Health to Wellness: A Review of Wellness Models and Transitioning Back to Health

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Health to Wellness: A Review of Wellness Models and Transitioning Back to Health

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Abstract: Wellness is a concept at the forefront of health promotion. It has practical and therapeutic benefits applicable across a plethora of life domains. However, to date, there is no agreed-upon definition on what constitutes wellness among researchers in the field. Existing literature has examined the phenomenon of wellness utilizing subjective self-report; however, there is a gap in the literature in terms of objective measures of wellness. Given the link between health and wellness, it is critical to examine wellness domains as they correlate with overall health. Due to the complexity of wellness and its importance in regard to individual and societal health, it is imperative to examine wellness not only from a subjective basis, but also in conjunction with objective explorations. Thus, the objective of this review is to: 1) provide a comprehensive examination of the numerous theoretical models of wellness and 2) propose new research directions in health-related research. Finally, in this review we suggest that combining subjective and objective explorations of wellness and health respectively will provide a more complete picture of the phenomenon of wellness as it relates to health and well-being.

Keywords: Wellness, Health, Wellness Models, Subjective Measures, Objective Measures

Introduction

Human instinct is to pursue a better quality of life. Quality of life represents the general well-being of both individuals and society and can manifest itself in numerous ways. For example, efforts such as: increasing physical fitness, emotional stability, spiritual growth, financial security, and social connectedness can be targeted in attempts to enhance one's quality of life. Although very complex, yet highly scientific, the process of improving all of the aforementioned aspects, as well as a variety of others, can be clumped together into a term known as wellness. As currently defined by the National Wellness Institute (2018), wellness is the active process of becoming aware of and making choices toward a more successful existence. Thus, it is the process of first identifying aspects of one's life that can be improved (e.g., physical fitness), then choosing to actively strive toward enhancing that particular deficit in one's life (e.g., regular physical activity). Wellness promotion augments health, which, in turn, can lead to the enrichment of one's quality of life. An individual's quintessential quality of life is reflective of an optimal state of health. Notwithstanding, the phenomenon of wellness signifies the relationship between quality of life and health.

Dating back to its earliest definitions, the concept of health has seen numerous characterizations relating to the body's ability to function. It was thought that to be in good health, one must be able-bodied and disease-free. However, in 1948 the World Health Organization (WHO) revisited this definition and constructed a new definition that added a novel piece to the conceptualization of health, the linkage of health to wellness. This definition is one that has been at the forefront of health and wellness promotion for years. Health, as defined by WHO is "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity" (WHO 1948, 1). This definition facilitated the conceptualization of wellness as a multi-faceted construct. As a result, Dr. Bill Hettler, co-founder of the National

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Wellness Institute, defined wellness as "an active process through which people become aware of, and make choices toward, a more successful existence" (Hettler 1984, 13). This definition of wellness is the one most utilized today and is still the official operational definition of wellness according to WHO. Nonetheless, consensus is lacking regarding a concrete definition and definitive structure of wellness (Miller and Foster 2010a, 2010b).

Foundational Wellness Models

In the wellness literature, numerous models have been proposed introducing various dimensions believed to significantly affect individual existence; however, there are three main models that have been most pivotal in terms of expanding directions of research: Dunn's (1961) High-level Wellness Model, Hettler's (1984) Holistic Wellness Model, and Witmer and Sweeney's (1992) Wheel of Wellness and Prevention Model. Wellness models have either emphasized health as a result of life events in terms of physical concepts out of individual control, active choices made by the individual, or practical applications of lifestyle choices and how they impact health based upon therapeutic interventions. Regardless of the specific research direction in the literature, these aforementioned models of wellness have provided theoretical underpinnings for wellness models over the past sixty years. Therefore, it is critical to review these pivotal models in order to grasp the history embedded in the timeline of wellness research.

Regarded as the "father" of the modern wellness movement, Halbert Dunn (1961) coined the term "high-level wellness." High-level wellness refers to disease and health on a graduated scale. This scale, also known as the "health grid," is made up of a health axis and an environmental axis. The environmental axis includes physical, biological, and socioeconomic components affecting the health of the individual, whereas the health axis ranges from death on one spectrum to peak wellness or absence of disease on the other. High-level wellness is achieved if both environmental, as well as health, are on the positive end of the continuum. Likewise, being low on the environmental and high on the health axes or vice versa constitutes average wellness. However, an individual who is low on both components yields low level wellness according to this wellness matrix. One's health status is a result of a combination of how favorable one's environment is, as well as his/her individual health status or being able-bodied and disease-free.

From an existentialist perspective, Hettler (1984, 13) defined wellness as "an active process through which people become aware of, and make choices toward, a more successful existence." His definition of wellness incorporates a holistic interdependent approach in which all aspects of wellness are seen to work together to contribute to a healthy lifestyle. Fully optimizing the six domains of wellness (i.e., physical, social, emotional, spiritual, occupational, and intellectual) is what constitutes the health status of an individual. Therefore, wellness is an "active" process of self-enrichment by appropriate decision making. This alludes to a wellness state in which individuals have the opportunity to become "more well" based upon healthy lifestyle choices. Thus, the individual is responsible for his/her own health via individual actions. Hettler's definition fostered a major shift in wellness composition toward a general examination of all factors that could potentially influence holistic health, as opposed to merely the physical aspects.

From a counseling perspective, Witmer and Sweeney (1992) introduced a model based upon a multi-disciplinarian approach that included specific character traits of individuals who were healthy and had a high quality of life. Their wheel of wellness and prevention model emphasized spirituality as its central tenet and most influential domain of a healthy individual. Furthermore, the authors highlight five interrelated life tasks that they believe encompass individual wellness (i.e., spirituality, self-direction, work and leisure, friendship, and love). This particular model focused on the unity of the mind, body, and spirit with nature and the environment.

In summary, the aforementioned models suggest that wellness can be conceptualized as a multi-dimensional construct with practical and therapeutic benefits (Horton and Snyder 2009) deriving from the unity of the body, mind, and spirit (Edlin and Golanty 1992; Hettler 1984; Priest 2007; Weaver 2002). Furthermore, wellness aids in achieving individual potential by way

of recognizing the person in his/her entirety, as well as operationalizing the individual's positive qualities and strengths to his/her advantage (Du Plessis and Botha 2012). Additionally, as stated by Myers, Sweeney, and Witmer, "wellness is 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" (Myers, Sweeney, and Witmer 2000, 252). Therefore, the concept of wellness proves to be vital to individual health given the vast connections between the self and external factors influencing quality of life and subsequent health.

Due to the critical nature of wellness, many wellness models have been established in accordance with the WHO definition of health in attempts to identify factors of life leading to both health care promotion and disease prevention. As models have expanded throughout the years, and our understanding of the interconnectedness of various facets of life has substantially improved, there has been a shift towards creating a model of wellness that encompasses more subjective rather than objective indicators of quality of life. Research has shown that these explorations can be very effective in their assessments of subjective perceptions of life (Hettler 1976; Myers and Sweeney 2004; Myers, Sweeney, and Witmer 2000). Moreover, subjective self-perceptions of various phenomena are utilized to inform research and clinical practice on health outcomes associated with these feelings. Although subjective explorations are beneficial and give a lot of important information, nothing can substitute for an actual testable observation of specific phenomena. Accordingly, there is a gap in the literature in terms of an agreed upon objective (testable) measure of wellness.

In order to address this gap, it is critical to examine wellness domains as they correlate with overall health. More specifically, due to the complexity of wellness and its importance in regard to individual and societal health, it is imperative to examine wellness not only from a subjective basis, but also in conjunction with objective explorations. By identifying the copious number of components and theoretical models of wellness, researchers can start to examine themes useful in the development of a succinct, but comprehensive, model. Over the years, existing literature has de-emphasized the contributions of objective health to the phenomenon of wellness, and has emphasized subjectively measured wellness concepts. The universal concept that the WHO avowed is that wellness is a subjective notion to be utilized in conjunction with the objective notion of health. However, no uniform objective index of wellness has been identified. By identifying an objective index of wellness, a more unified picture of the phenomenon of wellness will be generated. Furthermore, it will facilitate the development of specific interventions (e.g., behavioral and therapeutic programs) that would better address wellness deficits as a whole.

Thus, for the scope of this article, the overarching goal is to advance science by identifying a means to link wellness dimensions with objective physiological measures. Addressing these aims will advance scientific knowledge regarding a more concrete way to measure wellness. Suggestions from this article will provide insight into an effective way for researchers to combine various models into one universal multidisciplinary theoretical model of wellness. In addition, we will suggest a potentially more reliable way to measure wellness, specifically, with its inclusion of objective measures improving validity. Moreover, we aim to address gaps in the wellness literature with respect to measurement issues, detecting relationships useful for client tailored interventions, providing validation for self-report methodology frequently used in literature, and correlating both objective and subjective measures of wellness. Finally, we posit that we will be able to provide support suggesting that physiological measurements may indeed reflect objective indices of holistic wellness.

Chronological Evolution of Wellness Models

Models of wellness have evolved throughout the years due to advancements in our understanding of factors influencing health, as well as novel theories incorporating new components of wellness. Throughout this evolution, each model of wellness in some way or another, builds upon previously theorized models in hopes of proposing the model of best fit. Given the ambiguous nature of wellness, a plethora of models have been proposed attempting to encompass all life domains that entail subsequent influences on health. Therefore, the following is a brief synopsis of the major wellness models to date over the last sixty years presented in chronological order.

Dunn (1961) described wellness as the balance between one's physical health status and their external environment. Depending on how favorable one's environment is, wellness is subsequently impacted. He postulated that true vitality could only be achieved if people were "healthy" in a number of areas in their lives (e.g., physical, biological, and socioeconomic). Additionally, the capacity of an individual to be able-bodied and disease-free was thought to impact wellness. Individuals in a very favorable environment who were both able-bodied and disease-free were considered to be in a state of high-level wellness. This state of high-level wellness is considered by Dunn to be the optimal state of health.

Ardell (1977) described a wellness system in terms of medical care and health promotion. In his system of wellness, he advocated for the transitioning from primarily physical aspects of disease to a model that takes into account the inter-relationships of the whole person. He argued for a holistic model that balances relationships with the self, the environment, and the universe. Specifically, he proposed a system that concerned itself with the holistic person, not simply aspects of physical disease within the individual. His model incorporated inter-relationships among emotional, physical, social, and spiritual facets and how such aspects intertwined to affect one's medical condition in terms of disease prevention.

Although the avoidance of illness/disease was thought to be indicative of wellness, Lafferty (1979) argued that individuals must take responsibility for their health and make the proper decisions to improve health. Thus, a model was established in hopes of providing more understanding of health behaviors in an attempt to ultimately improve quality of life by identifying positive health choices. Lafferty (1979) described wellness as a dynamic construct that has an active and, essentially, never-ending existence in life. This is based upon the notion that the goal of maximal health is virtually unattainable and individuals will have to constantly strive to increase health. He proposed a model of wellness known as the "total person concept." In terms of his model, he suggests that humans are multidimensional beings who possess five major dimensions: emotional, intellectual, physical, social, and spiritual. What is important to note in this model is that he explicitly states that none of these dimensions function independently, but instead, are all interrelated and dependent upon one another as the balance amongst dimensions promotes wellness.

Hettler (1980) added to the previous model in which dimensions of wellness were defined in terms of what affects the health of an individual. He devised a model that included the dimension of occupational wellness. Occupational wellness refers to personal satisfaction and enrichment in one's life through work. It reflects one's attitude about one's work. Hettler believed this added dimension, paired with the others, fully captured the concept of wellness. Furthermore, optimization of all factors simultaneously would subsequently lead to optimal health. As the co-founder of the National Wellness Institute, he contrived six dimensions of wellness (physical, emotional, social, intellectual, spiritual, and occupational) that he believed interacted with each other to affect life quality, thus forming the "holistic wellness model." Holistic wellness refers to the condition of being in optimal health in which aspects of wellness contribute to overall wellness. Furthermore, Hettler posits that wellness is the active process of making choices toward an optimal living and successful existence. Hettler's model further solidified the

transition away from a definition of health as merely the lack of illness, but instead included various other components of everyday life.

Greenberg (1985) emphasized illness and health as separate entities in his model. It was proposed that one can be well and still possess an illness. Likewise, one can be free from illness, but not be well. This model, deriving its roots from Lafferty's (1979) model, included the same five elements, but instead of intellectual wellness, introduced a new term: mental health. Mental health refers to the encompassing of intellectual health and wellness and also the ability to learn. Therefore, Greenberg conceptualized health as a multifaceted concept, consisting of social, mental, emotional, spiritual, and physical components, that are separate from, rather than lacking, illness. Wellness is the integration of these components at any level of health or illness. Wellness and health are independent of one another in that even if one is physically sick, they can be well in other aspects (e.g., social, mental, emotional, and spiritual). Similar to Dunn (1961), Greenberg's high-level wellness refers to the balance of these components. One is said to be high in wellness if they can balance these components evenly. Low wellness refers to an unequal balance of components, such as an athlete who is high in physical wellness but may be low in emotional or social wellness.

Crose et al. (1992) established a systems model approach to wellness in which moderating variables were introduced, ultimately affecting the strength and direction of the relationship between health and wellness. These variables are culture, age, and gender. In addition, a new dimension of wellness, vocational wellness, was proposed. In this multidimensional systems model, four basic principles are emphasized: 1) health is multidimensional, 2) health is variable and not static, 3) health is self-regulating within life dimensions, and 4) health is self-regulating across life dimensions. The aspects of this model are physical, emotional, social, vocational, spiritual, and intellectual. This model was introduced as an approach to counseling in which gender was highlighted as a main moderating variable to target in terms of explaining differences in health and wellness.

Witmer and Sweeney (1992) took into account the ideas and theoretical concepts of Alfred Adler's "Individual Psychology," Carl Jung's "Analytical Psychology," and Abraham Maslow's "Humanistic Psychology," and developed a new model with the centralized theme that humans have an instinctual drive toward the pursuit of health. This "life span" wellness model emphasized the interconnectedness of all things. The major themes relate to totality in mind, body, spirit, and community. This "wheel of wellness" model aimed to demonstrate the interconnectedness of the characteristics of the healthy person, the life tasks, and the life forces. The five life tasks are friendship, love, self-regulation, spirituality, and work. These life tasks interact with life forces and global events as individuals strive for well-being. Spirituality is the central focus of the wheel, with self-regulation as its primary affecting component. Eleven characteristics are discussed as what is desirable for optimal health and functioning, and these characteristics influence the twelfth life task, self-regulation. The eleven characteristics are as follows: physical fitness and nutrition; sense of worth; sense of control; realistic beliefs; spontaneous and emotional responsiveness; intellectual stimulation, problem solving, and creativity; sense of humor; spiritual values; success in the work task; satisfying friendships and a social network; and satisfaction in marriage or other intimate relationships. Furthermore, the degree of work, friendship, and love all affect the eleven characteristics. Additionally, the authors cite that this particular model incorporates social, psychological, medical, and behavioral sciences as it outlines the aforementioned twelve dimensions of a healthy person throughout an individual's life span.

In order to establish a valid and reliable measure of perceived wellness from an individualistic approach as highlighted in Witmer and Sweeney's (1992) model, Adams and colleagues (1997) proposed a model based upon the works of several aforementioned wellness scholars. The authors tested their model as they proposed a survey designed to measure individual wellness perceptions. This perceived wellness approach is based upon the idea that

wellness is made up of "subscales" or dimensions that interconnect and comprise overall wellness.

Adams, Bezner, and Steinhardt (1997) developed the perceived wellness model. Wellness is described as the intertwining of various subsystems of wellness that are innately affective or elicit an emotional connection. Unlike previous models, this perceived wellness model was based on the notion that perceptions of wellness are connected not by the ways in which they affect one's health, but instead, by their affective nature, which subsequently influences health. The subscales included are physical, spiritual, intellectual, psychological, social, and emotional. This instrument, examining perceived wellness, or the perception of one's state of health, was distributed to young college adults and working adults alike in its initial validation.

Durlak (2000) constructed a model of wellness targeting areas of health in youth in an attempt at promoting health and preventing the formation and development of disease. His conceptualization of wellness involved three main components: social, physical, and academic or intellectual. The model aims to promote health at a young age, primarily in school age children, so that future health could benefit from earlier wellness promotion techniques. This particular model focused primarily on aspects of wellness that could be controlled and would subsequently reduce adverse effects on health in adult life if addressed in youth. Although previous models have included the component of intellectual wellness, this was the first model to include a term similar in concept but different in applicability—academic wellness. Academic wellness in this model focuses specifically on wellness in an academic setting. The ability to learn, higher order thinking skills, underachievement, and test anxiety are some tenets of this wellness component.

Similar to previous models of wellness, Renger and colleagues (2000) identify that balance amongst lifestyle factors is what improves quality of life, or wellness. In this particular model, knowledge in each of the realms of wellness is highlighted. The authors state that in order to achieve a high level of wellness, one must be knowledgeable about how to improve skills in particular areas of wellness, as well as have the desire to improve individual quality of life. Although other models mention environmental health as contributing to other wellness domains, this is the first model to include environmental health and wellness as its own component independently contributing to the wellness model.

Renger et al. based their conceptualization of wellness on a theoretical model known as the "Total Person Concept," a concept similar to Lafferty's (1979), but with an added dimension of environmental wellness. The overarching viewpoint here is that "wellness embodies a way of living that encourages individuals to seek a balance in their lifestyle designed to improve the quality of life" (Renger et al. 2000, 404). They highlight the importance of knowledge, perceptions, and skill in each individual area in order to improve wellness. It is stated that in order to achieve high-level wellness, "individuals must care for their physical selves, use their minds constructively, channel stress energies positively, express emotions effectively, become creatively involved with others, be sensitive to their daily spiritual needs, and interact effectively with their environment" (Renger et al. 2000, 404). The components of this model, therefore, are physical, intellectual, emotional, social, spiritual, and environmental health and wellness.

In an attempt to keep older adults healthy and proactive toward aging, a comprehensive model was established by Montague and colleagues (2002). This model emphasizes increasing knowledge of older individuals in helping them recognize the benefits of a healthy lifestyle. In this health promotion model, it is important to work from the inside out. This model places personal wellness as its focus and notes that each dimension of wellness interacts with personal wellness to enhance quality of life and individual health. Montague et al. (2002) developed a wellness model called the "whole-person" wellness model. In this model, personal or individual wellness at the center of the model has a bi-directional interaction with each of the wellness dimensions. Similar to Crose et al. (1992), the six dimensions of wellness in this model are physical, spiritual, vocational, emotional, social, and intellectual. All of these dimensions interact with personal wellness concepts and each of the other wellness dimensions. Personal wellness

concepts are defined as self-responsibility for dimensions of health, optimism, self-direction, personal choice, and self-efficacy. In this model, it is important to acknowledge that individuals are complex and multidimensional beings. Furthermore, this model recognizes that a collaborative effort must be present among the older adult, his/her family members, the community, and healthcare providers in order to promote health and quality of life.

Expanding upon the earlier Witmer and Sweeney (1992) model, Myers and Sweeney (2004) created "The Indivisible Self" model with the central tenet that wellness is more psychological in nature than physical. The authors state that wellness is a way of life oriented toward optimal health and well-being in the body. They focus on integration of the mind, body, and spirit in terms of wellness promotion. Furthermore, the authors state that by identifying characteristics of healthy individuals, counselors will be able to assist people in developing and maintaining healthy lifestyles and lifestyle choices that promote increased quality of life, and ultimately enhanced well-being. Thus, this model was developed with the intention of providing an assessment tool in psychological counseling effective in identifying targets areas for improvement in health and wellness. This model highlights seventeen dimensions of wellness (e.g., stress management, exercise, nutrition, and emotions) that holistically comprise "the Indivisible Self." The dimensions are comprised of those that enable healthy persons to interact with their environment effectively. These dimensions are further grouped into five second-order factors: essential self, creative self, coping self, social self, and physical self. This model has implications for mental health and counseling research in that it emphasizes lifestyle decisions as direct influential factors of health and wellness.

Similar to the Witmer and Sweeney's (1992) wheel of wellness, Travis and Ryan (2004) also divided wellness into a multidimensional wheel in which each section had an impact on the other. Their wheel consisted of twelve categories that they defined as ongoing processes occurring in everyday life. The authors also highlighted the importance of not only the absence of negative elements of health but, additionally, the presence of positive elements contributing to a healthy lifestyle. The proposed model emphasizes the psychological contribution to wellness in that Travis and Ryan (2004) state that subjective growth in areas of wellness accounts for better overall wellness. Moreover, these scholars developed a "Wellness Workbook" that outlined various categories of wellness. The categories are divided into a twelve-section wellness wheel consisting of transcending, finding meaning, sex, communicating, playing/working, thinking, feeling, moving, eating, sensing, breathing, self-responsibility, and love. Each of the sections implies that wellness is an ongoing process that has implications on other variables (thus its holistic nature). Wellness is seen as more than just the absence of the negative elements (illness and disease), but also the presence of positive elements (physical health and happiness). Thus, it is the process of integrating awareness, education, and growth of the subjective components that accounts for wellness. Dimensions of this model include physical, emotional, social, intellectual, spiritual, occupational, and environmental.

Anspaugh, Hamrick, and Rosato (2006) developed their model as an integration of two of the prominent models of the time (i.e., the Wheel of Wellness and the Wellness Workbook). They described wellness as a holistic approach, considering all aspects of influence on the body and not just health. They state that wellness is not just the lack of negative symptoms, but the presence of positive elements as well. It is the proactive and balanced approach of the mind, body, and spirit in terms of health and fitness. The concepts discussed in this model—physical, emotional, social, intellectual, spiritual, occupational, and environmental—are referred to as areas of human needs. The authors emphasize the importance of self-responsibility for continual growth in these dimensions of human needs. Thus, this model was established in terms of providing students with the knowledge and understanding necessary to take life into their own hands and make subsequent behavioral changes to improve health and wellness.

Consistent with the emerging theme of the time, Hales (2006) incorporates a definition of wellness identifying the importance of both the positive and negative elements of wellness.

Similar to Renger et al. (2000), this model states that the active process of seeking better health and maximizing wellness components leads to a high-level state of wellness.

Hales (2006) devised a holistic wellness model with an emphasis on wellness being perceived as the collective sum of the "absence of the negative elements (illness and disease) and also the presence of positive elements (physical health and happiness)" (Miller and Foster 2010, 6). Moreover, Hales states that one must actively work at improving wellness given that wellness is not a static state. High-level wellness can be achieved if one takes care of his/her physical self, constructively utilizes his/her mind, uses creativity to be involved with others, expresses emotions effectively, and is concerned about his/her psychological, physical, and spiritual environments. The components of this wellness model are physical, emotional, social, intellectual, spiritual, occupational, and environmental.

Botha and Brand (2009) developed a model for managers in higher education institutions in an attempt to expand upon prior holistic wellness models and further their utilization to that of individuals in higher education. The authors note that by identifying the health risks of managers in tertiary institutions and calculating health risks via wellness behaviors, wellness interventions could be proposed that would improve wellness behaviors and reduce health risks. Although similar to previous models of wellness, this particular model was targeted and tested on a specific population in higher education—managers. This model included dimensions of physical, social, emotional, intellectual, occupational, and spiritual wellness. This model was designed to serve as a theoretical foundation for the assessment of health levels and wellness behaviors by identifying unhealthy lifestyle behaviors.

Roscoe (2009) conducted a literature review synthesizing existing wellness models. In an attempt to develop a model useful in counseling and development, Roscoe utilized many of the preexisting wellness models to construct her model (e.g., Adams et al. 1997; Crose et al. 1992; Durlak 2000; Greenberg 1985; Hettler 1980; Lafferty 1979; Leafgren 1990; Myers, Sweeney, and Witmer 2000; Renger et al. 2000; Witmer and Sweeney 1992). This model consisted of seven dimensions social, emotional, physical, intellectual, spiritual, occupational, and environmental. Roscoe theorizes that her model is a synergistic and multidimensional construct that is represented on a continuum, not as an end state. Similar to that of Witmer and Sweeney (1992) and Myers and Sweeney (2004), this model has implications for counseling and development.

In an effort at creating a new assessment to measure holistic wellness in young adults, Brown and Applegate (2012) established the "Holistic Wellness Assessment." This assessment was proposed as a way of incorporating traditional wellness dimensions with a new wellness dimension of financial wellness. This measure explored aspects of other wellness instruments to date in order to gain an accurate reflection of the dimensions of wellness pertinent to today's young adults. Brown and Applegate (2012) created their holistic wellness model to be applicable to a college student sample. This model incorporates financial wellness, which is an important gap in the literature, according to the authors. The Holistic Wellness Assessment is a way in which college students can self-assess their own individual health status based upon the evaluation of identified wellness dimensions pertinent to this specific population. The eight dimensions of this wellness model are self-regard, self-awareness and responsibility, sustainability, relational, risk prevention, spirituality, physical health, and healthcare maintenance. The dimension of financial wellness is integrated within the self-regard, self-awareness and responsibility, and sustainability dimensions.

Summary

Although a plethora of wellness models has been constructed, one pivotal notion remains constant—wellness is a holistic concept comprised of various interrelated components of everyday life that are utilized to predict overall health. Wellness has several features, including: being holistic, consisting of multidimensional constructs, focusing on lifestyle behaviors, being about actions or processes, and recognizing the inter-relatedness between person and environment (Rachele et al. 2013). Although there is still some ambiguity on the exact dimensional structure of wellness, it is the summation and balance of multiple dimensions that researchers have consistently agreed upon in terms of what encompasses and, ultimately, defines wellness.

Dimensions have been presented stemming from a variety of backgrounds, such as: health care, counseling, occupational health, etc. As such, there are inconsistencies in what comprises the dimensions of wellness and the number of wellness dimensions in general. For example, some researchers have proposed intellectual wellness (Botha and Brand 2009; Crose et al. 1992; Hales 2006; Hettler 1980; Lafferty 1979; Roscoe 2009), others propose mental wellness (Brown and Applegate 2012; Greenberg 1985), while still others propose psychological wellness (Adams, Bezner, and Steinhardt 1997; Adams et al. 2000; Miller and Foster 2010a, 2010b; Myers and Sweeney 2004; Witmer and Sweeney 1992). When investigating the conceptualizations of each of these dimensions, we see that all involve stimulating activity of the mind in order to promote better overall health. However, although similar in nature, these dimensions have been defined differently and are oftentimes confusing to differentiate by mere definition alone. There are conflicting theories as to which dimension represents what and, more importantly, to an actual definition of the construct of wellness. Therefore, in an attempt to synthesize the definitions of dimensions of wellness included in the aforementioned theoretical wellness models, and to highlight identifiable characteristics associated with each dimension, we have provided a summary useful for making distinctions regarding such wellness dimensions (see Appendix). In this table we have included dimensions from previously mentioned models as well as other research in the field offering definitions on the various components (i.e., Agneessens, Waege, and Lievens 2006; Archer, Probert, and Gage 1987; Brown and Alcoe 2010; Cavallini, Wendt, and Rice 2007; Cook 2011; Foster and Keller 2007; Gallagher, Muldoon, and Pettigrew 2015; Helliwell 2006; Herr and Cramer 1988; Koenig 2004; Leafgren 1990; Leafgren and Elsenrath 1986; Myers, Sweeney, and Witmer 2005; Myers and Sweeney 2008; National Wellness Institute 2018; Reese and Myers 2012; Ryff and Singer 2006; Sidman, D'Abundo, and Hritz 2009).

Extant research has explored wellness dimensions both individually and collectively as a subjective way to assess health and wellness. Although there are benefits to subjective measures, such as being non-invasive, cost-effective, and quick, human error still poses a great risk in terms of validity and generalizability (Northrup 1997). For example, what one individual may perceive to be emotionally draining, another may not. Something psychologically taxing on one may pose no such discomfort for another. As such, a more concrete methodology for exploring the effects that dimensions of wellness have on health is warranted to address these issues with both generalizability and validity with respect to self-report. Moreover, individual differences in perception cause individuals to respond with ample variability. Accordingly, there is a gap in the literature in terms of a steadfast, generalizable way to link health and wellness.

A Novel Research Direction for Models of Health and Wellness

As a result of the plethora of models and accompanying dimensions that have been theorized throughout the years, the need for a model of wellness with more general applicability is warranted. The ambiguity and expansive nature of the numerous models is oftentimes dependent

on the area of research. As such, wellness models should be constructed in such a way that will allow generalizability across all domains of research. It is important to develop a unified definition of wellness and its constituent factors so that communities, and ultimately society, can support the growing field of holistic wellness that is fundamental in the promotion of health (Dolan, Peasgood, and White 2008).

Numerous attempts to define the concept of wellness have resulted in a failure to produce a uniform operational definition of wellness. Furthermore, we postulate that this synthesis of wellness domains will provide an effective way for researchers to combine various models into one theoretical model useful across various disciplines and areas of wellness research. In order for this synthesis to occur, common characteristics in which these dimensions can be combined must amount based upon their conceptual underpinnings. The aforementioned review supports the notion that there are often inconsistencies seen within conceptualizations of wellness and the proposed wellness indicators. For example, emotional wellness and psychological wellness are often seen as the same wellness dimension (Hamilton and Redmond 2010; Miller and Foster 2010b; Roscoe 2009). Emotional wellness has been defined as the affective response to a stimulus and the ability to control resulting behaviors. Similarly, psychological wellness has been defined as the ability to cope with stressors in a positive and adaptive manner, as well as the feelings and behaviors reflective of a stable mental and emotional state. Thus, theoretically one could combine Emotional and Psychological wellness into one construct given the consistencies in the conceptualizations across the domains. Another example is with the dimensions of Occupational and Vocational wellness. These wellness domains are similar in the fact that they both adhere to a definitive structure involving an individual and the extent to which they feel the workplace is meaningful and enriching to his/her life as well as the feeling that they provide skills beneficial to improving the workplace environment. In summary, a synthesis of domains may be an effective means of combining various dimensions into similar constructs allowing for more generalizability. Moreover, it may extricate the copious amount of wellness dimensions and promote the use of common agreed upon components of wellness useful for health promotion.

Connecting the ANS to Wellness

Given the fact that the previous theoretical models of wellness have been based solely on self-report data, there is a need in the literature in terms of objective measures of wellness. Researchers have used objective ways to measure wellness by correlating physiological, psychological, behavioral, and biomolecular responses to integrative medicine treatment (Knowles et al. 2016) and by correlating objective measures of physical health (e.g. cholesterol, pulse rate, blood pressure, body composition) to perceived wellness measures (DeStefano and Richardson 1992). Studies have also explored ANS function in relation to a host of other aspects related to wellness domains and their resulting effects on health and quality of life such as: sleep (Tobaldini et al. 2017), emotion (Kreibig 2010; Slonim 2014) cognition (Öhman, Hamm, and Hugdahl 2000; Quintana et al. 2012), social stress (Oliver, Datta, and Baldwin 2017; Porges 2001) and religion (Newberg and d'Aquili 2000). Although a plethora of extant research explores the connection between subjective factors contributing to wellness and ANS activity, no objectively measured index of wellness has yet to be established. Moreover, we argue that the current wellness literature has de-emphasized the contributions of health-related factors on the phenomenon of holistic wellness. Although the concept of wellness is subjective in nature (Miller and Foster 2010a), the WHO linked this subjective concept to the phenomenon of health, which is objectively measured. Thus, objective measures of health and wellness, as highlighted in the aforementioned studies, would prove very beneficial in terms of wellness promotion and tailored interventions.

As research has extensively shown, subjective measures are sufficient to identify a problem and objective measures provide pertinent information about the problem; however, the combination of both subjective and objective measures (e.g., smiley face sign in doctor's office

and vital sign check-up) proves optimal to the obtainment of a complete picture of a health-related phenomenon. In addition, by identifying an objective index of wellness, the result could theoretically reduce measurement error in assessing wellness domains, provide support and validity for subjective responses, provide a gold standard for objective wellness assessment, and enhance science by uncovering a new research direction for wellness research. Given the nature of the ANS and its relationship with health, we posit that this system can be utilized as a potential objective lens for a closer examination of the phenomenon of wellness. As one of the most important systems in the body in terms of stress and responses to stress, which ultimately impacts health, providing correlations with self-report data to measures of the ANS would be very beneficial in terms of health and, ultimately, health promotion. Finally, in developing this understanding of the effects that alterations in dimensions of wellness play on health, therapeutic interventions across various settings (e.g., work, school, home) can ensue, specifically targeting aspects of wellness in adolescents, college students, working professionals, and elderly adults alike, that can improve individual and societal health and better quality of life.

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Appendix: Definitions of Wellness Dimensions

Physical Wellness
Physical wellness is the normal functioning of biological and physiological processes in the body affecting normal development and functioning. It is the active and continual effort at both maintaining and improving the four primary physical fitness indicators in oneself. It is the knowledge about proper exercise habits and diet and nutrition in order to make healthy lifestyle choices by encouraging good exercise habits and healthy eating behaviors, and discouraging bad ones. Finally, it is having high physical resilience, thus having the positive perception and expectation of good physical health.

Social Wellness
Social wellness encompasses the quality and extent of interactions with others and the interdependence between the individual, others, the community, and nature (Roscoe, 2009). It is the ability to develop and maintain meaningful relationships, to contribute to the community in an effective and productive way, and to balance the various life interactions between the individual, society, environment, nature, and work. Finally, social wellness is actively seeking ways along the course of life to balance and integrate the interactions between oneself and the natural environment in order to enhance relationships and foster the establishment of a better living atmosphere and community suitable for all.

Emotional Wellness
Emotional wellness is the ability to both recognize and manage emotions and subsequent behaviors in a positive and healthy manner, while maintaining an optimistic approach to life and to be emotionally aware of and accept the various feelings about oneself, others, and life.

Intellectual Wellness
Intellectual wellness is the active and continual process of pursuing and retaining knowledge via stimulating intellectual activity. It involves problem solving, creativity, learning new skills and information, and a commitment to both sharing with and learning knowledge from others. One who is intellectually well will utilize such information to identify problems and/or critical issues, make sound judgments, propose potential solutions, and act in a way that promotes personal growth and the betterment of society.

Spiritual Wellness
Spiritual wellness is the continual process of seeking and finding a positive sense of meaning and purpose in life, while appreciating the intricacies of life itself. It is understanding that the world and universe are both very complex and that everything was created for a reason and has a specific purpose in life. It is developing a personal belief system and a system of faith in something that is beyond oneself (i.e. higher power) and living by those systems to govern everyday actions.

Occupational/Vocational Wellness
Occupational or vocational wellness is dependent on one's feelings about work and whether or not one feels work is meaningful and enriching and is a safe and positive environment contributing to personal growth. It is also related to the ability to balance occupational and other responsibilities, express personal values openly, have financial stability, and provide skills beneficial for enhancing the workplace atmosphere.

Environmental Wellness
Environmental wellness is actively striving toward improving one's local community and natural and physical environment via an individual's relationship with one's home, work, community, and nature. It is taking a responsibility in creating and maintaining sustainable living communities that can positively impact the global environment and reduce negative environmental hazards.

Psychological/Mental
Psychological wellness is wellness of the mind and it includes feelings and behaviors that are reflective of a stable mental and emotional state. It includes having an element of control over one's life and the ability to cope with the demands and stressors of life in a positive and constructive manner.

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