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Wellness in the Helping Professions: Historical Overview, Wellness Models, and Current Trends

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Abstract

Introduction: Wellness and the concept of holism have rich histories throughout the helping professions. However, Westernized medical models often promote the concept of treatment rather than prevention, limiting the helper's ability to focus on wellness when working with clients/patients. Therefore, in order to support a re-integration to holistic wellness and the prevention of illness, and re-focus on a wellness ideology, we conducted a thorough theoretical overview of wellness in the helping professions to: (a) provide a historical overview of wellness in helping professions, (b) discuss prominent wellness models, (c) review wellness assessments, (d) present wellness supervision models, and (e) offer implications for helping professionals, helping educators, and helping-professionals-in-training (HPITs) who would like to implement or re-integrate wellness techniques across occupational and personal realms.

Discussion: The history of healthcare is rich with wellness undertones and holistic foundations for practice. However, the helping professions have been shifting away from traditional wellness ideologies with the emphasis on current healthcare trends and the philosophical struggle of balancing both wellness tenets and a popular medical model for practice. Following a thorough discussion of historical implications of wellness, wellness models, wellness assessments, and wellness supervision, implications for a re-integration of a wellness ideology are highlighted for (a) helping professionals, (b) healthcare educators, and (c) HPITs.

In regard to practicing healthcare providers, helping professionals are only as helpful as they are well. We suggest that helping professionals refocus their practice to include wellness and integrate such practices into their daily routine to combat compassion fatigue and/or burnout (which are common occurrences among helpers). Wellness practices may include meditation; breathing exercises; reflection; journaling; and other avenues to reflect, respond, and re-center throughout the day to remain within their own window of tolerance, reducing potential for burnout. Helping professional educators, on the other hand, are tasked with training the next wave of helpers. As such, they are responsible for assessing personal levels of wellness in order to ensure they are modeling wellness-behaviors for their HPITs. Regarding healthcare training programs and curriculums, administrators may introduce wellness courses or infuse wellness throughout the life of the program/training experience so HPITs are learning about wellness education and how to implement it across diverse situations. Furthermore, consistent wellness infusion in curricula could promote wellness behaviors and practices beyond the training experience. Finally, HPITs (similar to practicing professionals and healthcare educators) are not insulated from the effects of unwellness. As such, HPITs are encouraged during their clinical experiences to assess their own wellness and partake in activities to increase their wellness awareness. HPITs can formally (see the section on wellness assessments) or informally assess (refer to the wellness models section) their current levels of functioning and learn of potential wellness discrepancies early on in their careers, which in turn can help mitigate negative effects of being a helper in the future.

Conclusion: With the influence of Westernized viewpoints and a medical model symptom-reduction focus, a re-orientation to wellness could benefit helpers. Furthermore, as helpers continue to face heavy caseloads, high stress environments, and increased propensity for burnout and related issues, increasing wellness and wellness awareness can serve as a protective factor against the deleterious effects of helping for both helpers and the individuals they serve. By reviewing the literature on wellness (e.g., models, assessments, supervision) in the helping professions and applying wellness perspectives in personal and professional endeavors, helping can once again be at the forefront of wellness-based treatment, training, and living.

INTRODUCTION

For many helping professionals, maintaining wellness while engaging in personal and professional activities involves an active approach [1]. This active maintenance is important considering that many researchers [2, 3, 4, 5] have suggested that well helping professionals are more capable of meeting their clients'/patients' needs. Even so, the concept of wellness is described differently across professions, making its achievement a challenging endeavor. Furthermore, healthcare professionals are often insulated in their professions, with separate guidelines for practice, individualized competencies for care, different levels of educational attainment, and varying standards for practice. Complicating things more, healthcare professionals are comprised of a diverse group of individuals such as athletic trainers, counselors, dentists, medical doctors, nurses, psychologists, pharmacists, and social workers, to name a few. For the purposes of this manuscript, we will use the terms "healthcare providers", "helping professionals", "healthcare professionals", and "helpers" interchangeably to include the aforementioned areas and any similar/related fields of healthcare. Though these helping professionals may have different backgrounds and levels of training, serve a variety of populations, and work within diverse settings, they all have one thing in common, the importance of wellness in their personal and professional lives.

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The World Health Organization (WHO) stated, "Health is a state of complete physical, mental, and social well-being and not merely in the absence of disease or infirmity" [6]. For this manuscript, we further describe 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" [7]. Specifically, in the helping professions, in order to best serve clients/patients, helpers must in fact, take care of themselves [3, 8]. In a field such as counseling, wellness is the philosophical foundation of the profession [9, 10] and researchers support the concept of utilizing a wellness philosophy when working with clients [11, 12]. Furthermore, wellness serves as the basis for the American Counseling Associations [13] Code of Ethics and standards of practice, as it is noted in the preamble to the ethical standards. Wellness is also incorporated into the Counsel for Accreditation in Counseling and Related Educational Programs [14] Standards, which serves as an accrediting body for counseling programs across the United States. Other helping professions, such as Psychology, have wellness tenets noted in their codes of conduct and ethical contracts (i.e., American Psychological Association, 2010, Ethical Principles of Psychologists and Code of Conduct), in the form of suggestions for mitigating negative effects of working with others (Section 2:2.06) and maintaining competence (Section 2:2.03). [15] Social work also references wellness in their Code of Ethics. [16] In the athletic training field, athletic trainers must routinely practice in the areas of prevention and wellness. [17] Finally, the American Medical Association [18] maintains that physicians and other healthcare providers have a responsibility to maintain their own health and wellness and offer suggestions for remaining well. In summary, wellness is intertwined throughout the healthcare professions and helper well-being is paramount in providing quality care for clients across helping realms.

Wellness in the Helping Professions

Though many helping fields are grounded in a wellness platform for supporting human development [9, 19, 10]; helpers may struggle implementing and maintaining wellness in their personal and professional lives. Further, wellness may not be the highest priority for clients, as health insurance limitations, managed care constraints, time-limited sessions/patient appointments, and an overall pathogenic westernized healthcare system makes it difficult to support well-being and holism in healthcare settings. Thus, helpers are often forced to treat issues after they arise, rather than preventing issues prior to the fact—an action that goes directly against a wellness orientation of care.

Within the United States (U.S.), millions of dollars are spent treating issues/concerns rather than on preventing them [20, 21]. Further, the U.S. federal government spends a majority of its healthcare dollars treating diseases (approximately 75% of its total budget per year; U.S; 21) and spends less than 1% at federal levels and less than 2% at state levels on prevention services [22]. As such, U.S. healthcare often focuses on the pathogenic/symptomatic side of the illness/wellness continuum [20] forcing helping professionals to place wellness and holism in the background of client treatment. This healthcare environment is only half of the story, however, as helpers often face a number of stressors that influence their personal wellness, as well.

Helping professionals are more susceptible to experiencing stressors leading to compassion fatigue, vicarious trauma, and/or burnout because of the difficult nature of working with difficult client/patient concerns [2, 23, 24-26]. Burnout and fatigue have far reaching implications for helpers—often resulting in higher risk of experiencing poor attitudes towards patients/clients, making clinical or medical errors, and difficulty maintaining positive relationships (both personally and

professionally) [2]. In addition, Kumar [2] stated that helpers experiencing burnout were also at increased risk of experiencing anxiety, substance abuse, marital issues, suicidal ideation or suicide, sleep disturbances, and depression. Even so, helpers operating from a wellness paradigm may be able to insulate themselves from detrimental aspects of helping and serve as agents of change towards promoting wellbeing in the self and in clients [23, 24]. For these reasons, we believe that the helping fields have drifted away from a wellness orientation and that a re-introduction to wellness is warranted across the helping professions.

One way to re-ignite a wellness focus within healthcare professions is to make a conscious effort to learn about and utilize wellness models, wellness assessments, and wellness supervision in our personal lives, in our therapeutic practices, and preparation programs. Therefore, in order to support a re-integration to holistic wellness and the prevention of illness, and re-focus on a wellness ideology, we conducted a thorough theoretical overview of wellness in the helping professions and: (a) provide a historical overview of wellness in helping professions, (b) discuss prominent wellness models, (c) review wellness assessments, (d) present wellness supervision models, and (e) offer implications for helping professionals who would like to implement or re-integrate wellness techniques across occupational and personal realms.

LITERATURE REVIEW

The History of Wellness

Along with the WHO's (1948) definition of well-being, wellness undertones began to arise in professions such as counseling, social work, and psychological theories (i.e., Humanistic Psychology; Positive Psychology; Strengths Counseling; Counseling Psychology). Alfred Adler discussed the holistic tenets of wellness in his early writings on individual psychology and stated that human beings strived for holism and had a purpose of continuing their existence on earth. [27] Furthermore, Adler believed that individuals' well-being was dependent upon their degrees of social interest and attitudes toward life. [28] His qualities of social interest and lifestyle are fundamental to wellness theory, wellness models, and theoretical assessments of wellness across the helping professions. Along with Adler; Jung, Rogers, and Maslow were trailblazers of the wellness movement, initially aiding the helping field in moving away from the more medical model-based treatment modalities [29, 20, 31].

Jung suggested individual psyches yearned for integration and that individuals had an instinctual desire for balance and wholeness [29]. Rogers discussed the importance of personal strengths and capacities as human beings and coined the term fully-functioning, encompassing individuals practicing health and self-actualization [30]. Roger's premise that individuals had an actualizing tendency with a capacity for learning and for growth was the cornerstone for Humanistic theory [30]. Branching from Rogers, Maslow maintained that individuals had the propensity for self-actualization and self-realization [31]. Maslow emphasized the incorrectness of helpers focusing on adverse behaviors [32, 33, 31]. In summary, the noted scholars built the foundation that the current wellness platform sits.

Additional pioneers to the wellness movement include Halbert Dunn, Bill Hettler, Mel Witmer, Tom Sweeney, Jane Myers, and Mark E. Young. Dunn also known as the architect of wellness, coined the term high-level wellness, or an integrated level of functioning oriented toward maximizing individual potential [34, 35]. Similarly, Hettler is often called the father of the modern wellness paradigm [36], designed the Hexagonal Model of Wellness, and established the National Wellness Institute [37]. Witmer [38] developed one of the

first wellness courses and collaborated with Sweeney [39] in developing the Wheel of Wellness and the Lifespan Development Model [40]. Branching off from Witmer's work, Myers and Sweeney propelled the wellness focus forward and created one of the most widely used wellness assessments, the Five Factor Wellness Inventory (5F-Wel) [41]. Witmer and Young have also been influential in emphasizing the impact of wellness and were instrumental in promoting wellness in counseling preparation programs for both counseling faculty and counselors-in-training (CITs) [42].

Other influential contributors to the wellness movement include Travis and Ryan [43] who developed one of the first wellness/illness continuum models to look at the dualistic sides of health and wellness, and Ardell [44] who similar to Dunn, discussed high-level wellness and the need to break away from doctors, diseases, and the reductionist/negativistic view of individuals. Further, Lawson [45], Lawson, and Myers [4] investigated wellness in counselors and concluded that when helpers take care of themselves, they are better able to care for others. Finally, Lenz, Smith [5], Blount, and Mullen [46] proposed integrating wellness tenets into the supervisory experience, as formal strategies in clinical supervision

were lacking. In summary, many scholars contributed to the modern wellness movement in the helping fields. These scholars' contributions have led to a holistic, positive, and strengths-based view of human beings and an overall focus on human potential, optimum human functioning, and the importance of assessing wellness, aligning with humanistic tenets. Wellness models and assessments were created in order to assess individual holistic wellness, as well as areas of concern (i.e., unwellness/illness). In the following sections, we present some of the wellness models and assessments within the helping professional literature.

Wellness Models

Wellness models within the helping professions represent diverse ideas of what it means to be well. In this section, we review the following models: (a) Hettler's Hexagonal Model of Wellness [37]; (b) Lifespan Development Model (LDM; 40); (c) Wheel of Wellness [40, 39]; (d) Zimpher's Wellness Model [47]; (e) Model of Spiritual Wellness [48]; (f) Perceived Wellness Model (PWM; 49, 50); and (g) Clinical and Educational Model of Wellness (CEMW; 51). For a concise depiction of the wellness models, please see **Table 1**.

Table 1: Wellness Models

Wellness Model	Main Tenets	Proposed Population/Use
Hettler's Hexagonal Model (Hettler)	• Occupational, emotional, intellectual, physical, social, physical, spiritual wellness	• Can be applied to diverse helpers and their diverse clients/patients (individualized wellness format allows for application to different lifestyles)
Lifespan Development Model (Sweeney & Witmer)	• Spirituality, work, self, love, friendship	• Holistic view of human functioning based on Adlerian life tasks • Baseline form which the Wheel of Wellness was later derived
Wheel of Wellness (Witmer, Sweeney, Myers)	• Stress management, self-care, realistic beliefs, nutrition, humor, gender identity, emotional awareness and coping, exercise, sense of control, sense of worth, cultural identity, problem solving and creativity • Spirituality at the core of the model	• Can be applied to diverse helpers and their diverse clients/patients • Allows for flexibility as to which tenets to focus on • Holistic view of well-being • Takes into account community factors
Zimpher's Wellness Model (Zimpher)	• Medical health, spiritual attitudes, energy forces, spiritual beliefs, psychodynamics, immune function, life-style management, interpersonal relations • Focus on health during bodily illness	• Used when working with individuals experiencing bodily unwellness (e.g., cancer) • Wellness approach to healing and recovery from illness • Focus on reducing destructive attitudes, assumptions, beliefs, & behaviors
Model of Spiritual Wellness (Chandler, Miner Holden, & Kolander)	• Emotional, occupational, social, intellectual, physical paradigms • Spirituality key component	• Beneficial for individuals who yearn for a balance between their personal and spiritual realms of wellness
Perceived Wellness Model (Adams, Bezner, & Steinhardt)	• Spiritual, social, emotional, intellectual, physical, psychological	• Can be used with individuals who believe true wellness involves a balance between all tenets of the model (equal representation)
Clinical & Educational Model of Wellness (Granello)	• Creativity, social relationships, physical and nutritional concerns, emotional regulation, cultural and environmental context, preventative self-care, cognition, spirituality	• Applied in clinical settings • Allows for individualization • Viewed within the context of the client's lifestyle and environment

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Hettler developed a six-pronged model of wellness comprised of: (a) occupational, (b) emotional, (c) intellectual wellness, (d) physical, (e) social, and (f) spiritual wellness [36]. The Hexagonal Model of Wellness contains dimensions believed to influence overall wellness and serve as the basis for the Lifestyle Assessment Questionnaire (LAQ, 37). Similar to Hettler's model, Sweeney and Witmer developed the LDM, incorporating the Adlerian life tasks of spirituality, work, self, love, and friendship [40]. Like Hettler's model, the LDM was the platform for the construction of the Wheel of Wellness [40]. Essentially, both the LDM and the Hexagonal Model of Wellness formulate a holistic view of human functioning, based on individuals' environment and lifestyle.

The Wheel of Wellness [40, 39, 52] aligns with Adlerian individual psychology tenets and includes involves the concepts of Love, work and leisure, self-direction, friendship, and spirituality. The Wheel of Wellness model is broken into tasks of: (a) stress management, (b) self-care, (c) realistic beliefs, (d) nutrition, (e) sense of control, (f) gender identity, (g) emotional awareness and coping, (h) exercise, (i) sense of humor, (j) sense of worth, (k) cultural identity, and (l) problem solving and creativity [40]. For the Wheel of Wellness, internal components and external effects from society and the environment were considered, making it a developmental, interactive model of wellness.

Branching from Hettler's model and the Wheel of Wellness, Zimpher believed individuals had the ability to find wellness in the presence of illness/disease and developed a unique model to represent individuals with cancer or other chronic diseases [47]. Zimpher's model includes eight areas that influence wellness: medical health, spiritual attitudes, energy forces, spiritual beliefs, psychodynamics, immune function, life-style management, and interpersonal relations. Overall, Zimpher promoted a proactive approach to wellness, rather than a reactive approach; a quality that is often bypassed in disease-based/treatment focused healthcare management.

Honing in on the specific components of wellness, Chandler, Miner Holden, and Kolander [48] established the Model of Spiritual Wellness, comprised of emotional, occupational, social, intellectual, and physical paradigms (similar to the Wheel of Wellness tenets). As Chandler and colleagues suggested with their title, spirituality is a key component of the model and individuals must have a balance between their personal and spiritual realms in order to achieve holistic wellness. Spirituality within the Model of Spiritual Wellness is influential to all aspects of individuals' wellness. Thus, for individuals that value spirituality, the Model of Spiritual Wellness may offer a path for spiritual development and wellness.

The Perceived Wellness Model (PWM; 49, 50) is a multidimensional model that also incorporates spirituality. The PWM supports wellness through experiences of balanced and consistent development in spiritual, social, emotional, intellectual, physical, and psychological tenets of human existence. The PWM posits that when individuals view their wellness tenets as equal, they are healthier [49].

Finally, the Clinical and Educational Model of Wellness (CEMW; 51) applies wellness to clients in clinical settings and includes: (a) creativity, (b) social relationships, (c) physical and nutritional concerns, (d) emotional regulation, (e) cultural and environmental context, (f) preventative self-care, (g) cognition, and (h) spirituality [19]. The CEMW tenets are individualized, in that they depend on the particular lifestyle of the client and should be viewed from the context of the client's life-style choices and environment [19]. The wellness models described above include many overlapping wellness tenets as well as individual proponents, which make them unique. Depending on the population helpers serve and the system in which they work, one specific model may offer a better fit for clients/patients (see Table 1 for more information). Gaining knowledge of the different wellness models serves as a starting point in helping professionals assessing their personal wellness, as well as using informal and/or formal wellness assessments with clients, colleagues, or client/patients.

Wellness Assessments

Within the helping professional literature, exist an array of wellness assessments used to measure specific wellness tenets or holistic wellness. Of the most relevant to the helping professions, we review the following measures: (a) Wellness Evaluation of Lifestyle (WEL; 53); (b) Five Factor Wellness Evaluation of Lifestyle (5F-Wel; 41); (c) Health Promoting Lifestyle Profile-II (HPLPII; 54); (d) Perceived Wellness Survey (PWS; 50); (e) Lifestyle Assessment Questionnaire (LAQ; 37); (f) Professional Quality of Life Scale-Third Edition-Revised (PRO-QOL-III-R; 55); and (g) the Helping Professional Wellness Discrepancy Scale (HPWDS; 9). For a concise depiction of wellness assessments, please refer to **Table 2 (next page)**.

Myers and colleagues developed the Wellness Evaluation of Lifestyle (WEL), a self-report assessment measuring wellness [53]. The WEL conceptualizes wellness based on Adlerian tasks (i.e., work, self, love, friendship, and spirituality) and incorporates global occurrences and life forces as wellness influencing events [56, 53]. Hattie and colleagues noted the psychometric properties of the WEL did not support the original Wheel of Wellness Model [56]. However, estimates of reliability (coefficient alpha values) for the WEL range from 0.60 to 0.90 [56], indicating relatively sound reliability [57].

The Five Factor Wellness Evaluation of Lifestyle (5F-Wel; 41) is a 90+ item questionnaire devised from the Indivisible Self Model. The 5F-Wel includes five main factors: physical, creative, coping, essential, and social, and takes into account the influence of family, community, and culture on individual wellness [58]. The 5F-Wel is a popular assessment of wellness and used in several studies assessing for variables like spirituality [59], ethnic identity [60, 61], self-esteem [61], relationship self-efficacy [62], and acculturation [60, 61]. Internal consistency for the 5F-Wel ranges from 0.80 to 0.96, and the instrument has been normed on populations with varying degrees of ethnicity, gender, age, and education level [10].

The Health Promoting Lifestyle Profile-II (HPLPII, 54) assesses a positive approach to living and striving to reach highest potential. The HPLPII is a 52-item assessment that is comprised of a scale ranging from Never to routinely (4-point Likert-type scaling). The HPLPII includes the areas of: (a) Interpersonal Relations; (b) Spiritual Growth; (c) Health Responsibility; (d) Stress Management; (e) Nutrition; and (f) Physical Activity. In the initial study of the HPLPII, Walker et al. [54] used item analysis, factor analysis, and reliability measures with a population of adults (N = 952). A six-factor structure resulted, accounting for 41% of the total variance. [54] Walker et al. [54] report Cronbach's alpha levels ranging from 0.79 to 0.87 in the subscales of the HPLIII with a total of 0.94.

Next, the Perceived Wellness Survey (PWS; 50) is comprised of 36-items assessing the degree to which adults perceive themselves as being well across the Perceived Wellness Model dimensions (i.e., spirituality, social, emotional, intellectual, physical, psychological). The PWS is comprised of 6-point Likert scaling from a score of 1 (very strongly disagree) to a score of 6 (very strongly agree) and involves scoring in each wellness dimension as well as an overall composite wellness score. Evidence of validity for the PWS scores is mixed [49, 50, 63, 64], with the majority of the investigations including college-level, white, female populations. Finally, the PWS internal consistency reliability ranges from 0.89 to 0.91 [49].

The Lifestyle Assessment Questionnaire (LAQ; 37), which is affiliated with Hettler's Hexagonal Model of Wellness, is a 100-item measure assessing four dimensions (lower scores

Table 2: Wellness Assessments

Wellness Assessment	Main Tenets	Intended Population/Use
Wellness Evaluation of Lifestyle (WEL) (Myers, Sweeney, & Witmer)	• Based upon work, self, love, friendship, spirituality • Incorporates global occurrences and life forces as wellness influencing events • 130+ item assessment	• Can be applied to diverse helpers and their diverse clients/patients (individualized wellness format allows for application to different lifestyles) • Use with caution as psychometric properties do not support Wheel of Wellness Model (from which the WEL was derived) • https://www.mindgarden.com/wellness-evaluation-of-lifestyle/248-well-individual-report.html?search_query=WEL&results=50
Five Factor Wellness Evaluation of Lifestyle (5F-Wel) (Myers, Leucht, & Sweeney)	• Five factor model of: physical, creative, coping, essential, social wellness • 17 lower order factors (e.g. humor, stress management, self-worth, love, friendship) • 90+ item assessment	• Has been normed with a diverse group of individuals and is offered in numerous languages • Adult and adolescent versions • Sound psychometric properties • https://www.mindgarden.com/99-five-factor-wellness-inventory
Health Promoting Lifestyle Profile-II (HPLPII) (Walker, Sechrist, & Pender)	• Strength-based approach to living and striving to reach highest potential • Interpersonal relations, spiritual growth, health responsibility, stress management, nutrition, physical activity • 52 item assessment	• Used to assess frequency of health-related activities influencing wellness • Generally used with adult populations • Sound psychometric properties • https://deepblue.lib.umich.edu/handle/2027.42/85349
Perceived Wellness Survey (PWS) (Adams, Bezner, & Steinhardt)	• Emotional, occupational, social, intellectual, physical paradigms • Spirituality key component • 36 item assessment	• Measure perceived health, not wellness • Beneficial for individuals who yearn for a balance between their personal and spiritual realms of wellbeing • Could be used in clinical/medical settings • Limitation is scale is normed on primarily white, college-age females • https://perceivedwellness.com/
Lifestyle Assessment Questionnaire (LAQ) (DeStefano & Richardson)	• Fitness, nutrition, self-care, drugs and driving, social environment, emotional awareness, emotional control, intellectual, occupational, spiritual • 100 item assessment	• Normed with undergraduate college students • Relatively sound psychometric properties when used within the norming population (college-age students) • Adolescent, College-age, Adult, Older-Adult versions • https://www.testwell.org/twfree.htm
Professional Quality of Life Scale-Third Edition-Revised (PRO-Qol-III-R) (Stamm)	• Quality of life, Compassion Satisfaction, Compassion Fatigue • 30 item assessment	• Includes unwellness tenets (e.g., burnout, compassion fatigue, vicarious trauma) • Can be utilized with helping populations • Sound psychometric properties • https://www.proqol.org/
Helping Professional Wellness Discrepancy Scale (HPWDS) (Blount & Lambie)	• Professional and personal development, religion/spirituality, leisure activities, burnout, optimism • 22 item assessment	• Normed on a population of helping professionals • Assesses frequency of wellness behaviors • Sound psychometric properties with normed population • https://www.tandfonline.com/doi/abs/10.1080/07481756.2017.1358060

resulting in lower wellness). Cooper [65] examined the factor structure of LAQ scores and his results failed to support the LAQ subscales and instead identified a two-factor model of behavior well-being and cognitive well-being. Similarly, Palombi reported the LAQ measured a unidimensional construct and reported the internal consistency of the LAQ subscales ranged from 0.67 to 0.94 [66]. In addition, Palombi reported coefficient alpha of the total LAQ as 0.93.

The Professional Quality of Life Scale-Third Edition-Revised (PRO-QOL-III-R; 55) measures helping professionals' quality of life via a 0 (never) to 5 (very often), 30-item frequency assessment. Stamm [55] noted that the PRO-QOL-III-R is divided into three main scales (Compassion Satisfaction, Burnout, and Compassion Fatigue/Vicarious Traumatization), with alpha reliabilities of 0.87, 0.72, and 0.80 respectively. Lawson [45] used the PRO-QOL-III-R while examining wellness (and related concepts) of ACA members (N = 501). Specifically, Lawson found that helping professionals scored significantly higher on the Compassion Satisfaction scale (M = 39.84, SD = 6.43, α = 0.77), lower on the Burnout Scale (M = 18.37, SD = 6.0, α = 0.82), and lower on the Compassion Fatigue/Vicarious Traumatization scale (M = 10.05, SD = 5.91, α = 0.85) than the original normed sample [45].

Finally, the Helping Professional Wellness Discrepancy Scale (HPWDS, 9) is a five-factor model including: (a) Professional and Personal Development Activities, (b) Religion/Spirituality, (c) Leisure Activities, (d) Burnout, and (e) Helping Professional Optimism. The HPWDS includes 22 items assessing the discrepancy between perceived wellness and aspirational wellness. Helping professionals reported their levels of perceived wellness (describing the frequency at which they engaged in a behavior/feeling) and their levels of aspirational wellness (describing the frequency at which they wished they engaged in a behavior/feeling) on a 5-point verbal frequency scale, ranging from 0 – 2 times per week to 12 or more times per week. The internal consistency reliability for the HPWDS was 0.869, and all five factors resulted in Cronbach alpha values of 0.80 or above.

The reviewed wellness models and assessments provides an overview of the diverse wellness-related items in the helping profession fields. The models and assessments include topics such as: (a) overall holistic wellness, (b) assessing wellness in individuals with chronic disease(s), (c) assessing wellness in helping professionals (counselors, psychologists, social workers), (d) health-related lifestyle behaviors, and (e) burnout and related unwellness behaviors. With the diversity in available models and assessments, individuals have the freedom to select the measure that best aligns with their life situation and/or meet their clients'/patients' unique wellness needs.

Wellness Models of Supervision

Within the helping profession literature, we found few explicit wellness models of supervision. However, in the absence of formal models, Lenz and Smith [5] developed a strategy to promote wellness among helpers and created the Wellness Model of Supervision (WELMS). The WELMS was derived from the holistic model for treatment planning (Myers et al., 2000), and includes four areas: (a) Education, (b) Assessment, (c) Planning, and (d) Evaluation. Callendar and Lenz employed a single-case research design to evaluate the efficacy of the WELMS in helping-professionals-in-training (HPITs) and determined that the WELMS was successful in promoting professional quality of life across client and HPIT interactions [68].

In addition to the WELMS, Blount and Mullen [46] created the Integrative Wellness Model (IWM), focusing on the importance assessing life balance in supervision practices and wellness tenets for HPITs. The IWM includes three phases of development (low, moderate, high) across four areas: (a) Awareness of Well-being, (b) Developmental Characteristics, (c) Supervisory Descriptors, and (d) Supervision Considerations. Through the supervisory experience, the supervisor is responsible for tailoring the session to match supervisee's levels of development. Furthermore, the IWM interlaces wellness throughout the entire supervisory process and supports the use of wellness psychoeducation, assessing wellness (either formally or informally), and creating wellness plans in order to preserve or increase HPIT wellness [46, 67]. Though the IWM is supported theoretically, there are no investigations testing the tenets of the model with helpers.

In a multi-synthesis of wellness in supervision-informed approaches to supervision [1], CITs receiving wellness psychoeducation, wellness assessment, wellness-related planning (e.g., wellness plans), and wellness evaluation as a consistent part of their training/supervisory experience rated themselves approximately two-thirds of a standard deviation more well (e.g., had higher levels of overall wellness) at the end of an internship-level course than HPIT peers who received supervision as usual. In addition, upon evaluating secondary outcomes across studies, Lenz and colleagues discovered that the HPITs participating in wellness-infused supervision rated themselves as more well and self-reported understanding wellness ideas to a greater degree as compared to HPITs receiving supervision as usual [1]. Finally, Lenz et al. suggested wellness-informed approaches to supervision could serve as a protective factor against unwellness (e.g., burnout) [1].

DISCUSSION

The history of healthcare is rich with wellness undertones and holistic foundations for practice. However, the helping professions have been shifting away from traditional wellness ideologies with the emphasis on current healthcare trends [69] and the philosophical struggle of balancing both wellness tenets and a popular medical model for practice. Many individuals contributed in the advancement of wellness and we can utilize wellness models, wellness-based assessments, and wellness-infused supervision to re-focus the helping professions in a strength based, positivistic philosophy, where helping professionals can enhance both personal wellness and wellness in the lives of others. The following highlights implications for a re-integration of a wellness ideology for professional helpers, educators, and HPITs and a focus on increasing wellness awareness, rather than pushing for a "gold standard" of well-being.

Helping Professionals

Helping professionals are only as helpful as they are well. Landreth and Bratton noted the oxygen mask analogy as it relates to helpers' well-being. Flight attendants are quick to inform passengers that if traveling with a child, adults must put the mask on themselves first prior to helping the child [70]. A general rule of thumb to acknowledge this process is "You cannot give away that which you do not possess" [70], indicating within the analogy, the adult will be of no help to the child if one is passed out from the lack of oxygen. The same philosophy holds true for helping professionals. It is critical for helpers to continue to be reflective practitioners beyond graduate school, learning to reflect, assess, and process difficult situations, personal challenges, or certain presenting issues that tend to trigger intense emotions. Moreover, helping professionals have an ethical responsibility to work through these reactions when challenges arise whether personally or professionally.

Wellness scholars tends to support an idea of "gold standards" of well-being (e.g., individuals must do certain things in order to be considered well) such as exercising, eating well, and getting a certain amount of sleep [10, 49, 50, 56,

58]. However, recent research findings identify a model of discrepancies between a helping professionals' perceived wellness and their aspirational wellness as a more accurate standard. Wellness is individualized and a "one-model" fits all approach is archaic. For example, some individuals function well on six hours of sleep, whereas others thrive on eight hours. Therefore, we suggest that it is more important to look at individual discrepancies between their perceived wellness (i.e., how well people think they are) and their aspirational wellness (i.e., how well people wish they were) in order to increase their overall wellness awareness. As noted, Blount and Lambie provided an assessment tool to assist helping professionals in assessing their ideal and perceived wellness [9]. We find the HPWDS to be a viable starting tool. If helping professionals' wellness discrepancy is large, they are encouraged to seek professional support through supervision or consultation, and/or reflect on how to decrease the discrepancies by setting short-term wellness goals. Consistent assessment or the development of a reflective practitioner approach is the first step towards mitigating burnout.

Helping professionals face a myriad of client problems on a daily basis in addition to their own possible stressful personal events. Individuals vary in their threshold of tolerance [71] for receiving and holding heavy, emotional events; with some helping professionals having a wider window of tolerance than others do. 'Window of tolerance' refers to the capacity at which individuals can receive and process information utilizing their rational brain, their prefrontal cortex versus their emotional brain, the limbic region. For example, a helping professional sees three clients in a row with severe trauma, choosing to schedule these clients back-to-back with no break for reflection or decompression time. Accordingly, the helping professional may reach his or her level of tolerance for holding these traumatic events before the workday is done. When the fourth client enters the room, the helping professional has limited emotional energy to provide, and feeling drained and thus, is more likely to respond with compassion fatigue. Over time, without periodic checks for reprieve, the helping professional's feelings of fatigue grow into burnout. Thankfully, there are several ways in which helpers can expand their window of tolerance. For example, helpers can gain education related to vicarious trauma [72] to help expand tolerance, find moments within the day or week to recharge through self-care practices, or seek consultation and/or therapy when they begin to feel compassion fatigue. We suggest that helping professionals refocus their practice to include wellness and integrate such practices into their daily routine to combat compassion fatigue and/or burnout. Wellness practices may include meditation [73]; breathing exercises [74]; reflection [75]; journaling [19]; and other avenues to reflect, respond, and re-center throughout the day to remain within their own window of tolerance, reducing potential for burnout.

Helping Professional Educators

Helping professional educators (e.g., faculty, seminar providers) are tasked with training the next wave of helpers. As such, they are responsible for assessing personal levels of wellness in order to ensure they are modeling wellness-behaviors for their HPITs. The oxygen mask analogy applies here as well; educators must model wellness to teach wellness. Further, these educators are at the front lines of re-focusing the future of the helping profession towards wellness practice. For example, healthcare educators can incorporate wellness-infused supervision practices (e.g., WELMS, IWM) with HPITs in order to support student well-being, as wellness-focused supervision may increase student wellness more than traditional supervision practices [1] and model the importance of a wellness ideology in a supervision forum. We believe infusing wellness practices in the helping professional preparation program curriculum will help re-incorporate a practice what you preach analogy, where HPITs will see their educators modeling wellness into everyday practice within and outside of the classroom.

Regarding healthcare training programs and curriculums, administrators may introduce wellness courses or infuse wellness throughout the life of the program so HPITs are learning about wellness education and how to implement it across numerous situations [42]. We believe the consistent wellness infusion will promote wellness behaviors and practices beyond the training experience. Further, education programs may support HPITs' wellness awareness by tracking and assessing wellness and potential wellness discrepancies longitudinally (e.g., HPWDS, 5F-Wel) in order to support growth in wellness personal wellness realms (e.g., physical, social). Following assessment, training programs may promote wellness change by implementing individualized wellness plans for HPITs. We encourage educators to use an action-oriented wellness plan, creating opportunities for check-ins, revisions, reflections, and practices to increase in wellness practices. If wellness is a primary focus in HPITs programs, we believe it has a higher propensity to be emphasized in future helping professional personal (individual) and professional (client) lives.

Helping-Professionals-in-Training (HPITs)

As noted, HPITs, with the encouragement of faculty, should preface learning through a reflective practitioner lens, involving self-reflection on actions and beliefs in order to engage in continuous growth and learning [75]. Upon introduction to their respective training program, we emphasize that HPITs attempt to view each assignment as a learning opportunity, not a point/grade achievement. Throughout the semester (if in a traditional academic setting) or learning experience, we iterate the need for a reflective practitioner approach emphasize to students, "if you believe you have stopped learning, leave the profession immediately – you will only do harm." Students find this statement amusing; but acknowledge the weight of this statement upon entering internship and observe helping professional burnout firsthand. Additionally, HPITs that perform well both academically and in demonstration of skills, maintain this approach throughout their master's program and beyond. Successful HPITs use opportunities of assignments, supervision, and office hours to reflect on their progress, areas of growth, and points of confusion. Further, HPITs are encouraged during their clinical experiences to assess their own wellness and partake in activities to increase their wellness awareness. As noted, HPITs can formally or informally assess their current levels of functioning and learn of potential wellness discrepancies [9]. Upon learning about areas where discrepancies are present, HPITs can create/modify their wellness plans in order to work on their well-being, allowing HPITs to model wellness behaviors for their clients/patients. Our hope is that educators provide opportunities to conduct these reflections as part of class time, scaffolding students' ability to develop an internal compass of check-in during stressful, challenging times.

Future Research and Action

While we have reviewed common models and assessments relating to wellness and wellness awareness, further research is required to understand protective factors of a wellness mindset in mitigating burnout, compassion fatigue, and vicarious trauma within the helping professions. In addition, longitudinal research could provide insight into behaviors and/or activities that appear more fruitful in infusing wellness back into helpers' reflective practices, educators' courses, and HPITs training. Finally, scales for measuring wellness may be created with methodical rigor and appropriate statistical analyses (e.g., scale development procedures; Factor Analysis) in order

to support enhancing wellness in diverse populations. Current scales need additional research to support use with varying populations.

Instead of merely saying we operate from a wellness model in the helping professions, it is important to walk the talk and incorporate wellness across all realms (e.g., training, personal lives, and work with clients/patients). Actively incorporating wellness practices, increasing our own wellness awareness, and promoting wellness in our clients/patients allows helpers to live by our words and support the holistic concept that everyone has the capacity for growth; and if individuals are empowered through knowledge and increased awareness, they are able to engage in positive transformation [76].

CONCLUSION

With the influence of westernized viewpoints and a medical model symptom-reduction focus, a re-orientation to wellness could be beneficial to the helping professions. Furthermore, many helpers are faced with difficult caseloads, restrictions on the type of care they can provide, high stress environments, and increased propensity for burnout and related issues. As such, many helpers are not fully implementing wellness with their clients/patients, let alone incorporating it into their personal lives. Therefore, we provided an overview of the historical foundations of wellness in the helping professions; reviewed prominent wellness models, wellness assessments, and wellness supervision models; and discussed implications for helping professionals, educators, and HPITs to approach professional and personal areas through a wellness perspective. With the knowledge already gained on wellness in the helping professions and a re-integration of wellness perspectives, helping can once again be at the forefront of wellness-based treatment, training, and living.

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