Riley, L. D.	2005	The relationship between wellness of counselor education students and attitudes toward personal counseling
Central Florida University	Roach, L. F.	2005	The influence of counselor education programs on counselor wellness
Central Florida University	Smith, H. L.	2006	The relationship among wellness, severity of disturbance, and social desirability of entering master's level counseling students
University of North Carolina, Greensboro	Williams, D.	2007	An examination of the relationship among athletic identity, sport commitment, time in sport, social support, life satisfaction, and holistic wellness in college student-athletes
University of North Carolina, Greensboro	Bigbee, A.	2008	The relationship between religion, social interest, and wellness in adults

Note. 5F-Wel = Five Factor Wellness Inventory.

(Mitchell, DD, 2001). In the following sections, these study findings are reported regarding their relationship to wellness correlates such as acculturation and ethnic identity.

Gay and lesbian adults. Dew (DD, 2000) studied 217 adult gay men (Dew, Myers, & Wightman, 2006) and found an inverse relationship between internalized homophobia and wellness. In a study comparing lesbians and heterosexual women (N = 221) in midlife, Degges-White and Myers (2007) found that all women in midlife experienced physical signs of aging as a common transition, but bisexual women experienced the greatest number of transitions overall. Lesbians whose subjective age was less than or equal to their chronological age reported higher wellness levels, and for these women, total wellness, as measured by the 5F-Wel, was a significant predictor of their life satisfaction.

Clinical populations. Research on wellness among clinical populations is sparse. A notable exception is a study by Degges-White, Myers, Adelman, and Pastoor (2003) with 60 outpatients who sought services at a practice specializing in the treatment of migraine headaches. Overall levels of wellness of participants were low compared with those of a nonclinical norm group of adults. Currently in preparation are studies of adolescents receiving treatment in community mental health agencies and predictors of their wellness (J. Watson, personal communication, May 16, 2005) and adolescents and peer mentoring programs for at-risk youth (R. Balkin, personal communication, May 16, 2005).

Wellness of Counselors-in-Training, Professional Counselors, and Counselor Educators

Noting the need for educators to focus on the mental, physical, and emotional stability of students and to evaluate their wellness, Hill (2004) stated that "well counselor educators may be more likely to produce well counselors" (p. 136). Several authors, notably Mahoney (1997), have emphasized the need for all professional helpers to devote attention to their personal wellness. Given this need, it was surprising that we were able to discover only five completed studies of wellness in counseling students, one study of wellness in professional counselors, and two recent, unpublished studies of counselor educator wellness.

Myers et al. (2003) assessed wellness among 263 counseling graduate students and found that doctoral students reported higher wellness levels than did entry-level students and that both groups of students reported higher wellness levels than did nonstudent adults. Roach (DD, 2005) surveyed 204 master's-level counseling students at three points in their training programs to investigate the influence on wellness of the length of time in their program. Although monotonic trend analysis revealed no differences in wellness over time, students who reported that their counseling training program offered a course in wellness had significantly higher wellness levels than did students who had no access to a course on wellness. Riley (DD, 2005) studied the relationship between wellness of counselor education students and attitudes toward personal counseling among 49 graduate students. She found a positive correlation between attitudes toward personal counseling and wellness and found that attitudes toward personal counseling predicted wellness, although the converse was not true.

Smith (DD, 2006) examined the relationship between psychological disturbance and social desirability among 204 entering master's-level counseling students. She found a statistically significant negative relationship between level of psychological disturbance and wellness level. However, she found no relationship between wellness and social desirability.

Moorhead, Gill, Barrio, and Myers (2008) have initiated a study to determine the effect of forgiveness on the wellness of counseling students. Their preliminary findings revealed a significant and strong inverse relationship between revenge and wellness. Morgan is examining counselor trainee perspectives on counselor wellness using information provided by participants in focus groups from formal wellness assessments with the goal of determining how counseling training programs can better promote wellness among counseling students (M. Morgan, personal communication, May 19, 2006). Finally, in a comparative study of medical residents and their spouses, Powers, Myers, Tingle, and Powers (2004) found that medical residents scored higher than counseling doctoral students on work satisfaction and lower on realistic beliefs.

Using a sample of 289 practicing male professional counselors, Mobley (DD, 2005) studied wellness as it related spe-

cifically to gender role conflict (GRC) and counselor training. He found that male professional counselors experienced both less GRC and higher wellness levels than did other groups of men; however, GRC did not predict wellness level. Neither variable was found to be related to the accreditation status of the training programs. Gerard and Myers are currently examining data comparing the wellness of professional counselors, professional quality of life, and career sustaining behaviors, with the expectation of providing data that will provide insight into how to enhance the wellness of counselors and reduce their experience of burnout (G. Lawson, personal communication, October 29, 2006).

Wester, Trepal, and Myers (in press) examined wellness among 180 counselor educators and found higher wellness levels for individuals in their sample when compared with Myers et al.'s (2003) study of counseling students. The variables higher levels of perceived stress and being the parent of a higher number of children were inversely correlated with wellness levels of this group. Differences among academic ranks were noted, with assistant professors reporting lower levels of Coping Self wellness, specifically Realistic Beliefs. (See Table 1 definitions.) A follow-up qualitative study is in process that includes intentional interviews with approximately 15 counselor educators to explore in greater detail the meaning of wellness in this population.

Correlates of Wellness

Multiple studies of correlates of wellness using the WEL and 5F-Wel have been conducted. These include the effects on wellness levels of psychological traits, employee characteristics, ethnicity and acculturation, emotional connections through mattering and attachment to companion animals, relationship issues, and other characteristics.

Psychological traits. In one of the earliest studies of wellness, Hermon and Hazler (1999) found that both short-term state and long-term trait constructs of psychological well-being correlated positively with each of the major life tasks in the Wheel of Wellness model for 155 undergraduate students. Sinclair and Myers (2004) studied the relationship between components of objectified body consciousness and wellness in 272 undergraduate, heterosexual, Caucasian women. They found a negative relationship between body shame and wellness and a positive relationship between appearance control beliefs and wellness. Makinson (DD, 2001) used structural equation modeling to demonstrate that social interest explained a significant portion of the variance in wellness among 187 adolescents. She found only a weak relationship between moral identity and wellness.

Employee characteristics. Both Hutchinson (DD, 1996) and Connolly and Myers (2003) found positive associations between wellness and job satisfaction for managers ($N = 161$) and employees ($N = 83$), respectively. Amery (DD, 2005) used the 5F-Wel with 30 oncology nurses in South Africa and noted lower wellness levels in this population compared with wellness levels for the norm sample for the instrument. She suggested that the stresses of cancer care are a major factor influencing these findings. In fact, perceived stress has been demonstrated to have an inverse relationship with wellness in several studies (e.g., Degges-White et al., 2003; Gibson & Myers, 2006; Myers & Bechtel, 2004; Myers & Degges-White, 2007; Powers et al., 2003).

Ethnicity and acculturation. Several researchers have examined ethnic identity and acculturation in relation to wellness. Chang (DD, 1998) found a strong, positive relationship among 208 Korean American adolescents between acculturation and Total Wellness, and a negative association between the need for differentiation from one's culture of origin and wellness. Dixon Rayle (DD, 2002) found that ethnic identity, but not acculturation, explained a significant portion of the variance in wellness levels for 176 adolescents from minority groups and that acculturation explained a significant portion of the variance for adolescents in general (286 nonminority and 176 minority adolescents); however, she found no significant differences in mean scores on any variable when comparing adolescents from minority and nonminority groups. In contrast, in a study of 245 African American men, Spurgeon (DD, 2002) found that racial identity did not predict wellness.

Emotional connections. Dixon Rayle (DD, 2002) also studied *mattering*, or sense of belonging, and found that this variable predicted a significant proportion of the variance in wellness levels for adolescents. Connolly (DD, 2000) found a strong positive relationship between mattering and wellness levels and noted that mattering and wellness levels together predicted 10% of the variance in job satisfaction for these adolescents. In a related study, Dice (DD, 2002) found weak but positive correlations between attachment to companion animals, coping resources, and Total Wellness among 327 adults over age 65. In contrast, Granello (DD, 1995) failed to find predictive relationships between either empathy or social support and wellness levels among 100 undergraduate students.

Other characteristics. Several additional variables have been demonstrated to correlate with wellness level. For example, Booth (DD, 2005) found that multiple role planning and wellness level predicted career aspirations for 90 Caucasian and 156 African American undergraduate women. Gill (DD, 2005) found strong associations between religiosity, spirituality, and wellness level among 167 low-income women in rural areas, and Webster (DD, 2004) underscored the singular significance of spirituality in understanding both health and wellness levels for 722 undergraduates. In a study with 242 undergraduates, Shurts and Myers (2006) found positive relationships between healthy love styles and the life tasks in the Wheel of Wellness.

Cross-Cultural and Cross-National Studies

The 5F-Wel has been translated into or adapted for five languages, including Korean (5F-Wel-K; Chang, DD, 1998; Hong, 2008), Turkish for adults (5F-Wel-TKA; Dogan, DD, 2005), Turkish for middle school students (5F-Wel-TKT;

Korkut & Myers, 2008), and Hebrew (5F-Wel-H) for middle school students (Tatar & Myers, 2008). Translations into Spanish (5F-Wel-S; Ivers & Myers, in press), Japanese (5F-Wel-J; Fukuhara, 2008), Chinese (Lau, Yuen, Chan, & Myers, 2008), and Lithuanian (Gustainiene & Pranckeviciene, 2008) are in process. Several studies have been conducted or are in process that examine cross-cultural differences in wellness levels in Israel, Manila, Korea, and Turkey. Although no comparison is made of wellness levels across cultures, Amery's study in South Africa (DD, 2005), nevertheless provided profiles of wellness levels from non-U.S. populations. Finally, Myers, Madathil, and Tingle (2005) conducted a study of 22 married couples living in India whose marriages had been arranged. The Indian participants scored higher on Spirituality and Nutrition but lower on Realistic Beliefs than did participants in an available norm group, all with large effect sizes.

Chang (DD, 1998) completed the first cultural adaptation of the WEL for use in a study of 208 Korean American adolescents. Hong (2008) has updated that adaptation and is currently field testing the 5F-Wel-K with a population of Korean American adults. Translation difficulties were described by Chang and Myers (2003), who noted that the meaning of *health* and of words such as *stress* and *coping* may vary across populations. Dogan, et al. (2005) studied 939 college students using the Turkish adaptation of the WEL and found an inverse relationship between scores on the Turkish Brief Symptom Inventory and the 5F-Wel Turkish adaptation levels. Confirmatory factor analysis revealed support for the IS-Wel model. Myers, Cervera, Wilse, and Henson (2006) also found support for the 5F-Wel model in a study of 738 Philippine undergraduates.

Tatar and Myers (in press) used the Hebrew translation of the 5F-Wel to compare wellness levels of 240 Israeli and 629 U.S. middle-school students and found higher Coping Self and Social Self wellness levels for the Israeli students and higher Essential Self wellness levels for the U.S. participants. Younger students scored higher than older students on Total Wellness, and both main effects and follow-up analyses revealed multiple age differences but not gender differences across the two samples.

Outcome Research

Several outcome studies have been published in which the 5F-Wel was used as a pretest and posttest assessment to determine the effectiveness of a wellness counseling intervention, and other studies on this topic are nearing completion. Choate and Smith (2003) infused wellness into 1st-year student success courses for 59 undergraduates and found that wellness scores increased significantly over the course of the semester. They included both qualitative and quantitative analyses to determine the nature of these score increases. Tanigoshi (DD, 2004) used an experimental design and randomly assigned 60 law enforcement officers in New Orleans either to treatment or to control groups, with officers in the treatment group receiving five individual counseling sessions to enhance wellness. The wellness of the treatment group increased significantly but that of the control group remained constant, indicating the potential for counselors to influence the wellness levels of law enforcement officers through strength-based interventions. Balkin's 2008 study includes an outcome component examining wellness and behavioral change with high school students who are at risk for academic failure (R. Balkin, personal communication, May 16, 2006).

Villalba and Myers (2008) conducted pretest and posttest assessments using the 5F-Wel-E with a group of 58 3rd-grade students. Following a 6-week group guidance program, Total Wellness and several wellness factors increased significantly for these students. Hartwig Moorhead, Green, McQuistian, and Ozimek (2008) used the 5F-Wel-E in a single-case study with a 13-year-old student diagnosed with Asperger's Syndrome and developed a wellness plan to increase his Creative Self and Physical Self wellness levels. Only the Physical Self scores showed significant gains at posttest; however, wellness counseling was again successful as measured by a significant change in wellness scores from pretest to posttest times.

Discussion

Models of wellness based in counseling were first introduced more than 15 years ago and have evolved from a theoretical to an empirical foundation. In particular, both the Wheel of Wellness and the Indivisible Self models have been the foundation for numerous studies of wellness as they relate to a variety of variables and across diverse populations. We reviewed multiple studies that are based in these models, and they have implications for additional research as well as for counseling practice. Following an extensive review of wellness counseling studies, Ginter (2005) noted that there are "sound reasons for viewing wellness as more than just a topic of study. . . . A consideration of wellness has real potential to serve as a primary contributor to counseling's future" (p. 153).

Studies of wellness represent every aspect of the entire life span; yet, there has clearly been a disproportionate emphasis on populations of convenience. As in the field of psychology, studies of undergraduates predominate in the wellness counseling literature, and relatively few studies of nonstudent adults have been conducted. The results of the studies that have been done are promising, yet the results, to date, are equivocal. Although research results offer promise for discriminating within and between groups relative to wellness factors, current knowledge remains insufficient as a base for wellness counseling interventions for all adults. Certain groups of adults are clearly at risk regarding specific aspects of wellness. For example, low-income and ethnic group members uniformly score lower on physical wellness factors than do Caucasians, and there seems to be a positive relationship between advancing age and wellness levels. Limited studies and restricted variability within study samples make these tentative conclusions important areas for future study. Two

broad areas of research seem important for life-span studies, specifically, the wellness levels of adults across the life span and the wellness levels of children.

It is noteworthy that few studies of children's wellness have been conducted. This is partly due to the difficulties inherent in dealing with minors for research purposes. The dearth of studies on children's wellness may also be attributed to the lack of suitable assessment instruments. The recent availability of the 5F-Wel-E and 5F-Wel-T will, it is hoped, help to change this situation. Early studies with these measures have shown them to be valid and useful in discriminating wellness factors among children and adolescents; yet, the pool of studies is so meager that few conclusions may be made. As noted by Holcomb-McCoy (2005) following a review of studies on children's wellness levels:

> Studies investigating the role of wellness in the development of children and in their later adult development are needed as well as the development of models of wellness specifically for children. . . . Surely, if counselors are to assist clients to live better and longer, the promotion of wellness must begin with our youngest clients. (p. 65)

In addition to developing a better understanding of the dynamics of wellness across the life span, studies of specific populations and subgroups remain an urgent need. With only two studies of wellness among gay, lesbian, and bisexual populations (these being with adults), it is clear that additional studies of sexual minorities, particularly adolescents, are needed. Dew et al. (2006) noted that a wellness approach is needed to depathologize sexual minorities and to inform the development of strength-based interventions with this population. Research that informs practice clearly should be a priority.

Although numerous studies of wellness among cultural minority populations have been conducted, most have used undergraduate students as participants and most have examined only African Americans and Caucasians. Little to nothing is known about the wellness levels of cultural groups across the life span or about variation across cultural groups, including Hispanics, Asian Americans, and Native Americans. Lee (2005) observed that

> much of what is known about the status of ethnic groups of color is framed within a deficit context. Wellness offers a way to reframe that status and consider it from a positive and developmental perspective. To date, few aspects of wellness among people of color have been examined, and wellness has been linked primarily to ethnic identity and acculturation. (p. 114)

It is clear that studies of the wellness levels of cultural groups in relation to additional variables, such as spirituality and social support, are needed to promote understanding of the unique strengths of these varied populations. Other minorities, including persons with disabilities and individuals from various faith traditions, continue to experience both discrimination in society and a lower level of service from professional counselors. Again, an understanding of the strengths of these individuals and how those strengths can help them deal with life challenges is needed as a basis for clinical practice.

A notable gap in the knowledge base of wellness is seen in the dearth of studies with clinical populations. The philosophy of wellness offers a new way of viewing pathology from a developmental, strengths-based perspective (Gerstein, 2006; Ivey, Ivey, Myers, & Sweeney, 2005). If we, as counselors, are to be strong advocates for services to clinical populations, we need both an extensive and strong knowledge base that helps us understand the uniqueness of these persons and outcome studies that demonstrate the effectiveness of our interventions. The few existing outcome studies that have been conducted indicate that there is tremendous promise for wellness counseling as a useful intervention with clinical populations (e.g., Degges-White et al., 2003) and persons whose level of job-related stress puts them at risk of decreased wellness (e.g., Tanigoshi, DD, 2004).

As is true of studies with clinical populations, outcome research in general is sparse in the wellness counseling literature. This lack of studies reflects Sexton's (2001) observations about the struggle within the counseling field regarding research. The literature is replete with "good ideas" that have yet to be tested and confirmed in practice. An example is Makinson and Myers's (2003) article suggesting the use of strength-based, wellness interventions as an alternative means of violent behaviors in children and adolescents. Their ideas make sense but have yet to be tested in practice. Until the validity of such ideas can be proven empirically, professional counselors will remain limited in their ability to advocate for the importance of counseling services with policy and decision makers.

People live in a global society yet continue to be hindered by a lack of understanding of the characteristics and uniqueness of people from varied cultural and geographic backgrounds. Cross-cultural studies of wellness are needed to inform the development of counseling services for all persons, regardless of country of origin. Virtually nothing is known about wellness in third world countries, for example, and very little more is known about wellness levels of persons of different faiths and cultural traditions. Additional cultural adaptations of wellness measures may help fill the gap and lead to new knowledge about the applicability of wellness counseling models in countries other than the United States. Perhaps new models are needed to fully understand wellness from a global perspective. Certainly more research is needed to determine whether the factor structure of wellness is similar across cultures and across the life span within cultures. Only new empirical studies can provide this information.

Conclusion

Counseling is a wellness-oriented, strengths-based approach to optimizing human growth and development. As professional

counselors, we are well trained in a positive, holistic philosophy that allows us to be advocates for optimum health and wellness in society. To be effective advocates, we need to operate from a solid knowledge base of empirical data that demonstrates, unequivocally, our understanding of diverse populations and the ability to apply interventions to create positive change. The evidence base for wellness counseling is in its infancy, yet is extensive enough at this point in time to provide an initial foundation for evidence-based practice. Additional studies are needed and offer the promise of placing the counseling profession in the forefront as a global advocate for programs to promote both longevity and quality of life for all individuals.

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